Core 1 - Health Priorities in Australia

CQ1: How are Priority Issues for Australia’s Health Identified?

Measuring Health Status

- measuring health status
  - role of epidemiology
  - measures of epidemiology (mortality, infant mortality, morbidity, life expectancy)

- critique the use of epidemiology to describe health status by considering questions such as:
  - what can epidemiology tell us?
  - who uses these measures?
  - do they measure everything about health status?

- use tables and graphs from health reports to analyse current trends in life expectancy and major causes of morbidity and mortality for the general population and comparing males and females

Many health concerns that governments identify as health priority issues to be addressed in order to achieve better health.

Health priority - health issues that are of greatest concern to governments and support organisations due to the effect they have on the overall health of Australians and the burden of health on the economy

Role of Epidemiology

Definition;

- Epidemiology is the study of disease in groups or populations through the collection of data and information, to identify patterns and causes
- To identify the health status of that population and its subgroups
  - Health status is the pattern of health of the population in general over a period of time
- It is also the;
  - Study of causes and distribution of sickness and death of a population
  - Disease amongst particular populations or groups within society e.g. children, ATSI peoples, young people etc.

Role;

- Used by governments and health related organisations to
  - Obtain a picture of the health status of the population
    - Describe patterns in communities
    - Describe and compare patterns of health
  - Identify patterns of health and disease
    - Prevalence – number of cases of disease in population at a specific time
    - Incidence – the number of new cases of disease occurring in a population
    - Distribution (extent)
    - Apparent causes (determinants and indicators)
    - Identify and promote behaviours that can improve health status of overall population (e.g. eat less fat and more fibre)
  - Analyse how health services and facilities are being used
    - Identify health needs and allocate health-care resources

Used By;

- Government
  - Allocating funds
- Department of Education
  - Teaches students about health, targets prevention, implements policies e.g. no hat no play
- Hospitals
Prioritise health problems, provide specific health information to patients

- Focus on quantifiable and direct measures of ill health;
  - Patterns of ill health, injury and death
  - Statistics on; births, deaths, disease incidence, disease prevalence, contact with health care providers, contact, hospital use, injury incidence, work days lost, money spent on health care

**Limitations:**

- Do not always show the variations in subgroups
  - E.g. Between ATSI and non-ATSI peoples
- Don’t always accurately indicate quality of life
  - In terms of disability, impairment, disability, or handicap
  - Impairment – is the loss of abnormality of body structure or physiological or psychological function
- Cannot provide the whole health picture
  - In some areas, like Mental health, data are non-exist
- Fail to explain “why” health inequities persist
- Do not account for health determinant
  - E.g. social, economic, environmental and cultural factors
- Stats also have;
  - Variable reliability
  - Numerous sources
  - Imprecise collection methods
- For example; National Bearau of Statistic collect data through surveying one adult and one child to picture health status on Australia = unreliable
  - Need a RANGE of primary data

**Broadening the Framework:**

- Provides valuable scientific info on disease and risk factors
- Focusing on health of population (not individuals)
- Basis for investigating issues and health inequities
  - Impact of low SES and social factors
- Must incorporate social perspective and factors to identify and combat leading causes/reduce inequalities
  - Poor aces to health services, low SES, health attitudes, and limited health education
- For example; higher rates of morbidity and mortality in rural/remote populations directly related to social and environmental contexts

**Measures of Epidemiology**

**Mortality**

- Refers to the number of deaths in a given population from a particular cause and/or over a period of time
- E.g. 2010: Standard death rate for Australia was 6 deaths per 1000 standard of population
- CVD caused 30% of all death in 2013
- Main causes of death in Australia are;
  - Cardiovascular disease, cancers and respirator diseases.
  - Leading causes of death are heart disease, stroke and cancers

**Infant Mortality**

- Refers to the number of infant deaths in the first year of life, per 1000 live births. Under 1 years old who die of any cause
- Considered most important indicator of health status of a nation and predict adult life expectancy
- Divided into
  - Neonatal (deaths in first 28 days of life)
  - Post-neonatal (deaths in the remained of the first year)
- E.g. The rate was 3.8 infant deaths per 1000 live births in 2011 and 4.31 per 1000 in 2016
- E.g. Despite decline it still accounts for 70% of all deaths for children aged 0-14
- The decline in infant mortality rates is because of;
  - Improved medical diagnosis and treatment of illness
  - Improved sanitation
  - Health education
  - Improved support services for parents and newborn babies
**Morbidity**
- Is the incidence or level of illness, disease or injury in a given population
- Quality of life decrease by illness, disease and injury
- Info on incidence and prevalence provides broader perspective than morality rates
- Measures and indicators
  - Hospital Use
    - Cause and number of admissions
    - Measure of rates of illness – acute rather than chronic
    - Pattern of serious diseases
  - Doctor visits and Medicare statistics
    - Services claimed on Medicare
    - For example; the stats and count on pregnancy and childbirth
  - Health survey’s and reports
    - Provide key health indicators
    - Bring together range of health info
    - Depends on self-reporting
  - Disability and handicap
    - Incidence of disease or accident leading to this
    - Can be in terms of self-car, mobility, verbal communication, SES status

**Life Expectancy**
- Is the length of time a person can expect to live. Average number of years of life, based on current death rates
- At birth is a common indicator of health status and is often used as evidence about improved health of Australians
- Australia has 5\textsuperscript{th} highest life expectancy in the world
  - E.g. Aussie males life 80.3 years and female is 84.4 years in 2014
- Life expectancy increases and thus there’s is an increase of our aging population
  - Number increase
  - Increased need for nursing homes
  - Need to provide care for growing number of dependant people
- Improved life expectancy since the 1970’s with improved medical knowledge and management can be attributed to;
  - Lower infant mortality
  - Declining overall death rates from cancer
  - Fall in deaths from traffic accidents

<table>
<thead>
<tr>
<th>Trend</th>
<th>Reason</th>
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</table>
| **Mortality** | Decreasing
|             | - Improvements in road safety measures                                  |
|             | - Facts in smoking rates                                                |
|             | - Improvements in preventative, detection and treatment of disease      |
| **Morbidity** | Increasing
|             | - Illness/disease with biggest “burden” being largely treated           |
|             | - Increase for certain risk factors such as obesity and high bloody pressure |
|             | - Lifestyle diseases                                                    |
| **Life Expectancy** | Increasing
|             | - Control of infectious diseases                                         |
|             | - Improved hygiene and sanitation                                       |
|             | - Advances in medical care                                               |
|             | - Better working condition                                               |
|             | - Nutrition and health education                                         |
|             | - Reduction in smoking                                                  |
| **Infant Morality** | Decreasing
|             | - Changes in behaviours                                                 |
|             | - Exposures                                                             |
|             | - Health intervention                                                   |
|             | - Technological advanced                                                |
Identifying Priority Health Issues

- identifying priority health issues
  - social justice principles
  - priority population groups
  - prevalence of condition
  - potential for prevention and early intervention
  - costs to the individual and community
- argue the case for why decisions are made about health priorities by considering questions such as:
  - how do we identify priority issues for Australia’s health?
  - what role do the principles of social justice play?
  - why is it important to prioritise?

Gov. and health authorities prioritise particular health issues to improve Australia’s health based on;
⇒ How much they contribute to the burden of illness on the community
⇒ Their potential to reduce this burden

Social Justice Principles

- Is a value that favour the reduction or elimination of inequity, the promotion of inclusiveness of diversity and the establishment of environments that supportive of all people
- Selected priorities must reflect these principles
- Inequities; differences in incidence and prevalence of death, and social, economic, political and cultural factors that influence health
- For example;
  ⇒ High incidence of diabetes in ATSI peoples
    ● Provision of equal access to resources, health services, education and information may reduce incidence of diabetes in ATSI peoples

<table>
<thead>
<tr>
<th>Social Justice Principle</th>
<th>Definition/Aim</th>
<th>Example – Close the Gap</th>
</tr>
</thead>
</table>
| Equity                   | ● Resources are allocated in accordance with the needs of individuals and populations with the desired goal of equality of outcomes  
                            ● Particular groups within Australia receiving more funding and being identified as priority groups in Australia because they have poorer health outcomes than other Australians. | ● ATSI are an example of a people group who require additional funding and resources in order to improve health outcomes.  
                                                                         ● Medicare for everyone  
                                                                         ● GPs who bulk bill  
                                                                         ● Royal Flying Doctor Service for rural areas  
                                                                         **OXFAM**  
                                                                         ● Combat the issue of poor housing, education by partnering with communities  
                                                                         ● Government has identified them as a priority group |
| Diversity                | ● Refers to the differences that exist between individuals and people groups.  
                            ● Ensure each group of people group within our diversity has access to health care and achieves good health outcomes. | ● Providing brochures in multiple languages and having interpreters in hospitals are examples of being inclusive of diversity  
                                                                         ● Translating services  
                                                                         ● Brochures in different languages,  
                                                                         ● ATSI doctors  
                                                                         **OXFAM**  
                                                                         ● Brochures in ATSI language – language barriers |
Supportive Environments

- Are environments where “people live, work and play that protect people from threats to health and that increase their ability to make health-promoting choices.”

- Rural and remote people are an example of people whose environment is not as supportive as other environments.
- Healthy schools canteens
- Restrictions on fast food adverts between 5-8pm for kids

OXFAM
- Oxfam implements and monitors a comprehensive National Action Plan that aims to improve these rates.

Priority population groups

- Subgroups with significantly different health statuses reflect inequities reflect diversity in population
- Identifying subgroups with inequitable health allows health authorities to;
  - Determine health disadvantaged groups
  - Better understanding social determinants of health
  - Identify prevalence of disease/injury in specific groups
  - Determine needs of group relation to social justice
    - Create equity
  - Allocate funding to reduce prevalence

<table>
<thead>
<tr>
<th>Priority Group</th>
<th>Health Inequities</th>
<th>Ways to Address this Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSPI people</td>
<td>Low SES backgrounds</td>
<td>Provide greater access to health services</td>
</tr>
<tr>
<td></td>
<td>Higher death rates from heart disease</td>
<td>Educate ATSI people who can provide knowledge to community</td>
</tr>
<tr>
<td></td>
<td>Higher incidences of disease risk factors (high blood pressure, cholesterol, smoking, lower use of preventive)</td>
<td>Doctors that speak their language</td>
</tr>
<tr>
<td></td>
<td>Lower life expectancy</td>
<td>Brochures with simple info for those who lack education</td>
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<tr>
<td></td>
<td>Highest smoking and alcohol consumption rates</td>
<td>Support services for teenage mothers</td>
</tr>
<tr>
<td></td>
<td>Less likely to exercise and eat fruit</td>
<td>Baby health care to reduce high infant mortality rates</td>
</tr>
<tr>
<td>Rural and isolated locations</td>
<td>Higher rates of illness e.g. CVD, cancers</td>
<td>Greater access to fresh foods (especially fruit and veg)</td>
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<tr>
<td></td>
<td>Lower life expectancy</td>
<td>Greater access to medical services</td>
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<tr>
<td></td>
<td>Less likely to visit GP or medical services</td>
<td>Improved education</td>
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<td></td>
<td>Less likely to engage in physical activity</td>
<td>Knowledge</td>
</tr>
</tbody>
</table>

Prevalence of Conditions

- Epi. Data provides information on indigence of mortality and morbidity, prevalence of disease and illness to identify risk factors
- Indicates the potential for change and health status of population (to a degree) which helps determine priority areas
- High prevalence rates
  - Indicate health and economic burden disease places on community
- E.g. CV disease is the leading cause of preventable death in Australia
  - the decrease in deaths from CVD can be attributed to effective health promotion strategies
- Conversely, increasing rates of type 2 diabetes indicate a need for a particular focus on the related determinants and risk factors

Potential for prevention and early intervention

- Poor lifestyle behaviours lead to majority of illnesses/diseases
  - This is difficult to change individual behaviours because they are a reflection of environmental situations (in which person lives)
- Things that determine health inequities (determinants across population)
To reduce burden of disease/make changes □ address both INDIVIDUAL behaviours and ENVIRONMENTAL determinants

Early prevention and early intervention → improved health status

E.G

Breast screening
- Free breast screening every 2 years for women aged 50-74 because 50% women diagnosed with breast cancer are 50-69.
- Aim to reduce the number of deaths
- In this age group breast cancer decreased by 37% since 1991 (when Breast Screen Aus. program introduced)
- From 68 deaths to 43 per 100,000 women
- Uses transportable vans
- Thus Early detection □ early intervention □ increase chance of survival

Lung cancer prevention strategies – no smoking zones

Vaccinations

Study of family history

Wearing sunscreen and protective clothing outdoors

Costs to the individual and community

Disease illness place economic and health burden measured in terms of;

- Financial loss
- Loss of productivity
- Diminished quality of life
- Emotional Stress

For example; 24 year old plumber who had a car accident resulting in spinal cord injury (paraplegic)

Individual costs;
- Loss of income, rehab costs (ongoing treatment with specialists if don’t have private health), physical pain, psychological costs (therapy, 5% increased chance of suicide), social costs (feel isolated, strain on relationship), life expectancy lowered

Community Costs;
- $2 billion (2% of total health expenditure) for spinal cord injuries in 2008, ambulance/health service to accommodate this treatment
- 2004-2005 most expensive was CVD at $5.9 Billion and 11% of total allocated health expenditure
- Health care amongst aged people are high □ 21% of total allocated health expenditure

<table>
<thead>
<tr>
<th>Indirect Costs</th>
<th>Direct Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td></td>
</tr>
<tr>
<td>Emotional – depression, worthlessness, trauma</td>
<td>Foregone earnings when too ill to work</td>
</tr>
<tr>
<td>Social – damaged relationships, social isolation</td>
<td>Cost of medication</td>
</tr>
<tr>
<td>Persistent pain and loss of quality of life</td>
<td>Rehab</td>
</tr>
<tr>
<td>Increased pressure on families to offer support</td>
<td>Hospital fees</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>Money spent on diagnosing, treating, caring for sick</td>
</tr>
<tr>
<td>Value of output lost when people become ill or die prematurely e.g.</td>
<td>Expenses of</td>
</tr>
<tr>
<td>Cost of forgone earnings</td>
<td>Medical services</td>
</tr>
<tr>
<td>Absenteeism</td>
<td>Hospital admissions</td>
</tr>
<tr>
<td>Retraining of replacement workers</td>
<td>Pharmaceutical prescripts</td>
</tr>
<tr>
<td>Increased use of Medicare □ higher taxes</td>
<td>Preventative initiatives</td>
</tr>
<tr>
<td>Decreased productivity</td>
<td></td>
</tr>
</tbody>
</table>
Example: Samuel is a 30 years father of 3 who has worked his life as a carpenter. Recently got melanoma skin cancer. Has surgery to remove the cancer and is now undergoing chemotherapy to stop growth and reproduction of melanoma. Effect during Treatment is as follows:

<table>
<thead>
<tr>
<th>Samuel</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Cost</strong></td>
<td></td>
</tr>
<tr>
<td>• Fatigue, nause, bowl problems, mouth ulcers and infections because of chemotherapy.</td>
<td>• Might have a contract as a carpenter meaning he is unable to complete this contract</td>
</tr>
<tr>
<td>• Fatigue restrict his movement so he might not be able to do daily chores well, cannot do his carpeting</td>
<td>• Colleagues have to work extra work for them</td>
</tr>
<tr>
<td>• Pain, loss of fitness, hair loss, decreases levels of overall health, disability</td>
<td>• Retraining another worker due to his absenteeism</td>
</tr>
<tr>
<td><strong>Social Cost</strong></td>
<td></td>
</tr>
<tr>
<td>• Immune system is down so he has to be extra careful not to catch an infection and thus cannot see friends and family who have slight illness</td>
<td>• Friends might feel shut out</td>
</tr>
<tr>
<td>• Hair falls out leading to being insecure self conscious leading him to detract from social activities</td>
<td>• Maybe is a community worker, or a volunteer, he is self-conscious and thus is unable to serve the community</td>
</tr>
<tr>
<td>• Isolation from people in chemo</td>
<td>• Loss of an active member of the community</td>
</tr>
<tr>
<td>• May want to disassociate with people due to judgement</td>
<td>• Burden on family</td>
</tr>
<tr>
<td>• Strain on relationships</td>
<td></td>
</tr>
<tr>
<td><strong>Emotional/Mental Cost</strong></td>
<td></td>
</tr>
<tr>
<td>• Uncertain about his health, strain on his mental state</td>
<td>• Might feel helpless as they cannot help</td>
</tr>
<tr>
<td>• Prospect of not seeing his kids grow up making him feel sad and desperate</td>
<td>• Stress on family</td>
</tr>
<tr>
<td>• Financial strain may give him anxiety and stress</td>
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<tr>
<td>• Loss of self-worth due to unemployment as he is a weaker</td>
<td></td>
</tr>
<tr>
<td>• Might need to see a specialist</td>
<td></td>
</tr>
<tr>
<td>• Depression, trauma, sadness and sense of hopelessness</td>
<td></td>
</tr>
<tr>
<td><strong>Financial Cost</strong></td>
<td></td>
</tr>
<tr>
<td>• Due to chemo cannot work, depending on his employment financial stress</td>
<td>• Sam and his family and friends rely on community resources (support groups, welfare) that the community is funding</td>
</tr>
<tr>
<td>• Loss of fitness cannot work no income</td>
<td></td>
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<tr>
<td>• Medical Bills private health insurance means more money</td>
<td></td>
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<tr>
<td>• Certain specialist treatment needs money</td>
<td></td>
</tr>
<tr>
<td>• Supporting his family and partner more stress leading them to rely on welfare payments</td>
<td></td>
</tr>
</tbody>
</table>

Argue The Case for why decisions are made about Health priorities considering questions such as;

<table>
<thead>
<tr>
<th>How do we Identify Priority Issues for Australia’s Health</th>
<th>What Role do the Principals of Social Justice play?</th>
<th>Why is it important to prioritise</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Priority issues are identified through epidemiological studies e.g. ABS by collecting data from a wide consensus</td>
<td>• Social justice principles encourage the culmination of Australia’s health status as a whole, rather than having significant differences in certain population groups.</td>
<td>• Prioritising encourages the formation of an equilibrium in the health status of Australia as a whole, rather than varying status’ for population groups.</td>
</tr>
<tr>
<td>• These highlight the prevalence of a condition and priority population group</td>
<td>• Allows for the equitable allocation of resources and funding to minimise gaps in health status amongst priority groups</td>
<td>• Epidemiological studies highlight the priority areas in regards to mortality and morbidity</td>
</tr>
<tr>
<td>• Also highlights morbidity, mortality, infant mortality and life expectancy</td>
<td></td>
<td>• thus providing early prevention and health promotion for these diseases, such as cardiovascular disease improves the health of the entire population, reducing the cost to individuals and the community.</td>
</tr>
</tbody>
</table>

**CQ2: What are the priority issues for improving Australia’s health?**
Groups Experiencing Health Inequities

Students learn about:
- groups experiencing health inequities
  - Aboriginal and Torres Strait Islander peoples
  - socioeconomically disadvantaged people
  - people in rural and remote areas
  - overseas-born people
  - the elderly
  - people with disabilities

Students learn to:
- research and analyse Aboriginal and Torres Strait Islander peoples and one other group experiencing health inequities by investigating:
  - the nature and extent of the health inequities
  - the sociocultural, socioeconomic and environmental determinants
  - the roles of individuals, communities and governments in addressing the health inequities

exist in terms of:
⇒ Unequal distribution of some illnesses or conditions throughout population (cross cultures, geo locations, ages, genders)
⇒ Health inequities as a result of SES factors (cultural and income etc.)

Aboriginal and Torres Strait Islander Peoples

<table>
<thead>
<tr>
<th>Nature and Extent of the Health Inequity</th>
<th>Sociocultural Determinants</th>
<th>Socioeconomic Determinants</th>
<th>Environment Determinants</th>
<th>Roles of Individuals, Communities and Governments</th>
</tr>
</thead>
</table>
| **Life Expectancy**                    | o Quality of social connections with family, friends, community | o Lower levels of education (more drop out of school) | o Over 20% live in remote and rural areas so there is a lack of access to health services | **Individual**
|                                       | E.g. Indig. Who had lack control over lived/removed from natural family assessed their health as fair or poor | o Lower levels of employment (linked to health risk factors) such as smoking | o Lack proper water and infrastructure (intergenerational trauma) | o Representation of health needs on committees e.g. councils |
|                                       | o Family □ children copy negative behaviours | o Unemploymen t rate of 16% ATSI are 3 times the normal which is 5% | o Rental housing commission s lead to poor living conditions and overcrowdi ng AFFECT 1 in 4 | o Empower ATSI people to reduce risk factors and decision making through education programs (e.g. art can strengthen cultural connection and income, community programs) |
|                                       | o Higher levels of discrimination and racism impacting health | o Median household income is 55% of non-ATSI people | o Poor levels of school attendance | o Incentives for health professionals to work with ATSI peoples |
|                                       | o Lack of trust with institutions and doctors less than 1% of health care workers in Aus. are ATSI – low number | o Rely on government assistance (income and house). This affects their self-esteem. Affects their independence and the mentality is passed | o Rely on government assistance (income and house). This affects their self-esteem. Affects their independence and the mentality is passed | o Individual initiated community programs (e.g. 45x more likely domestic violence ‘Fitzroy Crossing Women Resource Centre’ a safe house) |
|                                       | o Higher death rates from circulatory diseases, injuries, cancer, respiratory disease, endocrine, metabolic and nutrition diseases (2x higher) | o Expensive and lack of fresh fruit and vegies | o Rental housing commission s lead to poor living conditions and overcrowdi ng AFFECT 1 in 4 | o Increase educational opportunities such as scholarships |
|                                       | □ 12 years lower than non-indigenous Mortality | o Over 20% live in remote and rural areas so there is a lack of access to health services | o Expensive and lack of fresh fruit and vegies | o Take on board health messages and adapt behaviour accordingly |
|                                       | o Higher mortality rates at all ages from preventable causes in comparison to Aus | o Over 20% live in remote and rural areas so there is a lack of access to health services | o Expensive and lack of fresh fruit and vegies | **Community**
|                                       | □ 75% males and 65% females died younger than 65 years vs 26% male and 10% female non-indigenous | o Over 20% live in remote and rural areas so there is a lack of access to health services | o Expensive and lack of fresh fruit and vegies | o Empower and address inequities through discussion with elders in the community |
|                                       | o Higher death rates from circulatory diseases, injuries, cancer, respiratory disease, endocrine, metabolic and nutrition diseases (2x higher) | o Over 20% live in remote and rural areas so there is a lack of access to health services | o Expensive and lack of fresh fruit and vegies | o Community groups and support services (e.g. Redfern community “Clean Slate Without Prejudice” which promotes a sense of routine, self worth and belonging to break down the sociocultural barrier between ATSI youth and police to decrease crime rates, physical fitness, preventative action) ALSO (Echo Island furniture making store to increase self-worth) |
| **Infant Mortality**                   | o Infant Mortality rate twice that for non-Indigenous □ has increased in 2016 (but still not the same) | o Expensive and lack of fresh fruit and vegies | o Expensive and lack of fresh fruit and vegies | o Lobbying (e.g. Women in Fitzroy Crossing to ban sale of full strength alcohol which results in less violence, deaths, and domestic violence) |
|                                       | o Higher mortality rates at all ages from preventable causes in comparison to Aus | o Expensive and lack of fresh fruit and vegies | o Expensive and lack of fresh fruit and vegies | o Lobbying (e.g. Women in Fitzroy Crossing to ban sale of full strength alcohol which results in less violence, deaths, and domestic violence) |
|                                       | o Infant □ children copy negative behaviours (intergenerational trauma) | o Expensive and lack of fresh fruit and vegies | o Expensive and lack of fresh fruit and vegies | o Lobbying (e.g. Women in Fitzroy Crossing to ban sale of full strength alcohol which results in less violence, deaths, and domestic violence) |
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|                                       | o Lower levels of employment (linked to health risk factors) such as smoking | o Expensive and lack of fresh fruit and vegies | o Expensive and lack of fresh fruit and vegies | o Lobbying (e.g. Women in Fitzroy Crossing to ban sale of full strength alcohol which results in less violence, deaths, and domestic violence) |
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o ATSI youth 28x more likely to go to jail — low quality of life
o 3 times as likely to report having diabetes than non
o 7x more likely to get heart disease
o 3x more likely to get diabetes
o 1.5x to get diabetes
o Suicide rate 6x more for females

Trends Include
o Declined death rates from all causes for Indig. People.

Health Behaviours
o 2x higher smoking rates
o Increases illicit drug use and alcoholism
o Obesity higher
o Diets poor (high in fat and sugar)

E.g. nutritious food, health care
o Suicides
o More likely to have behavioural risk factors

E.g. “shackled by our own perceptions of ourselves” — lack of motivation and bad action
o Neighbourhood
o Disempowerment they feel as a result of years of oppression and discrimination – ranges from invasion of first fleet, white Australia policy, the stolen generation etc

Echo island successful timber factor torn down by govt so people “brainwashed to depend on “hand outs”

o Bad Income restricts access to good and services for health lifestyle
o E.g. nutritious food, health care
o ATSIs people aged 18+ earn 60% of non-Indig.

Income can’t afford health lifestyle

Lack of health literacy due to low levels of education

Lead to increased rates of risk behaviour such as smoking and physical inactivity

so nutritional deficiency

o Overcrowding means adolescents unable to work/ study in their home

leads to poor education

o Ensure participation ATSIs representative groups in address this to increase self-determination

o Communities and leaders of ATSIs involved in the design and implementation of close the gap programs

Australian Indigenous Doctors Association, National Aboriginal Community Controlled Health organisation, Aboriginal Community Controlled Health Services and Aboriginal Medical Services

o NGO’s who focus on ATSIs

“Live no and have Hope” Booklet; Diabetes Australia

rown in WA Narrogin, with ^ suicide levels, brought in a ATSIs health care worker and people

Government
o Provision of holistic, culturally appropriate health care activities

o Increased expenditure on education and health programs and community services (NT Emergency response 2007 for children health checks in NT and follow ups by the Howard Gov.)

o Aims to improve health care systems: $805 million Indigenous Chronic Disease Package

o ATSIs and Aboriginal Health and Medical Research Council

o Rudd Apology speech 2008 lead to the Close the Gap Campaign

o Long Term Action Plans

ose the Gap policy

- Is a government strategy that aims to reduce the disadvantage amongst ATSIs peoples with request to 7 goals (life expectancy, child mortality, access to early childhood education, educational achieved and employment outcomes

- THINGS they do: empower ATSIs peoples to control their health, implementation of National Action plan to partnership with Indigenous communities, delivery + control of health services, increasing maternal health care, addresses the social determents, prove a range of preventive actions, plan to close gap by 2030)

- Policy has been implemented for 9 years but in the 2017 report only 6 out of 7 goals were achieved which was Year 12 attainment

People Living in Rural and Remote Areas

- Rural: Dubbo, Wagga Wagga,

- Remote: The Kimberly’s, Northern Territory regions
<table>
<thead>
<tr>
<th>Nature and Extent of the Health Inequity</th>
<th>Sociocultural Determinants</th>
<th>Socioeconomic Determinants</th>
<th>Environmental Determinants</th>
<th>Roles of Individuals, Communities and Governments</th>
</tr>
</thead>
</table>
| o 10% in 2007 higher morality and illness rate in comparison to city (contributes to high % of ATSI living in these locations) | o Cultural factors “injury and illness is part of normal life”  
○ Cultural forces and attitudes  
□ Alcohol Use and high binge drinking | o High rates of unemployment  
○ Low SES as low levels of education and income in comparison to metro areas | o Higher risk on the road due to travelling long distances  
○ Lower % of adequately fluoride water supplies  
○ Poor access to health care services (often due to distance, cost of fuel) | o Participation in community supports groups during times of trouble |
| o 30% of Australia lives in rural and remote (2.2% live in remote areas)  
□ higher population of these people are ATSI | o More likely to suffer from chronic health conditions  
○ Less likely to report good health  
○ More likely to have health risks (obesity, physical inactive, alcoholism, smoking)  
○ Male death rates is 3x higher (1/3 from CVS compared to men in major cities. 40% more in remote.  
○ High rates of CVD, cancer, diabetes and mental health issues | o Less likely to seek for help for chronic condition  
○ Less attentive to health promotion  
□ Farmers are conservative and wouldn’t have Preston checks but health promotion has encouraged more to go to the doctor  
□ Cultures of “I’ll be ok” --> they are isolated and stubborn and less likely to see doctors  
□ Young kids have to leave school to work on the farm (in year 10) - parents think its inherent to look after  
□ During droughts, when mental health issues are high, farmers may not want to seek mental health help causing them to perhaps commit suicide | o Lack of financial stability due to seasonal nature of farming  
○ leads to stress and anxiety  
□ Decline in public infrastructure such as hospitals, schools, living and working conditions  
□ Money invested in land leading to no disposable income | o Empowered to reduce risk factors  
○ Provision of education and support (take part in local Men’s sheds)  
○ Do not act inappropriately  
○ Access support networks through improved internet access  
○ Attend remote based universities such as Charles Sturt, to improve knowledge, employment opportunities |
| o Remote patients 3x more likely to die within 5 years of diagnosis of some cancers  
○ More inactive  
○ Poorer diets  
○ Inherent to occupational hazards  
○ Less likely to utilise health care | o Increase relationship breakdown  
○ High rates of social isolation further compounded by geographical isolation  
□ Rural/remote person having premature baby may have to be flown to Westmead because costs have been cut by closing humidicribs in rural hospitals | o Increased environment disasters such as floods and droughts | o “Medicare Locals” work with health professionals to identify and improve community health needs  
○ Community services  
○ Strategies to focus on rural and remote health inequities | |
| o Remote patients 3x more likely to die within 5 years of diagnosis of some cancers  
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□ Decline in public infrastructure such as hospitals, schools, living and working conditions  
□ Money invested in land leading to no disposable income | o “Men’s Shed”  
○ The development of Multi-Purpose Service Programs that often connect with community services |
| | | o High rates of unemployment  
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○ Lower % of adequately fluoride water supplies  
○ Poor access to health care services (often due to distance, cost of fuel) | o “Men’s Shed”  
○ The development of Multi-Purpose Service Programs that often connect with community services |

## Individual
- Participation in community supports groups during times of trouble
- Empowered to reduce risk factors
- Provision of education and support (take part in local Men’s sheds)
- Do not act inappropriately
- Access support networks through improved internet access
- Attend remote based universities such as Charles Sturt, to improve knowledge, employment opportunities

## Community
- “Medicare Locals” work with health professionals to identify and improve community health needs
- Community services
- Strategies to focus on rural and remote health inequities
- Rural health: men’s health- older men left work and lost social aspect so this program provides social inclusion through peer support and self-help programs
- Beyond Blue strategies
- Community Support groups such as “Men’s Shed”
- The development of Multi-Purpose Service Programs that often connect with community services

## Government
- NGO: Royal Flying Doctor Service; start hospital level service in the air – in 2016; 283 188 patients were seen + 14, 432 nurse/GPS clinics were conducted (50% Government funding)
- Fly-In-Fly-Out; Health Care professional relieve country doctors and nurses to provide health education
- Provide incentives to target country high school students to come back to the country as doctors
- Expansion of treatment services
- National Strategy Framework (2011) for Rural and Remote groups
- The government has instituted the Rural and Remote General Practise Program to help increase the number of GP’s available in these areas; the fund services such as SARRAH - that provide allied health services
- NSW government increases allowances for travel and accommodation
High Levels of Preventable Chronic Disease, Injury and Mental Health Problems

- High levels of preventable chronic disease, injury and mental health problems
  - Cardiovascular disease (CVD)
  - Cancer (skin, breast, lung)
  - Diabetes
  - Respiratory disease
  - Injury
  - Mental health problems and illnesses

- Research and analyse CVD, cancer and ONE other condition listed by investigating:
  - The nature of the problem
  - Extent of the problem (trends)
  - Risk factors and protective factors
  - The sociocultural, socioeconomic and environmental determinants
  - Groups at risk

Cardiovascular Disease (CVD)

Nature of Problem
- Damage to, or disease of, the heart, arteries, veins and/or smaller blood vessels
- CVD = general term for CHD, PVD, and Stroke/CBD
- Common underlying causes:

Atherosclerosis
- Is the build up of fatty and/or fibrous materials often in patched (atheroma) on interior walls of arteries
- Is characterised by: presence of cholesterol, decreasing blood supply
- Narrows the artery and reduces elasticity limiting blood flow to tissues (and leading to lack of oxygen)
- Decreases/ hinders blood flow to the body’s tiss
- Can occur in any artery causing a reduction in
- Risk Factors: increased BP, smoking, died high in

Arteriosclerosis
- (A form of athero) Is the hardening of arteries
- When the fatty/fibrous/plaque deposits build up the walls lose elasticity due to aging
- As plaque builds up on artery walls they become harder and inelastic

Cholesterol
- Is a fatty substance produced by the liver and carried by blood supply to the rest of body
- Natural function = to supply material for cells walls and steroid hormones
- Excessive amounts in blood cause atherosclerosis leading to heart disease

- THREE major forms;

1. Coronary Heart Disease or ischemic (blockage in vessels to the HEART)
   - Most common form of CVD aka ischemic heart disease
   - Arteries leading to heart becomes narrow and blockages occur
   - Poor supply of blood to muscular wall of heart by its own blood supply vessels (the coronary arteries)
   - Two major forms: heart attack (acute myocardial infarction) or angina
   - Heart need continuous blood flow so cessation can result in death

2. Cerebrovascular Disease or Stroke (blockages to the vessels of the BRAIN)
   - Interruption of the blood supply to the brain in the form of a clot (atherosclerosis) or when a blood vessel haemorrhaged into the brain (high blood pressure)
   - Ischaemic Stroke
     - Most common
     - Caused by blood clot
     - Artery supplying blood to the brain becomes blocked (80% of cases)
   - Haemorrhagic Stroke
3. Peripheral Vascular Disease (blockage to the vessels in the LIMBS)

- Disease of the arteries, arterioles and capillaries that supply blood to the limbs (legs and feet)
- Results in tingling, numbness, cramping and gangrene (extreme cases where amputation may be needed to the limb) after exercise particularity
- 9/10 people with PVD are smokers
- Usually reducing blood supply to the extremities as a result of poor circulation

### Other Heart Problems;

<table>
<thead>
<tr>
<th>Heart Attack</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Causes by bleed to the brain (15%)</td>
<td>Break in the wall of a blood vessel in the brain</td>
</tr>
<tr>
<td></td>
<td>Aneurysm – weak or thin spot on a blood vessel wall</td>
</tr>
<tr>
<td></td>
<td>Hypertension is a risk factor more easily result in aneurysm</td>
</tr>
<tr>
<td></td>
<td>Often causes paralysis to one side of the body, speech problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Angina Pectoris</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a vessel supplying blood to the heart muscle is suddenly blocked;</td>
<td>completely (occlusion) by atherosclerosis leaving the heart muscle damaged</td>
</tr>
<tr>
<td></td>
<td>or by a blood clot that blocks a narrowed artery (thrombosis) leading to a heart attack.</td>
</tr>
<tr>
<td></td>
<td>Blockage/closure of artery preventing blood flow to the heart causing arrhythmia (disturbed rate and rhythm of heart beat)</td>
</tr>
<tr>
<td></td>
<td>Symptoms: short breath, burning chest pain, nausea, sudden collapse/unconsciousness, chronic pain, acute pain to shoulders/neck/arms/jaw, burning sensation in chest</td>
</tr>
<tr>
<td></td>
<td>Silden infarction when no pain or discomfort is exhibited so it is recognised by a electrocardiograph reading</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart Failure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the heart is ineffective in pumping blood around the body (inability to cater for the demands placed on it during everyday life)</td>
<td>Heart damage: failure of left or right atrium – cannot fix damage due to poor blood supply</td>
</tr>
<tr>
<td></td>
<td>Damage to Left Side caused by hear attack, blood accumulates to the lungs and the sufferer may be breathless</td>
</tr>
<tr>
<td></td>
<td>Damage to Right Side Pressure build up in right atrium, blood cannot return to heart in normal way and thus fluid accumulated in body’s veins/tissues/legs/liver</td>
</tr>
<tr>
<td></td>
<td>Can result from a variety of diseases; e.g. atherosclerosis, high BP, heart attack, damaged heart valve or other conditions that damage heart muscle directly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hypertensive Disease</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>When high blood pressure (hypertension) is severe/prolonged enough to cause damage to heart, brain or kidneys</td>
<td>Underlying problem is when arteries become blogged with fat/cholesterol</td>
</tr>
</tbody>
</table>

### The Extent of Problem (Trends)

<table>
<thead>
<tr>
<th>Mortality</th>
<th>Morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>The National Health Survey 2007 – 2008: 3.4 million Australians have CVD making it the leading cause of death major cause of morbidity</td>
<td>1 in 5 Australians had CVD (2010 – 2012)</td>
</tr>
</tbody>
</table>
Coronary heart disease leading cause of death for both males (15.9%) and females (14.3%) in 2010

Stroke 5.9% male and 9.8% female

Decrease of death from 42% (1996) to 32% (2010)

- Declining prevalence due to prevention started targeting to reduce modifiable risk factors
- Mortality and morbidity are decreasing due to increased awareness, detection and prevention
- A reduction in the levels of risk factors; ie., strategies to reduce smoking levels, increased monitoring hypertension, diet modification
- Improved medical care and treatment; led to reduced morality and improved quality of life

Costs $5.9 billion – 11% of total health expenditure
- Is the leading cause of disability
- 1.4 million Aus
- Was the reasons for 6% of hospitalisations in 2013-2014

### Risk and Protective Factors

<table>
<thead>
<tr>
<th>Risk</th>
<th>Protective</th>
</tr>
</thead>
<tbody>
<tr>
<td>A family history of heart disease (NM)</td>
<td>Regular Physical activity</td>
</tr>
<tr>
<td>Gender/ Being male (NM)</td>
<td>Eating a diet low in saturated fat and cholesterol</td>
</tr>
<tr>
<td>Advancing Age (NM)</td>
<td>Low consumption of alcohol</td>
</tr>
<tr>
<td>Smoking and alcohol abuse (M)</td>
<td>Consuming a diet low in salt</td>
</tr>
<tr>
<td>Raised blood fat levels (M)</td>
<td>Maintaining a healthy weight</td>
</tr>
<tr>
<td>High blood pressure and cholesterol (M)</td>
<td>Managing stress</td>
</tr>
<tr>
<td>Obesity and overweight conditions (M)</td>
<td>Avoiding exposure to tobacco smoke</td>
</tr>
<tr>
<td>Abdominal obesity (M)</td>
<td>Regular check ups at the doctor (early detection)</td>
</tr>
<tr>
<td>Physical inactivity (M)</td>
<td></td>
</tr>
<tr>
<td>Diabetes (NM for type 1 M for type 2)</td>
<td></td>
</tr>
<tr>
<td>The Pill (M)</td>
<td></td>
</tr>
<tr>
<td>Age-rates sharply over 65 (NM)</td>
<td></td>
</tr>
</tbody>
</table>

- **Smoking** increases blood pressure □ decreases exercise tolerance and increases the tendency for blood to clot
- A elderly person with a history of alcholism, inactivity, and obesity □ higher levels of atherosclerosis as he partakes in a range of risk factors □ increase the levels of cholesterol/plaque in his arteries □ this means he is more likely to have atherosclerosis, stroke and heart attacks
- Eating diets high in fat □ lead to high blood pressure and cholesterol □ also lead to abdominal obesity and diabetis □ compounded with the fact they are also less likely to partake in exercise □ increased risk of angina/stroke/heart attack

### Determinants

<table>
<thead>
<tr>
<th>Sociocultural</th>
<th>Socioeconomic</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with a family history of CVD more at risk</td>
<td>People with low SES or unemployed have higher death rated because income limits health choices (like buying fresh fruit and veggies and using gym)</td>
<td>People living in rural and remote more at risk as they tend to have less access to health info, services and technologies ie. Electrocardiogram monitors</td>
</tr>
<tr>
<td>Asians less prone to CVD because of generally low-fat diet</td>
<td>People with low education more at risk as poor education linked to poor health choices and less</td>
<td>The speed of medical treatment for heart attacks or a stroke greatly affects the results. □ People who access medical</td>
</tr>
</tbody>
</table>
therefor declining trend of CVD rates

- Peers influence people to make poor health choices, such as pressure to smoke, which can lead to increases in cardiovascular disease.
- Inherited genetics
- Growing up in a family that is overweight or obese, eats foods high in sugar and saturated fats or lives a sedentary lifestyle leads to children who grow up to live a similar lifestyle and make similar choices concerning these risk factors

<table>
<thead>
<tr>
<th>Knowledge on how to access health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Higher levels of education help produce lower incidence of cardiovascular disease</td>
</tr>
<tr>
<td>- Cardiovascular disease has higher rates in blue collar employment, such as trades and labour. This is often linked with other lifestyle choices often associated with these forms of employment such as higher rates of smoking and drinking as well as higher saturated fat diets.</td>
</tr>
<tr>
<td>- Lower income levels result in fewer health related choices as many incur cost to the individual, such as joining a gym, or buying lean meats rather than regular meat.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment swiftly have less chance of disability or death resulting from their stroke or heart attack</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Access to technology also impacts survival rates, but also is used in medical checks to test for atherosclerosis, angina and other cardiovascular diseases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Groups at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Smokers</td>
</tr>
<tr>
<td>- People with family history</td>
</tr>
<tr>
<td>- High BP (hypertension)</td>
</tr>
<tr>
<td>- High-fat diets leading to raised blood cholesterol and triglyceride levels</td>
</tr>
<tr>
<td>- People 65+ - represents 15% who have CHD and 70% of those who have stroke</td>
</tr>
<tr>
<td>- Males</td>
</tr>
<tr>
<td>- Blue collar worker (labourers, tradespeople who have higher levels of smoking/alcoholism/and high fat diets)</td>
</tr>
<tr>
<td>- ATSI peoples – 2.6x more likely to heart attacks and 1.7x for strokes</td>
</tr>
<tr>
<td>- Low SES = 40% higher death rate from CVD and higher rates of stroke</td>
</tr>
<tr>
<td>- People from rural/remote areas – higher burden from stroke than people from metro</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Health Promotional Campaigns</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medicare Benefits Schedule provide subsidies for patient care</td>
</tr>
<tr>
<td>- The Pharmaceutical Benefits Scheme, which continues to provide subsidies for a range of medicines used in the treatment of, or symptoms associated with, CVD.</td>
</tr>
<tr>
<td>- Significant investments in CVD research through the National Health and Medical Research Council (NHMRC), with a focus on investigating the causes, effects, impacts and complications of CVD.</td>
</tr>
<tr>
<td>- Funding is provided to organisations such as the National Stroke Foundation and National Heart Foundation, and through programs, which provide support and training to general practitioners and primary health care services.</td>
</tr>
<tr>
<td>- Healthdirect Australia has information on heart problems and cardiovascular health.</td>
</tr>
<tr>
<td>- The Heart Foundation has implemented many promotional activities</td>
</tr>
<tr>
<td>- The national Stroke Foundation</td>
</tr>
</tbody>
</table>

**HEART FOUNDATION**

- Is charity dedicated to heart disease
- CVD major cause of death in 2015 (45,392 deaths and kills 1 Australian every 12 mins)
- Has Fact sheets on website about CVD
- Funding foeds to; research, developing guidelines for health professionals, supporting patient care, advocating to government/industry, and helping Australia live healthier lifestyle
- Campaigns: Big Hear Appeal 2014, Jump Rope for Heart, Making the Invisible Visble, Mums United (guides for health eating), Heart Foundation Tick (on foods),
Cancer (Skin, Breast, Lung)

**Nature of Problem**
- Cancer refers to a large group of diseases that are characterised by the uncontrolled growth and spread of abnormal cells
- **Process:**
  1. Mutation in single cell whose genetic material influences/damaged by some foreign agent
  2. This changed cell divides and multiplies transferring damaged genetics to off-spring cells
  3. Develops a tumour (cells multiplies independently starving other nearby cells of nourishment)
     - Tumour – swelling or enlargement caused by a clump of abnormal cells
  4. This groups of cells is now referred to as neoplasm
     - Neoplasm – abnormal mass of cells that forces its way among health cells and interferes with their normal functioning
- Two types of tumours:

<table>
<thead>
<tr>
<th>Benign Tumours</th>
<th>Malignant Tumours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Cancerous</td>
<td>Cancerous</td>
</tr>
<tr>
<td>They generally grow slowly</td>
<td></td>
</tr>
<tr>
<td>Surrounded by a capsule that tends to control their spread</td>
<td>Without the restraints of a controlled capsule they spread to other parts of the body (spread through bloodstream)</td>
</tr>
<tr>
<td>Cure is surgical removal</td>
<td>Cause sickness and death and rely on intervention (to prevent metastases)</td>
</tr>
<tr>
<td>May cause some damage by robbing surrounding tissue of necessary nutrients or interfering with the function of vital organs</td>
<td>They starve surrounding tissue of necessary nutrients and invade healthy tissue</td>
</tr>
</tbody>
</table>

- **Metastases** - Are secondary or new tumours, which may develop some distance from the original malignant tumour
  - Malignant tumour has ability to invade surrounding tissue, blood vessels, and lymphatic channels, spreading into bloodstream or lymph fluid and other parts of body
  - BOTH of these (met and mal) are capable of spreading to many sited throughout the body, thus affecting the whole body with disease

**Types of Cancers:**
- Cancer is classified according to the type of cell in which it originated
- 90% of cancers a product of individual environment and lifestyle
- **Carcinogens** - are agents known to cause cancer that include;
  - Chemicals, pollution, radiation, cigarette smoke, dietary factors and alcohol
  - Precise cause is mystery
  - Different countries experience different degrees of incident of cancer to different body parts (environmental factors from one country to another may play a role in variation)

<table>
<thead>
<tr>
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<th>Site</th>
</tr>
</thead>
<tbody>
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<td>Carcinoma</td>
<td>Skin; membranes lining the respiratory, gastrointestinal and urinary tracts (lining of internal organs); the breasts</td>
</tr>
<tr>
<td></td>
<td>Is a cancer that begins in the skin or tissues that line or cover internal organs</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>Bones; cartilage; muscles; fat</td>
</tr>
<tr>
<td></td>
<td>IS a cancer that begins in bone, cartilage, fat, muscle, blood vessels or other connective or supportive system</td>
</tr>
<tr>
<td>Leukaemia</td>
<td>Blood-forming organs such e.g. bones; the liver; the spleen</td>
</tr>
<tr>
<td></td>
<td>Is a cancer that starts in blood-forming tissue, such as the bone marrow, and caused large numbers of abnormal blood cells to be produced and enter the blood</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>Infection-fighting organs e.g. glands and the spleen</td>
</tr>
<tr>
<td></td>
<td>Are cancers that begin in the cells of the immune system</td>
</tr>
<tr>
<td>Central nervous system</td>
<td>Brain tissue, spinal cord</td>
</tr>
<tr>
<td></td>
<td>Are cancers that begin in the tissues of the brain and spinal cord</td>
</tr>
</tbody>
</table>
Skin Cancer

- And sunspots (solar Keratosis) are most common of all skin disease in Australia
- Types of skin cancer;
  - Basal cell carcinoma - (non-melanoma)
    - Is a surface skin cancer originating from the basal cells that underlie the surface cells.
    - Most common type of skin cancer
    - Not usually fatal (non-melanoma)
  - Squamous cell carcinoma – (non-melanoma)
    - Is a surface skin cancer originating in the squamous or surface cells
    - Fastest growing form of cancer
  - Malignant Melanoma - (MOST DANGEROUS)
    - Cancer of the body cells that contain pigment (melanin) and mainly affects the skin

Extent of Problem (Trends)

- 1 in 2 males and 1 in 3 females will develop cancer by age of 85 (due to bad diet, smoke, drinking, and “at risk jobs”

- Cancer Trends in order of biggest burden
  - Prostate = 17.9% (most common – only affects males)
  - Bowel = 13.1%
  - Breast = 11.7% (most common for females)
  - Melanoma = 9.5%
  - Lung 9%

<table>
<thead>
<tr>
<th>Incidence</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing in incidence for both sexes</td>
<td>30% of all deaths in Australia 2010 – 33.1% of male deaths and 26.5% of female deaths</td>
</tr>
<tr>
<td>most significant have been for breast, skin and melanoma</td>
<td>Cancer mortality fell slightly from 1991 – 2010</td>
</tr>
<tr>
<td>Reasons for increase are; aging population, better detection of cancer, new technology, screening programs, better reporting</td>
<td>Age standardised death rate for all cancers decrease by 17% from 210/per 100,000 to 174/per 100,000 in 2010</td>
</tr>
<tr>
<td>Cancer occurs more in males and females</td>
<td>Lung cancer major cause of death</td>
</tr>
<tr>
<td>Most common types of cancer are MALES – prostate, FEMALES – breast</td>
<td>Men generally more at risk bc of diets</td>
</tr>
<tr>
<td>ALTOGETHER accounts for 61.3% of all cancers</td>
<td></td>
</tr>
</tbody>
</table>

Skin

- Most common Australian skin disease – highest rates in the world
- 80% of newly diagnosed cancers
- 2 in 3 Aussies diagnosed by age 70
- Incidence risen by 60%
- Melanoma 3rd most common cancer for men and women
- 50% of lifetime exposure occurs in early childhood and adolescent years
- Melanoma most common for 10 – 59 years
- Cancer Council of Australia: over 1400 Aus. Die from melanoma and non-melanoma each year

Breast

- 2nd most common cause of cancer related death in women (exceed by lung cancer)
- 2007 was underlying cause of death for 2680 women
- Affects 1 in 15 Aus. Women
- No cause
- Is detected (through breast self-examination and mammographic screening) women has better chance of survival

Lung

- Leading cause of cancer deaths in Aus. for men and women (largely preventable though)
- Most common occurring
- Females death rate (lower than men) is increasing
- Risk of lung cancer is 10x higher amongst smokers (than non)
- Less than 10% of all cases occur in non-smokers (in this case; pollution, ocup. Hazards, environ)
- High amounts of lung cancer amongst elderly (age 60+)
High incidence for people aged 60-65
More people getting cancer but LESS people dying shows early detection and intervention is working

**Risk and Protective Factors**
- Preventing death from cancer has often focused on early detection and treatment rather than on modifying long-term behaviour and exposure to risk factors
- It should be noted that exposure to a risk factor does not that a person will develop cancer
- Many people are exposed to at least one cancer risk factor but will never get cancer

<table>
<thead>
<tr>
<th>Risk</th>
<th>Protective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast</strong></td>
<td></td>
</tr>
<tr>
<td>Family history or personal history</td>
<td>Consume a diet high in fruits and veggies (low in fat)</td>
</tr>
<tr>
<td>High fat-diet</td>
<td>Practise self-examination</td>
</tr>
<tr>
<td>Early onset of menstruation</td>
<td>Have regular mammograms if 50+</td>
</tr>
<tr>
<td>Late menopause</td>
<td>Check family history</td>
</tr>
<tr>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td>Benign breast disease</td>
<td></td>
</tr>
<tr>
<td>Late age full-term Preg or childlessness</td>
<td></td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td></td>
</tr>
<tr>
<td>Older age</td>
<td></td>
</tr>
<tr>
<td>Physical inactivity</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td><strong>Skin</strong></td>
<td></td>
</tr>
<tr>
<td>Fair skin that burns rather than tans – red hair or fair hair</td>
<td>Avoid sunlight</td>
</tr>
<tr>
<td>Fair or red hair/blue eyed combined with residence in high sunny area (rural and remote areas)</td>
<td>Reduce exposure to the sun by wearing a hat, sunscreen, protective clothing and sunglasses</td>
</tr>
<tr>
<td>High number of hours in bright sunlight</td>
<td>Out of sun between 11-3 or 10-2</td>
</tr>
<tr>
<td>Prolonged exposure to sun (as a kid and adolescent)</td>
<td>Monitor skin changes</td>
</tr>
<tr>
<td>Number of moles on skin</td>
<td>Regular check-ups</td>
</tr>
<tr>
<td>Having compromised immune system</td>
<td>Not using solariums</td>
</tr>
<tr>
<td>SUN EXPOSURE</td>
<td></td>
</tr>
<tr>
<td>Family history of melanoma</td>
<td></td>
</tr>
<tr>
<td>Age 50+</td>
<td></td>
</tr>
<tr>
<td>Compromised immune system</td>
<td></td>
</tr>
<tr>
<td><strong>Lung</strong></td>
<td></td>
</tr>
<tr>
<td>Tobacco smoking</td>
<td>Avoid exposure to tobacco smoke</td>
</tr>
<tr>
<td>passive smoking too</td>
<td></td>
</tr>
<tr>
<td>Occupation exposure to cancer causing agents (carcinogens such as asbestos + chemicals)</td>
<td>Avoid exposure to hazardous materials such as asbestos</td>
</tr>
<tr>
<td>Urban Air pollution</td>
<td>Wearing appropriate safety devised and breathing</td>
</tr>
<tr>
<td>Diesel exhaust</td>
<td>Apparatus in work related risk environments</td>
</tr>
<tr>
<td>Family history</td>
<td>Avoiding exposure to passive smoke</td>
</tr>
<tr>
<td>Males</td>
<td>Act in accordance to legislation</td>
</tr>
<tr>
<td>Passive smoking</td>
<td></td>
</tr>
<tr>
<td>Low fruit and veg intake</td>
<td>Early detection and regular check-ups</td>
</tr>
<tr>
<td>Low SES</td>
<td></td>
</tr>
</tbody>
</table>

**Determinants**

<table>
<thead>
<tr>
<th>Sociocultural</th>
<th>Socioeconomic</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family History is more at risk</td>
<td>Low SES, unemployed, and low education have higher death rates as income limits health choices (e.g.</td>
<td>People living in rural/remote more at risk due to less access to</td>
</tr>
</tbody>
</table>
• ATSI people incidence for lung and cervical cancer (higher rates of smoking and lack of access to health services)
• Family who practise health-promoting behaviours (e.g. adopting healthy eating habits and attitudes towards tanning) the risk is reduced
• Environments that instils poor health habits = harder to break cycle
• Friends who do not encourage risk behaviours e.g. smoking, binge-drinking
• Media campaign that aim to promote protective behaviours e.g. cancer council
• Movies that promote and glorify risk behaviours e.g. smoking, drinking, partying

• Buying fruit and veggies and exercise, less knowledge on how to access health services
• Occupations involving high exposure to carcinogens (e.g. asbestos = more risk of lung cancer)
• People working outdoors (lifeguards = more prone to skin cancer)
• Low education, literacy skills = poor awareness of health implications of early signs
• Low income = harder to make healthy choices that cost more money

• Friends who do not encourage risk behaviours e.g. smoking, binge-drinking
• Media campaign that aim to promote protective behaviours e.g. cancer council
• Movies that promote and glorify risk behaviours e.g. smoking, drinking, partying

Groups at Risk

- Males in general have overall rates of cancer and a lower 5 year survival rate
- Low SES status
- Poor dieters (high fat, alcohol, lack of fibre)
- ATSI people living in rural/remote areas are limited to access health services

<table>
<thead>
<tr>
<th>Skin</th>
<th>Breast</th>
<th>Lung</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarette smokers</td>
<td>Women never given birth</td>
<td>Lower altitudes</td>
</tr>
<tr>
<td>People exposed to occupation/environmental hazards (asbestos)</td>
<td>Obese women</td>
<td>People with fair skin</td>
</tr>
<tr>
<td>People working in blue-collar occupations</td>
<td>50+ women</td>
<td>Outdoor occupations</td>
</tr>
<tr>
<td>Men &amp; women 50+</td>
<td>Direct relative with breast cancer</td>
<td>Spent too much time in sun without protection (hats and sunscreen)</td>
</tr>
<tr>
<td></td>
<td>do not practise self-examination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Start period early age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Late menopause</td>
<td></td>
</tr>
</tbody>
</table>

Injury

Nature of Problem

- Governments and health authorities pay attention to area of injuries as it affects all age groups and is PREVENTABLE
- Major cause of preventable morbidity and morality

<table>
<thead>
<tr>
<th>Causes</th>
<th>Consequences of injury can be short/long term e.g.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport-related injuries - car accidents</td>
<td>Loss of physical function</td>
</tr>
<tr>
<td>Motor Vehicle – drinking, driving, speeding, fatigue</td>
<td>Permanent disability or death</td>
</tr>
<tr>
<td>Suicide and self-inflicted injury</td>
<td>Loss of productivity in workplace</td>
</tr>
<tr>
<td>Homicides</td>
<td>Emotional trauma for individual and family</td>
</tr>
<tr>
<td>Interpersonal violence</td>
<td>Reducing earning capacity</td>
</tr>
<tr>
<td>Residential injuries (falls, drowning, poisoning, burns and scalds)</td>
<td>Financial burden of medicare and rehab costs</td>
</tr>
<tr>
<td>Industry-related injuries – people who operate machinery</td>
<td></td>
</tr>
<tr>
<td>Consumer product injuries</td>
<td></td>
</tr>
<tr>
<td>Sport and recreation-related injuries</td>
<td></td>
</tr>
</tbody>
</table>

- E.g. Young boy spills hot water from tea on his shoulder and chest region results in 2nd and 3rd degree burns on his chest. He has to wear a compression vest for 2 years to ensure his skin regrowth is okay.
- E.g. Rugby Union Wallaby Player, Dan Vickerman died in 2017 after committing suiciding from his suicidal thoughts.
E.g. Men who are in blue collar jobs have higher redundancy rates and higher levels of uncertainty in their jobs thus placing them at risk of suicidal thoughts – they are less likely to seek help and may feel hopeless leading to suicide.

E.g. Men who are farming may suffer through time where there is extreme harsh weather – this leads to poor and suffering crops – no crops = lack of income – may feel pressure from within the family and lose sense of hope – higher risk of suicide.

Job uncertainty may lead to family issues/divorce, lead to losing connections with friends and family – loss of connection = higher risk of suicidal thoughts.

**Extent (Trends)**

- 2010 injury deaths accounted for 6.2% of all deaths in Australia.
- Nearly HALF of all deaths people aged 1 – 44 were injury.
- Main cause of premature deaths – potential life lost under 65+ more than any other cause.
- Predominantly affects males; mortality rate is more than 2x higher than female.
- Death rates from unintentional injures DECLINING.
- Deaths from intentional injuries are INCREASING (suicide).
- 1 in 10 of all hospital admissions for older Australians were for injuries sustained in a fall.
- approx. 100,000 hospitalised as a result of falls – mainly women.
- Declines of poisoning due to better education.
- Suicide is leading cause of death in Australia for 15-44 year old men.

**Transport**

- Declined since 1970’s.
- Fell from 53/per 100,000 males in 1970 to 13.1/per 100,000 in 2004-05.
- Fell from 14/per 100,000 females in 1970 to 4.6/per 100,000 in 2004-05.
- 15-24 highest risk of death and MALES are higher.
- Hospital admission rates highest amongst 15-19 years.
- Fatalities peak amongst 20-24 years.
- Decline in MVI following government legislation in 1970; speed limits, drink driving laws, random breath testing, REDUCED road toll.
- Other factors; improved vehicle safety, better road engineering, motorcycle helmet legislation, restrictions on P plate holders, and road safety education.
- RTA 2005: 49% if 15-19 year old deaths were ACCIDENTS – 71% of this % was road deaths.
- RTA 2005: Drivers comprise of the largest population of young adult road crashes.
- RTA 2005: Persons under 20 years represent 5% of license holders but are involved in 15% of all crashes.

**Childhood Injuries**

- Children exposed to settings are risk of poisoning (home, streets, sporting environments).
- Injury (including accidents, poisoning and violence are major cause of death for ages 0-15.
- 50% childhood injury deaths occur under 5 years.
- Death rate attributed to poisoning, MTA and drowning fallen over recent years (reflecting health promotion).
- Transportation are most common type of injury in childhood.
- Drowning, burns and scald occur in high numbers amongst 0-4 years.
- Suicide and sporting is prevalent in 10-14 years.
- INFANTS (<12 months) – drowning in bath tubs, thermal causes.
- TODDLERS (1-4yrs) – drowning in pools, accidental poisoning, falls off playground.
- CHILDREN (5-14yrs) – falls off playground/skateboards etc, assault, transport injury.
- ADOLESCENTS (15-17yrs) – self-harm (4 times higher among females).
- YOUNG ADULTS (18-24yrs) – road accidents, assault, domestic abuse by partner (women).

**Risk and Protective Factors**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Protective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Driving – especially for young people

- Competing objects (carrying more passengers than number of seatbelts/ comfort/mobility)
- Complacently or impunity (feeling it won’t happen to me)
- Power and encapsulation (car power misused to show off)
- Lack of judgment
- Overload (erratic movements)
- Traps in the System (vulnerable to rules and traffic conditions)
- Social and psychological problems (peer influence)
- Social Norms (drinking, speeding are defined by parents or hero figures)
- Alcohol
- Fatigue
- Overconfidence
- Inexperience
- Dangerous conditions
- Rural and remote areas - lack of alternative transport and greater travelling

### Childhood

- Lack of supervision
- Unsafe environment, such as lack of pool fencing and exposure to poison
- Not adhering to road safety rules
- Failure to use child restraints
- Traffic injuries in school zones
- Driveway
- Children running onto road

### Adhering to road safety rules
- Avoid driving when fatigued, drugs/alcohol influence
- Obeying laws like wearing seatbelts and driving below speed limit
- Reducing distractions like mobile phones and loud noise
- Regular road/car maintenance

### Determinants

<table>
<thead>
<tr>
<th>Sociocultural</th>
<th>Socio-economic</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury hospitalisation rates are higher for ATSI children</td>
<td>Males aged 25-64 in most disavow. Areas are 2.2x more likely to die in traffic accident and 1.6x from suicide</td>
<td>Work in rural/remote areas are more at risk of workplace injuries as more exposed to dangerous machinery</td>
</tr>
<tr>
<td>ATSI person 3x likely to die in accident (due to less access to treatment and low education)</td>
<td>People less income are more likely to engage in risk taking behaviour and not afford vehicle maintenance</td>
<td>Rural areas more at risk of suicide due to lower employment rates and less access to support networks</td>
</tr>
<tr>
<td>Media exposure of laws for road use helped reduce injury rates from traffic</td>
<td>Unemployed/less income not able to afford safety devices to prevent childhood injury</td>
<td></td>
</tr>
<tr>
<td>Attitudes towards driving and risk taking amongst males</td>
<td>Societal awareness of hazardous environments</td>
<td>Work in rural/remote areas are more at risk of workplace injuries as more exposed to dangerous machinery</td>
</tr>
<tr>
<td>Societal awareness of hazardous environments</td>
<td></td>
<td>Rural areas more at risk of suicide due to lower employment rates and less access to support networks</td>
</tr>
</tbody>
</table>

### Groups at Risk

- The elderly – at risk of falls
- Children – at risk of poisoning, road trauma, drowning, violence, burns and scalds
- Adolescents – at risk of suicide and traffic-related injuries
- People living in rural and remote areas – at risk of workplace accidents e.g. mining and farming accidents
- ATSI peoples – higher risk of being admitted in hospital bc there are larger proportions of them in rural + remote areas.
Reasons for fall of Injury death rate since 1980’s

<table>
<thead>
<tr>
<th>Health Promo</th>
<th>General Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Road safety campaigns targeting issues such as speeding and drink driving</td>
<td>● Government legislation of seatbelts (compulsory since 1970s), speed limits and drink driving laws (random breathe testing since 1982)</td>
</tr>
<tr>
<td>● The “stop, revive, survive” campaigns</td>
<td>● Improved vehicle safety, better road engineering e.g. ANCAP 5 star safety ratings</td>
</tr>
<tr>
<td>● Driver reviver facilities e.g. The Lions Club where people who travel long distances are able to stop for a free cup of tea to prevent fatigue and over exhaustion on the road</td>
<td>● Motorcycles and bicycles helmet legislation</td>
</tr>
<tr>
<td>● Memorable campaign slogans such as: “If you drink and drive, you’re a bloody idiot” or “No-one thinks big of you”</td>
<td>● More restrictions on P plate drivers e.g. 0 alcohol policy cannot use mobile phones in vehicles, curfews i.e. Only 1 passenger after 11pm</td>
</tr>
<tr>
<td>● Graphic TV advertisements e.g. RTA and brave injury</td>
<td>● Better road safety education e.g. “U turn the Wheel” for year 10 students</td>
</tr>
<tr>
<td>● Improved roads and roadside language e.g. better use of signs crossings</td>
<td>● More stringent road-worthiness checks on vehicles e.g. Pink slips to ensure cars are safe and registrations</td>
</tr>
<tr>
<td>● More stringent road-worthiness checks on vehicles e.g. Pink slips to ensure cars are safe and registrations</td>
<td>● Changes to speed limits in school zones e.g. 40km/h zones</td>
</tr>
<tr>
<td>● Increased fines for speeding and loss of license for repeat offenders;</td>
<td>● Legislation for wearing of seatbelts and alcohol consumption before driving</td>
</tr>
<tr>
<td>● Legislation for wearing of seatbelts and alcohol consumption before driving</td>
<td>● Extension of the P-plate period to gain more experience and more hours required for driver training</td>
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</table>

A Growing and Ageing Population (HIDA)

- a growing and ageing population
  - healthy ageing
  - increased population living with chronic disease and disability
  - demand for health services and workforce shortages
  - availability of carers and volunteers.
- assess the impact of a growing and ageing population on:
  - the health system and services
  - health service workforce
  - carers of the elderly
  - volunteer organisations.

- Growth in population is driven by net overseas migration that natural increase
- Australia’s population is ageing
- 9% of population is aged 70+ expected to increase to 13% 2021 and 20% in 2051
- Life expectancy increased by more than 25 years since Federation (even at birth) = Aging population will continue
- Less children + less taxpayers □ So increase taxes, more immigration
- Growing and Ageing population comes as a result of; higher fertility rates, more babies born, increase of life expectancy, increase of immigration, and lower death rates (mortality rates)

Healthy Ageing

ACHPER notes

- Describes the ongoing activities and behaviours you undertake to reduce the risk of illness and disease to increase your physical, emotional and mental health
- Also means combating illness and disease with some basic lifestyle realignment that can result in a fast and enduring recovery.
- Health aging BENEFITS □ FOR the individual and the Australian society
- Healthy ageing needs to focus on;
  - Quality of life
    - No disease, superannuation, contributing in society
• E.g. Superannuation helps pensioners (as living on the pension is not adequate) and therefore they will have more income, which will allow them to have disposable income to spent on luxuries. As a result, better quality of life.
• E.g. casual worker get less superannuation so women look after kids and eventually can’t afford to retire

⇒ Independence
• Allow elderly to stay at home longer (than at retirement facilities). In order to enhance these services such as: “Meals on wheels” (deliver food to the door) and “community nurses” (that change dressings, administers/deliver prescriptions etc.)

⇒ Lengthening the number of healthy years
○ Benefits to the nation if older Australians are healthy;
⇒ Less pressure on health care system
⇒ Increased ability to continue working and contributing
  • E.g. Grandparents taking care of their grandchildren. Benefits = sense of purpose and happiness, helping the parents out (no need for child care ⬜ less demand for these services.) and mentality is in a better place

⇒ More enjoyable retirement as a result of less chronic illness
⇒ Greater likelihood of contributing to personal and community needs

Textbook
○ Government Actions;
  • As a consequence of aging population, government has responded by encouraging people to plan for financial security and independence for later life ⬜ e.g. superannuation
  • Government provides services, focusing on disease prevention, to ensure that workforce is as productive as possible
  • Priority for government to encourage healthy aging so elderly are less likely to access health and aged care services
  • People who are unhealthy in later life due to sickness and injury ⬜ working years shortened ⬜ resulting in reduction in economic growth

○ Government Ambassador for Aging is responsible for;
  ⇒ Promoting positive and active ageing
  ⇒ Encouraging the contribution made by older people
  ⇒ Promoting community government programs and inatives to the public
  ⇒ Assisting older people to access these programs

○ National Research Priority “Promoting and maintain good health” includes national research goal known as “Ageing well, ageing productively”:
  ● Focuses on disease prevention, reducing illness periods, maintaining economic and disease prevention ⬜ LEAD to better health outcomes for old people THUS reducing economic burden

Increased Population Living with Chronic disease and Disability
○ Significant improvement in number of people surviving heart attacks, stroke and cancers
○ Ageing population has lead to an increase in the number of Aus. with chronic disease or disability because their risk of disability is greater (INCREASING elderly = INCREASING number of people with chronic diseases)
  • E.g. A 90 year old woman has many health issues that compound to result in poor health outcomes. Has had 2 bypass surgeries, arthritis, is lactose intolerant and was diabetic

○ Chronic/non-communicable diseases account for 80% of total burden of disease in Aus.
  ● Estimated to be responsible for 75% of deaths by 2020 (WHO)

○ Future levels of chronic disease could be reduced if young people control more risk factors that develop chronic disease like; smoking, poor diet, obesity risk factors, diabetes, alcoholism and lack of physical activity
  • E.g. Obesity is a risk factor for diabetes
  • E.g. If you are physically inactive you are less likely to release endorphins within the body to elevate your mood. As a result there is not enough “feel good” hormones within the body and thus people are more likely to feel depressed. This may lead them to turn to alcoholism and tobacco, as they are depressed. Risk factors compound = unhealthy aging.
Concept: Not necessarily a “burden of disease”
- It is about starting protective behaviours at a young age
- Making sure people at a young age take on health promotion messages does not just start at old age
- Concepts of physical activity changes ie. From weight baring to old people do more low weight in high repetitions aims to stop osteo, arthritis and strengthen bones
- Falling can change an independent person old people do more walking and swimming as it isn’t heavy or weight baring

Degenerative diseases: degeneration = wearing out diseases, comes with old age how quickly you develop a degenerative damage depends on your lifestyle behaviours at a young age
- If you look after body prevent from degenerative disease OR REDUCE THE IMPACT OF THEM e.g. if you have family history of type 2 diabetes, if you exercise and healthy you have less likely chance you are slowing down the degenerative process
- Growing technologies and healthy services, modern technology has contributing positively POSITIVELY to healthy ageing = people now can have double bypass and still live a healthy and production life BUT THIS IS EXPENSIVE, morbidity
- A person who is sick will see doctor more, use PBS more called “the grey tsunami”

The notion of the inverted triangle
- People of the “baby-boomer” are going into retirement but this is not being replaced with amount of people going into the workforce changed pension to 67 years
- Money comes into this: superannuation women who go in and out of working due to maternity care have 20 – 30% less super than a man woman has to rely on the aged pension, relies on Medicare in Medicare, you have to wait for a long period of time before getting surgeries e.g. getting a hip replacement
- Healthy 70 year old woman, on the aged pension, falls, needs a hip replacement, she waits in the hospital waiting bc she has no care at home, has to say hospital as she has no carer
- Healthy ageing want people to have healthier lives, have better balance, so they don’t get degenerative diseases because it can lead to disability and not being able to live independently at home
- E.g. people who live alone at home should be in there, it is healthier for an elderly person to live at home with the support of volunteer organisations
- PENSION increased to 67

Government Policy
- Assist people to stay at home as long as it is safe to do so
- Give them services to support them at home
- 2011 most people 94% of people lived in private dwellings (ABS 2011)
- There are 3 broad aged care programs My aged care makes an assessment on whether or not:
  - TOP: Residential Care, very small portion of elderly
  - Middle: Home Care Packages: 15 hours, people cooking and cleaning house, includes medication etc. there are subsidies from the government to make it cheaper to encourage you to stay home IT IS CHEAPER for government
  - Entry level (home support): e.g. meals on wheels, 2 hours a week of health

Services
- “Meals on Wheels” takes a bus around and they have lunch every month, nice connections, sense of social life
- Services of social support
  - For people who need more support elderly who need help with getting in and out of the shower
  - Home modifications, help with equipment, minor home maintenance
  - Elderly going into respite care, nursing care, allied health (podiatry, dietician, occupational therapy etc.)
  - Respite (for elderly and the disabled) = can book elderly into retirement places, if carers want to go for holidays and get a break
  - Local councils are also an example of people who can provide health promo

Ottawa Charter
- North Ryde RSL;
  - Supportive Environment
  - Strengthen action because elderly are being social
Elderly often experience sensory deprivation, which can lead to anxiety, nervousness, and depression. Elderly can feel this way through a lack of social and emotional outlets.

**Meals on Wheels**

- The people who deliver food to elderly check up on them everyday, giving a sense of support.

### Demand for Health Services and Workforce Shortages

**Demand for Health Services**

- As a consequence of an increase in people living with chronic disease or disability, the demand for health and aged care services (shopping, retirement homes) has risen.

- This is due to:
  - Ageing population
  - Growth of population – due to immigration, babies born etc
  - Burden of disease – old people get sick often due to lifestyle, increased technology
  - Increases in aged pensioners

- E.g. Old woman dies at age 88 despite having lots of chronic diseases throughout life (CVD, knee problems, arthritis, stroke). This is because of the greater access to healthcare technological advances that have led to better health technologies.

- Impact on the Health system and services
  - Treatment costs
  - Government expenditure
  - Demand in health services

- E.g. independent elderly woman living alone falls, good ambulance response and goes to emergency with a broken hip and so has to live in a retirement home. She is moved to geriatric ward but the hospital beds are full (no available retirement home places) to the lack of services available.

- E.g. If someone by-pass surgery it requires 8 hours of surgical time and the employment of an anaesthetist; the demand for these people will be high. Afterwards, costs for rehab and additional treatment costs are needed to prevent further issues = lots of money.

- Government initiatives to meet the needs of older people include:
  - Increased residential aged care places
  - More funding for dementia in aged care
  - Attracting, retaining and training aged care workers
  - Community services e.g. meals on wheels, home-help services

### Workforce Shortages

- Poor health means that people can't contribute in the workforce, leading to a general shortage of labour.

- After 2010 more Australians retiring from labour force than joining (baby boomers ageing).

- Dependency ratio is 5 working people per person over 65, by 2041 expected to project to 2.5 working people.

- E.g.
  - In the past life expectancy was 70-75 and retirement age was 65 meaning people were out of work and dependant on government for 15-20 years.
  - Today average life expectancy is 80-85 and retirement age STILL 65 meaning people out of work and dependant for 20-30 years
  - = 13 years extra of burden on the government more costs needed

- Not all professions last physically; jobs cannot be performed by elderly.

- E.g. lifting heavy items amongst during trade work cannot be performed and enhance the risk of chronic injury, thus people retire more quickly and are more subject to chronic diseases such as arthritis and back injuries.

- People on health currently amongst oldest worker in Australia increased by 2.8 years.

- 2002 Senate inquiry into nursing found “the shortage of qualified staff in aged care has now reached crisis point.”

- High workforce needed in aged care due to issues surrounding chronic disease and disability.

- Government has taken action in response to this concern by improving retirement income system in the following ways; (to increase financial security and independence thus decreasing the economic burden on the government)
  - Means-tested age pension available to provide income for people after retirement.
⇒ All Australian employers must provide compulsory superannuation cover for all eligible employees. 9% of gross salary is minimum
⇒ Voluntary, private superannuation contributions and other forms of private savings, made by employees, are also encouraged

Availability of carers and volunteers

- Australia’s population consists of volunteers and carers who are ageing with rest of population
  - Carer: Person who looks after an older person or someone with a chronic disease/disability
    - E.g. A working parent has his elderly father living with him gets welfare and incentives to encourage his work
  - Volunteer: person who freely performs a service, such as supported the health needs of the elderly
    - E.g. volunteer for a NGO or a person who works at a local Church Community Aid
- Home and Community Care (HACC) offer services that help elderly people remain in their homes but with access to health care e.g. Meals on Wheels, and Community nursing
- Older Australians contribute to society in myriad ways such as
  - Being paid workers, carers, volunteers or family members
- Australians 55+ contribute approx. $75 billion per annum in unpaid caring and volunteering, 50% by people aged over 65+
  - Data demonstrated that caring and volunteering are beneficial to the economy and that elderly can make substantial contribution
    - E.g. Day care is very expensive money is saved through grandparents who look after their grandchildren while their kids at work this means they are contributing to unpaid care and aid in saving government expenditure
- Paid and unpaid work = essential to a well function and caring society thus enhancing quality of life
- Projected that there will be little growth in number of available carers compared to anticipated rise in demand for home-based support shortage of carers in future
- Impacts/Trends
  - Increase of volunteer carers as people retire and current carers/baby sitters become older (positive)
  - Increase of qualified carers are required for the elderly and thus an increase of burden on friends and family to provide the care, carers are becoming older, and govt./private providers give diverse care at home/community (negative)
  - Skilled volunteers, best practise, knowledge (positive)
  - Challenges = sporting organisations, regional areas, increase in demand, and elderly restraints

CQ3: What role do health care facilities and services play in achieving better health for all Australians?

Health Care in Australia

<table>
<thead>
<tr>
<th>Students learn about:</th>
<th>Students learn to:</th>
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<tbody>
<tr>
<td>health care in Australia</td>
<td>evaluate health care in Australia by investigating issues of access and adequacy in relation to social justice principles. Questions to explore includes:</td>
</tr>
<tr>
<td>- range and types of health facilities and services</td>
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<tr>
<td>- responsibility for health facilities and services</td>
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</table>
Provide essential services of diagnosing, treating and rehabilitating the ill and injured
- Preventing illness and promoting health
- Organised and financed by both public and private sectors
- Focus on prevention because it is cheaper and less burden on the community
- Is a complex interrelationship between the: all levels of government, health insurance funds, public/private providers, institutions (hospitals), and other organisations
- Was aimed for diagnosis, treatment and rehabilitation since 1990’s government has tried to do more in illness prevention and health promo
- The influence of the media, together with increased emphasis on health education and promotion, have led to a greater understanding of personal responsibility for health and the importance of health within the community. Furthermore, health practitioners are now recognising the importance of their role in health education, community empowerment, advocacy and public health policy.

Range and Types of Health Facilities and Services

<table>
<thead>
<tr>
<th>Institutional (Physical Buildings)</th>
<th>Non-Institutional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospitals: Public, Private and Psychiatric</td>
<td>1. Pharmaceuticals</td>
</tr>
<tr>
<td>2. Nursing homes/Hostels</td>
<td>2. Medical services: GP’s and Specialists</td>
</tr>
<tr>
<td>3. Ambulance services</td>
<td>3. Health-related Services: Ancillary e.g. dental</td>
</tr>
<tr>
<td>5. Research Organisations: National Health and Medical Research Council</td>
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</table>

**Hospitals**
- Both public and private provide general and specialised acute health care such as medical, surgical and obstetrical care
- Provide general and specialised health care
- Number of admissions increased by length of stay decreased

**Public – 70%**
- Operated and financed by the state and commonwealth
- Free of charge for patients
- Serve a great proportion of elderly and very young patients
- Highly specialised
- Provide complex services such as heart transplants
- Perform same-day surgery
- Allocated a doctor and provided with a bed

**Pharmaceuticals**
- Drug supplied through hospitals, doctors, private prescription and over the counter (over the counter = 1/3 of all sales)
- Most prescriptions drugs are part of the PBS
  - Pharmaceutical Benefits Scheme is where drugs are subsidized by the federal government depending on patients level of eligibility
  - July 2012 Max patient contribution was $36.10 per medicine; for concession, veterans, and low SES is $5.90
  - PBS safety net caps the amount a family will pay for PBS subsidised medications in a calendar year for those who need long-term meds ensure no one is precluded due to low SES
<table>
<thead>
<tr>
<th><strong>Private – 30%</strong></th>
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<tbody>
<tr>
<td>Owner by individuals and community groups</td>
<td></td>
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<tr>
<td>Service must be paid for by the patient</td>
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<tr>
<td>Shorter waiting time – same day</td>
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<tr>
<td>Perform short-stay surgery, Elective procedures (those not classified as emergences)</td>
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<tr>
<td>Less complex procedures</td>
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<tr>
<td>May choose doctor but must pay for accommodation and services. Medicare and private health insurance will refund much of this expense</td>
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<tr>
<td>Issues of equity</td>
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<thead>
<tr>
<th><strong>Psychiatric</strong></th>
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<tr>
<td>Care for patients diagnosed with mental illness (often severe)</td>
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<tr>
<td>Have decrease as a shift away from institutionalisation to integrated hospital care and community-based residential services</td>
<td></td>
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<tr>
<td>Number of these have failed</td>
<td></td>
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<tr>
<td>Range of service providers include; DP’s, private psychiatrist, and community services based public health services and special residential mental health care facilities</td>
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<table>
<thead>
<tr>
<th><strong>Medical services: GP’s and Specialists</strong></th>
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</thead>
<tbody>
<tr>
<td>Medical practitioners, doctors, specialists, health professionals, GP’s</td>
<td></td>
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<tr>
<td>Tret minor illnesses</td>
<td></td>
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<tr>
<td>Work in medical centres, hospitals and many private surgeries</td>
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<tr>
<td>Used the most. Medicare refunds patients payment for consolidations</td>
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<tr>
<td>Number of consultations have increased in the last 20 years</td>
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<tr>
<td>Due to a more informed population, large number of GP’s, Improved access via Medicare, increased healthy promo, awareness of preventions such as immunisation, Pap smears and general health check-ups</td>
<td></td>
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<tr>
<td>Refer clients to specialists</td>
<td></td>
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<tr>
<td>Use of services increase with age</td>
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<thead>
<tr>
<th><strong>Health-related Services: Ancillary e.g. dental</strong></th>
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</thead>
<tbody>
<tr>
<td>Include: Ambulance, dentistry, nursing, OT, speech, physio, optometry, counselling</td>
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<tr>
<td>Dental services have increased due to more people keeping natural teeth</td>
<td></td>
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<tr>
<td>Trends towards preventative care</td>
<td></td>
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<tr>
<td>Health-related services include ambulance work, chiropody, dentistry, health inspection, nursing, occupational and speech therapy, pharmacy, physiotherapy, optometry, radiography, counselling, social work, and dietary planning and advice.</td>
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<table>
<thead>
<tr>
<th><strong>Community and Public Health Services</strong></th>
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</thead>
<tbody>
<tr>
<td>Environment conducive to positive health</td>
<td></td>
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<tr>
<td>Support + promote but not recognised part of health care system</td>
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<tr>
<td>Supplying health equipment, aids and appliances</td>
<td></td>
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<tr>
<td>Impacts environment</td>
<td></td>
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<tr>
<td>Positive and promoted health but not part of health-care system e.g. Food industry policies info panel for production and delivery so health and safety standards are met</td>
<td></td>
</tr>
<tr>
<td>E.g. Town planners and engineers have a role in providing infra-structure that is safe and promotes positive health — for example, safe roads, adequate sanitation and sewerage facilities, areas for physical activity such as playgrounds and sports fields, and the clear signage of environmental hazards.</td>
<td></td>
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<table>
<thead>
<tr>
<th><strong>Nursing Homes/Hostels</strong></th>
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<tbody>
<tr>
<td>Provide care and long term nursing attention for those who are unable to look after themselves e.g. the aged, chronically ill, dementia sufferers</td>
<td></td>
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<tr>
<td>Private charitable</td>
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<tr>
<th><strong>Research Organisations</strong></th>
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<tbody>
<tr>
<td>Such as the National Health and Medical Research Council</td>
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</table>
Private for profit
State Government
Federal Government must finance homes
ACAT – needy in residential care or move to hostel

Ambulance Services

Responsibility for Health Facilities and Services

<table>
<thead>
<tr>
<th>Government</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonweal</td>
<td>o Formation and information of national health policies</td>
</tr>
<tr>
<td></td>
<td>o Control of the health systems financing to: Residential care, medical services, research, public hospitals, public health activities, Medicare Levy, income taxes, GST etc.</td>
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<td></td>
<td>o Funded through taxes</td>
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<tr>
<td></td>
<td>o They provide funds to state and territory governments for health care</td>
</tr>
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<td></td>
<td>o Influences healthy policy making and delivery</td>
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<td></td>
<td>o Has special direct responsibility for special community services e.g. ATSI, war veterans</td>
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<td></td>
<td>o Operate Assistance programs e.g. Medicare, PBS, work safe Australia</td>
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<tr>
<td>State or Territory</td>
<td>o Implement government funding</td>
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<tr>
<td></td>
<td>o Provide and deliver health services such as: hospital services, mental health programs, dental health services, home and community care, child + adolescent family services, women’s health programs, health promotion, rehab programs</td>
</tr>
<tr>
<td></td>
<td>o Regulation, Inspection Licensing and monitoring of premises including institutional and personnel’s</td>
</tr>
<tr>
<td></td>
<td>o The Fund community health services, public hospitals and health activities</td>
</tr>
<tr>
<td></td>
<td>o E.g. Run hospital and ambulance services</td>
</tr>
<tr>
<td>Private Sector</td>
<td>o Private hospitals, GP’s, specialists, dentists</td>
</tr>
<tr>
<td></td>
<td>o Privately owned and operated they are approved by the Commonwealth Department of Health and Ageing</td>
</tr>
<tr>
<td></td>
<td>o Many religious organisations, charity groups and private practitioners run such services</td>
</tr>
<tr>
<td></td>
<td>o Some private organisations, such as the Heart Foundation and the Cancer Council, receive funding from both state and Commonwealth government</td>
</tr>
<tr>
<td></td>
<td>o Insurance so you can have quick treatment</td>
</tr>
<tr>
<td></td>
<td>o Privately owned and operated</td>
</tr>
<tr>
<td>Local</td>
<td>o Varies from state to state but mainly concern environmental control and a range of personal, preventative and home-care services</td>
</tr>
<tr>
<td></td>
<td>⇒ They include the monitoring of sanitation and hygiene standards in food outlets; waste disposal; the monitoring of building standards; immunisation; Meals on Wheels; and antenatal clinics.</td>
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<tr>
<td></td>
<td>o The state health department controls some of these services (immunisation, for example), while local councils are responsible for implementing them.</td>
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<tr>
<td></td>
<td>o Have limited responsibility</td>
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<tr>
<td></td>
<td>o Implement state health policies and control environmental issues</td>
</tr>
<tr>
<td></td>
<td>o Must implement state health department services e.g. immunisation</td>
</tr>
<tr>
<td></td>
<td>o Community health centres e.g. Kuringai Elderly services</td>
</tr>
<tr>
<td>Community Groups</td>
<td>o Formed largely on a local needs basis and established to address problems and promote health specific to an area</td>
</tr>
<tr>
<td></td>
<td>o However, where concerns exist nationally, groups are more extensive, usually highly structured and linked in the provision of information, knowledge and support.</td>
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<tr>
<td></td>
<td>o Examples of prominent community groups are Cancer Council, Cancer Support Groups, Carers Australia/NSW, Dads in Distress, Sexual Health Services and Diabetes Australia.</td>
</tr>
</tbody>
</table>

Equity of Access to Health Facilities and Services
Equity of access to health facilities and services refers to the health system's ability to provide equal access to diverse, affordable and appropriate health care to all individuals and populations when they require it.

Australia’s Health System aims to provide people with equity of access (social Justice) to affordable and appropriate health care when they need it and the equitable distribution of health-care facilities/services to all.

This succumbs from an equitable distribution of health care facilities and services.

Individual’s ability to access is affected by:
- Geographic isolation.
- Socio-economic status.
- Knowledge and understanding of health information and services available. e.g. lack of education, literacy skills, language barriers.
- Cultural and religious beliefs.

Access can be impacted by:
- Staff shortages.
- Lack of funding/equipment.
- Waiting list in public hospitals
- Medical shortages

**Government initiatives**

<table>
<thead>
<tr>
<th>Medicare, the PBS and Medicare Safety Net</th>
<th>Are designed to allow simple and equitable access for all Australian citizens to a basic level of health care, regardless of limiting factors such as availability, affordability, distribution of facilities and services.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical cover for all Australia</td>
</tr>
<tr>
<td></td>
<td>Does not cover ALL health services so some health services still un-accessible for people with low SES still experience inequity e.g. ATSI people</td>
</tr>
</tbody>
</table>

**Pharmaceuticals benefits scheme (PBS):**

- Subsidises most prescription medicines to allow all individuals, regardless of SES, access to necessary prescription medication.

**More specialized actions:**

<table>
<thead>
<tr>
<th>ATSI: 'Healthy for Life' program</th>
<th>Aimed to address the prevalent cultural barriers impacting on ATSI access to primary health care services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aimed to improve prevention, early detection and management of chronic diseases.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rural and Remote Individuals: Royal Flying Doctor Service (RFDS)</th>
<th>Patient assisted travel schemes (PATS) and the Cancer Assist Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Can assist)* → enables individuals to more so successfully attain quality and equal health care by utilizing strategies such as aviation methods and the provision of financial subsidies</td>
</tr>
<tr>
<td></td>
<td>*Canassist specifically targets cancer patients in rural and remote areas. By funding for accommodation to those rural and remote patients requiring treatment in metropolitan areas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Socio- Economic: Medicare scheme</th>
<th>Is a service that is paid for via the populations taxes and ultimately provides the Australian population with equal access to affordable and high quality medical services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Example: this scheme enables patients to visit public hospitals and receive treatment free of charge. Moreover; in specific relation to cancer, the BSNSW service provides Australian women with free mammographic screening to enhance accessibility to early detection for those individuals of low SES.</td>
</tr>
</tbody>
</table>

**Health Care Expenditure versus expenditure on early intervention and Prevention**

- Significantly higher proportion of the health budget is allocated to recurrent health care expenditure as oppose to sustainable expenditure on early intervention and prevention.
2 Types of expenditure (includes from Australian state and governments, private health insurance, households and individuals)

- Re-Current expenditure: Ongoing costs e.g. salaries and bandages
- Capital Expenditure: e.g. Hospitals, buildings, equipment

**Health Care Expenditure**

- Refers to the allocation of funding and other economic resources for the provision and consumption of curative health services
- Continuously increasing with 90% of allocated money to treating curing illness
  - 2010-2011: $130 billion spend on health and curative approaches it costs more to cure than to prevent
  - Health-care expenditure has steadily been increasing and will continue to do so while the focus is on ‘curative’ medicine; that is, the focus is on curing a disease or illness, rather than preventing it.
    - For example, it costs more to ‘cure’ a disease such as coronary heart disease once it has developed than it does to fund measures to prevent the illness occurring.
    - Early intervention: might focus on education, healthy eating practices, weight control and active lifestyle activities.
    - Curative measures: such as treatment of heart disease, stroke, clogged blood vessels, kidney failure, blindness and foot/leg amputation are more costly and contribute considerably more to health expenditure
    - As a result, many feel that prevention is both undervalued and under-resourced, even though funding for health promotion and illness prevention has increased in recent
  - Curative measures incur ongoing and recurring costs due to: chronic illnesses, staff wages, equipment, infrastructure, and the development of new treatments and technologies
  - E.g. individual treatment of heart disease vs. cost of funding to prevent it amongst the population

**Early Intervention and Prevention**

- Preventative health refers to public health e.g. immunisation, education etc
- Benefits:
  - Cost-effectiveness — preventing illness and injury would result in huge savings in funds and resources used for acute health care.
  - Improvement to quality of life — the positive health outcomes for individuals that result from prevention include improvements in morbidity rates and longevity — that is, a longer and healthier life.
  - Containment of increasing costs — prevention is the best way of containing the continually increasing costs of health care. Otherwise, these costs could result in adequate health care being unaffordable for ordinary Australians.
  - Maintenance of social equity — a policy of prevention helps to provide greater equity (in the health-care system), which otherwise would be under threat as health costs continue to rise significantly.
  - Use of existing structures — prevention activities use existing and accessible community structures (such as general practitioners) rather than relying on special services and technological procedures. General practitioners are in a good position to measure risk factors and educate their patients on illness prevention and health promotion.
  - Reinforcement of individual responsibility for health — the use of prevention strategies empowers individuals to take control of their personal health by modifying their behaviour.
- Despite 70% of premature death health care expenditure still exceeds for intervention and prevention
- Prevention is undervalues and under-resourced long time before measures translate to a lowering incidence of life-style related diseases
- E.g. GP’s trained to show role of preventative health for patients 82% see GP at least once year so GP is at the frontline of health promotion

**Prevention adopts the new PUBLIC HEALTH APPROACH/MODEL:**

- Focus on social factors causing ill health
- It recognises that health promotion is the most cost-effective way that addresses social health issues
“Public health focuses on prevention, promotion and protection rather than treatment; on populations rather than individuals; and on factors and behaviours that cause illness”

Strategies that could be used to prevent illness and death in the community include:

- Education (relates to developing personal skills under the action area of Ottawa Charter).
- Legislation.
- Improved coordination amongst all levels of government.
- Higher taxes on items known to contribute to ill health, such as tobacco and alcohol.
- Support programs, e.g. weight reduction.
- Health promotion e.g. slip slap slop, sunSmart, QUIT, national cervical & breast screening programs → take time to show measurable effect!!! (yet marked falls in mortality and morbidity)
- People more accountable for expenditures e.g. higher life insurance premiums for smokers

Rising Expenditure

- Health care costs are rising! → Increase in funding by AUS government, guided by WHO:
  - This is due to:
    - Ageing population: less people contributing to the workforce due to chronic illness.
    - Less individuals paying income taxes.
    - Limited vacancies in aged facilities resulting in congested hospital wards, packed emergency rooms and limited space for rehabilitation of illness.
    - Therefore younger population needs to pay greater taxes to accommodate for the non-contributors/burden on health care system.
  - Money needs to be increased
  - Politically popular for capital expenditure on hospital but government cannot see imminent benefits of prevention/promotion funding (and will not fund it)
  - Emerging treatments and technology: costly and create inequities.
    - Government needs to ensure funds are allocated effectively to guarantee ill/sick individuals receive adequate health care, whilst also allocating funds to early intervention and prevention strategies to prevent such occurrences → takes years for benefits to be seen

Impact of Emerging treatments and technologies on health care, eg. Cost and access, benefits of early detection

- Main Reason for huge rise in cost of healthcare is attributed to advances in medical technology
  - Technologies, research and contemporary surgical strategies are being adopted by hospitals, yielding countless benefits such as an increased chance of early detection and an improved quality of life, yet resulting in a rise in healthcare costs.

EXAMPLES: (more so access and early detection rather than prevention)

- Diagnostic procedures such as Ultrasounds, advances in image technology as seen with keyhole surgery and MRI.
- Advances in image technology used in keyhole surgery make operating procedures far more accurate and less risky for the patient. Laser-fitted flexible endoscopes penetrate very small incisions and make repairs to hernias, kidneys, knees and other structures with new levels of precision, leaving minimal scarring and tissue damage.
- Continual improvement in the materials, construction and compatibility of parts associated with hips, knees
- Making it easier to quit smoking by developing tablets that specifically target nicotine receptor subtypes
- Development of new drugs that assist treatment of HIV by stopping the virus from making copies of itself and its ability to bind to new cells genetic testing, which could lead to finding a disease earlier and preventing death
- Advances in developing prosthetics to replace missing limbs. Improved microchips are powering electronic attachments to muscles, enabling stronger, better con-trolled movements by patients.
- Improvements in artificial organs such as kidney and heart machines responsible for keeping people alive until a real organ can be found. It is hoped that artificial organs will eventually be used extensively in organ transplant
- Therapeutic advances such as new radiological scanners and non-invasive surgical procedures (e.g. laparoscopy) preferred over conventional ‘open’ surgical procedures result in;
  - More comfortable hospital experience → less pain, quicker recovery, and shorter stays.
- Particularly beneficial for the elderly as they face reduced risks and improved recovery from surgery.
  - New and more powerful drugs to combat disease.
  - Developments in prosthetics, using microchips in artificial limbs.
  - Childhood vaccination programs e.g. whooping cough
  - Genetic testing to find it early and stop death
  - 3D mammogram: increase cancer detection rates, decrease number of false positives

<table>
<thead>
<tr>
<th>Shift</th>
<th>Limitation</th>
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<tbody>
<tr>
<td>● Most research on early detection and skin cancer</td>
<td>● Hard to balance the cost of new technologies, limited resources and need to maintain health at an acceptable level</td>
</tr>
<tr>
<td>● PBS reduces the sum of drugs making it more accessible</td>
<td>● Research, development, testing, medical and specialist’s fees and highly sophisticated equipment amount to millions of dollars, making some technologies unaffordable unless privately donated or subsidised by government.</td>
</tr>
<tr>
<td>● Pap smears; mammograms and risk identification programs (smoking, alcohol etc) are examples of early intervention programs</td>
<td>● Access prevents (SES and location) prevents people from participating in early detection and treatment</td>
</tr>
<tr>
<td>● ThinPrep Pap smears are 56% more effective at identifying low-grade abnormalities and 22% more effective for high grade</td>
<td>● There is currently no Medicare rebate on this, making it expensive</td>
</tr>
<tr>
<td>● 3D mammogram: increase cancer detection rates, decrease number of false positives</td>
<td>● E.g at Sydney Breast Clinic 3D mammogram costs $322 (33% back from Medicare), irrespective of private health insurance that favours those with higher SES it is expensive equipment, usually located in the Sydney, and thus it is a disadvantage to people in rural and remote communities</td>
</tr>
<tr>
<td>● For example, a mammogram which involves an x-ray of the breast may reveal a tumour in the very early stages and require keyhole surgery. Without the benefit of early detection, the breast may need to be removed, a much more serious outcome for the patient both personally and financially.</td>
<td>● Furthermore, issues relating to access to dental health are gaining prominance.</td>
</tr>
<tr>
<td></td>
<td>● While fluoride added to the water supply considerably improved dental health for a period of time, other factors such as the high cost of dentistry and widespread consumption of cordial drinks and mineral water (which does not contain fluoride) has meant that dental health problems are on the rise, with socioeconomically disadvantaged groups being the most affected.</td>
</tr>
</tbody>
</table>
# Health Insurance; Medicare and Private

<table>
<thead>
<tr>
<th>Definition</th>
<th>Medicare</th>
<th>Private</th>
</tr>
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<tr>
<td>Is Australia’s universal health-care system established in 1984</td>
<td>Is “top up” insurance</td>
<td></td>
</tr>
<tr>
<td>Was established to provide Australians with affordable and accessible health care</td>
<td>Chosen by 45% of the population</td>
<td></td>
</tr>
<tr>
<td>Its key features are: universality, equity and simplicity</td>
<td>Takes the pressure of the public health budget/system</td>
<td></td>
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<tr>
<td></td>
<td>It is not compulsory</td>
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</tr>
<tr>
<td></td>
<td>The extra insurance allows people to cover private hospital and ancillary expenses (such as dental, physiotherapy and chiropractic services) and aids and appliances (such as glasses).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Features</th>
<th>Medicare</th>
<th>Private</th>
</tr>
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<tbody>
<tr>
<td>Funded by taxes and the Medicare Levy: 1.5% of taxable income and 1% extra for high income earners without private health</td>
<td>Is paid for by contributors, but the scheme is subsidised by the Commonwealth government</td>
<td></td>
</tr>
<tr>
<td>Provides free treatment as public patient in a public hospital</td>
<td>Is chosen to provide shorter waiting times and choice of doctor + private hospital</td>
<td></td>
</tr>
<tr>
<td>Provides free or subsidised treatment by medical practitioners (including GP’s) who bulk bill</td>
<td>Also covers ancillary expenses: dental, physio, chiro</td>
<td></td>
</tr>
<tr>
<td>Bulk billing: Rather than patient pays doctor, Medicare reimburses patient – Medicare pays doctor and patient pays nothing</td>
<td>Divided into hospital, general treatment and ambulance covers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shorter waiting times for treatment, choose hospital to stay in, choose doctor, ancillary benefits, security, protection, peace of mind, private rooms in hospital and insurance cover whilst overseas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>An individual who pays hospitals, and/or general treatment cover to a registered health care fund can get the federal governments 30% reduction on the cost of private health insurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare started in 1984 people moved out of private systems placing pressure on the public systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This was as there was a demand for health services from the ageing population and an increase in ‘free’ Medicare patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Government created Medicare surcharge of 1% and 10-40% rebate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1998, to decrease this burden on the public health system, the Commonwealth Government introduced a rebate for people who have private health insurance. The rebate is income-tested, ranging from 10% to 40%.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private Health Insurance Rebate paid by the government on your hospital and extras cover premiums. [The rebate] will be means tested from 1 July [2012]. Australians who earn more than $84000 (single) or $168000 (couple/family) in the next financial year will pay much more for hospital and extras insurance, as their rebate will be reduced.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lifetime Health Cover (LHC) is a surcharge</td>
<td></td>
</tr>
</tbody>
</table>
that adds 2% to your premium for every year you don’t have hospital insurance after age 31. It can add up to 70% and applies for the first 10 years of your hospital cover.

- **Medicare Levy Surcharge (MLS)** is an extra tax for high-income earners on top of the Medicare Levy that you can avoid by taking out hospital cover. You can choose cover with an annual excess of up to $500 (single) or $1000 (family). It was 1% for everyone above the cut-off, but from 1 July [2012] a stepped rate of 1–1.5% will apply.
- Lifetime health-care incentive in 2000 resulted in an increase of people with private health care (43.4% in 2007 to 46% in 2011)

### Advantages
- Free treatment as public patient in a public hospital
- Affordable to entire population
- Equity in health care
- Possibility of bulk billing
- Ease of access to population
- Universality
- Special benefits for family
- Free or subsidised treatment by medical practitioners: covers 85% of scheduled fee for medical services
- Medicare Benefits Scheme may cover optometrist and oral surgery
- Medicare Safety net
- Choice of GP

### Disadvantages
- No ancillary – does not cover dentistry, physio, chiropractic treatment and appliances payment and there is a gap
- Long waiting lists for surgery
- Hospital and state government budgets strained due to additional costs
- Compulsory levy – even if you do not use it
- No choice for doctor or hospital
- Waiting tie for selective surgery
- Shared accommodation
- Triaging system places people in prioritise e.g. women tears her ACL and has to wait 1.5 years for surgery on the public system vs. private person who gets surgery within 1 week and is fully recovered after 6 months

### Medicare

<table>
<thead>
<tr>
<th>Who pays?</th>
<th>Commonwealth Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>How paid for?</td>
<td>Levy or tax linked to salary</td>
</tr>
<tr>
<td>What benefits?</td>
<td>Basic medical services (doctors and specialists), Choice of general practitioner, Basic hospital services in public hospitals, Specialist health care, Cover for 80 per cent of the scheduled fee for medical services</td>
</tr>
</tbody>
</table>

### Private health insurance

<table>
<thead>
<tr>
<th>Who pays?</th>
<th>Commonwealth Government, Private contributors</th>
</tr>
</thead>
<tbody>
<tr>
<td>How paid for?</td>
<td>Monthly premiums for various forms of cover</td>
</tr>
<tr>
<td>What benefits?</td>
<td>Hospital cover – hospital services, doctor of choice, hospital of choice – private or public hospital, Ancillary services – for example, dental, optical, chiropractic, Some special benefits – for example, sports equipment, Cover while overseas</td>
</tr>
</tbody>
</table>

Very expensive out of pocket costs for the individual
- People with a low SES such as young people, the elderly, and other groups are not able to have it
- Federal government costs to encourage people to have private health insurance
- Already paying for health cover (Medicare via Tax)
- Less equitable costs for the patient have increased and this is a barrier to needed care
◆ Describe the Adv. and Disadv. of Medicare and Private Health Insurance e.g. costs, choice, ancillary benefits

◆ Evaluate Health Care in Australia by investigating issues of access and adequacy in relation to social justice principles

| equitable is the access and support for all sections of the community? | much responsibility should the community assume for individual health problems? |

Complementary and Alternative Health Care Approaches

- Complementary and alternative health care approaches
  - reasons for growth of complementary and alternative health products and services
  - range of products and services available
  - how to make informed consumer choices
- critically analyse complementary and alternative health care approaches by exploring questions such as:
  - how do you know who to believe?
  - what do you need to help you make informed decisions?

- Complementary and alternate approaches (CAM) are healing systems, practises and products that do not fall within conventional medicine
  - Areas such as hypnosis, homeopathy, naturopathy etc
- Currently 42% of Australian use some of these practises
- Complementary therapies – complement conventional medical treatment e.g. meditation after surgery
- Alternate therapies – are those that offer alternatives to conventional diagnosis e.g. herbal medicines instead of prescription antibiotics such as penicillin
  - Have exited for centuries as Traditional Chinese medicine has accounted for 30-50% of all medicines in china with Japan the most consumption in the world
- WHO supports national polices on alternative medicines as more acceptance of the role in support mainstream
- Australia spends over $4 on alt medicines or practitioners

<table>
<thead>
<tr>
<th>Types</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biologically Based Approaches</td>
<td>Diets, Herbs, Vitamins</td>
</tr>
<tr>
<td>Manipulative and body based therapies</td>
<td>Massage, Chiropractic, Osteopathy</td>
</tr>
<tr>
<td>Mind-Body interventions</td>
<td>Yoga, Spirituality, Relaxation</td>
</tr>
<tr>
<td>Alternative Medical Systems</td>
<td>Homeopathy, Naturopathy, Ayurveda</td>
</tr>
<tr>
<td>Energy Therapies</td>
<td>Reiki, Magnets Qigong</td>
</tr>
</tbody>
</table>

Reasons for Growth and Complementary and Alternative health products and services

- Population of developed countries = grown and more interest in CAM over the past decade
- Two third of Aus. population using CAM treatments
- Deals with social change
- Greater globalisation and societal trends towards individualism have meant improved access to of info worldwide + less acceptance of normal GP’s
- See CAM as a opportunity to;
Exercise choice
Greater control over Health
Empowerment

- Rise in consumption of organic foods (foods w/o commercial chemicals and pesticides etc.) evidence of strengthening consumer confidence in aspects of health
- Other reasons:
  - WHO’s recognition of usefulness and their endorsement of a list of medicinal plants to be used in prep of herbal medicines
  - Recog. Of alt. medicines are the traditional medicines of world population
  - Effectiveness of treatment for people who find modern medicine ineffective
  - Desire for people to have a natural/herbal approach rather than synthetically produced
  - Holistic nature of medicine (focusing on the whole patient with treatments involving the balance and interrelationship between all dimension of health)
  - Strengthen and belief within culutres
  - Increased migration and increased accpetnace by Aussies in value multicultural influences

Range of Products and Services Available

<table>
<thead>
<tr>
<th>Product/Service</th>
<th>Definition</th>
<th>Method</th>
<th>How it helps?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Ancient system of healing developed over thousands of years</td>
<td>Involves inserting very small needles for up to 20-30mins</td>
<td>Claimed to be effective in wide range of conditions such as stimulating the mind and body’s own healing response</td>
</tr>
</tbody>
</table>
| Aromatherapy    | - Use of pure essential oils to influence or modify, body or spirit  
- Acts in accordance with holistically principles  
- Strengthens persons vital energies and self-healing abilities having direct effects on mind and body | Essential oils inhaled through vaporisers and applied through baths and massage | Treatment of depression, sleep disorders, stress symptoms and anxiety |
| The Bowen Therapeutic Technique | - System of muscle and connective tissue movements that gently realigns the body and balances and stimulates energy flow | - Tissue movements  
- Effect on supporting self-healing properties in the body | Effective in the treatment of soft-tissue injuries, musculoskeletal problems, back and neck aches, arthritic symptoms, stress, migraines, asthma, sinus and bronchial symptoms, and menstrual irregularities. |
| Chiropractic    | Relationship between the spine and the functioning of the nervous and musculoskeletal system. | Chiropractors ‘adjust’ the spine, using specific rapid thrusts delivered by the hand or small instruments. | Aimed at correcting subluxations, removing interference to normal nervous system control over bodily function, and promoting healing and better health. |
| Herbalism       | - Uses plants and herbs exclusively.  
- The oldest form of medicine, it is still used as a primary source of medicine for over 75 per cent of the world’s population. | Herbalists use the whole plant form of a medicine rather than chemical extracts from plants. | - Used to restore and support the body’s own defence mechanisms.  
- Herbal treatment is based on the individual’s symptoms, lifestyle and overall health. |
<table>
<thead>
<tr>
<th><strong>Homeopathy</strong></th>
<th>A system of medicine that recognises the symptoms unique to each person.</th>
<th>It aims to stimulate the individual’s healing powers to overcome the condition.</th>
<th>Work gently and rapidly to alleviate symptoms.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Iridology</strong></td>
<td>Is the analysis of the human eye to detect signs of the individual’s physical, emotional and spiritual well-being.</td>
<td>A range of naturopathic treatments can then be prescribed to improve general and immune system health.</td>
<td></td>
</tr>
</tbody>
</table>
| **Massage** | - Is one of the oldest and simplest forms of therapy.  
- It is an excellent method of inducing relaxation. | Forms of massage include remedial massage, therapeutic massage, sports massage and Swedish massage. | It helps reduce blood pressure, stress and anxiety levels, and overall it is beneficial to the immune system. |
| **Meditation** | Is a state of inner stillness. | Involves focusing on an object, breathing or verbally repeating a word (a mantra). With practice, the individual can reach a meditative state, in which they experience inner peace and stillness. | The benefits of meditation include strengthening of the immune system, improved sleep, lower blood pressure and increased motivation and self-esteem. |
| **Naturopathy** | Focuses on the holistic treatment of the individual by seeking to address symptoms of illness as well as resolving underlying causes of illness. | Naturopaths recognise the importance of developing a partnership with their clients, because it is important for the individual to take responsibility for making positive lifestyle changes. | |

**How to make informed consumer choices**

<table>
<thead>
<tr>
<th>Ask questions such as:</th>
<th>To assist in making informed choices, a consumer should</th>
<th>Other info:</th>
</tr>
</thead>
</table>
| o What type of treatment is offered?  
o How will it benefit me? | o Gather information from reputable sources; such as a local general practitioner, info about the nature, its credibility  
o Ask friends + family of their experiences and if it is valuable | o WHO recognised them to be valuable and significant  
o Chiro, naturopathy, and accuputer offered as uni courses in Australia |
<table>
<thead>
<tr>
<th>What are the practitioner’s qualifications?</th>
<th>Use the internet or other sources to investigate treatments for their condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much will the treatment cost?</td>
<td>Discuss treatment with a relevant organization, such as the Chiropractor’s Association of Australia</td>
</tr>
<tr>
<td>Are there any side effects?</td>
<td>Seek information from people who use the treatment</td>
</tr>
<tr>
<td>Can this be combined with conventional medicine?</td>
<td>Development of regulatory authorities and professional associations to ensure qualification and claims for success substantiated</td>
</tr>
<tr>
<td></td>
<td>moving into an evidence based approach for health care</td>
</tr>
<tr>
<td></td>
<td>more people have research and understanding skills on who to believe</td>
</tr>
</tbody>
</table>

Critically Analyse Complementary and Alternative Health Care approaches by exploring questions such as: How do you know whom to believe? What do you need to do to make informed consumer choices?
CQ4: What actions are needed to address Australia’s health priorities?

Health Promotion Based on the Five action areas of the Ottawa Charter

- Health promotion based on the five action areas of the Ottawa Charter
  - Levels of responsibility for health promotion
  - The benefits of partnerships in health promotion, eg government sector, non-government agencies and the local community
  - How health promotion based on the Ottawa Charter promotes social justice
  - The Ottawa Charter in action

- Argue the benefits of health promotion based on:
  - Individuals, communities and governments working in partnership
  - The five action areas of the Ottawa Charter
  - Investigate the principles of social justice and the responsibilities of individuals, communities and governments under the action areas of the Ottawa Charter
  - Critically analyse the importance of the five action areas of the Ottawa Charter through a study of two health promotion initiatives related to Australia’s health priorities

Levels of Responsibility for Health Promotion

- Governments have recognised that health promotion goes beyond the health sector
- Is most effective if individuals and families, groups in the community, governments and other organisations take a shared responsibility and joint action to improve the health outcomes for all Australians

2004 The NSW Health and Equity Statement: In all fairness “help to gauge existing strategies policies, programs o reduce health inequities and provide a framework for future planning”, identifying SIX focus areas

1. **Strong beginnings – Investing in the early years of life**
   - Health care in the antenatal period and under the age of 8 to secure good health outcomes throughout their lifespan, by reducing inequities to meet the needs of children

2. **Increased Participation – Engaging communities for better health outcomes**
   - Better health to strengthen community action in the NSW health system

3. **Developing a stronger primary health care system**
   - Improve accessibility and effective of primary health care system, especially for those for greatest needs
   - GPs, and nurses etc. e.g. Breast Screening Vans, and the Aboriginal community

4. **Regional planning and inter-sectorial action – Working better together**
   - Increase capacity of NSW health system to work together inter-sectorial aka government and department work together to address determinants (tackle unemployment, poor education, poor housing etc.)
   - E.g. NSW Health School Vaccine, housing commissions, Centrelink

5. **Organisation development – Building our capacity to act**
   - Capacity to act and address health inequities through improved systems and infrastructure
   - E.g. geriatricians, nursing homes for aged care populations

6. **Resources – For long term improvement in reducing health inequities**
   - Reorient patterns of invest within NSW to explicitly address health inequities
   - Investment of infrastructure e.g. Napean, Blacktown re-built to increase Western population

<table>
<thead>
<tr>
<th>Table 4.1: Contribution of participation to better health outcomes</th>
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<td><strong>Individual</strong></td>
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<tr>
<td>Increases the involvement of patients and carers in decisions about their health</td>
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<td>Improves quality of care</td>
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<tr>
<td>Level</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
</tbody>
</table>
| **Individuals and families**  | ● Abide by policies  
   ● Make Healthy lifestyle decisions  
   ● Seek health info  
   ● Take responsibility to promote their own health by partaking in community activities  
   ● Become health role models for their children  
   ● When individuals from community participate in decision-making there is higher chance of success | ● Participate in health campaigns such as City to Surf, Walking initiative by the heart Foundation  
   ● Follow ‘no hat no play policy’  
   ● Promote health to young kids within the family by implementing health promo on the TV |
| **Groups in the community + Industry (e.g. schools, workplaces, media)** | ● Work together to improve specific health problems  
   ● Address health issues and contribute to initiating health changes  
   ● Promoting NGO’s and health info  
   ● Promoting and adhering to Initiatives  
   ● Enhancing health within the workplace  
   ● Develop and reinforce individuals knowledge and skills to empower and adopt healthy lifestyles | ● Carpooling  
   ● Healthy Canteen  
   ● “Jump Rope for Heart” at schools by the heart foundation  
   ● Promoting health on the media  
   ● Ensuring there are workplace benefits ie. Free gym memberships |
| **NGO’s (In Australia and also IGO’s)** | ● Specific research into health issues  
   ● Implement strategies and campaigns  
   ● Provide funding and resources to areas  
   ● Establish programs that increase health | ● Heart Foundation tick  
   ● Slip, slop, slap  
   ● SunSmart Program in Schools  
   ● Sun Heralds – City to Surf |
| **All Levels of Government**   | **Local/Councils**  
   ● Work within the community to create health promotion specific to the community  
   ● Create supportive environments  
   ● Work with other levels to strengthen community action  
   ● Has statutory responsibilities for health protection under the Public Health act 2010 and Food Act 2013 have to regulate environmental premise and good business | **State:**  
   ● Work together to develop health policies  
   ● Provide health info to the public  
   ● Developing health frameworks  
   ● Work with communities to identify problems  
   ● Establishing policies and rules  
   ● Guidelines on local sport sun exposure (ie. Compulsory hats when playing cricket, cancelling games if over 40+ degrees)  
   ● Provision of food services  
   ● Sun protection through the provision of shade  
   ● Sporting and recreation places open  
   ● Water fluoridation  
   ● Recreation facilities such as walking tracks, bicycle tracks  
   ● Healthy canteens  
   ● Walk it – collaboration between councils  
   ● Speed limits  
   | **Commonwealth/Federal:**  
   ● Federal government interacting with international agencies  
   ● Encourage states to work together  
   ● Create supportive environments  
   ● Funding Health Research  
   | **Commonwealth/Federal:**  
   ● Interacting with IGO’s such as WHO  
   ● Signing international treaties  
   ● Funding AIHW to collect data  
   ● Developing dietary guidelines |
The Benefits and Partnerships in Heath Promotion e.g. Government Sector, Non-government Agencies and the Local Government

- Ottawa actions areas is well represented through a variety of strategies then;
  - The risk of people or populations adopting poor health behaviours in the first place is reduced
  - People already engaged in poor health behaviours are encouraged to reduce or eliminate these actions to result in improvements in their health and decrease burden on health system

- Integrated health promotions (of the individuals, community, government and NGO’s) creates optimal conditions for achieving programs aims and is aimed at all environments to promote the same message and support
  - E.g. Heart Foundation Tick, school fundraisers, adhering to public policy and road limits

- Individuals and communities included in planning of campaigns needs to be addressed so health promotion is enabled (done by, with and for the people)
  - This encourages participation, empowers individuals and community to take actions to improve their health
  - E.g. in consultative communities, meetings, survey’s, analysing local health data
  - High schools making students wear hats during break compulsory leads to more involvement if the heat is designed by the students
  - E.g. Close the gap involved Aboriginal elders to contribute and thus is more effective as cultural appropriate services can be administered such as ATSI doctors

- Capacity building;
  - Involved the development of sustainable skills, organisational structures, resources, and commitment to health improvement
  - To prolong and multiply health gains many times over
  - Leads to skills application to improve other future health issues

- Strategy is only deemed effective if the health of the individual, population is improved
  - Health improvements can be sustained only if the person knowledge and skills are improved so they can maintain their new health behaviour leads to the collection of healthier individuals becoming a community of healthier people

- Government and NGO’s must work with the community to identify priorities and build the capacity of individuals within individuals
  - Identify current trends and priorities
  - Share information with other organisations and agencies to assist with research and information collection prevents ad hoc (impromptu or for single purpose rather than a coordinated one) health promotion
  - Ensure health promo is evidence based or subject to evaluation
  - Full potential of an approach only realised when providers are connected and integration

◆ Argue the benefits on health promotion based on: Individuals, communities and the governments working in partnership with the 5 action areas of the Ottawa Charter

The benefits of partnerships in health promotion include:
  - Addresses needs of individuals and communities
  - More comprehensive health promotion
  - Better results in health promotion goals
  - Empowers individuals to act
  - More efficient health promotion (no doubling up and reduced waisted time/money)
  - Empowerment: (see above)
  - Access to completed research: This reduces the potential for duplication (time wasting research).
  - Sharing information: This improves social cohesion and leads to a vibrant, more informed society.
  - Improved skill: When people improve their skills, they make better choices and healthier decisions.
  - E.g The Department of Health and Ageing is funding a unique partnership between the Australian Local Government Association, the National Heart Foundation of Australia and the Planning Institute of Australia who are working together to develop Healthy Spaces and Place.
  - E.g. BreastScreen Australia: free screening program to detect breast cancer. State governments have primary responsible for the implementation of the program, the federal government provides overall monitoring and evaluation. The cancer institute also provides ongoing research to help the program. And the individual must attend these places
How Health Promotion based on the Ottawa Charter promotes social justice

<table>
<thead>
<tr>
<th>Equity</th>
<th>Diversity</th>
<th>Supportive Environments</th>
</tr>
</thead>
</table>
| ● Fair Access  
   ● Resources are allocated in accordance to needs  
   ● Policies should ensure equal access  
   ● E.g. Same health care access in rural Australia  
   ● Flying doctor service receives a large amount of tax-payer money and government funding, equitable money spent on resources such as incentives for health professionals and fuel | ● Greater equality in accessing health care  
   ● Catering to a diverse population with different needs  
   ● E.g. Info designed to education people about health in language the community understands  
   ● E.g. having ATSI doctors and pamphlets in different languages | ● Environments where people live, work and play  
   ● Environments who protect people from threats to health  
   ● Environments that increase peoples ability to make health promotion choices  
   ● E.g. Links to creating supportive environments e.g. smoke free zones, 40km school zones etc. |

**IN RELATION TO OTTAWA CHARTER**

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Equity</th>
<th>Diversity</th>
<th>Supportive Environments</th>
<th>Responsibility</th>
</tr>
</thead>
</table>
| **Build healthy public policy** | ● Public policy is designed with the aim of producing equity in health status, regardless of social markers  
   ● E.g. Medicare provides access to health services for socioeconomically disadvantaged people  
   ● E.g. PBS addresses equity by subsidises costs of prescriptions (for low SES) as not all people can afford = equal access  
   ● Taxation less for low SES  
   ● Bulk Billing  
   ● Centrelink  
   ● PDHPE in all schools | ● Public policy accounts for the diversity of our population, seeking to provide for all people groups.  
   ● E.g. The ‘close the gap’ initiative aims to remove the health inequity for ATSI people in 1 generation  
   ● Cultural sensitive  
   ● Non-english resources | ● Policy should aim to produce an environment that supports healthy choices.  
   ● E.g. no smoking in pubs and clubs  
   ● ‘no hat, no play’ in schools policy to promote supportive environments and decrease UV exposure and skin cancer risks  
   ● Healthy canteens  
   ● 40 km/h school zones  
   ● Speed cameras  
   ● Health care cards for low SES | ● Comm government legislates public policy e.g. PBS, seatbelts  
   ● NGO’s help in decisions  
   ● Communities and schools create policy within their community e.g. school rules (no hat no play) and enforces and smoke free workplaces, compulsory fence for pools |
| **Create supportive environments** | ● An environment is not supportive if it does not seek to provide equity.  
   ● Eg. Increasing access to health facilities for rural and remote people  
   ● Provision of health enhancing items in rural remote areas  
   ● Flying Doctor Service | ● In order to be supportive, the environment must also cater for the diversity of the people in that environment.  
   ● Eg. Providing translators for specific groups in specific community health centres/hospitals etc  
   ● E.g. providing a Kid Helpline for children who need counselling  
   ● Culturally appropriate health services  
   ● ATSI doctors in ATSI communities | ● Creating environments that encourage healthy choices is vital in health promotion.  
   ● Persons location + people around either barriers or helps break down barriers to good health  
   ● Should acknowledge environ influence person  
   ● Eg. Ensuring good parks for outdoor activities  
   ● Local council improve lighting/security on local bike track (in the) | ● All levels of government (local + state - neighbourhood settings, federal – policies)  
   ● E.g. local council smoke free areas  
   ● Shade structure to prevent sun damage  
   ● Recycling programs (natural)  
   ● Removing harmful chemicals from environment  
   ● Providing support services for mental health problems |
<table>
<thead>
<tr>
<th><strong>Strengthen community action</strong></th>
<th><strong>Develop personal skills</strong></th>
<th><strong>Re-orient health services</strong></th>
</tr>
</thead>
</table>
| ● Equity both with and between communities is important in health promotion.  
● Communities of people suffering inequity in health need to be utilised and empowered in order to improve their health.  
● Resources equally available to all communities (financial, structural)  
● Government and NGO’s highly responsible through grants, donations, funding, provision of expertise  
● E.g. ATSI involved in the development and implementation of health promotion for ATSI  
● Resources for all communities  
● Support groups  
| ● Each community has its own diversity and needs to be consulted in health promotion.  
● Directly involved  
● E.g. large Jewish population in Bondi, Lebanese in Bankstown etc. should be empowered in relation to health promotion initiative specific for them  
● Effective ATSI programs always have ATSI people involved to ensure cultural aspects are considered  
● ATSI people working with communities  
● Refugees have input into health plans  
| ● Communities that become empowered need an environment that supports their healthy choices □ they find their own catalyst for self-improvement and set goal empowering  
This requires access and availability of services and facilities.  
● E.g. bushwalks being maintained in the blue mountains to encourage locals to walk  
● E.g. lobby Groups  
● Support groups  
● Healthy Town challenge  
● Jump Rope for Heart  

| ● Health services must address the inequities in health.  
● Through culturally sensitive services  
● Doctors know each person culture and  
| ● Health services must meet the diverse needs of the communities they are in.  
Through culturally sensitive services that respect diverse needs  
| ● Health services must help provide a supportive environment.  
● Partnership with communities  
| ● Community groups, health professionals, and institutes, all levels of government  
| morning and evening to increase fitness)  
● Smoke free areas  
● Breast screening  

● Health services must address the inequities in health.  
● Through culturally sensitive services  
● Doctors know each person culture and  

Health services must meet the diverse needs of the communities they are in.  
Through culturally sensitive services that respect diverse needs  
Health services must help provide a supportive environment.  
Partnership with communities  
Community groups, health professionals, and institutes, all levels of government  

- E.g. ATSI involved in the provision of expertise  
• Donations, funding, through grants, highly responsible (financial, structural)  
• Communities (financial, structural)  
• Resources equally available to all communities  
• Participation and availability of services and facilities.  
• E.g. bushwalks being maintained in the blue mountains to encourage locals to walk  
• E.g. lobby Groups  
• Support groups  
• Healthy Town challenge  
• Jump Rope for Heart
provide equal access to education and training about health promotion services regardless of ability
- *E.g.* mental health promotion and services in rural and remote locations for low SES people
- Flying Doctor Service
- Culturally sensitive health places

<table>
<thead>
<tr>
<th>Governments</th>
<th>Communities</th>
<th>Individuals</th>
</tr>
</thead>
</table>
| **Build Healthy Public Policy** | ● All levels of government are responsible for the creation and maintenance of policies that aim to improve health  
- *E.g.* the close the Gap statement of intent | ● Contribute towards the development of health policies and are involved in carrying the policies out.  
- *E.g.* ATSI community involvement in the development and implementation of 'close the gap' | ● Act in accord with the policies delivered.  
- *E.g.* not smoking in public areas |

| Create Supportive Environments | ● Responsible for the planning, implementation and management of infrastructure.  
- *E.g.* Location of hospitals, parks, community centres. Council approve developments, remove waste etc | ● Help maintain healthy environments and promote healthy behaviours.  
- *E.g.* Clean up Australia day, fun runs, maintain parks, fields and ovals, YMCA gyms etc | Make better health choices using and maintaining the environment.  
- *E.g.* putting rubbish in the bins provided |

| Strengthen Community Action | ● Engage with community groups in the creation of policies.  
- *E.g.* allowing communities to provide feedback on policies before signing them  
- Alzheimer’s Australia | ● Contribute to and take ownership of policies being empowered to act and implement them.  
- *E.g.* Aboriginal community controlled health services | Promote community activities that promote health, be involved in community actions.  
- *E.g.* promote fun runs  
- Engage in community discussions around health |

| Develop Personal Skills | ● Develop policies and provide funding towards developing personal skills.  
- *E.g.* K-10 PDHPE compulsory  
- Advertisements (2 & 5) etc | ● Run education and training programs to develop personal skills in relation to health.  
- *E.g.* community health centres education (pre-natal classes, brochures etc.  
- School education system curriculum  
- Quit helpline etc. | Seek to develop their own skills in relation to health. Enabled to take charge of their own health  
- *E.g.* research behavioural choices for health  
- Act on advice from GPs and health practitioners,  
- Enrol in community programs etc. |

| Re-orient Health Services | ● Fund, research and create policies around prevention and health promotion. Looking at all the determinants of health and not just curative services.  
- *E.g.* T.V advertisements  
- Training of primary health sector to promote health as well as cure. | ● Conduct research, and be involved in the promotion of health.  
- *E.g.* cancer council conducts research around cancer, but also promotes better health choices in relation to the prevention of cancer | Seek to make healthy life choices, and help others to do the same, including participation in health promotion.  
- *E.g.* participating in jump-rope-for-heart |

**Investigate the principles of social justice and the responsibilities of the individuals, communities and governments under the action areas of the Ottawa Charter**
## The Ottawa Charter in Action

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing Personal Skills</td>
<td>Requires the provision of information, education and life skill development. &lt;br&gt; This increases options and control for individuals over their own health. &lt;br&gt; It is essential to equip people for life long learning and to develop skills for coping with ill health. &lt;br&gt;This is done through school, home, and community settings. &lt;br&gt; Strengthening health literacy &lt;br&gt; Empower Individuals</td>
<td>o <strong>PDHPE classes</strong>&lt;br&gt; Teach children how to make healthy choices, adhere to protective behaviours and how to stretch/warm up/cool down during sport o <strong>Fact sheets</strong>&lt;br&gt; o <strong>education programs</strong>&lt;br&gt; o <strong>Slip Slop Slap media campaign</strong>&lt;br&gt; o <strong>mandatory health education in PDHPE classes</strong></td>
</tr>
<tr>
<td>Creating Supportive Environments</td>
<td>The environments in which young people live, learn, play, work and worship profoundly affect their health. &lt;br&gt; There is a link between people’s health and their environment, requiring a socioecological approach to health. &lt;br&gt; Safe working environments that are enjoyable, assess health impacts of developing infrastructure (buildings, energy etc), and protect natural and built environments.</td>
<td>o <strong>“I’ve got your back!” – Youth connected</strong>&lt;br&gt; Bring message and awareness about cyber bullying and bullying o <strong>Environment</strong>&lt;br&gt; Lights on the streets for runners o <strong>Get Healthy at Work</strong>&lt;br&gt; NSW government imitative aims to help improve the health of working adults by focussing on healthy eating, healthy weight, physical activity, active travel, smoking, harmful alcohol consumption.&lt;br&gt; Provides businesses with support, tools and resources to address workplace factors that contribute to poor healthy, promote better health in a workplace setting and support workers to reach health goals o <strong>smoke free zones</strong>&lt;br&gt; o <strong>shade cloths at parks</strong>&lt;br&gt; o <strong>doctors from different cultures</strong>&lt;br&gt; o <strong>Healthy Schools Canteen</strong>&lt;br&gt; o <strong>speed limits around schools</strong></td>
</tr>
<tr>
<td>Strengthening Community Action</td>
<td>Strengthening community actions means supporting collective efforts in communities to increase their access to and control over the social determinant’s of health &lt;br&gt; Community action is strengthened through communities being involved in setting priorities, making decisions, planning strategies and implementing them to improve health outcomes. &lt;br&gt; Community becomes more empowered when they take part in gaining more control over the decisions and actions that affect their health &lt;br&gt; Is all about community involvement in the health promotion process</td>
<td>→ <strong>Close the Gap</strong>&lt;br&gt; Launched in 2006 following National Indigenous Health Equality Campaign&lt;br&gt; Human Rights and Equal Opportunity Commission&lt;br&gt; National Aboriginal Community Controlled Health Organisation&lt;br&gt; Oxfam&lt;br&gt; Congress of ATSI nurses&lt;br&gt; Australian Indigenous Doctors Associations&lt;br&gt; o <strong>ATSI community involved in decision making committees</strong>&lt;br&gt; o <strong>Heart Foundation walking</strong></td>
</tr>
<tr>
<td>Re-orientating Health Services</td>
<td>Reorienting health services is about the shift towards a system which promotes health, rather than curative services. &lt;br&gt; The shift is to focus on the needs of the entire individual, not just their injury, illness or disease.</td>
<td>→ <strong>Family Planning NSW - leading the way</strong>&lt;br&gt; A service that provides reproductive and sexual health services in NSW&lt;br&gt; In regards to sexual health&lt;br&gt; Do not have to get a referral or visit a doctor → <strong>Women’s health centres</strong></td>
</tr>
</tbody>
</table>
● Preventative rather than curative  
● Distributing health services to places that need them  
● HOLISTIC approach to health promotion  
● TAKING the health service out of building and out of hospitals and deal with diseases more holistically to deal with the issue e.g. person struggles to breathe  
● Take medical people and put them into the community e.g. Vaccinations, NSW health go into schools to give children vaccines  
● Bringing health professionals in community settings  
● E.g. the Jane McGrath foundations, Breast Cancer vans that go out to country areas in Australia, rural/remote people go into vans to get checked  
● Taking the health promotion to the people  
● Blood bank goes to KPMG to collect blood whilst checking their blood pressure and moving services to where people are  

● To cater for the specific health needs of women and children  

do Tobacco Use  
● New clinical guidelines for health professionals and their role in supporting the cessation of tobacco use  
● GPs need to use guidelines on making smokers quit  
● GPS offices and waiting rooms now filled with Quit advertisements to help people quit  
● GPs bring up quit smoking so that people are more inclined to make an attempt to quit smoking  
● Doctors and pharmacists promoting QUIT smoking  
● Cancer screening in R&R areas  
● Vaccinations at schools  
● Mobile Breast Screen, Stop revive survive  

Building Healthy Public Policy  
● Policy development at all levels seeks to promote health. It includes: legislation, fiscal measures, taxation, and organizational change.  
● Policies need to identify obstacles to health and seek to remove them, making the healthier choice the easiest one.  
● Also providing FUNDING to NGO’s and hospitals  

o Taxation subsidies on low-alcohol beer  
o Legislation requiring the wearing of seatbelts  
o Occupation health and safety regulations  
o School polices related to sun safety and provision of health foods in canteens  
o Legislation  
o Compulsory wearing seatbelt warning  
o Random breath testing  
o Intensive speed camera programs  
o Roadside drug testing have all contributed to the decrease in road injuries and fatalities  

EXAMPLE: Heart Foundation Walking  

<table>
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<tr>
<th>Build Healthy Public Policy</th>
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<th>Strengthen Community Action</th>
<th>Develop Personal Skills</th>
<th>Reorient Health Services</th>
</tr>
</thead>
</table>
| ● Addresses National health priority  
● National Program grant recipient  
● Links to broader advocacy work | ● Area Coordinator Training  
● Community Development Approach  
● Group Walking Events  
● Partnerships “Park Walks”  
● ABC radio promotion  
● Regional forums  
● Volunteer Recruitment and training  
● HFW month | ● Social Support  
● Neighbourhood ‘Walkability’ Checklist  
● Walker Recognition scheme  
● Broader HF work – Healthy planning | ● Newsletters  
● Walkers Kit  
● Events and Seminars  
● Health info service link  
● Walking organiser training | ● Referred to by professionals  
● Linked to GP’s |

◆ Critically analyse the importance of the 5 action areas of the Ottawa Charter through a study of TWO health promotion initiatives relating to Australia’s health priorities

Road Safety (2010)  
● This is a framework that aims to half the road fatalities by 2020.  
● It describes speeding as the greatest contributor to road fatalities in NSW.
- It also aims to reduce the cost of speed-related crashes, which were over $827 million per year.
- Road Safety utilises the five (5) action areas of the Ottawa Charter in seeking to achieve safer roads for all Australians.

<table>
<thead>
<tr>
<th>Examples for Campaign</th>
<th>Building Healthy Public Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Legislation was created in order to allow fixed speed cameras in NSW.</td>
<td></td>
</tr>
<tr>
<td>- Even small reductions in speed save lives and decrease morbidity caused by road accidents.</td>
<td></td>
</tr>
<tr>
<td>- 50Km/h urban speed limit was part of the nationwide strategy</td>
<td></td>
</tr>
<tr>
<td>- Road safety courses are being developed to develop safer driving habits and further testing has been added to the requirements for driver training e.g. hazard perception test and driver qualification test</td>
<td></td>
</tr>
<tr>
<td>- Penalties have also increased for drink driving, speeding, and road rage.</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
<th>Creating Supportive Environments</th>
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<tbody>
<tr>
<td>- Make speeding socially unacceptable using the ‘Speeding – no one thinks big of you’ campaign.</td>
</tr>
<tr>
<td>- Increased awareness of the police operations targeting young drivers through the ‘P plate speeding campaign’.</td>
</tr>
<tr>
<td>- The installation of fixed speed cameras, particularly around school zones and traffic lights (safety cameras), including the warning signs for the cameras.</td>
</tr>
<tr>
<td>- Intelligent Speed Adaptation systems have been and are being tested to provide information to the driver regarding speed limits or that limit the speed of the vehicle to that of the zone.</td>
</tr>
<tr>
<td>- Roads upgraded with higher safety standards</td>
</tr>
<tr>
<td>- Cycle ways constructed to separate cyclists from traffic.</td>
</tr>
<tr>
<td>- Road crossing facilities, audio/tactile signals, and ramps for wheelchairs, prams and shopping trolleys upgraded in safety for pedestrians.</td>
</tr>
</tbody>
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<tr>
<th>Strengthening Community Action</th>
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<tbody>
<tr>
<td>- Sponsoring the RTA Speed Blitz Blues to raise awareness of the consequences of speeding in an attempt to change attitudes to speeding.</td>
</tr>
<tr>
<td>- Works with community-based organisations to provide ‘driver reviver’ stops to combat fatigue related accidents.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Developing Personal Skills</th>
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<tbody>
<tr>
<td>- ‘speeding campaign’ to provide information about the difference 5Km/h makes to an accident.</td>
</tr>
<tr>
<td>- Remove myths about being familiar with the roads meaning safer driving through the ‘country speeding campaign’.</td>
</tr>
<tr>
<td>- The ‘notes campaign’ targets 17-25 year-old drivers increasing awareness of speeding and mortality in the hope to encourage them to think before acting in order to modify speeding habits.</td>
</tr>
<tr>
<td>- The introduction of the Graduated Licensing Scheme improves the knowledge and driving ability of young drivers and school education programs on road safety aims to protect children and instill long-term safe behaviours.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Re-orientating Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The ‘Slow Down Road show’ travels around the state educating the community about the consequences of speeding.</td>
</tr>
<tr>
<td>- Many of the other strategies and campaigns mentioned that increase road safety awareness promote a preventative approach to road safety issues, and are examples of reorienting health services towards health promotion.</td>
</tr>
</tbody>
</table>

**Effectiveness**
- This health promotion has been successful in reducing road fatalities since 2010 and reduced hospitalisations from road related accidents.

**The National Tobacco Strategy (1997)**
- The primary objective was to elevate quitting on smokers' personal agendas.
The campaign recognised that to potentiate the intention to quit smoking, an individual needed to gain fresh insights.

Smokers needed to see material as personally relevant and gain confidence in their own ability to quit smoking (self-efficacy) as well as see they would gain more than they lost by giving up smoking.

<table>
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<th>Examples for Campaign</th>
<th>Effectiveness</th>
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<tbody>
<tr>
<td><strong>Building Healthy Public Policy</strong></td>
<td></td>
</tr>
<tr>
<td>Regulating tobacco sales by enforcing laws to bane sales to minor, limiting visibility of tobacco products</td>
<td>Laws and fine ensure retailers don’t sell to minors, people won’t be reminded to buy them if they are not on display</td>
</tr>
<tr>
<td>Tobacco tax to increase customs duty, and reducing the extent of promotion discounts</td>
<td>Less affordable to smokers</td>
</tr>
<tr>
<td><strong>Creating Supportive Environments</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation of promotion: Eliminating promotion of tobacco products, discoursing and addressing the harm caused through the media</td>
<td>People not exposed to messages that may glorify smoking</td>
</tr>
<tr>
<td>Regulating the Place of Use: ensure that indoor areas of workplaces and public places are covered by legislation smoking prohibitions e.g. no smoking in schools</td>
<td>Smokers may be encouraged to gid up or reduce smoking by not being able to smoke at work, also protects passive smoking</td>
</tr>
<tr>
<td>Tailored, personalised counselling by trained provides or fact to face people</td>
<td>Continual support from a councillors may help smokers overcome temptations</td>
</tr>
<tr>
<td><strong>Strengthening Community Action</strong></td>
<td></td>
</tr>
<tr>
<td>Find and support quitters who speak about the benefits their live</td>
<td>ATSI smokers may be more inclined to listen to quit messages from those who have been smokers and are members of their community</td>
</tr>
<tr>
<td>Ensure ATSI organisations are represented on expert and decision making committees</td>
<td>Key stakeholders are represented ensuring cultural considerations are made when decision making</td>
</tr>
<tr>
<td>The Centre for Excellence in ATSI tobacco control has been funded to develop culturally appropriate ATSI tobacco control resources</td>
<td>Will be target specifically at ATSI community, which ensure no cultural barriers</td>
</tr>
<tr>
<td><strong>Developing Personal Skills</strong></td>
<td></td>
</tr>
<tr>
<td>Self help materials in print or online and tailored advice delivered electronically or by post</td>
<td>Smokers having access to indo to help themselves irrespective of location</td>
</tr>
<tr>
<td>Making children get age-appropriate indo about short and long term effect of smoking e.g. healthy Harold and PDHPE</td>
<td>Education at young age from many sources will deter children from smoking at old age, equip with refusal skills in the future</td>
</tr>
<tr>
<td>Distribute QUIT materials promotion Quit line in disadvantaged areas e.g. house estates, regional areas</td>
<td>Smokers would be disadvantaged if they get these services are more educated equity</td>
</tr>
<tr>
<td><strong>Re-orientating Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Advice from doctors and other health providers, intensive counselling at specialist clinics</td>
<td>Supported by health professionals in order to improve health conditions</td>
</tr>
<tr>
<td>Train multilingual pharmacist and other health professions in areas with dense numbers of certain cultures and media releases/pamphlets in different languages</td>
<td>Language barriers are broken down and QUIT messages delivered to all members of community irrespective of cultural background</td>
</tr>
</tbody>
</table>

**Effectiveness**

- Campaign surveys indicated a decline from 23.5% in May 1997 to 20.4% in November 2000
- Has been on a steady decrease for people aged less than 15 years
- People who are committed smoking decreased heaps from 1999 – 2005

The Heart Foundation + McGrath Foundation
<table>
<thead>
<tr>
<th>Building Public Health Policy</th>
<th>The Heart Foundation - CVD</th>
<th>The McGrath Foundation – Cancer (Breast)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Smoking laws and regulations as it is a big factor</td>
<td>o The government provides research and funds the McGrath Foundation</td>
<td>o The government has put money in to fund more breast care nurses to be employed</td>
</tr>
<tr>
<td>o Compulsory physical activity classes from Kindergarten – Year 10 in PDHPE</td>
<td>o have allocated funding for health promo amongst breast care</td>
<td>o The federal government is allocating funding into research</td>
</tr>
<tr>
<td>o Research funding from the federal government to promote their work</td>
<td>o $20.5 million currently from the federal government goes into funding breast care</td>
<td>o The government has put money in to fund more breast care nurses</td>
</tr>
<tr>
<td>o The National Health and Medical Research Council funds them</td>
<td>ohave allocated funding for health promo amongst breast care</td>
<td>o Funding for breast cancer nurses to make women feel more comfortable and inclined</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strengthening Community Action</th>
<th>The Heart Foundation Walking Initiative –provides old people with an opportunity to interact with community and go for a walk to strengthen physical dimension of health</th>
<th>Mothers Day Classic/Other fun runs brings together people who have had cancer, are affected by indirectly/directly come together to increase money</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Jump Rope for Heart – The community is the primary schools promoting physical activity amongst children</td>
<td>o The community is the primary schools promoting physical activity amongst children</td>
<td>o Funding breast care nurses, specific nurses to create supportive environments for women who are breast cancer nurses: they have empathy, are familiar and have specialist knowledge</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Creating Supportive Environments</th>
<th>The Heart Foundation Walking Initiative – Aimed at bringing people together to go for walks, bush walks etc.</th>
<th>Breast cancer morning teas in schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Website has Heart Foundation Recipes</td>
<td>o Aimed at the elderly</td>
<td>o Mothers Day Classic/Other fun runs brings together people who have had cancer, are affected by indirectly/directly come together to increase money</td>
</tr>
<tr>
<td>o The Heart Foundation Tick on foods – the red tick creates supportive environments making it easier for consumers to purchase foods low in sugar, salt and fat</td>
<td>o The community is the primary schools promoting physical activity amongst children</td>
<td>o Funding breast care nurses, specific nurses to create supportive environments for women who are breast cancer nurses: they have empathy, are familiar and have specialist knowledge</td>
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<tr>
<th>Reorientating Health Services</th>
<th>The heart foundation provides guideless, publications, training and support for the health professionally community</th>
<th>Go into the doctor and getting a pap smear, breast mammogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>o They train professionals to be more aware of heart attack symptoms and signs</td>
<td>o The “Curve Lurve” caravans going to rural/remote communities providing breast screening opportunities taking health service and moving it out to the people, they travel around the countryside and people can get info about breast cancer</td>
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</tr>
<tr>
<td>o NGO trains professionals</td>
<td>o Breast cancer nurses help people by going around to different areas</td>
<td>o Breast cancer nurses help people by going around to different areas</td>
</tr>
<tr>
<td>o Chemists can now do blood pressure check out of the DR surgery and is in an area more covenant ie. The shopping centre</td>
<td>o Book the red cross caravans for donations of blood everyone is screened</td>
<td>o Book the red cross caravans for donations of blood everyone is screened</td>
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<tr>
<td>o Booking the red cross caravans for donations of blood everyone is screened</td>
<td></td>
<td>o Go into the doctor and getting a pap smear, breast mammogram</td>
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<tr>
<th>Developing Personal Skills</th>
<th>The website provides pdf’s and e-resources on the website about; different forms of heart issues, info about blood pressure, cardiac rehab</th>
<th>On the website have information about Breast Cancer Awareness – Stats, and “What is Breast Cancer Awareness”</th>
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<tr>
<td>o App with breast cancer information</td>
<td>o “Curve Lurve”</td>
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<td>➔ A national breast cancer awareness initiative aimed at young women</td>
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<td>➔ Encourages women to be comfortable with their breasts and take care of them</td>
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Effectiveness

- Jump rope for heart was effective
- 400,000 students and 2,300 schools participate annually
- 98% of schools rate ‘excellent’ or ‘very good’
- Most students 97% reported an increase (from little to a lot) in their physical activity levels