CHAPTER 2

WHAT ARE THE PRIORITY ISSUES FOR IMPROVING AUSTRALIA’S HEALTH?

- groups experiencing health inequities
- 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

Despite Australia’s ranking as one of the healthiest nations in the world, our high life expectancy, low mortality rates and improving health status of the whole population are not shared by all groups. Aboriginal and Torres Strait Islander people suffer extraordinarily poor health status, while other groups including socioeconomically disadvantaged people, people in rural and remote areas, overseas-born people, the elderly and people with disabilities also experience different health status and experience a variety of health inequities.

- Aboriginal and Torres Strait Islander peoples

Currently, 75% of Indigenous Australians live in cities and regional centres, while 25% live in remote areas. The median age of the Indigenous population is 21 years, compared with 36 years for the non-Indigenous population.

- the nature and extent of the health inequities

The magnitude of the health inequities experienced by Indigenous Australians is starkly demonstrated by a comparison of life expectancy data. For example, the life expectancy of an Indigenous female born in 2001 is 65 years. This is equivalent to the life expectancy for a non-Indigenous female born in 1922! The life expectancy of 59 years for an Indigenous male born in 2001 equates to the life expectancy for a non-Indigenous male born in 1910!

The gap between Indigenous and non-Indigenous life expectancy is currently about 17 years.
Mortality rates for Indigenous Australians continue to be unacceptably high in comparison to other Australians. Between 2001 and 2005, death rates for Indigenous males and females in most states were almost three times those for non-Indigenous males and females.

Infant mortality (measured per 1000 live births) remains about three times higher than for the whole population at 15 per 1000 for males and 12 per 1000 for females.

The five leading causes of death for Indigenous people were:

- diseases of the circulatory system
- cancers
- endocrine, metabolic and nutritional disorders (including diabetes)
- respiratory diseases
- injuries.

Note that injuries caused by transport, assault and self-harm, were responsible for deaths amongst young Indigenous males at three times the non-Indigenous rate.

There are, however, some positive trends too. Indigenous mortality rates decreased significantly in Western Australia between 1991 and 2005; and throughout Australia the gap between Indigenous and non-Indigenous infant mortality rates has closed considerably since 1991.
Morbidity

Indigenous Australians continue to experience lower health status than other Australians as a result of higher levels of disability and reduced quality of life. The burden of disease among Indigenous Australians represents 3.6% of all disability-adjusted life years (DALYs), yet they represent only 2.5% of the total population.

In 2004–2005, Indigenous adults were twice as likely as non-Indigenous adults to report their health as fair or poor (29% compared with 15%), as well as twice as likely to report high or very high levels of psychological distress compared to non-Indigenous adults.

The main causes of poor health among Indigenous people include mental disorders, circulatory diseases, diabetes, respiratory diseases, cancers, musculoskeletal conditions, eye and ear problems and kidney disease (which has increased markedly between 2001 and 2004–2005).

In 2005–2006, Indigenous people were hospitalised at 5 times the rate of non-Indigenous people and at 14 times the rate for care involving dialysis.

In positive indicators, fewer Indigenous people suffer skin cancers and cases of prostate cancer than the overall population. Additionally, rates of asthma, back pain and hearing problems among Indigenous people have all declined between 2001 and 2005.

In the 2004–2005 NATSIHS survey, when Indigenous Australians were asked about their feelings of calmness and happiness, 71% reported being happy, 56% reported being peaceful, and 55% reported being full of life all or most of the time.
Indigenous Australians experience significant socioeconomic and sociocultural challenges. Cultural divisions and conflicts since European settlement, ill-advised or ineffective programs of integration, separation, education and welfare support have all contributed to the poor state of Indigenous health. Even as recently as 2008, the Australian Government’s intervention into Indigenous communities, designed to reduce reported widespread child abuse, has demonstrated just how complex the interaction of social, cultural and political factors can be (see Feature Article on the following page).

In the 21st century our holistic understanding of health and its multiple determinants is needed to address many health inequities. The most critical challenges for Indigenous Australians include:

- **Lower incomes**: Median household income for Indigenous families in 2006 was equal to about 55% of median household income for non-Indigenous families.
- **Higher rates of unemployment**: The unemployment rate of 16% for Indigenous people in 2006 was three times the rate of 5% for non-Indigenous people.
- **Lower educational attainment**: The proportion of Indigenous people who had completed Year 12 in 2006, ranged from 36% of people aged 18–24 years (less than half the non-indigenous rate) to 9% of people aged 55 years and over (just over a quarter of the non-indigenous rate). Overall, Indigenous males and females reported similar rates of Year 12 completion (22% compared with 24%). Poor levels of school attendance are a major problem for many Indigenous groups.
- **Lower rates of home ownership**: The proportion of Indigenous families who owned or were purchasing their own homes in 2006 was half the rate of other Australian households (34% compared with 69%).

Despite the inequities reflected by these social indicators, progress is being made in some areas. There are other less tangible cultural factors that can be observed, though perhaps not so easily measured, in the Indigenous population, or in some groups within that population. There is a reported sense of ‘loss of control of their own lives’ among some Indigenous Australians, which contributes further to the level of inequity. Communal approaches to family and parenting, the remoteness of some communities, incompatibility with many aspects of Australia’s political, legal and educational systems, and lack of role models in some areas of society have all been identified as social determinants that contribute in some way to the inequities experienced by Australia’s Indigenous people.

It is difficult to precisely measure the relationship between these social determinants, multiple risk factors and health status. However, in the 2008 AIHW on Aboriginal health and welfare, it emphasised that the underlying social determinants mentioned above, clearly increase the likelihood of exposure to a number of the following health risk factors.
Intervention ‘has done lasting harm’

The Howard Government’s intervention into Northern Territory communities has caused ‘immediate and lasting harm’ to Aborigines and provoked mistrust and anger towards western culture, doctors say.

Far from helping indigenous people, the emergency reforms launched in June last year have compounded feelings of disempowerment and had a negative impact on wellbeing and health.

The claims have been made by the Australian Indigenous Doctors Association (AIDA) in a submission to the review board, headed by Peter Yu.

It will report back to the Rudd Government later this year on the progress of the controversial measures to combat child sex abuse, with its recommendations to determine the future course of indigenous policy in Australia.

In an 18-page submission, the AIDA acknowledges ‘in principle support’ for aspects of the intervention, such as an increase in police, additional teachers and ‘much-needed government attention’ on the issue of Aboriginal health.

But, the submission says, research conducted by AIDA suggests the intervention has done far more harm than good. ‘Our research shows that the NTER (NT Emergency Response) has caused immediate and lasting harm,’ it says. ‘As medical professionals, we are deeply concerned about the impacts.’ It also warned some negative impacts of the reforms may ‘not be realised until further down the track’.

The organisation said the child health checks often duplicated existing services and should be viewed as the basic right of all Australians to access to health care. ‘Community members expressed feelings of loss of responsibility, loss of control, loss of power and a hardening of mistrust towards the Australian Government and dominant western culture in Australia. ‘This has resulted in feelings of anger and powerlessness, it has caused cultural, social and emotional harm.’

Many Aboriginal people also felt the reforms, such as welfare quarantining and grog bans, were discriminating against them, it said. ‘Our interviews very powerfully evoked a sense a regressing to the old days: many people referred to the feelings of shame, humiliation and loss of dignity that particularly characterised an earlier ‘protectionist period’ when the government controlled every aspect of indigenous people’s lives.’

AIDA has recommended the Government adopt an approach using existing good practice in indigenous health along with a genuine partnership with Aboriginal people.

Source: Tara Raven, The Australian, 29 August 2008
**Tobacco use**

Tobacco use was the main contributor to the burden of disease among Indigenous Australians. In 2004–2005, 50% of the Indigenous population reported being daily smokers, with the majority having taken up smoking before 13 years of age. Smoking rates among Indigenous people are twice those for other Australians. Regular smokers also reported higher levels of illicit substance use.

**Alcohol consumption**

In 2004–2005, 1 in 6 Indigenous Australians reported chronic levels of risky drinking. This was a slight increase from 2001 and similar to non-Indigenous levels. More Indigenous than non-Indigenous Australians are likely to abstain from drinking, especially in remote areas, but Indigenous Australians binge drink at twice the rate of other Australians.

**Illicit drug use**

 Twice as many Indigenous Australians over 15 years old (28%) reported using an illicit drug in the past 12 months as other Australians (15%). Substance use is a contributing factor to illness and disease, accident and injury, violence and crime, family and social disruption, and workplace problems. Marijuana and amphetamines were the most commonly used drugs. Apart from alcohol, illicit substance use contributed most to the burden of disease.

**Overweight and obesity**

Over 50% of Indigenous Australians are overweight, similar to non-Indigenous rates. Obesity rates among Indigenous Australians living in non-remote locations have increased since 1995 and become more prevalent with age.

**Poor nutrition**

There is little difference between Indigenous and non-Indigenous compliance with the National Health and Medical Research Council (NHMRC) nutritional guidelines. Fresh fruit intake is slightly lower in remote areas due to availability.

**Physical inactivity**

Indigenous Australians, in particular females, were more likely than non-Indigenous Australians to be sedentary or to exercise at low levels.

**Exposure to violence**

The 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) reported Indigenous exposure to violence at twice the rate of other Australians. This rate had doubled since 1994. Exposure was three times more likely in remote locations. Young men were the most likely to have experienced physical or threatened violence.

**Poor housing conditions**

In a 2004 survey, overcrowding was reported to affect 1 in 4 Indigenous Australians, and was most prevalent in rented dwellings. In 2006, over 30% of Indigenous community housing dwellings needed major repairs or replacement.
Environment

With regard to environmental determinants, housing standards are clearly a priority issue. Other environmental issues that affect health in remote communities include water supply, training for ATSI environmental officers, transport, communication and health and safety relating to dogs.

It is important to make the point, though, that despite the detrimental effect of some of these risk factors, positive achievements are also being made in reducing exposure to them and their underlying determinants.

The AIHW report, *The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples 2008*, provides a comprehensive overview of the health and welfare of Australia’s Indigenous population. The full report can be downloaded from the AIHW website:


Aboriginal health is a major problem for this nation. Given the generally poor state of current health indicators, it is fair to say that the strategies and programs undertaken so far have had limited success.

Modern approaches to healthcare and health promotion acknowledge the fact that Indigenous health status results from the interaction of multiple determinants, and requires a similarly multi-faceted response from the healthcare system. This should include an ‘intersectoral’ approach, based on partnerships between people and agencies at many levels and in a variety of sectors.

Government

There are two peak agencies which coordinate Indigenous health services at the federal government level, while a third peak body in New South Wales oversees Indigenous health at a state level.
The Office of Aboriginal and Torres Strait Islander Health (OATSIH)

This agency has been established within the Department of Health and Ageing to bring greater focus to the Australian Government’s delivery of mainstream health services to Indigenous Australians. It is also responsible for administering and funding ATSI community controlled health and substance use services.

OATSIH provides direct grants to around 245 organisations, of which around 80% are ATSI community controlled or managed.


The National Aboriginal Community Controlled Health Organisation (NACCHO)

This agency works with the Department of Families, Housing, Community Services and Indigenous Affairs. It is the national peak Aboriginal health body representing Aboriginal Community Controlled Health Services throughout Australia. It is an autonomous body that advocates for improvements to ATSI health.

www.naccho.org.au

The Aboriginal Health and Medical Research Council of NSW (AH&MRC)

This is the peak body for Aboriginal health in New South Wales and is comprised of over 60 Aboriginal Community Controlled Health Organisations throughout the state.

The AH&MRC provides vital health and health-related services in association with its member organisations. These combined services include:

- health service delivery
- supporting Aboriginal community health initiatives
- development and delivery of Aboriginal Health education
- research in Aboriginal Health
- collecting, evaluating and disseminating Aboriginal health data
- policy development and evaluation.

The AH&MRC aims to ‘reduce ill health, suffering, distress and helplessness in Aboriginal communities by the direct provision of primary healthcare, including social and emotional wellbeing services and support programs for Aboriginal communities’.

www.ahmrc.org.au
Community

Indigenous Australians do not access primary healthcare services to the extent they should, as a consequence of lack of availability of services, transport and distance to services, cost and language or cultural barriers.

OATSIH, NACCHO and the AH&MRC all aim to improve the access of Indigenous people to primary healthcare services. These agencies base their strategies on the principle of working in partnership with the Aboriginal and Torres Strait Islander community controlled health sector. Improved access and stronger delivery of comprehensive primary healthcare at the community level are the most sustainable ways of making a significant long-term difference to Indigenous health status.

Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal Medical Services (AMSs) are primary healthcare services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate healthcare to the community that controls it. Aboriginal communities run hundreds of such local health services. Some are large, providing a wide range of services through numerous medically trained staff. Others are small, relying solely on Aboriginal health workers and nurses to deliver primary care, education and preventative services. All of these services are independent, but together they form a health network that shares the philosophies of self-determination and a holistic view of health.

The nature of the services provided varies from one community to another, though generally they include clinical care, health education, promotion, screening, immunisation and counselling, as well as specific programs such as men’s and women’s health, aged care, transport to medical appointments, hearing health, sexual health, substance use and mental health.

‘Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.’ (NAHS, 1989).
The responsibility for producing Aboriginal health solutions lies with the local Indigenous people working in their own communities and using their own philosophies, to promote healthy behaviours and deliver culturally appropriate primary healthcare services.

**Individuals**

An individual’s capacity to reduce their risky health behaviours and to increase their protective health behaviours or promote good health in others is influenced by a variety of factors; these include age, family history, community support, education, role modelling, access to health services and socioeconomic status. While individual responsibility for health might differ in some ways for mothers, fathers, the elderly, health professionals or educators, it is education and access that appear to have the greatest impact.

There is a strong focus in many Aboriginal Health Services on providing education and support for Indigenous mothers and children, on increasing the number of Aboriginal health workers, community support workers and medically trained staff and on increasing community capacity by empowering individuals. Health services focus on improving the knowledge and skills of community members. Women and mothers are often targeted as custodians of health knowledge and practice. A recent initiative to target men’s health has also been introduced and funded by OATSIFH.

The Healthy for Life (H4L) Program provides support for local health services and programs, including improved health training and education for Indigenous people. Among its initiatives is the National ATSI Child and Maternal Health Exemplar Site Initiative, which identified and documented three outstanding child and maternal health services. The resultant website has been used to educate and promote best practice in this area of health.


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**Socioeconomically disadvantaged people**

Socioeconomic status (SES) describes the ‘position’ or ‘power’ of a person or group in the community. In Australia, Socioeconomic Indexes for Areas (SEIFA), which measure the average SES of people living in a local area, such as within a postcode region, are used to produce an Index of Relative Socioeconomic Disadvantage (IRSD).

Socioeconomic disadvantage is the existence of:

- limited material resources (including income)
- reduced access to educational opportunities

![Index of relative socioeconomic disadvantage scores by health area, NSW 2006](image)
• less safe working conditions
• lower employment status
• worse living conditions during childhood
• less access to services
• greater likelihood of racism or discrimination.

— the nature and extent of the health inequities

Many studies have identified a strong relationship between low socioeconomic status and lower health status. Health status is better or worse according to where a group or individual is positioned on this social ladder. For instance, those with the most resources and access are healthier than those in the middle, who in turn are healthier than those with the least resources and access.

People from areas of lower socioeconomic status:
• are more likely to suffer cardiovascular disease, diabetes, asthma, mental illnesses and arthritis
• lose more years of life due to diabetes, cardiovascular disease, road traffic accidents and lung cancer
• experience lower life expectancy as a result of these and other causes.

— the sociocultural, socioeconomic and environmental determinants

Studies have highlighted a strong relationship between low socioeconomic status and low health status which, for an individual, may persist from birth through to adulthood and into old age (and possibly to the next generation). If this is the case, it presents difficult challenges for governments and health service providers who aim to improve the health status of the socioeconomically disadvantaged.

Inadequate income, single parent family structure, poverty or family breakdown can all contribute to low SES, and by their nature they increase the likelihood of a person to have reduced access, limited resources, restricted educational opportunity and control over their life.

People from areas of lower socioeconomic status are more likely to:
• be daily smokers
• eat less than the recommended servings of fruit and vegetables
be overweight or obese
be sedentary or physically inactive
report higher levels of psychological stress
visit a doctor or emergency clinic
depend on government assistance
avoid the use of preventative health services.

The relationship between socioeconomic disadvantage, health determinants and health status is very complex. Just as low SES appears to lead to poor health, so poor health can lead to low SES. This can result in a cycle of problems. For example, illness or disability might cause unemployment or reduced capacity to work or study. This would lead to reduced income, which might limit capacity to pay for medical services like dental checkups, or health insurance. In turn, this would contribute to a lower level of health, which might restrict employment opportunities, and so the cycle continues.

Lower levels of education result in poorer health knowledge, which might affect health behaviours. However, studies indicate that the most critical influence of lower education levels on health is a sense of ‘lack of control’ over life and the future.

—the roles of individuals, communities and governments in addressing the health inequities

Socioeconomically disadvantaged Australians experience universally poorer health status than other Australians. They also report greater use of doctor and casualty outpatient services, but are less likely to use preventive services.

Government

Federal and state governments recognise the costs of poor health among people with low SES and are committed to continually make improvements in funding and broad policy to reduce health inequities. At the national level, Medicare and the Pharmaceutical Benefits Scheme (PBS) are programs designed to address the needs of the socioeconomically disadvantaged, by providing lower cost health services and medications for those who can least afford them.

The key priorities in the State Health Plan are for other government and non-government services and the private sector to work together and bridge the health gap between the people with the best health and those with poorer health in New South Wales.

State government responsibilities relate to service provision and prevention. Exposure to risk factors is higher among low SES people and the NSW Government has strategies in place to address this. Some of these strategies relate to:

• child health and wellbeing
• immunisation
• mental health
• obesity
• sexual health

• oral health
• chronic disease
• urban planning
• tobacco
• drugs and alcohol.

The State Health Plan reflects the NSW Government’s priorities for the development of the public health system towards 2010 and beyond. A full copy is available on the Department of Health’s website:


Communities and individuals

The success of these strategies is dependent on services and information being successfully delivered into the most disadvantaged communities. Reduced exposure to risk factors and better delivery of primary care services is critical in order to reduce the inequitable burden of disease these communities suffer.

The prevention of disease and the management of illness within communities rather than
hospitals will become increasingly important and relevant to changing needs. This will require the development of an increasingly community-based health workforce. As socioeconomic disadvantage is caused by many different factors, any agencies that can provide community healthcare, childhood services, parenting and maternity services, community language services, housing assistance, employment training, home care, meals, migrant services, education and other services that address the actual causes of low SES will improve the health outcomes of low SES people.

– people in rural and remote areas

People who live in regional areas represent 29% of the Australian population and those who live in remote areas represent 3%. In general, they experience higher levels of mortality, disease and health risk factors than Australians living in major cities.

– the nature and extent of the health inequities

Compared to their city dwelling counterparts, people living in rural and remote areas:
• experience similar levels of diabetes, cerebrovascular disease (stroke), coronary heart disease, depression and anxiety
• experience slightly higher levels of cancer in rural areas but lower levels of cancer in remote areas
• are more likely to suffer acute or chronic injury
• experience lower life expectancy, increasing with remoteness
• were less likely to report very good or excellent health
• were more likely to show high to very high levels of psychological distress amongst males.

– the sociocultural, socioeconomic and environmental determinants

Information about people in rural and remote areas can parallel closely with information about Indigenous Australians and about low socioeconomic status. People living in rural and remote areas have fewer educational and employment opportunities, lower income and less access to goods and services; they may even have less access to basic necessities like fresh fruit and vegetables.

The long distances between population centres, sparse population distribution and difficulty providing health services, staff and goods all contribute to lower health status in rural and remote areas.

People living in rural and remote areas were more likely to:
• drink alcohol in risky quantities that would be harmful in the short term
• be overweight or obese
• consume less low-fat or skim milk or to eat under the recommended two serves of fruit per day
• consume four or more serves of vegetables per day
• experience lower birthweights, particularly among teenage mothers.

– the roles of individuals, communities and governments in addressing the health inequities

Government

The Rural Health Priority Taskforce provides advice to the NSW Government about improving health services to people in rural areas of the state. Among the main responsibilities identified in the State Health Plan are the need to:
• attract and retain more health professionals in rural and remote communities
• provide sustainable quality health services
• make health services more accessible for people in rural and remote areas via initiatives such as Telehealth, a visual telecommunications system for clinicians and patients.
• implement innovative models of service, staffing, networking, rural and remote health professional support, professional development and family support.

The NSW Government runs programs such as the Medical Specialist Outreach Assistance Program, offers a range of scholarships and grants to support rural health professionals and in cooperation with the Australian Government, runs the Multi Purpose Service (MPS) Program, as one model of service delivery to address the difficulties of providing health, aged and community services in rural and remote communities.

**Communities**

Rural communities struggle to sustain adequate health and medical services for their residents. They work in partnership with governments and other agencies to adapt to changing demands and circumstances that require flexibility and constant adaptation. These communities find it difficult to run services based on the same models established for services in the larger centres and cities.

Since November 2008, there were 49 multipurpose services running in New South Wales rural communities. These programs set aside the normal program guidelines and constraints so that smaller communities can integrate services, better match services to community needs, achieve gains in productivity, reduce administration overheads and share resources. The MPS model is aimed at:

• establishing viable acute health, aged care and community services
• improving access to appropriate services
• increasing coordination, flexibility and innovative service delivery.

In order to run health services, it is essential that rural communities are able to attract and retain properly trained staff. The Australian Rural Health Education Network (ARHEN) is another agency that plays an important role in sustaining health and medical services in the bush. This is a network of University Rural Health Departments committed to increasing retention of health professionals in rural areas. Their initiatives include training and educational opportunities for medical and health professionals that are linked to rural placements for graduates. They also carry out research into the satisfaction rates of rural doctors and health workers.

– overseas-born people

The Australian population comprises 24% of people born overseas. Because of their own natural selection or government selection policies, they are most often people who can afford to emigrate and who have lower levels of illness and disease. Nevertheless, within the entire population of people born overseas, there is great diversity of group characteristics and of health status.

– the nature and extent of the health inequities

The ‘healthy migrant effect’ is reflected in the very low death rates for people born in Hong Kong and Vietnam. Most residents born overseas, especially in South-East Asia, enjoy lower rates of death than other Australians. However, there is a tendency for this effect to reduce as length of residence increases and exposure to typically Australian lifestyle and risk factors becomes more prevalent.

People born overseas:

• suffer higher levels of psychological distress if they have come from war zones, don’t speak English or have trouble in the resettling process
• have hospitalisation rates almost 20% lower than other Australians
• are hospitalised for the following diseases, according to country of birth, at greater levels than others:
  – tuberculosis—India, Vietnam, Philippines, China
  – lung cancer—United Kingdom and Ireland
  – diabetes—Greece, India, Italy, Vietnam
  – heart attack—India
  – heart failure—Italy, Greece, Poland
  – dialysis—Greece, Italy, Vietnam, Philippines, Croatia, India
  – breast cancer—women from England and Northern Ireland

• generally experience death rates lower than for Australian-born people, but with some exceptions, including:
  – lung cancer among people born in the Netherlands and the United Kingdom and Ireland
  – diabetes among people born in Croatia, Greece, India, Italy, Lebanon and Poland
  – coronary heart disease among people born in Croatia and Poland
  – influenza and pneumonia among people born in the United Kingdom and Ireland.

## Migrants are often less exposed to harmful risk factors for cardiovascular and other diseases, such as overweight or obesity, physical inactivity and high risk alcohol consumption in their countries of origin. Nevertheless, the 2004–2005 National Health Survey reported that there were higher levels of exposure to some risk factors for some groups. These included:
• current daily smoking—Oceania (includes New Zealand, Papua New Guinea, Solomon Islands, Kiribati, Fiji, Antarctica)
• sedentary or low exercise levels—Southern and Eastern Europe, North Africa and the Middle East, South-East Asia
• consuming less than the recommended five serves of vegetables per day—every other country-of-birth group

### Table 2.2 — Health risk factors by country of birth, people aged 18 years and over, 2004–2005 (per cent)

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>Current Daily Smoker</th>
<th>Risky/High-Risk Alcohol</th>
<th>Sedentary/Low Exercise Level</th>
<th>Overweight/Obeseness BMI</th>
<th>1 or Fewer Serves of Fruit</th>
<th>4 or Fewer Serves of Vegetables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>22.3</td>
<td>15.3</td>
<td>69.2</td>
<td>50.1</td>
<td>47.8</td>
<td>84.4</td>
</tr>
<tr>
<td>Other Oceania</td>
<td>26.1</td>
<td>12.5</td>
<td>66.8</td>
<td>58.3</td>
<td>44.4</td>
<td>89.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>18.6</td>
<td>15.5</td>
<td>68.6</td>
<td>51.1</td>
<td>45.6</td>
<td>86.7</td>
</tr>
<tr>
<td>Other North-West Europe</td>
<td>18.0</td>
<td>11.8</td>
<td>67.3</td>
<td>50.9</td>
<td>42.0</td>
<td>87.0</td>
</tr>
<tr>
<td>Southern &amp; Eastern Europe</td>
<td>18.4</td>
<td>6.0</td>
<td>81.8</td>
<td>59.5</td>
<td>29.4</td>
<td>88.8</td>
</tr>
<tr>
<td>North Africa &amp; the Middle East</td>
<td>22.8</td>
<td>2.2</td>
<td>79.5</td>
<td>47.5</td>
<td>40.1</td>
<td>92.2</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>15.6</td>
<td>4.4</td>
<td>76.7</td>
<td>29.4</td>
<td>43.5</td>
<td>92.6</td>
</tr>
<tr>
<td>All other countries</td>
<td>14.8</td>
<td>4.7</td>
<td>74.4</td>
<td>34.2</td>
<td>44.5</td>
<td>89.6</td>
</tr>
</tbody>
</table>

Source: ABS 2006. National Health Survey: Summary of Results 2004–05, Australia. Cat No 4364.0
• varying body weights and heights showing they are more likely to be overweight or obese than people born in Australia—Oceania and Southern and Eastern Europe.

– the roles of individuals, communities and governments in addressing the health inequities

**Government**

Many Australians born overseas experience cultural and language barriers that should be addressed so that they can achieve positive health outcomes.

The main approach by governments to the health of people born overseas is to provide translation and language services to improve communication of health issues and access to health services among culturally and linguistically diverse (CALD) communities. This is a more cost-effective approach than duplicating services to specifically address the needs of overseas born people.

The NSW Multicultural Health Communication Service (MHCS) works with health services to provide non-English speakers with access to important health information. These services are strongly promoted to clinical staff and include phone and on-site translation, information and advice, as well as printed materials. They are available to any community members or health professionals who need them.

The NSW Government identifies the delivery of health services to CALD communities and refugees as one of its objectives. Support is also given to health services to extend their coverage in line with the settlement patterns of new arrivals and refugees.

**Communities**

Community participation in health service planning has been able to maximise the quality of health services because communities themselves are best equipped to identify and address the health needs of their members. Historically though, there has been limited capacity for CALD communities to provide input and feedback. Capacity to improve health outcomes improves as communities are given greater opportunity to contribute to health service planning and development.

The critical role of communities is to provide support for their members by advocating, promoting and engaging in the use and delivery of culturally appropriate health services. The training and education of CALD community members to join and support the healthcare profession is the most enabling of all strategies.

The capacity of CALD communities to provide and support healthcare services is governed by the age of the community. The longer a community has been established, the greater capacity to provide appropriate and effective healthcare services.

Many government and non-government services work in partnership with CALD communities to provide a range of healthcare services.

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**Activities**

**Activity 1 (Page 25)**

Read Tara Raven’s article, ‘Intervention “has done lasting harm” ’ on page 26. With reference to the listed determinants of Indigenous health, write a one page challenge or justification of the intervention.

**Activity 2 (Page 28)**

Use the diagram of the Indigenous healthcare system (Fig. 2.8 on page 30) to construct a table which contrasts the strengths and weaknesses in the current structure.
**Activities cont.**

**Activity 3 (Page 28)**
Access the website of the ‘National ATSI Child and Maternal Health Exemplar Site Initiative’. **Investigate** the three exemplar sites for maternity and child healthcare services.


**Activity 4 (Page 33)**
Access the State Health Plan on the NSW Health website. Research the targets and strategies established by the NSW Government to address two of the areas of health listed in the text.


**Activity 5 (Page 33)**
Use local directories to **identify** and profile a health service provider that supports socioeconomically disadvantaged people in your community.

**Activity 6 (Page 34)**
Access the website for the AMVRDAA ‘Rural Workforce Rescue Package’ fact sheet. Familiarise yourself with the AMA plan for increasing doctor numbers in rural areas.
- Critically analyse the plan, comparing pluses and minuses in a PMI chart.
- Write a set of your own alternative strategies for improving rural health services.


**Activity 7 (Page 37)**
As a class, contact a local healthcare service and ask them to **describe** their experience with the Multicultural Health Communication Service.

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**Review Questions**

1. **Identify** those groups experiencing health inequities within the Australian population.
2. **Describe** three trends in the mortality rates of Indigenous Australians.
3. **Analyse** the impact of a range of health determinants on the health status of Indigenous Australians.
4. **Account** for the impact of low socioeconomic status on health.
5. **Distinguish** between the roles of governments and communities in providing health services to rural and remote communities.
6. **Contrast** the health status of Australians born overseas with the health status of other Australians.
high levels of preventable chronic disease, injury and mental health problems

research and analyse CVD, cancer and ONE other condition listed by investigating:

- cardiovascular disease (CVD)

the nature of the problem

Cardiovascular diseases are diseases of the heart and the blood vessels.

Coronary (ischemic) heart disease results from blockages to the coronary arteries, usually caused by deposits of fatty or other depository material on the inner wall of the artery (atherosclerosis). It restricts oxygen supply to the cardiac muscle and as a result will likely bring on a heart attack (myocardial infarction). The effects of the attack depend on the level of oxygen starvation to the cardiac muscle. They may vary from a falter in the rhythm of the heartbeat to permanently weakened heartbeat or death.

Stroke (cerebrovascular disease) affects the brain, not the heart, but it is a disease of the circulatory system. It occurs when the blood supply to the brain, or part of the brain, is cut off or severely restricted. This is usually caused by the same factors that cause a heart attack. When an artery is blocked the part of the brain to which blood supply has been reduced is damaged and stops working. In turn, the functions of the body controlled by that part of the brain become paralysed. Strokes can range from slight memory loss or repairable nervous or muscular impairment (perhaps even unnoticeable) to extreme permanent debilitation of the brain or body or death. A stroke has a tendency to recur.

Hypertension is high blood pressure. Blood pressure is measured at two levels: systolic (higher) as the ventricles contract and diastolic (lower) between contractions, or at rest. The normal values for an Australian adolescent should be about 120/70 mmHg.

Arteriosclerosis refers to the loss of elasticity of the blood vessels, which restricts the ability to control blood flow. This may result from age, smoking or dietary factors. Atherosclerosis consists of hard material that accumulates in arteries and builds up from a mixture of fat (mainly cholesterol), blood clots, calcium and fibrous tissue formed when arteries heal. These build-ups of plaque cause blockages in the arteries, restricting blood flow to the heart and other organs. This is also a causal factor in other cardiovascular diseases.

extent of the problem (trends)

In 2004–2005, 18% of Australians were reported with cardiovascular disease. The most common of these was hypertension, reported by 11% of the population.

Death rates for all cardiovascular conditions have declined consistently since the 1970s.

In the decade from 1996–2005 the age-standardised death rate for coronary heart disease (CHD) fell by 43% in males and 41% in females.

There was no downward trend in the death rates for stroke between 1950 and 1975, but since the mid-1970s, consistent reductions for both males and females have occurred. Age-standardised death rates for cerebrovascular disease fell by 37% for males and 35% for females between 1996 and 2005.

Deaths resulting from heart failure have also declined. Death rates for heart failure as an underlying or associated cause of death fell by 29% for both males and females between 1997 and 2003.

risk factors and protective factors

Risk factors which are a predominant influence on cardiovascular disease include age (over 65), gender (women increase risk after menopause), diabetes and family history of CVD (generally pre 55 onset).

Other factors which can be modified to reduce the risk include smoking tobacco, dietary factors (fat, salt, sugar and alcohol), high blood pressure, high blood cholesterol, lack of physical activity, overweight and sustained high stress levels.
Protective factors include diet (low in fat, salt and alcohol), non-smoking, regular physical activity, stress management, monitoring blood pressure (maintaining around 120/80) and blood cholesterol (high HDL).

— the sociocultural, socioeconomic and environmental determinants

Factors which affect the nature of health outcomes are a complex pathway of causes. The broad features of a society and its environment influence the socioeconomic and living conditions of an individual or a group. These conditions are combined with knowledge and attitudes to influence health behaviours, and then interact with biomedical factors to produce health outcomes.

Example 1: An individual’s low socioeconomic status may result from poor educational achievement and employment status, which would contribute to a low income. This may lead the individual to decide to buy cheaper meat with higher fat content. This in turn contributes to high blood cholesterol, which increases the risk of cardiovascular disease. Longer working hours as a result of poor employment status might also reduce the individual’s opportunity for adequate physical activity.

Example 2: The geographic size of Australia leads to some people living and working in isolated rural environments. This leads to increased likelihood of lower income, which increases the likelihood of depression or anxiety. This may increase the use of tobacco, contributing to hypertension and cardiovascular disease. The rural dwelling also reduces access to health services, and therefore the likelihood of accessible emergency services arriving on time in the case of a heart attack.

— groups at risk

There are some groups which suffer higher risk, prevalence and burden associated with specific diseases. By targeting increased spending and interventions to these groups, governments and health promoters can improve their health outcomes and ensure the most efficient use of health resources. The generic list of groups described by the Institute of Health and Welfare as ‘priority population groups for health interventions’ includes:

- indigenous people
- rural and remote
- socioeconomically disadvantaged
- veterans
- prisoners
- overseas born people.

Four age groups are also prioritised for health interventions. These are:

- mothers and babies
- children
- young people
- older people.

Other groups identified as being at increased risk of suffering or dying from cardiovascular diseases include people who originate specifically from India, Italy, Greece and Poland; and members of families with a history of premature cardiovascular disease.
– cancer (skin, breast, lung)

– the nature of the problem

Cancers are a group of diseases, all of which result from the uncontrolled and abnormal division of cells. Diseased cells may arise in any organ or tissue of the body. It is most common for people to classify cancers by the organ affected, such as skin cancer or lung cancer, though doctors classify cancers by the affected cell type:

- carcinomas—originating in epithelial tissue, such as the skin or organ linings
- sarcomas—originating in connective tissue, such as the bone cells
- leukaemias—originating in tissues that produce blood cells
- lymphomas—originating in lymph tissue.

These cells continue to divide, but do not differentiate, eventually growing into clumps called tumours. They may invade other tissues or organs, (a process known as metastasis) hindering their normal function.

Lung cancers are identified as small cell, which has usually spread by time of detection; and non small cell, which can be treated locally if identified early. The risk is increased ten times for smokers, and increased again according to the age of the smoker when it was taken up, their daily intake and how long they have been smoking.

Breast cancer is described in stages, according to the size of the tumour and whether it has spread. Stages 0, 1, 2, 3a, 3b, 3c and 4 represent a range of symptoms from the presence of abnormal cells, through different combinations of tumour size and spread, to tumours that have spread widely. The survival rates are 98% for cancers that have not spread beyond the breast and 83% for those that have spread.

Skin cancers range from benign hyperkeratoses (often called sun spots), to basal cell carcinomas (BCC), squamous cell carcinomas (SCC) and malignant melanomas. Despite being classified as skin cancers, the malignant melanomas are aggressive cancers that spread internally, doing damage to organs other than the skin. The damage associated with exposure to UV radiation is more severe in young skin, though symptoms may take years to develop.

– extent of the problem (trends)

By the age of 75 years, 1 in 3 males and 1 in 4 females will have been diagnosed with cancer. This will increase to 1 in 2 males and 1 in 3 females by age 85 years.

There has been a decrease in cancer-related deaths since 1985, but during the same time there has been an increase in new cases. This paradox is the result of improved screening techniques and better survival rates. It is projected that new cases will continue to increase by about 2.5% annually, largely due to the ageing population.

Among males the most common cancer is prostate cancer, which experienced a large increase in incidence between 1984–2004. The next most common cancers for males are colorectal cancer, lung cancer and melanoma.

Among females, breast cancer is the most common. It increased slightly in incidence up to 1994, but has been stable since. The next most common cancers for females are colorectal cancer, melanoma and lung cancer.

The incidence of lung cancer among men and cervical cancer among women have decreased slightly in the past two decades. The incidence of prostate and colorectal cancer among men; lung and breast cancer among women; and melanoma skin cancer and non-Hodgkin’s lymphoma for both men and women increased slightly during the same time.

– risk factors and protective factors

Risk factors which are a predominant influence for most cancers generally include age, gender, family history and inheritance of specific genetic mutations.
Protective factors against cancers generally include not smoking, eating healthily, being physically active, maintaining healthy weight, avoiding sun exposure, avoiding alcohol and monitoring changes in the body for the purpose of early detection.

**Specific risk factors for skin, breast, lung**

Specific cancers also have unique risk factors apart from these general risks. When considering these specific risks, it is important to include the influence of the general risks too.

Skin cancer risk is increased due to fair skin and eye colour, the presence of some types of moles, and geographic location in a high sunlight longitude. High UV exposure, including solariums, is the main modifiable risk factor.

Protective factors against skin cancer include staying in the shade and out of the sun, using protective clothing, sunscreen, hats, sunglasses, monitoring skin changes and having regular checkups as recommended.

Breast cancer risk in women is increased due to early onset menstruation or late menopause, late first full-term pregnancy or childlessness. A high-fat diet and being overweight are the most common modifiable risk factors.

Protective factors include breast self-examination, use of breast screening mammograms at the recommended age and familiarity with family history.

Lung cancer risk is increased due to smoking tobacco and exposure to carcinogenic particles, including asbestos. Protective factors against lung cancer include not smoking, or reducing smoking for those who already smoke, use of appropriate safety measures to avoid exposure to dust and other dangerous inhalants.

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**The sociocultural, socioeconomic and environmental determinants**

There are a multitude of factors which interact to affect the nature of health outcomes for cancers.

Example 1: The challenges of moving to a new country may lead to increased psychological stress. This, combined with cultural acceptance of tobacco use may lead to increased smoking as a way of coping with stress. Increased smoking may increase the risk of lung cancer and other cancers. Poor English language skills might also impact on reduced access to early detection or monitoring programs, which could further increase risk.

Example 2: Living in an affluent consumer society puts financial pressure on a family to have two incomes in order to buy a house and live comfortably. This may put pressure on a young couple to pursue career goals and delay having a family in order to increase income. In turn, a woman may not have her first child until later in life. The late birth of a first child increases the risk of breast cancer.

Example 3: Many Australians who have a genetic heritage of being fair skinned and live in a hot, sunny climate, also enjoy a social heritage of outdoor sports and water activities. They may also be the target of advertising media of the tanned, fit Aussie body as an ideal in the promotion of beauty and sexuality. The growing desire for sun exposure to imitate these images can increase the risk of developing dangerous skin cancers.
– groups at risk

The list of groups described by the Institute of Health and Welfare as ‘priority population groups for health interventions’ and the priority age groups appears on page 40 of this section.

Other groups identified as being at increased risk of suffering or dying from cancers include people born in the United Kingdom and Ireland, and members of families with a history of some specific cancers.

– injury

– the nature of the problem

The term ‘accidents and injuries’ is used by the World Health Organization to classify deaths resulting from external causes. For statistical purposes this group includes motor vehicle accidents, suicides, drowning, poisoning, homicides, falls and other misadventures attributed to external causes. Minor injuries can lead to repairable damage, while more serious injuries can lead to a reduced functioning of the body, permanent disability or death.

– extent of the problem (trends)

More than 1 in 20 Australians were hospitalised as a result of injury between 2005–2006. Deaths due to injury have declined in recent decades. In particular, road traffic deaths have continued to fall, reaching their lowest level in 2008. Suicides and drug-related deaths have also fallen since the late 1990s.

Injuries caused by falls continue to grow in prevalence as a result of an increase in the ageing population.

– risk factors and protective factors

In general, risk factors which are a predominant influence on injury include age and gender, as well as a person’s occupation.

Risk of drowning or poisoning is increased by environmental factors such as safety precautions in the home and consistency of parental supervision. Risk of injury or death in a motor vehicle accident is increased by limited driver experience, speed, alcohol, driver fatigue and multiple passengers.

– the sociocultural, socioeconomic and environmental determinants

Social determinants can interact to increase the risk of injury, just as they interact to increase the risk of illness.

Example 1: Media has promoted increased independence of young people through social networking, technology and marketing. Increased independence in an affluent society can result in increased access to motor vehicles. In particular, young males with their characteristic sense of impunity, can impact on a disproportionate number of traffic accident deaths for this group.

Example 2: The affluent society also increases the percentage of homes with swimming pools. Despite fencing laws, it is a common occurrence, especially in time-poor households due to work commitments, or with limited money available because of a large mortgage, to ignore a faulty gate or fail to properly supervise young children. The result can be a higher likelihood of infant drowning.

Environmental determinants for injury vary in different places, but are influenced by the ability of a family or employer to comply with legislation and regulations that apply to planning, standards and OH&S laws.
The household environment includes adaptations such as pool fencing, thermostatic water temperature limiters, electric switch protection, safety latches and many other mechanisms.

In the workplace, safety guards on machines, OH&S regulations, harnesses and scaffolding on rooftops, safety clothing and protective equipment and workplace safety guidelines reduce the risk of injury.

– groups at risk

The list of groups described by the Institute of Health and Welfare as ‘priority population groups for health interventions’ and the priority age groups appears on page 40 of this section. The priority age groups can be further divided into groups at increased risk of suffering or dying from injuries. Specifically, these are younger males for motor vehicle accidents; children for poisoning and drowning; and the elderly for falls.

– mental health problems and illnesses

– the nature of the problem

Mental health disorders and mental illness are related conditions that affect the emotional, cognitive, behavioural and social wellbeing of the sufferer. Mental health disorders are diagnosable illnesses that can include anxiety, depression, substance abuse disorders, dementia, bipolar disorder and schizophrenia.

Mental illness have similar effects but to a lesser extent or for a shorter period of time. They may develop into mental health disorders. It is common for sufferers to experience other illnesses along with a mental illness.

Traditionally there has been a stigma attached to these conditions, often leading to isolation and discrimination.

– extent of the problem (trends)

In 2005, apart from suicide or dementia, mental or behavioural disorders accounted for 2.7 deaths per 100,000 persons. This represents a significant reduction since the 1990s.

About 6.5% of Australians aged over 65 suffer dementia. About two thirds of these are females. Incidence of dementia is predicted to escalate by 17% to 2011 and by 150% to 2031. This increasing trend is the result of Australia’s ageing population.

– risk factors and protective factors

Risk factors for mental illness can be internal characteristics of the individual or external features of the environment. The existence of several risk factors is likely to have a cumulative effect that will increase the likelihood of developing a mental illness. Equally, the impact of risk factors can be offset by the presence of protective factors.

<table>
<thead>
<tr>
<th>RELATING TO THE CHILD</th>
<th>RELATING TO THE ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>overly fearful or anxious</td>
<td>harsh and overly controlling parenting styles</td>
</tr>
<tr>
<td>withdrawal and avoidance of new situations</td>
<td>cultural discrimination, academic failure</td>
</tr>
<tr>
<td>reckless behaviour and poor understanding of consequences</td>
<td>parental health problems including physical or mental illness or substance abuse</td>
</tr>
<tr>
<td>argumentative, non-compliant, aggressive</td>
<td>poor attachment to school, poor attendance</td>
</tr>
<tr>
<td>poor attachment to parents or caregivers</td>
<td>bullying, social exclusion, peer rejection</td>
</tr>
<tr>
<td>low intelligence, poor language skills</td>
<td>family violence or conflict, criminal activity</td>
</tr>
<tr>
<td>Divorce, single parent, financial hardship</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 2.3 Risk and protective factors for mental illness
Our living environments are affected by features of our society such as the economy, education system, cultural mix and the nature of urban and rural dwellings. Within these broad environments, individuals learn to cope with a range of social factors that might include unemployment and poverty, family breakdown, trauma and loss, academic demands, same sex attraction, immigration or difficult life transitions.

Individuals then draw on their own social skills, family support, personality, school climate and other relationships and knowledge to develop their own ways of coping.

When their ability to cope is compromised by drugs and alcohol, racism, bullying, negative thoughts, hereditary traits, social isolation and other factors the likelihood of mental problems or disorders is increased.

### Groups at risk

The list of groups described by the Institute of Health and Welfare as ‘priority population groups for health interventions’ and the priority age groups appears on page 40 of this section. A further division with the priority age groups suffering from mental illness include people aged 25–44 years and males.

The most typical mental health service contact involves a patient who is an Australian-born non-Indigenous male aged 20–34 years, who has never been married and lives in a major city.
Activities

Activity 8 (Page 39)
Access the Heart Foundation website and investigate the most recent research on risk and protective factors for heart disease.

⇒ www.heartfoundation.org.au

Activity 9 (Page 41)
Access the Cancer Council website and report on the role of the council in reducing the impact of cancer on the health of the population.

⇒ www.cancer.org.au

Activity 10 (Page 43)
Access the ‘Law and Policy’ section of the WorkCover NSW website. In groups, select a topic and prepare a short presentation for the class.

⇒ www.workcover.nsw.gov.au

Activity 11 (Page 44)
Access the ‘Education and children’s services’ section of the homepage website given below. On the ‘Fact sheets and downloads’ tab, select a topic that interests you and make an oral presentation to the class.

⇒ www.responseability.org/site/index.cfm?display=21924

Review Questions

1. Outline the characteristics of two different cardiovascular diseases.
2. Describe how socioeconomic status can influence the likelihood of developing cardiovascular disease.
3. Assess the impact of modifiable risk factors on the incidence of cancer.
4. Predict the influence of screening programs and early detection on future trends in incidence and mortality resulting from cancers.
5. Compare the characteristics of three types of diabetes?
6. Identify the groups most at risk of developing chronic obstructive pulmonary disease (COPD).
7. Construct a set of simplistic graphs to represent the recent trends in mortality from CVD, three prevalent cancers, diabetes and motor vehicle accidents for males and females.
a growing and ageing population

assess the impact of a growing and ageing population on:

- the health system and services
- health service workforce
- carers of the elderly
- volunteer organisations

General demographic patterns

In 2007, the Australian population reached 21,015,042, growing at about 1.5% annually. Most of the growth in New South Wales has occurred in and around Sydney and along the coast while some inland areas are experiencing declining populations. The age structure of the population is also changing. In the period between 1956–2006 the proportion of people aged up to 14 years grew by 46%, the proportion aged 65 and over grew more than 200% and the proportion aged 85 years and over grew 700%. The percentage of the population aged over 65 years had passed 13%, clearly depicting an ‘ageing population’.

Trend and impact: Improved health on hospitalisation and general practice

As a general trend older Australians, especially up to 75 years, are experiencing better health and demanding less of the healthcare system. However, the lower demand at this age is offset by the increasing number of people living longer. Consequently, the demand for health and aged-care services increases noticeably after 75 years of age.

Older people are staying in hospital at a declining rate but remain much higher users of hospitals than younger people. Over half of all people in hospital at one time will be aged over 65 years. This means that the majority of hospital resources will be focused on older people. As the percentage of the population

\[ \text{FIGURE 2.16 Changing population structure} \]

Note: The age group 85+ includes all ages 85 years and over, and is not directly comparable with other 5–year age groups.
Aged over 65 increases, services will need to be expanded or adapted to meet increased demand. An increase in hospital beds and primary care staff, a move towards day visits and community-based service delivery and increased focus on prevention are all consequences of the increasing demand.

Approximately 25% of GP visits were made by older patients at an annual rate of 8.6 per person, compared to 4 per younger person. The percentage of visits by people aged 75 years and over has increased significantly over the past decade, though the percentage of visits by people aged 65–75 years has increased only slightly, further supporting the notion of improved health in people aged up to 75. The most common reasons for GP visits relate to the management of chronic disease and include hypertension, immunisation, diabetes, osteoarthritis and health check ups.

One of the key directions of the National Chronic Disease Strategy is to encourage primary healthcare, particularly general practice, to engage in early intervention, through appropriate screening and identification of risk factors, and support for self-management (NHPAC 2006). The pattern of earlier interventions like flu vaccinations, as well as screening programs like the bowel cancer screening program will continue to expand. The growing focus and desire for similar programs will increase the demand for GPs and related health professionals. The need for non-hospital services such as optometry, pharmaceutical and mobility services is also growing as the population ages.

**Trend and impact: Aged facilities**

Only 6% of people aged over 65 years live in residential and aged-care facilities. As a consequence aged-care services have increasingly been delivered in the home rather than in hospitals or residential care facilities. At the same time, nursing homes and residential aged care are expanding to meet requirements. These trends both result in pressure on existing carers and the need for new carers and staff, including volunteers.

**Trend and impact: Mental health conditions**

It is estimated that in 2006 about 6.5% of people aged 65 years and over and 22% of people aged 85 years and over had dementia. Because dementia is one of the most disabling health conditions, a large proportion of people with severe and advanced dementia require full-time care and live in cared accommodation. This increases with age and is placing increasing pressure on carers, aged-care providers and government funding.

**Trend and impact: Injuries from falls**

A high percentage of the people who move into aged-care facilities are transferred from hospitals, especially after suffering injuries from falls.

Injury from falls is estimated to cost the NSW healthcare system over $1.2 billion in direct costs annually. Preventive programs can be effective in reducing costs. The ‘Stay on your Feet’ program run in northern New South Wales reduced hospital admissions from falls by 20% for people aged over 60 years.

**Trend and impact: Sociocultural profiles**

Australians aged over 65 years reflect an increasingly multicultural profile. In 2006, 35% of elderly people were born overseas and 61% of those were born in non-English speaking countries.

Such a change requires flexibility in the provision of services. Health professionals need to be trained in culturally appropriate approaches to care, while service providers need to recruit staff increasingly from CALD communities. The implications for universities and hospitals are also profound, as they adapt their training and education programs to meet new student and consumer profiles.
Trend and impact: Environmental

It is too simplistic to say that older people are moving away from cities as they retire or seek change, while younger people are increasingly moving into cities to seek greater access to services and security of employment. Nevertheless, the ‘Sea Change’ phenomenon does exist and many coastal communities are increasingly addressing the health needs of retirees who have swelled their ranks.

The impact is largely on governments to redistribute appropriate services from the cities to rural centres. The availability and mobility of trained staff, the capacity to monitor and respond to population movements, issues associated with planning and shared responsibilities between different governments and regions all present challenges.

Trend and impact: The aged as care providers

Older Australians are increasingly being called upon to provide care for others. Grandparents provide care for 60% of children receiving childcare, equating to 20% of all children. Older people also represent a major source of primary care for partners or other older people with a disability or poor health.

– healthy ageing

There are great benefits available to individuals and the nation if older Australians are healthy. The economic and medical burden created by illness and disease among a growing number of older people presents a major challenge for governments and the healthcare system. Healthy older Australians:

• are less likely to leave the workforce for health reasons
• are more likely to enjoy retirement
• contribute more to their own communities
• have fewer healthcare needs
• experience less chronic disease and disability
• place less pressure on the national health budget and healthcare system.

Positive determinants for maintaining the health of older people include sufficient income, safe housing and the right conditions for achieving independence and mobility. Older people are similar to...
younger people in that their behaviours regarding health risks will influence their health status. The difference is that the health status of older people has already been influenced by the cumulative effects of many years of health-related behaviours.

The risk factors that contribute to the health status of older people include high blood cholesterol, impaired glucose tolerance, high blood pressure, obesity, physical inactivity, risky alcohol consumption, smoking and poor diet.

The protective factors that contribute to the health status of older people include influenza vaccination, behaviours that counter the risk factors, social support and access to services.

– increased population living with chronic disease and disability

Most health problems experienced by older Australians result from the accumulated effects of poor lifestyle behaviours over many decades. As the age of the sufferer increases, so does the level of disability experienced. Progressively, increased disability leads to greater reliance on carers and greater demand for healthcare services. The National Chronic Disease Strategy targets a small and familiar cluster of conditions that are responsible for most of Australia’s burden of disease. They include:

- cardiovascular diseases, such as ischaemic heart disease, stroke, hypertension
- cancers
- chronic lung disease
- obesity
- injurious falls in older people
- diabetes (type 2)
- poor emotional and psychological wellbeing.

These conditions place a huge burden on the healthcare system because they lead to increased levels of dependence and disability. Nevertheless, they result from an equally small cluster of modifiable risk factors and are therefore open to significant improvements through preventative actions and early intervention strategies. These risk factors are:

- tobacco smoking
- nutrition
- alcohol consumption
- physical activity
- stress—psychosocial risk factors.

In New South Wales, obesity is a major challenge. Half of all people are overweight or obese, less than 10% eat the recommended daily intake of vegetables, only half of the population participate in an adequate level of physical activity, and almost one-third engage in risky drinking behaviour. The resulting increase in demand for healthcare services, medications, treatment and support places a massive strain on the healthcare system.

In response to these increased levels of chronic disease and disability the NSW Government has included a range of strategies for managing chronic illness in its State Health Plan. Some of these strategies include:

- Align New South Wales’s activities with the Australian Better Health Initiative.
- Develop and implement new community-based models of care for older people, those with chronic disease and those in need of post acute care through the Clinical Service Redesign Program beginning in 2007.
- Expand programs to prevent and reduce the impact of chronic diseases to improve survival rates and quality of life.
Enhance services for early detection, prevention and management of chronic disease.

- Implement a range of initiatives to address childhood and adult obesity, such as the Fresh Tastes@School NSW Healthy School Canteen Strategy.
- Strengthen the capacity of the public health system to respond to the specialist healthcare needs of people with a disability, including older people.

### Demand for Health Services and Workforce Shortages

In 2005–2006, subsidies for aged-care homes totalled approximately $5.3 billion. Service providers who offer aged care include private and religious or charitable organisations, state, territory and local governments. All service providers, regardless of who they are, must meet Australian Government standards. Most older Australians prefer to live in their own homes for as long as they can. While they are at home a range of care packages is available. These include:

- Home and Community Care (HACC) Programs: These programs include home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, allied health services, home- and centre-based respite care, and advice and assistance.
- The Extended Aged Care at Home (EACH) and EACH Dementia programs: These aim at delivering care at home that is equivalent to high-level residential care.
- Community Aged Care Packages (CACPs): Provide support services to older people with complex needs living at home who would otherwise be eligible for admission to at least ‘low-level’ residential care.
- Aged care homes: For those who can no longer stay at home publicly funded aged-care homes provide residential care at two levels. High-level care provides nursing care when meals, laundry, cleaning and personal care are required, while low-level care provides assistance with meals, laundry and personal care. Eligibility for any care is assessed by an Aged Care Assessment Team.

One of the main challenges in meeting the health needs of an ageing and changing population is the capacity of the government to train, mobilise and allocate qualified doctors, dentists, nurses and allied health professionals to the regions, communities and services that need them most.

Currently, supply is not able to satisfy demand for a variety of reasons, which present governments and healthcare agencies with a challenge to expand, adapt and diversify in an effort to increase their capacity. The problems include:

- Growth in the number of health courses and graduates is proportionately slower than growth in the demands and healthcare needs of the population.
- The health workforce is ageing and a high percentage of clinicians are approaching retirement.
- Careers in caring and health have to compete vigorously in a highly competitive labour market.
- Employment in the health sector may not meet people’s preference for more flexible working hours and a shorter working week.

### Table 2.4

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<th>Service Type</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>HACC (2004–05)</td>
<td>561,789</td>
<td>20.9</td>
</tr>
<tr>
<td>Permanent residential care (2006)</td>
<td>145,175</td>
<td>5.4</td>
</tr>
<tr>
<td>Veterans Home Care (2005–06)</td>
<td>70,997</td>
<td>2.6</td>
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<tr>
<td>Residential respite (2005–06)</td>
<td>33,801</td>
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<tr>
<td>DVA Community nursing (2005–06)</td>
<td>32,057</td>
<td>1.2</td>
</tr>
<tr>
<td>CACP (at June 2006)</td>
<td>29,972</td>
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</tr>
<tr>
<td>EACH (at June 2006)</td>
<td>1,984</td>
<td>–</td>
</tr>
<tr>
<td>Transition care (2006)</td>
<td>296</td>
<td>–</td>
</tr>
<tr>
<td>Informal care</td>
<td>690,000</td>
<td>25.6</td>
</tr>
</tbody>
</table>

Source: AIHW, Ageing and Aged Care

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**Table 2.4**

<table>
<thead>
<tr>
<th>Size and shape of aged care sector</th>
<th>Number</th>
<th>% of 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>HACC (2004–05)</td>
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<td>20.9</td>
</tr>
<tr>
<td>Permanent residential care (2006)</td>
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<tr>
<td>Residential respite (2005–06)</td>
<td>33,801</td>
<td>1.3</td>
</tr>
<tr>
<td>DVA Community nursing (2005–06)</td>
<td>32,057</td>
<td>1.2</td>
</tr>
<tr>
<td>CACP (at June 2006)</td>
<td>29,972</td>
<td>1.1</td>
</tr>
<tr>
<td>EACH (at June 2006)</td>
<td>1,984</td>
<td>–</td>
</tr>
<tr>
<td>Transition care (2006)</td>
<td>296</td>
<td>–</td>
</tr>
<tr>
<td>Informal care</td>
<td>690,000</td>
<td>25.6</td>
</tr>
</tbody>
</table>

**Table 2.4**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number</th>
<th>% of 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>HACC (2004–05)</td>
<td>561,789</td>
<td>20.9</td>
</tr>
<tr>
<td>Permanent residential care (2006)</td>
<td>145,175</td>
<td>5.4</td>
</tr>
<tr>
<td>Veterans Home Care (2005–06)</td>
<td>70,997</td>
<td>2.6</td>
</tr>
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**Table 2.4**

<table>
<thead>
<tr>
<th>Size and shape of aged care sector</th>
<th>Number</th>
<th>% of 65+</th>
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The increased wealth, education and sophistication of modern society have increased the level of demand for health services and technological advances.

As the shortfall of health workers grows there is greater pressure on existing staff and services.

The uneven concentration of healthcare providers in the large cities has created extra pressure in outer metropolitan, rural and remote areas, where the availability of healthcare staff and services continues to decline.

### Availability of Carers and Volunteers

The number of Australians aged 85 years and over has doubled over the past 20 years and is projected to increase to 4.2% of the total population by 2036. Providing care for the elderly, among whom the need for services and care is greatest, is split 80% by family and friends, in particular spouses and adult daughters, and 20% by organisations.

The paid workforce is complemented by informal care networks of friends and family, many of whom are also ageing and often disabled themselves. As the proportion of older people in the population continues to grow, it is anticipated that there will be an equivalent increase in demand for aged care and especially informal home-based support. Projections indicate that the growth in the informal workforce will not be able to meet this increased demand and so a gap in the supply of informal home-based care will arise.

Care workers are poorly paid; they often work short hours to be able to do their caring, typically neglect their own health and feel a sense of despair about the plight of their care recipients. They continue to struggle to raise awareness of their situation.

A variety of important issues need to be addressed in an effort to attract new carers and retain existing carers. Foremost they need a guarantee of financial security if their work is to be continued. Their health and wellbeing can best be addressed by providing respite and access to health services. Flexible work hours would assist carers to be able to earn adequate income and provide the care so valued by their recipients.

Carers often feel that they do not have the political power to influence spending and planning decisions. Strong representation at all levels of government would add strength and provide much needed support to the caring
Health priorities in Australia

Chapter 2

Profession. Initiatives that increase acknowledgment and respect of carers will be critical in a future where more carers than ever will be needed.

Activities

Activity 12 (Page 47)
Analyse Figure 2.16. Describe the changes that have occurred over 50 years for each age group and identify one implication of each change that governments will need to address.

Activity 13 (Page 47)
Select one of the trends described above. Consider its impact and develop a plan to counter that impact. Your plan should include strategies that integrate three different levels of government.

Activity 14 (Page 49)
Interview an elderly friend or family member. Ask a series of questions to find out what makes them happy and healthy. What are their priorities? What did they do in their lives that harmed or protected their health?

Activity 15 (Page 50)
Create a diagram to demonstrate how this cluster of determinants relates to the cluster of chronic diseases.

Activity 16 (Page 51)
In groups, access the Aged Care Australia website. Each group selects one of the ‘Need Help…?’ tabs. Imagine that you are a carer or adviser to an elderly person. Propose a brief set of guidelines about what you would tell that elderly person who needed these questions answered. Present your proposal to the class.

www.agedcareaustralia.gov.au

Activity 17 (Page 52)
Use local directories and the internet to contact a volunteer organisation in your local area. As a class, create your own directory, including summary details about who runs each service, what each service does and whom it serves.
1. **Outline** what happened to the age structure of the Australian population between 1956 and 2006.

2. **Account** for the trend towards providing more aged-care services in the home rather than at hospitals or other residential facilities.

3. **Demonstrate** some of the differences between people aged 65–75 years and people aged over 75 years.

4. **Predict** the impact of implementing the National Chronic Disease Strategy.

5. **Deduce** the most important requirements for healthy ageing.

6. **Interpret** the implications of identifying such a small cluster of risk factors for the main chronic diseases in the National Chronic Disease Strategy.

7. **Recommend** an initiative to match each of the strategies for managing chronic illness in the State Health Plan.

8. **Define** the problems faced by government in meeting the health needs of an ageing and changing population.