

PDHPE - HSC CORE 1: Health Priorities in Australia

Critical question 1: How are priority areas for Australia's health identified?

- **Measuring health status**

Epidemiology is the study of patterns of health including frequency and distribution of illness, disease and injury in society. Epidemiology uses statistics to report on the incidence of illness and disease and commentary to describe how the incidence affects the community and its groups.

Common measures of epidemiology include:

- Mortality
- Infant mortality
- Morbidity
- Life expectancy

Mortality is information about deaths within specific population groups. Rates are reported per 100,000 with relation to specific diseases causing death within the context of the population group to which the victim belongs.

Infant mortality reports on deaths in the first year of life. It is reported in terms of the number of deaths per 100 live births. Infant mortality does not take into account still born foetuses or miscarriages.

Morbidity is the incidence of sickness or ill health in a given population. Morbidity is reported in terms of specific illnesses or occurrences of ill health. A variety of sources such as the Australian Bureau of Statistics are used to provide statistical information about such things as notifiable cases of STDs and other communicable diseases.

Life expectancy is defined as the average number of years that an individual of a given age can expect to live. Life expectancy is most often referred to at birth and is used to compare health status:

- ❖ between national population groups
- ❖ of present and past generations
- ❖ across international populations

- **The Health Status of Australians:**

CURRENT TRENDS:

Life Expectancy - life expectancy has almost doubled in the last 100 years, particularly in the second half of the 20th century **due to:**

- ❖ **improving medical facilities and technology**
 - ❖ **the introduction of National Health Strategies (e.g. media campaigns to promote better nutrition, safer driving, safe sexual practices, and immunization), education through schools, the media and health promotion with regards to the risk factors associated with lifestyle related diseases (e.g. educating people to perform self detection of the early signs of illnesses such as breast, testicular and skin cancers)**
 - ❖ **improved co-operation among health care agencies and groups which has established an environment more supportive of individual and community health.**
- Causes of death among the general population have moved away from infectious diseases (such as flu, pneumonia and diarrhoea) to lifestyle diseases (such as CVD and cancer)**

Major Causes of Illness and Death

- CVD (general decline since 1960's, particularly in males over 45 year olds)
- Cancer (increased incidence, decreased mortality, lung cancer most common in males, breast cancer most common in females)
- Respiratory diseases (incidence increasing, mortality decreasing, most common are asthma, bronchitis and emphysema-related conditions)
- Accidents/injuries. (General decrease in mortality - deaths have halved in last 20 years. Transport related, drowning, suicide and workplace accidents are most common causes of death)

"It should be the concern of all Australians that a nation which can claim to be one of the healthiest in the world harbours major inequalities in health status within its population".

Better Health Commission (1998) *Health for All Australians* Commonwealth of Australia

Overall, Australians do benefit from good health but when the health status of specific groups within the population is examined we see a very different story. Some groups where inequities occur are:

- Socioeconomic differences
- Aboriginal and Torres Strait Islander health
- Gender differences
- Age differences
- Rural and remote dwellers

Use websites, magazines and newspaper articles to find relevant, up to date information and statistics.

Groups experiencing health inequities:

Aboriginal and Torres Strait Islander peoples

- Comprehensive and accurate data difficult to obtain as only 30% of these populations live in cities, and many live in remote communities.
- **LIFE EXPECTANCY:** 10 –20 years less than the general population
 - ✦ Male 57 years: 19 years less than non indigenous population
 - ✦ Female is 62 years: 20 years less than non indigenous population
- Higher **MORTALITY RATES** compared with the indigenous population for every specific major cause of death.
- The **LEADING CAUSES OF DEATH** in this population are:-
 - ✦ Circulatory diseases (10-20 times higher in 25-54 year olds)
 - ✦ Respiratory diseases
 - ✦ Cancers (most significant differentials are liver cancer in males and lung and cervical cancer in women)
 - ✦ Injury and poisoning
 - ✦ Diabetes (10 times higher in the 20-50 year age group)
- Higher rates of:-
 - ✦ Preventable causes: circulatory and respiratory disease, diabetes, nutritional disease, infectious and parasitic disease
 - ✦ mental illness (rates of self harm and suicide are higher, and substance abuse, domestic violence, child abuse and disadvantage are contributing additional problems.
 - ✦ digestive disorders
 - ✦ elevated blood pressure
- More indigenous people are obese according to the BMI.
- Mortality from preventable causes is twelve to thirteen times higher
- Significantly, 25–54 year olds experience death rates that are five to eight times those of non-indigenous people.
- Higher **INFANT MORTALITY** (est. 2-4 times higher than overall Australian Population.
- **HOSPITALISATION RATES** that are two to five times higher than those for the total population.

- Leading causes of hospitalisation of indigenous people are:-
 - ✦ Males: Kidney dialysis (25%), injury (13%) and respiratory diseases (12%)
 - ✦ Females: Dialysis (25%), pregnancy and childbirth (17%), respiratory diseases (9%) and injury (8%).

- More likely to engage in risk behaviour that contributes to illness and death
 - ✦ 50% of ATSI are smokers (only 25% of overall Australian population)
 - ✦ Less likely to be regular drinkers of alcohol
 - ✦ Those ATSI who do drink, binge.

- **Socio-cultural factors** have also contributed to indigenous poor health. These include:-
 - ✦ Poor public health measures – Eg. Inadequate housing, waste disposal and water.
 - ✦ A lack of access to appropriate health services.
 - ✦ A medical system that does not cater for aboriginal spirituality
 - ✦ The Aboriginal experience of dispossession and marginalisation
 - ✦ Continued economic disadvantage and poor health status
 - ✦ High frequency of ear infection in children → hearing loss which affects learning

- Recent **TRENDS**:-
 - ✦ A decline in death rates for all causes for indigenous males (reflects a similar reduction for all Australian males).
 - ✦ No decline in mortality rates for indigenous females.
 - ✦ Increased death rates from diabetes.

As many **aboriginal and Torres Strait islanders** are of the **low socio-economic status** group and **live in rural/remote areas** the inequities associated with these groups are relevant to ATSI people.

Socio-economically disadvantaged

Someone who experiences significant financial limitations due to income, occupation and/or education.

- In all age groups, men and women who have lower status backgrounds have higher **MORTALITY** and higher levels of **MORBIDITY** than those who are more affluent.
- As a group they are less educated about their health.
- More likely to die from cardiovascular disease (CVD).
- Higher INFANT MORTALITY.
- Higher levels of blood pressure
- More likely to smoke (As occupational status falls smoking increases)
- Generally sick more often and die earlier.
- Have higher rates of obesity, smoking, physical inactivity and alcohol consumption (especially in males)
- Far less likely to engage in preventative health measures. Eg. 'Pap' smears & dental check-ups.
- Children from low income families:-
 - ✦ Are ill more often
 - ✦ Have higher levels of chronic asthma

- Unemployed males and females are more likely to experience serious chronic illness.
- Youth unemployment is significantly higher than the national rate. Unemployment can lead to despair and a sense of helplessness, which is linked to **social** problems including violence, vandalism and crime. It is also a contributing factor to depression and suicide.
- Where socio-economically disadvantaged people are gathered in medium or high density housing there are often higher levels of social problems. These social problems can include domestic violence, violence, vandalism and family breakdown.
- Socio-economically disadvantaged people have difficulties raising the level of their health. Lack of income and education can reduce alternatives relating to employment, housing, nutrition and generally raising their standard of living.

- **SOCIO-ECONOMIC DISADVANTAGE IS CONSIDERED TO BE THE MOST IMPORTANT INDICATOR OF POOR HEALTH IN AUSTRALIA.**

Australians born overseas

- Generally enjoy a higher level of health than people born in Australia. Largely due to the migration eligibility criteria. They have:-
 - † Lower **MORTALITY** rates
 - † Lower **HOSPITALISATION RATES**
 - † Reduced incidence of **lifestyle related risk factors**

- Despite their general good health there are some significant inequities among overseas-born Australians population (1 in 4) including:-
 - † Born in UK and Ireland: High mortality rates or lung cancer
 - † Born in Asia: Higher rates of diabetes and cervical cancer
 - † Europe, NZ, Africa, Middle East & the Americas: Higher rate of diabetes
 - † Lower incidence of skin cancer in all overseas-born Australians

- Illness and disability among migrant groups increases with length of stay in Australia.

- More than half the immigrants arriving in Australia are from non-English speaking backgrounds (NESB).

- NESB people experience a decline in health status over time due to a number of factors including:-
 - † Socio-economic disadvantage
 - † Limited access to employment, health information and community services
 - † Stress of resettlement.
 - † Language difficulties
 - † Change of lifestyle practices

- People from NESB are less likely to:-
 - † Report medical conditions
 - † Immunise children
 - † Exercise

- More likely to be slightly overweight.

- Have varying understandings and expectations of health care due to different cultural background.

People living in rural and isolated locations

- Lower health status than people living in cities and metropolitan areas.
- Higher **MORTALITY** and **MORBIDITY** rates (rates increase with the increase in distance from a city or major town)
- Lower **LIFE EXPECTANCY**
- Death from injury is 69% higher in remote areas. Rates of suicide are also elevated.
- Death rates from diabetes, homicide and heart disease are significantly higher
- Death rates from cancer are similar to those in metropolitan areas
- Poorer health status of rural communities is partly explained by:-
 - ✦ Lack of **access** to health services
 - ✦ Lower **Socio-economic status** and employment levels
 - ✦ Occupational hazards
 - ✦ Poorer overall living conditions caused by the harsher environment.
 - ✦ Large proportion of Aboriginal and Torres Strait Island Peoples who generally have a poor health status

People with disabilities

- **Disabilities**: limitations to everyday functioning abilities. There are several types of disabilities including:
 - ✦ Physical: arthritis, respiratory diseases, circulatory diseases & musculoskeletal disorders. Most common type of disability.
 - ✦ Sensory disorders: Eg. Diseases of the eye or ear
 - ✦ Mental disorders
- In 1998 it was estimated that 19% (3.6 million) of the Australian population had a disability of some kind.
- **Handicap**: more severe and relates to an individual's limitations or inability as experienced in more complex tasks, such as, caring for oneself, moving around and communication.
- Most commonly reported severe handicap is related to psychiatric conditions and head or brain injury. All are likely to suffer multiple or interrelated conditions.
- People with disabilities can experience inequities from financial constraints. This includes:-
 - ✦ Lack of access to employment opportunities
 - ✦ Possible need for ongoing health care
- In 1998, 6% of Australians were classified as having a severe or profound handicap.
- The profound and severely handicapped have a lower life expectancy (male 5 years and female 7.6 years shorter)

Women

- Biological and behavioural factors attribute to the difference in health status between women and men. Including genetics, stereotyping, sexuality and occupation.
- Women have a six year longer life expectancy than men.
- More likely to see a GP or treat themselves by having a day of reduced activity
- A third of young women are underweight
- Women more likely to be on a fat modification diet
- Fewer than 2% are happy with their bodies
- Almost 1 in 5 binge drink once a week
- 40% do little or no exercise
- More than half are very stressed by at least three areas of their lives (eg. Work, money, studies)
- A third smoke
- More than half of the single mothers smoke
- Women have considerably lower rates for most causes of death
- The leading causes of disease and injury burden are:-
 - 25-44 years: Mental disorders (33.8%), Cancer (13.1%) – particularly breast cancer. The largest single cause of disease and injury burden in this age group is depression.
 - 45-64 years: Cancer (33%) – breast, lung & colorectal, cardiovascular disease & mental disorders. The largest single cause of disease and injury burden in this age group is breast cancer.
 - 65+: cardiovascular disease (37%), cancer (21%) and nervous system and sense organ disorders (18%). . The largest single cause of disease and injury burden in this age group is ischaemic heart disease.

Men

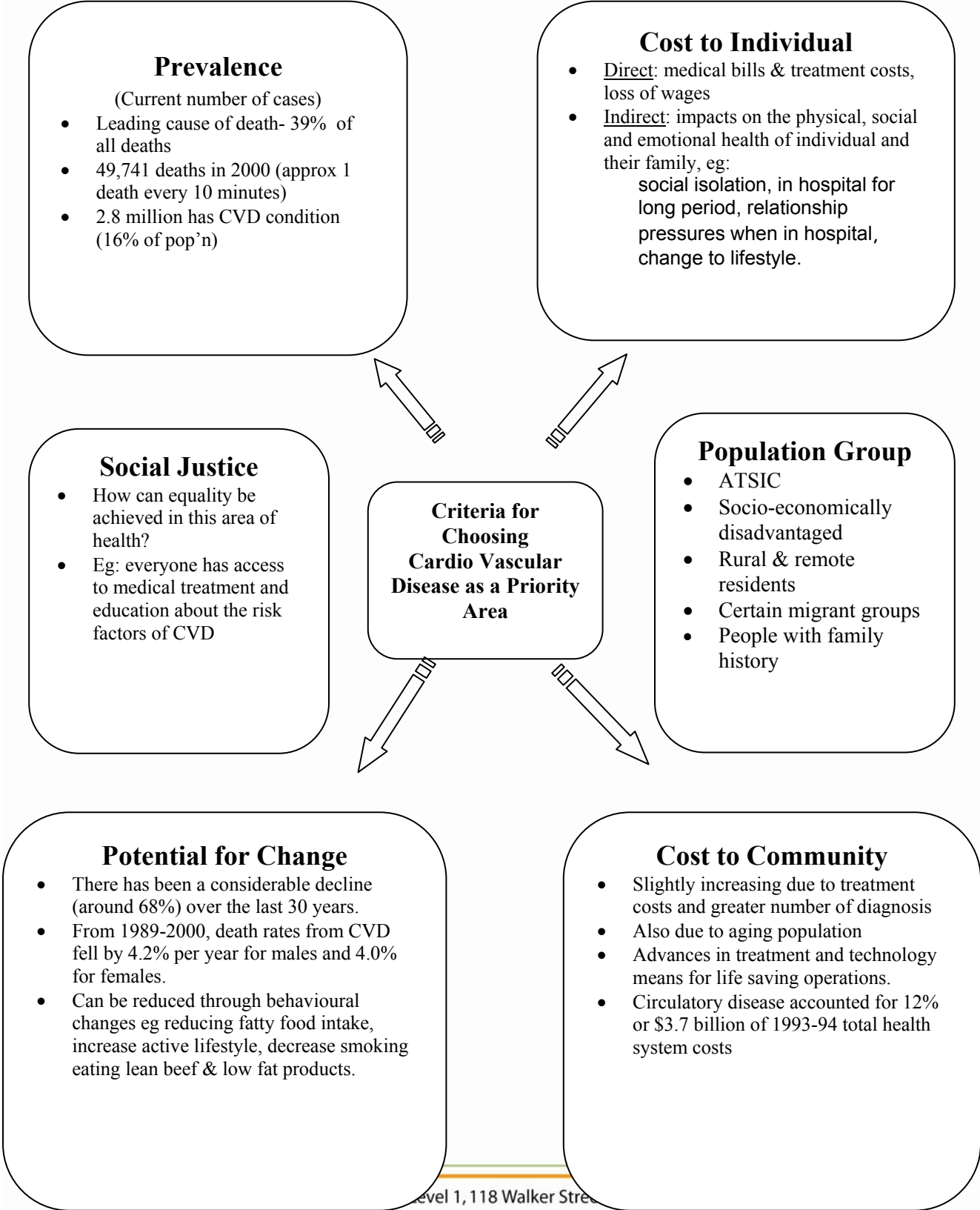
- males aged 15-24 are more likely to die from:-
 - suicide – 6.3 times higher in men than in women
 - drug dependence – 4.5 times higher
 - motor vehicle accidents – (3 times higher)
 - Cancers – 1.3 times higher in men
- Men over 65 years of age are more likely to die from:-
 - Coronary heart disease (CHD) – 1.6 times more likely
 - Lung cancer – 3.5 times higher
 - Suicide – 4.6 times higher
 - Motor vehicle accidents – 1.9 times higher
- Men aged between 15 and 25 years are are more than twice as likely to die as women.
- Men at any age have a 25% higher death rate than that of women
- More males smoke and have higher levels of smoking related illnesses
- Some occupations expose males to more hazards – mining, construction and farming have a greater proportion of males and are considered high risk occupations.
- Young males are more likely to undertake high risk behaviour in motor vehicles and play more contact sports.
- The leading causes of disease and injury burden are:-
 - 25-44 years: Mental disorders 27% (mainly substance abuse), unintentional injury 15.5% (largely MV accidents) and intentional injury 12% (suicide and self-inflicted injury). The largest single cause of disease and injury burden in this age group is suicide and self-inflicted injury.
 - 45-64 years: cardiovascular disease (26%) and cancer – lung and colorectal (25%). The largest single cause of disease and injury burden in this age group is ischaemic heart disease.
 - 65+ years: cardiovascular disease (36%) and cancer – lung, prostate and colorectal (27%). The largest single cause of disease and injury burden in this age group is ischaemic heart disease.

Older people

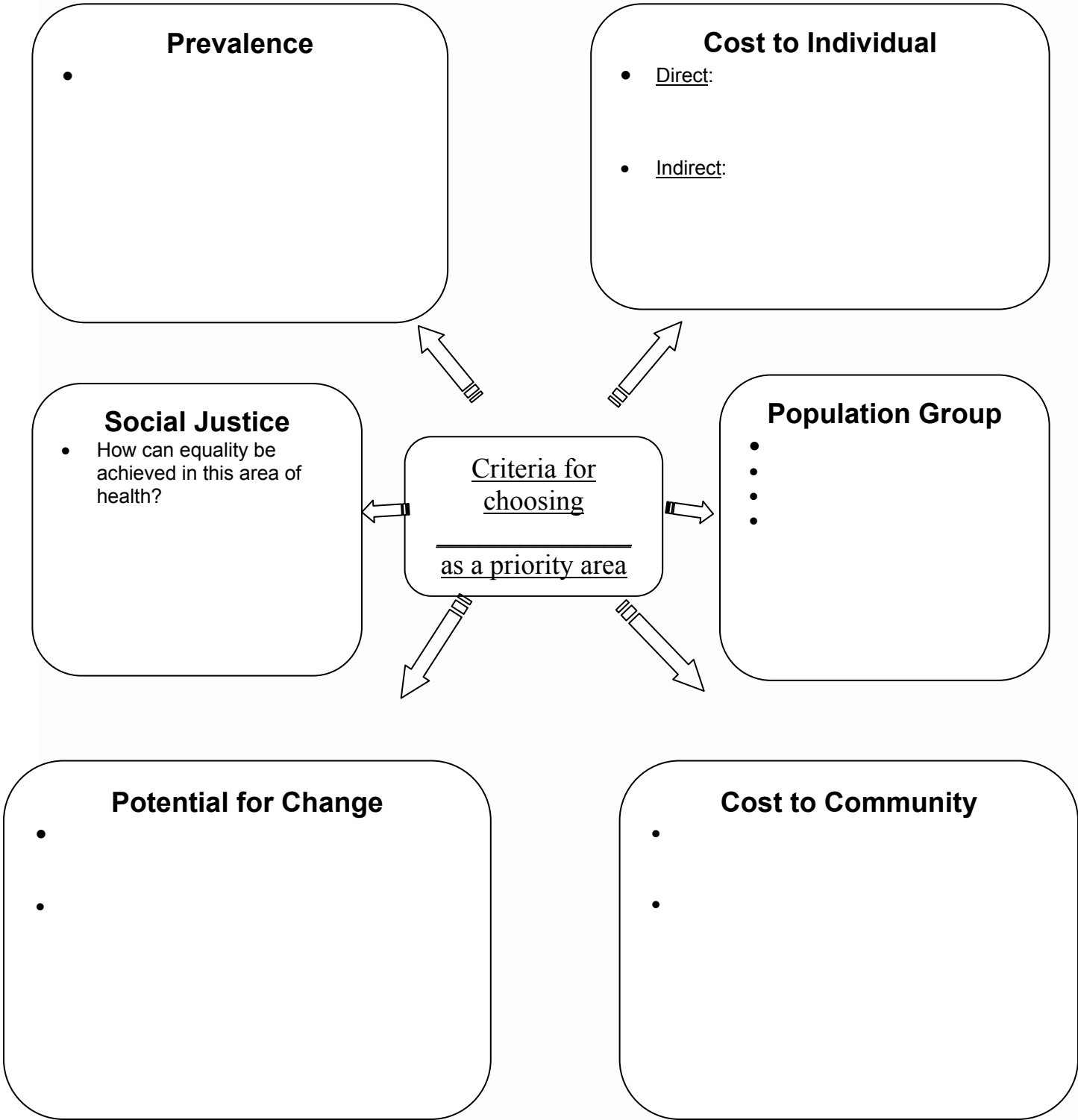
- Ageing population
- Most common causes of mortality include:
 - Cancer
 - Cardiovascular disease
 - Disease of the respiratory system
- Medical advances, improved awareness and less smoking has led to a significant decline in cardiovascular diseases for older people.
- Death from malignant neoplasms (cancers) is increasing.
- Most common disabling conditions reported include:-
 - Arthritis
 - Circulatory system problems
 - Other musculoskeletal problems
 - Vision problems
 - Hypertension
 - Mental problems are a greater cause of disability for those over 80.
- Growing old, socio-economic status and education all affect the health status of this group.
- Higher rates of hospital admissions and longer stays.
- As people reach the upper levels of older age there is a concern that the levels of dementia and other disabilities will increase. The exact impact is still unknown.

Identifying priority areas

The Six Criteria for choosing the National Health Priority Areas
 Example using Cardiovascular disease



Copy this sheet and complete the 6 Criteria for selecting each NHPA as a priority area of health.



You could use this mind map to plan your response for an exam question such as: **Q.** Justify the selection of cancer as a National Health Priority Area.

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