TOPIC 3
Role of health-care facilities and services in achieving better health

OVERVIEW
3.1 Health care in Australia
3.2 Complementary and alternative health-care approaches
3.3 Topic review

OUTCOMES
In this topic students will:
• explain the different roles and responsibilities of individuals, communities and governments in addressing Australia’s health priorities (H5)
• argue the benefits of health-promoting actions and choices that promote social justice (H14)
• critically analyse key issues affecting the health of Australians and propose ways of working towards better health for all (H15)
• devise methods of gathering, interpreting and communicating information about health and physical activity concepts. (H16)
Health-care facilities and services play a vital role in achieving better health for all Australians. They provide the essential services of diagnosing, treating and rehabilitating the ill and injured, as well as preventing illness and promoting health. Traditional health facilities such as hospitals and doctors’ surgeries are increasingly being used to provide accurate health information to the public. In addition, the state and territory governments provide services specifically aimed at both the prevention of disease and the promotion of health — for example, immunisation programs, anti-smoking campaigns, and school medical and dental health services.

However, the health of Australians depends not only on the provision of quality health-care services and facilities, but also on factors such as housing, employment, education, hygiene, income and environmental safety. For health-care services and facilities to be effective in both curing and preventing disease, the health-care sector must develop partnerships with other sectors of the community to implement health-related activities that promote health.

**FIGURE 3.1** Health-care facilities and services provide a vital role in achieving better health outcomes for all.

### 3.1 Health care in Australia

The health-care system involves complex interrelationships between:
- Commonwealth, state and local governments
- health insurance funds
- public and private providers of services; for example, doctors
- institutions; for example, hospitals
- other organisations, such as community health services.

The system is both extensive and diverse in nature. Traditionally, it has provided:
- diagnosis
- treatment
- rehabilitation
- care for people with long-term illness or disability.

However, since the mid 1990s, the Australian government has strengthened its commitment to involving the wider health-care system in improving health outcomes and health gains (illness prevention and health promotion), rather than simply providing health-care services. The current role of the health-care system in Australia is to provide quality health facilities and services to meet the health needs of all Australians. Health services are organised, financed and delivered by both public (government) and private (fee-for-service) sources.
Health care is dominated by medicine in Australia. Emphasis has been placed on the diagnosis and treatment of illness by the medical profession. This medical governance means medical professionals largely control and deliver health care. Some medical practitioners have acknowledged the potential positive impact of complementary and alternative health-care approaches and have referred patients.

Health care within Australia is mostly about clinical diagnosis, treatment and rehabilitation. Historically, health has lacked a preventative focus, but the emphasis began to change with the new public health approach. In recognition that lifestyle diseases are the major causes of illness and death, prevention programs have gained prominence in recent years. The influence of the media, together with increased emphasis on health education and promotion, have led to a greater understanding of personal responsibility for health and the importance of health within the community. Furthermore, health practitioners are now recognising the importance of their role in health education, community empowerment, advocacy and public health policy.

### 3.1.1 Range and types of health-care facilities and services

The many health-care facilities and services provided in Australia can be divided into two broad types: institutional and non-institutional. These are illustrated in figure 3.3.
FIGURE 3.3 Institutional and non-institutional care in Australia

<table>
<thead>
<tr>
<th>Institutional care</th>
<th>Non-institutional care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hospitals</td>
<td>• Medical services such as those provided by medical practitioners and specialists</td>
</tr>
<tr>
<td>– public</td>
<td>• Health-related services; for example dental, optical, pharmaceutical, physiotherapy</td>
</tr>
<tr>
<td>– private</td>
<td>• Community and public health services such as supplying health equipment, aids and appliances</td>
</tr>
<tr>
<td>– psychiatric</td>
<td>• Research organisations such as the National Health and Medical Research Council (NHMRC)</td>
</tr>
<tr>
<td>• Nursing homes</td>
<td></td>
</tr>
<tr>
<td>• Other services such as ambulance</td>
<td></td>
</tr>
</tbody>
</table>

Hospitals — public and private
In Australia, hospitals provide most institutional care. Hospitals are classified as either public or private, and the majority are accredited with the Australian Council on Healthcare Standards (which monitors the quality of care provided and the health outcomes of patients).

Public hospitals are operated and financed by the state governments and the Commonwealth Government. They serve a greater proportion of elderly and very young patients. Public hospitals also appear to provide more highly specialised and complex services, such as heart and lung transplants in the large teaching hospitals. They also provide same-day surgery and take most of the non-admitted patients (outpatients).

Private hospitals are owned and operated by individuals and community groups. They also provide same-day surgery and perform more short-stay surgery, elective procedures (those operations that are not classified as emergencies) and less complex procedures requiring less expensive equipment, such as operations on the eye, ear, nose, mouth, throat, musculoskeletal system and breast.

Patients in all hospitals are classified as being either private or public, according to their choice of service. If they choose to be in a public ward in a public hospital, then they are allocated a doctor by the hospital and provided with a bed — all free of charge. If they choose private treatment, either in a public or private hospital, then they may choose their own doctor but must pay for the service and accommodation provided by the hospital and the doctor. Medicare and any private health insurance of the patient will refund much of this expense.

Equity is the allocation of resources according to the needs of individuals and populations. The goal is to achieve equality of outcomes. The issue of equity of access to public hospitals has been debated in recent
years. Some evidence suggests that private patients have more rapid access to elective surgery (such as plastic, ear, nose and throat, and orthopaedic surgery) than do public patients. Urgency categories have therefore been applied to patients’ conditions.

**Inquiry**

**Access to hospitals**

For elective surgery, access to private hospitals is almost immediate. Yet some waiting lists for elective surgery in public hospitals are over a year long. As a class, debate equity of access to public and private elective surgery in terms of social justice principles.

**Nursing homes**

Nursing homes provide care and long-term nursing attention for those who are unable to look after themselves — the aged, the chronically ill, and people with dementia or a disability. Some nursing homes cater specifically for young people with a disability. There are three types of nursing home — private charitable, private for profit and state government — but the Commonwealth Government assumes responsibility for most of the financial cost of running nursing homes in Australia.

Aged-care assessment teams have been established to ensure only highly dependent people are placed in residential care. They also recommend the placement of a large proportion of clients in accommodation outside of institutions, such as hostels. Hostels provide long-term accommodation and a basic level of health care for young people with a disability, and the aged and frail.

**Psychiatric hospitals**

Treatment of people with severe mental illness has changed over recent years, moving away from institutional care to a system of care that integrates both hospital services and continuing care within community settings. Given the resulting reduction in extended hospitalisation of people with mental illness, the number of public psychiatric hospitals has fallen. At the same time there has been a corresponding increase in the number of beds in community-based residential services. The range of service providers for mental health care today includes general practitioners (GPs), private psychiatrists, community-based public mental health services and specialised residential mental health-care facilities.

**Medical services**

Doctors, specialists and other health professionals provide a number of services. The most extensively used service is that of the GPs who diagnose and treat minor illnesses. According to the ABS *Patient Experience Survey 2015–16*, 82% of people aged 15 years or over had seen a GP at least once in the previous year.

GPs work in medical centres, hospitals and many private surgeries throughout Australia. Under Medicare, all Australians are eligible to claim refunds for their payments for medical services outside hospitals (and for services as private patients in hospitals). The whole or part of the cost of a GP consultation is reimbursed by Medicare.
The number of consultations with GPs has increased over the last two decades. This can be attributed to improved access to doctors and the increased promotion and awareness of individual illness prevention strategies, such as immunisation, Pap smears and general health checkups.

General practitioners sometimes refer their patients to specialists, who have particular skills in a field of medicine as well as the usual medical training. Examples of specialists are allergists (treat allergies), cardiologists (treat heart conditions) and gynaecologists (treat disorders of the female reproductive system).

Health-related services

Health-related services include ambulance work, chiropody, dentistry, health inspection, nursing, occupational and speech therapy, pharmacy, physiotherapy, optometry, radiography, counselling, social work, and dietary planning and advice. The number of dental services has risen in recent years as an increasing number of people retain their natural teeth, and also as a result of the trend towards preventative dental care.

Pharmaceuticals

In Australia, pharmaceutical drugs are supplied through hospitals and doctors by private prescription and over the counter in shops. Over-the-counter medicines account for about one-third of all sales.

Most prescription drugs sold in Australia are subsidised through the Commonwealth Government’s Pharmaceutical Benefits Scheme (PBS). Through this scheme, the government subsidises the cost of a wide range of prescription medicines. The amount of subsidy depends on a patient’s level of eligibility. From 1 January 2018, the patient contribution under the general rate is a maximum of $39.50 for each medicine. The patient contribution for concession card holders, such as low-income earners, war veterans and invalids, is $6.40.

Some people who are chronically ill or require regular long-term medications are protected from excessive cost by the PBS Safety Net. The PBS Safety net caps the amount a family will pay for PBS subsidised medications in a calendar year. The aim of the Safety Net scheme is to ensure no-one is precluded for financial reasons from access to the medicines they need. People who do not have a government concession card become eligible for the Safety Net Concession Card when $1521.80 (in 2018) has been spent on PBS medicines. Pharmaceutical Benefits Scheme medicines can then be purchased at a lower price, usually $7.15 per prescription.
for the rest of the year. If the person holds a government concession card they are eligible for a Safety Net card when they have spent $384.00 (2018) on prescriptions. All PBS medicines for the rest of the year are then free.

Inquiry

Equity in purchasing prescription drugs

Use information on the PBS website and in the preceding text to determine the maximum price in each of the following scenarios that a person would pay for prescription drugs.
1. A teenager is prescribed a weight reduction drug costing $46. The drug is not on the PBS list.
2. An adult needs blood pressure tablets that are on the PBS list.
3. An adult has already spent $1522 on prescription drugs during the year and now requires an additional script.
4. A concession card holder spent $385 on prescription drugs in the previous year.
5. A single mother needs a special drug for her five-year-old son. The drug costs $110 each visit to the chemist because it is not on the PBS list.

Evaluate each of the scenarios in terms of access, equity and social justice principles.

Community supports

Community supports are a significant factor in the provision of an environment that is conducive to positive health. These supports promote health but are not a recognised part of the health-care system. The food industry, for example, implements policies to ensure the production and delivery of food that meets health regulation and food safety standards, and displays nutrition information on food packaging to inform the public about nutrition. As another example, town planners and engineers have a role in providing infrastructure that is safe and promotes positive health — for example, safe roads, adequate sanitation and sewerage facilities, areas for physical activity such as playgrounds and sports fields, and the clear signage of environmental hazards.
Inquiry
Health-care facilities and services
1. Considering the health-care facilities and services that are available to you, which is most relevant to you? Why?
2. Critically analyse the accessibility of this health-care service to you.
3. Would this health-care service be useful to all members of the community? Why?
4. Explain the factors that could act as barriers to access to this facility.
5. Is this service specifically aimed at curing illness or does it also provide health promotion information?
6. Outline the features of an effective community health-care service.

Resources
Weblink: PBS

3.1.2 Responsibility for health-care facilities and services
Health-care facilities and services in Australia are provided by government organisations and a range of private and community groups. There are five levels of responsibility:

- Commonwealth Government
- state and territory governments
- private sector
- local government
- community groups.

Commonwealth Government
The Commonwealth Government is predominantly concerned with the formation of national health policies and the control of health system financing through the collection of taxes. It provides funds to the state and territory governments for health care, and influences their health policy making and delivery.

The Commonwealth Government also has direct responsibility for special community services, such as health programs and services for war veterans and the Aboriginal community.

The Commonwealth Government contributes major funds to:
- high level residential care
- medical services
- health research
- public hospitals
- public health activities.

Pharmaceuticals are funded by both the Commonwealth Government and non-government sources.
State and territory governments
The various state and territory governments have the prime responsibility for providing health and community services. The principal functions of state and territory health authorities include:

- hospital services
- mental health programs
- dental health services
- home and community care
- child, adolescent and family health services
- women’s health programs
- health promotion
- rehabilitation programs; for example, following heart surgery
- regulation, inspection, licensing and monitoring of premises, institutions and personnel.

The state and territory governments also contribute major funds to:

- community health services
- public hospitals
- public health activities.

Private sector
The private sector provides a wide range of services, such as private hospitals, dentists and alternative health services (for example, chiropractors). Privately owned and operated, these services are approved by the Commonwealth Department of Health. Many religious organisations, charity groups and private practitioners run such services. Some private organisations, such as The Heart Foundation and the Cancer Council Australia, receive funding from both state governments and the Commonwealth Government.

Local government
The health responsibilities of local governments vary from state to state, but mainly concern environmental control and a range of personal, preventative and home care services. They include the monitoring of sanitation and hygiene standards in food outlets, waste disposal, the monitoring of building standards, immunisation, Meals on Wheels, and antenatal clinics. The state health department controls some of these services (immunisation, for example), while local councils are responsible for implementing them.

Community groups
Many community groups also promote health. They are formed largely on a local needs basis and established to address problems specific to an area or region. However, where concerns exist nationally, groups are more extensive, usually highly structured and linked in the provision of information, knowledge and support. Examples of prominent community groups are Cancer Council Australia and support groups run by state-based cancer councils, such as Cancer Council NSW; Carers Australia and state-based members of the National Network of Carers Association, such as Carers NSW; Dads in Distress; Family Planning NSW; and Diabetes Australia.

Inquiry
Responsibility for health care
1. Identify the health services and facilities funded by the state or local government available in your local area.
2. Discuss the responsibility of the Commonwealth Government and state governments in providing adequate health-care services to the community.
3. Discuss equity of access and support for general health care for all sections of the community.
4. Discuss the level of responsibility that the community should assume for individual health problems.
3.1.3 Equity of access to health facilities and services

Access to health facilities and services is about the health system’s ability to provide affordable and appropriate health care to people when they require it. Access also refers to equitable distribution of health-care facilities and services to all sections of the Australian population. An individual’s ability to access health-care facilities and services can reflect their:

- socioeconomic status
- knowledge of available services
- geographic isolation
- cultural and religious beliefs.

Access might also be affected by issues such as:

- shortages of qualified staff
- lack of funding or equipment
- patient waiting lists for surgery or other treatment in public hospitals
- waiting times in outpatient clinics or emergency departments.

The majority of Australians have access to fundamental medical care through the national health insurance system — Medicare. However, this health insurance system does not cover all health services such as dental and physiotherapy. As a result, some health services are inaccessible to those who cannot afford them.

An individual’s ability to access services and facilities can also be influenced by their knowledge and understanding of health information and the services available to help them. A knowledge gap may exist as a result of the individual’s lack of education, their poor literacy skills or, in the case of migrants and some Indigenous groups, a language barrier.

Inquiry
Better access to mental health care

Read the snapshot ‘Better access to mental health care’, then answer the following questions.

1. Which health professionals are involved in the team approach to improving access to mental health care?
2. What did the Better Health Access initiative introduce?
3. What evidence is there that the introduction of this initiative improved access to mental health services?

SNAPSHOT
Better access to mental health care

Mental health-related services are provided in Australia in a variety of ways — from hospitalisation and other residential care, hospital-based outpatient services and community mental health care services, to consultations with specialists and GPs.

The first professional encounter for many people seeking help for a mental illness is usually their GP. Data from the Bettering the Evaluation and Care of Health (BEACH) survey of GPs estimated that there were 13.9 million mental health-related GP encounters in 2010–11. This corresponds to 620 encounters per 1000 population.

The introduction of the GP Mental Health Treatment Medicare items as part of the Better Access initiative in November 2006 meant that Medicare rebates are available to provide early intervention, assessment and management of patients with mental disorders. It promotes a team approach to mental health care, with GPs encouraged to work with psychiatrists, clinical psychologists and other allied mental health professionals to increase the available care. It has resulted in a noticeable growth in Medicare Benefits Schedule.
(MBS)-subsidised specific GP mental health services. Since 2007–08, when the Better Access initiatives were fully operational, there has been an average annual growth rate in services per 1000 population of 17.0%. In 2010–11, GPs provided 2.1 million MBS-subsidised mental health-related services to 1.2 million patients.

Source: Australian Government Department of Health and Ageing, media release, 9 October 2006 and AIHW, Mental Health Services in brief 2012, pp. 3, 4.

Application

Researching access inequities

Choose one population group that suffers inequities in health status, for example:
(a) Aboriginal and Torres Strait Islander peoples
(b) migrants
(c) rural dwellers
(d) people who are homeless.

Research information and statistics about your selected group’s access to health-care facilities and services. Create a PowerPoint presentation or an oral report on the impact of the level of access on the health status of your selected population group. Present it to your class.

Inquiry

Rural healthcare concerns

Read the snapshot ‘Rural healthcare concerns highlighted in Royal Flying Doctor Service survey’, then answer the following questions.
1. What remote-area equity issues did the Royal Flying Doctor Service survey reveal?
2. From a social justice point of view, why is it important for healthcare services to be available to people in remote communities?
3. Explain how proposed changes to Medicare might help people in remote communities to access better healthcare.

SNAPSHOT

Rural healthcare concerns highlighted in Royal Flying Doctor Service survey

Rural and remote Australians remain deeply concerned about poor access to healthcare, and want the Federal Government to spend more to fix the problem.

That is the key finding from the latest Royal Flying Doctor Service (RFDS) research, released on Tuesday.

The RFDS surveyed more than 450 country Australians, and one-third nominated access to doctors and specialists as their single biggest healthcare concern.

A third of respondents called for more government funding of services, particularly for mental health and preventative care.

RFDS chief executive Martin Laverty said it raised a question for governments as to whether policies aimed at bridging that gap had failed.

‘We have an oversupply of doctors in this country; the problem is, the doctors are simply not all working in areas where they’re most needed,’ he said.

‘It brings into question the success of repeated programs of Commonwealth governments to encourage doctors to work in remote and country Australia.

‘The question for government is, are our incentives for doctors sending them to where they’re most needed?’
Access to doctors in remote areas a challenge

The survey found encouraging news in other areas. Two-thirds of respondents said they needed to travel for one hour or less to see their GP or another non-emergency medical professional. But for Australians living in more remote places, a visit to the doctor could mean a 10-hour round trip or more. RFDS chief medical officer in Queensland Abby Harwood said governments could do other things to improve their access to care beyond putting more bodies on the ground. ‘There is a lot of telephone and email consultation going on between people out bush and their GPs, but that requires actually having a pre-existing relationship with a healthcare provider who knows you,’ she said. ‘Technology such as video-conferencing is a fantastic opportunity, [but] currently the telecommunications infrastructure out in these areas is not quite sufficient to be able to do that reliably.’

GPs not paid by Medicare for teleconference consultations

Unlike specialists, who can bill Medicare for video-conferencing consultations with patients, GPs currently are not paid unless their patient attends a consultation in person. Dr Harwood said that meant GPs who assisted remote patients over the phone or by teleconference were doing so on their own time and usually out of their own pocket. ‘From my experience, most of us would just do it [for free] out of the service that we provide,’ she said. ‘At the moment it’s either the healthcare provider doing it for free, or the person accessing the GP is paying for it out of their pocket with no subsidy. ‘When you consider the petrol bills, how much it costs in fuel to drive a 1,000 km round trip, a lot of them would rather pay out of their own pocket to do that [if the doctor is not already doing it for free].’

Dealing with issues before crisis point

Dr Harwood seconded the call for a greater focus on preventative care for rural and remote patients, who were too often only dealing with medical issues once they had reached crisis point. She said changing that made medical and economic sense. ‘[When there’s a crisis] a patient then has to travel in and out of their regional centre or capital city, which obviously causes a lot of disruption and it’s expensive,’ she said. ‘I don’t think anyone has actually measured the full cost to Australia as a country, taking into account that social dislocation and the economic disruption when people need to leave their properties, leave their workplace. ‘It’s been proven over and over again that good primary health care, delivered to people out there on the ground, can often prevent those crises from happening.’

Significant boost in GP numbers ‘in all areas’

Assistant Minister for Health David Gillespie, who has responsibility for regional health issues, is on leave. But in a statement, a federal Department of Health spokeswoman said there had been a significant boost in GP numbers ‘in all areas of Australia’ over the past decade. ‘A 2017 budget announcement included funding of $9.1 million over four years from 2017–18 to improve access to mental health treatment services for people in rural and regional communities,’ the statement read. ‘Currently, Medicare provides rebates for up to 10 face-to-face consultations with registered psychologists, occupational therapists and social workers for eligible patients under the Better Access initiative.’ ‘From 1 November 2017, changes to Medicare will take effect so that seven of the 10 mental health consultations can be delivered through online channels [telegenhealth] for eligible patients, that is, those with clinically diagnosed mental disorders who are living in rural and remote locations.’ ‘Relevant services can be delivered by clinical psychologists, registered psychologists, occupational therapists and social workers that meet the relevant registration requirements under Medicare.’


Inquiry

The issue of access

1. Critically analyse the differences in access to health facilities and services that exist between rural and metropolitan populations. You will find some information about equity of access to health care at the Health priority survey findings for people in the bush weblink in your Resources tab.
2. Explain how differences in access might affect the health status of rural and metropolitan populations.
3. Use the information in the most recent Rural health Alliance Fact Sheets to explain why rural health warrants ongoing attention.
4. Discuss how the government’s funding of health-care facilities and services affects access to our health-care system.
5. Explain why people from lower socioeconomic groups have lower levels of access to health-care facilities and services.
6. Explain the rural health access problems facing the Aboriginal community in Australia. The Rural and remote weblink in your Resources can help get you started.
7. Use examples from the above questions to evaluate access to health care in terms of social justice principles.

### Resources
- Weblink: Health priority survey findings for people in the bush
- Weblink: Rural health Alliance
- Weblink: Rural and remote

### Equity of access
Summary screen and practice questions

#### 3.1.4 Health-care expenditure versus early intervention and prevention expenditure

**Health-care expenditure** is the allocation of funding and other economic resources for the provision and consumption of health services. It includes expenditure by Australian state and territory governments, as well as private health insurance, households and individuals. In 2016–17, the Australian federal government budget included $71.4 billion on health programs, $22.7 billion on Medicare, $17.9 billion on hospitals and $10.4 billion on the Pharmaceutical Benefits Scheme.

Health-care expenditure has steadily been increasing and will continue to do so while the focus is on ‘curative’ medicine; that is, the focus is on curing a disease or illness, rather than preventing it. For example, it costs more to ‘cure’ a disease such as coronary heart disease once it has developed than it does to fund measures to prevent the illness occurring. In this example, early intervention might focus on education, healthy eating practices, weight control and active lifestyle activities. In contrast, curative measures such as treatment of heart disease, stroke, clogged blood vessels, kidney failure, blindness and foot/leg amputation are more costly and contribute considerably more to health expenditure. As a result, many feel that prevention is both undervalued and under-resourced, even though funding for health promotion and illness prevention has increased in recent years.

![Figure 3.8](image.png)

*FIGURE 3.8* The cost of prevention is usually small in terms of the cost of cure.

*There’s absolutely nothing wrong with you, so I’m writing a prescription for a puncture repair kit in case you get a leak in your bubble.*
Health-care expenditure in Australia still far exceeds expenditure on illness prevention and health promotion. This is due to an emphasis on medical treatments to cure illness dominating the allocation of public health resources and spending. The new public health model focuses on the social factors that lead to ill health. This model places the emphasis on health promotion as the most cost-effective way in which to address the social issues of health.

Governments, individuals and communities are being made more accountable for their expenditures. Many people whose health is sound because they practise positive health behaviours (exercising, not smoking, healthy eating and so on) resent paying increased taxes to support those who choose in-appropriate lifestyles. Insurance companies recognise the problem, and charge higher premiums for smokers who wish to be covered for life insurance. Lifestyle factors could cause up to an estimated 70 per cent of all premature deaths. Yet, more than 90 per cent of Australia’s health expenditure is allocated to treating and curing illnesses.

Unfortunately, it often takes some years for prevention measures to translate into a reduction in the incidence of lifestyle-related diseases. However, preventative programs for cardiovascular disease, cancer and traffic accidents have been visible over the past two decades — for example, QUIT, SunSmart, the ‘Girls make your move’ initiative, national cervical and breast screening programs, Stop Revive Survive and drink-driving campaigns. Training programs for general practitioners have made them more aware of the importance of preventative health for their patients and promoting positive lifestyles. Because approximately 82 per cent of Australians see their GP at least once a year, this frontline advocacy is an important form of health promotion. Together with treatment, early intervention and prevention programs seem to have contributed to marked falls in mortality and morbidity rates from these problems.

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

- educating school children about positive health behaviours
- better coordination among the various levels of government
- restrictions on advertising
- legislation
- higher taxes on products such as alcohol and tobacco
- the provision of support programs to help people give up addictive habits such as smoking and high alcohol consumption.

There are strong arguments for increasing the funding and support for preventative health strategies.

1. **Cost-effectiveness** — preventing illness and injury would result in huge savings in funds and resources used for acute health care.
2. **Improvement to quality of life** — the positive health outcomes for individuals that result from prevention include improvements in morbidity rates and longevity — that is, a longer and healthier life.

FIGURE 3.9 It may take some time to realise the benefits of expenditure on preventative programs.
3. **Containment of increasing costs** — prevention is the best way of containing the continually increasing costs of health care. Otherwise, these costs could result in adequate health care being unaffordable for ordinary Australians.

4. **Maintenance of social equity** — a policy of prevention helps to provide greater equity (in the health-care system), which otherwise would be under threat as health costs continue to rise significantly.

5. **Use of existing structures** — prevention activities use existing and accessible community structures (such as general practitioners) rather than relying on special services and technological procedures. General practitioners are in a good position to measure risk factors and educate their patients on illness prevention and health promotion.

6. **Reinforcement of individual responsibility for health** — the use of prevention strategies empowers individuals to take control of their personal health by modifying their behaviour.

The arguments for preventing various lifestyle diseases are convincing, but the quality of the extended life span experienced is an issue to be considered. Some researchers are investigating whether delaying the onset of illness through preventative strategies and extending the life span has the effect of increasing the rates of sickness and prolonging the period of illness in the later years of life.

---

**Inquiry**

**Prevention is always better than the cure**

Read the snapshots ‘Risk factors and disease burden’ and ‘National study proves prevention better than cure’, then answer the following questions.

1. Based on the statistics presented in the articles list the arguments supporting greater spending on health promotion and illness prevention.
2. What strategies are suggested for improving illness prevention measures?
3. What problems do the writers suggest make it difficult for governments to spend money wisely on health care?
4. Do you think that spending on health promotion and illness prevention is a good investment for the Australian people? Why or why not?

---

**SNAPSHOT**

**Risk factors and disease burden**

To ensure our health system is aligned to our country’s health challenges, policy makers must be able to compare the effects of different conditions that cause ill-health and premature death. Burden of disease analysis considers both the non-fatal burden (impact of ill-health) and fatal burden (impact of premature death) of a comprehensive list of diseases and injuries, and quantifies the contribution of various risk factors to the total burden as well as to individual diseases and injuries.

The Australian Burden of Disease Study 2011 found the single leading risks factors contributing to disease burden were:

1. tobacco use (accounting for 9.0% of the total burden)
2. high body mass index (BMI) (related to overweight and obesity) (7.0% based on enhanced analysis by the AIHW published in 2017 which used updated evidence of diseases associated with overweight and obesity and enhanced modelling techniques)
3. alcohol use (5.1%)
4. physical inactivity (5.0%)
5. high blood pressure (4.9%) [1, 2].
In addition, an analysis of the joint effect of all dietary risks suggested that they accounted for around 7.0% of disease burden.

There were 29 risk factors included in this study. All these risk factors combined (the joint effect) contributes greatly to the burden for endocrine disorders, cardiovascular diseases, injuries, kidney and urinary disease and cancer. The joint effect of all the risk factors included in this study accounted for 31% of the total burden of disease and injury in Australia in 2011. This illustrates the potential for health gain through disease and injury prevention by reducing exposure to these risk factors.

Enhanced analysis by the AIHW found that overweight and obesity contributed to 7.0% of the disease burden in Australia in 2011. This is due to updated evidence of diseases associated with overweight and obesity and enhanced modelling techniques.

Source: AIHW, 7 August 2017

SNAPSHOT

National study proves prevention better than cure

The University of Queensland and Deakin University have released a groundbreaking report with dozens of recommendations that strongly support more spending on prevention, but also warn that not all prevention measures are wise investments.

The Assessing Cost Effectiveness of Prevention (ACE-Prevention) project is the result of five years of research, funded by the National Health and Medical Research Council. It is the most comprehensive evaluation of health prevention measures ever conducted world-wide, involving input from 130 top health experts.

Led by Professor Theo Vos from the University of Queensland and Professor Rob Carter from Deakin University, the research team assessed 123 illness prevention measures to identify those which will prevent the most illness and premature deaths and those that are best value for money.

Among the recommendations to drastically reduce the rate of serious illness and the associated pressure on the nation’s health system are:

- a 10 per cent junk food tax
- mandatory salt limits in bread, margarine and cereals
- taxing alcohol at 10 per cent more than the current rate for spirits (to address the tax loophole whereby cask wine is cheaper than soft drink), banning alcohol ads and raising the drinking age to 21
- increased tobacco tax (a further 5 per cent on the April 2010 25 per cent increase) and subsidised smoking cessation aids
- boosting skin cancer awareness with an intense SunSmart campaign
- the introduction of a four-in-one ‘poly-pill’ containing three blood pressure lowering ingredients at a low dose and a cholesterol-lowering drug, available to at-risk individuals and Indigenous people aged 35+ at an affordable price
- screening for early stages of diabetes and chronic kidney disease from age 45, given dialysis treatment costs an average $70,000 per person per year
- lap banding for the severely obese
- bone mineral density tests for older women to identify early stages of osteoporosis
- early intervention screening and better follow-up programs for those with mental health problems, including identifying minor depression in adults and childhood depression and anxiety
- for Indigenous people, screening for early signs of diabetes and chronic kidney disease from age 25.

University of Queensland Professor Theo Vos said with health and aged care expenditure projected to grow to $246 billion in 2033, and health care becoming more expensive with the proliferation of high-tech treatments, the need to find proven, affordable illness prevention measures is pressing.

‘Governments desperately need reliable information to use their health budgets more efficiently, so that they can direct the limited resources to where they have the best health outcomes. This will ensure best value health care,’ Prof Vos said.

‘An initial investment of $4 billion and less than $1 billion in following years would be required to put in place the 43 most cost-effective prevention measures. This would give Australians an extra million healthy years over their lifetime. The costs would be more than matched by future savings from not having to treat disease’.
The ACE-Prevention research team also found that several preventive health practices currently applied in Australia have limited benefit and should be reconsidered. These include inefficient current practice in cardiovascular preventive treatment with expensive drugs favoured over cheaper alternatives, prostate-specific antigen (PSA) testing for prostate cancer, aspirin to prevent heart disease, weight loss programs and school-based illicit drug awareness campaigns.

Deakin University’s Prof Rob Carter cautioned that: ‘While the economic case to increase funding for health promotion is strong, it’s important we make tough but necessary reallocations away from ineffective measures with poor cost-effectiveness and towards those that we know are more cost-effective.’

Speaking at the launch in Melbourne today, Todd Harper, CEO of Australia’s first health promotion organisation, VicHealth, said: ‘Public health currently receives only 2 per cent of the health budget. Governments must place greater importance on proven prevention strategies to avoid the massive rise in preventable illnesses in the next few decades.’

Public Health Association of Australia President Professor Mike Daube added: ‘By acting now, we could prevent a million premature deaths among Australians now alive. The jury is in and we have clear evidence on what works in some crucial areas. The only real opposition to action will come from commercial interests. It is up to Governments to take the action that can keep Australians alive and healthy.’

The ACE-Prevention project was funded by the NHMRC and is supported by VicHealth, the Public Health Association of Australia and Lowitja Institute for Aboriginal and Torres Strait Islander Health Research (incorporating the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health).

Source: VicHealth, 8 September 2010

3.1.5 Impact of emerging new treatments and technologies on health care

Almost daily, we hear of new treatments and technologies that will improve healing and health care generally. Much of this relates to health technologies used in diagnostic procedures, such as ultrasound, keyhole surgery and magnetic resonance imaging (MRI). In Australia, non-invasive surgery (laparoscopy, for example) is preferred in many cases to conventional ‘open’ surgical procedures. It generally results in less pain, shorter hospital stays and faster recovery times. These advantages are particularly significant for the elderly, because they face reduced risks and improved recovery from surgery.

Examples of developments in emerging treatments and technologies include:

• advances in image technology used in keyhole surgery make operating procedures far more accurate and less risky for the patient. Laser-fitted flexible endoscopes penetrate very small incisions and make repairs to hernias, kidneys, knees and other structures with new levels of precision, leaving minimal scarring and tissue damage.
• progress is advancing in the treatment of eye conditions with drugs rather than lasers
• continual improvement in the materials, construction and compatibility of parts associated with hips, knees, heart valves and eye lenses, making operations safer and shorter
• making it easier to quit smoking by developing tablets that specifically target nicotine receptor subtypes
• administering chemotherapy through ‘wafers’ or dissolvable discs inserted into the brain at the time of the operation rather than through a vein, port or orally after the operation
• development of new drugs that assist treatment of HIV by stopping the virus from making copies of itself and its ability to bind to new cells. Many HIV sufferers can now look forward to a much longer life than anticipated late last century.
• genetic testing, which can lead to finding a disease earlier and preventing death
• advances in developing prosthetics to replace missing limbs. Improved microchips are powering electronic attachments to muscles, enabling stronger, better controlled movements by patients. The 3-D printing of bones and other body parts is an emerging industry.
• improvements in artificial organs such as kidney and heart machines responsible for keeping people alive until a real organ can be found. It is hoped that artificial organs will eventually be used extensively in organ transplants.

Unfortunately, all new technologies come at a price. In the context of a largely publicly funded health-care system, balancing the cost of new technologies, limited resources and the need to maintain health at an acceptable level is difficult. Research, development, testing, medical and specialists’ fees and highly sophisticated equipment amount to millions of dollars, making some technologies unaffordable unless privately donated or subsidised by government.

Much research is currently being done on early detection because the benefits, both personal and financial, far outweigh surgery or other curative techniques. Regular mammogram testing for breast cancer, Pap smears and use of vaccines to prevent HPV (human papillomavirus) infection, PSA tests for prostate cancer and risk identification programs (smoking, blood pressure, cholesterol) are examples of early intervention programs.

Skin cancer is the most common form of cancer in Australia. As a result it is the target of considerable research. Discovery of a link between inherited genes, environmental influences and skin cancer is making the prospect of developing a screening program for early detection a real possibility. A genetic link that increases the chances of melanoma is also being investigated, making the prospect of biological therapy in preference to surgery a more cost-effective and individually appealing option.

Early detection has considerable benefits for individuals. Screening programs are not as invasive as the surgery that might be required should the condition progress undetected. For example, a mammogram which involves an x-ray of the breast may reveal a tumour in the very early stages and require keyhole surgery. Without the benefit of early detection, the breast may need to be removed, a much more serious outcome for the patient both personally and financially.

Unfortunately, access may prevent some people from participating in early detection and treatment programs. Socioeconomic circumstances and geographic location may influence health care to the point where the diagnostic, treatment and/or rehabilitation processes are not fully utilised. For example, cardiac patients may have limited access to exercise facilities in some areas, socioeconomic conditions may inhibit families in poorly maintained houses from understanding and addressing childhood asthma, and language barriers may make it difficult for some people to understand the extent or locations of the screening services that are available to them.
Furthermore, issues relating to access to dental health are gaining prominence. While fluoride added to the water supply considerably improved dental health for a period of time, other factors such as the high cost of dentistry and widespread consumption of cordial drinks and mineral water (which does not contain fluoride) has meant that dental health problems are on the rise, with socioeconomically disadvantaged groups being the most affected.

**FIGURE 3.11** Dental health, while not life threatening, does contribute to quality of life. Dental health can be improved through early detection.

**FIGURE 3.12** Thermal imaging is one of a number of methods used in early detection, but it is very expensive.
3.1.6 Health insurance: Medicare and private

Accidents and illness can cost individuals a considerable amount of money. The Commonwealth Government is committed to providing equitable health services to all people, which it attempts to achieve through its basic health insurance scheme, Medicare (introduced in 1984).

Medicare

Medicare is Australia’s universal health-care system, established to provide Australians with affordable and accessible health care. The funds to operate the Medicare system are obtained from income taxes and the Medicare levy, paid according to income level. This is currently 2 per cent of a person’s taxable income, but can vary according to individual circumstances. You can find further details by accessing the Medicare levy weblink in your Resources tab.

Medicare provides individuals with access to:
- free treatment as a public patient in a public hospital
- free or subsidised treatment by medical practitioners, including GPs, specialists, and some specified services of optometrists and dentists.

Regardless of what doctors or specialists charge, every Australian is covered for 85 per cent of an amount that is set down by the government as a common (scheduled) fee. Some doctors charge more than the scheduled fee. Many doctors bulk bill patients, which means the patient pays nothing and the doctor receives up to 100 per cent (85 per cent in the case of specialists) of the scheduled fee from Medicare.

Medicare benefits also cover optometrist services and oral surgery, but not private dentistry, physiotherapy, chiropractic treatment and appliances.

Private health insurance

Many people choose to ‘top up’ their health cover by taking out private health insurance. The extra insurance allows people to cover private hospital and ancillary expenses (such as dental, physiotherapy and chiropractic services) and aids and appliances (such as glasses).

People choose private health insurance for a number of reasons, including:
- shorter waiting times for treatment
- being able to stay in a hospital of their own choice
- being able to have a doctor of their own choice in hospital
• ancillary benefits, such as dental cover
• security, protection, peace of mind
• private rooms in hospital
• insurance cover while overseas.

Lower levels of private health insurance are found among the young, the elderly and other groups that have less available income. After the introduction of Medicare in 1984, many people opted out of private health insurance and figures declined through the 1990s (see figure 3.13). The fall in the membership of private health insurance funds created pressures on the public health system, leading to lengthy debate by politicians and health authorities. The strain on the health system was caused mainly by the increasing demands for service from an ageing population and the increased numbers of ‘free’ Medicare patients. In 1998, to decrease this burden on the public health system, the Commonwealth Government introduced a rebate for people who have private health insurance. The rebate is income-tested across four tiers, or bands, of income. It also introduced a Medicare levy surcharge (on top of the 2 per cent Medicare Levy) on individuals who earn more than $90 000 (2018 amount) and families who earn $180 000 or more (2018 amount), and do not have an appropriate level of hospital insurance.

A further change was the lifetime health-care incentive, which was introduced from 1 July 2000. This incentive gives lower lifetime premiums to people who join a health insurance fund early in life and maintain their hospital cover, compared with the premiums for someone who joins after age 30. These policies are aimed at attracting people to private health insurance.

Despite predictions of a fall, the number of Australians covered by basic private hospital insurance rose from 44.7 per cent of the population in 2007 and has remained around 47 per cent since 2012. General trends in basic private hospital insurance are shown in figure 3.13.

### TABLE 3.1 A comparison of Medicare and private health insurance

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Private health insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who pays?</strong></td>
<td></td>
</tr>
<tr>
<td>• Commonwealth Government</td>
<td>• Commonwealth Government</td>
</tr>
<tr>
<td>• Taxpayers</td>
<td>• Private contributors</td>
</tr>
<tr>
<td><strong>How paid for?</strong></td>
<td></td>
</tr>
<tr>
<td>• Levy or tax linked to salary</td>
<td>• Monthly premiums for various forms of cover</td>
</tr>
<tr>
<td><strong>What benefits?</strong></td>
<td></td>
</tr>
<tr>
<td>• Basic medical services (doctors and specialists)</td>
<td>• Hospital cover</td>
</tr>
<tr>
<td>• Choice of general practitioner</td>
<td>– hospital services</td>
</tr>
<tr>
<td>• Basic hospital services in public hospitals</td>
<td>– doctor of choice</td>
</tr>
<tr>
<td>• Specialist health care</td>
<td>– hospital of choice</td>
</tr>
<tr>
<td>• Cover for 85 per cent of the scheduled fee for medical services</td>
<td>– private or public hospital</td>
</tr>
<tr>
<td></td>
<td>• Ancillary services — for example, dental, optical, chiropractic</td>
</tr>
<tr>
<td></td>
<td>• Some special benefits — for example, sports equipment</td>
</tr>
<tr>
<td></td>
<td>• Cover while overseas</td>
</tr>
</tbody>
</table>
Inquiry
Medicare and private health insurance
1. Explain how the Medicare system of health insurance functions.
2. Outline the benefits of the Medicare system.
3. Explain how private health insurance might benefit some people.
4. Read the snapshot ‘Health insurance isn’t right for everyone’. What are the advantages of having private health insurance?
5. Use figure 3.13 to describe trends in private hospital insurance.
6. Outline government strategies for attracting people to private health insurance.

SNAPSHOT
Health insurance isn’t right for everyone
Private health insurance premiums increased again this April, and health insurers and for-profit comparison sites are ramping up their advertising campaigns in a bid to retain customers.

Especially at the end of the financial year young consumers face a barrage of fear-laden advertising from health insurers and for-profit switching sites designed to pressure them into increasingly pricey policies. In a recent advertisement, policy comparison site iSelect depicts a zoo employee suffering severe injuries after being bitten by a snake and then implies checking your hospital cover is a good idea.

Such campaigns are designed to confuse you into thinking taking out private health insurance is a matter of life and death — but nothing could be further from the truth.

Accidents and emergencies
In Australia, not everyone needs private health insurance, especially if you are in a life-threatening situation. In a situation like that depicted in the iSelect advertisement, if someone is bitten by a snake, they’ll end up in their nearest public hospital as an emergency-ward patient and receive high quality emergency care for free.

Even assuming the snake bite victim gets transported in an ambulance, private cover isn’t necessarily going to help with that cost. It’s worth noting that private health insurance can help with the costs for ambulance, for residents in Queensland and Tasmania ambulance cover is provided for free by their state governments.

In Victoria, Northern Territory, South Australia and rural Western Australia you can purchase an ambulance subscription. Only in ACT, NSW and metropolitan Western Australia is hospital insurance the easiest way to get cover for ambulance.

Premium pain
With consumers staring down an average premium price hike of 54.6% since 2009, it’s little wonder 2016 saw a decline in the number of people taking out private cover and a ramping up of fear-based marketing designed to lead consumers into thinking they need to persist with pricey private health insurance.

Given the complexity of the products, consumers often turn to health insurers for advice. CHOICE believes this is contributing to consumers being downgraded into poor value ‘junk’ policies as insurers try to keep them in the system.

Another issue is the reliance on for-profit comparison sites, all of which have a clear incentive to sell consumers any kind of health insurance product — including junk policies — rather than advising against the need for the product in the first place.

Tax and health insurance
There are two financial incentives the government uses to push people into private health insurance. The first is the Medicare Levy Surcharge (MLS). The MLS is an additional tax paid by high income earners (singles earning over $90 000 and couples over $180 000) who don’t have private hospital cover. It begins at $900 a year for singles, and increases the more you earn. Since there are budget hospital policies that cost less than this, if you’re on a high income if you can reduce your tax bill by simply buying insurance.

The other stick the government wields to drive people to private health insurance is a charge called the Lifetime Health Cover (LHC) loading. The LHC loading affects you if you take out hospital cover after your 31st birthday, or if you have any long gaps between cover. If you don’t take out hospital cover before you turn 31, and you do eventually take it out, you’ll pay an extra 2% on your premiums for every year you waited. If you never get
private health insurance, the LHC loading will never affect you. In any case, CHOICE crunched the numbers and figured out you’re probably better off paying the loading, instead of buying insurance you don’t want just to reduce your bill later on.

**Young people should be asking: Do I need health insurance?**

Insurers make much of the importance of taking out private cover before you turn 31 to avoid the 2% per year Lifetime Health Cover loading (see above) — but consumers only pay the loading once they take out private cover later in life.

‘It’s important to realise that every Australian already has health cover through Medicare, and if you’re deciding to go private, it pays to be aware of exactly what you’re getting in terms of cost, coverage and value for money,’ says Matt Levey, CHOICE’s director of content, campaigns and communications.

‘We want Aussies to fight back against the industry fear campaign so we’ve created a free tool at doineedhealthinsurance.com.au,’ Levey says. ‘The site asks you a few simple questions to help you decide if you actually would benefit financially from taking out private hospital cover.’

**Source:** CHOICE, 21 July 2017

---

**Inquiry**

**Medicare and private health insurance**

1. The Commonwealth Government provides information to help consumers understand and make decisions about health insurance.
   - (a) Find a Lifetime Health Cover calculator, and use it to enter birth dates for a range of age groups to help understand how the Lifetime Health Cover loading is calculated.

2. Describe the role of the **Private Health Insurance Ombudsman**.

3. Enlarge the following chart. Use the chart to summarise the advantages and disadvantages of Medicare and private health insurance, particularly in terms of cost, choice and benefits.

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Private health insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td><strong>Disadvantages</strong></td>
</tr>
</tbody>
</table>

---

**TOPIC 3**

Role of health-care facilities and services in achieving better health
3.2 Complementary and alternative health-care approaches

Complementary and alternative medicine (CAM) refers to healing practices that do not fall within the area of conventional medicine. It encompasses health areas such as hypnosis, homeopathy, naturopathy, meditation, herbalism and acupuncture. While many of these types of medicines and practices have existed traditionally as alternatives to mainstream medicine, more recently a growing acceptance of their role in supporting mainstream techniques has given rise to the term ‘complementary’.

Alternative medicine has existed for many centuries, particularly in Asian countries. Traditional Chinese medicines account for 30–50 per cent of all medicines consumed in China. Japan has the highest consumption of herbal medicines in the world.

TABLE 3.2 Types of complementary and alternative medicine and examples

<table>
<thead>
<tr>
<th>Types</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biologically based approaches</td>
<td>Diets, Herbs, Vitamins</td>
</tr>
<tr>
<td>Manipulative and body-based therapies</td>
<td>Massage, Chiropractic, Osteopathy</td>
</tr>
<tr>
<td>Mind–body interventions</td>
<td>Yoga, Spirituality, Relaxation</td>
</tr>
<tr>
<td>Alternative medical systems</td>
<td>Homeopathy, Naturopathy, Ayurveda</td>
</tr>
<tr>
<td>Energy therapies</td>
<td>Reiki, Magnets, Qigong</td>
</tr>
</tbody>
</table>

Populations of developed countries have steadily grown more interested in alternative treatments and medicines over the past decade. Herbal medicines are becoming a popular alternative to modern medicine in developed countries, resulting in an increase in international trade in herbal medicines. Each year, Australians spend about $4 billion on alternative medications or practitioners.

Practitioners of modern medicine are starting to recognise the value of alternative and complementary health-care approaches and are incorporating some of these into their treatments of clients. The World Health Organization supports countries in their development of national policies on alternative medicine to study its potential usefulness. Australians are increasingly buying herbal remedies and consulting alternative health-care practitioners such as chiropractors, homeopaths, naturopaths and Chinese herbalists.

For more information about complementary and alternative medicine (CAM) access the CAM weblink in your Resources tab.

3.2.1 Reasons for the growth of complementary and alternative health products and services

Government surveys show that two-thirds of Australians are currently using CAM treatments. The trend towards using CAM has a lot to do with social change. Greater globalisation and societal trends towards individualism have meant improved access to information worldwide and less acceptance of traditional medical practices. Many people see CAM as an opportunity to exercise choice, exerting greater control over their health through empowerment. The rise in consumption of organic foods is evidence of strengthening consumer confidence in aspects of health care over which they have control.

Other reasons for the increasing popularity of complementary and alternative medicine generally include:

- World Health Organization recognition of the usefulness of many alternative approaches and its endorsement of a list of medicinal plants to be used in the preparation of herbal medicines
- recognition that alternative medicines are the traditional medicines of the majority of the world’s population
- the effectiveness of treatment for many people for whom modern medicine has proved ineffective
- the desire of many people to have natural or herbal medicines rather than synthetically produced medicines
- the holistic (focusing on the whole person) nature of alternative medicine, which is attractive to many people
- the strength of traditional beliefs for many cultures
- increased migration and increased acceptance by Australians of the value of multicultural influences.

The growth in CAM adds another dimension to medical health in its direction and expectations. Consumers, aided by medical information readily available on the internet, have moved to exercise greater choice in addressing personal health care, particularly in areas where there appears an element of uncertainty with traditional approaches.
3.2.2 Range of products and services available

The following examples are from the wide range of alternative health-care approaches.

- **Acupuncture** is an ancient system of healing that has developed over thousands of years as part of the traditional medicine of Eastern countries. Acupuncture treatment involves inserting very fine needles into the skin. They are left in either briefly or for up to 20–30 minutes. Acupuncture is claimed to be effective in a wide range of conditions, stimulating the mind and the body’s own healing response.

- **Aromatherapy** is the use of pure essential oils to influence or modify the mind, body or spirit. Aromatherapy acts in accordance with holistic principles by strengthening the person’s vital energies and self-healing capabilities, thus having a direct effect on the mind and body. Essential oils can be inhaled through vaporisers and applied through baths and massage. Aromatherapy is used in the treatment of depression, sleep disorders, stress symptoms and anxiety.

- The **Bowen Therapeutic Technique** is a system of muscle and connective tissue movements that gently realigns the body and balances and stimulates energy flow. This has the effect of supporting the self-healing properties of the body. The technique is believed to be effective in the treatment of soft-tissue injuries, musculoskeletal problems, back and neck aches, arthritic symptoms, stress, migraines, asthma, sinus and bronchial symptoms, and menstrual irregularities.

- **Chiropractic** is based on the relationship between the spine and the functioning of the nervous and musculoskeletal system. Chiropractors ‘adjust’ the spine, using specific rapid thrusts delivered by the hand or small instruments. The adjustments are aimed at correcting subluxations, removing interference to normal nervous system control over bodily function, and promoting healing and better health.

- **Herbalism** uses plants and herbs exclusively. The oldest form of medicine, it is still used as a primary source of medicine for over 75 per cent of the world’s population. Herbalists use the whole plant form of a medicine rather than chemical extracts from plants. They believe that we have an innate ability to heal ourselves. Thus, herbal medicines are used to restore and support the body’s own defence mechanisms. Herbal treatment is based on the individual’s symptoms, lifestyle and overall health.
• **Homeopathy** is a system of medicine that recognises the symptoms unique to each person. It aims to stimulate the individual’s healing powers to overcome the condition. Homeopathic medicines work gently and rapidly to alleviate symptoms.

• **Iridology** is the analysis of the human eye to detect signs of the individual’s physical, emotional and spiritual well-being. A range of naturopathic treatments can then be prescribed to improve general and immune system health.

• **Massage** is one of the oldest and simplest forms of therapy. It is an excellent method of inducing relaxation. It helps reduce blood pressure, stress and anxiety levels, and overall it is beneficial to the immune system. Forms of massage include remedial massage, therapeutic massage, sports massage and Swedish massage.

• **Meditation** is a state of inner stillness. It involves focusing on an object, breathing or verbally repeating a word (a mantra). With practice, the individual can reach a meditative state, in which they experience inner peace and stillness. The benefits of meditation include strengthening of the immune system, improved sleep, lower blood pressure and increased motivation and self-esteem.

• **Naturopathy** focuses on the holistic treatment of the individual by seeking to address symptoms of illness as well as resolving underlying causes of illness. Naturopaths recognise the importance of developing a partnership with their clients, because it is important for the individual to take responsibility for making positive lifestyle changes.

Access the Health Direct weblink in your Resources tab for more examples of products and services available in the area of complementary and alternative medicines.

### Application

**Alternative health-care approaches**

Choose one type of alternative health care. Use the internet to research it fully, using the following key words:

(a) history
(b) nature (including what it is, how it works and who practises it)
(c) benefits
(d) treatment
(e) cost
(f) level of training required by practitioner
(g) groups who would benefit.
Inquiry

Integrated medical care

Lifehouse is a cancer research and treatment facility, integrating clinical care, research and education, and holistic care for cancer patients. It is named in honour of cancer specialist Professor Chris O’Brien, whose own experiences during cancer treatment led him to believe that alternative and complementary treatments, such as natural medicines and meditation, had a role and could benefit patients in trying to put the body back ‘in balance’. Find out more about the centre and its holistic approach and write a short report on your findings.

Resources

Weblink: Lifehouse
Weblink: Health Direct

studyon

Core 1 Question 3 Topic 2 Concept 2

3.2.3 How to make informed consumer choices

When choosing any type of health or medical service it is important to investigate the service offered and the credibility of the practitioner. A client needs to ask the following questions.

- What is the treatment you offer? How can it benefit me?
- What experience and training do you have?
- What are your qualifications?
- How much will the treatment cost?
- Can this treatment be combined with conventional medication?

An important first step in making informed choices is to gather such specific information about the nature of the alternative medicine, its credibility as an effective type of treatment, and the qualifications and experience of practitioners. Asking friends and community members about their experiences and recommendations can also be valuable.

Some alternative medicines are considered to be very effective, and the World Health Organization recognises them to be valuable and significant treatments. Chiropractic medicine, naturopathy and acupuncture, for example, are offered as university courses within Australia. Other forms of alternative medicines have endeavoured to ensure the highest quality of treatment by providing courses within their organisations; for example, the Bowen Therapy Academy of Australia offers an introductory course followed by a six-month practitioner course to obtain accreditation.

Application

Developing personal consumer skills

Using the questions listed above as a guide, or your own questions, investigate the credibility of one type of alternative medicine. Your investigation methods may include:

(a) gathering information from local practitioners
(b) experiencing the chosen treatment
(c) researching the qualifications required to practise
(d) contacting training organisations to collect information
(e) interviewing people who regularly use this treatment.
Present your findings as a report and share this with the class.

Inquiry
Making informed consumer choices

1. When selecting an alternative medicine, what information would you require to make an informed choice?
2. Discuss methods of accessing correct and relevant information about alternative medicines in your local area.
3. How do you know which practitioners and health-care organisations to believe?
4. In small groups or in pairs, create a PMI chart as follows to summarise the advantages and any drawbacks of alternative medicines.

<table>
<thead>
<tr>
<th>Plus</th>
<th>Minus</th>
<th>Interesting</th>
</tr>
</thead>
</table>

study on
Core 9.1 Question 3 Topic 2 Concept 3
Making informed consumer choices Summary screen and practice questions

3.3 Topic review
3.3.1 Summary
- The role of health care in Australia is to provide quality health facilities and services that meet the needs of all Australians.
- The health-care system involves a complex interrelationship between Commonwealth, state and local governments, health insurance funds, public and private providers, institutions and other organisations.
- The range of health-care facilities and services in Australia include public and private hospitals, psychiatric hospitals, nursing homes, medical practitioners and specialists, community programs, health promotion services and other health professionals who offer alternative health care.
- Health-care facilities and services are essential in diagnosing, treating and rehabilitating the ill and injured. They also play an important role in preventing illness and promoting health.
- Efficient and effective health-care services, along with adequate public housing, employment, education, hygiene and environmental safety, are all crucial factors that have an impact on levels of health.
- Access to health-care facilities and services is affected by a number of factors, including affordability, location, knowledge of service and language barriers. These factors result in inequity in access to health care.
- The private sector within the community plays an important part in providing health-care services, such as the health-promotion strategies undertaken by The Heart Foundation.
• Individuals have a responsibility to take actions to promote their own health, thus lessening the financial burden on taxpayers.

• Emerging health treatments and technologies are having considerable impact on many areas of health including screening, programs, drug administration, surgery, treatment, prosthesis and general medical procedures. While technological advancements such as keyhole surgery and MRI scans improve patient outcomes, they do come at a price.

• Medicare is the national health insurance program that was introduced to support the health of all Australians. It covers a proportion of basic medical and public hospital expenses. Medicare is funded by Australian taxpayers.

• Private health insurance allows people to be covered for extra medical and private hospital costs.

• The Commonwealth Government has introduced an income-tested rebate as an incentive for people to join private health insurance. It has also introduced a levy on high earners who do not have private health insurance. Most recently, it set up the ‘lifetime health cover’ scheme to encourage membership.

• A large proportion of health expenditure in Australia is devoted to curative services, with a small fraction allocated to health promotion. Ill health is costly to the government and the individual. Our taxes fund the bulk of the medical systems within Australia.

• Health promotion is a much more cost-effective means of reducing disease and illness in the long term.

• Complementary and alternative medicine is growing in popularity in developed countries. Greater globalisation and societal trends towards individualism have contributed towards this phenomenon. Some people are becoming disillusioned with the biomedical treatments on offer.

• There are a range of alternative health-care approaches, such as acupuncture, chiropractic, herbalism, naturopathy and iridology.

• It is important to make informed decisions when choosing an alternative health-care approach. The individual needs to investigate the services on offer, the costs, the qualifications and experience of the practitioner, and the health claims being made before committing to it.

### 3.3.2 Questions

**Revision**

1. Outline the range and type of health-care facilities and services that exist in Australia. (H1) (3 marks)
2. Briefly explain the role of health care within Australia. (H5) (4 marks)
3. Explain the differences between institutional and non-institutional health-care facilities and services. What services does each provide to promote health? (H5) (4 marks)
4. Describe the roles and responsibilities of the following groups in the provision of health services. (4 marks)
   (a) Commonwealth Government
   (b) State and territory governments
   (c) Local governments
   (d) Private sector (H5)
5. Discuss the issue of equitable access to health-care facilities and services across the Australian population. (H14) (5 marks)
6. Using examples, discuss the level of responsibility a community should assume for individual health problems and suggest what should be done. (H5) (5 marks)
7. Outline the benefits of early intervention in terms of health-care expenditure. (H14) (3 marks)
8. Discuss the impact of emerging new treatments in terms of cost and access. (H15) (5 marks)
9. Explain how Medicare attempts to provide equity in access to health care. (H14) (5 marks)
10. Discuss the benefits of private health insurance. (H14) (4 marks)
11. Describe measures taken by the Commonwealth Government to support private health insurance. (H15) (4 marks)
12. Explain what you can do, as an individual, to reduce the cost of health care to taxpayers. (H5) (4 marks)
13. Explain why complementary and alternative health-care approaches have grown in popularity in developed countries over recent years. (H14) (5 marks)

14. Identify and discuss the information you need to make informed decisions about alternative health-care approaches. (H16) (5 marks)

**Extension**

1. How can the Commonwealth Government justify spending more of its total health expenditure on illness prevention and health promotion than on curative services? (H15) (5 marks)

2. Argue the benefit of adopting health promotion actions that promote social justice. (H14) (5 marks)

3. Identify and analyse the key factors affecting the health of Australians. Suggest strategies that could lead to improved health for all Australians. (H15) (6 marks)

**3.3.3 Key terms**

**advocacy** is the act of championing or arguing for a particular issue or cause. p. 87

**bulk billing** is a payment option in the Medicare system. The service provider (doctor) bills Medicare directly for the consultation fee, thereby accepting the Medicare benefit as full payment for the service, and the patient pays no fee to the doctor. p. 104

**chemotherapy** is the treatment of cancer using chemical agents or drugs that are selectively toxic to malignant cells. p. 101

**chiroprapy** involves diagnosis and treatment of disorders of the foot, ankle and lower leg. p. 90

**elective procedures** are those operations that are not classified as emergencies. p. 88

**equity** is the allocation of resources according to the needs of individuals and populations. The goal is to achieve equality of outcomes. p. 88

**health-care expenditure** is the allocation of funding and other economic resources for the provision and consumption of health services. p. 97

**holistic** means focusing on the whole patient. Treatments involve the balance and interrelationship between a patient’s physical, social, emotional and spiritual needs. p. 109

**keyhole surgery** is surgery performed through a very small incision (usually 0.5–1.5 cm), usually using a laparoscope or endoscope, devices for viewing inside the body. p. 101

**levy** is a payment collected by the government from a person’s income. p. 105

**medicare** is Australia’s universal system of health care that provides services that are accessible to all Australians. p. 104

**optometry** is a health-care profession that addresses problems with eyes and vision. p. 90

**organic foods** are foods produced without using commercial chemicals such as pesticides and fertilisers. p. 109

**PBS Safety Net** caps the amount a family will pay for PBS subsidised medications in a calendar year. p. 90

**Pharmaceutical Benefits Scheme (PBS)** is a Commonwealth Government program that provides subsidised prescription drugs to Australian residents, ensuring affordable access to a range of essential medicines. p. 90

**psychiatric hospitals** care for patients diagnosed with mental illness. p. 89
residential care refers to care given to a patient away from their home. It takes into account the needs and wishes of the person. An example of high level residential care is a clinic that provides help and treatment to sufferers of anorexia. p. 92

socioeconomic status is a measure of an individual’s place in society, based on their income, education, employment and other economic factors such as house and car ownership. p. 94