TOPIC 13
Equity and health

OVERVIEW

13.1 Inequities in the health of Australians
13.2 Inequities experienced by population groups in Australia
13.3 Bridging the gap in populations’ health status
13.4 Topic review

OUTCOMES

In this topic students will:
• describe the nature and justify the choice of Australia’s health priorities (H1)
• analyse and explain the health status of Australians in terms of current trends and groups most at risk (H2)
• analyse the determinants of health and health inequities (H3)
• 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)
13.1 Inequities in the health of Australians

CRITICAL QUESTION
Why do inequities exist in the health of Australians?

13.1.1 Factors that create health inequities

Health inequities are experienced by a range of populations, which might include Indigenous peoples, the socioeconomically disadvantaged, Australians born overseas, people living in rural and remote locations, and people living with disabilities. The factors that are considered to create this inequity include:

- daily living conditions
- quality of early years of life
- access to services and transport
- socioeconomic factors
- social attributes
- government policies and priorities.

Daily living conditions

Living conditions are people’s everyday environments, including the places where they live, play and work. People in poor living conditions are at greater risk of contracting and spreading communicable diseases. When this is combined with having a large or extended family in the one home, a cycle of ill health can develop because individuals are continually reinfected. Some Indigenous people in remote areas live in improvised dwellings such as sheds or ‘humpies’. The ability to maintain an adequate level of hygiene to prevent the spread of disease in these circumstances can be difficult.

Likewise, the socioeconomically disadvantaged and the elderly can find themselves renting or occupying housing that is older and run-down. These conditions contribute to a higher incidence of respiratory diseases, especially asthma. Older dwellings are more likely than newer buildings to need costly maintenance of items such as the plumbing. Socioeconomically disadvantaged individuals who cannot afford adequate insulation or safe heating in their homes are often the victims of injury or deaths related to burns.

Some socioeconomically disadvantaged people also live in overcrowded conditions. Many individuals living in a confined area may increase the possibility of stress-related illnesses and there is a greater potential for domestic violence or abuse.

Quality of early years of life

The early years of life are extremely important for a child to develop to their full potential. Even before a baby is born they are affected by individual, environmental, socioeconomic and sociocultural factors. These factors continue to have an influence throughout the individual’s life span.

Genetic and environmental factors

The combination of genetic material from each parent may increase the child’s risk of developing a particular disease such as diabetes, or decrease the risk for diseases such as skin cancer and be a protective factor. Besides passing on genetic material that may influence the hair colour and height characteristics of her child, a mother can also pass on the effects of drug use and other lifestyle behaviours. Premature births and fetal alcohol spectrum disorder are common when mothers abuse substances during pregnancy. Babies born prematurely have lungs that are not fully developed at birth, so they must stay on a ventilator in hospital. Babies born with
drug addiction suffer withdrawals and may not fall into regular sleeping patterns for some time. Mothers that drink alcohol heavily during pregnancy have a higher chance of developing fetal alcohol spectrum disorder. FASD is an irreversible lifelong condition that leads to physical and developmental disorders in children. Smoking also contributes to low birth weight babies who experience health disadvantages from the moment they are born. Research suggests that a child who is born with a low birth weight or prematurely may continue to experience poor health throughout their life.

Young children who are exposed to passive smoking in the home environment are at greater risk of developing respiratory illnesses such as asthma. This debilitating disease can impact on the quality of life and restrict a child’s ability to exercise and manage their weight effectively. The effects of being exposed to toxic chemicals by cleaning products or vapours given off by plastic products in the home is also a serious concern. These invisible potential carcinogens may take years of exposure before they develop into cancer or cause some type of allergic reaction that can have a long-term health consequence. The outdoor environment is also a potential source of ill health. Air quality, noise pollution and a safe water supply all have an impact in the early years of life.

**Socioeconomic status of parents**

The socioeconomic status of the parents has a bearing on a child’s potential to achieve good health. Parents on higher incomes can afford private health insurance and are able to gain easier access to diagnostic testing and treatment for young children who experience ill health. They also have greater opportunity and choice of housing and areas to live in. Parents from lower socio-economic circumstances may be unaware of problems with their child’s development, which may only be picked up through routine screening programs conducted in schools or at baby health centres. It is more common for people from lower socioeconomic status backgrounds to not immunise their children for infectious diseases such as whooping cough, which can spread through the community and delay the development of other young children. However, recent reports suggest a significant number of children from a small selection of high socioeconomic postcodes are not being fully immunised.

People from higher socioeconomic status backgrounds are more likely to provide adequate housing that suits the needs of their children. Housing that lacks an adequate water supply or sanitation increases the risk of children contracting infectious diseases. Overcrowding can contribute to domestic disharmony and place stress on relationships. A family’s ability to afford nutritious food influences the development of a child. An adequate supply of essential nutrients is important for proper brain development and physical growth. Too many kilojoules can lead to obesity which in turn can make exercising difficult. People from low socioeconomic backgrounds tend to eat a higher proportion of takeaway meals that are high in fat and rich in kilojoules. These dietary habits are passed on to the child and affect their early years.

More affluent areas also have easy access to GPs, a variety of health services to choose from and a range of specialists who can deal with serious health issues. Any child with a serious illness will also be supported through community services and access to major hospitals with modern diagnostic equipment and treatment procedures. These all help to promote good health in the early years of life.
Sociocultural factors in the early years

Sociocultural factors also play an important role in the early years of life. Beyond the basic needs of food, water, clothing and shelter are love and security. Some cultures have strong family support structures, with the older relatives and siblings taking care of the young when both parents have to work. However, some families cannot provide this level of support and infants might spend more time with friends or in daycare where their nurturing experiences will be different. Attitudes towards, and access to, education can determine a person’s level of health literacy as well as future opportunity for training and employment. High quality education in the early years can determine a child’s ability to understand and interpret health information and so promote good health. Accessibility to education is more challenging in remote and rural areas of Australia, however, while regular attendance at school is an ongoing challenge in many Indigenous communities.

Inquiry

Quality of the early years

Create a mind map to summarise factors that impact on the quality of the early years of life and can lead to inequities in health.

Access to services and transport

To have access to health services, there must be a good infrastructure and an awareness in the community of the care available. The elderly, in particular, can find it difficult to travel to medical specialists and diagnostic services especially if they are also socioeconomically disadvantaged or disabled. If they must rely on public transport, elderly people can find it difficult to arrange and to access transport, particularly when their area is serviced infrequently.

Rural and remote areas experience the greatest disadvantages in accessing health services. This has led to many people relying on health care that is provided to them on a rotational basis or on telemedicine. The NSW Rural eHealth program supports clinical staff in remote areas by teleconferencing.

There are groups in the community who can remain unaware of important health messages. Non–English-speaking migrant groups, for example, may be unaware of important health promotion initiatives presented in the mass media. It therefore becomes essential to use community resources such as websites, cultural groups and newspapers to reach these groups. Area health centres also become a vital link.

Migrants may also find it difficult to locate doctors who speak their language and who are culturally sensitive to their needs. Indeed, the reluctance of Indigenous people to seek ‘traditional white medicine’ comes from past distrust and, in remote areas, from language barriers.

Finally, those people without health insurance have to go on waiting lists for public hospital treatment, so their access to health services may be delayed. A low socioeconomic status accompanied by a disability can become a double disadvantage in achieving good health.

Socioeconomic factors

A person’s socioeconomic status contributes to their standard of health. People of a low socioeconomic status tend to have a poorer attitude towards maintaining their health. This is partially reflected in the fact they are more likely to use a primary or secondary health facility (that is, a doctor or hospital), rather than a preventative health service such as immunisation, dental checkups or breast screening. In research studies they report their health as being fair to poor. In contrast, socioeconomically advantaged people are more likely to be able to afford private health insurance and have access to elective preventative health procedures more.
Socioeconomically disadvantaged people can be caught in poverty traps caused by generations of unemployment. Attitudes passed down through the family can contribute to the devaluing of work and education by younger people. Because these young people have relatively poor role models, they are less likely to travel or experience the broader views of society.

People of a low socioeconomic status tend to adopt unhealthy behaviours, such as higher rates of smoking, excess alcohol consumption, a high-fat diet, irregular eating patterns and patterns of physical inactivity. These all contribute to the higher mortality and morbidity rates that are experienced by this group. Life expectancy is 2.6 years lower than higher socio-economic groups. Because they are on relatively low incomes, people of a low socioeconomic status are less able to buy medicines to treat minor illnesses, and their nutritionally poor diet lowers their immunity to many infections. Long periods of unemployment or job insecurity may contribute to poor mental health. As a group they have a higher incidence of disability and serious chronic illnesses, such as cardiovascular disease, cancer and diabetes.

People whose socioeconomic status is classified as high are more likely to listen to health promotion messages and act upon them. This reflects their higher education levels and higher levels of health literacy. They are able to afford private health insurance and therefore wait shorter periods for treatment. Their place of residence also usually promotes health rather than making it deteriorate. Research has shown that high socioeconomic areas have fewer takeaway food outlets and more access to footpaths, parklands and other sporting and recreation facilities, which have positive impacts on health. A higher socioeconomic status increases one’s chances of having good health.

**SNAPSHOT**

**Most tenants report benefits to living in social housing**

The latest data from the National Social Housing Survey, released today by the Australian Institute of Health and Welfare (AIHW), show that when asked about the benefits of social housing over 90% of social housing tenants reported that it made them more settled and allowed them to continue to live in their current area.

The report, *National Social Housing Survey: detailed results 2016*, looks at the experiences of tenants of public housing, community housing and state owned and managed Indigenous Housing (SOMIH) across a range of indicators.

The majority (74%) of social housing tenants were satisfied with the services from their housing provider, however this varied by housing program. Satisfaction was highest amongst community housing tenants (80%), with SOMIH tenants reporting the largest increase in satisfaction, up 10 percentage points to 68% since the previous survey in 2014. For public housing 73% of tenants were satisfied with the services from their housing provider.

‘Tenants who were 65 and older were most likely to report “feeling settled” and “able to continue living in the same area”, while younger tenants (15–24) were more likely to report the ability to “improve their job situation” and “to start or continue education or training”, as a benefit from living in social housing,’ said AIHW spokesperson Mr Matthew James.

Public and community housing plays a role in assisting people who are homeless. The latest data from the AIHW Specialist Homelessness Services collection, show that around 14% of clients who were homeless, were assisted into public and community housing in 2015–16.

‘According to the survey, 16% of community housing tenants reported that they had experienced homelessness sometime in the previous five years,’ said Mr James.
In 2016, the most frequent service accessed by tenants in the previous 12 months—across all jurisdictions and housing programs—was health and medical services (7 in 10), while the use of mental health services ranged between 1 in 4 and 1 in 6.

Other services accessed included, for example by public housing tenants, advice and referral services (12%), day-to-day living support services (11%), aged care (8%), training and employment services (8%), drug and alcohol counselling (4%), and supported accommodation services (4%).

New data showed that 3% of public housing tenants, 4% of community housing tenants and 5% of SOMIH tenants used domestic and family violence services in the 12 months prior to the survey.

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**Inquiry**

**Most tenants report benefits to living in social housing**

Read the snapshot ‘Most tenants report benefits to living in social housing’, then answer the following questions.

1. Which groups are in most need of housing assistance in Australia?
2. To what extent is the provision of social housing (rental housing provided by the government or not-for-profit community organisations) able to support society’s more vulnerable people?
3. Critically analyse the factors that contribute to health inequity due to rising costs of housing. Discuss as a class.

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**Occupation**

Each occupation carries an element of risk that can affect a person’s health. General office work might seem relatively safe, but stress, exposure to radiation or repetitive strain injury can cause debilitating physical conditions that can reduce the quality of a person’s life.

Workers who use heavy machinery or who are involved in the transport industry are at greater risk of injury leading to disability or death. People in rural and remote areas are particularly affected. There are also industrial processes that put some workers at risk of developing cancers through chemical contamination and respiratory dysfunction through inhaling vapours. This is more likely to affect males, as they tend to take on jobs with a higher physical risk than females. Migrants, workers on low incomes, and the young are also more likely to take risks at work to maintain employment.

**Access to and level of education**

A person’s education level generally determines their level of income, socio-economic status and health. The more time a person spends in education, the greater the potential there is for them to develop a good level of health literacy. Young people who leave school early and remain unemployed are at a greater risk of developing poor mental health and depression, leading to self-harm behaviours. It is also likely that their socioeconomic status will remain low throughout their life.

Migrants from non–English-speaking backgrounds face the difficulty of learning a new language, so they may not fully understand health promotion messages contained in health lessons and in the media. These students should receive health literature presented in their own language.

Statistically, Indigenous people are less likely to have post-school qualifications and, as a group, they tend to leave school at an early age. For Indigenous populations in rural and remote areas, traditional schooling may seem culturally inappropriate, as Indigenous languages and customs are not taught as part of all school curriculums.

Some Indigenous communities are developing their own schools, as are many migrant groups. The growth in independent schools has the benefit of promoting the customs of particular cultures, and may encourage a better attendance rate by students who might otherwise drop out of mainstream schools, as the following case study shows.
CASE STUDY

Indigenous children and impaired hearing — effects on education

‘Indigenous children who are unwell, tired, hungry or emotionally insecure have less capacity to take advantage of available opportunities to learn.’ (MCEETYA Taskforce on Indigenous Education Paper, Solid foundations: Health and education partnership for Indigenous children aged 0–8, p. 4).

Poor health is a major stumbling block to effective learning. It can entail absence from school or training sessions or, where attendance occurs, it can seriously impair students’ capacity to learn.

Australia’s Indigenous population suffers from comparatively high rates of lower life expectancy at birth, low birth weight and failure to thrive in infancy, poor quality diet, disease, low levels of social and emotional well-being, substance misuse, childhood trauma and injuries.

It is important that teachers are aware of these issues and how they might impact on schooling ...

What educators can do

Teachers are not equipped to deal with these issues as they present in students. Partnerships with health agencies and communities are required for effective action.

However, education can play an important preventive role and help to break the cycle.

There are two issues which recur among these case studies — nutrition and hearing loss — where direct intervention by educators can be practicable.

Nutrition: Hungry kids won’t concentrate. It’s that simple. Providing food has been criticised as outside the province of schools and training institutions, a welfare operation which builds dependency. But if a Vegemite sandwich makes the difference between a good session and one which is disrupted, then, in the short term, a Vegemite sandwich is the way to go.

Hearing: Conventional education and training relies heavily on auditory input. The comparatively high incidence of otitis media (OME or ‘glue ear’) among Indigenous young people in some parts of the country seriously diminishes their capacity to respond ...

The issue

Research has established that Indigenous Australians have a very high prevalence of upper respiratory problems and related diseases, including OME. During the critical years for speech and language development, as well as for growth and elaboration of the nerve pathways between the inner ear and the temporal cortex of the brain, the great majority of Indigenous children are experiencing fluctuating hearing loss. Such sensory deprivation during the developmental period subsequently makes it much more difficult for these children to learn English as a school language.

OME in advantaged populations around the world is approximately 5% in childhood, falling to less than 1% after age 12. The prevalence of OME among Indigenous Australian children living in remote communities has been found to range from 40–70%, with younger children experiencing more frequent infectious episodes.

Eardrum perforations and ruptures typically begin within the first three months of life. With repeated ruptures, healing, and re-ruptures, the eardrums become scarred and thickened. In many cases the ruptures become too large to heal and require reconstructive surgery to repair ...

What happened?

Ear examination and hearing testing was provided for 1032 students. Those students found to have active ear disease were provided with medical treatment, in cooperation with families, schools and community clinics.

In summary, 79% of this group of Indigenous students were found to have an educationally significant hearing disability ...

Workshops were held at each of the six schools, for teachers and assistant teachers, community liaison officers and other staff. This covered topics such as: ear disease, auditory deprivation and language development; implications for schools and support services for students with hearing disabilities; phonological awareness (PA) intervention program for Indigenous language-users who are speakers of English as a foreign language; classroom acoustics, and FM classroom hearing aids and speaker systems; structuring learning environments to promote inclusion of students with hearing disabilities.
The in-service program concluded with a negotiated plan for how each school would be involved ... Students’ literacy and phonological awareness levels were tested at the beginning and end of the project to measure the impact of the school-based intervention program.

The main findings

- Indigenous Australian students in this project had a very high prevalence of ear disease and persisting hearing disabilities compared to non-Indigenous students ...
- The relationship between hearing loss and decreased school achievement for Indigenous students was again strongly established.
- Hearing support services at school are especially relevant for Indigenous students learning English as a second language — this can’t be underestimated! English is the school language, and students who have to work at the stressful activity of trying to understand what is said on the basis of second language or foreign language issues, and then have a hearing loss on top of that, encounter a nearly impossible task ...
- Phonological awareness scores predict literacy level
- Something again that is entirely reversible — classroom acoustics. They vary throughout the Territory schools considerably, but they are generally very poor listening environments for students with hearing disability, especially when they are learning English as a foreign or second language ...
- Many students have reduced capacity to process auditory information. Central auditory processing disorders may be part of the sequel to the early onset of conductive hearing loss ...
- Finally, the one statement that reflects the data clearly from over a thousand students in the Territory: high attending Indigenous students who have ear disease and hearing loss, where there has been intervention, stay in school longer and achieve above intensive English.


Inquiry
Identifying factors that cause health inequity

Critically analyse the case study ‘Indigenous children and impaired hearing — effects on education’. Identify the factors contributing to health inequity and discuss the effectiveness of the strategies used.

Social attributes

Australia is considered to be a very multicultural society, with its own blend of races, values, attitudes, religions and range of socioeconomic status. These unique attributes or features contribute to the overall patterns of illness and death, and can work towards better health for all, or create health inequities in subgroups within that society. Discrimination, racism and gender differences can impact the level of health achieved by those affected. Mental health issues, substance abuse and self-harming behaviours are common and can lead to social exclusion.

Social exclusion

Social exclusion refers to the segregation that people experience if they are not adequately participating in the society in which they live. These people may feel disconnected and unable to access education, employment, housing, healthcare and social security services opportunities. If social exclusion continues for a long period of time it can expose generations to a lifetime of ill health that is difficult to overcome. The current poor health of many Indigenous Australians can be attributed to discrimination and their dispossession from their traditional lands.
Individuals or subgroups of the population can become socially excluded when they do not have proper political representation, their health needs are not being considered in government policies, or they are unable to gain equal access to resources. Societies need to work towards making all subgroups of the population feel valued and supported. Young people, the disabled, the elderly and various ethnic groups need to know their health needs are being addressed and that they are able to access health services, regardless of geographic location, issues of discrimination or socioeconomic status.

**Discrimination**
Being part of a group that has been or continues to be discriminated against can lead to poorer health outcomes. The fact that women’s wages are lower, relatively, than males’ wages means that their health can be affected if they delay treatment for financial reasons. The fact that women’s sport receives less media attention has been thought to impact negatively on the participation patterns of younger females. Moreover, the media’s narrow stereotyping of women has caused some women to become obsessed with body image. This has resulted in the higher prevalence of eating disorders among women.

**Discrimination** is the unfair treatment of a person or group based on factors such as their sex, race, cultural origins, age and disability. It can also be experienced by individuals who are living with a disability. They will often require medication or continual treatment to relieve their condition, some of which will be covered by Medicare but not all. Depending on their disability, the person may be financially dependent on a pension, which limits their income and results in a relatively low standard of living.

**Government policies and priorities**
The federal and state governments are responsible for prioritising health care and allocating funds to the general health areas and specific population groups. The national health priority areas (cardiovascular disease, cancer control, injury prevention, mental health, diabetes, asthma, arthritis and musculoskeletal conditions, obesity and dementia) receive a higher level of funding.

Indigenous people, although having health that is two to three times worse than that of non-Indigenous people, receive only marginally higher funding. Government economic and social policies of the past, which did not allow Indigenous people to determine their own affairs, have contributed to their ill health. Now that this issue is being addressed, Indigenous health is anticipated to improve.

The cost of health care is always increasing, which means that there are often competing priorities for government funding. Inevitably some areas won’t receive as much as they require. The introduction of Lifetime Health Cover was designed to ease the burden on the public health-care system by encouraging people to take out hospital insurance earlier in life. There is a risk that this policy may achieve an improvement in health only for those who can afford it.

The introduction of mandatory sentencing laws in the Northern Territory in 1997 greatly affected the health of Indigenous people. For the general Indigenous population, it represented another form of discrimination, and was a source of emotional suffering. Indigenous people are over-represented in gaols in the Northern Territory and throughout Australia. For those who are imprisoned, the exposure to violence, drug taking, abuse and the spread of sexually transmitted infections can have lifelong health consequences.

**Inquiry**

**The effect of multiple risk factors on health**
1. With reference to a specific population group — for example, the socioeconomically disadvantaged — explain how multiple risk factors contribute to the health inequity of this group.
2. Recommend strategies for the management of health care for this group.
13.2 Inequities experienced by population groups in Australia

CRITICAL QUESTION
What inequities are experienced by population groups in Australia?

The syllabus requires students to study the health inequities experienced by any two of the following population groups:

- Indigenous peoples
- people from geographically remote areas (this text includes rural areas)
- the homeless
- people living with HIV/AIDS
- the incarcerated
- the aged
- people from culturally and linguistically diverse backgrounds
- the unemployed
- people with disabilities.

Indigenous peoples and geographically remote population groups (rural) have been selected in this text because they suffer considerably poorer health than the general population. Students are strongly encouraged to follow their own interests in selecting their focus populations. Summaries of other population groups are included in this section for students to begin their own, more detailed research.

Application
Challenging generalisations about health inequity

Complete the following for the two population groups you have selected.
1. Brainstorm generalisations held by society about your chosen populations.
2. Examine the current health data to determine areas of inequity and the degree to which the gap is reducing or increasing. Use a visual method such as an Infographic or mind map to highlight the degree to which the gap is reducing or increasing.
3. Analyse the impact of the health determinants.
4. Examine the media’s role in influencing social attitudes and public policy with reference to at least two specific examples.
5. Evaluate government interventions.

Once you have completed your research make a presentation to the class of your findings.

13.2.1 Indigenous peoples

Indigenous people have poorer health than the rest of the population. The current epidemiology indicates that this gap is likely to increase and that health promotion initiatives need to target the factors that contribute to this inequity.

Epidemiology and areas of inequity

Epidemiology is the study of disease in groups or populations. The epidemiology indicates the health disadvantages for Indigenous people begins at an early age. Indigenous mothers tend to give birth to babies with a lower birth weight and there is a higher infant mortality rate. The Indigenous population (798 400, or
3.3 per cent, in September 2017) is a relatively young one as a result of a much lower life expectancy (see figure 13.3). In 2016 the median age of the Indigenous population was 23 years, compared to 38 years for the non-Indigenous population. Although the Indigenous population represents approximately 2.8 per cent of the total population, they have health that is two to three times worse and it is showing little improvement.

**FIGURE 13.3 Age structure of Australia’s Indigenous and non-Indigenous population, 2017**

![Age structure graph]

*Source: Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*

**Life expectancy**

The AIHW report *Australia’s health 2016* indicated that life expectancy at birth for Indigenous males was 69.1 years, 10.6 years lower than that of non-Indigenous males. The life expectancy at birth for Indigenous females was 73.7 years, 9.5 years lower than that of non-Indigenous females.

**Mortality rates**

In 2016 the infant mortality rate for the whole of Australia was 3.2 deaths per 1000 live births. The infant mortality rate for Indigenous people was much higher: 6.2 deaths per 1000 live births.

Reliable mortality statistics for Indigenous people of all ages are available only from Western Australia, the Northern Territory and South Australia. The mortality rates for Indigenous people increase with their degree of remoteness. About 22 per cent of Indigenous people live in remote areas, compared with only two per cent of non-Indigenous people. As a whole population, Indigenous people die younger than non-Indigenous people. Current research suggests that there is evidence of a small improvement in mortality rates for Indigenous people in the period 2003–2011 (see the snapshot, page xxx).

**Morbidity**

Indigenous people fare worse in nearly every cause of disease. Their morbidity rates are particularly high for cardiovascular disease, respiratory illnesses, diabetes and injuries.

Figure 13.4 shows the main causes of death of Indigenous and non-Indigenous people by age.
Hospitalisation

The hospitalisation rate for Indigenous people is about two to three times that of other Australians. The higher rate can be partially attributed to having to stay at hospitals for treatment because of factors related to remoteness, but Indigenous health overall is generally poorer, with particularly high rates of chronic kidney disease. The hospitalisation rate for Indigenous people would be 30 per cent more than the rate for non-Indigenous people if hospitalisations for kidney dialysis was excluded from the statistics. The rates of hospitalisation by diagnosis and Indigenous status is shown in figure 13.5.

Source: AIHW analysis of National Hospital Morbidity Database
Inquiry

Differences in epidemiology
1. What is the difference between the life expectancy of Indigenous and non-Indigenous Australians?
2. Examine the data in figures 13.4 and 13.5 and write a short report on the most significant information that they reveal.
3. Read the snapshot ‘Significantly higher disease burden for Indigenous Australians - but improvements made’. (a) Identify the health determinants that have been improving recently. (b) What are the areas of health determinants where further work is needed?
4. Research the latest epidemiology data for Indigenous Australians. The Indigenous health weblinks in the Resources tab may be used as a starting point. Discuss the latest trends and whether any improvements have been made.

SNAPSHOT

Significantly higher disease burden for Indigenous Australians — but improvements made

While Indigenous Australians face a substantially higher disease burden than non-Indigenous Australians, improvements have been seen, with more possible, according to a new report released today by the Australian Institute of Health and Welfare (AIHW).

The report, Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011, analyses the impact of diseases and injuries in terms of the number of years of healthy life lost through living with an illness or injury (the non-fatal burden) and the number of years of life lost through dying prematurely from an illness or injury (the fatal burden).

‘Indigenous Australians experienced a burden of disease that was more than twice that of non-Indigenous Australians,’ said AIHW spokesperson Dr Fadwa Al-Yaman.

Chronic diseases caused 64% of the overall burden among Indigenous Australians, with mental & substance use disorders accounting for the largest proportion of the burden (19%). This was followed by injuries including suicide (15%), cardiovascular diseases (12%), cancer (9%) and respiratory diseases (8%).

Just over half (53%) of the overall burden was fatal burden, and males accounted for a greater share of the total than females (54% compared with 46%).

While the gap in disease burden between Indigenous and non-Indigenous Australians remains significant, the report shows some improvements among the Indigenous population in recent years.

‘Between 2003 and 2011, total burden of disease in the Indigenous population fell by 5%, with an 11% reduction in the fatal burden,’ Dr Al-Yaman said.

‘However, over the same period, there was a 4% increase in non-fatal burden. This suggests a shift from dying prematurely to living longer with disease.’

The non-Indigenous population experienced a 16% decrease in fatal burden and a 4% decrease in non-fatal burden over this period.

The largest reduction in the Indigenous rate of total disease burden was for cardiovascular diseases. There were also falls in the burden caused by high blood pressure, physical inactivity and high cholesterol.

The Northern Territory and Western Australia had higher rates of Indigenous burden of disease than New South Wales and Queensland (the 4 jurisdictions for which estimates are reported). Large inequalities were also seen across remoteness areas, with Remote and Very remote areas having higher rates of disease burden than non-remote areas.

The report shows that a significant portion of the overall disease burden was preventable.

‘By reducing risk factors such as tobacco and alcohol use, high body mass, physical inactivity and poor diet, over one-third of the overall burden for Indigenous Australians could be avoided,’ Dr Al-Yaman said.

These risk factors — and the associated health conditions — are profiled in the AIHW’s most recent biennial health report, Australia’s health 2016.

Advising the AIHW on the Indigenous component of the Australian Burden of Disease Study was a group of experts and representatives from a range of organisations, including the Australian Government Department of Health, the Department of the Prime Minister and Cabinet, jurisdictional health departments, and the National Aboriginal Controlled Community Health Organisation (NACCHO).

Source: Australian Institute of Health and Welfare
Impact of health determinants

Despite advances in medicine, technology and treatment of disease, Indigenous health lags behind that of the general population. The reasons for the poor level of health of Indigenous people can be attributed to factors such as:

- poor living conditions
- poverty
- low levels of education
- unemployment
- colonisation
- dispossession
- discrimination
- difficulties maintaining culture
- importance of land
- funding not commensurate with needs
- hospitalisation rates
- traditional understandings about health.

Poor living conditions

According to the 2014–15 Social Survey, an average of 21 per cent of all Aboriginal and Torres Straight Islander persons were living in overcrowded households compared with 6 per cent of non-Indigenous Australians. The main problems appear to be a shortage of bedrooms and adequate living areas, the need for building repairs and the breakdown of household utilities. Overcrowding was more common in remote areas, where 41 per cent of Indigenous Australians lived in overcrowded households compared with 15 per cent in major cities. In the Northern Territory, overcrowding affected 59 per cent of Indigenous people in rented and community housing. This overcrowding leads to greater levels of stress, increased risk of abuse and the spread of infectious diseases.

Poverty

The household income of Indigenous people is substantially lower on average than that of other Australians. In 2014–15, the median household income of Indigenous people was $542 per week compared with $852 per week for non-Indigenous people. Government benefits are the main source of income for more than half of the Indigenous population. The tendency towards large households, and cultural traditions that promote the sharing of resources mean that this income is not sufficient to maintain good health. In remote areas, food is more expensive and limited in its availability. Poor nutrition has contributed to the high incidence of diabetes in this population.

Poverty can also preclude Indigenous people from taking out private health insurance, so many must rely on Medicare. Long-term poverty also contributes to poor mental health and the high rate of suicide and self-harm behaviours.

Low levels of education

Indigenous people as a whole population have a lower level of education. National surveys of Indigenous peoples report that school participation rates are lower than for all Australians and governments have initiated programs to try to address this. Level of education is linked to potential income, so until education levels improve, many Indigenous people are destined for low incomes and potential ill health — a vicious cycle.

In 2015, the Australian Bureau of Statistics reported a steady increase in Indigenous students attending schools, and an increase in the numbers of those staying on until year 12 (see figure 13.6). This is a positive sign for the future.
Unemployment
Surveys have shown that Indigenous people are almost three times as likely as non-Indigenous people to be unemployed. According to the Australian Bureau of Statistics, the unemployment rate for Indigenous people was 21 per cent in 2014–15 compared with 17 per cent in 2008. This rate is 3.6 times the non-Indigenous unemployment rate. Challenges reported by Indigenous Australians seeking work include: job shortages in the local area, distance, transport problems as well as insufficient education or training. Those not seeking work reported childcare, study, a long-term health condition or disability as a reason. In 2014–15, 40 per cent of unemployed Indigenous Australians reported high to very high levels of psychological distress. Employment promotes emotional and economic well-being and can lead to improved standards of living and health.

European colonisation
Despite Indigenous people’s courage and determined resistance, their land was colonised. This resulted in the displacement of Indigenous people from their lands to native camps, missions or areas deemed unsuitable for early settlers. European colonisation introduced previously unknown diseases such as smallpox, leprosy and venereal diseases, to which Indigenous people had little resistance. Indigenous people’s previous nomadic way of life ensured their camp sites never became polluted, but once they were forced to live in the same small areas, their health became seriously affected.

The European colonisation of Australia led to the clearing of large areas of land for farming, resulting in a change in diet for Indigenous people. Traditional foods, which had provided adequate protein, carbohydrate, fruit and vegetables, were replaced with handouts of flour, tea, sugar, jam and dried meat, which led to malnutrition. Farmers began culling many of the kangaroos, thus reducing the supply of fresh meat, and the physical activity gained from hunting and gathering was lost. By being forced to live in designated areas with no natural water supply, some Indigenous people have also become susceptible to trachoma, a disease that results in blindness.

Indigenous people still suffer from the social and cultural disruption caused by European colonisation, as is evident in the high incidence of mental health problems in the Indigenous population.

Dispossession
Indigenous people managed the land carefully and were thus able to sustain their way of life for tens of thousands of years. Written records of ownership were not needed, as Indigenous people knew their own community boundaries. Being dispossessed of their land has meant that Indigenous people have lost their economic independence and traditional way of life, leading to a substandard level of health for many.

Indigenous people who were removed from community lands were forced to move to missions or housing commission accommodation in the cities. As they lost their connection to country, they became detached from their culture and traditional way of life. Indigenous people’s spiritual belief in the Dreaming and their links
to the land have been severed by dispossession. The psychological scars of dispossession run very deep in Indigenous people and contribute to poor mental health for many.

Australian government policy in 1951 aimed to force assimilation and gave legal power to police and administrators to remove Indigenous children from their parents to white training institutions, missions or childless white couples. This resulted in generations of Indigenous people losing ties to their family and culture. This policy was not abandoned until the 1970s, when a more appropriate program of self-determination was proposed. Few accurate records were kept, so many families are still separated today. The Stolen Generation has many emotional issues to resolve before a good level of mental health can be achieved for the affected people.

SNAPSHOT

The personal tragedy of the Stolen Generation

All my mother could say was, ‘Oh, no, not my Baby, please let me have her. I will look after her.’

As that policeman walked up the hospital path to get my little sister, May and Myrtle and I sobbed quietly. Mother got out of the car and stood waiting with a hopeless look. Her tears had run dry I guess. I thought to myself, I will gladly go, if they will only leave Geraldine with Mother.

‘Mrs Clements, you can have your little girl. She left the hospital this morning,’ said the policeman.

Mother simply took the policeman’s hand and kissed it and said, ‘Thank you, thank you.’

Then we were taken to the police station, where the policeman no doubt had to report. Mother followed him, thinking she could beg once more for us, only to rush out when she heard the car start up. My last memory of her for many years was her waving pathetically, as we waved back and called out goodbye to her, but we were too far away for her to hear us.

I heard years later how after watching us go out of her life, she wandered away from the police station three miles along the road leading out of the town to Moonahculla. She was worn out, with no food or money, her apron still on. She wandered off the road to rest in the long grass under a tree. That is where old Uncle and Aunt found her the next day.

Source: AIHQ media release, 19 June 2012.

Inquiry

Consequences of dispossession

The snapshot ‘The personal tragedy of the Stolen Generation’ is an extract by an Indigenous person taken from her family at a young age.

1. Describe the emotions reflected in the language of Margaret Tucker.
2. Explain what might have been the possible effect on her mother’s health.
3. As a class, discuss the implications of the Stolen Generation for all Australians. Look at the effect on Indigenous health and what needs to be done in the future.
Discrimination
Indigenous people were included in the census for the first time in 1967. In 1962, all Aboriginal Australians were allowed to vote for the first time. This speaks volumes about how Indigenous people have been discriminated against. The anti-discrimination laws that have been introduced in recent years have helped to improve the treatment of Indigenous people, but there are still many areas of discrimination that affect their health and still need to be addressed.

Indigenous people are over-represented in the judicial system. There is a high rate of suicide among young Indigenous males in custody. Moreover, the gaols are often far away from the family, thus preventing support from family members.

Discrimination continues to occur daily in the housing market and employment sector. Verbal abuse and harassment does little to improve the self-esteem and self-worth of people who statistically suffer poor mental health.

Difficulties maintaining culture
Indigenous people are becoming increasingly urbanised, which makes it increasingly difficult to preserve cultural traditions. Nevertheless, they have managed in many ways to do so, and it is a source of great pride. Groups such as the Bangarra Dance Theatre and artists from the Utopia region in the Northern Territory have kept traditions alive and provide role models to younger Indigenous people. There are many more such examples.

In remote areas, traditional languages are still used and the easing of certain laws has allowed some traditional hunting activities to continue. This has helped to improve nutrition and physical activity patterns. Greater self-determination has seen the development of Aboriginal schools, which are better able to cater for the needs of Indigenous youth. However, there is still more to be done to ensure that Aboriginal languages are fostered and maintained.

The importance of land
As mentioned earlier, land holds a central place in the identity of Indigenous people. It helps define who they are and it is treated with great respect because they and their ancestors are intrinsically connected to it. Indigenous people campaigned for many years for land rights, and since the 1970s, various state and territory governments have granted Indigenous groups ownership of their land.

Another way for Indigenous people to gain access to or control of traditional land is through the Native Title Act 1993 (Cwlth). Reinstating ownership over land may help to heal the emotional and mental scars of dispossession, allowing Indigenous people to re-establish their spiritual connection with the land.

Inquiry
Examining the importance of land to Indigenous people
Read the extract from *Maybe Tomorrow* written by Indigenous author Boori Pryor and then critically analyse it in terms of the following.
1. Explain what his essential message is for the future.
2. Outline how this might be achieved.

SNAPSHOT
Maybe tomorrow
... If people can see the beauty of Aboriginal culture, which is this country, then this will be a much happier place. The land and Aboriginal culture go hand in hand. You can’t separate them. The land is the giver of life. It is our mother. It’s like the vein of life. If you cut this, if you separate these two things, we die ... To feel happy about yourself, you must feel happy about the place you live in. To feel happy about the place you live in, you must
get to know that place. To get to know that place, you must ask the people who have lived there the longest, the Aboriginal people. We have the key that can open the door to the treasures of this land.


Funding not commensurate with needs
In 2010–11 the estimated health expenditure for Indigenous Australians was $4.6 billion or 45 per cent of Australia’s total health expenditure. This represents $7995 per person for Indigenous Australians, compared to $5437 per person for non-Indigenous Australians, despite the fact that Indigenous people’s health is two to three times worse. They generally have higher rates of hospitalisation in all causes and the incidence of diabetes is increasing to alarming levels. To improve Indigenous health, funding needs to be increased in proportion to needs.

Hospitalisation rates
Indigenous Australians have hospitalisation rates two to three times that of non-Indigenous Australians. Generally, Indigenous people have restricted access to GPs, pharmaceuticals, culturally appropriate health services and private health insurance. It is usually Aboriginal health workers who provide the primary health care in Indigenous communities, and their services need to be strengthened and developed further. The number of Indigenous doctors is slowly increasing, with some universities offering places specifically for Indigenous medical students. It is important that Indigenous people be in greater control of developing their own health services in accordance with what they perceive their needs to be.

Holistic understandings about health
Traditionally, medical care was administered by respected elders who used the bush medicines that could treat burns, coughs, colds, stings and headaches, for example. Today, tea tree oil and eucalyptus oil are part of our modern treatment procedures. The lifestyle diseases of diabetes, ischaemic heart disease and high blood pressure were previously unknown among Indigenous people.

In the Northern Territory, some Indigenous groups have resurrected ‘Grandmothers’ Law’, which is part of Indigenous childbirth practices. They have managed to move Indigenous women away from white-run hospitals to birthing centres that are culturally sensitive to Indigenous women’s issues.

CASE STUDY
Aboriginal health retreat using bush foods and medicines a ‘promising’ model for improvement
(By Nadia Daly)
Wild yams and fish, traditional bush medicines, Aboriginal herbal remedies and even sand massages are all part of a holistic health program designed to turn back an ‘epidemic’ of chronic disease in north-east Arnhem Land in the Northern Territory.

A remote Indigenous-led health program which has shown ‘impressive’ results could be rolled out as a model to reduce high rates of chronic disease among Indigenous people, according to a public health expert.

The Hope for Health project was started by volunteers and Aboriginal Yolngu people on Elcho Island, aiming to tackle chronic health problems by incorporating traditional health practices and knowledge with western medicine.

After crowdfunding $90 000, the group held its first health retreat camp on the island last year.

‘The most common conditions we see [are] chronic kidney disease, type 2 diabetes, and cardiovascular disease,’ said Kate Jenkins, a naturopath based on the island, who coaches participants and is a case manager on the project.

The men and women who participated in the program reported good results from the outset, and more detailed data received three months later was even better.

‘We knew we were getting good results on the ground — you start to see people transforming,’ Ms Jenkins said.
‘You barely recognise some photos of individuals — they’re walking around glowing now. ‘But once we saw the hard data … it just blew the whole community away.’

Hope for Health said 85 per cent of participants showed a reduction in waist circumference, almost two-thirds had improved kidney function, and four in five people had reduced their blood pressure.

So far the results looked ‘promising’, said Adrian Bauman, a professor of Public Health at the University of Sydney.

‘The results among those 25 participants are impressive: they lost a clinically useful amount of weight, they had improvements in kidney function, blood sugar and blood pressure levels,’ he said.

‘Why did this project work so well?’

Yolngu participant Valerie Bulkunu said the experience helped her make long term changes, such as swapping two-minute noodles and cordial for more wholesome home-cooked food.

‘It’s changed my family’s lifestyle, to cook our own food,’ she said.

‘We get a lot of vegetables from the shop, I’ve been purchasing a lot of greens from the shops. Meats, frozen meats, chicken, kangaroo.’

Her experience and new knowledge also encouraged her sisters to give up smoking, she said.

Professor Bauman said the key to replicating the project would be ascertaining exactly why it worked.

‘One of the interesting questions is, “why did this project work so well when we’ve had such little success in these kinds of projects in the past?”’

Hope for Health’s Kate Jenkins said the answer was the hands on support provided in the local language, and the fact the project was driven by the community and guided by Yolngu leaders.

Looking to the future

The group is now focused on making the program sustainable in the long term, securing funding from public donations on their website and hoping to win government grants.

‘We get contacted weekly by different communities wanting Hope for Health to go to their community; that’s beyond our capacity at this point,’ said Ms Jenkins.

Professor Bauman, who holds particular interest in chronic disease, cautioned that the evidence must be considered preliminary at this stage, but said it showed great potential for being a model for improving remote Aboriginal health around the country.

‘What we need to do is that the government fund a replication study where this is tested in six communities; they’re given funding, they go away and do it in their own way,’ he said.

‘Get a scientific independent evaluation. And if you got six different communities who all achieve similar health gains of this one, then it’s got to be on that State Government, Federal Government take seriously, scaling up to 30, 50, 100 communities.

‘If we could prevent one of these people from going onto dialysis it would more than pay for the whole program.’

Valerie Bulkunu also has big plans for the project and her community on Elcho Island.

‘It’s not [only] about healthy food, it’s also about growing our own gardens, we’d like to see that,’ she said.

‘Growing plants and native plants, that’s what I want to see in the future.’

Source: ABC News, June 2017

Summary of health data and determinants for Indigenous peoples

Seventy-nine per cent of Indigenous peoples live in regional and metropolitan areas, but their relative health decreases with increasing levels of remoteness.

Areas of inequity

Mortality compared to the Australian population:

- life expectancy for Indigenous males born in 2016 is 69.1 years (compared with 79.7 for non-Indigenous males), and 73.7 years for Indigenous females (83.1 for non-Indigenous females)
- the leading causes of death are diseases of the circulatory system, diabetes and chronic lower respiratory disease
- Indigenous people die at younger ages relative to non-Indigenous Australians
- infant mortality rates are decreasing
• there have been improvements in overall mortality, but the health gap is widening between Indigenous people and non-Indigenous Australians.

Morbidity compared to the Australian population:
• Indigenous people are more likely to experience disability or reduced quality of life due to ill health and self-report their health as fair to poor
• the main areas of ill health are due to cardiovascular disease, mental disorders, chronic respiratory diseases, type 2 diabetes and cancers
• Indigenous people have higher hospitalisation rates for dialysis, injury, respiratory infections, digestive diseases and substance abuse
• Indigenous people suffer higher rates of poor dental health
• psychological distress is higher in Indigenous people, with females especially affected.

TABLE 13.1 Impact of health determinants for Indigenous peoples

<table>
<thead>
<tr>
<th>Individual</th>
<th>Sociocultural</th>
<th>Socioeconomic</th>
<th>Environmental</th>
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<tbody>
<tr>
<td>Higher rates of smoking contribute to cancers (42 per cent of Indigenous people smoke).</td>
<td>Higher fertility rates can compound problems caused by overcrowding and teen pregnancies, resulting in additional stress.</td>
<td>Lower relative incomes limit Indigenous people’s capacity to buy their own home, purchase luxury items such as cars, or afford more nutritious foods or private health insurance. Their quality of life is reduced.</td>
<td>Some rental housing contributes to poor living conditions and overcrowding worsens with increasing levels of remoteness.</td>
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<tr>
<td>Not all Indigenous people consume alcohol, but those who do drink do so at high risk levels, contributing to poor mental health and injuries.</td>
<td>Higher mortality rates at a younger age mean Indigenous people experience grief and loss more frequently.</td>
<td>Some Indigenous people rely on government assistance for income and housing, which can affect their self-esteem and ability to become independent. They become burdened with a welfare mentality that can be passed on by subsequent generations.</td>
<td>Some Housing Commission areas increase the risk of exposure to violence, substance abuse and criminal activity.</td>
</tr>
<tr>
<td>Substance abuse is an issue, with higher rates of illicit drug use contributing to poor mental health, suicides and injuries.</td>
<td>Traditional high fibre and protein diets are being replaced with refined carbohydrates and fats, leading to nutritional deficiencies.</td>
<td>Cultural beliefs of kinship contribute to extended families living within the same household, which can contribute to the spread of infectious diseases (this is more common in remote areas).</td>
<td>Poor transport infrastructure in some areas can limit services and social networks, resulting in social isolation and depression.</td>
</tr>
<tr>
<td>Obesity levels increase with age and remoteness, which is contributing to CVD and diabetes.</td>
<td>Cultural beliefs of kinship contribute to extended families living within the same household, which can contribute to the spread of infectious diseases (this is more common in remote areas).</td>
<td>Loss of cultural ties can put Indigenous people at risk of poor mental health.</td>
<td>Increased remoteness limits availability of safe drinking water and adequate waste disposal, which increases the risk of the spread of infectious diseases.</td>
</tr>
<tr>
<td>Physical activity levels decrease with increasing age and contribute to CVD and diabetes.</td>
<td>Loss of cultural ties can put Indigenous people at risk of poor mental health.</td>
<td>Indigenous people suffer higher levels of discrimination and racism, which impacts mental health.</td>
<td>The availability of fresh fruit and vegetables decreases with remoteness, which can lead to nutritional deficiencies.</td>
</tr>
<tr>
<td>Indigenous people have a reduced sense of being in control of their lives, which puts them at risk of depression.</td>
<td>Indigenous people suffer higher levels of discrimination and racism, which impacts mental health.</td>
<td>Indigenous people prefer to use culturally sensitive health services when available.</td>
<td>Indigenous people tend to be involved in higher risk occupations such as trades, transport and mining, which puts them at a higher risk of injuries.</td>
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<td></td>
<td>Indigenous people have lower levels of educational attainment and retention rates at schools, which affects mental health.</td>
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Media’s role

The media’s role is to provide a balanced perspective of Indigenous peoples. Negative issues such as violence, crime, and substance and child abuse must be addressed by all subgroups of the population. The media could work towards breaking down stereotypes of people and populations experiencing inequities. The media’s aim should be to increase public awareness, and stimulate society and the government to act by increasing funding and resources. Media coverage of supportive actions that individuals, businesses and governments can take to address discrimination, is a step towards breaking down stereotypes. Beyondblue’s Invisible Discriminator campaign encourages everyone in Australia to recognise their own discriminatory behaviour and to change it for the collective good of society. A positive perspective and compassion need to be far greater focuses in the reporting of issues: an appreciation of traditions, a respect for cultural values and beliefs, promotion of role models and educating society about sensitive issues such as the Stolen Generations and land rights.

The general media supports anti-discrimination laws and challenges racism in sporting contexts. The Commonwealth Government provides funding for Indigenous media — newspapers, magazines, radio and television stations that give Indigenous people important health and social information in their own languages with cultural sensitivity.

One analysis of the role of media in the portrayal of Indigenous peoples is provided in the Conversation article ‘Negative Indigenous health coverage reinforces stigma’. The author suggests a focus on responsible reporting on Aboriginal health topics and personal journeys. The article also suggests that a focus on positive models of change and commitment in Aboriginal communities may lead to change. The West Australian Indigenous Storybook is one such initiative that aims to embrace a holistic view of health and to showcase community based programs that could be replicated in other communities.

**SNAPSHOT**

‘Negative Indigenous health coverage reinforces stigma’

Think of Aboriginal health and you’ll probably recall messages of large gaps in life expectancy, increasing rates of chronic diseases such as diabetes, kidney disease and asthma. Or that the last ten years has been a ‘wasted decade’ for Aboriginal people.

It won’t be too much of a surprise, then, to learn that 74% of media articles about Aboriginal health are negative. That’s the finding of a media study by my colleagues and I at the Public Health Advocacy Institute Western Australia (PHAIWA).

No one would argue it is difficult to generate negative stories about Aboriginal communities when the data shows:

- the estimated gap between Indigenous and non-Indigenous people’s life expectancy in Australia is greater than in New Zealand, Canada and the United States
- Aboriginal people are four to five times more likely to die between the ages of 25 and 54 years than non-Indigenous Australians
- Aboriginal employment rates fell from 48% in 2006 to 46.2% in 2011
- More than 26% of Australia’s adult prisoners are Aboriginal, even though they represent just 2.5% of the country’s total population

The news is bad. But does the media do all it can — or make enough of an effort — to look for positive stories? My colleagues and I analysed all articles relating to Aboriginal health from print media in The West Australian, The Australian and The Sunday Times (WA) and from the ABC Online news service during 2012, a total of 335 articles.

We found that overwhelmingly, the articles were negative in their portrayal of Aboriginal health, with 15% of the coverage positive and 11% neutral.

The most common negative topics were alcohol, child abuse, petrol sniffing, violence, suicide, deaths in custody and crime.

The most common positive topics included education, role modelling for health, sport and employment.

The media plays a significant role in framing the way we think about issues. When Aboriginal people are persistently portrayed as drunks, welfare dependents and violent perpetrators, it can fuel racist attitudes among the wider population and this type of racism has a major impact on the health of Aboriginal Australians.

In some cases, these stereotypes can be internalised, creating a sense of shame and presenting barriers to participating in mainstream society. This perpetuates the cycle of disadvantage.
Yet it would not be appropriate to blame the media in isolation for negative portrayals of Aboriginal health. Drawing attention to problems experienced in Aboriginal communities is a legitimate and well-tried approach for those who seek to generate action. Media coverage of disadvantage and negative outcomes is often presented by journalists as a response to comments by advocates for action, and as a means of expressing and generating concern and outrage, and seeking change.

There is also a legitimate role for media in reporting evidence-based information relating to disadvantage. Although these issues are important to highlight, particularly from an advocacy perspective, they tell only half the story and rarely provide positive aspects or hopes for the future.

So, how can we positively influence the way in which Aboriginal health is portrayed in the media?

One strategy to overcome the sense of hopelessness created through negative media, is to focus on positive models of change and commitment in Aboriginal communities. There is great value in capturing positive changes, in collecting and amplifying the voices of Aboriginal people and organisations who are role models, and who run successful ventures in their communities.

The West Australian Indigenous Storybook, produced by PHAIWA, does just this. The storybooks portray only positive stories and are written largely by Aboriginal public health or community development practitioners. The books look more deeply into issues and illustrate responsible and less sensationalist reporting on a diverse range of topics and issues that affect health including personal journeys, Aboriginal art, language, education, sport, environmental stewardship and preventive health projects. These achievements are worth talking about.

Upskilling Aboriginal advocates through media training is also required, particularly when, by nature, many are shy. Aboriginal corporations should consider this within their annual budgets and professional development plans.

In Western Australia, this training is provided free of charge by PHAIWA but in other states, budgets may need to be allocated. This training is important to balance the power relationship between journalists and Aboriginal people.

Positive media representations of Indigenous Australians can provide hope for the future. Encouraging journalists to talk with Aboriginal people about their life, culture and concerns may result in news stories that are more accurate and portray a less distorted and stereotypical view of Aboriginal communities.

One effective training method is the integration of a visit to an Aboriginal community during cadetships or university training, where students talk directly with them about their hopes, fears and problems.

This has been trialled in a partnership between the Combined Universities Centre for Rural Health (CUCRH) and Edith Cowan University, where eight final-year journalism students spent a month with Aboriginal communities in two Western Australian towns. We also need to develop ethical media policies and procedures that promote fair reporting of issues relating to Aboriginal communities, such as the clash of media and Aboriginal cultures, timelines, values and trust.

An organisation such as the Media, Entertainment and Arts Alliance which already has a code of ethics could lead the charge and provide regular training on how journalists can better promote cultural diversity in reporting. A precedent has been established with the reporting of suicide. Mindframe aims to inform appropriate reporting of suicide and mental illness, to minimise harm and copycat behaviour, and reduce the stigma and discrimination experienced by people with mental illness is working. So, we know it can be done; now we just have to make it happen.

Source: The Conversation, April 2014

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**Inquiry**

**Negative Indigenous health coverage reinforces stigma**

Read the snapshot ‘Negative Indigenous health coverage reinforces stigma’ and refer to your own knowledge to answer the following questions.

1. To what extent does the Australian media reportedly portray Aboriginal health negatively?
2. (a) List the most common negative topics.
   (b) List the most common positive topics.
3. What strategies are suggested in the article to promote media skills within the Aboriginal community?
4. **Mindframe** is an Australian government national media initiative. Use the link in your Resources tab to outline the aims of Mindframe. Examine the media’s role in influencing social attitudes and public policy.
Evaluating government interventions

In addition to mainstream health services, the Commonwealth Government provides specific Indigenous-based health services such as community support services, screening programs, social and emotional well-being services, transport services and accommodation. Specific interventions include:

- the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023*, which outlines goals and updates progress on action taken by the Australian Government, the Aboriginal community-controlled health sector and other key stakeholders.
- Care for Kids’ Ears to increase awareness of ear disease and hearing loss in Indigenous communities. Left untreated ear infections can lead to hearing loss which may limit the social and emotional development of a child.
- Cashless debit card, a Federal Government initiative designed to support disadvantaged communities and decrease the level of consumption of drugs, alcohol and gambling which impacts on the health and well-being of communities, families and children.
- Puggy Hunter Memorial Scholarship Scheme which funds Indigenous peoples who wish to take up health profession training. Indigenous peoples are also included in the national suicide prevention strategy to improve mental health, national drug campaign to reduce the use of dangerous drugs and the national tobacco campaign to reduce smoking.

Inquiry

Indigenous peoples

1. Using the summary on pages XXX–XX as a guide, investigate two to three government interventions aimed at trying to improve the health of this particular population group. Evaluate the effectiveness of the interventions, keeping in mind the characteristics of an effective health promotion strategy (see subtopic 13.3.4).
2. Conduct research into at least two perspectives of the Federal Government’s Cashless Debit Card scheme. Prepare a balanced outline of the arguments for and against the continued use of this scheme using supporting data and recent examples.
3. Recommend any future directions or strategies the government should take to make further improvements in this population’s health status.

13.2.2 People in rural and geographically remote locations

Epidemiology and areas of inequity

Around a third of Australians live in rural and remote areas. The epidemiology of people in rural and remote areas indicates that they have higher levels of risk factors and suffer from poorer health than people living in metropolitan areas. Overall, they have higher mortality rates, hospitalisation rates for some causes of illness and a lower life expectancy. Of the 2.1 per cent of the overall population who live in remote or very remote areas, 16.3 per cent of the population in remote areas and 45.1 per cent of the population in very remote areas are Indigenous Australians.

Life expectancy

People living in rural and remote areas of Australia have life expectancies lower than those of the general population, and life expectancy decreases with remoteness. The higher death rates outside major cities may reflect higher proportions of these populations who are in Aboriginal and/or Torres Strait Islander Communities. Indigenous Australians have a lower life expectancy and are more likely to live outside of
major cities. Recent reports by the Australian Institute of Health and Welfare (2016) suggest that 69 per cent of people living in outer regional and remote areas are overweight or obese. The results are intended to assist local communities in defining their priorities for improvements in health care.

**Mortality**

Mortality rates in Australia increase with remoteness. In 2015, the mortality rate of people living in remote and very remote areas was 1.3 times higher than the mortality rate for people living in major cities. According to the 2017 AIHW report on rural and remote health, coronary heart disease was a leading cause of death while diabetes was 2.3 times more prevalent as a cause of death for people in remote and very remote areas compared to people living in major cities. The rate of dying due to road transport accidents was more than 5 times more likely in remote and very remote areas compared to major cities. The lowest infant mortality rates in Australia are found in the capital cities, and the highest rates are found in remote areas. The main contributing factors to infant mortality are congenital anomalies, SIDS and low birth weight.

**Hospitalisation**

The hospitalisation rates for injury in rural and remote areas are higher than in metropolitan areas. People living outside major cities are more likely to have long-term health conditions such as arthritis, asthma, back problems, deafness, long-sightedness, diabetes, heart, stroke and vascular disease. However, people living outside major cities were less likely to be short-sighted. The trend for males to be hospitalised more than females is a pattern that occurs in metropolitan areas and in rural and remote areas. With greater remoteness, both male and female hospital separation rates rise. The difference between areas can be related to environmental, lifestyle and occupational factors.

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**Inquiry**

**Trends in causes of death**

For five of the causes of death outside of major cities in figure 13.7, write a statement that describes the data.

**FIGURE 13.7** Top five leading causes of premature death by remoteness area 2011–13.

<table>
<thead>
<tr>
<th>Rate ratio (compared with Major cities)</th>
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</thead>
<tbody>
<tr>
<td>0.5</td>
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<tr>
<td>1.0</td>
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<tr>
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<td>3.0</td>
</tr>
<tr>
<td>4.0</td>
</tr>
<tr>
<td>8.0</td>
</tr>
</tbody>
</table>

**Remoteness area**

- Major cities
- Inner regional
- Outer regional
- Remote
- Very remote

1. **Coronary heart disease**
2. **Lung cancer**
3. **Suicide**
4. **Colorectal cancer**
5. **Breast cancer**

**Notes**

1. ‘COPD’ refers to chronic obstructive pulmonary disease.
2. Colours represent the rate ratio of the age-standardised premature mortality rate for each remoteness area, compared with the age-standardised premature mortality rate for Major cities.

**Source:** AIHW National Mortality Database; Table S3.2.4
Impact of health determinants

Rural and remote populations have poorer health in comparison to urban and city dwellers. Their health may be influenced by a number of factors, including:

- geographic and social isolation
- exposure to drought, flood and fires
- access to services
- lack of infrastructure
- structural factors
- occupational hazards
- unemployment
- education
- attitudes towards illness
- barriers to using health services.

Geographic and social isolation

As the distance from a major urban centre increases, people’s socioeconomic status tends to decrease, contributing to a poorer level of health. People in remote areas suffer the poorest levels of health in the population group as a whole. Geographical isolation reduces people’s access to health care and makes them dependent on health services provided on a rotational basis by the Royal Flying Doctor Service, or on travelling vast distances to seek attention. For example, delays in the treatment of burns victims contributes to the fact that burns are a major cause of death in remote areas for young children and the elderly. There is a greater dependence on ‘telemedicine’ provided over the telephone or by radio and on the self-administering of appropriate medication.

Geographical isolation also leads to social isolation. A lack of personal support structures contributes to the higher incidence of poor mental health and depression, leading to behaviours involving self-harm or attempted suicide. The suicide and self-harm rate for young gay men is high in rural and remote areas because of conservative attitudes to sexuality that might exist in these communities.

The rates of homicide and domestic violence become higher with increasing levels of remoteness. Many women who are isolated may not report abuse, as they may fear reprisal, lack financial independence, lack transport or be pressured by their community to remain where they are. The elderly are at greater risk of burns and injuries related to falls, because a high proportion live in their own homes, which, naturally, lack specialist facilities. Nursing homes, hostels and home care services are often full and are a long way from family and friends.

Exposure to drought, flood and fires

People in rural and remote areas can be subjected to a greater level of physical danger and injury as a result of the many natural disasters particular to their region. Repeated sequences of drought, flood or fire can emotionally scar and depress individuals who depend on the land for their livelihood. Years of hard work can be swept away overnight, and the task of rebuilding lives can be delayed for weeks or months. In 2017, the
average age of farmers in Australia was 56 years; this was 17 years older than the average Australian worker of 39 years. Diets may be affected, as fresh fruit and vegetables may be unavailable for long periods and they may have to rely on canned and preserved goods during periods of isolation. Even re-establishing their livelihood can expose individuals to the risk of developing infections and diseases from contaminated water or from disposing of dead livestock.

Access to services
The level of medical services reduces as remoteness increases. Access to screening clinics and support groups is restricted in most rural areas, and the primary health-care provider in remote areas tends to be a nurse rather than a doctor. This is because many doctors choose to work in the cities, for family, social and financial reasons but also because of ‘burnout’. In some rural areas, the local GP is the only source of medical help, and doctors can find themselves on call almost 24 hours a day, seven days a week.

When individuals need specialist treatment, they are required to travel long distances and usually have to stay away from home for lengthier periods if the treatment is continuing. Patients with chronic conditions may find themselves hospitalised for longer periods because it is too far to travel home and return for treatments. This separation from the family and home can cause distress.

The elderly in rural areas have less access to nursing homes or hostel-type care at hospitals because they focus more on acute care. The elderly therefore remain at home, which is likely to contribute to the higher number of deaths caused by falls with increasing levels of remoteness.

SNAPSHOT
Desperate need for better access to antenatal screening in the bush
Rural women across Australia desperately need and deserve much better access to advanced ultrasound and other antenatal screening services, and the federal and state governments must work together urgently to ensure this is provided, the Rural Doctors Association of Australia (RDAA) and Rural Doctors Association of Queensland (RDAQ) said today.

A study published recently in the *Medical Journal of Australia* found that, since 2000, there has been a 14.3 per cent fall in maternal-age-adjusted rates of Down syndrome births among mothers living in urban areas of Queensland, but no fall for mothers who live in rural areas of the state, when geographic location only is considered.

The authors of the study have suggested that a range of factors — including unequal access to advanced ultrasound screening for rural women — are the likely explanations for the difference.

‘This study provides yet more evidence that rural Australians are facing tremendous disadvantages in accessing local health services,’ RDAA President Dr Peter Rischbieth said. ‘There is an urgent need for much better access to local healthcare, including advanced antenatal screening through ultrasound, in rural and remote areas.

‘It is very difficult for many rural women to access advanced ultrasound screening locally during their pregnancy, due to a lack of advanced ultrasound machines and a lack of sonographers who are specifically trained in screening for Down syndrome and other conditions.

‘While antenatal blood tests are certainly useful in screening for these conditions, a combination of blood tests and advanced ultrasound screening is the “gold standard” in ensuring the optimum accuracy of results early in pregnancy . . .

‘There is also precious little financial support available for rural women who may need to travel long distances to major centres to access advanced ultrasound screening.

‘The federal and state governments must work urgently to address the disadvantage suffered by rural Australians when it comes to healthcare access. Paramount in this is implementing a national Rural Health Obligation to ensure rural Australians have better access to rural doctors, local rural hospitals and rural health services.’

President of the RDAQ, Dr Christian Rowan, said . . . ‘The lack of access to optimum antenatal screening is denying rural women and their families a basic choice that pregnant women in the cities take for granted, that is access to the most accurate test for Down syndrome and other conditions early in their pregnancy . . .’

Inquiry

Health service inequity

1. Describe the health inequity that is the issue in the snapshot ‘Desperate need for better access to antenatal screening in the bush’.
2. Why is it difficult for rural women to access advanced ultrasound screening?
3. In what way is the Rural Doctors Association attempting to address social justice principles in relation to health service access?
4. Use the internet to find out about the Rural Health Obligation. Who is proposing it and what has been the government’s response?

Lack of infrastructure

Sparse infrastructure in rural areas means that many individuals must rely on private motor vehicles for transport. The high numbers of road accidents suggests that travelling long distances at high speeds and on roads that are often poorly maintained contributes to the elevated injury statistics.

As some rural regions experience high rates of unemployment, many businesses relocate to other rural centres, leaving buildings unoccupied and people having to travel much further for goods and services. The decline in some regions means that funding to some towns is reduced, which again contributes to the downward spiral.

Structural factors

In many rural areas, economic resources are tied up in assets such as machinery, livestock, natural resources and crops. People from farming families may be asset rich, but cash poor, so their ability to satisfy basic needs and maintain their socioeconomic status may be hampered by this situation.

The livelihood of all rural community members depends on producers having good seasons and getting good prices for their crops, livestock and other produce. Globalisation and the removal of trade barriers has meant that some rural areas have become unable to compete, so they have had to develop new enterprises to survive and take out loans to finance these new ventures, creating uncertainty and stress for families.

The very nature of rural work exposes people to the harsh conditions of all types of weather. Working conditions tend to deteriorate with remoteness and carry a higher element of risk. Workers may be required to live in shared accommodation during seasonal work periods, and this can lead to mental stress due to
separation from their families. In general, living conditions also tend to deteriorate with increasing remoteness and the difficulty of maintaining adequate hygiene puts people at risk of developing infections and diseases. Some of the positive structural factors of rural life are the strong social support offered by the community in times of hardship, the affordability of housing and the lifestyle. Indeed, many city people are drawn to country areas to improve the quality of their lives.

**Occupational hazards**
The operation of heavy machinery in mining, forestry, agriculture and transport puts rural people at a higher risk of injury and disability. The fact that many rural workers must travel long distances to find work increases the risk of road-related injuries and fatalities, and creates stress when families become fragmented. Agricultural workers who work with pesticides, herbicides and chemicals must ensure appropriate use and handling procedures are followed to reduce the risk of developing respiratory diseases and cancers.

**Unemployment**
In some rural areas, unemployment is becoming an increasing problem, leading to a trend for young people to move to the cities to find work. Those who move are separated from the family, while those who remain may face long-term unemployment and be at risk of low self-esteem and depression. The high rate of suicide in rural young people, particularly males, is of great concern. The long-term unemployed also tend to develop unhealthy lifestyle patterns, which are associated with higher rates of alcohol consumption, smoking and physical inactivity leading to obesity.

**Education**
Unless children in rural areas live close to a major centre, they are more likely to have to attend a boarding school, which leads to further fragmentation of the family. Children of primary-school age in isolated areas may choose to be involved in the School of the Air, but after primary school they must choose whether to attend boarding school or continue their education through correspondence. Unfortunately, the high rate of unemployment in some rural areas does not always provide an incentive for some young people to pursue further education.

**Attitudes towards illness**
Rural people living further away from regional centres are more likely to delay treatment, because it is inconvenient to travel long distances unless it is a serious illness. Statistically, rural people visit their doctors less often than city people. Rural males tend to adopt lifestyles with few positive health-related behaviours and accept work-related injury as a normal consequence of their way of life. There is also a belief in some rural areas that country people need to be tough to survive, and admitting illness may be seen as a sign of weakness.

**Barriers to using health services**
The perception that ‘small towns talk’ is likely to be accurate and may prevent some people from seeking out health services other than their GP. They may fear embarrassment or the difficulties caused by a lack of privacy.
Ethnicity can also be a barrier for using health services, because migrants may feel that their customs will not be respected or that language difficulties prevent them from seeking the appropriate treatment. An increasing number of former refugees are relocating to regional areas.

**Summary of data and determinants for rural and geographically remote populations**
Rural and geographically remote populations include populations in areas outside major cities, which account for approximately a third of the Australian population (including the 2.1 per cent of the population who live in remote or very remote areas).
TABLE 13.2 Impact of health determinants for rural and geographically remote populations

<table>
<thead>
<tr>
<th>Individual</th>
<th>Sociocultural</th>
<th>Socioeconomic</th>
<th>Environmental</th>
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<tbody>
<tr>
<td>Higher rates of smoking, especially in remote areas, which contributes to different cancers.</td>
<td>Cultural expectation to be tough can cause individuals to take more risks with their health and take more risks at work, resulting in more injuries.</td>
<td>Lower relative incomes and employment opportunities limit capacity to buy their own home, purchase luxuries or private health insurance. Many farmers are asset rich but cash poor.</td>
<td>Poorer living conditions and over-crowding increase with remoteness.</td>
</tr>
<tr>
<td>High levels of alcohol consumption, which increases with remoteness. This contributes to CVD, poor mental health and injuries. Males are more at risk.</td>
<td>This attitude of toughness can see individuals delay seeking treatment, resulting in poorer health for specific medical conditions.</td>
<td>Reliance on bank finance can affect mental health, especially in times of poor harvest or as a result of globalisation. Debts can be passed on to the next generation or force families to leave traditional homes.</td>
<td>Some communities are at a higher risk of violence, substance abuse and criminal activity because of their relative isolation.</td>
</tr>
<tr>
<td>Lower levels of illicit drug use, except for cannabis which is contributing to poor mental health, suicides and injuries.</td>
<td>In remote areas individuals live in communities that can be socially isolated and this increases the risk of mental health problems and domestic violence.</td>
<td>Primary production and mining jobs increase exposure to chemicals and pesticides and transport-related injuries.</td>
<td>Poor transport infrastructure in some areas can limit services and social networks, resulting in social isolation and depression.</td>
</tr>
<tr>
<td>Obesity levels tend to increase with age and remoteness and contributes to CVD and diabetes.</td>
<td>Many rural areas have higher proportions of migrant populations who can suffer discrimination and racism. This impacts on their mental health and self-esteem.</td>
<td>Individuals in remote areas and some rural areas have lower levels of educational attainment and retention rates at schools, which affects mental health.</td>
<td>Limited health services result in people having to travel long distances or stay for extended periods away from the family for health care, usually in hospitals.</td>
</tr>
<tr>
<td>Physical activity levels decrease with increasing age and also contribute to CVD and diabetes. Males are more at risk.</td>
<td>Rural areas also tend to have strong community support networks that work in times of natural disaster to promote good mental health for those in need.</td>
<td>Remote areas have limited access to a variety of goods and services, however, some goods and services are becoming more accessible online.</td>
<td>Increased remoteness limits the availability of safe drinking water, fresh food and adequate waste disposal, which increases the risk of the spread of infectious diseases and nutritional deficiencies.</td>
</tr>
<tr>
<td>Diets in regional areas are more likely to include adequate fruit and vegetables, but this decreases with remoteness.</td>
<td>Cultural expectation to be tough can cause individuals to take more risks with their health and take more risks at work, resulting in more injuries.</td>
<td>Lower relative incomes and employment opportunities limit capacity to buy their own home, purchase luxuries or private health insurance. Many farmers are asset rich but cash poor.</td>
<td>Variable road conditions contribute to higher incidence of road-related injuries.</td>
</tr>
</tbody>
</table>

Areas of inequity

Mortality (in comparison to major cities):
- life expectancy decreases as remoteness increases. People in regional areas have life expectancies one to two years less than people in major centres and people in remote areas have life expectancies seven years less than people in major centres.
- the leading causes of death are circulatory disease, cancers, respiratory diseases and injury
- death rates are 1.4 times higher for all ages in remote and very remote areas.

Morbidity (in comparison to major cities):
- health in general is slightly poorer
- there is a higher incidence of certain chronic diseases. The incidence of cancer is significantly higher in regional areas due to sun exposure and smoking. Cancer incidence in very remote areas is significantly lower in very remote areas compared to major cities.
• high incidence of self-reporting of cardiovascular diseases
• higher hospitalisation rates for dialysis and preventable conditions because of delays in seeking treatment or limited access to medical professionals
• higher rates of poor dental health due to less access to fluoridated water
• psychological distress is higher in remote areas. Males in outer regional and remote areas are 1.2 times more likely to report very high levels of psychological distress than males in major cities.
• females reported cases of diabetes 1.3 times higher than females in major cities and arthritis 1.2 times higher.

Media’s role
The role of the media is to provide a balanced perspective on life in rural and remote areas. Negative issues such as the harshness of the environment, drug use, isolation, violence and the occurrence of natural disasters needs to be balanced with the positives. The media should aim to increase public awareness and encourage the government to act by increasing funding for services and infrastructure. The positive perspectives of rural life need to be promoted in the media: an appreciation of the ever-changing environment, a respect for rural values and beliefs, promotion of an alternative lifestyle at an affordable cost and educating society about sensitive issues such as the effects of globalisation and natural disasters on communities. The media also encourages healthy competition between the city and country in sports.

The media supports rural communities in public debates regarding the social and financial effects of globalisation, increases in fuel costs and interest rates. Regional media networks use newspapers, magazines, radio and television stations to provide important health and social information.

One positive media initiative is the development of the annual Glove Box Guide to Mental Health, which aims to connect rural communities and to encourage conversation about mental health by harnessing the strong readership of The Land in rural and remote locations. In partnership with the Centre for Rural and Remote Mental Health (CRRMH) and the Rural Adversity Mental Health program, The Land produces a newspaper-style special feature annually in a digital and printed format to target rural and remote readers. Shared stories, practical information and online tools and apps are provided, with the aim of empowering individuals and communities, and to reduce the stigma surrounding mental health issues. This media initiative uses the 80 per cent reach to farmers weekly to make a difference to the high rates of mental illness. Printed copies are distributed by the partner health agencies to people geographically isolated from many specialised health services.
Evaluating government interventions

In addition to mainstream health services, the Commonwealth Government provides specific rural-based health services such as the Royal Flying Doctor Service, which provides better access to health. Specific interventions include the:

- General Practice Rural Incentives Programme (GPRIP), an Australian Government incentive that aims to promote careers in rural medicine
- Nurse scholarship program, which is an incentive for nurses to move to rural areas
- National Rural and Remote Health Infrastructure Program, to improve access to health services
- Rural Health Education Foundation, which televisions health information to remote areas for GPs and nurses. Other national strategies are also accessible for most large rural centres
- Rural eHealth Strategy, a NSW state government initiative to connect rural and remote patients electronically with services and clinicians.

Inquiry

Rural and geographically remote populations

1. Using the summary on pages XXX–XX as a guide, investigate two or three government interventions aimed at trying to improve the health of this particular population group. Evaluate the effectiveness, keeping in mind the characteristics of an effective health promotion strategy (see sub-topic 13.3.4).

2. Recommend any future directions or strategies the government should take to make further improvements in this population’s health status.

13.2.3 Inequities for other population groups — summaries

Summary of data and health determinants for the homeless

A person is classified as homeless if they do not have access to safe, secure and adequate housing. Homelessness affects men, women, families, young people and children. There are four categories of homelessness:

- primary, when individuals live on the streets, in parks, squats or cars
- secondary, when people live with friends or relatives
- tertiary, when people live in boarding houses for the short or long term.
- marginal, when people live in caravans.

More than 100 000 people are homeless each year, with an increasing number being young people.

Areas of inequity

Mortality (compared to the rest of the Australian population):

- the longer a person is homeless (primary category), the lower their life expectancy
- the main causes of premature death (primary category) are attributed to substance abuse, particularly overdoses and violence
- the health gap is widening because homelessness is affecting an increasing number of people from various socioeconomic circumstances.

Morbidity (compared to the rest of the Australian population):

- long-term homeless people have higher rates of problematic drug use and suffer poor mental health; for example, depression and schizophrenia. These conditions can develop after the person becomes homeless and are not necessarily the initial cause of homelessness.
- homeless people have higher rates of infectious diseases such as gastroenteritis, nutritional deficiencies and respiratory illnesses such as bronchitis and asthma
- blood-borne diseases such as hepatitis, as well as STIs are also more prevalent
- homeless people are at greater risk of physical and sexual assault and injury
- Indigenous peoples are over-represented in the homeless population in relation to their proportion of the total population.
TABLE 13.3 Impact of health determinants for homeless people

<table>
<thead>
<tr>
<th>Health determinants</th>
<th>Individual</th>
<th>Sociocultural</th>
<th>Socioeconomic</th>
<th>Environmental</th>
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<tbody>
<tr>
<td>Problematic drug use can contribute to poor mental health and the emergence of psychiatric disorders such as schizophrenia.</td>
<td>Family and relationship breakdowns can leave individuals without support or accommodation for the short or long term.</td>
<td>The homeless suffer severe disadvantage with no assets, little security or stability in their lives, which impacts mental health.</td>
<td>Some homeless people are exposed to harsh environmental conditions which place them at greater risk of developing severe respiratory illnesses.</td>
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<tr>
<td>Drug dependence can lead to overdoses and involvement in crime to support habits.</td>
<td>Domestic violence can leave a person no choice other than to be homeless or seek alternative temporary accommodation.</td>
<td>A lack of affordable housing can force people into becoming homeless, especially in major cities, resulting in depression.</td>
<td>Homeless people living in ‘squats’ do not have an adequate water supply, sanitation or electricity to maintain hygiene or quality of life.</td>
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<td>Alcohol consumption contributes to the injuries and assaults that particularly affect young homeless people.</td>
<td>Society’s acceptance of alcohol as a less harmful drug contributes to higher consumption rates, especially by young people who can develop dependence.</td>
<td>Unemployment can force individuals into poverty, which restricts choices and causes social alienation.</td>
<td>Homeless people who live in parks are at greater risk of sexual and physical assault.</td>
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<tr>
<td>Smoking is common and contributes to bronchitis and other respiratory illnesses.</td>
<td>Media stereotypes can encourage young people to rebel and move out of home without adequate support.</td>
<td>The homeless become dependent on handouts and welfare and lose a sense of control over their lives.</td>
<td>Some homeless people rely on health care delivered to them by volunteer organisations in mobile vans or when they visit refuges.</td>
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<td>Unsafe sexual practices spread STIs and can result in unwanted pregnancies.</td>
<td>Government allowances make it easier for young people to leave home rather than resolving family conflicts.</td>
<td>Young people with behaviour disorders are often unable to continue with schooling and leave prematurely without skills.</td>
<td>A limited supply of places at refuges means that organisations have to prioritise placements, with older males missing out.</td>
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<tr>
<td>Ignorance of health messages means needles may be shared, which increases the risk of contracting HIV or hepatitis.</td>
<td>Media’s role</td>
<td>Economic recession can cause families to lose their homes, especially if they are single parent families on welfare.</td>
<td>‘Soup kitchens’ provide meals for the homeless free of charge and provide a point of contact to support homeless people who otherwise would not seek help.</td>
<td></td>
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<tr>
<td>Behaviour disorders can mean individuals can’t maintain normal relationships as part of a family. This can be a source of stress.</td>
<td>Homeless people can experience difficulty in delaying gratification, resulting in compulsive spending or gambling.</td>
<td>Most outreach services target young people and women with children first as they are at greater risk.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless people can experience difficulty in delaying gratification, resulting in compulsive spending or gambling.</td>
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Media’s role
The media’s role is to provide society with a sympathetic perspective of the issues faced by the homeless. Negative issues that focus on drug dependence, mental health issues, crime and rebellion must be addressed in a compassionate manner. The media needs to work in a positive way to focus on issues, such as:

- lobbying governments for increased funding for services and accommodation for the homeless
- finding ways to reduce domestic violence and resolve family conflict that keeps families intact
- warning young people of the dangers of problematic drug use and raising awareness that homelessness can affect people in all walks of life in times of economic uncertainty.
The media can promote employment programs, community networking programs, national strategies on mental health and initiatives that create stronger family structures. The Big Issue magazine is one example of media increasing awareness of inequities in our society. It documents stories that relate to people in difficult living circumstances and promotes employment for homeless people as vendors. This assists the homeless by enabling them to purchase nutritious food, to work and to reduce the stigma of being homeless within the wider community. The Commonwealth Government can use its media outlets (ABC and SBS) to educate and stimulate debate on the homeless and address negative issues on drugs or crime compassionately.

SNAPSHOT

The Big Issue celebrates 20 years of helping Australia’s disadvantage
(By Patrick Wright and Justine Longmore)

The Big Issue, the magazine known for its slogan ‘a hand up, not a hand out’, is celebrating 20 years of helping people across Australia.

The magazine — which gives homeless and disadvantaged people a chance to help themselves by working as vendors — was first sold on the steps of Melbourne’s Flinders Street Station on June 16, 1996.

In the two decades since then, the organisation has spread across Australia, with more than 500 vendors now working to distribute the magazine every fortnight.

The Big Issue is celebrating its 20th anniversary this month with a bumper special edition and celebrations around the country. Russell has been selling The Big Issue for 16 years. He currently sells the magazine on the streets of Melbourne, but he has previously worked in Brisbane and Sydney.

He said the extra income and the social aspects of the job meant a lot to him.

‘It’s meant a massive amount. It’s mostly that it gives me that extra money,’ he said.

‘I’ve been broke: it’s no fun. When you’re selling The Big Issue, when you’ve got $20 or $30 in your pocket, you’re not broke.’

Some of Russell’s customers have been buying the magazine from him for years.

‘Most of my customers ... they know what I’ve been up to the previous couple of weeks,’ he said.

‘I’ve watched my customers’ kids grow up ... they’re teaching their kids respect as well.’

Russell recently met with Prime Minister Malcolm Turnbull and told him the magazine ‘gives so many vendors so much confidence’.

The magazine has come a long way since its launch, which was supported by The Body Shop and its Australian owner, Graeme Wise.
The first edition featured a busker in front of Melbourne’s Art Centre on the cover and sold for $2. About 6500 people in need have sold more than 10 million copies of the magazine since then, collectively earning $23 million. Circulation has increased nearly four-fold — from 7000 in 1996 to 26,500 currently — and a magazine now costs $7. About 400,000 subscription issues have been packed by homeless and disadvantaged women taking part in the magazine’s Women’s Subscription Enterprise program. Sally Hines, The Big Issue’s national manager, said the magazine was still going strong despite headwinds for print publications. ‘We certainly haven’t seen a decline in our circulation. Indeed, it continues to grow,’ she said. ‘Vendors continue to earn more money each year which is fabulous.’ The magazine’s anniversary edition features photographs by former editor Alan Attwood capturing memories of his time at the magazine. Mayors in Melbourne, Brisbane, Adelaide, and Darwin will work alongside vendors to sell the magazine on Friday.

Source: ABC News, June 2016

Inquiry

The Big Issue celebrates 20 years of helping Australia’s disadvantage

Read the snapshot ‘The Big Issue celebrates 20 years of helping Australia’s disadvantage’, then answer the following questions.

1. What benefits does selling and creating the Big Issue bring to homeless people?
2. How do these benefits enable homeless people to improve their health?

Evaluating government interventions

The Commonwealth Government provides mainstream health services, plus other interventions such as:

- SAAP — Supported Accommodation Assistance Program to assist homeless people, women and children escaping domestic violence
- National Homeless Strategy 1999 — aims to halve homelessness by 2020
- Stronger Family and Communities Strategy — builds support networks
- Household Organisational Management Expenses Advice — helps people plan budgets
- Family and Relationship Counselling — assists with dysfunctional relationships
- Counting the Homeless Project — collects accurate data to plan strategies and allocate resources
- Network Job Placement and Employment Training Program — finds jobs for young people
- Reconnect program — assists young people who are homeless or at risk of homelessness to stabilise their living situation and improve their engagement with family, work, education and their local community.

Inquiry

Homeless people

1. Using the summary on pages XXX–X as a guide, investigate two or three government interventions aimed at trying to improve the health of this particular population group. Evaluate the effectiveness, keeping in mind the characteristics of an effective health promotion strategy (see subtopic 13.3.4).
2. Prepare a short class presentation to recommend any future directions or strategies the government should take to make further improvements in this population’s health status. Ensure your recommendations are based on supporting facts and recent trends.
Summary of health data and determinants for people living with HIV/AIDS

HIV is a retrovirus that can reduce the human immune function so that relatively minor infections become deadly. There is no known cure. There are four stages to the virus:

- primary stage (first two to six weeks), when the initial infection occurs and people may report flu-like symptoms
- asymptomatic HIV infection stage (months to years later), with no outward signs or symptoms
- symptomatic HIV infection stage, where symptoms appear
- the late stage disease, which presents as AIDS (acquired immune deficiency syndrome). In the AIDS stage a person’s immune system is no longer able to protect them from developing pneumonia or various types of cancers.

The virus is mainly spread through sexual intercourse without a condom and sharing infected needles. The virus was first discovered in the 1980s and in 2015, there were an estimated 25,313 people living with an HIV diagnosis in Australia. Indigenous peoples are at higher risk of contracting the disease because of their relatively poor health overall.

Areas of inequity

Mortality (compared to other countries):
- the death rate from HIV/AIDS in Australia is far lower than in many other countries. In contrast, the Philippines has recorded a 140 per cent increase in new infections between 2011 and 2017.
- In the early 1990s about 1000 people died from AIDS each year in Australia. The incidence of AIDS in Australia has been successfully reduced through the use of anti-retroviral medications (ARV). ARV medications stop HIV from progressing to AIDS, where the immune system becomes damaged and unable to fight off infection. However, to manage its recurrence, people need to have ongoing and regular HIV testing.

Morbidity (compared to other countries):
- Australia has a low prevalence of HIV notifications. In 2015, 1025 new diagnoses were made and the rate has stabilised over the 2012–15 period.
- HIV is no longer a disease that by law must be reported (notifiable disease)
- when a person develops AIDS they become vulnerable to diseases such as Kaposi’s sarcoma, pneumocystis carini pneumonia, toxoplasmosis, cytomegalovirus disease and thrush, which affects the oesophagus, throat or lungs. The body’s immune system is usually able to prevent these conditions from becoming life-threatening. However, when a person develops AIDS their body’s immune system is compromised and cannot fight these infections.
- 84 per cent of people in Australia aware of their HIV status were receiving ARV treatment.

Media’s role

The media’s role is to provide society with a sympathetic perspective of the issues faced by people with HIV. Negative issues that focus on drug use or alternative lifestyles must be addressed in a more caring and sensitive manner. The media can work in a positive way to focus on issues such as lobbying the government for increases in funding for improved services, support networks, research for a cure or providing greater support for the carers of people with HIV. The media also needs to continue to make the public aware of the causes of the spread of HIV.

The general media supports people with HIV through supporting anti–discrimination laws, especially regarding employment and highlights laws that protect us from self-harming behaviours related to substance abuse.

The Commonwealth Government provides programming that specifically targets issues for the gay community that are broadcast on radio and television stations (ABC and SBS). Furthermore, the media can emphasise the ongoing importance of regular HIV testing to delay the progression from HIV to AIDS.
TABLE 13.4 Impact of health determinants for people living with HIV/AIDS

<table>
<thead>
<tr>
<th>Impact of health determinants</th>
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<th>Socioeconomic</th>
<th>Environmental</th>
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</thead>
<tbody>
<tr>
<td>Unsafe sexual practices are the major contributing factor to the spread of HIV. Gay men are at particular risk and the most widely affected (68 per cent of transmissions).</td>
<td>Some sections of society are less tolerant of LGBTQI communities and may engage in vilification, which places additional stress on individuals within these groups with HIV.</td>
<td>Young people who leave school at an early age may miss important safe sex information.</td>
<td>Safe injecting rooms have helped to reduce the number of notifications of HIV spread by injecting drugs.</td>
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</tr>
<tr>
<td>Injecting drug use accounts for 1.7 per cent and has reduced over the years because of health initiatives such as needle exchange programs and information.</td>
<td>Anti-discrimination laws aim to protect individuals with HIV from harassment.</td>
<td>Overseas travellers must take special precautions not to contract HIV when visiting high risk countries. There is no vaccine to protect against it.</td>
<td>Mobile needle exchange vans that go to areas at greatest risk also help to reduce the spread of HIV to specific subgroups of the population.</td>
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</tr>
<tr>
<td>Having several sexual partners and having intercourse at an early age also increases the risk of contracting HIV or any other STI.</td>
<td>The stigma attached to having any STI results in people delaying seeking diagnosis and risks the infection of other individuals.</td>
<td>Sex workers need to be educated and made accountable for the spread of the disease.</td>
<td>Improved access to condoms at places such as clubs, service stations and supermarkets has contributed to safer sex practices.</td>
<td></td>
</tr>
<tr>
<td>Reluctance to use a condom contributes to possible contraction of any STI or HIV.</td>
<td>Religious beliefs of celibacy or abstinence before marriage can help to protect individuals from contracting HIV.</td>
<td>HIV also affects the partners and families of individuals with the virus, who must learn to adopt new health habits and/or take ARV medication.</td>
<td>Mandatory reporting enabled statistics to be gathered that helped track the spread of the virus. Mandatory reporting no longer applies.</td>
<td></td>
</tr>
<tr>
<td>Individuals who visit sex workers also increase the risk of exposure to the virus.</td>
<td>Individuals who have a blood transfusion are at minor risk due to blood screening.</td>
<td>Babies are at risk of infection during birth or via breast milk if their mother is infected.</td>
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</tr>
<tr>
<td>Overseas travellers must take special precautions not to contract HIV when visiting high risk countries. There is no vaccine to protect against it.</td>
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</tr>
</tbody>
</table>

Evaluating government interventions
In addition to mainstream health services, the Commonwealth Government provides specific HIV-based health services such as:
- Home and Community Care (HACC) — provides community support services
- National HIV Strategy — national needle and syringe program and screening programs.
HIV-infected individuals can also access any of the national strategies and interventions that target disease related to cancer and pneumonia.

Inquiry
People living with HIV/AIDS
1. Using the summary from table 13.4 above as a guide, investigate two government interventions aimed at trying to improve the health of this particular population group. Evaluate the effectiveness, keeping in mind the characteristics of an effective health promotion strategy (see subtopic 13.3.4).
2. Recommend any future directions or strategies the government should take to make further improvements in this population’s health status.
Summary of health data and determinants for people who are incarcerated

The incarcerated population includes adults in prisons (median age 34.3) and youth offenders (aged 10–17 years) in juvenile justice institutions. Males make up 92 per cent of the incarcerated population, with 25 per cent of them from Indigenous backgrounds. The prisoner population is relatively young with 68 per cent aged under 40 years, compared to 38 per cent of the general adult population. Male imprisonment rates remained relatively stable between 2014–15 and 2015–16, with female rates increasing by 5 per cent. The number of female offenders proceeded against for illicit drug offences has almost doubled since 2008–9.

Areas of inequity

Mortality (compared to the general population):
- slightly higher mortality rate
- natural causes account for most prison deaths. These deaths may result from illnesses that are most frequently cardiac-related. The number of deaths from self-inflicted injuries has dropped significantly since 2001.
- there is a high mortality rate among offenders who are released
- there is a high rate of deaths due to drug overdoses, usually heroin in combination with another drug
- young offenders had death rates nine times higher than those of a similar age
- the health gap is widening between incarcerated people and the general Australian population.

Morbidity (compared to the general population):
- incarcerated people suffer poorer mental and physical health in general
- smoking rates among prison entrants are high with 74 per cent being current smokers and the majority reportedly smoke daily. In contrast, smoking rates among the general community have declined. The recent ban on smoking in NSW correctional centres may impact these figures.
- they experience high rates of blood-borne diseases such as hepatitis B and C and STIs
- drug dependence is a common health problem for many
- they suffer a higher proportion of mental illness as a result of daily substance abuse, depression, psychosis or expulsion from school
- cases of traumatic brain injury (TBI) are high. TBI is caused by jolts or blows to the head from fights, assaults and contact sports.
- young offenders suffer more chronic illnesses, exposure to infectious diseases, behavioural problems and substance use disorders.

Media’s role

The media’s role is to provide a balanced perspective of incarcerated people. Negative issues such as violence, crime and substance abuse must be addressed in a way that increases the public’s awareness and forces government action. The media can work in a positive way to focus on issues such as successful rehabilitation programs, community service work undertaken by offenders, issues in society that contribute to discrimination, racism and unemployment, causes of deaths in custody, and alternatives for young offenders to avoid incarceration.

The media is obliged to follow all laws regarding the disclosure of identity or information that may jeopardise a fair trial for those waiting in gaol or in the juvenile justice system. The general media also supports anti-discrimination laws and challenges racist attitudes in society, which help to promote the government’s policy of multiculturalism and tolerance within society.
**TABLE 13.5** Impact of health determinants for incarcerated people

<table>
<thead>
<tr>
<th>Individual</th>
<th>Sociocultural</th>
<th>Socioeconomic</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Higher rates of smoking contribute to 20–30 per cent of cancer cases in prisoners.</td>
<td>• Incarceration results in stigmatisation by society. This is a vicious cycle that ex-offenders find difficult to deal with, causing more depression and possible suicide.</td>
<td>• During incarceration offenders may have limited opportunities to earn a small allowance for luxuries. Therefore family support can be essential. Food, water, shelter, clothing and health care are provided to maintain general health.</td>
<td>• Incarcerated people are held in shared cells with other possibly violent offenders, which places them at risk of injury or STIs.</td>
</tr>
<tr>
<td>• High rates of alcohol and drug use contribute to drug dependence and increase the risk of poor mental health/suicide, chronic health problems and injuries.</td>
<td>• Social exclusion due to incarceration can make it difficult for offenders to adjust to normal life.</td>
<td>• Education programs for offenders aim to improve their prospects of employment on release. Many offenders have low levels of years of schooling or educational attainment, resulting in low self-esteem.</td>
<td>• The government provides health services, but offenders are at a high risk of mental health problems and spreading blood-borne diseases and STIs because of risk-taking behaviours.</td>
</tr>
<tr>
<td>• Incarcerated people are more likely to engage in unsafe sexual practices that can spread STIs.</td>
<td>• Higher mortality rates at younger ages means incarcerated people experience grief and loss more frequently.</td>
<td>• Ex-offenders are severely disadvantaged by limited income. Their property and possessions may also have been repossessed, given away or abandoned. Suicide attempts are common within the first two weeks of release.</td>
<td>• Lack of privacy and boredom contribute to a high incidence of self-harming behaviours and substance abuse when the opportunity presents itself.</td>
</tr>
<tr>
<td>• High rates of unsafe tattooing and body piercing increase the spread of blood-borne diseases such as hepatitis.</td>
<td>• Family instability and parental imprisonment contribute to poor mental health and a lack of adequate adult role models to set behavioural boundaries for children.</td>
<td>• Ex-offenders are separated for extended periods, causing depression.</td>
<td>• Recreational opportunities are limited and must be shared with other offenders. Fights can develop over racial taunts.</td>
</tr>
<tr>
<td>• Incarcerated people have a reduced sense of being in control of their lives, which puts them at risk of depression/suicide.</td>
<td>• Indigenous cultures value freedom and incarceration can be difficult to cope with. Some deaths in custody have resulted.</td>
<td>• Families become separated for extended periods, causing depression.</td>
<td>• Exposure to hardened criminals can cause relatively new offenders to become involved in more crime for self-protection.</td>
</tr>
<tr>
<td>• Poor sleeping habits, forgetfulness, headaches and poor appetite are reported more commonly by incarcerated people.</td>
<td>• Incarcerated people suffer higher levels of discrimination in employment, which impacts mental health.</td>
<td>• The government provides health services, but offenders are at a high risk of mental health problems and spreading blood-borne diseases and STIs because of risk-taking behaviours.</td>
<td>• Recreational opportunities are limited and must be shared with other offenders. Fights can develop over racial taunts.</td>
</tr>
</tbody>
</table>

**Evaluating government interventions**

In addition to mainstream health services, the Commonwealth Government provides specific health services within each place of incarceration. These can include community support services, screening programs, social and emotional well-being services, transport services, rehabilitation and education programs. Specific interventions include:

- Naltrexone Exit Program to reduce addictions to illicit drugs
- Smoking bans in selected prisons
- Crisis Care Unit to deal with mental health
- The Keeping Safe Program to control blood-borne infectious diseases
- Work Camps that teach social skills and integrate incarcerated people into the community through project work.
Inquiry
Incarcerated people

1. Using the summary on pages XXX–X to above as a guide, investigate two to three government interventions aimed at trying to improve the health of this particular population group. Evaluate the effectiveness, keeping in mind the characteristics of an effective health promotion strategy (see subtopic 13.3.4).
2. Recommend any future directions or strategies the government should take to make further improvements in this population’s health status.

Summary of health data and determinants for the aged

The aged includes those individuals 65 years and over living on pensions or as self-funded retirees. They live either at home, in hostels, residential care units or nursing homes. One in seven Australians is an aged person (15.1 per cent of the total population in 2015).

Areas of inequity

It was reported by the ABS in 2017, that Australian women had the highest life expectancy ever recorded (84.5 years at birth). In the past 125 years to 2015, life expectancy increased by 33.2 years for males and 33.7 years for females. This increase in life expectancy ‘reflects a major shift in causes of death from infectious to chronic diseases’.

Mortality (compared to the Australian population):
- life expectancy when measured at age 65 is 84.5 years for males and 87.2 years for females
- life expectancy when measured at age 85 is 91.2 years for males and 92.3 years for females (reductions in cardiovascular disease are contributing to improved life expectancy)
- leading causes of death include coronary heart disease and cerebrovascular disease (stroke) cancer (males: lung and prostate; females: breast cancer; colorectal cancer was common to both sexes), chronic pulmonary obstructive diseases, dementia, diabetes and diseases of the arteries. In 2016, the ABS reported dementia as the leading cause of death among Australian women for the first time.
- specific age death rates reveal 65–74-year-olds most commonly die from pancreatic cancer, cirrhosis of the liver and ovarian cancer (females). Deaths in 75–84-year-olds are most often due to coronary disease and dementia. Those 85 years and over most commonly die from influenza, pneumonia and kidney failure.

Morbidity (compared to the Australian population):
- the aged experience higher rates of disability with severe core activity limitation (severe limitations on self-care, communication or mobility)
- the aged can expect to live longer with some type of disability, with adult hearing loss, reduced eyesight and arthritis being the most common minor illnesses. More serious conditions include Parkinson’s disease for males, and osteoarthritis and fractures for females.
- the ABS in 2017 reported an increase in drug-induced deaths. The deaths were most commonly associated with medications prescribed for the treatment of anxiety and pain.
- hospitalisation rates are higher for the aged, males in particular. It is common that after discharge the aged are placed into residential care or die from complications.
- more than half (52 per cent) of people aged 85 years and over had high blood pressure (the highest of any age group in 2014)
- dementia has emerged as a leading cause of death for females (2016)
- the majority of aged people self-report their health as good to excellent, but only fair to poor with increasing age. Females are in better health than males at all ages.
Media’s role

The media’s role is to provide society with a sympathetic perspective of the issues faced by aged people. Negative issues such as diminished driving skills and limited knowledge of technology must be addressed in a compassionate and caring way. The media can work in a positive way to focus on issues such as lobbying the government for increases in the pension, improvements in residential care and support services, greater subsidisation of medicines, treatments and research into conditions that affect the aged, and continued recognition of the sacrifices made by war veterans and widows. Aged role models from the wider community can be promoted in media stories and meaningful discussion about challenges faced by Australians in this age group.

The general media supports anti-discrimination laws and challenges ageist attitudes in society, which help to promote tolerance. The Commonwealth Government provides funding for specialist radio and television programs (such as on the ABC and SBS) that cater for the interests of the aged and broadcasts information in a variety of languages to suit older migrants.

The aged living at home may suffer nutritional deficiencies because of poor access to shops or the costs of living.

Loss of a long-term partner may lead to a need to learn basic independent living skills.

Australian society tends to undervalue its aged people and their contributions, resulting in the aged feeling forgotten.

The fractured family groups lessen the support available to the aged and increases the reliance on residential care, which can lead to depression in the aged.

Extended periods of family separation can also lead to episodes of depression.

The aged who suffer dementia place a higher level of stress on the family.

Much of the aged population is from migrant backgrounds who may still use traditional medical treatments.

House maintenance can be an issue for some aged people living at home. Older homes can be damp, have stairs and require expensive plumbing and electrical work. Pneumonia, falls and burns are common among aged people.

The aged in residential care have good access to health services and information. However, those living at home can be less informed and rely on community services who visit on a weekly basis.

Rising costs of property ownership force many aged people to move to more affordable rural areas which can be further away from essential health services.

Public transport is often not suitable for the aged and so they may rely on food deliveries such as Meals on Wheels, or taxi services, including ambulance transport.
Evaluating government interventions

In addition to mainstream health services, the Commonwealth Government provides specific aged-based health services such as community support services, screening programs, social and emotional well-being services, transport services and accommodation. Specific interventions include:

- Pharmaceutical Benefits Scheme (PBS), which gives reliable and affordable access to a wide range of medicines
- Immunise Australia Program, which provides vaccinations against infectious diseases such as influenza
- National Diabetes Register, which helps collect data
- National Suicide Prevention Strategy, which targets mental health
- National Bowel Cancer screening, to detect pre-cancerous cells in people aged 50–74 years
- Home and Community Care (HACC), which provides services for the aged and promote independent living support.

Inquiry

The aged

1. Using the summary on pages xxx–x as a guide, investigate two to three government interventions aimed at trying to improve the health of this particular population group. Evaluate the effectiveness, keeping in mind the characteristics of an effective health promotion strategy (see subtopic 13.3.4).
2. Recommend any future directions or strategies the government should take to make further improvements in this population’s health status.

Summary of health data and determinants for people from culturally and linguistically diverse backgrounds (CALD)

People from culturally and linguistically diverse backgrounds (CALD) include migrants, overseas students and refugees. Australia has the largest immigrant population in the world: one in five Australians speak a language other than English at home (ABS 2016).

![Figure 13.13](image-url)
TABLE 13.7 Impact of health determinants for people from culturally and linguistically diverse backgrounds

<table>
<thead>
<tr>
<th>Impact of health determinants</th>
<th>Individual</th>
<th>Sociocultural</th>
<th>Socioeconomic</th>
<th>Environmental</th>
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</thead>
<tbody>
<tr>
<td>• Higher rates of smoking by people from the Oceania countries (New Zealand, Papua New Guinea, Solomon Islands, Kiribati and Fiji) contribute to the development of cancers.</td>
<td>The government screens migrants and refugees for health problems to prevent the spread of infectious diseases and limit the costs to the health and welfare systems.</td>
<td>Highly skilled workers (GPs, engineers, nurses) and unskilled workers (factory hands and farm labourers) are targeted to fill vacancies in the Australian workforce, so they tend to benefit from full employment.</td>
<td>Migrant workers are located in areas of greatest need; for example, doctors and farm labourers to rural centres, factory hands and nurses to metropolitan cities. Each location can have a specific effect on their general health.</td>
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<tr>
<td>• Low exercise levels or a sedentary lifestyle by people from Southern and Eastern Europe, North Africa, the Middle East and South East Asia contribute to some individuals becoming overweight.</td>
<td>Anti-discrimination and racism laws aim to reduce mental health issues.</td>
<td>However, the exploitation of unskilled workers has occurred in some instances and resulted in them being paid low wages, working in an unsafe manner or forced into cramped dormitory-style living conditions.</td>
<td>People from CALD backgrounds tend to move into areas of similar cultures, which provides them with social and support networks, but these areas can also be of a low socioeconomic status.</td>
<td></td>
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<tr>
<td>• Low consumption of vegetables by most subgroups of this population can contribute to some nutritional deficiencies in diets. However, those individuals who continue with their own country’s traditional foods are more likely to maintain good health.</td>
<td>Multicultural policies aim to encourage assimilation into Australian society.</td>
<td>As part of the targeted migration program the government provides financial assistance for a period of time.</td>
<td>People from CALD backgrounds can potentially have larger or extended families living under the same roof, leading to overcrowding and potential stress.</td>
<td></td>
</tr>
<tr>
<td>• A self-selection process by the migrants themselves means that they are generally more financially secure and emotionally prepared to change countries.</td>
<td>Family bonds and relative support are generally high, which contributes to good health.</td>
<td>Education levels and English language skills can vary dramatically between people of CALD and can sometimes result in poor health literacy. However, most health information is printed in a variety of languages with interpreter services also available to ensure access. English speaking classes are also available.</td>
<td>Through Medicare the government provides access to a national health service for all people of CALD backgrounds.</td>
<td></td>
</tr>
</tbody>
</table>

Areas of inequity
Mortality (compared to the Australian-born population):
• slightly lower mortality rate overall
• lower death rates that vary according to country of origin: People born in the United Kingdom, Poland and New Zealand have death rates similar to Australian-born people. People born in the United States have recorded the highest standard death rates. People born in south-east or north-east Asian countries have the lowest standard death rate, particularly people born in Vietnam, who have approximately half the death rate of Australian-born people.
• people born in the Netherlands, the UK and Ireland have higher death rates from lung cancer. People born in Germany, Greece, India, Italy, Lebanon and Poland have higher death rates from diabetes. People born in Poland also have higher death rates due to coronary heart disease. People born in the UK and Ireland have more deaths due to influenza and pneumonia.

• the health gap is slightly wider (overseas-born people are healthier) when they first arrive, but narrows the longer they stay and adopt an Australian lifestyle.

Morbidity (compared to the Australian-born population): people born overseas
• generally have health as good as if not better than Australian-born people
• have lower hospitalisation rates and lower rates of disability overall, however, compared to the general population, people born overseas higher rates of tuberculosis (India, Vietnam, Philippines and China) and dialysis (Greece, Italy, Vietnam, Philippines, Croatia and India), as well as a range of other conditions
• have fewer mental health or behavioural problems
• have lower incidence of asthma.

However, their health decreases the longer they stay in Australia and adopt similar lifestyle behaviours to that of Australian-born people. Individuals from refugee backgrounds can also suffer significant psychological distress from exposure to war, conflicts and separation from family.

Media’s role
The media’s role is to provide society with a balanced perspective of people from culturally and linguistically diverse backgrounds. Negative issues such as limited English speaking skills, system rorting, religious/cultural differences and interracial violence must be addressed in a way that increases the public’s awareness and forces the government into action. The media can work in a positive way to focus on issues such as the success of multiculturalism, the cosmopolitan nature of some of our major cities and the contribution of people from CALD backgrounds in art, sport, science, research, medicine and education.

The general media supports anti-discrimination laws and challenges racist attitudes, which helps to promote the government’s policy of multiculturalism and tolerance. The Commonwealth Government provides specialist radio and television stations (ABC and SBS) to broadcast information in a variety of languages with cultural sensitivity and to promote deeper understanding and tolerance within our community. Government laws allow newspapers and magazines to be printed in foreign languages with relative freedom of speech.

Evaluating government interventions
In addition to mainstream health services, the Commonwealth Government provides interpreter services and health information in a variety of languages. Community support services, screening programs, transport services and crisis accommodation can all be accessed by individuals from culturally and linguistically diverse backgrounds. Specific interventions include:

• bilingual heart health program for Greek–Australian women, which was conducted in Greek community centres and provided educational information
• Partners in Culturally Appropriate Care (PICAC), to support culturally appropriate care to older people from CALD backgrounds
• the oral health promotion program for older migrants, which targeted Greek and Italian social clubs and provided free products and dental hygiene advice.
Inquiry
People from culturally and linguistically diverse backgrounds

1. Using the summary on pages XXX–XX as a guide, investigate two to three government interventions aimed at trying to improve the health of this particular population group. Evaluate the effectiveness, keeping in mind the characteristics of an effective health promotion strategy (see subtopic 13.3.4).
2. Recommend any future directions or strategies the government should take to make further improvements in this population’s health status.

Summary of health data and determinants for the unemployed

Being unemployed can be short term (less than a year) or long term (more than a year) and fluctuates according to economic and climatic factors. The longer an individual is unemployed, the closer their health begins to resemble that of the socioeconomically disadvantaged. Unemployment can affect any person of working age and is concentrated in some households, which then become dependent on welfare payments. Young people are especially vulnerable and more than a quarter of the long-term unemployed in Australia are aged 15–24. Underemployment is also an issue because individuals want to work but cannot get enough hours or an adequate wage, which results in them living in relative poverty.

Areas of inequity

Mortality (compared to the Australian population):
• the longer a person remains unemployed the lower their life expectancy
• long-term unemployment contributes to premature mortality for the most disadvantaged groups of the jobless
• the long-term unemployed have higher death rates for nearly all causes of death
• the health gap is widening because unemployment is affecting an increasing number of people from various socioeconomic circumstances and can result in individuals living in relative poverty for long periods of time, which dramatically affects mental health.

Morbidity (compared to the Australian population): the long-term unemployed
• have higher rates of problematic drug use and poor mental health, such as depression. These conditions can develop after the person becomes unemployed and is not necessarily the initial cause of joblessness.
• have higher rates of diabetes, arthritis and respiratory diseases (asthma) and circulatory diseases such as heart disease and stroke
• make more visits to doctors, hospital outpatient services and emergency departments
• can suffer low self-esteem and loss of confidence, which places them at greater risk of self-harming behaviours, suicide and attempted suicide.

Media’s role

The media’s role is to provide society with a sympathetic perspective of the issues faced by the unemployed. Negative issues that focus on laziness, ‘dole bludging’, rorting the system, generational unemployment or drug abuse must be addressed in a compassionate manner. The media needs to work in a positive way to focus on issues such as stimulating the economy, providing jobs and training for young people, removing the stigma of being labelled as unemployed and the effects of unemployment on families, who descend into poverty. The media can also remind people that unemployment can affect people in all walks of life in times of economic uncertainty.

The general media can promote employment programs, community networking programs, national strategies on job creation and initiatives that create strong economic growth. In addition the Commonwealth
Government through its media (ABC and SBS) can support anti-discrimination laws, fight racism and keep the population informed about workplace safety, industrial relations issues and minimum wages.

**Evaluating government interventions**

In addition to mainstream health services, the Commonwealth Government provides specific employment programs such as the Community Job Program, Network Job Placement, Employment and Training Programs, and Reconnect for young people. Other initiatives include the:

- National Suicide Prevention Strategy and beyondblue, which target mental health
- National Drug Strategy, which targets drug abuse
- National Tobacco Campaign, which targets smoking
- National Affordable Housing Agreement (NAHA), which provides emergency housing
- ASICs Money Smart program, which provides advice on how to live on a budget and a low income.

**TABLE 13.8 Impact of health determinants for the unemployed**

<table>
<thead>
<tr>
<th>Impact of health determinants</th>
<th>Individual</th>
<th>Sociocultural</th>
<th>Socioeconomic</th>
<th>Environmental</th>
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</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>can limit mobility and restrict employment options. Some employers have strict guidelines regarding this area of health.</td>
<td>Parents who are both long-term unemployed set an example for their children, who may adopt a welfare mentality.</td>
<td>The long-term unemployed can suffer severe disadvantage with diminishing assets, mounting bills and threats of eviction from their homes by banks or owners, which affects mental health.</td>
<td>Some people are exposed to dangerous environmental conditions, such as asbestos, which places them at greater risk of developing severe respiratory illnesses.</td>
</tr>
<tr>
<td>Individuals with debilitating conditions or who have suffered a work injury may no longer be able to find work in their chosen occupation.</td>
<td>Society sometimes views older people as not being able to cope with the workload and they are therefore replaced with younger workers.</td>
<td>A lack of employment can force families to separate to find work, which places relationships under stress.</td>
<td>Geographic remoteness can limit the jobs available in a community.</td>
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<tr>
<td>Age can limit some people to certain types of employment. For example, labourers tend to be younger males, not older men.</td>
<td>Media stereotypes can encourage young people to lead the life of a ‘dole bludger who just surfs everyday’.</td>
<td>Unemployment can force individuals into poverty that restricts food choices and causes social alienation.</td>
<td>Natural disasters can devastate entire industries, which do not recover quickly.</td>
<td></td>
</tr>
<tr>
<td>Drug dependence can lead to a criminal conviction and affect job applications.</td>
<td>Some young unemployed people who are receiving government allowances may lose the incentive to actively seek work.</td>
<td>The unemployed become dependent on handouts and welfare and lose a sense of control over their lives.</td>
<td>Industry restructuring leads to a demand for different skill sets and redundancy.</td>
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</tr>
<tr>
<td>Smoking is common in the unemployed and affects their ability to carry out manual work.</td>
<td>Behaviour disorders can make individuals unable to maintain normal relationships or deal with work-related stress.</td>
<td>Young people with conduct disorders are often unable to continue with schooling and leave prematurely without skills. They therefore cannot find employment easily.</td>
<td></td>
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</tr>
<tr>
<td>Compulsive disorders such as gambling can affect work performance.</td>
<td>Globalisation and technology have made some jobs redundant, so the people who previously performed those jobs require retraining.</td>
<td>The long-term unemployed find it difficult to maintain or develop skills and so lose confidence and self-esteem.</td>
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</tbody>
</table>
Inquiry
The unemployed
1. Using the summary on pages xxx–x as a guide, investigate two to three government interventions aimed at trying to improve the health of this particular population group. Evaluate the effectiveness, keeping in mind the characteristics of an effective health promotion strategy (see subtopic 13.3.4).
2. Recommend any future directions or strategies the government should take to make further improvements in this population’s health status.

Summary of health data and determinants for people with disabilities
Disabilities include impairments, activity limitations or participation restrictions that affect everyday activities. They can be classified as mild, severe or profound. The types of disability are:
- physical
- sensory/speech
- intellectual
- psychiatric
- acquired brain injury (ABI).

In 2015, 4.3 million people or 18.3 per cent of the Australian population reported living with some type of disability, with around 1 in 3 of them having a severe or profound disability.

Areas of inequity
Mortality (compared to the Australian population):
- as life expectancy increases for the average Australian, so does the life expectancy for people with a disability due to advances in medicine and early diagnosis
- In 2015, the ABS reported 78.5 per cent of people with disability reported a physical condition as their long-term health condition, while 21.5 per cent reported mental and behavioural disorders.
- increased life expectancy also results in increased years spent with a disability and can affect quality of life. Disability may affect a person’s mobility, communication or learning. This will impact the person’s ability to earn an income, attend training opportunities and engage in social activities.
- life expectancy is increasing for specific conditions such as Down Syndrome and cystic fibrosis. Further research on other disabilities will provide hope for others.
- the health gap is steady or narrowing slightly because of better treatment and early diagnosis of specific diseases which cause disability. However, people can expect to live longer with some type of disability which affects their quality of life.

Morbidity (compared to the Australian population):
- the level of disability an individual experiences increases with age
- prevalence rates of disability have remained stable over the years, with many people experiencing multiple disabilities
- disability rates for Indigenous people are higher overall, with earlier onset of disability and more premature deaths due to disability
- young people’s disability is often related to psychiatric or work/accident-related injuries
- older people’s disability is often related to musculoskeletal conditions, arthritis and heart ailments
- aged people’s disability is often related to long-term conditions, such as CVD, cancer, dementia, hearing and vision impairment.
**TABLE 13.9** Impact of health determinants for people with a disability

<table>
<thead>
<tr>
<th>Impact of health determinants</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Age increases the risk of developing a disability: for example, dementia, hearing loss.</td>
<td>Societies’ attitudes are improving towards the disabled, but instances of discrimination still occur, which can affect mental health and feelings of independence.</td>
<td>The disabled can find it difficult to cope with inflation and changes in the economy and generally have a lower quality of life.</td>
<td>Exposure to chemicals and unsafe workplace practices can increase the risk of injury or long-term disability.</td>
<td></td>
</tr>
<tr>
<td>Genetic factors can act to protect or place some individuals at higher risk of particular diseases, such as schizophrenia.</td>
<td>Society is moving away from institutions to community care residences to improve the health of the disabled and make them feel more a part of society.</td>
<td>The disability support pension provides enough income for basic necessities and little for luxuries. Medicines, therapy and equipment are subsidised but are an added cost for the disabled.</td>
<td>The disabled in residential care have good access to health services and information. However, those living at home must rely on community services that may visit on a weekly basis.</td>
<td></td>
</tr>
<tr>
<td>Gender can also place particular sexes at higher risk because of their lifestyle behaviours. For example, females are at a higher risk of developing depression and males take more risks, resulting in a physical disability caused by a motor vehicle accident or work injury.</td>
<td>Families experience emotional and financial stress if they are forced to care for the disabled in their own home if government support is insufficient.</td>
<td>The disabled may find it difficult to find suitable work and become reliant on welfare payments that restrict income and affect self-esteem.</td>
<td>Some young disabled people are forced to live in aged care facilities that do not suit their social needs.</td>
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</tr>
<tr>
<td>Females tend to adopt healthier lifestyles than males and seek out preventative health services more often.</td>
<td>Families may also become affected if the disabled are placed in residential care away from their local area.</td>
<td>The young disabled are less likely to complete year 12.</td>
<td>Disabled people still experience difficulty accessing some public transport and buildings, which affects their independence.</td>
<td></td>
</tr>
<tr>
<td>Substance abuse can contribute to mental illness or increase the risk of CVD.</td>
<td></td>
<td>Family income may be reduced to a carer’s pension if the disabled are at home.</td>
<td>Limited financial resources means that there is only a small number of disability workers who can provide support for the disabled.</td>
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**Media’s role**

The role of the media is to provide society with a sympathetic perspective of the issues faced by people with disabilities. Negative issues that focus on their limitations must be addressed in a more caring and sensitive manner. The media can work in a positive way to focus on issues such as lobbying the government for increases in pensions and allowances, employment opportunities for the disabled, greater support for the carers of people with disabilities, and improvements in access to public transport and buildings. The media also needs to raise awareness of the causes of disability, especially from environmental factors, and continue the push for the disabled to be integrated into mainstream society.
FIGURE 13.14 Disabled people still experience difficulty accessing some things able bodied people take for granted, which affects their independence.

The general media supports disability discrimination laws and highlights laws that protect people from self-harming behaviours related to substance abuse, motor vehicles and violence which can cause disability. The Commonwealth Government provides specialist radio and television stations (ABC and SBS) to cater for some of the needs of the disabled, including broadcasts of some TV programs with subtitles for the hearing impaired.

Evaluating government interventions
In addition to mainstream health services, the Commonwealth Government provides specific initiatives for people with disabilities such as community support services, screening programs, transport services and accommodation. Specific interventions include:

• National Disability Insurance Scheme (NDIS), aimed at funding disability support
• the Pharmaceutical Benefits Scheme (PBS), which subsidises medicines
• ‘beyondblue’, which targets depression, especially in young people
• road safety campaigns such as ‘Towards Zero’ and ‘Get your hand off it’ that target preventable injuries
• job placements that get people with disabilities into the workforce.

Inquiry
People with disabilities
1. Using the summary on pages xxx–x as a guide, investigate two to three government interventions aimed at trying to improve the health of this particular population group. Evaluate the effectiveness, keeping in mind the characteristics of an effective health promotion strategy (see subtopic 13.3.4).

2. Recommend any future directions or strategies the government should take to make further improvements in this population’s health status.

13.3 Bridging the gap in populations’ health status

CRITICAL QUESTION
How may the gap in health status of populations be bridged?

13.3.1 Funding to improve health
The Commonwealth Government provides funds for most non-medical health services, pharmaceuticals and health research. In collaboration with the state governments and territories, it jointly funds public hospitals, home and community care for the aged and disabled, and some residential facilities for the aged, including war veterans’ homes. As the costs of health care have increased, so has the responsibility of the government to
provide cost-effective management of the limited resources in health. This limited funding must be distributed in a way that responds to the needs of many groups in the population. The improved accountability on the use of funds is anticipated to improve the health outcomes for a larger percentage of the Australian population.

Funding for health

According to the Australian Bureau of Statistics, total health expenditure in 2015–16 was $170.4 billion. Almost all of the Commonwealth Government funding for the provision of health services is made up from general revenue such as taxation. Medicare gives Australian residents access to health care. A Medicare levy of up to 2 per cent of taxable income covers around 20 per cent of the total Commonwealth Government health expenditure. The Medicare levy is reduced if taxable income falls below a certain threshold. Financial incentives for private health insurance membership are offered as rebates. Some people without the appropriate level of private hospital insurance cover may be required to pay a Medicare levy surcharge. The introduction of this additional surcharge for those high-income earners who do not have private health insurance was aimed at forcing more people to contribute to the cost of their own health care.

The four major kinds of Commonwealth health funding mechanisms are:
• health-care agreement grants, which are given to the state and territory governments to operate the public hospitals and other health services
• medical benefits that provide rebates to patients using private doctors and optometrists
• pharmaceutical benefits scheme that subsidises medicines
• health program grants, which are used to fund health-care services for people with special needs; to promote the use of higher technology; to improve GPs’ skills and associated services; and to fund services such as Meals on Wheels.

Funding for specific populations

The Australian Government Department of Health announces in its budgets the funding that will be directed to specific health areas and populations over either the year or over a five-year period. The state and territory governments allocate funds and administer specific programs. Cooperative action and the sharing of initiatives for the benefit of all Australians are features of the Council of Australian Governments (COAG).

Inquiry

Health funding for specific populations

1. Research the most recent health budget announcements and issues. Choose a specific population and write a brief report on a health funding initiative to support it.

Limited resources

The public health system has been pushed to its limits, and this is reflected in the waiting lists for public hospitals. The government initiative ‘lifetime health cover’ aims to encourage a larger proportion of the population back into private health insurance so that individuals will contribute more to their own health care. Resources may then be directed to more disadvantaged groups so that they have more equitable access to health care.

Most health funding and resources are currently directed towards acute and chronic care, but increased awareness of the importance of prevention has led to more funds and resources being allocated to health promotion and research. GPs are receiving greater support in developing a preventative role in health.

The rising cost of wages and modern technology has increased the level of accountability by governments and the health-care system. The distribution of resources is such that duplication of services is avoided and areas of greatest need are established. This has led to the closure of some hospitals and the opening of others in higher demand areas.
The Commonwealth and state governments are being held more accountable for delivering health services that are cost-effective, that maximise the use of resources and meet the health needs of all groups within the population. This results in the development of health infrastructure that can address many health inequities. The increase in the number of area health centres aims to improve people’s access to health care and information.

Increased accountability has been achieved because of improved data collection and a greater awareness in the community of the importance of good health. Individuals themselves are being asked by governments to be more accountable and to act in ways that are health promoting.

**Inquiry**

**Funding of health**

1. Explain why additional funding does not automatically solve the problems of health inequity in Australia. Use specific examples.

2. ‘Funding should go to where there is the greatest chance of success rather than the greatest need.’ Is it possible to do both? Discuss.

**13.3.2 Actions that improve health**

Funding alone will not solve health inequity. To improve the health of disadvantaged groups in the population we also need to encourage actions such as enabling, mediating and advocating.

**Enabling**

*Enabling* refers to an individual’s control over the cultural, social and economic factors that affect their health and health potential. A supportive environment, access to information, strong life skills, and opportunities to make healthy choices promote enabling. The self-empowerment of individuals encourages them to use their knowledge and skills to promote lifestyle changes that are long term and beneficial. The emphasis is on developing partnerships with health workers and other health activists who can provide access to health information, help with the development of health skills, and lobby to reshape public health policy.

**Mediating**

According to the Ottawa Charter, the prerequisites and prospects for health cannot be ensured by the health sector alone. There needs to be coordinated action by the health sector, governments, non-government and voluntary organisations, industry, local authorities and the media.

Inevitably, conflicts will arise and these will require mediation. Mediation means working to bring about consensus and reconciling the different interests of individuals, communities and sectors in a way that promotes and protects health. Any introduced changes can affect people’s way of life, living conditions, organisational structures and the distribution of limited health resources. The health needs of the whole population must be balanced with those of disadvantaged groups, whose health is often far worse. To reconcile these conflicts, health promotion practitioners and social groups need to advocate the case for change and the
redistribution of resources. By involving the public in identifying and addressing the health needs of communities, a consensus of opinion can be achieved. The decisions will reflect a greater empathy for disadvantaged groups and local needs because they take into account different social, cultural and economic conditions.

**Advocating**

Advocating for health is a combination of individual and social actions resigned to speak up for specific groups, gain political commitment, policy support, social acceptance and systems support for a particular health goal or program. Advocating the special needs and concerns of specific groups leads ultimately to a more coherent, community-centred and culturally appropriate health policy. The ‘whole of government’ approach to health ensures consistency in health service availability and programs. Many disadvantaged groups in the population have little access to political forums in which their needs can be addressed. Migrants who do not speak English may be unaware of the health services and resources available to them or how to initiate changes in government policies that will lead to improved health outcomes. Such groups require advocates to promote their concerns; the advocates could be religious leaders, community elders, advisers or councillors.

### 13.3.3 A social justice framework for addressing health inequities

We discussed social justice principles in topic 1. These include equity, diversity and supportive environments.

Achieving improvements in social justice requires a framework to address the causal factors of health inequity. This framework consists of:

- empowering individuals in disadvantaged circumstances
- empowering disadvantaged communities
- improving access to essential facilities and services
- encouraging economic and cultural change.

**Empowering individuals in disadvantaged circumstances**

A priority for empowering individuals is improving their level of health literacy. A greater knowledge of health and services empowers individuals, so that they can cope with circumstances and develop problem-solving skills. By encouraging individuals to accept responsibility for their own health, they are more likely to pursue healthier lifestyles and adopt health-promoting behaviours. Strong personal support networks are essential in giving the individual the confidence to make lifestyle changes.

**Empowering disadvantaged communities**

The first step in strengthening a disadvantaged community is to instil a sense of ‘connectedness’ in its members by creating a network. Individuals who, in the past, felt disempowered soon develop a sense of empowerment by being part of a group that makes decisions affecting their health. They can then plan and implement programs that are culturally sensitive and specific to their needs. This may involve changing aspects of their environment, finding information, reallocating resources or advocating the review of policies that make them disadvantaged. Lobbying governments will also increase awareness in the wider community and help to educate members in other similar communities.
Improving access to essential facilities and services

Improvements in infrastructure are likely to allow disadvantaged individuals to seek treatment earlier and on a more regular basis. Having more Indigenous primary health-care workers and more purpose-built facilities that cater for cultural differences will improve access to health.

Encouraging economic and cultural change

Government funding is essential to building supportive environments that promote better health for disadvantaged groups. The provision of an adequate health infrastructure ensures that many disadvantaged individuals will no longer live in conditions that perpetuate the cycle of ill health. Because many disadvantaged minority groups are considered to have a low priority for the allocation of funds, they must draw attention to their needs by lobbying the government and changing people’s attitudes. This in turn can be used to change society’s values and beliefs so that they become more sympathetic to change. Health inequity will not be addressed unless the population considers it to be an important enough issue.

CASE STUDY

Cardiologist takes heart care services to rural Queensland in $1 million converted truck
(By Courtney Wilson and Eric Tlozek)

A Queensland cardiologist has taken his practice on the road to deliver specialist heart care services to rural and regional areas, working from a converted semitrailer.

Dr Rolf Gomes spent more than $1 million developing the mobile medical clinic, which he dubbed Heart of Australia.

An Australian first, the clinic was a custom-built, 25-metre long semitrailer fully equipped with specialist diagnostic equipment.

‘The idea came to me over five years ago when I was practicing out in some of the regional areas as a junior doctor and registrar,’ Dr Gomes said.

‘I experienced at that time how difficult it was for patients out in these areas to access the services that patients in the city take for granted.’

The truck was fitted out to perform stress testing, cardiac ultrasound, Holter monitoring and a whole suite of other non-invasive cardiac and respiratory tests.

‘What that allows us to do, in a practical sense, is to close that loop from symptom to diagnosis to treatment, potentially all within 24 hours,’ Dr Gomes said.

The semitrailer will be staffed by a rotating team of cardiologists and respiratory specialists.

Cardiac sonographer Stefanie Purcell came on board to help treat patients in Dalby, in south-west Queensland.

‘It’s just as good as what I would get in a public hospital or a private hospital,’ Mrs Murcell said.

‘It’s more than enough space and the facilities are the same as what we would get in Brisbane.’

‘We hope to save lives in the bush’

Heart disease was the leading cause of death in Australia, with people who lived in rural or remote areas facing significantly higher risks.

‘One in five people in urban areas suffer from some form of cardiovascular disease, but in the country areas in can be as high as one in four,’ Dr Gomes said.

He hoped bringing specialist cardiac care to remote areas to help change that.

‘The hope is to ultimately to save lives in the bush,’ Dr Gomes said.

‘One of the things with cardiovascular disease is that if you detect the symptoms early there are lots of treatments which will prevent you having a heart attack, and certainly prevent people dying unexpectedly or unnecessarily.’
Truck to travel up to 80,000 km a year
Dr Gomes says after he graduated and later opened his own private practice, he realised it would be possible to take his practice to his patients.

‘I looked around and thought “there’s no reason why we can’t take everything I do here, put it in a mobile entity and bring the services out to the people in the bush”,’ he said.

A partnership between Heart of Australia and Arrow Energy helped make the idea a reality, and Dr Gomes’s potentially life-saving mobile service hit the road for the first time earlier this month.

Its first circuit will see the truck travel in a fortnightly rotation across the Surat Basin, stopping at Dalby, Roma, Charleville, St George and Goondiwindi.

The Heart of Australia team is planning on travelling between 70,000 and 80,000 kilometres a year.

Source: ABC News, October 2014

Inquiry
Connecting in a rural community
1. Read the snapshot ‘Cardiologist takes heart care services to rural Queensland in $1 million converted truck’ and explain the benefits of this initiative to rural and remote communities of Queensland.
2. How does this initiative play a role in addressing disadvantage in the community? Using the Heart of Australia weblink in your Resources tab, research and outline the full range of services currently being offered by the Heart of Australia.
3. Explain how the elements of the social justice framework apply to this health initiative.
4. Research the current location of this mobile service. Research the availability of regular health services in this community. Outline any differences you notice between the availability of medical services for this community and those in a large city environment such as Sydney.

Resources
- Weblink: Heart of Australia
- Weblink: Cobar Shire Council

13.3.4 Characteristics of effective health promotion strategies
Any strategy that aims to improve the health status of a particular population must have certain characteristics. It must:

• move that group towards equity in health
• involve working with the target group in program design and implementation
• have cultural relevance and appropriateness
• ensure that those who deliver the strategy are credible
• provide practical help in allowing people to participate
• focus on skills, education and prevention
• have an effect on social factors and infrastructures
• set targets that are relevant to the population concerned
• support the whole population while still providing extra resources to those in high risk groups
• involve collaboration between various sectors and inform all groups of how they are contributing to the overall plan.

In this section, the characteristics of an effective health promotion strategy will be examined using the Health Promoting Schools initiative as a focus. This initiative was a joint project of the New South Wales departments of Health and of Education and Training, the Catholic Education Commission of New South
Wales and the Association of Independent Schools, New South Wales. The strategies were originally developed from the Ottawa Charter and are actively promoted globally by the World Health Organization. Any other health promotion strategy can be used to examine the following characteristics.

Working with the target group in program design and implementation
To develop a health-promoting school requires the interaction of students, parents, teachers and community groups.

Students and other groups should identify the key health issues and environmental circumstances that result in any health inequities. As a group, they can use problem-solving skills to develop strategies that target their specific health needs and then implement programs in a coordinated way. Involving all the relevant groups increases the success and sustainability of the initiatives.

Students may choose to conduct surveys or questionnaires of fellow students or parents to determine issues of importance. Alternatively, they may become involved in leadership groups such as the student representative council to raise issues or give input on school policies. Through their involvement, students learn about the interrelatedness of health and the natural and social environment. Moreover, by being empowered through involvement, individuals learn that they can take action to affect the determinants of their health.

Application
Investigating school policies
1. Investigate what steps your school has taken towards becoming a health-promoting school. Report back to the class.
2. Suggest ways in which this policy is effective.
3. Suggest ways in which this policy could be more effective.

Ensuring cultural relevance and appropriateness
Each school has its own identity, which is a product of the cultural influences particular to that area. These are sometimes reflected in the school ethos, such as ‘we learn to live’. However, a school’s culture can also be seen in the languages spoken by the students, the sports played, the subjects it emphasises, its rules, and its important events and celebrations.

Minority ethnic groups may make up a large proportion of a school population and schools can adopt policies and procedures that complement what is taking place in students’ homes. For example, when planning physical activities, a school may need to take into account any students who need to fast as part of the Islamic festival of Ramadan.

The school can also address specific health problems by, for example, providing children from low socio-economic backgrounds with breakfast at school because they would otherwise not have eaten. Input from respected ‘elders’ of the community can also strengthen any such initiatives.

Inquiry
Ensuring relevance
Debate the relevance of your school’s ethos and general culture in promoting health. Consider anti-bullying policies, peer support and mentoring programs.

Focusing on skills, education and prevention
In order to focus on skills, education and prevention, the curriculum can be developed across all key learning areas to promote health. For example, drug education in PDHPE classes can be supported by the use of
relevant news articles and stories in English classes, thereby consolidating students’ health literacy skills. Other approaches to consider are:

- encouraging students to develop skills in decision making, problem solving and interacting through all the key learning areas
- giving students opportunities to practise healthy decision making
- educating parents about the problems that young people face
- educating students about the problems faced by other young people.

**Inquiry**

**Developing skills**

Think critically about your school canteen. Does it provide the chance to practise healthy decision making? Discuss as a class.

**Support the whole population while directing extra resources to those in high-risk groups**

A school with an effective health-promoting strategy may need to seek or allocate additional resources to target the groups within the school who are particularly at risk of poor health — for example, those most likely to have inadequate nutrition at home, or those suffering from eating disorders such as anorexia. At the same time, the school would still need to ensure that attention is being paid to the overall health-promoting strategy that affects the rest of the students. Achieving this balance requires the support of the whole school.

**Intersectoral collaboration**

Collaboration between the health sector, the Department of Education and Training and a non-government organisation led to the introduction of Life Education vans to some schools. Other examples of collaboration between sectors are:

- the Healthy Canteen policy in some schools leading to negotiations with businesses that provide food to the schools
- schools working with the family and community groups to provide programs such as reading support.

Schools working on a health-promoting strategy need to consider similar ways of involving the various sectors, for example:

- finding businesses to sponsor sports events
- getting the school involved in Jump Rope for Heart
- fundraising in the community for the purchase of equipment and the building of facilities.

**13.4 Topic review**

**13.4.1 Summary**

- The keys to social justice principles are valuing diversity, achieving equity and creating supportive environments.
- Disadvantaged groups in the population may be exposed to multiple social-risk factors, which contribute to health inequity.
- Health inequities arise because of differences in daily living conditions, the quality of the early years of life, access to services and transport, socioeconomic factors, social attributes and government policies and priorities.
- Funding alone will not solve all health inequity problems; the appropriate health infrastructure is also needed.
- The Medicare levy (up to 2 per cent) covers only around 20 per cent of the total health expenditure, the balance being made up from general revenue.
• The main types of health action that create sustainable improvements in the health of disadvantaged groups are enabling, mediating and advocating.
• The social justice framework for addressing health inequities includes empowering individuals in disadvantaged circumstances, empowering disadvantaged communities, improving access to facilities and services, and encouraging economic and cultural change.
• The gap in health inequity is increasing for some populations.
• The health of Indigenous people is two to three times worse than the rest of the population.
• The median household income per week for Indigenous Australians is less than that of non-Indigenous Australians.
• In rural areas, levels of health decrease as remoteness increases.
• Rural people are exposed to a higher risk of work-related injuries.
• More than 100,000 people are homeless each year, with an increasing number being young people.
• There is no known cure for HIV/AIDS, although modern treatments extend the life expectancy of those infected.
• Males make up 92 per cent of the incarcerated population, with 25 per cent from Indigenous backgrounds.
• One in seven Australians is an aged person.
• Australia has the largest immigrant population in the world; one in five Australians was born in a non-English speaking country.
• Young people are especially vulnerable to unemployment and made up a quarter of the long-term unemployed population in 2016.
• In 2015, 18.3 per cent of the Australian population was affected by some type of disability.

13.4.2 Questions
Revision
1. Critically analyse how your school provides a supportive environment that enables you to achieve good health. (H3) (12 marks)
2. Briefly outline the principles of social justice. (H1) (3 marks)
3. Explain how the principles of diversity and equity, along with supportive environments, promote social justice. (H14) (5 marks)
4. Health inequities are experienced by a range of population groups. Identify a specific population group and discuss how inequities are created. (H2) (5 marks)
5. Identify the key differences in health between males and females. (H2) (2 marks)
6. Account for the effect that racism and discrimination can have on a person’s health. (H15) (5 marks)
7. Describe the health of Indigenous Australians. (H2) (4 marks)
8. Explain how actions such as enabling, mediating and advocating can improve the health of Indigenous people. (H14) (5 marks)
9. Suggest strategies to improve the health of Indigenous Australians. (H15) (3 marks)
10. Describe how the Commonwealth Government disperses funds for health. (H5) (4 marks)
11. Critically analyse the effect that limited resources have on the health-care system. (H1) (12 marks)
12. Outline the essential framework for addressing health inequities. (H14) (3 marks)
13. Identify the characteristics of an effective health promotion strategy. (H3) (2 marks)
14. Briefly outline the most common settings for health promotion. (H5) (3 marks)
15. Outline the major health concerns for Australian children. (H2) (3 marks)
16. Explain what intersectoral collaboration is. Use a specific example in your response. (H5) (5 marks)
17. Critically analyse the effect that colonisation and dispossession has had on Indigenous Australians’ health. (H3) (12 marks)
18. Identify the major factors that affect the health of rural and remote communities. (H2) (2 marks)
19. Recommend strategies to improve the health of people in rural and remote areas. (H15) (3 marks)
20. Explain why geographical remoteness is significant in affecting an individual’s health. (H3) (5 marks)
21. Choose two subgroups of the population and justify the use of the Pharmaceutical Benefits Scheme to provide affordable medicines for the group. (H14) (8 marks)
22. Account for the impact of the health determinants on a homeless person’s ability to maintain good health. (H3) (5 marks)
23. Explain the media’s role in providing a balanced perspective of the incarcerated. (H5) (5 marks)
24. Briefly describe the mortality and morbidity patterns for aged people. (H1) (4 marks)

**Extension**

Analyse the appropriateness of a current health promotion strategy targeting a particular health inequity of a disadvantaged group. Make a PowerPoint presentation for the class. (H14) (10 marks)

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**13.4.3 Key terms**

**advocating**: a combination of individual and social actions designed to speak up for specific groups, gain political commitment, policy support, social acceptance and systems support for a particular health goal or program. p. 597

**discrimination**: the unfair treatment of a person or group based on factors such as their sex, race, cultural origins, age and disability. p. 555

**enabling**: forming partnerships with individuals or groups to empower them, through mobilising human and material resources, and using knowledge and skills in order to promote and protect their health. p. 596

**epidemiology**: the study of disease in groups or populations. p. 556

**health literacy**: the ability to understand and interpret health information and use it to promote and maintain good health. p. 550

**health policy**: a set of formal government statements that define priorities and plans in response to health needs, available resources and other political pressures. p. 596

**health promotion**: a combination of science, medicine, practical skills and beliefs aimed at maintaining and improving the health of all people. p. 595

**infant mortality**: the number of infant deaths in the first year of life, per 1000 live births. p. 557

**living conditions**: people’s everyday environments, including the places where they live, play and work. p. 548

**mediating**: working to bring about consensus and reconciling the different interests of individuals, communities and sectors in a way that promotes and protects health. p. 596

**morbidity**: the incidence or level of illness or sickness in a given population. p. 557

**Ottawa Charter**: a document that represents a global approach to health promotion by the World Health Organization. It aims to enable people to increase control over and improve their health. It outlines prerequisites for health. p. 600

**social exclusion**: occurs when a community or group shows bias against particular individuals, which results in them being excluded or feeling left out. p. 554

**social justice**: is a value that favours the reduction or elimination of inequity, the promotion of inclusiveness of diversity, and the establishment of environments that are supportive of all people. p. 597