



## PDHPE - Health Priorities In Australia

### How are priority issues for Australia's health identified?

- **MEASURING HEALTH STATUS**

'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' – World Health Organisation, 1946

- **Role Of Epidemiology**

Epidemiology is the study of the patterns and causes of health and disease in populations, and how to apply this study to improve health.

- **Measures Of Epidemiology**

The common indicators of the health of a community include measures of mortality, infant mortality, morbidity and life expectancy.

Measure of epidemiology	Definition	Trends in Australia
<b>Mortality</b>	Mortality refers to the number of deaths in a given population from a particular cause and/or over a period of time.	Death rates are decreasing
<b>Infant mortality</b>	Infant mortality refers to the number of infant deaths in the first year of life, per 1000 live births.	Infant mortality rates are decreasing
<b>Morbidity</b>	Morbidity is the incidence or level of illness, disease or injury in a given population	Morbidity is decreasing for most major health conditions. However, an increase in diabetes and mental health problems is evident.
<b>Life expectancy</b>	Life expectancy refers to the length of time a person can expect to live. The average number of years of life remaining to a person at a particular age based on current death rates.	Life expectancy is increasing.

- **IDENTIFYING PRIORITY HEALTH ISSUES**

When determining the disease burden on the community, health authorities need to consider a number of factors. Including:

- *Social justice principles*
- *Priority population groups*
- *Prevalence of the condition*
- *Potential for prevention and early intervention*
- *Costs to the individual and community*

- **Social Justice Principles**

Social justice aims to decrease or remove inequity from a population by encouraging supportive environments and an inclusiveness of diversity for all people.

The four principles relating to social justice are:

- **P** – *Participation*: the empowerment of individuals and communities to be involved in planning and decision making for good health
- **E** – *Equity*: fair allocation of resources and entitlements without discrimination
- **A** – *Access*: the availability of health services, information and education
- **R** – *Rights*: equitable opportunities for all individuals to achieve good health.

The inequities in health need to be addressed and recognised. The high incidence of diabetes in the indigenous population and the high incidence of injury are significant inequities in health.

The provision of equal access to resources, health services, education and information.

- **Priority Population Groups**

Priority health issues are identified when certain population groups are greatly affected by certain causes of illness and death than are the general population.

The identification of priority population subgroups with inequitable health status is important for determining health priority issues. It allows health authorities to:

- Determine the health disadvantages of groups within the population
- Better understand the social determinants of health
- Identify the prevalence of disease and injury in specific groups
- Determine the needs of groups in relation to the principles of social justice

- **Prevalence Of Condition**

The prevalence of a disease or illness refers to the number of cases of that disease in a population at a specific point in time. Priority health issues are identified when prevalence of a disease is higher.

- **Potential For Prevention And Early Intervention**

The majority of diseases and illnesses suffered by Australians result from poor lifestyle. It is difficult to change individual behaviours because often reflect the environmental situation in

which the individual lives. Environmental, social, cultural and political factors all play a part and must be addressed in order for health status to improve.

#### - **Costs To The Individual And Community**

Costs of illness and disease can be classified into direct or indirect.

- *Direct costs* –money spent on diagnosing, treating and caring for the sick. These costs include hospital and medical expenses, pharmaceuticals and money spent on research, prevention programs and education
- *Indirect costs* –costs not directly related to the health system, such as absenteeism, the burden on careers and family, and quality of life.

#### **What are the priority issues for improving Australia's health?**

##### • **GROUPS EXPERIENCING HEALTH INEQUITIES**

Inequities: are unfair differences in levels of health status between groups in society

Sociocultural determinants: of health, including family, peers, media, religion and culture

Socioeconomic determinants: of health, including employment, education and income

Environmental determinants: of health, including geographical location, and access to health services and technology.

Main groups that experience health inequities in Australia:

- *Aboriginal and Torres Strait Islander peoples*
- *Socioeconomically disadvantaged people*
- *People in rural and remote areas*
- *Overseas-born people*
- *Elderly people*
- *People with disabilities*

#### - **Aboriginal And Torres Strait Islander Peoples**

##### **THE NATURE AND EXTENT**

Indigenous people experience a much poorer level of health compared with that of non-indigenous people, they die at a younger age and are more likely to have a reduced quality of life.

- Life expectancy for indigenous females is 10 years and males is 12 years lower than the life expectancy of non-indigenous people.
- Higher mortality rates → 70% of indigenous people that died were younger than 65 years, compared to 21% of non-indigenous people who died younger than 65 years.
- Death rates were almost three times as high for indigenous males and females as for the non-indigenous population
- Infant mortality rate is three times higher than the national average

ATSI SOCIOCULTURAL, SOCIOECONOMIC AND ENVIRONMENTAL DETERMINANTS		
SOCIOCULTURAL	SOCIOECONOMIC	ENVIRONMENTAL
<p>- <b>Exposure to violence</b> → is twice the rate of other Australians, more likely in remote areas.</p> <p>- <b>Tobacco use</b> → more than twice likely to be regular smokers. In 2004-05 50% of indigenous people were daily smokers.</p> <p>- <b>Overweight/obesity</b> → rates have increased since 1995, of people in non-remote locations. Due to the food that is provided for them and lack of fitness facilities.</p>	<p>- <b>Lower incomes</b> → low education leads to a lower income. This results in a low paying job or unemployment.</p> <p>- <b>High unemployment rates</b> → this is due to either a low education or not having the skills acquired for the job</p> <p>- <b>Poor nutrition</b> → unable to afford healthy eating habits. Fresh fruit is lower in remote areas due to availability.</p> <p>- <b>Low education</b> → not having the income to afford high quality education</p>	<p>- <b>Geographic location</b> → 24% live in remote areas – income is a main factor into areas that can be afforded</p> <p>- <b>Accesses to health services</b> → indigenous people that live in remote areas don't have the same access to services as people in the city.</p>

## THE ROLES OF INDIVIDUALS, COMMUNITIES AND GOVERNMENTS IN ADDRESSING THE HEALTH INEQUITIES

### Individuals

- *Educate themselves*

### Communities

- *Provide support services*
- *Modifying laws for alcohol consumption in certain areas*
- *Providing healthy, supportive environment*
- *Empower members of communities to access health services*

### Government

- **Federal Government**
  - *The office of Aboriginal and Torres Strait Islander Health (OATSIH)*
    - Administers funding
    - Brings greater focus to the Australian Government delivery of mainstream health services to Indigenous Australians
  - *The National Aboriginal Community Controlled Health Organisation (NACCHO)*
    - Advocates for empowerment to ATRSI health
  - *Close the Gap*
    - Aims to reduce the health inequities – infant mortality, life expectancy
- **State Government**
  - *The Aboriginal Health and Medical Research Council of NSW (AH & MRC)*
    - Provides vital health and health related services
    - Aims to reduce ill health, suffering, distress and helplessness

- **Socioeconomically Disadvantaged People**

**THE NATURE AND EXTENT**

Socioeconomically disadvantaged people have a lower life expectancy, higher rates of premature mortality, an increased incidence and prevalence of disease.

Research in Australia identifies a strong relationship between low SES and lower health status and confirms that socioeconomically disadvantaged people:

- Are more likely to suffer CVD, diabetes, asthma, mental illnesses and arthritis
- Lose more years of life due to diabetes, CVD, road traffic accidents and lung cancer
- Experience lower life expectancy

**SOCIOCULTURAL, SOCIOECONOMIC AND ENVIRONMENTAL DETERMINANTS**

People from areas of lower SES are more likely to:

- Be daily smokers
- Eat less than the recommended servings of fruit and vegetable
- Be overweight or obese
- Be physically inactive

E.g. Disability or illness might cause unemployment, which leads to reduce income, which might limit capacity to pay for medical services. Alternatively, lower levels of education result in poorer health knowledge, which might affect health behaviours.

<b>THE ROLES OF INDIVIDUALS, COMMUNITIES AND GOVERNMENTS ADDRESSING HEALTH INEQUITIES</b>	
<b>GOVERNMENT</b>	<b>COMMUNITIES AND INDIVIDUALS</b>
<ul style="list-style-type: none"> <li>- At the national level, Medicare and the PBS are designed to address the needs of the socioeconomically disadvantaged by providing lower cost health services and medications.</li> <li>- State government responsibilities relate to service provision and prevention. Some of these strategies relate to: Child health and well being, immunisation, mental health, obesity, sexual health, oral health, urban planning and drugs &amp; alcohol,</li> </ul>	<ul style="list-style-type: none"> <li>- Relies on services and information being successfully delivered into the most disadvantaged communities.</li> <li>- Reduced exposure to risk factors and better delivery of primary care services is critical in order to reduce the inequitable burden of disease these communities suffer.</li> <li>- This requires the development of an increasingly community-based health workforce.</li> </ul>

• **HIGH LEVELS OF PREVENTABLE CHRONIC DISEASE, INJURY AND MENTAL HEALTH PROBLEMS**

- **Cardiovascular Disease (CVD)**

**THE NATURE OF THE PROBLEM**

Cardiovascular disease includes all disease of the heart and blood vessels. The four major types of cardiovascular disease include:

- *Coronary heart disease* –poor blood supply to the heart

- *Stroke* – poor blood supply to the brain
- *Peripheral vascular disease* – poor blood supply to the limbs
- *Heart failure* – when the heart is less effective at pumping blood around the body

### RISK AND PROTECTIVE FACTORS OF CVD

Risk factors are those that increase the likelihood of developing a disease or illness. They can be behavioural, biomedical or social.

<b>Non-modifiable</b> – which you have NO control over	<b>Modifiable</b> – you do have control over
<ul style="list-style-type: none"> <li>- Age</li> <li>→ Risk of CVD increases with age</li> <li>- Sex</li> <li>→ Females have a greater prevalence of CVD than males</li> <li>→ Males are more likely to die from CVD than females</li> <li>- Family history</li> </ul>	<ul style="list-style-type: none"> <li>- Tobacco smoking</li> <li>- Overweight/obese</li> <li>- Alcohol consumption</li> <li>- Poor nutrition</li> </ul>

### GROUPS AT RISK

There are some groups, which suffer higher risk, prevalence and burden associated with CVD, these include:

- *ATSI people*
- *Low SES people*
- *The elderly*
- *People living in rural communities*
- *Overseas- born Australians*

- **Cancer (skin, breast, lung)**

### THE NATURE OF CANCER

Cancer refers to a diverse group of diseases with a common feature – the uncontrolled growth and spread of abnormal body cells.

Two types of tumours:

1. *Benign tumours* – not cancerous, grow slowly, can be surgically removed and may cause damage to surrounding tissue and interfere with the function of vital organs.
2. *Malignant tumours* – cancerous, spread to other body parts, cause sickness and death.
- 3.

### THE EXTENT OF CANCER

Cancer is the only major cause of death increasing in both sexes in Australia. The main reasons for the increases are:

- *The ageing of the population*
- *Better detection of cancer*
- *New technology and screening programs*
- *Better reporting of cancer*

- **A GROWING AND AGEING POPULATION**
- **Healthy Ageing**

The economic and medical burden created by illness and disease among growing number of older people presents a major challenge for governments and the healthcare system.

Healthy older Australians are:

- o *Less likely to leave the workforce for health reasons*
- o *Decrease your chances of getting a lifestyle illness or disease*
- o *More likely to enjoy retirement*
- o *Contribute more to their own communities*
- o *Fewer healthcare needs*

Positive determinants for maintaining the health of older people include sufficient income, safe housing and the right conditions for achieving independence and mobility.

- **Increased Population Living With Chronic Disease And Disability**

Chronic diseases are those diseases that persist over a long period of time. Chronic diseases more commonly affect older people and are associated with disability decreased quality of life and increased costs for health care and long-term care. By making improvements to individual health behaviours, people can prolong their life and also postpone the age of onset of disability. Coronary heart disease and strokes account for the largest number of deaths amongst older people and are also a major cause of disability.

- **Demand For Health Services And Workforce Shortages**

The government has recently proposed a number of initiatives to meet the needs of older Australians, including:

- o *The provision of more nurses in emergency departments*
- o *Expansion of the roles of nurses*
- o *Increase in community care*

People suffering poor health are unable to contribute to the workforce, leading to general shortages of labour. The government has taken action in response to the concern by improving Australia's retirement income system.

- **Availability Of Carers And Volunteers.**

Australia's workforce consists not only of paid workers, but also carers and volunteers, who are ageing with the rest of the population. Caring and volunteering activities are beneficial to the economy and that older Australians make a substantial contribution as volunteers and carers. Over half a million volunteers are aged over 65 years.

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

#### • **HEALTH CARE IN AUSTRALIA**

Improving the health status of the population is a major goal for all societies. In Australia, planning for health care must also be taken into consideration.

## - Range And Types Of Health Facilities And Services

### Institutional facilities and services

→ **Hospitals:** provide general and specialised healthcare. Patients in hospitals are classified as public or private.

- *Public hospitals* –operated and financed by the government, and the healthcare service is free of charge for patients
- *Private hospitals* –owned and operated by individuals and community groups. Paid for by the patients, Medicare and private health insurance refund most of the expense.

→ **Nursing home:** care and long-term nursing attention for those who are unable to look after themselves e.g. chronically ill, the elderly and people with disabilities. The federal government funds the running of all nursing homes through taxes.

→ **Psychiatric hospitals:** provides treatment for people with severe mental disorders.

### Non-institutional facilities and services

→ **Medical services:** provided by doctors, specialists and other health professionals. General practitioners are most commonly used.

→ **Health-related services:** include other services such as dentistry, optometry, nursing, ambulance services and physiotherapy.

→ **Pharmaceuticals:** drugs supplied through prescription from doctors or hospitals (PBS) or over the counter. The federal government prescribes the Pharmaceutical Benefit Scheme (PBS) drugs for people with special needs.

## - Responsibility For Health Facilities And Services

Levels of Responsibility	Description
<b>Federal Government</b>	<p>The federal government is responsible for the formation of national health policies. They control funds obtained through taxes and allocate these to state or local government health sectors.</p> <p>The government assists:</p> <ul style="list-style-type: none"> <li>○ <i>Medicare</i></li> <li>○ <i>PBS</i></li> <li>○ <i>National Heart Foundation</i></li> <li>○ <i>Royal Flying Doctor Service</i></li> </ul>
<b>State Or Territory Government</b>	<p>State or territory governments have the responsibility for providing funding for health and community services. For example:</p> <ul style="list-style-type: none"> <li>○ Public hospitals</li> <li>○ Medical practitioners</li> <li>○ Family health services.</li> </ul> <p>Governments also regulate private hospitals and provide immunisation.</p>
<b>Local Government</b>	<p>Local level of government is responsible for implementing state health policies and controlling local environmental issues. Providing a range of personal, preventive and home care services. For example:</p> <ul style="list-style-type: none"> <li>○ <i>AA meetings</i></li> </ul>
<b>Private Sector/NGO's</b>	<p>Provides a wide range of services. For example:</p> <ul style="list-style-type: none"> <li>○ <i>Private health services</i></li> </ul>



- *Dental*
- *Physiotherapy*
- *Chiropractic services*
- *Asthma Foundation*
- *Diabetes Australia*
- *National Heart Foundation*

Generally privately owned, funded and operated through businesses, charity or religious groups.

#### **Community Groups**

On a community level these groups are responsible for promoting health within a more concentrated or focused area of health. For example:

- *Meals on Wheels*

#### **- Equity Of Access To Health Facilities And Services**

There are two dimensions to equity of access to health facilities and services.

- *Horizontal equity* – equal treatment for similar needs. Medicare aims to provide the majority of Australians with equal access to basic healthcare. PBS ensures a range of necessary prescription medicines are made available at affordable prices.
- *Vertical equity* – priority treatment of those groups with increased health needs and reduced access to health facilities and services.

Horizontal and vertical equity are both essential aspects of a complete health system, governments find it easier to work on a horizontal level of equity. Less complex and does not involve the issues associated with needing to prioritise population groups.

#### **- HealthCare Expenditure Versus Expenditure On Early Intervention And Prevention**

##### Health expenditure

Health expenditure is the allocation of funding and other economic resources for the provision and consumption of health services. Two types:

- *Recurrent expenditure* – regular ongoing costs (salaries, bandages)
- *Capital expenditure* – infrequent costs (buildings, equipment)

Different illnesses have different patterns of expenditure by type of health service. Cardiovascular diseases, cancers and injuries accounted for a relatively high proportion of total expenditure on hospital patient services.

##### Intervention and prevention expenditure

'Public health' is also referred to as 'preventive health'. Public health interventions focus on prevention, promotion and protection rather than on treatment. It centres populations rather than on individuals and on the factors and behaviours that cause illness.

Early intervention and prevention strategies are carried out by all governments, as well as non-government agencies. For example:

- *Cancer Council*
- *Heart Foundation*

Programs aimed at prevention and health promotion, such as school education and support programs, are efficient and increasingly accepted and used.

Governments still have not fully acknowledged health promotion as a cost-effective method

of reducing morbidity and mortality. The new public health approach focuses on shifting away from medically dominated expenditure to health promotion expenditure. Governments do not use preventative strategies because they aren't a quick fix, which means they will not stay in office if they focus on preventative measures.

**- Impact Of Emerging New Treatments And Technologies On Health Care, E.G. Cost And Access, Benefits Of Early Detection**

Much of the rise in healthcare costs can be attributed to advances in medical technology. Diagnostic and therapeutic advances come at a considerable cost. Medicare or the Pharmaceutical Benefit Scheme greatly increases their availability and use, and therefore the cost to the community.

Treatments and technologies have emerged that address the essential needs of access and early detection. Two programs that have been effective in achieving this are:

- *Cancer screening* – national population screening programs for breast, cervical and bowel cancers. Their goal is to reduce morbidity and mortality, through early detection and pre-cancerous abnormalities and effective follow-up treatment.
- *Childhood vaccinations*—covers children's vaccinations for tetanus, whooping cough, polio, mumps and meningococcal.

**- Health Insurance: Medicare And Private**

Medicare

Medicare is the public health insurance system in Australia. It aims to make health care accessible to all and is largely funded by taxes. 'Bulk billing' is when the doctor only charges 85% of the scheduled fee. 'Close the Gap' has governments encouraging doctors and health funds to offer services at a no-gap charge.

Public health insurance covers:

- *Free treatment in public hospitals*
- *Shared ward accommodation*
- *No choice of doctor*
- *Some dental procedures*

Private

Whilst Australia taxpayers pay for Medicare, the individual, usually in monthly installments, pays for private health insurance. The increase in private health insurance membership that resulted was only temporary. Young people and the elderly are the groups least likely to take out private health insurance.

The benefits of private health insurance include:

- *Single-room accommodation*
- *Hospital/doctor of choice*
- *Ancillary benefits (physio, dental etc.)*
- *Overseas cover*
- *Shorter waiting time for elective surgery*

**• COMPLEMENTARY AND ALTERNATIVE HEALTH CARE APPROACHES**

**- Reasons For Growth Of Complementary And Alternative Health Products And Services**

Alternative medicines fall outside the realm of mainstream medicines. They are often based on untested or unscientific methods and knowledge. It is also referred to as 'complementary medicine'.

There are several reasons for the increasing use of complementary and alternative healthcare approaches. Complementary and alternative health care:

- *Shifts the focus away from drugs and surgery*
- *Encourages the use of 'natural' products*
- *Personal connection with the healer*
- *Cannot be scientifically tested, no proof they don't work*
- *Lower costs*
- *Trusted by many people*

#### - Range Of Products And Services Available

Products/service available	Description
Acupuncture	Uses fine needles to stimulate changes in the energy balance of the body to restore health
Aromatherapy	Uses essential oils from flowers, plants, trees and resins in order to stimulate or relax, prevent infection or maintain resistance to disease.
Chiropractic	Disorders that occur throughout the body are due to spinal displacements and can be relieved through manipulation of the spine
Herbal medicine	Herbs are used following traditional customs as an alternative to pharmaceutical drugs
Iridology	Diagnoses the state of the body from examination of the iris
Naturopathy	Based on the belief that the body can heal and maintain itself. Herbs, vitamins and diet are used to help the person take responsibility for their own health.
Reflexology	Reflexes in the feet and hands relate to most parts of the body and can promote relaxation.
Colonic therapy	Uses water flushes to clean and detoxify the lower intestine. Can relieve backache, headache, bad breath, skin problems and fatigue.
Shiatsu	Therapists use fingers, thumbs, elbows, knees, palm and feet to restore the flow of energy through the body.

#### - How To Make Informed Consumer Choices

When purchasing or using any product, it is necessary for the customer to decide whether the claims made are in fact legitimate. It can be difficult to gather evidence regarding the success of alternative healthcare approaches. Drug companies fund the medical research in Australia, not too many tests are conducted on alternative medicines. It is also difficult to run scientific tests on alternative physical therapies, as you cannot provide a 'placebo' effect within your research.

#### What actions are needed to address Australia's health priorities?

- **HEALTH PROMOTION BASED ON THE FIVE ACTION AREAS OF THE OTTAWA CHARTER**

#### - Levels Of Responsibility For Health Promotion

The breakthrough for health promotion came in the form of the Ottawa Charter for Health Promotion in 1986.

Individuals

Emphasis was placed on enabling people to make the changes required through the provision of education, the teaching of life skills, providing equal access to resources and providing opportunities to make changes.

Community

Responsibility for health promotion is no longer solely with the health sector. Mediation between governments, health professionals, organisations, researchers, media, industry, communities, families and individuals. This is referred to as ‘intersectoral collaboration’.

**- The Benefits Of Partnerships In Health Promotion, E.g. Government Sector, Non-Government Agencies And The Local Community**

By combining a broad range of sectors in health promotion initiatives, all social determinants of health are better addressed. Governments, non-government organisations, community groups, schools, housing, businesses and recreation clubs can all combine resources to ensure a better outcome for health promotion strategies.

Bringing different sectors of the community together for health promotion programs is the development of a stronger community network, as people work together towards a mutually beneficial goal.

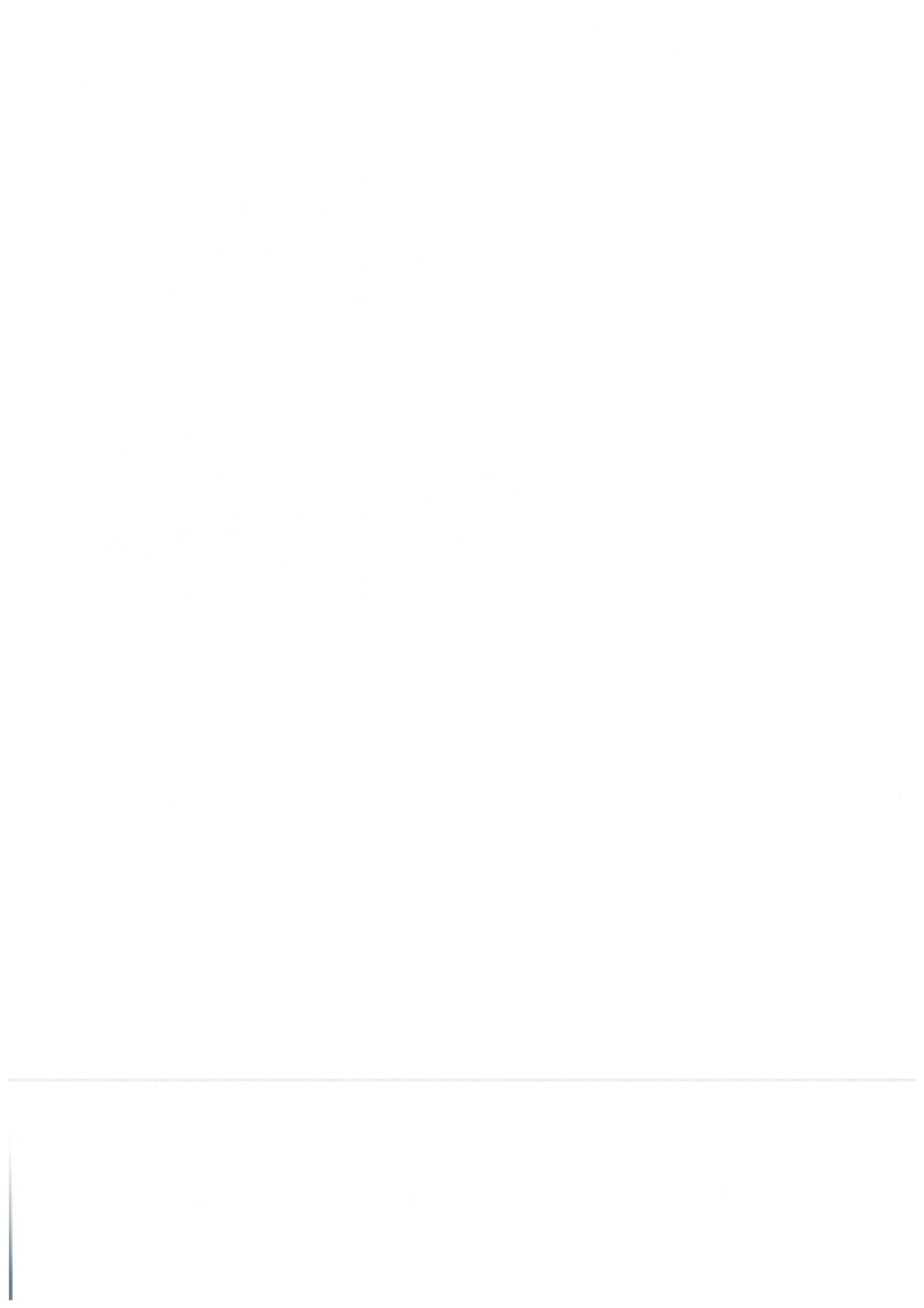
**- How Health Promotion Based On The Ottawa Charter Promotes Social Justice**

The Ottawa Charter identifies three basic strategies for health promotion.

- *Advocate* – gain political commitment, policy support and social acceptance of a health program. Can be achieved through media campaigns and political lobbying.
- *Mediate* – sectors of the community need to work together in the best interest of health. Conflict may arise regarding distribution of resources and different practices used.
- *Enable* – empower individuals, so that they can take action to protect their health. May be in the form of skill development or in the opportunity to have a say in the shaping of public policies.

<b>ROAD SAFETY</b>	
<b>Action Area</b>	Description
<b>Developing personal skills</b>	<p>Improving the knowledge and skills of individuals so they can make informed decisions and be a positive influence to people around them. People can make their own decisions and have control over their own health. Personal skills can be provided in the home, at school, work and within the community. For example:</p> <ul style="list-style-type: none"> <li>○ <i>Driver reviver</i></li> <li>○ <i>Breathing testing in bars</i></li> <li>○ <i>Providing community buses</i></li> </ul>
<b>Creating supportive environments</b>	<p>A supportive environment significantly increases the chance of a person being able to make positive changes to their health. The place they live and the people around them can either create barriers to good health or help to break down barriers. Health promotion aims to create safe, stimulating,</p>

	<p>satisfying and enjoyable living and working conditions. For example:</p> <ul style="list-style-type: none"> <li>○ <i>Demerit points</i></li> <li>○ <i>Non-smoking areas</i></li> <li>○ <i>Seatbelts</i></li> </ul>
<b>Strengthening community action</b>	<p>This increases a community's control over the determinants of health. The community should have a say in setting priorities for health, making decisions, planning and implementing health promotion strategies. Communities that combine their skills and resources for health provide social support for health and gain increased influence and control over the determinants of health in their community. For example:</p> <ul style="list-style-type: none"> <li>○ <i>RBT</i></li> <li>○ <i>Roundabouts</i></li> <li>○ <i>Rest areas</i></li> </ul>
<b>Reorienting health services</b>	<p>The process of reorienting health services encourages the health sector to move beyond its traditional role of providing curative services. The health sector should focus solely on the treatment of illness and disease but also on disease prevention and health promotion. For example:</p> <ul style="list-style-type: none"> <li>○ <i>Support and counseling for offenders of drink driving</i></li> </ul>
<b>Building healthy public policy</b>	<p>Through implementing legislation, and policies governments can work towards creating equity among individual across different populations. For example:</p> <ul style="list-style-type: none"> <li>○ <i>Driver education</i></li> <li>○ <i>Advanced driving courses</i></li> </ul>





## PDHPE - Core 1 Notes

# Core 1 – Health Priorities in Australia

## How are Priority issues for Australia's health Identified?

To identify Health Priority issues within a population group it is necessary to understand the health status of that population and its sub groups. The health status of a nation is the pattern of health in the population in general over a period of time.

### **Measuring Health Status**

#### **Role of Epidemiology**

**Epidemiology** is the study of disease in groups or populations through the collection of data and information, to identify patterns and causes.

Used by gov't's health/related orgs to gain image of or consider patterns of disease in terms of **Prevalence** (existing cases at a point in time)

**Incidence** (no. of new cases at a point in time)

**Distribution** (the extent/where)

#### **Apparent Causes**

Information gathered helps researchers/authorities to;

- Describe + compare patterns of health resources
- Evaluate health behaviours + strategies to control/prevent disease
- Identify + promote behaviours to improve health status of overall population
- Identify needs → allocate healthcare resources

Data collected focuses on ill-health, injury, death rather than good health, wellbeing.

Commonly used stat's; births, deaths, disease incidence/prevalence, hospital use, injury incidence, money spent on healthcare.

Limitations of epidemiology; focuses on physical causes and not on sociocultural factors that contribute to +/- health. These include;

- do not always show sig' variations between health groups e.g. indigenous/non.
- do not provide the whole picture e.g. quality of life/lack of mental health data
- do not answer why health inequities persist
- do not account for health determinants (sociocultural factors e.g. environmental, location, employment, education)

- Some data may not be accurate or reliable

### Measuring Epidemiology

- ◇ Mortality; no. of deaths in pop' from a particular cause over a period of time (usually 1 year). Objective, easily measurable. 2007 showed 6 deaths per 1000 standard pop'. Highest causes; cardiovascular diseases (33.8%), cancers(29.2%), respiratory diseases (8.4%).
- ◇ Infant Mortality; no. of infant deaths in 1<sup>st</sup> year of life, per 1000 live births. Divided into neonatal (first 28 days) and post-neonatal. Heavy declines in rates, 4.2 per 1000 births in 2007. Decline can be attributed to; medical diagnosis/treatment ^, health edu, sanitation ^, support services ^. Indigenous rates almost 3 times that of non.
- ◇ Morbidity; the incidence or level of illness, disease or injury in pop' that do not result in death. All conditions that reduce quality of life, this info gives broader perspective of nation's health.
- ◇ Morbidity measures; hospital use (admissions, patterns of diseases, treatment), doctor visits + Medicare stats (reasons, days away from work), surveys + reports (self-reporting/perceptions), disability / handicap.
- ◇ Life Expectancy; expected time person to live. Average no. of years of life remaining based on death rates. At birth; 83 females, 79 males. LE also calc' at 65 an 85. Trend, LE ^. Top 5 in world. Improvements from; lower infant mortality, down cardio disease deaths, down overall cancer deaths, down traffic deaths, better treatment, medicine, technology.
- ◇ As LE ^, ageing population. Means ^ demand for health services.

### Identifying Priority Health Issues

Tuesday, 7 June 2011

- ◇ Health issues prioritised. Generally based on; Contribution to burden of illness, potential to reduce the burden.
- ◇ Priority issues include; health inequities exp' by certain groups, growing/ageing pop', high levels of chronic disease/other health problems.
- ◇ No. of factors considered in determining disease burden on community/potential to reduce;

### Social Justice Principles

Notion of eliminating inequity in health, promoting inclusiveness of diversity, establishing supportive environments. 4 principles **PEAR**

1. Participation; Empowerment of indiv' + communities to plan/make decisions for ^ health.
2. Equity; Fair allocation of resources + entitlements without discrimination
3. Access; availability of health services, info, edu
4. Rights; Equitable opportunities for all/rights to achieve ^ health.

(E.g. although nation health status good compared to other nations, an alarmingly ^ incidence of diabetes in indigenous pop'. Also injury ^ 15-24 age group. Provision of equal access to resources, health services, edu, info, may decrease incidence of diabetes + injury in respective groups.)

Selected priority issues → must reflect SJ principles. Must address inequities;



## Priority Population Groups

Aus → diversity and multiculturalism. Subgroups have sig'ly different health statuses – identifying of priority pop' groups; important to determine health priority issues. E.g. elderly, women, indigenous.

Identifying groups; allows health authorities to;

- ◇ Determine health disadvantages of specific groups
- ◇ Better understand social determinants of health
- ◇ Determine needs of groups in relation; identify prevalence of disease/injury

Epidemiological info reveals;

- ◇ ATSI pop' → higher death rates and morbidity rates; most priority areas
- ◇ Low socioeconomic; higher incidence of disease risk factors (e.g. smoking, high blood pressure), lower use of preventative services.
- ◇ Rural/remote locations; ^death rates, heart disease, injury compared to urban
- ◇ Men at more risk than women → no. of diseases, e.g. heart disease

## Prevalence of Condition

- ◇ Epi' data; guides to priority areas.
- ◇ High prevalence (widespread) disease leads to economic burden on community.
- ◇ Cardio' disease leading cause of preventable death in Aus.

## Potential for Prevention and Early Intervention

- ◇ Most diseases result of poor lifestyle choices. For change to occur; ind' behaviours + environmental determinants need to be addressed. E.g. SES, access to info/services, infrastructure, employment etc. → some determinants.
- ◇ Prevention + early intervention may lead to ^health status

## Costs to the Individual and Community

- ◇ Can place great burden on indi'; financial loss (e.g. no job), cost of treatment, decrease quality of life, emotional stress.
- ◇ Illness, disease, death → burden on community; costs.
- ◇ Direct costs; money spent on diagnosis, treatment, caring for sick, prevention. E.g. research, medicine, hospital admissions, prevention initiatives.
- ◇ Indirect costs; include loss of productivity, retraining replacement workers/casuals.

-----Revision Questions page 22-----

1. Australia is a very healthy nation compared to the rest of the world. Many health indicators show our high standing in the world; shown by Epidemiology. We have 3<sup>rd</sup> best life expectancy in world. Or health continues to improve. We have a high amount of \$ spent on health services, initiatives, treatment which contribute to this improvement. We are also in the top third in the world in terms of; breast/lung/colon cancer, stroke, maternal mortality, tobacco smoking, teeth and more. However, Aus' does have an ageing population. Access to health services is good, a balanced diet is generally available, and education is quite good.

2. Prevalence; existing cases at a point in time – how widespread it is.  
Incidence; The amount of new cases
3. Australia has a declining infant mortality rate because; medical diagnosis/treatment ^, health edu, sanitation ^, support services ^.
7. Major causes of morbidity; cancers, diabetes, heart disease, disability and handicap, respiratory disease.

Major causes of mortality; cardiovascular disease, cancers, respiratory diseases.

---

## What are the priority issues for improving Australia's health?

### ***A Growing and Ageing Population***

- Aus' population on the rise. Increased due to more births, less deaths, net overseas migration. June 2007; estimated 21 million. Projected to increase.
- Population is also ageing. 9% is 70 and over. Expected to increase to 13% by 2021, and 20% by 2051. Consequence of low fertility, increasing life expectancy.

### **Healthy Ageing**

- Govt has responded to ageing pop'; encouraging to plan for financial security + independence. Govt has provided elderly with support, services, depending on their needs.
- Govt tries to ensure work force is stable. Priority area for encouragement of health ageing.
- If unhealthy later in life, working years likely to be shortened, then reduction in economic growth.
- Govts' promoting good health thru' life, disease prevention. People active, healthy are less likely to need aged care services later in life. Govt appointed an Ambassador for Ageing.
- A for A responsible for; promoting + ageing, encouraging older people to make contributions, community/gov programs and initiatives, assisting older people to access these programs.
- National Research Priority; 'Promoting and maintaining good health'. Focuses on points mentioned above for positive ageing so that burden on govt is lessened.

### **Increased Population living with Chronic Disease and Disability**

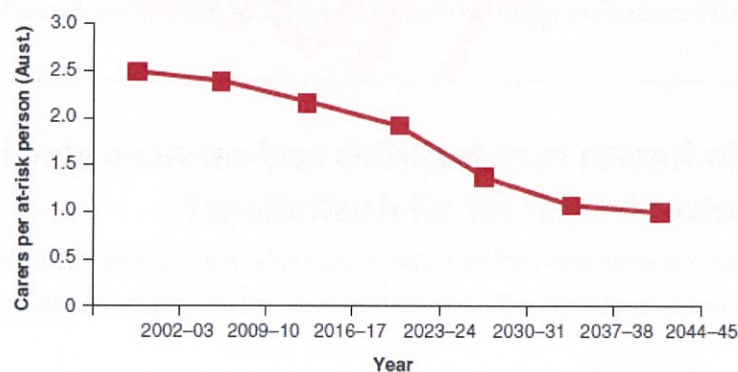
- Sig improvements in people surviving heart attacks, strokes, cancers. Also ageing pop' means more living with chronic disability or disease.
- Chronic, non-communicable diseases → 80% total burden of disease. Future levels of these could be reduced if younger control risk factors; smoking, obesity, drinking, inactivity.

### **Demand for Health Services and Workforce Services**

- Demand for health and aged care services gone up. No. of new initiatives have been proposed including;
  - More nurses to cater for demand in emergency departments + other high demand areas
  - Expansion of roles of nurses
  - Increase in community care, e.g. home-help services, meals on wheels.
- Additional concerns; people suffering poor health are unable to contribute to work force, leading to labour shortages. Govt. has taken action to improve retirement income system
  - Age pension available for people after retirement
  - Compulsory superannuation. (Approx. 9% of gross salary into super fund)
  - Voluntary, private superannuation encouraged. People encouraged to plan for independence, financial security for later years of life → reduce economic burden of govt.

### Availability of Carers and Volunteers

- **Carer**; thru' family relationship, friendship, looks after an older person. Also volunteers.
- Work force consists of paid workers, but also carers and volunteers. Older (but able) Aus' can contribute by being paid workers, carers, volunteers, family members.
- Over 55's contribute approx. \$75 billion per annum unpaid caring + volunteering. Over 50% of this amount from people over 65.
- Caring + volunteering are beneficial to economy, older Australians. Paid and unpaid work is essential to a functioning and caring society → ultimately enhances quality of life for Aus's.
- Estimated; little growth in no. of available carers, compared to increased demand. In future → likely to be a shortage in carers.



**Figure 2.31:** The trend in the numbers of carers per at-risk person, and projections to 2045. Carers will be in greater demand as the population ages. (Source: NSW Health.)

### Inquiry – Carers and Volunteers – Question 1-3

1. Assess impact of growing + ageing population on carers of elderly and volunteer orgs.

Big impact → larger demand. Also provides more to be volunteers/carers but still shortfall. More pressure on existing carers/volunteers. Own health can be affected because of stress.

2. Reasons for projected shortage of carers in the future.  
More disease/people affected. Too many elderly, higher survival rates. Carers becoming elderly and need to be cared for. Less incentive to bring more people to becoming carers.
3. Suggest measures that could be taken to encourage people to carry out caring and voluntary activities
  - Higher pay, certificates, qualifications, recognition from employers so they can get other jobs. Advertising campaigns, group volunteer work, fringe benefits e.g. healthcare for carers, tax cuts. Moral encouragement, guilt-tripping, show it feels good to help out.

-----Snapshot page 79-----

1. Asthma, arthritis, heart disease, chronic obstructive pulmonary disease, depression, diabetes, osteoporosis. (common chronic diseases)
2. Trends; people with chronic disease(s) 60% more likely to not be labour force. Approx. 1 third Au' aged 25-64 reported at least one chronic disease. Men with chronic diseases twice as likely to be out of labour force, Women 20% more likely to be out of labour force. Deaths also decreased the potential work force. Cancer 52%, heart attack 19%. Loss of 540 000 full time workers (approx. 10 % of full time work force)
3. These trends can be reversed by trying to prevent these diseases e.g. not smoking, mental health initiatives. Also by correct treatment of diseases.
4. Chronic diseases place a huge impact/burden on the workforce. Considering approx. 10% of the full time work force are affected by either disease or disability, it means there is an immense impact on the workforce. It means a loss of productivity, economic growth, as well as brings about costs for training new employees, loss of productivity caused on other workers as a result of missing team workers.

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

- Health care services and facilities play a vital role in achieving better health for Aus'.
- Health care to be effective → partnerships with other sectors of the community

### ***Health Care in Australia***

- Interrelationships between Commonwealth govt, health insurance funds, private/public providers of services (e.g. doctors, dental), institutions (e.g. hospitals), other orgs (e.g. community health services). [see diagram]
- Extensive and diverse; diagnosis, treatment, rehab, extended care.
- Health care in Aus → dominated by medicine [e.g. clinical diagnosis, treatment and rehabilitation]. However, shift occurring as health practitioners recognise

importance of their role in health edu/promotion, community empowerment, advocacy of health behaviours.

- More money needs to be allocated to health promotion, prevention of illness.

## **Range and Types of Health-Care Facilities and Services**

Two broad categories

<b>Institutional care</b>	<b>Non-institutional care</b>
<ul style="list-style-type: none"> <li>• Hospitals               <ul style="list-style-type: none"> <li>— public</li> <li>— private</li> <li>— psychiatric</li> </ul> </li> <li>• Nursing homes</li> <li>• Other services such as ambulance</li> </ul>	<ul style="list-style-type: none"> <li>• Medical services such as those provided by medical practitioners and specialists</li> <li>• Health-related services; for example dental, optical, pharmaceutical, physiotherapy</li> <li>• Community and public health services such as supplying health equipment, aids and appliances</li> <li>• Research organisations such as the National Health and Medical Research Council (NHMRC)</li> </ul>

### **1. Institutional**

#### **Hospitals**

- Either public or private.
- Public → operated by state govt' + commonwealth govt. Serve greater proportion of elderly/very young.
- Generally → more highly specialised services/equipment. Because can afford expensive equipment from govt funding.
- Private → operated by individuals and community groups. Also provide same-day surgery.
- More of short-stay surgery, elective procedures, less complex procedures carried out.
- Patients classified according to choice of service → private or public.
- If public → allocated doctor, bed, treatment all free.
- If private → choose doctor, pay for services/accommodation by hospital/doctor. Medicare and any private health insurance can refund much of the expense. (Usually gap to pay)
- Issue of equity of access been debated → some private have more rapid access to elective surgery. Urgency categories have been applied to patients' conditions.

#### **Nursing Homes**

- Care and long-term attention for people unable to care for selves; elderly, chronically ill, mental ill, disabled.
- 3 types → private charitable, private for profit and state government.
- Commonwealth govt assumes most financial cost for running Nursing home.
- Have assessments to classify care needs so highly dependent placed in most attentive care.

## Psychiatric Hospitals

- Treatment of people with mental illness→modern approach involves hospital services and care integrated within community.
- Range of care includes GPs, private psychiatrists, community based specialists, residential mental health facilities, therapy etc.
- Due to different approach, less hospitalisations→drop in psychiatric hospitals.
- No's beds in community-based residential services increase.

### 1. Non-Institutional Care

## Medical Services

- Includes doctors, specialists, other health pro's.
- Extensively, GPs→diagnose + treat minor problems/illnesses. Patients can be referred to various specialist e.g. cardiologist, radiologist, dermatologist.
- Whole or part cost of seeing GP covered by Medicare. Some GPs Bulk Bill (patient does not pay anything and doctor reimbursed by Medicare 75-85% of scheduled fee)
- GP visits have ^ in recent years due to access, awareness, check-ups, prevention strategies.

## Health Related Services

- Includes ambulance, dentistry, optometry, pharmacy, physio, chiro etc.

## Pharmaceuticals

- Drugs supplied thru' hospitals/doctors by prescriptions. Also thru' over the counter.
- Most prescription done through PBS (Pharmaceutical Benefits Scheme)→patients pay set amount and govt pays balance. Subsidised further if e.g. disabled, pensioners, low-income.
- Some chronically ill→protected by PBS Safety Net. To ensure no one prevented due to financial access. If certain \$ reached→get prescription drugs for free or low price for rest of year.
- If \$1264.90 spent→only \$5.60 per prescription for rest year.
- If drugs on PBS scheme list→pay \$34.20 in 2011.

## Community Supports

- Sig factor→environment conducive to + health.
- Supports promote health but not recognised by health-care system.
- E.g. town planners/engineers role in infrastructure→playgrounds, exercise facilities, safe roads, safe sports grounds. Also foods with nutrition info, standards for food sanitation.

---

## Questions page 92

1. General Practitioners.
2. Very accessible in our community. Yes, all members of the community should be able to access a GP, whether in a medical centre, private practise or public practise. Various levels of govt and community work in partnership to give equality of availability of GPs to all members regardless of SES.

3. Yes, everyone needs the health knowledge of GPs and their ability to cure/prevent illness.
  4. Education, income, knowledge, transport, access, disability, language/cultural, environment, displacement.
  5. Specifically aimed at curing illnesses.
  6. Relevant goals + info → specific to community, accessible → affordable, cultural differences, all able to participate, all contribute to initiatives, address social justice principles, health care info, promote health / have initiatives.
- 

### ***Responsibility for Health-Care Facilities and Services***

- Facilities + services provided by range of groups. 5 levels of responsibility
  1. Commonwealth govt
  2. State and territory govt
  3. Local Govt
  4. Private Sector
  5. Community groups

1. Commonwealth govt  
 Formation of national health policies, control of health system financing, funding (Medicare/PBS), funding states govt, and responsibility for special community services (e.g. veterans, Aboriginal community). Also research, public health activities, residential care.

2. State and Territory govt

Primarily providing health + community services. Hospitals = major responsibility. Others include mental, dental, health promotion, community care, rehab programs, regulations.

3. Local Govt

H responsibilities vary from state to state. Main concerns → environmental control, personal, preventative and home care services.

Includes; monitoring of sanitation, hygiene standards in food, waste, building standards, immunisation, etc. Local council implements these e.g. immunisation.

4. Private Sector

Wide range of services; private hospitals, dentist, alternative health services (e.g. chiro). Privately owned, approved by Commonwealth.

Many religious orgs (e.g. Salvation army), charity groups (e.g. Red Cross) and private orgs (e.g. cancer council). Many of these receive funding from both state and commonwealth govt.

5. Community Groups

Promote health e.g. Asthma foundation, cancer support groups, Diabetes Aus. Formed largely on a local need basis to address problems specific to an area. Where concerns are national, groups are linked and structured.

### ***Equity of access to health facilities and services***

- Access; about Health system's ability to provide affordable + appropriate health care to people who require it. Also refers to equitable distribution of health-care facilities to all sections of population.

- An individual's ability to access can be affected by

SES status, knowledge of available services (education, literacy, skills, language), geographic location (e.g. rural) cultural/religious beliefs (e.g. Muslim women going to male GPs).

- Access might be affected by

Shortages of qualified staff, lack of funding or equipment, patient waiting lists for surgery or other treatments, waiting times in outpatient clinics or emergency departments.

- Majority of Aus' have access to fundamental health care through national health insurance system – Medicare.
- However, Medicare does not cover all health services (e.g. dental, physio), and as a result some services are inaccessible if cannot afford.

Example of inadequate access; waiting times for elective surgery. Median waiting time rose to 34 days (2008). Longest waiting→total knee replacement (156 days). This especially disadvantages people of low SES.

### ***Health-care expenditure vs. early intervention and prevention expenditure***

**Health Care Expenditure:** allocation of funding and other economic resources for provision and consumption of health services. By state/territory govts, private health insurance, households and indiv.

- Total health care expenditure 07/08 is 104 Billion (9% GDP)
- Expenditure ^, will continue to ^ whilst focus is on 'curative' medicine i.e. It costs more to cure rather than prevent E.g. Cardio Vascular Disease→edu, healthy eating, active lifestyle, promotion/initiatives→more cost effective than treatment (by-pass surgeries etc.)
- More \$ diverted to health expenditure (90%+) than health promotion (<10%).
- Preventable programs together with treatment/early intervention for CVD, Cancer and traffic accidents have reduced deaths and morbidity over last two decades. E.g. quit initiative, Sun-Smart, Cervical/Breast screening programs, Stop-Revive-Survive.
- Strategies for prevention

Education in schools for + behaviours, improved Coord levels of govt, restrictions on advertising, legislation, higher taxes on products [alcohol, tobacco], support programs for addictions.

- Arguments for ^ funding for prevention
  1. Cost-Effective→preventing injury, illness. Long-term benefits in savings, reduction of burden.
  2. Quality of life→+ health outcomes through whole life, making healthier, longer, decreased morbidity.
  3. Containment of Increasing costs→prevention means these health care costs decrease. E.g. care/rehab
  4. Maintenance of Equity→Lesser threat to equity problems if demands are lessened



5. Use of Existing Structures→By prevention services, no need for more building. GP's already established→expand role to give preventative measures.
6. Empowerment of Individ→Use of prevention strat' to have more control over personal health.

### ***Impact of emerging new treatments and technologies on health care***

- New treatments such as MRI's, keyhole surgery, chemotherapy, non-invasive surgery, improved drugs, image technologies (ultrasound), laser, materials (knees/hips), artificial organs. Can treat and delay come fatal diseases efficiently e.g. HIV / Cancer.
- Allow for shorter hospital stay, less pain, faster recovery.
- Very expensive→issue of equity/access. Means financially exclusive. SES, isolation, culture as barriers. E.g. cannot take advantage of exercise/rehab/hospital/expert services in rural.
- Prevention/curative still cheaper than the treatments and rehab. E.g. Early detection means only keyhole surgery needed, instead of major surgery such as a mastectomy.
- Dental health issues on rise→consumption of carbonated/sugary drinks, high cost of regular dental care.

### ***Health Insurance: Medicare and private***

- Commonwealth govt committed to providing equitable health services to all citizens.

### **Medicare [introduced 1984]**

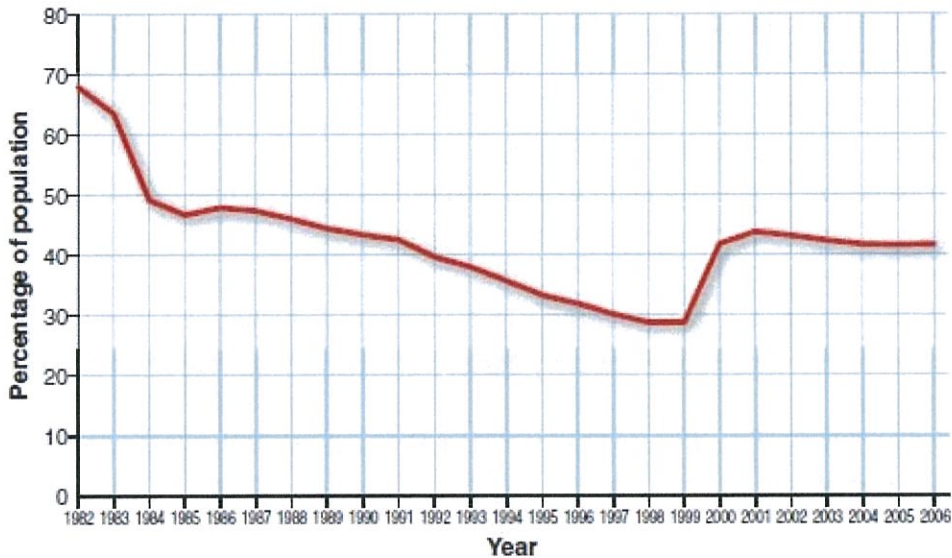
- Aus' universal health system. Aims for affordable, accessible. Funds from taxes, Medicare Levy (paid according to income level currently at 1.5% taxable income but can vary).
- Medicare provides access to; free treatment in public hospitals, free/subsidised treatment from health pro's (GPs and specialists).
- Regardless of charges, Aus's covered 85% of set scheduled fee.
- Doctors have options of bulk billing →patient pays nothing and doctor receives up to 100% (specialists 85%) of scheduled fee from Medicare.
- However, Medicare does not cover some private services (e.g. private physio, chiro)
- Hospitals→equipment/technology for major operations that private hosp' might not be able to afford.

### **Private Health Insurance**

- Many take out private health insurance. Covers additional expenses →dental, physio, chiro, aids, appliances.
- Advantages of private HI→shorter waiting times, choice of hospitals, GPs, specialists, private rooms, insurance whilst overseas, confidence/peace of mind.
- Lower levels of private HI among those with less available income. After introduction of Medicare→some left private HI. Contributed to strain on public

health system. 1998, to release pressure, Comm' govt introduced 30% tax rebate for those with private HI. Also now have 1% Levy surcharge if earn more than \$80 000 (meaning 2.5%).

- Further changes 2000, lower lifetime health cover premiums if join HI fund early in life. Aimed to attract young to private HI. If don't join → extra 2% premium when don't have it each year after 30.
- Aus' now has highest proportion pop' covered by private HI – estimated 45%.



**Figure 3.13:** Percentage of the population in Australia covered by registered private health insurance funds, 1982–2006 (Source: Australian Health Insurance Association, February 2007, data from Private Health Insurance Administration Council.)

## Medicare and private health insurance

1. Explain how the Medicare system of health insurance functions.
2. Outline the benefits of the Medicare system.
3. Explain how private health insurance might benefit some people.
4. Read the snapshot 'Private health insurance tips'. What are the advantages of having private health insurance?
5. Use figure 3.13 to describe trends in private health insurance.
6. Outline government strategies for attracting people to private health insurance.

1. Funds raised from tax payers and the Medicare Levy by Commonwealth govt.
2. Medicare offers all Australian's medical and health services, e.g. public hospitals, GPs, specialists, medication. Tries to ensure all have access and affordability. Generally, Aus' are covered for 85% of a scheduled fee when seeing a medical professional. Bulk billing is available for doctors, and means patients do not pay. Medicare pays the doctors most of the scheduled fee, if not all.

3. Private health insurance generally means more choice, quicker attention. E.g. choice of doctors, hospitals, private rooms, smaller waiting lists for elective surgery, more confidence/comfort. Some specialised services are covered by private insurance that might not be by Medicare e.g. physio, chiro, equipment, appliances, overseas health insurance.
  4. As stated above, in addition it is cheaper because you do not have to pay the additional Medicare levy surcharges and you will receive a rebate if you have private HI.
  5. With the anticipated introduction on Medicare, many people opted out of private health insurance. Numbers privately insured continued to fall at a fairly steady rate. The changes made in 1998 meant more people started to take out private HI, with a peak in 2001, caused by further changes in 2000. Fairly steady since then at approx. 44% having private HI.
  6. The govt has tried to attract young to private HI, by placing the surcharge and making it beneficial to join younger in life. Lifetime cover also means people are obliged to keep private HI during life, thus ensuring people who take out private HI keep it and the majority of people have it.
- 

### **Complementary and Alternative Health Care Approaches**

- (CAM) refers to healing practices that do not fall within the area of conventional medicine.
- Many have existed traditionally as alternatives to mainstream medicine, recently with a growing acceptance of their role in supporting mainstream techniques
- Alt/Comp → existed many centuries especially Eastern countries. E.g. China, Japan
- Developed countries → CAM increasing interests e.g. herbal becoming popular in Aus now.
- Practitioners starting to recognise value of CAMs and incorporating some into treatments.
- WHO supports policy developments in exploration of potential.
- Other e.g. include chiro, naturopaths, meditation, hypnosis.
- Referred to as holistic; treats source of problems + overall state of health e.g. spiritual, physical.

### **Reasons for Growth of complementary and alternative health products and services**

- Approx. 42% Aus. Using CAM. Trend → social change.
- ^ access to info, globalisation, cultural influences, individualism, choice, empowerment
- WHO recognises usefulness, endorses certain plants
- Recognition that majority of world's pop'n have CAM as trad medicine
- Many people turn to CAM if modern medicine not curing problem or dissatisfied.
- Desire for natural products, services, environmental awareness
- Holistic approach attracts new-age types
- Some have belief in traditional cultural have strengths
- ^ migration and increasing acceptance, for value of multiculturalism

- Growth in CAM→adds dimension, direction, expectations for health. Consumers have ^ choice, info e.g. internet.
- Visibility→training colleges/unis/courses for specialising in CAM→qualifications. Credibility.
- Many added to Private HI rebates; recognition of role/importance/cultural.

### **Range of products and services available**

- Wide range of approaches, types,
- E.g. acupuncture (needles, stimulating body, mind, helping joints, muscles, circulation)
- Aromatherapy (oils for mind, body, spirit) inhaled, rubbed
- Chiro (musculoskeletal, nervous system), herbalism (plants + herbs; aimed to restore + support body's own healing systems)
- Others; homeopathy (indiv symptoms), iridology (analysis of eye), massage (relaxation), meditation (inner focus/ energy), naturopathy (symptoms + causes/lifestyle)

### **How to make informed consumer choices**

- Important to investigate services offered, credibility of practitioner(s)
- Need to ask what the treatment is, benefits, specificity to indiv', experience/training of practitioner, costs, qualifications, if able to be combined with conventional medicine + covered at all. Consider research, side-effects, timeframe.
- Need to cross-reference with GPs as some CAMs can interfere with conventional medicine.
- Importance→nature of CAMs. Experiences of others, advice of those who have done it.
- Some CAMs recognised by WHO, e.g. chiro, naturopathy. Even offered at uni. Other forms have high courses + accreditation.