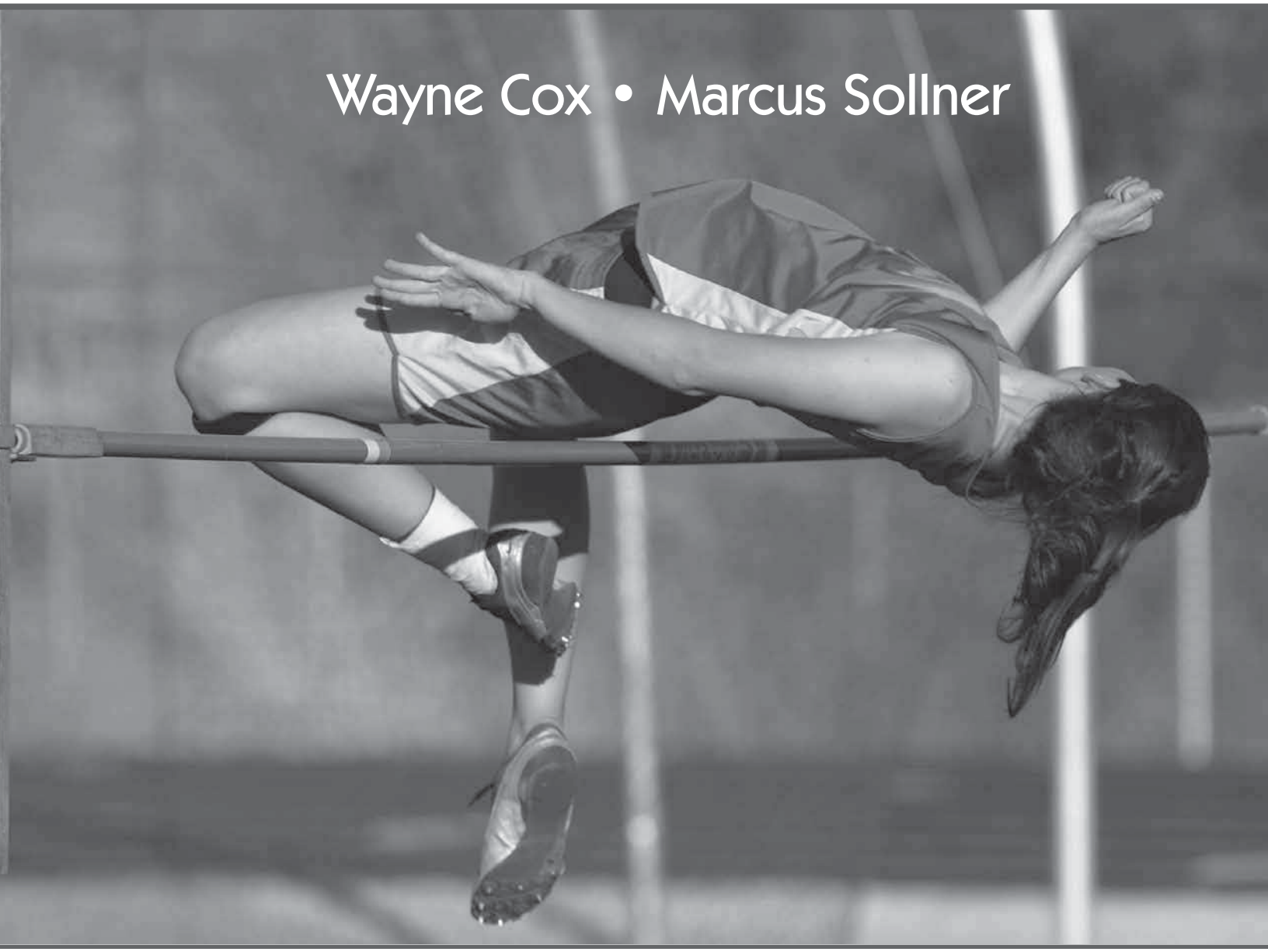
DOT POINT

HSC PDHPE



Wayne Cox • Marcus Sollner

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Private Bag 7023 Marrickville NSW 1475 Australia
Tel: (02) 9516 1122 Fax: (02) 9550 1915
sales@sciencepress.com.au
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Contents

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Introduction

What the book includes

This book provides questions and answers for each dot point in the Board of Studies syllabus for the following topics in the Year 12 PDHPE course.

- Health Priorities in Australia
- Factors Affecting Performance
- Sports Medicine
- Improving Performance

Format of the book

The book has been formatted in the following way:

1. Main topic statement from syllabus.

1.1 Syllabus requirement.

1.1.1 First question for this syllabus requirement.

1.1.2 Second question for this syllabus requirement.

The number of lines provided for each answer gives an indication of how many marks the question might be worth in an examination. As a rough rule, every two lines of answer might be worth one mark.

How to use the book

Completing all questions will provide you with a summary of all the work you need to know from the syllabus. You may have done work in addition to this with your teacher as extension work. Obviously this is not covered, but you may need to know this additional work for your school exams.

When working through the questions, write the answers you have to look up in a different colour to those you know without having to research the work. This will provide you with a quick reference for work needing further revision.

Verbs to Watch

account, account for
State reasons for, report on, give an account of, narrate a series of events or transactions.

analyse
Identify components and the relationships among them, draw out and relate implications.

apply
Use, utilise, employ in a particular situation.

appreciate
Make a judgement about the value of something.

assess
Make a judgement of value, quality, outcomes, results or size.

calculate
Determine from given facts, figures or information.

clarify
Make clear or plain.

classify
Arrange into classes, groups or categories.

compare
Show how things are similar or different.

construct
Make, build, put together items or arguments.

contrast
Show how things are different or opposite.

critically (analyse/evaluate)
Add a degree or level of accuracy, depth, knowledge and understanding, logic, questioning, reflection and quality to an analysis or evaluation.

deduce
Draw conclusions.

define
State the meaning of and identify essential qualities.

demonstrate
Show by example.

describe
Provide characteristics and features.

discuss
Identify issues and provide points for and against.

distinguish
Recognise or note/indicate as being distinct or different from, note difference between things.

evaluate
Make a judgement based on criteria.

examine
Inquire into.

explain
Relate cause and effect, make the relationship between things evident, provide why and/or how.

extract
Choose relevant and/or appropriate details.

extrapolate
Infer from what is known.

identify
Recognise and name.

interpret
Draw meaning from.

investigate
Plan, inquire into and draw conclusions about.

justify
Support an argument or conclusion.

outline
Sketch in general terms; indicate the main features.

predict
Suggest what may happen based on available data.

propose
Put forward a point of view, idea, argument, suggestion for consideration or action.

recall
Present remembered ideas, facts or experiences.

recommend
Provide reasons in favour.

recount
Retell a series of events.

summarise
Express concisely the relevant details.

synthesise
Put together various elements to make a whole.

Health Priorities in Australia

Notes

Factors Affecting Performance

Notes

Sports Medicine

Notes

Improving Performance

Notes

DOT POINT

Health Priorities in Australia

Notes

1. How are priority issues for Australia's health identified?

1.1 Using epidemiology to measure health status.

1.1.1 Epidemiology is used to measure health status of a population.

(a) What is epidemiology?

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(b) Identify sources of epidemiological data.

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1.1.2 Who would use epidemiological data?

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1.1.3 Identify types of information that epidemiological data could provide to analysts about a given population.

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1.1.4 Discuss the potential limitations of using epidemiological statistics.

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1.1.5 Outline uses of epidemiological data concerning the health status of Australians.

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1.1.6 Measures of epidemiology to determine the health of a community can include data on morbidity, mortality and life expectancy. Outline the meaning of these terms.

(a) Morbidity.

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(b) Mortality.

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(c) Life expectancy.

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1.1.7 Compare differences between mortality and morbidity, giving example of their uses.

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1.1.8 Distinguish between prevalence and incidence of a disease.

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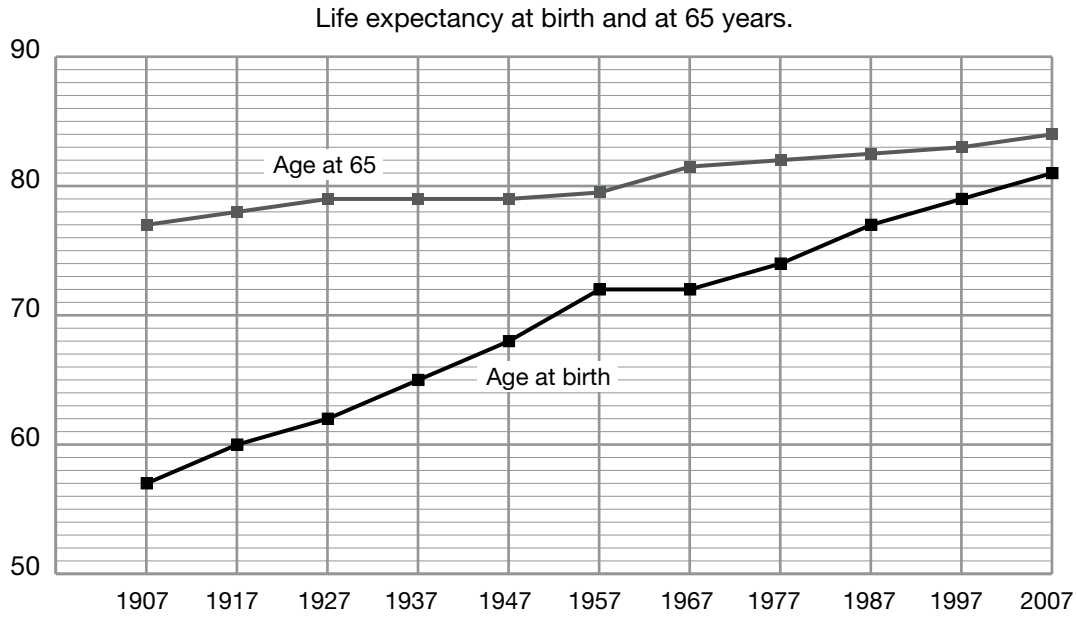
1.1.9 The graph shows figures for life expectancy in Australia. Answer the questions below the graph.



(a) Outline any trends represented by the two graph lines.

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(b) Outline the significance of the upper line showing life expectancy at age 65.

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1.1.10 The life expectancy for people in Australia is increasing. Identify reasons to account for this trend.

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1.1.11 The table provides information about life expectancy at birth, for males and females, in a number of countries, in 2007.

Life expectancy at birth in 2007

Country	Life expectancy of males (years)	Life expectancy of females (years)
Australia	79.0	83.7
Austria	77.3	82.9
France	77.5	84.4
Greece	77.0	82.0
Hungary	69.2	77.3
Iceland	79.4	82.9
Japan	79.2	86.0
Korea	76.1	82.7
Mexico	72.6	77.4
New Zealand	78.2	82.2
Netherlands	78.0	82.3
Poland	71.0	79.7
Sweden	78.9	83.0
Turkey	69.3	74.2

(a) Compare life expectancy for men and women in Australia in 2007.

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(b) Based on these figures, identify where Australia ranks in life expectancy compared to the countries listed and suggest reasons to account for this.

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1.1.12 From the table below identify differences in the mortality rates for males and females for the top five causes of death.

Ten leading causes of death in Australia, all ages, 2007

	Male			Female		
Rank	**Cause of death**	**Number of deaths**	**Percentage of all male deaths**	**Cause of death**	**Number of deaths**	**Percentage of all male deaths**
1	Coronary heart disease	12 119	17.2	Coronary heart disease	10 610	15.8
2	Lung cancer	4715	6.7	Cerebrovascular diseases	6975	10.4
3	Cerebrovascular diseases	4516	6.4	Dementia and Alzheimer's disease	4905	7.3
4	Chronic obstructive pulmonary disease	2965	4.2	Lung cancer	2911	4.3
5	Prostate cancer	2938	4.2	Breast cancer	2680	4.0
6	Dementia and Alzheimer's disease	2415	3.4	Chronic obstructive pulmonary disease	2187	3.3
7	Colorectal cancer	2221	3.1	Heart failure and complications and ill-defined heart disease	2083	3.1
8	Diabetes	1923	2.7	Diabetes	1887	2.8
9	Unknown primary site cancers	1832	2.6	Colorectal cancer	1886	2.8
10	Suicide	1453	2.1	Unknown primary site cancers	1655	2.5

1.1.13 From your studies of epidemiology, answer the following.

(a) Has the overall death rate increased, decreased or stayed stable over the last 10 years?

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(b) Has the prevalence of the leading causes of death increased, decreased or stayed stable over the last 10 years?

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1.2 Identifying priority health issues.

1.2.1 Identifying priority health issues is difficult as different people have different ideas as to what is most important. Epidemiological data is used, but other criteria must also be considered.

(a) Suggest reasons why it is important to prioritise health issues.

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(b) Identify the five criteria used in Australia for identifying priority health issues.

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1.2.2 Social justice is one criterion used to determine priority health issues in Australia. Outline what is meant by social justice.

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1.2.3 The principles of social justice are supportive environments, equity and diversity. Explain the meaning of these principles to illustrate your understanding of each.

(a) Supportive environments.

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(b) Equity.

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(c) Diversity.

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1.2.4 Another criterion for identifying priority health issues is the prevalence of the condition. Explain what is meant by this term and why it is important.

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1.2.5 Describe the potential costs an individual may incur as a result of ill health.

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1.2.6 Describe potential costs to the community that may be attributed to the poor health of an individual.

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1.2.7 Resources are allocated to the prevention and early intervention of diseases.

(a) Discuss why this is important.

(b) Explain why this is of particular significance in Australia.

(c) Identify changes an individual can make to minimise the chances of contracting a preventable chronic disease, injury or mental health problem/illness.

1.2.8 Describe criteria used to identify national health priority issues (NHPIs).

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

2.1 Groups experiencing health inequities.

There are six population groups who experience lower levels of health than the general population. To answer questions about these groups you should refer to the Australian Institute of Health and Welfare website for current statistics. You need to research Torres Strait Islander peoples and one other group experiencing inequalities in more detail.

2.1.1 An important step in improving the health of Australians is to identify health inequities within the population.

(a) Describe what is meant by health inequity.

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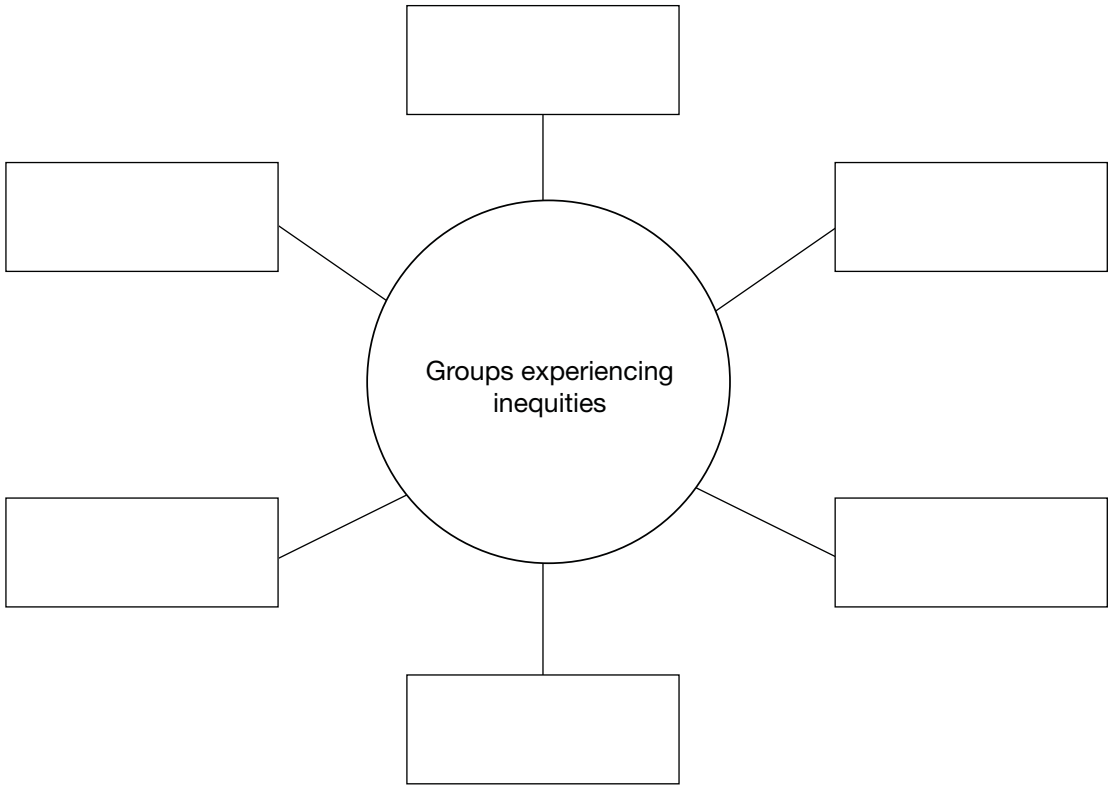
(b) Complete the mind map below to show the six population groups which experience lower levels of health than the general population.



2.1.2 Determinants of health can be classed as sociocultural, socioeconomic or environmental. Identify examples of each type.

(a) Sociocultural determinants.

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(b) Socioeconomic determinants.

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(c) Environmental determinants.

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2.1.3 Aboriginal and Torres Strait peoples make up about 2.5% of the total Australian population and they experience significantly more ill health than other Australians.

(a) Outline the current mortality and morbidity trends of Aboriginal and Torres Strait Islander (ATSI) peoples.

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(b) Identify sociocultural, socioeconomic and environmental determinants which have influenced the health of Aboriginal and Torres Strait Islander (ATSI) peoples.

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(c) Suggest strategies to deal with health inequities of Aboriginal and Torres Strait Islander peoples.

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2.1.4 There is a relationship between the socioeconomic status of individuals and their health.

(a) Identify types of data which can be used to define socioeconomic status.

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(b) Outline the current mortality and morbidity trends for socioeconomically disadvantaged people (those with low social economic status).

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(c) Outline factors that have influenced these trends.

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(d) Suggest strategies to tackle health inequities of socioeconomically disadvantaged people.

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2.1.5

(a) Outline the current mortality and morbidity trends of people living in rural and remote areas.

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(b) Identify factors that have influenced these trends.

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(c) Suggest strategies to deal with health inequities of people living in rural and remote areas.

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2.1.6

(a) Outline the current mortality and morbidity trends for overseas-born Australians.

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(b) Identify factors that have influenced these trends.

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(c) Suggest strategies to tackle health inequities of overseas-born Australians.

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2.1.7

(a) Outline the current mortality and morbidity trends of the elderly.

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(b) Identify factors that have influenced these trends.

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(c) Suggest strategies to deal with health inequities of the elderly.

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2.1.8

(a) Outline the current mortality and morbidity trends of people with disabilities.

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(b) Identify factors that have influenced these trends.

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(c) Suggest strategies to tackle health inequities of people with disabilities.

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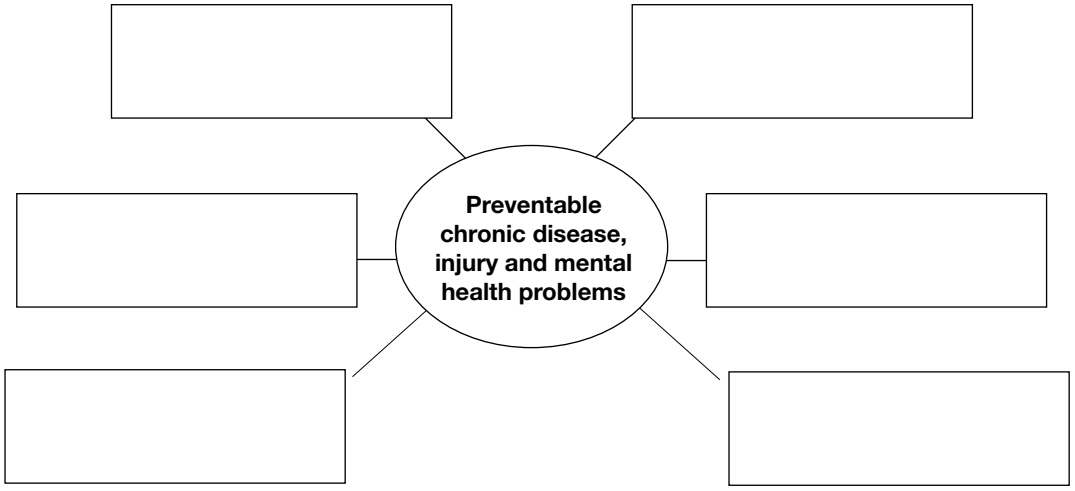
2.2 High levels of preventable chronic disease, injury and mental health problems.

2.2.1 Complete the following diagram to show the main preventable chronic disease, injury and mental health problems in Australia.



2.2.2 Cardiovascular disease (CVD) is a chronic but preventable health problem. It is one of the leading causes of sickness and death in Australia.

(a) Describe what is meant by cardiovascular disease.

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(b) Describe the extent of cardiovascular disease in Australia.

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2.2.3 For cardiovascular disease, describe the following factors.

(a) Modifiable risk factors and protective factors.

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(b) Non-modifiable risk factors.

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(c) Protective factors.

2.2.4 Use examples to show that determinants of cardiovascular disease can be sociocultural, socioeconomic and environmental.

(a) Sociocultural.

(b) Socioeconomic.

(c) Environmental.

2.2.5 Outline the actions an individual can take to reduce the chances of contracting cardiovascular disease.

2.2.6 Justify the inclusion of cardiovascular disease as a priority health issue for Australia.

2.2.7 Another health priority area is cancer. Complete the following table to summarise information about cancer.

Factor	Cancer
Nature of the problem	
Trends (the extent of the problem)	
Risk factors – for groups at risk from breast, lung and skin cancers	
Protective factors for breast, lung and skin cancer	
Determinants: Sociocultural Socioeconomic Environmental	
Reasons for inclusion of cancer as a national health priority issue (NHPI)	

2.2.8 Complete the table to summarise information about other national health priorities.

Factor	Nature of the problem	Incidence, trends and priority groups
Diabetes		
Respiratory disease (asthma and chronic obstructive pulmonary disease (COPD))		
Injury		
Mental health problems and illnesses		

2.2.9 Complete the following table to summarise information you have researched about ONE issue, other than cardiovascular disease and cancer, which is a national health priority. This issue could be diabetes, respiratory disease, injury OR mental health problems and illnesses.

Factor	Named health priority
Risk factors	
Protective factors	
Determinants: Sociocultural Socioeconomic Environmental	
Reasons for inclusion as a national health priority issue	

2.2.10 Explain reasons why the government and health authorities need to recognise the importance of social, economic and environmental determinants on the health status of an individual.

2.3 A growing and ageing population.

2.3.1 The table below shows changes over time in the proportion of different age groups making up the Australian population.

Australian population

Age range (years)	1970		2010	
	Millions of people	Percentage	Millions of people	Percentage
0-14	3.6	28.8	4.2	19.1
15-64	7.0	62.8	15.0	67.4
65-84	1.0	7.8	2.6	11.7
85 and over	0.1	0.5	0.4	1.8

(a) Identify two trends apparent in this data.

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(b) List possible problems that could arise with the development of an ageing population as illustrated by these figures.

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2.3.2 Outline what is meant by healthy ageing.

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2.3.3 Identify structures that support an individual's ability to maintain good health as they age.

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2.3.4 Examine the reasons for increasing numbers of people living with chronic disease and or disability.

2.3.5 Carers and volunteers make a substantial contribution to the care of the elderly in Australia. Discuss the potential limitations of relying on volunteers and carers to assist the elderly.

2.3.6 Examine the effects of an ageing population on health care services.

Notes

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

3.1 Health care in Australia.

3.1.1 Outline the role of the health care system in Australia.

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3.1.2 In Australia, health care facilities can be classified as providing either institutional or non-institutional care. Distinguish between institutional and non-institutional health care services.

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3.1.3 Examine the responsibilities of the commonwealth, state and local governments for health facilities and services.

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3.1.4 The principles of social justice require that all Australians should have equal access to affordable, high quality medical services.

Describe how the Pharmaceutical Benefits Scheme (PBS) and the PBS Safety Net reflect the ideology of social justice.

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3.1.5 There are claims of inequities in the Australian health care system for some sections of the community.

Discuss implications of such claims and explain how these inequities might impact on an individual's health status.

3.1.6 Compare the types of health care services likely to be accessed by a young person and an elderly person.

3.1.7 Compare the health care services provided to those who live in urban and rural areas.

3.1.8 What does the term advocacy mean in relation to heath promotion?

3.1.9 Explain what is meant by the following statement and justify your response.

'At present in Australian society we have a sickness system not a health care system.'

3.1.10 Explain why prevention is better than cure for both financial and social reasons.

3.1.11 Describe the support structures an individual can access for a degenerative disease.

3.1.12 Identify new treatments and technologies that have impacted on health care.

3.1.13 Medicare was introduced by the Australian government in 1984.

(a) What benefits does Medicare provide to Australians?

(b) Outline how Medicare is funded.

(c) Identify advantages of taking out private medical insurance.

3.1.15 Describe initiatives established by the Australian government to decrease the burden of public health care.

3.2 Complementary and alternative health care approaches.

3.2.1 There are many healing practices that do not fall within the area of conventional medicine. Complete the table with three examples of these alternative or complementary health care services or products.

Alternative/complementary services/products	Function of the service/product

3.2.2 Account for the growth of alternative and complementary medicines in Australia.

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3.2.3 Justify the inclusion of alternative medicines in private health care rebates.

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3.2.4 Explain why alternative/complementary medicine is often referred to as holistic medicine.

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3.2.5 Health care expenditure has been steadily increasing for a number of years.

(a) Account for the increasing financial burden on the Australian health care system.

(b) Outline a possible solution to the escalating problem of health care costs.

3.2.6 Outline the consumer skills an individual needs when selecting alternative medical services.

4. What actions are needed to tackle Australia's health priorities?

4.1 Health promotion based on the five action areas of the Ottawa Charter.

4.1.1 Outline the five main action areas of the Ottawa Charter.

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4.1.2 The Ottawa Charter was developed to help promote health worldwide.

(a) Outline the two main aims of health promotion.

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(b) Explain the potential limitations of health promotion in Australian society.

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4.1.3 The first principle of the Ottawa charter relates to empowering the individual. Explain what empowerment of the individual means and how it relates to health promotion.

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4.1.4 The Ottawa Charter recommended strengthening community action with regards to health. Compare the role of the community sector in the past with its role in recent times.

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4.1.5 Outline the reasoning behind health care professionals involving the individual and the community in health care decisions.

4.1.6 It has been said that, health care professionals and the government are solely responsible for an individual's health.

Discuss this statement using examples to illustrate your understanding.

4.1.7 The World Health Organisation (WHO) has recognised the importance of intersectoral action on health. Explain what is meant by intersectoral collaboration and provide an example.

4.1.8 Evaluate the effectiveness of one health promotion initiative for a national health priority area you have studied.

4.1.9 Explain why the Ottawa Charter was created.

4.1.10 It is said that health promotion based on the Ottawa Charter promotes social justice.

(a) Recall the principles of social justice.

(b) Is access to health care equitable for all groups in Australia? Explain.

(c) Recall population groups in Australia that do not experience social justice and show how this relates to their levels of health.

4.1.11 Since the application of the Ottawa Charter, individuals and communities have more power to contribute to public policy. What impact does this have on health services?

4.1.12 Analyse the significance of the five action areas of the Ottawa Charter for Australia's health priorities. Then show that all of these action areas play important roles in reducing the prevalence of one named Australian national priority area.

4.1.13 Show how Australia is tackling the identified priority health priority area of cardiovascular disease (CVD) by using health promotion initiatives related to the five action areas of the Ottawa Charter.

(a) Developing personal skills: Outline how modifying personal behaviours and accessing information can help reduce the prevalence of cardiovascular disease (CVD).

(b) Creating supportive environments: Identify personal support networks in workplaces, schools and where we live which can help reduce the prevalence of cardiovascular disease (CVD).

(c) Strengthening community action: Suggest community-based support networks that help reduce the prevalence of cardiovascular disease (CVD).

(d) Reorienting health services: Outline ways money and resources used on curative services has been redirected to prevention and promotion in order to help reduce the prevalence of cardiovascular disease.

(e) Building a public health policy: Recall legislation the government has implemented to reduce the prevalence of cardiovascular disease.

4.1.14 Show how Australia is tackling the identified priority health priority area of cancer by using health promotion initiatives based on the five action areas of the Ottawa Charter.

(a) Developing personal skills: Identify how modifying personal behaviours and accessing information can help reduce the prevalence of cancer.

(b) Creating supportive environments: Outline ways that identifying personal support networks in workplaces, schools and where we live can reduce the prevalence of cancer.

(c) Strengthening community action: Suggest community-based support activities that will reduce the prevalence of cancer.

(d) Reorienting health services: Recall the ways money and resources used on curative services has been redirected to prevention and promotion to reduce the prevalence of cancer.

(e) Building a public health policy: Identify legislation the government has implemented aimed at helping to reduce the prevalence of cancer.

4.1.15 Show how Australia is tackling the identified priority health priority area of diabetes by using health promotion initiatives based on the five action areas of the Ottawa Charter.

(a) Developing personal skills: Identify how modifying personal behaviour and accessing information can help reduce the prevalence of diabetes.

(b) Creating supportive environments: Recall how identifying personal support networks in workplaces, schools and where we live can help deal with diabetes.

(c) Strengthening community action: Suggest community-based support networks that could help with diabetes.

(d) Reorienting health services: Recall the ways money and resources used on curative services can be redirected to prevention and promotion to reduce the prevalence of diabetes.

(e) Building a public health policy: Identify legislation the government has implemented to reduce the prevalence of diabetes.

4.1.16 Show how Australia is tackling the identified priority health priority area of mental illness by using health promotion initiatives based on the five action areas of the Ottawa Charter.

(a) Developing personal skills: Identify how modifying personal behaviours and accessing information can help reduce the prevalence of mental illness.

(b) Creating supportive environments: Suggest how identifying personal support networks in workplaces, schools and where we live can reduce the prevalence of mental illness.

(c) Strengthening community action: Recall community-based support networks that will reduce the prevalence of mental illness.

(d) Reorienting health services: Identify how money and resources used on curative services can be redirected to prevention and promotion to reduce the prevalence of mental illness.

(e) Building a public health policy: Identify legislation the government has implemented to reduce the prevalence of mental illness.

4.1.17 Show how Australia is tackling the identified priority health priority area of respiratory disease by using health promotion initiatives based on the five action areas of the Ottawa Charter.

(a) Developing personal skills: Suggest ways that modifying personal behaviours and accessing information can help in the prevention and management of chronic respiratory disease.

(b) Creating supportive environments: Explain how identifying personal support networks in workplaces, schools and where we live can reduce the prevalence of a respiratory disease such as asthma.

(c) Strengthening community action: Identify community-based support networks that will reduce the prevalence of a respiratory disease such as asthma.

(d) Reorienting health services: Outline the ways money and resources used on curative services can be redirected to prevention and promotion to reduce the prevalence of a respiratory disease such as asthma.

(e) Building a public health policy: Recall the legislation the government has implemented to reduce the prevalence of a respiratory disease such as asthma.

4.1.18 Show how Australia is tackling the identified priority health priority area of injuries by using health promotion initiatives based on the five action areas of the Ottawa Charter.

(a) Developing personal skills: Suggest how modifying personal behaviours and accessing information can help reduce the prevalence of injuries in the community.

(b) Creating supportive environments: Outline ways that identifying personal support networks in workplaces, schools and where we live can reduce the prevalence of injuries.

(c) Strengthening community action: Recall community-based support networks that will reduce the prevalence of injury.

(d) Reorienting health services: Describe how money and resources used on curative services can be redirected to prevention and promotion to reduce the prevalence of injury.

(e) Building public health policy: Describe how government implementation of legislation has helped to reduce the prevalence of injury in the population.

4.1.19 You have studied two health promotion initiatives related to Australia's health priorities. For one of those initiatives, answer the following questions.

(a) Identify the initiative.

(b) Outline the five action areas of the Ottawa Charter.

(c) Describe how each of the five action areas of the Ottawa Charter has been important in the development or application of this initiative.

(d) Analyse the impact of this initiative on one of Australia's named health priority areas.

Notes

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Answers

Notes

1.1.1 (a) Epidemiology is the study of patterns (distribution and frequency) of health and disease across a population. It involves collecting, verifying and analysing data on a population.

(b) Epidemiological data comes from many sources, e.g. hospitals, doctors and other health professionals, public and private health insurance providers and health surveys as well as government statistics on information such as births and deaths.

1.1.2 Epidemiological data is used by governments, in conjunction with health professionals, to target specific health trends within particular groups or populations. It is used to develop policies and strategies aimed at promoting health of individuals within the population.

1.1.3 The types of information provided by the data include: births, cause of death, disease incidence and prevalence, frequency and duration of contact with health providers, e.g. doctors, hospital usage (types of treatment and reason for admission), money spent on health care and days absent from work.

1.1.4 The limitations of epidemiological data include:

- lack of reliability of data (e.g. if sources are varied and numerous, or an imprecise method of collection is used)
- poor comprehension of surveys by some individuals
- non-standardised questioning in some surveys
- data may not be complete and thus not give a full picture of health problems within a population
- data can show correlations, but a correlation does not prove a causal relationship.

1.1.5 Epidemiological data can be used to identify and promote behaviours and strategies which will help to:

- control and prevent disease
- identify health care needs and allocate resources
- describe and compare patterns of health in groups or populations
- allow health professionals and governments to establish health priorities.

1.1.6 (a) Morbidity is the degree of illness and injury in a given population. Injury and sickness which does not lead to death can still reduce quality of life on a temporary or permanent basis.

(b) Mortality is the number of deaths in a given population from a particular cause in a given time period, usually one year.

(c) Life expectancy refers to the average number of years a person can expect to live at any given age (often given as life expectancy at birth). Life expectancy is based on current death rates.

1.1.7 Mortality rates (death rates) are available for all known causes of death and can be an excellent tool in establishing inequities across groups and even countries. Standardised mortality rates allow comparisons to be drawn across different diseases or causes of death such as malignant neoplasm, cardiovascular disease and injury. Infant mortality is an often used health status indicator as it draws upon many contributing factors, such as technology, neonatal and postnatal care, available access to care, socioeconomic status, and isolation. It is a good indicator of health status as it takes into account many political and social influences.

Morbidity rates are also excellent indicators of social and political influences – reflecting attitudes to workplace safety, environmental safety, recreational and even home safety. Rates of road or pedestrian injuries, workplace injuries and sporting injuries can illustrate policy and place a personal emphasis on prevention or treatment. Morbidity information provides information about conditions which, while not resulting in death, can still reduce quality of life of many people within the community.

1.1.8 The prevalence of a disease is the number of existing cases of a disease in a population at a given time.

The incidence of a disease refers to the number of new cases of a disease arising in a population over a given time period.

1.1.9 (a) The lower graph line shows that life expectancy at birth is greater now than ever before. People are living longer. Life expectancy at birth increased from 57 years in 1907 to 81 years in 2007. The graph shows an initial rapid increase, a plateau in the 1960s (death from cardiovascular disease and lung cancer increased) and then another rapid increase.

The upper graph line shows that life expectancy for those already aged 65 years has increased slightly, from 77 years in 1907 to 84 years in 2007.

Another trend is the decrease in the discrepancy between life expectancy at birth and at 65 years.

(b) The upper graph line shows that once people survive childhood, life expectancy increases. In 1907, the main causes of death were infant mortality and infectious diseases. If you survived childhood your chances of living a relatively long life were very good. In 1907, life expectancy was only 57 years for anyone born in that year. For those who had already lived to 65 years, the life expectancy was about 77 years.

In 2007, the major causes of death were cardiovascular diseases, stroke and cancers. The life expectancy for anyone born that year had risen to 81 years, those who had already reached 65 years were likely to survive until about 84 years.

1.1.10 Reasons for the increase in Australia's life expectancy during the first half of the 20th century include the following.

- Improvements in living conditions, e.g. cleaner water, better sewerage systems, improved housing.
- Mass immunisation leading to fewer deaths from infectious diseases particularly a rapid decline in infant death in the first half of the 20th century.

In the latter half of the 20th century the major cause of death changed from infant mortality to cardiovascular disease. The life expectancy decreased during this period due to the following factors.

- Healthier lifestyles and living conditions.
- Lower death rates from infant mortality, cardiovascular disease, cancer and traffic accidents.
- Increased levels of education and thus public awareness of health risks, e.g. smoking and lung cancer, sunlight and melanoma.
- Increasing levels of disease prevention and screening.
- Improvements in technology and research leading to medical advances in diagnosis and treatment of disease, e.g. antibiotics and other drugs, scans and surgical techniques.
- Improvements in management of health and aged care.

1.1.11 (a) Women (83.7 years) live longer than men (79.0 years) in Australia.

(b) Australia has one of the highest life expectancies of the countries listed. In the data provided, we have the third highest life expectancy for both men (behind Iceland and Japan) and women (behind Japan and France).

Australia is high on this list because of factors such as our socioeconomic conditions; good quality of health care; high standard of living; good education; low infant mortality rates; and our programs for prevention, screening and treatment of diseases.

1.1.12 The leading cause of death for both men and women in Australia, in 2007, was coronary heart disease. This accounted for 17.2% of male deaths and 15.8% of deaths for women.

For women, the other major causes of death, were stroke (cerebrovascular disease – 10.4%), dementia and Alzheimer's disease (7.3%); lung cancer (4.3%) and breast cancer (4.0%).

For men, the other major causes of death were lung cancer (6.7%); stroke (cerebrovascular disease – 6.4%); chronic obstructive pulmonary disease, e.g. asthma (4.2%) and prostate cancer (4.2%).

These top five causes of death account for about 40% of all deaths. Circulatory diseases (heart disease, stroke and pulmonary disease) are important causes of death for both sexes, as is cancer. For men lung cancer is slightly more common, and the incidence of prostate cancer in men is similar to the instance of breast cancer in women. Dementia and Alzheimer's disease is a bigger killer for women than for men.

1.1.13 (a) Overall death rate has declined over the last 10 years, however from 2005 to 2008 it remained stable. The death rate for men has remained consistently higher for men than for women, although the gap is decreasing.

(b) Over the last 10 years there has been a decrease in deaths from cardiovascular disease, stroke and cancer. In the same period there has been an increase in deaths from dementia and Alzheimer's disease.

1.2.1 (a) Resources are limited. All health issues are important, but it is not possible to fund every suggested initiative designed to improve the health of a population, so it is essential to prioritise.

(b) Five criteria for identifying priority health issues are:

- principles of social justice
- priority population groups
- prevalence of conditions
- the potential for prevention and early intervention
- costs to the individual and the community.

1.2.2 Social justice is the principle of treating everyone equally regardless of such factors as race, religion, socioeconomic level and gender. This means that everyone should receive the same quality health services, clean water supply and sanitation. It may involve supporting disadvantaged groups to a greater degree than others so that they may reach health equal to that of the general population.

1.2.3 (a) Supportive environments means that the social, political and environmental conditions should help the individual or community to achieve optimal health.

(b) Equity means the distribution of resources to ensure that all individuals/groups achieve healthy outcomes (some groups may need greater resources than others). It involves creating equal opportunities for all people to achieve health.

(c) Diversity is recognising the cultural, religious and other differences of all groups in society so that they may be allocated resources to achieve optimal health outcomes.

1.2.4 Prevalence of a condition refers to how common a health issue is at a particular time. Prevalence of a condition is indicated by the number of cases of morbidity for a particular disease or health issue within a given population at a specific time.

Determining the current health status allows the identification of risk factors and an understanding of the overall burden of the health issue on the community. With this knowledge, the government, health professionals and communities can allocate resources to decrease the economic and social burden on society.

1.2.5 Potential costs to the individual can be monetary, psychological and physiological. Monetary costs include costs for health care services and loss of income. Psychological costs can include emotional distress and depression. Physiological costs can include loss of quality of life and even death. Family and friendships may suffer or even break down due to any or all of the other costs.

1.2.6 Potential costs to the community can be both direct and indirect. Direct costs include money spent on health care services such as treatment, diagnosis, rehabilitation, research, prescriptions and education. Indirect costs include days off work which may affect both the employer and other employees; and the effect of the individual's behaviour on other people.

1.2.7 (a) Preventing a disease, or attacking it in the early stages can lessen its overall impact upon society. The financial burden on both the individual and community (diagnosis, treatment and rehabilitation) is reduced, together with the social impact (pain, suffering and anxiety). Resources are needed to prevent diseases and also for early intervention, but these will be less than if the disease is allowed to take hold and spread through the community.

(b) The majority of Australia's health problems can be attributed to poor lifestyle choices. Therefore if individuals modify their behaviour by making healthy lifestyle choices they can decrease their chances of contracting a disease or becoming a casualty of unsafe behaviour. Prevention and early intervention could provide significant improvements in health. However, this is often difficult to achieve without environmental changes and outside support.

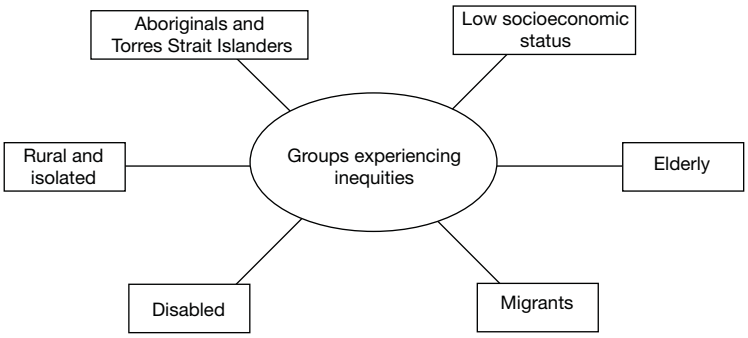
(c) People have potential for change. An individual can make sound health choices regarding nutrition, exercise and drug-taking, have regular health check-ups, avoid exposure to carcinogens, take safety precautions whenever possible and modify any lifestyle behaviours that are detrimental to health.

1.2.8 The criteria used to identify national health priority issues (NHPI) include the following.

- Prevalence of the condition means the current levels of morbidity and mortality and the current trends of these factors.
- Cost to the individual and cost to the community are costs experienced by these groups due to ill health. They can be measured in monetary and social terms.
- Priority populations are the specific population groups that exhibit higher levels of the priority issue than the general population.
- Potential for prevention and early intervention means the lifestyle behaviours that can be modified by the individual to decrease the likelihood of contracting the NHPI.
- Social justice includes the three factors of supportive environments, diversity and equity, so that individuals have equal opportunities to improve their health status.

2.1.1 (a) Health inequity occurs when individuals or communities experience relatively high levels of a disease, or other health issue, due to circumstances which are quite often beyond their control. For example, some groups have shorter life expectancies, poor access to health services, higher levels of avoidable risk factors and/or reduced ability to make healthy life style choices.

(b)



2.1.2 (a) Sociocultural determinants of health include peers, family, media, culture and religion.

(b) Socioeconomic determinants of health include employment, education and income.

(c) Environmental determinants of health include geographic location and access to health services and resources.

2.1.3 (a) Aboriginal and Torres Strait Islander peoples have lower life expectancy than non-indigenous Australians. Indigenous males live 18.7 years less than non-indigenous males whilst females live 18.2 years less than non-indigenous females. Infant mortality is also four times the national average. Indigenous people experience higher morbidity rates for cardiovascular disease, cancer, motor vehicle accidents, homicide, suicide, respiratory diseases, eye and ear diseases, and nutritional diseases such as diabetes.

(b) Sociocultural determinants – effects of past practices such as removing these people from their land; cultural dislocation; and family separation (including forced separations).

Socioeconomic determinants – education, employment and income. Aboriginal and Torres Strait Islander peoples generally experience relatively low socioeconomic status which is reflected in low incomes, high unemployment and low educational levels reached, higher levels of unemployment, poor quality and overcrowded housing, greater levels of drug-taking (smoking and drinking), poor diets (high in saturated fats and low in nutrients) and greater exposure to violence.

Environmental determinants – geographic isolation and the problems associated with living in remote locations; their physical environment including housing, water supply and sanitation available; protection from environmental threats, e.g. pests and climate extremes.

(c) Individuals, communities and governments all need to tackle the health inequities of Aboriginal and Torres Strait Islander peoples. Possible strategies include:

- Increase the level of education and awareness of health issues and healthy lifestyle practices through prevention and health promotion initiatives, e.g. improving nutrition and reducing chronic disease risk factors.
- Cultural awareness and reconciliation programs.
- Increase the funding for health care services and facilities.

2.1.4 (a) Socioeconomic status is based on levels of income, education, employment and housing.

(b) People from lower socioeconomic status have higher levels of morbidity and mortality than the general population. This applies across all age groups and for both men and women. Infant mortality is also higher than the general population figures.

(c) Influencing factors include: lower levels of education (therefore less informed); higher levels of unemployment and lower incomes (cannot afford health services or other basic necessities); greater levels of drug-taking (more smoking and drinking); and poor diets (high in saturated fats and lacking in nutrients). People from lower socioeconomic status backgrounds also tend to make less use of preventive health services (health check-ups, diagnostic services, immunisation).

(d) Various, e.g.

- Increase the level of education and awareness of health issues and healthy lifestyle practices through prevention and health promotion initiative.
- Correct the imbalance in access to health services by increasing the funding for health care services and facilities in disadvantaged areas.

2.1.5 (a) People from rural and isolated areas generally have higher levels of mortality and morbidity from injury, suicide, and mental health problems than the general population.

(b) Factors that have influenced these trends include feelings of isolation and depression leading to mental health problems and suicide. The occurrence of severe weather events such as drought and flooding has been a significant contributing factor. Geographic isolation and insufficient health professionals in rural areas also negatively affect morbidity and mortality rates. Manual labour and exposure to heavy machinery can result in higher levels of injury.

(c) Possible ways to alleviate the inequities for people living in rural and remote areas include:

- Increasing promotional initiatives, aimed at mental health and suicide prevention, which can also help alleviate the depression and anxiety.
- Establishing more support networks and counselling services, such as the Community Health Adolescent Murray Lands Peer Support (CHAMPS).
- Incentives from government and from the local community may attract health professionals to the area and improve availability of services.
- Greater safety education and improved technology may reduce the current level of physical injuries.

2.1.6 (a) Australians born overseas generally have higher health levels than the general Australian population, with lower death rates and hospitalisation rates. However, some groups have higher death rates from specific causes, e.g. lung cancer in people from the United Kingdom.

(b) Higher health levels of people born overseas can be attributed to the stringent selection criteria for entry into Australia. However, the longer these people stay in Australia the more likely they are to adopt poor lifestyle behaviour such as increases in smoking and drinking, greater exposure to the sun (UV rays) and less healthy dietary choices (processed foods high in fats and sugars). Migrants commonly adopt the practices of a new country in order to assimilate and integrate.

(c) Possible strategies include:

- Increasing awareness and education through prevention and promotion initiatives such as the NSW Multicultural Health Week which focuses on multicultural community health. This may lead to informed decision making (in regards to healthy lifestyle behaviour).
- If language barriers are apparent, the provision of material written in a range of languages may help to alleviate potential confusion caused by communication breakdown.

2.1.7 (a) Elderly people generally have higher levels of mortality from cardiovascular disease, injury, suicide, and mental health problems than the general population. They also generally have higher levels of morbidity from injury, e.g. accidental falls, and mental health problems than the general population. Significant health conditions include arthritis, hypertension and dementia.

(b) Factors influencing these trends may include the following.

- Insufficient health subsidies for eyewear or hearing aids and devices.
- Poor upkeep of pathways, guttering and stairs (leading to increased injury).
- Insufficient take-up of immunisation programs such as the flu vaccine.

(c) Possible ways to alleviate the inequities include the following.

- Increasing initiatives, aimed at mental health and suicide prevention, to help alleviate depression and anxiety.
- Implementing more support networks and counselling services, e.g. physical activity and social networking groups.
- Safety education and improved technology to reduce injury levels.
- Increased home-care services.

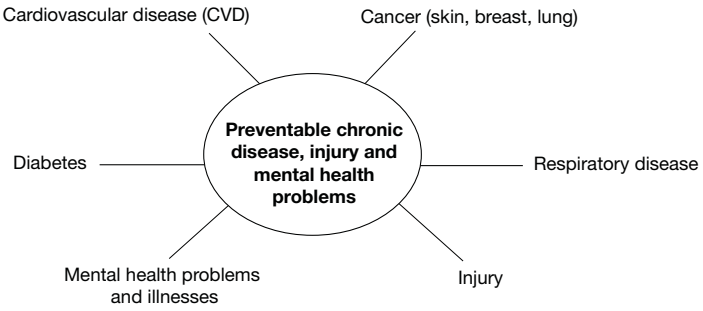
2.1.8 (a) People with disabilities generally have higher levels of mortality and morbidity than the general population.

(b) Factors primarily responsible for diseases or injuries that cause disabilities include musculoskeletal disorders, arthritis, hearing loss and mental disorders.

(c) Possible ways to alleviate the inequities include the following.

- Increasing promotional initiatives to improve the general public's awareness of the impact of disabilities upon the individual.
- Greater funding to research the causes of disabilities and possible ways to alleviate their impact on people's lives.
- Implementing more support networks and counselling services for those with mental disabilities.
- Increased home medical services to allow disabled with limited mobility increased access to care.

2.2.1



2.2.2 (a) Cardiovascular disease **(**CVD) is a degenerative disease that affects the heart and blood vessels of the circulatory system. It includes coronary heart disease (blockage of the coronary arteries which supply blood to the heart walls), peripheral vascular disease (disease of blood vessels) and stroke (interruption of blood supply to brain cells). The cause of most cardiovascular disease is atherosclerosis, the formation of plaques of fatty tissue on the inside walls of blood vessels.

(b) In Australia, CVD is the leading cause of death and sickness, and is responsible for 32% of all deaths. At present the incidence of CVD, morbidity and mortality are decreasing.

2.2.3 (a) The modifiable risk factors for cardiovascular disease (CVD) are smoking, raised blood fats (caused by a diet high in saturated fats and raised cholesterol levels), hypertension, obesity and physical inactivity.

(b) The non-modifiable risk factors that an individual has no control over are family history, gender (males have a higher incidence than females), and age (as an individual becomes older, the chance of contracting CVD increases).

(c) Protective factors include:

- avoiding exposure to tobacco smoke
- regular physical activity
- a diet low in cholesterol, salt and alcohol
- maintaining a healthy weight
- recognising history of heart disease in the family and modifying diet and exercise regimes accordingly
- monitoring of blood pressure and cholesterol levels and making any necessary adjustments
- decreasing stress levels wherever possible
- being proactive to early signs or symptoms of the disease.

2.2.4 (a) Sociocultural determinants: Changes in cultural values can affect the incidence of cardiovascular disease (CVD). For example, media campaigns have helped to change attitudes to smoking, making it less acceptable to society and a reduction in smoking has helped to bring about a decrease in the incidence of CVD. People at higher risk of CVD include those with a family history of the disease, those with a lower socioeconomic status, Asians and also Aboriginal and Torres Strait Islander peoples.

(b) Socioeconomic determinants: People with lower socioeconomic status tend to have lower income so they are less able to afford healthy food; with less education, they may also be unaware of the value of good health choices and how to access health services.

(c) Environmental determinants: People living in rural and remote areas may have less access than city dwellers to doctors, medical services and technology, e.g. electrocardiograms (ECG). In a medical emergency it takes them longer to receive help as they may have to travel long distances.

2.2.5 Various, e.g.

- Eat in moderation, monitoring to maintain a well-balanced diet, low level of saturated fats and salt.
- Maintain a healthy weight.
- Avoid smoking and exposure to tobacco smoke.
- Regular physical aerobic exercise.
- Manage stress.
- Have regular health checks (cholesterol levels, blood pressure, circulatory checks).

2.2.6 Cardiovascular disease satisfies all the criteria of a national health priority issue.

- CVD is the most prevalent in terms of both mortality and morbidity statistics.
- Most predisposing factors causing CVD are modifiable; therefore the individual has the potential to change these behaviours.
- CVD is overrepresented in certain population groups and these people quite often do not experience the same levels of social justice that they are due.
- CVD costs both individuals and the community a disproportionate amount of money and resources, thus putting a burden on all areas of society.

Factor	Cancer
Nature of the problem	Cancer refers to a group of diseases that cause uncontrolled cell growth and spread abnormal cells, thus producing tumours. Tumours can be benign or malignant. Benign tumours are usually slow-growing and generally stay localised within a capsule that limits their spread. Malignant tumours are fast-growing and can spread to invade surrounding tissue or spread to other parts of the body.
Trends (the extent of the problem)	Cancer affects 1 in 4 females and 1 in 3 males by the age of 75. Cancer is more common in men than in women, except between the ages of 25 and 54 where the incidence is higher in women than in men. Cancer is a major cause of death, with lung cancer being the most common cause and the rate decreasing for men and increasing for women. Cancer mortality rates are decreasing due to improvements in early detection and treatment. Cancer morbidity is increasing in both males and females. The most common cancers in females are breast cancer, melanoma, lung and colorectal cancers. The most common cancers in males are prostate, colorectal, melanoma and lung cancer.
Risk factors – for groups at risk from breast, lung and skin cancers	**Modifiable risk factors** are exposure to carcinogens such as cigarette smoke, UV-rays and industrial chemicals, poor diets that are high in fat and low in fibre, excessive alcohol consumption, obesity and lack of exercise, multiple sexual partners, and early age for first sexual intercourse. **Non-modifiable risk factors** are gender, age, family history and fair skin colour. Risk cancers are specific to the type of cancer. **Breast cancer** – highest risk is for women who are obese; have never given birth; are over 50 years old; have a family history of breast cancer; started menstruating early; and had late menopause. **Lung cancer** – highest risk is for cigarette smokers; those exposed to dangerous chemicals, e.g. asbestos; those over 50 years old. **Skin cancer** – highest risk is for those with fair skin; those experiencing intermittent sun exposure without protective clothing; young people; those living in areas with high hours of sunlight, at lower latitudes.
Protective factors for breast, lung and skin cancers	**Breast cancer:** • Eat a balanced diet high in fruit and vegetables and low in fats. • Self-examination of body areas, e.g. breasts, and be aware of signs and symptoms. • Regular mammograms after 50 years. **Lung cancer:** • Avoid smoking and exposure to tobacco smoke. • Avoid hazardous chemicals, e.g. asbestos. **Skin cancer:** • Reduce sun exposure (hat, protective clothing, sunglasses). • Monitor all skin or mole changes. • Have regular health checks by a doctor.
Determinants: Sociocultural Socioeconomic Environmental	**Sociocultural** – Cultural background is important, e.g. higher incidence of lung cancer in Aboriginal and Torres Strait Islander peoples. Increased risk with a family history of cancer. Cultural values and attitudes can be important, e.g. if friends and family support reducing sun exposure to protect against skin cancer or promote sun bathing. **Socioeconomic** – Income, occupation, education, wealth, employment can all affect cancer rates. People with lower socioeconomic status have higher rates of cancer. Occupations with exposure to carcinogens, e.g. asbestos are more at risk. Low education levels are linked to poor choices and less access to health services. **Environmental** – Exposure to UV radiation, tobacco smoke, toxins in the workplace, home or environment will increase the risk of developing cancer. Those living in rural and remote areas have less access to screening and other health services.
Reasons for inclusion as a national health priority issue (NHPI)	Cancer satisfies all the criteria: • Cancer has the second largest prevalence for both mortality and morbidity statistics. • Many predisposing factors causing cancer are modifiable, and the individual has the potential to change these behaviours. • Cancer is overrepresented in certain population groups and these people quite often do not experience the same levels of social justice. • Cancer costs both individuals and the community a disproportionate amount of money and resources thus putting a burden on all areas of society.

2.2.8

Factor	Nature of the problem	Incidence, trends and priority groups
Diabetes	Diabetes is a disease that affects the pancreas, the organ that regulates the production of insulin. If insulin production is compromised, this affects blood glucose levels; and glucose cannot be used by cells for energy, leading to fatigue. There are three types of diabetes: type 1, type 2 and gestational. Type 2 diabetes is most common.	Mortality rate due to diabetes is stable. It increases with age. Morbidity is increasing - the incidence and prevalence of diabetes (type 2 specifically) has increased in the past 20 years. Priority populations – elderly, obese and ATSI peoples.
Respiratory disease (asthma and chronic obstructive pulmonary disease (COPD))	Asthma is a chronic disease causing episodes of wheezing, chest tightness and shortness of breath due to narrowing of the trachea and the airways within the lungs and obstruction to airflow. The underlying problem is usually inflammation of the air passages, which tend to overreact by narrowing too often and too much in response to a wide range of triggers. The symptoms of asthma are variable and usually reversible, either spontaneously or with treatment.	Decreasing mortality and morbidity. Priority populations – asthma: 0-15 years; COPD – elderly.
Injury	Injury is a major cause of preventable morbidity and mortality in Australia and a major cause of hospitalisation. Affects all age groups and is one of the leading causes of potential years of life lost. A huge economic and social burden with absenteeism, loss of productivity, huge medical and rehabilitative costs and time. Has a wide-reaching effect – industrial, home, workplace, school, sport-related injuries. Motor vehicle injuries have continued to rise, particularly in the 25-44 year-old age bracket. Motor vehicle deaths and morbidity still a huge concern.	Decreasing mortality and morbidity overall although death rates from intentional injury are increasing. Injury is a major cause of mortality and morbidity for males aged 1-44 years. Priority populations rural, blue collar workers, teenagers, male youth.
Mental health problems and illnesses	Mental health disorders have perhaps the greatest range of any of the major health issues in Australia. In terms of severity, mental health can involve issues such as depression and dealing with anxiety all the way to clinical depression, bipolar disorder, schizophrenia and many different stress disorders. When it comes to the cost to the community, mental health has perhaps the greatest single impact, as loss of productivity, stress and sick leave are all related to this major problem. Also, mental health has a significant link to other major health priorities and is recognised as an important determinant in many stress-related disorders within families and communities.	Increasing morbidity and decreasing mortality. Priority populations – young males 15-25 years, elderly.

2.2.9 Various, e.g. diabetes.

Factor	Diabetes (or the health issue you researched)
Risk factors	Type 1 – Genetics and possibly a viral infection when young. Type 2 – (age-onset diabetes) Genetic predisposition, family history, ethnicity, e.g. ATSI peoples, Pacific islanders and Chinese have a greater risk. Develops with age. A diet high in refined sugars, saturated fats and excessive alcohol intake. Lack of exercise. Obesity. High blood pressure. Smoking cigarettes. Non-modifiable risk factors are family history, age, cultural background, and pregnancy. Modifiable risk factors include diet and lifestyle choices.
Protective factors	Type 1 diabetes – cannot be prevented, but a healthy life style assists in its management. Actions to reduce chances of contracting diabetes: There are a number of precautions and positive health choices an individual can make to decrease the chances of contracting diabetes, e.g. • monitor the diet by decreasing the level of saturated fats and sugars • eat a well-balanced diet in moderation • moderate alcohol intake. • regular physical activity • have regular health checks (blood glucose levels).
Determinants Sociocultural Socioeconomic Environmental	**Sociocultural** – Cultural background, e.g. Aboriginal and Torres Strait Islander peoples are at higher risk of type 2 diabetes. Pacific island, Indian or Chinese cultural background increases the risk of diabetes. Family history is the main risk for type 1 diabetes. Social acceptance of risk factors, e.g. high alcohol consumption. The population is ageing so the incidence of diabetes is increasing. **Socioeconomic** – Low socioeconomic status and the associated poor lifestyle choices increases the risk of type 2 diabetes.These people are more likely to consume more alcohol, and a diet high in fats and sugar, and have a less active lifestyle. **Environmentlal** – Geographic isolation can make detection and treatment difficult. Greater access to technology can lead to a more sedentary lifestyle.
Reasons for inclusion as a national health priority issue	Diabetes satisfies all the criteria that a national health priority issue must exhibit. • Diabetes has the third largest prevalence for both mortality and morbidity statistics. • The majority of predisposing factors that cause diabetes are modifiable, therefore the individual has the potential to change these behaviours. • Diabetes is overrepresented in certain population groups and these people quite often do not experience the same levels of social justice as the rest of the population. • Diabetes costs both individuals and the community a disproportionate amount of money and resources therefore putting a burden on all areas of society.

2.2.10 The government and health authorities have to recognise the importance of social determinants because they play an integral role in the health status of individuals. Social determinants reflect the social environment and quality of life in which an individual exists. If the government is willing to challenge these inequities, health status can be greatly improved.

Education levels of many Australians are considerably limited, which means that many lifestyle choices may be made without sound knowledge of the consequences. For example, choosing foods that are high in saturated fats can ultimately lead to high blood cholesterol levels and possibly cardiovascular disease.

Socioeconomic status can also impact upon an individual's health status as it may be difficult or impossible to afford private medical insurance, therefore making services such as diagnostic and ancillary treatments out of reach for many. Statistics show that people from lower socioeconomic status are more likely to engage in risk-taking behaviours such as drug abuse, namely smoking and drinking.

An individual's occupation can negatively impact upon health. For example, many blue collar workers are exposed to carcinogens (chemicals such as asbestos) as well as heavy machinery that has the potential to cause fatal injuries. Also, office workers have sedentary occupations that can lead to obesity and high blood pressure, which are causal factors for cardiovascular disease and diabetes.

Unemployment and low-income employment both have a negative effect on the psychological and physical welfare of the individual and family unit. Lack of disposable income can mean basic needs such as food, clothing and accommodation are unable to be obtained. Mental health issues associated with unemployment include lack of self-esteem, depression, and a higher prevalence of suicide.

Ethnicity affects the health status of individuals. The longer the residency, the greater the impact of the Australian culture on the lifestyle choices of those born overseas. This can be seen by changes in diet, for example, eating fast foods that are high in saturated fats and processed sugars, thus leading to higher rates of cardiovascular disease and colorectal cancer. Changes to lifestyle also occur, e.g. increased exposure to the sun leading to skin cancer.

An individual's gender can have an impact upon life expectancy, obesity, disease and injury. Males are more likely to take risks, work in hazardous occupations, and ignore health problems leading to greater morbidity and premature mortality. Women have gender-specific risks such as ovarian cancer and complications associated with childbirth.

Age directly impacts on the individual's health status. As people becomes older they are more likely to develop chronic degenerative diseases such as cardiovascular disease, cancer and diabetes. Older women are more likely to develop osteoporosis and suffer more fractures as a result of this.

Geographic location directly affects an individual's ability to access health services and information. For example, those in remote areas of Australia have reduced access to health services and are often less healthy.

If government and health officials work together, they can tackle these determinants by focusing on preventive and promotional initiatives that can help overcome inequities.

2.3.1 (a) Various, e.g.

- The Australian population has increased from 12.5 million in 1970 to 22.2 million in 2010.
- The percentage of the population aged 0-15 years has decreased from 28.8% to 19.1%.
- The percentage of the population aged 65-84 and over has increased from 7.8% to 11.7%.

(b) Various, e.g.

- Increasing numbers of people in the population with chronic diseases and disabilities as life expectancy increases.
- Fewer people in the workforce to support dependent young and old people.
- Greater demand on health facilities and nursing homes.
- A shortage of carers.

2.3.2 Healthy ageing is where individuals take a proactive approach to their health as they get older, maintaining a better quality of life while ageing. This involves engaging in both physical exercise and mental stimulation; being involved in social interactions regularly; and having regular medical check-ups. These activities reduce the risk of illness and disease and improve physical, mental and emotional health during the ageing process, so that individuals can be productive members of the community for longer.

2.3.3 The support structures available to an individual to maintain good health include government agencies, community groups and non-government organisations. These structures provide settings, services and resources so that individuals can optimise their level of health. The government structures legislation (e.g. no smoking areas), and allocates funding for home nursing, state-run hospitals, bulk-billing and PBS (Pharmaceutical Benefits Scheme) subsidised health care services.

Non-profit groups include National Heart Foundation and the NSW Cancer Council, which both provide a multitude of health services to individuals.

Community groups include Meal on Wheels (who distribute free meals to the elderly), Ways (who provide mental health support/counselling) and other organisations who provide more specific services targeting need within the local community. Local clubs also provide facilities for classes and interest group meetings.

2.3.4 The number of people living with chronic disease and disability is increasing because of improvements in technology and medical care which enable people to live longer. Often people who would have previously died from an accident or a disease (e.g. cancer, stroke and heart attack), may now survive but live in constant pain or with a disability. For example, a person who might previously have died from injury sustained in a motor vehicle accident, or as the result of a stroke, may now survive but be confined to a wheelchair.

2.3.5 Limitations of relying on carers and volunteers include the following.

- Volunteers are not reportable to an employer so consequently people can be left in distress waiting for a person to assist them.
- The qualifications and the integrity of these people may be questionable, depending on the criteria used to engage their services.
- Carers and volunteers are ageing along with the rest of the population, so the number available to help others is decreasing. This will impact on the elderly people who wish to stay in their own home and need support in order to do so.

2.3.6 At present there is an escalating health budget and as the ageing population continues to grow, a greater degree of pressure is being placed on health care services, particularly ones that are used by the elderly. An ageing population will put an enormous strain on health care services as ageing increases the likelihood of deterioration of health and greater susceptibility to disease. Consequently elderly people access a greater percentage of health care services than the general population. The types of services affected may include: admission to hospitals, diagnostic equipment, prescriptions, transportation (ambulances) and palliative care.

If the government places more money into creating more services this money must be taken from other areas, which can impact other individuals. This becomes a supply and demand equation with infinite wants and limited resources, which can lead to a decrease in quality of health care provided.

3.1.1 The primary role of the health care system in Australia is to provide quality health care services and facilities to meet the needs of all Australians. The fundamental roles are diagnosis, treatment, rehabilitation and care for people with illness or injury.

3.1.2 Institutional services include those services undertaken within public and private hospitals, psychiatric hospitals and nursing homes.

Non-institutional services are medical services provided by health practitioners including general practitioners, pharmaceutical services, and community services such as those providing food and shelter for the homeless, health promotion programs and medical devices. These mostly occur outside the walls of institutions but may be linked through funding and even staffing.

3.1.3 Australia's health care system is a three-tiered system.

The federal government is responsible for planning national health policies, collecting taxes to fund the health system, guiding state health policy, allocating money for special projects and promotions, as well as maintaining standards of health. Major funds are contributed towards high level residential care, public hospitals, medical services and health research.

The state and territory governments are responsible for planning and delivering specific health promotions and disease prevention and treatment. They allocate money towards public hospitals, dental and family health services; health programs, e.g. rehabilitation, mental and women's health; home and community care; and the inspection and licensing of institutions and personnel.

Local governments are given specific health roles by the state government, for which they are accountable. They are responsible for implementing and monitoring a large range of activities and programs, e.g. waste disposal, hygiene standards in restaurants, building standards, immunisation and Meals on Wheels.

3.1.4 The Pharmaceutical Benefits Scheme (PBS) provides commonwealth government subsidised prescription drugs to all Australian residents. There is a further subsidy for individuals who may not be able to access medication due to monetary constraints, e.g. pensioners, invalids and those on low incomes.

The PBS Safety Net means that individuals with a chronic health complaint that requires ongoing medication can access free prescription medication once they reach a certain amount deemed by Medicare.

Both these services work on the notion that no person should be precluded from necessary medication due to low income.

3.1.5 If the principles of social justice are applied fairly, all individuals should be given the same level of health services, regardless of age, gender, socioeconomic status, or nationality. Any inequities within the Australian health care system will greatly impact upon an individual's health status.

Inequities do exist in a number of areas within the Australian health care system, e.g. those living in isolated areas, who have difficulties in physically accessing services, and also those with lower socioeconomic status who cannot afford optional health services which are not covered by Medicare, e.g. ancillary services such as dental care and physiotherapy.

An implication of this is a reduced status of health for such groups and individuals which leads to increased social costs. Unemployment and increased absenteeism increase the financial stress on the community, plus increased family problems may arise due to the subsequent financial stress. All this may lead to increased resentment and division within society and possibly to social unrest. Another implication is the increased risk of disease outbreaks due to inadequate treatments and education.

Ignored inequities will contribute to a disproportionate increase in mortality and morbidity in disadvantaged groups already burdened by an inequality in disease distributions, e.g. Aboriginal and Torres Strait Islander peoples. It is the responsibility of both government and non-government organisations to alleviate as many inequities as possible so that individuals experience higher levels of social justice.

3.1.6 The types of health care services that people access change as they age. In childhood and adolescence, services accessed are likely to be immunisation, check-ups, treatment for illness, dentistry services and possible emergency treatment for trauma. However, as they age it is more likely they will access opticians, diagnostic services, pathology, and hospitalisation for treatment of a disease, along with pharmaceuticals. In later life, ill health may result in ongoing rehabilitation after surgery, larger amounts of pharmaceuticals, longer hospitalisations, nursing services and possibly a nursing home. With ageing, degenerative diseases become more apparent and greater levels of health services are generally used.

3.1.7 People who live in rural areas are disadvantaged when it comes to the level of health services provided. In general there are less non-institutional health care services available in rural than urban areas, such as fewer medical professionals and community-based prevention programs. The institutional services in rural areas, including both public and private hospitals, are smaller and offer fewer specialists for specific health problems. People from rural areas are often forced to travel to larger cities for treatment. Geographic isolation means availability of emergency treatment is difficult to access and this increases the risk of mortality. The majority of people who live in urban areas have a greater array of institutional and non-institutional health care services.

3.1.8 Advocacy in relation to health care means that individuals and community support a specific cause in relation to health care. This may include championing the cause through demonstrable actions such as legislation, advertising initiatives or providing resources at a grass roots level.

3.1.9 Australia's health care system was labelled a sickness system because until approximately 20 years ago the majority of the resources were directed towards diagnosis, treatment and rehabilitation. However, in more recent times, this has become less evident, with more money and resources directed to prevention of disease and promotion of health. It is recognised that every dollar spent in prevention-type initiatives saves between nine and ten dollars in curative services. So this proactive approach to health care should help alleviate the increasing health care budget.

3.1.10 Prevention is better than cure for a number of reasons.

Financially it is far more efficient to spend money on prevention and promotion initiatives as this ultimately reduces the need for money to be spent on curative services. Every dollar spent in prevention-type initiatives saves between nine and ten dollars in curative services. Prevention of ill health will help to decrease the predicted expense increases due to an increasing and ageing population.

Prevention will reduce both social and financial costs to the community caused by loss of work. The social costs of disease, including pain and anxiety for patients, relatives and friends, cannot be underestimated. These factors greatly impact upon society, so if they can be minimised through preventive strategies all sectors of the community will benefit.

Preventing disease means that individuals will enjoy greater quality of life, and they will be healthier while they live longer.

3.1.11 The support structures that an individual can access for a degenerative disease are many and varied. There are government and non-government structures as well as institutional and non-institutional support services.

The non-institutional services available for degenerative care include the diagnostic and treatment services provided by health professionals, pharmaceuticals, as well as public and private health care providers such as MBF and Medicare, which provide health care insurance.

The institutional services are the hospitals (public and private) where diagnosis, treatment and rehabilitation take place. Specialised units of care, such as oncology wards for cancer treatment and cardiac wards for degenerative heart complaints, have been developed to deal specifically with the needs of these diseases. In addition, rehabilitative and educative units are often attached to these and allow a more complete treatment including a preventive plan to be put in place to reduce further complications and/or health issues.

The majority of health care structures are government funded; however, there are a large number of non-governmental support structures that provide services.

Many community support organisations offer counselling and support networks along with prevention and promotion programs. These are crucial in the rehabilitative process and are often directed at returning independence and mobility as well as reducing risk behaviours. They may include dietary information and supply for patients with heart disease or diabetes or the establishment of basic training programs to reduce the weight of individuals. The care ranges from surgical to rehabilitative and includes a wide variety of resources. Many of these organisations also provide funding for research.

3.1.12 Various, e.g. magnetic resonance imaging (MRI scans), laser eye treatment, lens implants, chemotherapy, keyhole therapy, nicotine patches, prosthetics (e.g. artificial limbs), artificial organs, blood filtering equipment, dental implants, drugs.

3.1.13 (a) Medicare allows for the provision of basic health care to all Australian residents. It allows for:

- Free treatment in public hospitals as a public patient.
- Free or subsidised treatment by medical practitioners. Medicare has set up a list of fees (the scheduled/common fee) and it pays 85% of that amount. Doctors have the option to bulk-bill patients. This allows the patient to be seen without paying any money. The government pays the doctor a scheduled amount for each visit.
- Optometry and oral surgery fees.

(b) When Medicare was introduced, an extra tax was introduced – the 1.5% Medicare levy. At this stage, many people in Australia initially dropped out of private funds, which added to the burden on the health system. To encourage people to rejoin funds, the commonwealth government then offered a 30% tax rebate for those in private funds, and charged an additional 1.5% levy on high income earners who did not have private medical insurance. To encourage people to join funds at a younger age, people who join before 30 years of age are offered lower lifetime premiums.

(c) Various, e.g.

- Being able to choose the hospital you attend and perhaps opt for a private room.
- Choosing the doctor you want to look after you in hospital.
- Wait times for hospital beds are generally shorter.
- Ancillary benefits are available, e.g. dental treatment, physiotherapy.
- The extra protection reduces anxiety which is important for many people.

3.1.15 An important initiative the Australian government has established to decrease the burden of public health care is identifying national health priority areas and recognising that these diseases need to be reduced, especially as they are often largely preventable due to lifestyle choices that can be changed. The government has also recognised and implemented support structures to deal with the particular disadvantaged groups who experience greater levels of ill health than the general population.

The idea of social justice has been important in dealing with the fair allocation of resources and money that facilitates better health care. Both public and private organisations are being made to be more accountable for their spending and deliver more efficient and effective health care services.

The government has also become far more proactive when dealing with health care issues, rather than being reactive to health issues. Examples of proactive measures include: educating individuals regarding the dangers of certain lifestyle practices such as alcohol consumption by providing guidelines for safe drinking levels; creating greater restrictions on advertising of certain products such as introducing junk food advertising restrictions during children's television shows; and providing support structures for people who find themselves addicted to certain habits or practices.

3.2.1 Various, e.g.

Alternative/ complementary services/products	Function of the service/product
Naturopathy	Provides a holistic approach to treatment of the individual by evaluating symptoms of the disease/injury and treating the causes of the illness.
Acupuncture	A traditional medicine that involves inserting needles into the skin in particular areas to alleviate illness by stimulating the natural healing response.
Chiropractic	Treatment based on the role of the nervous system coordinating all of the body's functions and the idea that disease results from a lack of normal nerve function. Employs manipulation and specific adjustment of body structures such as the spinal column. Chiropractors manipulate the spine with their hands to realign the vertebrae and relieve the pressure on nerves.
Meditation	Based on the concept of focusing on an object or one's breathing to reach a meditative state, whereupon the individual will experience inner peace which will help the body to resolve any health conditions.

3.2.2 There are a number of reasons for the growth of alternative and complementary medicines in Australia.

- The World Health Organisation (WHO) has recognised the valuable contribution these medicines have made worldwide.
- Many of the alternative medicine courses are now recognised by universities within Australia, for example chiropractic medicine and acupuncture.
- Many of the alternative medical services are now recognised by private health care insurers so patients are able to claim refunds following treatment.
- Many people turn to alternatives when conventional medicine proves ineffective.
- The changing demographic within Australia has seen a greater Eastern influence, from areas where many of these practices have been used for hundreds of years.
- The holistic nature of alternative medicine has attracted people.
- Resistance to conventional methods like the use of antibiotics.

3.2.3 Complementary and alternative medicines have been included in many private health rebates for a number of reasons.

Health care insurers recognise the invaluable service these practices provide, many of which are cheaper than Western medicines. Alternative medicines can also complement Western medicine. For example, many people who have cancer may choose Western medical practices for treatment, like chemotherapy, which can make the patient nauseous. They may then choose an alternative medical practice such as acupuncture to alleviate the nausea, rather than taking more Western drugs, which may have additional side effects.

3.2.4 Alternative medicine is often referred to as holistic medicine as it not only treats the source of the problem but also takes into account the individual's overall state of health. It is recognised that there may be a number of imbalances, which have led to the disease or the ill health of the individual. Quite often, alternative medicine practices deal with not only the body but also the mind as they are thought to work in unison**.**

3.2.5 (a) The escalating burden on the Australian health care system can be attributed to a number of factors, but the greatest single factor is the ageing population of Australia. An ageing population means that more money is being spent on people with chronic degenerative diseases, which require many health care services. These types of diseases impact upon diagnostic, curative and rehabilitation services, which are expensive and labour-intensive.

Another problem is the enormous cost of new technologies and the cost of research, development and testing of new drugs and equipment.

(b) As a number of problematic diseases in Australia are lifestyle related, greater emphasis must be placed upon preventive measures. These include educating individuals about how to modify risk-taking behaviours so as to decrease the chance of contracting a particular type of disease. Individuals also need to be more proactive in their health care choices, having regular check-ups and adhering to advice from health professionals and/or community services.

3.2.6 When selecting alternative medical services an individual needs consumer skills to find out the following.

- The potential health benefits.
- Any possible side effects of the treatment.
- The qualifications and training of the health professional.
- The cost and if there are any rebates.
- The length of the treatment.
- Any personal recommendations for this medical service from relatives, friends or colleagues.

If the consumer is completely satisfied with this information, then treatment may proceed.

4.1.1 The five main action areas of the Ottawa Charter are:

- developing personal skills (individuals becoming responsible for their health choices)
- creating supportive environments (taking care of each other and the environment)
- strengthening community action (encouraging social support networks)
- reorienting health services (reallocating money and resources towards prevention and promotion rather than curative services)
- building a public health policy (creating legislation to improve health standards).

4.1.2 (a) There are two main aims of health promotion.

- To improve the health of the individual and community.
- To prevent future illness occurring.

(b) The limitations to health promotion in Australia could include:

- inequities that exist because of language and/or cultural barriers
- physical barriers due to isolation
- educational barriers which result in individuals unable to accurately access or assess information
- inaccurate information supplied by less than reputable sources
- financial constraints where individuals cannot afford to access information or services
- the assumption that all individuals want to improve their health or take preventive health measures.

4.1.3 Empowerment of the individual means giving the individual the authority to make decisions based on knowledge without relying on others. When relating this to health promotion it means that individuals become able to make sound decisions about their own health based on currently available health information.

4.1.4 In the past, prior to the establishment of the national health priority areas (NPHA), the community played a very passive role in health care. This meant that the limited health services provided were only reactive to health problems in the local community. There was little or no consultation between members in the community regarding community concerns.

The community's role has now changed in a number of important ways. Today the local community can no longer take a passive role in health care. There is far greater consultation between all community members, and the focus of health care has moved towards proactive preventive health care measures. This has been particularly evident in areas where certain health issues have been identified as problematic within the local community. This empowerment of individuals and groups within communities is the catalyst for the success of initiatives. With control and ownership, community activities and initiatives become more goal-focused and specific to the needs of locals.

4.1.5 Health care professionals have included the individual and community in consultations about health care decisions because:

- If these groups are involved, they are more likely to be supportive of any initiatives or outcomes that are derived from the consultation.
- If all people are part of the consultation process, and they all have equal input, then any potential bias should be prevented.

4.1.6 Health care professionals and the government do have important roles to play in maintaining the health of individuals. However, they are no longer considered to be the only deciders of the how, who and where of health care. The increasing recognition of the individual and the community as stakeholders in health care has proven to be invaluable in improving health care services. An example is the establishment of community groups in drought-affected areas to deal with the escalating levels of depression and suicide by farmers. The community groups allow individuals to discuss problems and vent concerns in an atmosphere of empathy and understanding. This illustrates how the community and individuals are filling a greatly needed service, which the government and health professionals would struggle to provide. If all sectors collaborate to provide health care services to meet the needs of the community, then all parties will feel satisfied. It would be naive of the government and health professionals to believe that they can solely cater for all health needs without extensive consultation with all concerned parties.

4.1.7 Intersectoral collaboration refers to health sectors and non-health sectors working in partnership to tackle particular health issues. An example of this is the federal government working in conjunction with community, individuals and non-government organisations to reduce the incidence of smoking.

4.1.8 Various, e.g. An example of a health promotion initiative that has been highly effective in the national health priority area of cardiovascular disease (CVD) is the National Heart Foundation's healthy heart tick.

The healthy heart tick is supposed to allow people to make healthier food choices as it indicates food which has lower levels of saturated fats. This encourages food manufacturers and food outlets to produce and sell healthier products. Consumers can easily recognise the logo on foods and be satisfied that they have met stringent guidelines. This initiative has been particularly effective in raising the profile of cardiovascular disease, which is at present responsible for more mortalities and morbidity than any other national health priority issues.

4.1.9 The Ottawa Charter for health promotion (formulated in 1986) consists of a set of guidelines for all nations to use as a way of achieving better health for all by the year 2000. The charter was developed at a health conference held in Ottawa in response to the growing expectations around the world of the need for action to improve public health worldwide. The charter gave direction to health promotion through clear definitions and action plans.

4.1.10 (a) The principles of social justice include the following.

- Participation in decision-making.
- Equity in the fair allocation of resources.
- Access to a range of health services.
- Rights to equal opportunity.

(b) Health care is not equitable for all groups in Australia as there are barriers to prevent individuals from accessing health care services. Language barriers prevent people from accessing health care services because they lead to a lack of awareness of services and/or inability to comprehend information regarding healthy choices. Physical barriers, such as geographic location, mean those from rural areas have less access to health care services as there are fewer institutional and non-institutional services available in rural and remote areas. Those who are from lower socioeconomic backgrounds quite often cannot afford the same health care services as those from more affluent backgrounds as not all health care services are covered by Medicare.

(c) These include low socioeconomic status, Aboriginal and Torres Strait Islander peoples, geographically isolated and rural people, people with disabilities, Australians born overseas and the elderly.

If any of the principles of social justice are not fully available to these individuals and groups then their chance of good health is vastly diminished. Some examples of the inequities that these population groups experience include lower levels of education, higher unemployment, language barriers, physical disabilities, racial prejudice, and geographic isolation, all of which will impact upon their levels of health. Thus these population groups all experience lower levels of social justice than the rest of the population.

4.1.11 Individuals and communities have a great deal to contribute to public policy, and this can potentially have a positive impact upon public health. Both groups will benefit from their contribution towards public policy. Often these groups are aware of which particular disadvantaged groups of the community are in need of support. They are also aware of changes that need to be implemented to improve health inequities. The new public health approach advocates the active involvement of communities and working in partnership with health professionals and the government to improve health care services. If individuals and communities can be involved in the consultation process it will lead to greater acceptance of health policies and strategies to improve health. An example of this is involving Aboriginal elders in the consultation process to deal with health problems specific to them. If the elders are involved, the community and individuals are more willing to accept the strategies and the changes will have greater community support.

Different community groups place different levels of importance on health priorities depending on how much the priority impacts upon their individual health. Over time these priorities may change. Whilst general health policies and priorities are devised for the greater population, specific priorities and policies will be more effective in dealing with specific health issues. For example, if a certain geographic area of Sydney has targeted youth drug-taking as a problematic issue within the community, then strategies and policies can be implemented to deal with this particular issue. Issues like this will take higher priority within the community as they directly impact upon people from within that geographic area. By targeting and prioritising specific issues within communities, health care professionals and local governments will achieve better outcomes for all concerned.

4.1.12 Various – your answer should include ideas and examples such as the following.

The action areas that are most significant to particular priority areas change according to the initiatives at a particular time. The initiatives that both government and non-government agencies establish will vary according to the particular health problems identified. The five action areas are all important in each of Australia's priority health areas, and they interact to achieve the most successful outcomes possible for each priority area. To establish which action area is most significant to each priority area requires a largely subjective judgement.

- At present one area where strengthening community action is very important is that of mental health and suicide, as the NSW drought has seen a huge increase in mental health problems, including suicide, in the rural community.
- The building of healthy public policy has been extremely important in the establishment of strict guidelines for tobacco smoking in public hotels, clubs and public areas like parks and beaches. This will hopefully reduce the levels of smoking and passive smoking, which should decrease the incidence and prevalence of lung cancer and cardiovascular disease.

- The principle of creating supportive environments has been significant in a number of priority areas. The creating of the 'no hat, no play' initiative, and the provision of shaded areas in schools, has the potential to impact upon future levels of skin cancer in our society. At the same time the 'Fresh Tastes at School' initiative, which recognises the importance of healthy canteens at school, will potentially impact upon cardiovascular disease, obesity, diabetes and colorectal cancer.
- Developing personal skills is an essential part of all priority areas but is especially significant in the area of mental health. Linked closely with the supportive environments, personal skills such as recognising stressors, taking time out and setting realistic goals may reduce stress-related health issues.
- Reorienting health services is largely recognised in the area of cancer and cardiovascular disease. Through recognition of risk behaviours and identification of non-modifiable characteristics, services such as screenings, diet advice and education can be targeted to reduce the onset of these diseases.

Various, e.g. lung cancer

In order to reduce the incidence of lung cancer, a broad approach is needed that looks at a combination of issues in all action areas of the Ottawa Charter. Tackling lung cancer is best achieved by a collaborative effort from industry, individuals, government and groups. To reduce lung cancer, smoking and exposure to cigarette smoke must be reduced. This requires a combination of legislation (e.g. retail restrictions), personal skills (e.g. quit programs), supportive environments (e.g. smoke-free workplaces), community action (e.g. anti-smoking lobby) and reorienting health services (e.g. screening) to reduce the prevalence and incidence of smoking-related lung cancer. (See more examples in the answers to the next five questions.) Only by collaborative action in all action areas can any health initiative be successfully tackled.

4.1.13 (a) Developing personal skills. Accessing information about cardiovascular disease can make people more aware of risk factors for the disease and the support services available. Behaviour can then be modified to reduce the risk of developing cardiovascular disease. Examples of initiatives people can take are as follows.

- Accessing information on the internet from the National Heart Foundation (NHF) to increase personal knowledge of cardiovascular disease (CVD) so as to be able to make lifestyle changes.
- Reading pamphlets from the NHF or in your local doctor's waiting room to increase knowledge about cardiovascular disease and awareness of risk factors.
- Reading the nutritional information on food containers to make better food choices and reduce risk of cardiovascular disease.
- Modifying personal behaviours, such as decreasing intake of saturated fats and increasing exercise to reduce the risk of developing cardiovascular disease.

(b) Creating supportive environments. Identifying personal support networks in our schools, workplaces and the community allows us to take advantage of these and use their support to help reduce our risk of cardiovascular disease (CVD) by improving our diet and exercise. Examples of such environmental support network initiatives are as follows.

- Free or subsidised exercise programs provided in the workplace.
- Workplace fitness provisions such as gyms for office-based workers. Encouragement being provided and time allowed for workouts.
- Low-fat food options in workplace canteens.
- More parks and walking paths provided in local areas.
- Healthy canteens at schools (Fresh Tastes at School).
- Parents providing low fat, healthy food choices for children at home.

(c) Strengthening community action. There are a number of community-based support networks and initiatives that may help to decrease the prevalence of cardiovascular disease (CVD). These include the following.

- Demands for manufacturers to use standards-based framework for the use of labels such as 'lite' and low fat.
- Health-promoting schools networks enforcing healthy lifestyle practices.
- Promoting healthy canteens in private schools.
- The healthy heart tick on foods accredited by the National Heart Foundation (NHF).
- The lose weight-gain life initiative.

(d) Reorienting health services. Some of the health care budget is now directed to prevention of cardiovascular disease (CVD) through initiatives such as the following.

- Cholesterol check-ups which can identify risk factors and early indicators and help to avoid longer term illness.
- Allocation of money to the National Heart Foundation (NHF) for research, prevention and promotion.
- Happy Harold and the Jump Rope for Heart programs aiming to raise the awareness of cardiovascular disease (CVD) and raise funds for prevention and promotional programs.

(e) Building a public health policy. The government has legislated for a number of initiatives aimed at reducing risk of cardiovascular disease in the community. For example:

- Smoke-free environments in public hotels and public beaches.
- Smoke-free government buildings.
- 'Fresh Tastes at School' mandatory in government schools.
- Mandatory nutritional information on food containers.

4.1.14 (a) Developing personal skills. Accessing information about cancer can make people more aware of risk factors for the disease and support services available. Behaviour can then be modified to reduce the risk of developing cardiovascular disease. Examples of initiatives people can take are as follows.

- Accessing information on the internet from the NSW or Australian Cancer Council to increase personal knowledge.
- Reading pamphlets from the Cancer Council or in your local doctor's waiting room.
- Being aware of risk factors for the disease.
- Modifying personal behaviours to reduce risk factors, e.g. quitting smoking, applying sunscreen, regular personal and medical examinations.

(b) Creating supportive environments. Identifying personal support networks in our schools, workplaces and the community allows us to take advantage of these and use their support to help reduce our risk of cancer by improving our environment, e.g. by reducing people's exposure to ultraviolet light and cigarette smoke. Examples of such environmental support network initiatives include the following.

- Providing shaded areas in schools and parks.
- 'No hat, no play' rule at schools.
- Surf-lifesavers providing free sunscreen at beaches.
- Parents supporting the 'Car, home, smoke-free zone' initiative.

(c) Strengthening community action. Various community-based support activities increase awareness of cancer and work towards reducing its prevalence. Some examples are:

- Designated days such as Pink Ribbon Day, Daffodil Day and World Cancer Day to raise awareness and funds for cancer research.
- Being cancer smart in the workplace and outdoors.
- Australia's Biggest Morning Tea allows community members to be active supporters and increases cancer awareness.
- NSW Cancer Council shops provide cancer-safe products, e.g. sunglasses and clothing that protects from ultraviolet exposure.

(d) Reorienting health services. Some money and resources has been diverted to programs for prevention and promotion about cancer. Examples include the following.

- Cancer Council donations for research and promotion.
- Royal Australian College of Surgeons research.
- Health warnings and promotions, e.g. 'Every cigarette is doing you damage'; 'Quit for life'; 'Car, home smoke-free zone'.

(e) Building a public health policy. The government has used legislation to help reduce the prevalence of cancer. Examples include the following.

- Mandatory health warnings on cigarette packets.
- Smoke-free zones at beaches, workplaces, pubs and clubs.
- *Occupational, Health and Safety Act* 2000 so employers must make the workplace safer for employees.
- Mandatory healthy canteens, e.g. Fresh Tastes at School.
- Legislation for safety standards for sunscreen and clothing (SPF, UV-rays).

4.1.15 (a) Developing personal skills. The accessing of information about diabetes allows people to modify their behaviour and thus reduce their risk of developing diabetes. These skills include the following.

- Accessing information on the internet from the NSW or Australian Diabetes Association to increase personal knowledge.
- Reading pamphlets from Diabetes Association and in your local doctor's waiting room.
- Being aware of risk factors for diabetes and modifying personal behaviours where necessary, e.g. modifying diets and being aware of hereditary factors.

(b) Creating supportive environments. Identifying personal support networks in our schools, workplaces and the community allows us to take advantage of these and use their support to help reduce our risk developing diabetes. They can also help people with diabetes to cope with the problems they experience. Examples are:

- Jelly Bean Club for children in upper and lower primary school.
- Diabetes kids camps.
- First aid training in schools and the workplace.

(c) Strengthening community action. Community-based support networks help to reduce the prevalence of diseases such as diabetes by fundraising, increasing awareness and through education and advocacy. Such networks include:

- The Great Australian Bite campaign for Diabetes Australia.
- Stay Active Australia and World Health Day.
- Diabetes Awareness Week.

(d) Reorienting health services. Prevention is better than cure. Money and resources can be directed towards services that aim to educate the public about diabetes and the actions people can take to reduce their risk of developing this disease and to improve the health of people who already have diabetes. Such services include:

- Free diabetes testing in shopping malls.
- Diabetes school care-line.
- Multilingual diabetes information pamphlets.

(e) Building a public health policy. In an effort to reduce the prevalence of diseases such as diabetes, the government can sponsor legislation, and programs such as:

- Educational training for all general practitioners.
- Fresh Tastes at School which is mandatory in government schools.
- Compulsory labelling on foods so people can make informed choices.

4.1.16 (a) Developing personal skills. The accessing of information about mental illness allows people to modify their behaviour to reduce their risk of the disease. These skills include:

- Accessing information on the internet from the Black Dog Institute and Beyond Blue to increase personal knowledge.
- Reading pamphlets from the Black Dog Institute and Beyond Blue or in your local doctor's waiting room.
- Being aware of risk factors for the disease and modifying personal behaviours.

(b) Creating supportive environments. Environmental support networks help to prevent the prevalence of diseases such as mental illness. Such networks include:

- Mental Health Week held at schools.
- Youth centres in the community.
- Professional school forums, e.g. Mind Matters.
- Family stress leave.

(c) Strengthening community action. Community-based support networks help to reduce the prevalence of mental illness by fundraising and increasing awareness and through education and advocacy. Such networks include:

- Sane Australia, raising the profile of mental health.
- Mind Matters kits.
- Black Dog Institute, raising awareness in the community.

(d) Reorienting health services. Prevention is better than cure. Money and resources can be directed towards services that aim to educate the public about mental illness. Such services include:

- Government funding for Beyond Blue and Black Dog Institute.
- Funding of Mind Matters courses for students and teachers.
- Free diabetes testing in shopping malls.
- Diabetes school care-line.
- Multilingual pamphlets about mental illness.

(e) Building a public health policy. In an effort to reduce the prevalence of mental illness, the government has sponsored legislation, and programs such as the following.

- Compulsory codes of safety in the workplace.
- Job Start for depression.
- Education in PDHPE lessons, e.g. Mind Matters.
- Anti-bullying policies in schools and workplaces.
- Training about mental health for all general practitioners.

4.1.17 (a) Developing personal skills. Accessing information about chronic respiratory diseases such as asthma, chronic obstructive respiratory disease, hay fever, bronchitis and chronic sinusitis allows people to obtain information that has the potential to make informed decisions and modify their behaviour if necessary. These skills include the following.

- Accessing information on the internet from sites such as the Asthma Foundation to increase personal knowledge.
- Improved fitness and exercise involvement.
- Recognising and reducing or avoiding known triggers for asthma.
- Testing peak flow daily to monitor asthma levels.

(b) Creating supportive environments. Improving environmental conditions is essential for reducing prevalence of respiratory diseases such as asthma. Examples of these are:

- Supply of preventive and reliever medication, e.g. at schools and sporting clubs, helps to prevent or mitigate asthma attacks.
- Reducing costs of puffers to chronic sufferers, helps to ensure an asthmatic always has a puffer available.
- Education and awareness will lead to a reduction in triggers such as fibres in the home by reducing carpet, curtains and dust.
- Banning of smoking to encourage smoke-free zones and reducing all asthma triggers.
- Asthma-friendly schools campaign.

(c) Strengthening community action. Community-based support networks help reduce the prevalence of respiratory diseases such as asthma by:

- School-based education and first aid training.
- Asthma Awareness Day increases knowledge of asthma and how to manage it.
- Promotion of high-profile sportsmen and women who have suffered from asthma, makes people aware that this disease can be managed successfully and provides good role models.

(d) Reorienting health services. Redirecting money to support programs of prevention and promotion will reduce the prevalence of respiratory disease such as asthma. Money is now being used on the promotion of services such as the following.

- Peak flow testing on a daily basis ensures an asthmatic is aware of the risk of an attack.
- Exercise as a tool for coping with asthma as it improves cardiopulmonary fitness.
- Ways to prevent and treat exercise-induced asthma will encourage people to maintain their fitness with the health benefits it brings.

(e) Building a public health policy. Government legislation to help reduce the prevalence of asthma includes the following.

- Reduction of cost of medications to chronic sufferers through government assistance programs.
- Decreased smoking in public places, e.g. airports, to decrease asthma attack triggers.
- Mandatory food labelling to decrease allergy-induced asthma.

4.1.18 (a) Developing personal skills. Personal skills are a major contributor to the reduction of injury. These skills include:

Enhancing resilience, self-esteem, and coping skills through education and practice.

Improving safety skills such as:

- advanced driver skills
- planning when using alcohol, e.g. use taxis or have a designated driver
- conflict resolution skills
- reduction in personal use of drugs and alcohol
- improved preparation and total body fitness in sports
- swimming skills to reduce childhood drowning and beach injuries
- improved training within the workplace to reduce industry injuries.

(b) Creating supportive environments. Improving environmental conditions is essential for reducing the prevalence of injury. Examples of these are the following.

- Dual lane expressways can reduce head-on incidence and impacts.
- Improved venues and grounds as well as facilities encourage safety.
- Improved protective sportswear and regulations as well as adherence to game rules will reduce injury.
- Drop-off zones in schools, 40 kph zones and no double parking reduce risk of injury or death from accidents.
- Improved and enforced occupational health and safety (OH&S) regulations at work reduces workplace injuries.
- Counselling and support services to identify and help people at risk of suicide.

(c) Strengthening community action. Community-based support networks help reduce the prevalence of injury, for example:

- Driver reviver education and community involvement reduce injury due to driver fatigue.
- Mental health awareness, school counsellors and increased support mechanisms provide ways for people to decrease stress and seek help.
- Youth hotlines and domestic violence hotlines provide support and advice about reducing risk of injury.
- Community, school, workplace volunteers, e.g. safety monitors and crossing supervisors, lessen the risk of accidental injury.
- School-based education, e.g. Mind Matters helps to improve self-esteem and decrease stress.

(d) Reorienting health services. Redirecting money to support programs for prevention and promotion will reduce the prevalence of injury. Examples of this are:

- Prescreening athletes before involvement in high level sport allows certain body types to be directed to specific playing positions to reduce injury, e.g. prop (thick neck).
- Identification of factors that cause anxiety and depression allows those who are at risk to be offered assistance.

(e) Building a public health policy. Government legislation to help reduce the prevalence of injury includes the following.

- Vehicle safety legislation, e.g. seatbelts, vehicle registration and the use of airbags all help to reduce injury in motor vehicles.
- New P-plate legislation for passengers and speed limits, as well as time on plates with parental supervision, helps to decrease road accidents.
- Improved transport system and increased public transport effectiveness through government funding, provides a safe means of travel.
- Legislation on home safety such as pool fencing reduces drowning.
- Occupational Health and safety (OH&S) legislation and inspections throughout all workplaces, ensures safer working conditions.
- Improved gun laws, reduces availability of guns and thus reduces the risk of gunshot injury and suicide.
- Childproof containers and correct labelling legislation, for medications and poisons, reduces the risk of accidental poisoning.

4.1.19 Various, depending on the initiative studied.

(a) You can select initiatives mentioned in the questions above or any other of your choice.

(b) The five action areas are strengthening community action, building of healthy public policy, creating supportive environments, developing personal skills and reorienting public health services.

(c) Describe how each of these areas has been important for the initiative you studied.

(d) Identify a health priority area (e.g. Aboriginal and Torres Strait Islander peoples, ageing population, diabetes, cardiovascular disease). Describe ways in which the initiative you studied has helped tackle the health priority area that you named. What sort of impact has the initiative had on this health priority area? What problems has it helped solve and how has it achieved this?

Notes