What are the priority issues for improving Australia’s Health?

In this chapter you will investigate the groups experiencing health inequities in Australia and the particular health conditions that are preventable. You will be able to assess the impact of a growing and ageing population on health services.

Groups experiencing health inequities

Not only are there significant inequalities in health status between various countries, there are also enormous inequalities in the health status of population groups within Australia. Some of these inequalities involve injustice and should be described as ‘inequities’. A selection of these inequalities and inequities is described below.

Aboriginal and Torres Strait Islander peoples

No greater contrast in the extremes of health status can be found in Australia than that between Aboriginal and Torres Strait Islander peoples and the rest of the Australian population. Aboriginal and Torres Strait Islander peoples die at a much younger age and are more likely to experience disability and reduced quality of life because of ill-health. There has been some progress in collecting information on the health of Aboriginal and Torres Strait Islander peoples over the last decade but...
many challenges in this area remain due to the fact that the population is relatively small: 2.5 per cent of the total population with approximately 25 per cent living in remote areas. The life expectancy of Indigenous Australians is approximately 10 years less than the overall Australian life expectancy. There is some discrepancy between various states and territories, but for those Indigenous Australians born during 1998–2001, the life expectancy at birth of a male is approximately 67 years and for a female is approximately 73 years.

Death rates for Aboriginal and Torres Strait Islander peoples are higher for every specific major cause of death. Other inequities include higher infant mortality (estimated at two to three times higher than the overall Australian figure) and higher mortality rates.

**Leading causes of death**

The leading causes of death in the Aboriginal and Torres Strait Islander population are circulatory diseases, cancer, diabetes and respiratory diseases.

Compared with non-Indigenous females and males, Indigenous females and males are, respectively, four and five times as likely to die from avoidable causes. Indigenous people are five times as likely to die from heart attack, twice as likely to die from cancer, 18 times as likely to die from diabetes and twice as likely to die from suicide as non-Indigenous people. Indigenous death rates are 8.8 times as high as non-Indigenous death rates for diabetes, 5.7 times as high for cervical cancer, 4.2 times as high for kidney diseases and 3.3 times as high for digestive diseases.

For each of the seven leading contributors to total disease burden Indigenous Australians have higher disability-adjusted life years (DALY) rates than do non-Indigenous Australians. Compared with the rate for the total Australia population, the DALY rates for Indigenous Australians are:

- 5.1 times higher for diabetes
- 4.6 times higher for cardiovascular disease
- 4.1 times higher for intentional injuries
- 2.5 times higher for unintentional injuries
- 2.5 times higher for chronic respiratory disease
- 1.7 times higher for cancer
- 1.6 times higher for mental disorders.

Non-communicable diseases explain 70 per cent of the disease burden gap between Indigenous Australians and the total Australian population. Cardiovascular disease is the leading cause (23 per cent of the gap) followed by diabetes (12 per cent), mental disorders (12 per cent) and chronic respiratory diseases (9 per cent).

Indigenous Australians are more likely than non-Indigenous Australians to die from cancer (such as cancers of the lung and liver) because the cancer is more likely to be fatal, or the cancer may be at a more advanced stage by the time it is recognised. Cervical cancer is more common among Indigenous women than among non-Indigenous women, but breast cancer is less common.

Indigenous Australians are more likely to die from transport accidents, intentional self-harm and assault than other Australians. Injury rates are around three times those of the total Australian population. Figure 2.1 illustrates the leading causes of death from injuries for Indigenous Australians males and females.

**Figure 2.1** Leading causes of death from injuries for Indigenous Australian males and females

Source: AIHW, Australia’s Health, 2008
Major health issues

Mental health is very important to the total well-being of the whole Indigenous community. Mental health refers to the social and emotional well-being of individuals. It includes how well individuals can cope with stress or adversities that they come across during their life. Trauma and grief related to the history of a new settlement invading Indigenous communities, the impact of colonisation by Europeans, loss of land and culture, high rates of premature mortality, high levels of incarceration, family separations and Aboriginal deaths in custody have been identified as underlying the great burden among Indigenous people of ‘mental health problems’, which may lead to ‘mental illness’. Compared with non-Indigenous Australians, Indigenous Australians aged 18 years or older are almost one-and-a-half times more likely to report experiencing at least one stressor (82 per cent). The stressors reported most frequently by Indigenous people are death of a family member or close friend (46 per cent), serious illness or disability (31 per cent) and inability to find employment (27 per cent).

Diabetes is a major health problem among Indigenous people. Overall, diabetes is around three-and-a-half times more common among Indigenous people than among other Australians. Only around one-half of people with diabetes know they have the condition.

Kidney disease is a very serious health problem for many Indigenous Australians. End-stage renal disease (ESRD), which occurs when the kidneys are no longer able to function, is much more common for Indigenous people than for non-Indigenous people across most of the country.

Asthma is 1.6 times more common for Indigenous Australians than for non-Indigenous people. Hospital admissions for a respiratory condition (including asthma) are over three times more common for Indigenous people than for non-Indigenous people. Death from a respiratory cause is around four times more common for Indigenous people than for non-Indigenous people.

The most common communicable diseases among Indigenous people include tuberculosis, influenza, meningococcal infection, syphilis, gonorrhoea and HIV/AIDS.

One in three Indigenous people have eye and/or sight problems, such as refractive error (requiring glasses for correction), cataract (clouding of the lens), trachoma (a bacterial infection that can lead to blindness if untreated) and diabetic retinopathy (damage to the retina, at the back of the eye, caused by diabetes). There has been progress in the area of eye health. Progress is limited amongst Indigenous Australians, however, due to the difficulty in accessing services. For example, the services may not be available where they live, are not culturally appropriate or are too expensive.

Disease of the middle ear can cause permanent hearing loss that limits life opportunities, particularly in education and in employment. Middle ear disease is reported by 12 per cent of Indigenous Australians. Otitis media was almost three times more common for Indigenous people than for non-Indigenous people.

The overall level of oral health and dental care is lower for Indigenous people than for non-Indigenous people. Nearly twice as many Indigenous six-year-olds as non-Indigenous six-year-olds have tooth decay.

Skin infections often are the result of poor living conditions. The most common skin infections affecting Indigenous people are scabies (caused by a mite) and streptococcal pyoderma (a bacterial infection). Scabies, in particular, is a problem in many remote Indigenous communities, where up to half the children may be infected.

Causes of the inequities

To explain the extreme inequities in Indigenous Australian health status simply in terms of lifestyle and risk factors ignores the broader socio-cultural factors that severely limit their access to better health. The contributors to the poor health status of many Indigenous people are:

- social factors, such as dispossession, dislocation and discrimination
- disadvantages in education, housing, income and employment
- physical environmental factors.

Lack of access to appropriate health services is another problem. Poor public health measures have negative effects on Indigenous health. Historically, the Aboriginal experience of dispossession and marginalisation has contributed significantly to their continued economic disadvantage and poor health status.

In 2007, the Human Rights and Equal Opportunity Commission of Australia (HREOC) presented a paper at an international symposium on the social determinants of the health of Indigenous Australians. Opposite is an extract from the paper.

The full version of the paper opposite is available at the website of the Human Rights and Equal Opportunity Commission of Australia, which can be accessed via www.oup.com.au/pdhpe12
Social determinants and the health of Indigenous peoples in Australia: a human-rights based approach

Improving the health status of Indigenous peoples in Australia is a longstanding challenge. The gap in health status between Indigenous and non-Indigenous Australians remains unacceptably wide.

‘The relative socioeconomic disadvantage experienced by ATSI peoples compared to non-Indigenous people places them at greater risk of exposure to behavioural and environmental health risk factors’ as does the higher proportion of Indigenous households that ‘live in conditions that do not support good health’.

Indigenous peoples also do not enjoy equal access to primary health care and health infrastructure (including safe drinking water).

Historically, ATSI peoples have not had the same opportunity to be as healthy as non-Indigenous people. This occurs through the accessibility of mainstream services and lower access to health services, including primary health care, and adequate provision of health infrastructure in some ATSI communities.

Indigenous peoples in Australia experience socio-economic disadvantage on all major indicators. For example:

• the average gross household income for Indigenous peoples in Australia was $364 per week, or 62% of the rate for non-Indigenous peoples ($585 per week);
• the unemployment rate for Indigenous peoples was 20%; three times higher than the rate for non-Indigenous Australians;
• Indigenous students were also half as likely to continue to year 12 as non-Indigenous students.

Poverty is associated with poor health. For example:

• Poor education and literacy are linked to poor health status, and affect the capacity of people to use health information.
• Poorer income reduces the accessibility of health care services and medicines.
• Overcrowded and run-down housing is associated with poverty and contributes to the spread of communicable disease.
• Poor infant diet is associated with poverty and chronic diseases later in life.
• Smoking and high-risk behaviour is associated with lower socio-economic status.

Indigenous peoples stated that their health status is linked to ‘control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity’.

Relatively permanent, negative features of the social environment trigger chronic stress: intergenerational poverty, racism, and so on. It can impact on the body’s immune system, circulatory system, and metabolic functions through a variety of hormonal pathways and is associated with a range of health problems, particularly diseases of the circulatory system. These are currently the biggest killer of Indigenous people in Australia.

[The] ability of communities to decide on, and address, their own health priorities has been found to increase the impact of primary health care in communities.

The right of self-determination includes the right of peoples to freely ‘dispose of their natural wealth and resources’ and that ‘in no case may a people be deprived of its own means of subsistence’.

Native title and the title to communally owned land is the ‘natural wealth and resources’ of Indigenous peoples.

Supporting traditional culture (including customary law and governance structures) is likely to help improve the health status of people living in remote communities.

While Indigenous commentators have highlighted the social and culturally related health benefits of access to land, many possible positive health impacts are likely including improved diet, exercise, and the reconnection of Indigenous peoples with their traditional economic bases.

The poverty and inequality that Indigenous peoples experience is a contemporary reflection of their historical treatment as peoples. The inequality in health status that they continue to experience can be linked to systemic discrimination.

Racism is a stressor that affects mental and physical health. 21.5% of the Indigenous children under 12 surveyed experienced racism in the previous 6 months. This was associated with increased smoking, marijuana use, and alcohol consumption.

[Many Indigenous people] had either been removed themselves and/or had relatives who, as a child, had been forcibly or otherwise removed from their natural family.

[The] effect on parents was that they had higher rates of substance abuse and mental health problems. Their children were twice as likely to have emotional and behavioural problems, to be at high risk for hyperactivity, emotional and conduct disorders, and twice as likely to abuse alcohol and drugs.

This paper demonstrates that the social determinants of health for Indigenous peoples reflect more than just their relative disadvantage.

An approach to social determinants that fails to recognise the fundamental connections between health status and the enjoyment of human rights will fail.

HREOC
Critical inquiry

1 Discuss why the financial resources devoted to improving Indigenous health have so far had little impact.
2 Apart from financial support, identify other strategies that have been introduced to improve Indigenous health. Evaluate how effective they have been.
3 Propose alternative strategies that could be introduced to reduce health inequities in the Indigenous population.
4 Analyse the health problems that are faced by Aboriginal and Torres Strait Islander peoples as a result of historical events.
5 Using the extract on page 23:
   a Outline the findings that you believe would have the most severe impact on Aboriginal and Torres Strait Islander health.
   b For each of the above findings, explain how it would impact on health.

Socio-economically disadvantaged people

A person’s socio-economic status is determined by several factors, including income, occupation and education. Socio-economically disadvantaged people are those who, as a result of one or more of these factors, experience significant financial limitations. Inequalities occur as a result of socio-economic differences in material resources, access to educational opportunities, safe working conditions, effective services, living conditions in childhood, racism and discrimination.

Socio-economically disadvantaged people:

• have reduced life expectancy
• are more likely to die from cardiovascular disease, respiratory disease and lung cancer
• have higher infant mortality
• have higher levels of blood pressure
• are more likely to smoke
• are more often generally sick.

Socio-economically disadvantaged people are more likely to suffer from long-term health conditions, such as diabetes, diseases of the circulatory system (which include heart disease and stroke), arthritis, mental health problems and respiratory diseases (including asthma).

Another significant difference is that socio-economically disadvantaged people are far less likely to engage in preventative health behaviours, such as having ‘Pap’ smears and dental check-ups. However, they are more likely to visit doctors, hospitals as an outpatient, and accident and emergency services.

Youth unemployment is also a major issue because it is significantly higher than the national rate. Unemployment can lead to despair and a sense of helplessness among young people, and is therefore linked to social problems, including drug use, violence, vandalism and crime. It is also a factor contributing to depression and suicide in young people.

Medium-density and high-density housing developments often experience higher levels of social problems, as do some suburban and country areas where groups of socio-economically disadvantaged people are gathered. These social problems can include domestic violence, vandalism and family breakdown.

It is difficult for many socio-economically disadvantaged people to make significant positive changes to their lifestyle and improve their health. This does not mean that improvements in health status are not possible for socio-economically disadvantaged people. However, a lack of income and education can reduce alternatives regarding employment, housing and nutrition, and can generally affect the ability to raise standards of living. Socio-economic disadvantage is considered to be the most important indicator of poor health in Australia.
People in rural and remote areas

People living in rural and remote areas have poorer health status than those living in cities and metropolitan areas. This is revealed in the higher death rates and lower life expectancy in rural and remote areas; life expectancy decreases with increasing remoteness. Death from coronary heart disease, ‘other’ circulatory disease and motor vehicle accidents are significant in these areas. Injury (in particular, motor vehicle accidents and suicide) contributes mostly to high death rates, and these deaths are mainly male. Males in these areas are 1.4 times as likely to suffer depression or psychological distress as males living in major cities. Females in rural and remote areas have a high incidence of diabetes and arthritis. Cerebrovascular disease (stroke) and coronary heart disease (such as heart attack) are similar across rural and remote areas for both males and females. Children in these areas tend to have decayed, missing or filled teeth. This may be attributed to the lower proportion of adequately fluoridated water supplies.

The poorer health status of rural communities is partly explained by a lack of access to health services, and partly by lower socio-economic status, occupational hazards and poorer overall living conditions caused by the harsher environment. People in rural and remote areas are more likely to engage in behaviours associated with poorer health, although their diet is likely to include more vegetables. More people living in rural and remote areas smoke, particularly among males and females aged 25–44 years. Males in rural and remote areas are generally at a greater risk of harmful drug and alcohol use than are females in those areas. Australians in rural and remote areas are slightly more likely to be overweight or obese and are also more likely to report sedentary behaviour. The latter was particularly true for males.
Elderly

Australia has an ageing population and this trend is expected to continue. It is estimated that the number of people aged over 65 years will increase by more than 1 million before 2015. The most common causes of mortality in people aged over 65 years are cancer, coronary heart disease and stroke. There has been a significant reduction in cardiovascular disease in older people as a result of declining smoking levels, awareness of other contributing risk factors and medical advances.

The most common conditions reported by people aged over 65 years are arthritis, vision problems, hearing problems and hypertension. It must be noted that growing old is not the only factor contributing to poor health status. Poor health in older people is also linked to socio-economic status and education. This contributes to older people experiencing higher rates of admission to hospital, and lengthier stays in hospital.

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As more people in Australia reach older age levels there is concern that the incidence of dementia and other disabilities will increase. It seems logical to assume that an older population means, overall, a more unhealthy population. This might occur, but it is also possible that the older people who will live longest will also be the healthiest older people. These relatively healthy older people might not develop as many medical problems. An older population overall will probably mean a less healthy population overall, but it is uncertain whether this will be a slight change or a more significant change in the health status of the Australian population.

Overseas-born people

Australia has a very ethnically diverse community, and it is interesting to explore the differences in health status between people born overseas and those born in Australia. In general, immigrants on arrival in Australia have better health than the Australian-born population; often with lower rates of death, hospitalisation, disability and disease risk factors. The differences in health that do exist, however, tend to decrease with length of residence. Reasons for the better on-arrival health status of immigrants are:

- the highly selective health criteria applied by the Australian Government to people seeking to migrate
- the fact that people of poor health and low socio-economic status are less likely to have the economic resources to change countries.

Of all people born overseas who have migrated to Australia, more than half come from non-English speaking backgrounds. Many people from non-English speaking backgrounds experience a deterioration in health status after arrival in Australia. Factors that contribute to this deterioration include:

- socio-economic disadvantage
- poor language skills that limit their access to employment, health information and community services
- the stress associated with resettlement.

People from non-English speaking backgrounds are less likely to report medical conditions they may be experiencing, less likely to immunise their children, less likely to exercise and more likely to be slightly overweight. Some ethnic groups within Australia, as a result of their culture, have different understandings of health and illness, and varying expectations of health care.

The Australian Institute of Health and Welfare indicated in 2008 that the health behaviours of most concern for people born overseas are that they are more likely to smoke, exercise less, be overweight and/or obese and have fewer or no daily serves of fruit. These are risk factors for a number of long-term health conditions, such as respiratory diseases, lung cancer and cardiovascular diseases.

Figure 2.3 In general, immigrants on arrival in Australia have better health than the Australian-born population

Research and Review

1 Describe why, on arrival in Australia, immigrants generally have better health than those born in Australia.

2 Many people from non-English speaking background experience a deterioration in health once they have migrated to Australia. Discuss the barriers faced by people from non-English speaking backgrounds when trying to maintain or improve their health.

Overseas-born people

Visit or contact your local council or community health centre and review the health services and strategies that are designed to specifically target people from a non-English speaking background.

Elderly

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People with disabilities

Disabilities are defined as any limitations to normal functional abilities. This is a very broad definition and, as such, disabilities of some form or other are experienced by 4 million people in Australia. The large majority of disabilities are of a physical nature, including arthritis, respiratory diseases, circulatory diseases and musculoskeletal disorders. Sensory disorders (such as diseases of the eye and ear) are also common, as are mental disorders.

A handicap, by definition, is more severe in nature than a disability, and relates to an individual’s limitations as experienced in more complex tasks, such as caring for oneself, moving around and communicating. The most commonly reported severe handicaps relate to psychiatric conditions, and head or brain injury.

People with disabilities and handicaps are more likely to experience multiple or interrelated conditions. This is especially so with brain injury.

People with disabilities can experience inequities due to financial constraints. These include factors such as lack of access to employment opportunities and the possible need for ongoing health care. They also encounter more difficulty accessing health services, have lower life expectancy and experience poorer health across a range of areas.

Critical inquiry

1. Predict the consequences that will result from an increase in the aged population in Australia.
2. Outline steps that have been taken to lessen the possible social and economic impact of an ageing population.
3. Propose other strategies that could be employed to deal with this issue.
4. Argue whether the government should bear the ultimate responsibility for caring for the elderly.
5. Identify the most common long-term health conditions for persons aged 65 years and over.
6. Identify the four most commonly reported conditions for:
   a. males aged over 75 years.
   b. females aged over 75 years.
7. Identify the conditions that increase significantly with age.

practical application

Health inequities

1. ‘Regardless of any policy, funding or strategies, health inequities will always exist in Australia.’ Prepare and engage in a debate on this issue.
2. Research and analyse Aboriginal and Torres Strait Islander peoples and ONE other group experiencing health inequities by investigating:
   a. the nature and extent of the health inequities
   b. the socio-cultural, socio-economic and environmental determinants
   c. the roles of individuals and governments in addressing the health inequities.

Figure 2.4 Four million Australians (one in five) have some degree of disability

Research and Review

Describe the difference between a disability and a handicap.
High levels of preventable chronic disease, injury and mental health problems

Chronic disease causes much suffering and disability and reduces quality of life. Australia’s main health problems that cause the greatest overall disability and/or premature death include cardiovascular disease, cancer, diabetes, asthma, injury and mental health problems and illnesses.

Cardiovascular disease

Cardiovascular disease includes all the diseases and conditions of the heart and blood vessels. Despite the health achievements made, cardiovascular disease is still a major cause of death.

The nature of cardiovascular disease

The major cardiovascular conditions are coronary heart disease, stroke and peripheral vascular disease. One of the major contributing factors to cardiovascular disease is a build-up of fatty tissue (called atherosclerosis) on the inside lining of the arteries. This build-up interferes with the supply of blood around the body.

Coronary heart disease

Coronary heart disease is the most common type of cardiovascular disease and accounts for just over 20 per cent of all deaths. It occurs when the blood supply to the heart is decreased by a narrowing (usually caused by atherosclerosis) in one or more of the coronary arteries. If the blockage severely decreases blood flow to the heart it can lead to a condition called angina. Angina is chest pain that occurs as a result of cramping of the heart muscle due to constricted arteries. In some cases the decrease in the blood supply can result in a more serious sudden heart attack, which can be fatal.

Cerebrovascular disease

Cerebrovascular disease is a disease of the arteries of the brain. An interruption (usually caused by atherosclerosis) of the blood supply to the brain results in what is commonly known as a ‘stroke’. A stroke can also occur as a result of a blood vessel bursting in the brain. The effects that a stroke has on the person will depend on which part of the brain has had its blood supply restricted.

Peripheral vascular disease

Peripheral vascular disease is a type of cardiovascular disease that affects the blood vessels in the limbs. Hardening of the arteries that interferes with blood supply to the muscles and skin is known as arteriosclerosis. This disease has close links to smoking, and to diabetes and certain other diseases. In extreme cases, this can result in gangrene and possibly limb amputation.

Extent of and trends in cardiovascular disease

Cardiovascular disease is the second leading cause of disease and accounts for approximately 35 per cent of all deaths in Australia. The death rate increases sharply with age and causes the greatest number of deaths among older people. Despite this high percentage, there has been a downward trend for all cardiovascular disease, and levels are below those of a hundred years ago. Heart attack rates are falling and survival from the attacks is improving. Since the mid-1970s, consistent declines have been noted for both males and females.

The decline in cardiovascular disease can be attributed to two main factors:

- improved medical care (for example, drugs to manage blood pressure)
- a reduction in risk behaviour that contributes to cardiovascular disease (for example, smoking).

Critical inquiry

1. The decrease in cardiovascular disease is very pleasing. In your opinion, discuss whether this trend is going to continue.

2. Propose any emerging management strategies in the area of cardiovascular disease.

Source: AIHW, Australia’s Health, 2008
Risk factors and protective factors for cardiovascular disease

Risk factors
The factors that make the occurrence of a disease more likely are called risk factors. The potential for individuals to alter their lifestyle to prevent disease will vary according to the environmental factors identified earlier; for example, socio-economic status.

Some risk factors for cardiovascular disease cannot be modified. The non-modifiable risk factors for cardiovascular disease are:

- **Age**—The risk of cardiovascular disease increases as people age; this is often the result of the slow progression of atherosclerosis.
- **Heredity**—People with a family history of cardiovascular disease are more prone to developing the disease themselves.
- **Gender**—Males are more at risk of coronary heart disease than are females.

Other risk factors for cardiovascular disease can be modified. The modifiable risk factors for cardiovascular disease are:

- **Smoking**—Smokers are up to five times more likely to develop a cardiovascular disease than are non-smokers. The chemicals contained in cigarette smoke (such as nicotine, tar and carbon monoxide) can increase heart rate, constrict the vessels (reducing blood flow) and reduce the oxygen-carrying capacity of the blood.
- **High blood pressure**—Blood pressure is one of the most common causes of heart disease; high blood pressure is linked to a high-salt diet and being overweight. If left untreated, it significantly increases the risk of both cerebrovascular disease and coronary heart disease.
- **High blood fats**—High levels of cholesterol and triglycerides (types of lipids or ‘fats’) in the blood significantly increase the chances of cardiovascular disease. Dangerously high levels of these substances can often be decreased by low-fat diets.
- **Overweight and obesity**—People who are overweight are at an increased risk of heart disease because of the extra burden placed on the heart and lungs, and because obesity is linked to high blood pressure and an increased level of blood fats.
- **Lack of physical activity**—People who do not engage in regular physical activity can have a less efficient heart, higher levels of blood fats and a propensity to gain weight. These factors combine to increase the risk of coronary heart disease. Besides these major risk factors, other possible influences include poor nutrition, alcohol, the contraceptive ‘pill’ (especially coupled with smoking) and diabetes.

Protective factors
Protective factors are the opposite of risk factors in that they help lower a person’s chances of developing heart disease. Some protective factors are discussed below:

- **Maintain healthy levels of blood pressure and blood cholesterol**—Regular blood pressure and cholesterol checks will assist in early identification and management of any factors associated with heart disease.
- **Quit smoking**—Stopping smoking is the single most important action a person can take to reduce his or her risk of cardiovascular disease.
- **Enjoy healthy eating**—Healthy eating means enjoying a variety of foods from different food groups. Healthy eating involves choosing mainly vegetables and fruits; moderate amounts of lean meats, poultry, fish and reduced-fat dairy products; and moderate amounts of polyunsaturated or monounsaturated oils and fats.
- **Visit the doctor regularly**—Regular visits to the doctor can assist in maintaining any early signs of risk for cardiovascular disease. This includes assessing blood pressure, cholesterol, family history and lifestyle factors. With this information, a doctor can provide individualised advice on the best ways for the patient to lower his or her risk and lead a healthy-heart lifestyle.
- **Be physically active**—Regular, moderate-intensity physical activity is good for the heart. Engaging in at least 30 minutes of physical activity, such as brisk walking, on most days of the week can help lower blood pressure, lower blood cholesterol and assist in maintaining a healthy weight range.
- **Achieve and maintain a healthy weight**—Being overweight and carrying too much weight around the waist are risk factors for cardiovascular disease and diabetes. Therefore, maintaining a healthy body weight by eating healthily and participating in regular physical activity will act as a protective factor to cardiovascular disease.

Figure 2.6 Smoking is a major risk factor for cardiovascular disease
prevention support in rural and remote areas. The higher percentage of Aboriginal and Torres Strait Islander peoples in remote populations is also a contributing factor. People in these communities are more likely to consult elders for advice regarding health issues, and are often reluctant to access conventional Western health care.

Higher rates of cardiovascular disease in males can, to a certain degree, be attributed to the fact that they are more likely to ignore early warning signs and less likely to access health services. This behaviour might be due to social expectations and the concept of masculinity, or might be due to genetic and biochemical characteristics of males.

The effective use of the mass media and education in health promotion has contributed to the decline in cardiovascular disease. A greater awareness of the behaviour that prevents cardiovascular disease has resulted from health promotion campaigns conducted by both government and non-government agencies; for example, the National Heart Foundation. Increased access to healthy products (such as low-fat, low-salt foods) has led to improved nutrition, and improved exercise amenities in public parks and the workplace have promoted physical activity. For some groups, however, increased access to a healthier lifestyle might not be possible; for example, for people who are socio-economically disadvantaged.

Groups at risk of cardiovascular disease

The groups at highest risk of developing cardiovascular disease are males, Aboriginal and Torres Strait Islander peoples (see the article opposite), socio-economically disadvantaged people and those born in Australia. Within these broad population groups the more specific groups at risk include people with a family history of cardiovascular disease, people who smoke, people with high blood pressure, people who are overweight, ‘blue-collar’ workers and people aged over 65 years.

Socio-cultural, socio-economic and environmental determinants

A social determinant contributing to cardiovascular disease is socio-economic status. Socio-economically disadvantaged people are more likely to develop cardiovascular disease, and the well-documented reduction in the condition over the past 20 years is not as significant in this group. The risk of cardiovascular disease for women of low socio-economic status is twice that of women from a higher socio-economic status. People who are socio-economically disadvantaged demonstrate more risk behaviour, such as smoking, obesity and physical inactivity. This is a major contributor to these differences in the incidence of cardiovascular disease.

There are variations in the incidence of cardiovascular disease between people who live in metropolitan areas and those who live in remote or rural locations. The variation is most notable in coronary heart disease, and can be linked to higher levels of smoking and obesity, a lack of access to appropriate health services, and a lack of availability of

Critical inquiry

Read the article opposite, then complete the following tasks:

1. Describe the reasons for Indigenous Australians dying from cardiovascular disease at a rate that is 1.4 times higher than other Australians.

2. Describe the nature of cardiovascular disease presented in the article.

3. Identify the risk factors and protective factors outlined.

4. Discuss the socio-cultural, socio-economic and environmental determinants that impact on members of the community.

5. Evaluate the effectiveness of the proposed strategies suggested.
Too many of us have gone early: priorities in heart health education for Aboriginal people

By Penny Abbott, Joyce Davidson and Louise Moore

Aboriginal people have a higher burden of cardiovascular risk factors and heart disease and poorer outcomes after heart attacks when compared with other Australians … The importance of education about heart attack symptom recognition and prompt hospital presentation, as well as risk factor management, by general practitioners and other health practitioners working with Aboriginal people, is highlighted …

Cardiovascular disease (CVD) is the single greatest cause of premature death in Aboriginal people. Prompt presentation to hospital with heart attack symptoms is critical … [Participants] highlighted the need for community recognition of the symptoms of heart attacks and the importance of early hospital presentation. Strikingly, they did not identify risk factor management as a key heart health message for their community …

[Compared] to other Australians, Indigenous Australians have 1.4 times the likelihood of dying from a heart attack before reaching hospital, twice the likelihood of dying in hospital, and less chance of undergoing revascularisation procedures. Late presentation to hospital is likely to contribute to these suboptimal outcomes and geographic barriers are not enough to explain this. In a Northern Territory study, Indigenous people sought hospital care for heart symptoms much later than non-Indigenous people (10 vs 3.26 hours) regardless of whether they were from urban or remote communities …

In Australia, a substantial number of heart attack patients present first to their GP, causing unnecessary delay. Studies have shown a lack of knowledge of symptoms and the correct course of action is associated with low education, low income and language barriers. In addition social and emotional factors are important, with embarrassment and not wanting to bother others cited as common reasons for late presentation …

The main causes of delayed hospital presentation of Aboriginal people with heart attack symptoms are lack of symptom recognition, failure to act despite knowledge that a heart attack is probably occurring, and taking inappropriate action.

Mass media campaigns, including that of the National Heart Foundation of Australia, have had mixed results and are generally less effective in reaching marginalised communities. However, there is evidence that health professionals can make a difference through individual patient education, particularly highlighting to patients that they are at high personal risk of a heart attack and that symptoms are not always dramatic, and promoting the correct course of action in the event of heart attack symptoms, including the use of action plans …

Aboriginal people have a much higher burden of all vascular risk factors. Reduction of these biomedical and behavioural risk factors will help prevent premature heart disease and is a strong focus of Aboriginal heart health programs … Aboriginality is itself a recognised risk factor for CVD, decreasing the thresholds for initiating medical management of other risk factors such as hypertension and hyperlipidaemia [a condition characterised by elevated or abnormal levels of lipids or lipoproteins in the blood] …

In addition, it is unclear whether beliefs as to the causes of coronary heart disease affect heart attack survivors’ ability to change their risk behaviour. Studies are contradictory on this point. Cultural differences can affect understandings of the relationship between heart disease and vascular risk factors.

One study of urban Aboriginal people’s perception of diabetes found that the people interviewed saw diabetes as a series of acute illnesses that needed to be dealt with when they happened, rather than as a preventable or manageable chronic disease …

It is possible that cultural understandings about the relationship between risk factors and heart attacks may contribute to some of the practical challenges encountered in improving Aboriginal heart health, such as decreased adherence to prescribed risk factor medication and lower attendance at cardiac rehabilitation. Exploration of Aboriginal people’s perceptions of the causation of heart disease and what they can do to prevent it may improve the quality of heart health education for Aboriginal people.

It is important for health professionals to discuss how to recognise and act on possible heart attack symptoms with high-risk Aboriginal patients …

Investigation of the reasons behind delayed hospital presentation by Aboriginal people with heart attack symptoms, and effective strategies for CVD risk factor education are required. Better knowledge of cultural understandings about heart disease and CVD risk factors may increase the effectiveness of heart health education programs for Aboriginal people.

Australian Family Physician, Vol. 37, No. 4
Cancer

Over the last decade, improvements in early detection and treatment of cancer have resulted in improved survival and a decline in mortality for most cancers, despite the overall cancer incidence rate remaining virtually unchanged. Cancer was the leading cause of the total burden of disease and injury in Australia in 2003, with four-fifths of this burden due to premature death.

The nature of cancer

Cancer refers to a group of diseases that result when the process of cell division becomes uncontrolled. These cells multiply in a random manner and form tumours (swellings). Tumours can form and remain localised with no threat of spreading. These are called benign tumours, and can be treated surgically. However, if the tumour has the potential to spread uncontrolled throughout surrounding normal cells and affect their functioning, it is called malignant.

If left untreated these cancer cells can break off and enter the blood stream and lymphatic system and travel to other parts of the body, where they can cause new cancers to grow. This is known as metastasis, and results in the formation of what is called secondary cancer.

There are various types of cancer. Some develop slowly; some quickly. Some have known causes; others are of unknown cause. Cancers are classified according to the area of the body where they initially began. The four classifications of cancer are:

- carcinoma—cancer of epithelial cells (including skin, mouth, throat, breasts and lungs)
- sarcoma—cancer of bone, muscle or connective tissue
- leukaemia—cancer of the blood-forming organs of the body
- lymphoma—cancer of the infection-fighting organs of the body.

Extent of and trends in cancer

Since the 1990s, cancer has replaced cardiovascular disease as the greatest cause of years of life lost or fatal burden. Cancer is second among the causes of death in Australia. It accounts for approximately 30 per cent of all deaths. According to a 2008 AIHW report, in 2005 there were 38,838 deaths from cancer. Of these, 21,860 were of males (33 per cent of all male deaths) and 16,978 were of females (27 per cent of all female deaths). Cancer reaches its highest incidence and mortality in the 65 years and over age group, in whom it accounts for 45.5 per cent of deaths.

In the past 15 years the incidence rate of melanoma has increased more rapidly than that of any other type of cancer. With an ageing population, it is anticipated that there will continue to be increases in melanoma and breast cancer.

As Figure 2.9 shows, some types of cancer have decreased in incidence, while others have increased. After taking all cancers into account, however, there has been an increase in incidence in the last 20 years. The overall cancer incidence rate was higher among males than females. Reasons for the increase in cancer incidence include:

- exposure to risk factors (for example, ultraviolet radiation)
- improvements in the quality of detection techniques (for example, prostate-specific antigen, or PSA, testing for prostate cancer, and mammograms for breast cancer)
- more widespread use of personal and medical detection techniques (for example, self-examination for breast and skin cancers)
- people being less likely to die from other causes (for example, from coronary heart disease and accidents).

A benign tumour is not cancerous so does not pose a threat to life or long-term health.

A malignant tumour invades the tissue around it and may spread to other parts of the body. It is a threat to life or long-term health.

Research and Review

1 Define ‘cardiovascular disease’ and ‘atherosclerosis’.
2 Describe the three major types of cardiovascular disease.
3 Identify the trend in cardiovascular disease. Explain reasons for this trend.
4 Outline the modifiable and non-modifiable risk factors for cardiovascular disease.
5 Discuss the socio-cultural, socio-economic and environmental determinants that contribute to cardiovascular disease.

Internet support concerning cancer can be accessed via www.oup.com.au/pdhpe12

Figure 2.8 Skin cancer is a form of carcinoma
While there has been a fall in the death rate from cancer, there has been an increase in the number of people in the 65 years and over age group who have the highest rates of cancer incidence and mortality.

By the age of 75 years, one in three Australian males and one in four females will have been diagnosed with cancer at some stage of their life. The risk by age 85 years increases to one in two for males and one in three for females.

The risk of dying from a cancer before the age of 75 years is one in eight for males and one in 11 for females. The risk of dying from cancer before the age of 85 years is double those proportions: one in four for males and one in six for females.

The most common type of cancer among new cancer cases registered for females in 2004 was breast cancer. This was followed by colorectal cancer, melanoma and lung cancer. These four accounted for 59 per cent of all registered cancers in females in 2004.

Males accounted for 53 per cent of the cancer burden. Prostate cancer was the most common cancer among men. The use of prostate-specific antigen tests in screening for prostate cancer has allowed researchers to determine the cause of death. Colorectal cancer, lung cancer and melanoma (a malignant tumour, most often on the skin) were the next most common cancers diagnosed.

Figure 2.9 Trends in the incidence of selected cancers

Overall, there has been a decrease in the incidence of certain cancers as the graph above illustrates. The decrease in the cases of lung cancer is due, mostly, to reduced rate of smoking in males. Stomach and bowel (colorectal cancer) cancer are decreasing as a result of better diet and improved food preservation. There is a downward trend in deaths from breast cancer as a result of improved treatments and screening. An increased use of 'Pap' tests is a significant contributor to the decline in cervical cancer.

Critical inquiry

Explain why there has been an increase in cancer incidence, but a decrease in mortality.

Research and Review

1. Research the incidence of prostate cancer. It was anticipated that there would be a levelling off, and even a possible decrease, in the incidence of this disease. Has this occurred?

2. Research the incidence of cancer in females to determine whether the trends presented are still current.

Risk factors and protective factors for cancer

As with cardiovascular disease, the risk factors for cancer can be divided into two categories: those that can be modified and those that cannot be modified. The risk factors vary according to the type of cancer.

Skin cancer

The major cause of skin cancer is exposure to the sun’s ultraviolet rays. The sun is at its most damaging between the hours of 11.00 am and 3.00 pm. Exposure to sunlight in childhood increases the chances of skin cancer later in life. Further risk factors include having fair skin (which readily burns) and having a large number of moles. Both of these increase the risk of developing melanoma. These are hereditary factors, which cannot be modified.

Breast cancer

There are still many unanswered questions regarding the cause of breast cancer. The major risk factor that is unavoidable is, of course, gender. Family history of breast cancer increases the risk of developing the disease. Risk factors associated with lifestyle are believed to be obesity, and a late maternal age (over 40 years) at the time of the first full-term pregnancy.

Figure 2.10 Media coverage of the breast cancer diagnoses of Kylie Minogue and other high-profile breast cancer sufferers has raised awareness of breast cancer

Source: AIHW, Australia’s Health, 2008

Figure 2.9 Trends in the incidence of selected cancers

Figure 2.10 Media coverage of the breast cancer diagnoses of Kylie Minogue and other high-profile breast cancer sufferers has raised awareness of breast cancer

Chapter 2 | WHAT ARE THE PRIORITY ISSUES FOR IMPROVING AUSTRALIA’S HEALTH?
Lung cancer
The risk factors related to lung cancer that cannot be modified are gender, age and family history. Risk factors that can be modified include smoking and exposure to carcinogenic chemicals; for example, asbestos and lead. People who are regular smokers are up to 20 times more likely to develop lung cancer. It is never too late to give up smoking because the body has the capacity to repair the damage done by smoking, and thus reduce the risk of lung cancer.

Breast cancer
The increased incidence of breast cancer in females can, in part, be linked to changes in family structure and the changing role of women in society. The average age at marriage is now later, as is the average age of a female's first pregnancy. This delay is a response to greater financial demands placed on young families, and the desire of females to focus on establishing a career before having a family. The result has been more females experiencing their first full-term pregnancy after the age of 40 years, and thus increasing their risk of breast cancer.

Socio-cultural, socio-economic and environmental determinants

Skin cancer
The incidence of skin cancer is increasing as a result of improved education relating to detection. Education and media health promotion strategies have alerted the community to the importance of detecting skin anomalies early, and reporting for medical advice. This increased education and awareness has resulted in common, less-harmful skin cancers being recorded and treated more frequently than in the past, thus resulting in a higher rate of incidence. On the negative side, the media are sometimes guilty of promoting tanned skin as being desirable, and thereby encouraging people to expose themselves to dangerous ultraviolet rays.

In Australia, society has for many decades regarded a suntan as 'healthy' and attractive. There has been a shift in attitudes, however, and it is now less fashionable to aspire to the traditional image of the 'bronzed Aussie' lifesaver.

Exposure to the sun in the workplace, and in recreational and school activities, is of concern with respect to rates of skin cancer.

Lung cancer
The incidence of lung cancer is decreasing in males, reflecting a decrease in the smoking rate over the past two decades. Improved education and effective health promotion strategies have contributed to this behavioural change, as has society's changing attitude to smoking. People are more aware of passive smoking and less tolerant of other people's smoking, especially in public areas and the workplace.

Improved workplace safety codes and equipment have also resulted in reduced exposure to carcinogenic substances (for example, asbestos) in the workplace. People of low socio-economic status, however, are more likely to be employed in occupations that involve exposure to dangerous materials, and involve high-risk tasks. These occupations include mining and construction.

In females, the incidence of lung cancer has increased, and smoking levels in young females remain high. The changing role of females in the workplace might be a cause for this increase in lung cancer. Females are challenging traditional gender roles and stereotypes, and are more active in a range of occupations that previously were the domain of males. These occupations are, in most cases, more 'high-powered', which can lead to higher stress levels. For some of these women, smoking might be a factor in presenting an image of being 'in control'. The media might also have a negative influence through the promotion of high-profile, attractive females smoking, and in the promotion of a link between smoking and weight control (which is, of course, important in relation to perceptions of body image).
The National Drug Strategy Household Survey: tobacco smoking

Tobacco smoking is the single most preventable cause of ill health and death in Australia, contributing to more drug-related hospitalisations and deaths than alcohol and illicit drug use combined. It is a major risk factor for coronary heart disease, stroke, peripheral vascular disease, cancer and a variety of other diseases and conditions …

The tangible costs of tobacco use in Australia were estimated to be $10.8 billion in 2004–05 or about 1.3% of gross domestic product …

[One] in six Australians aged 14 years and over smoked daily (16.6%) … Males were more likely to be daily smokers (18.0%) than females (15.2%). Former smokers outnumbered smokers at 25.1% of the population … and 55.4% had never smoked … Compared with overall smoking rates, smoking is far more common among those of lower socioeconomic status and among Indigenous Australians.

In Australia, the overall smoking rate has been declining since the 1950s, when an estimated 70% of males and 30% of females smoked. Between 1985 and 2007, the prevalence of daily smoking declined by 14.7 percentage points for males and 10.9 percentage points for females … [Daily] smoking among those aged 18 years and over declined from 19.2% in 1998–99 to 16.1% in 2006–07 …

In 2007, about one in 18 persons aged 12–19 years smoked daily. Rates were around 2% for those aged 12–15 years and markedly higher for those aged 16 years and over [see Table 2.1]. About 97% of the 12–15 years age group reported having never smoked a full cigarette; about the same proportions for both males and females …

The ability of teenagers to purchase cigarettes increases their likelihood of smoking. Accordingly, all states and territories in Australia have legislation that prohibits the supply of cigarettes to people under the age of 18 years.

Estimates from the Australian Secondary Schools Alcohol and Drug surveys show that the proportion of current smokers aged 12–15 years who had purchased their most recent cigarette (instead of acquiring it in some other way) declined markedly from 52% in 1987 to 17% in 2005, and for current smokers aged 16–17 years the decline was from 64% to 29%.

Children are particularly susceptible to the effects of passive smoking … For children, this so-called environmental tobacco smoke increases the risk of a range of health problems. These include respiratory infections, middle ear infections, onset and worsening of asthma, decreased lung function, eye and nose irritation, low birth weight, and sudden infant death syndrome.

The benefits of reducing children’s exposure to environmental tobacco smoke at home include reduced school absenteeism, increased school performance, reduced uptake of smoking, and lower consumption of tobacco among children who smoke …

With the general decline in smoking prevalence, and the increasing awareness of the effects of environmental tobacco smoke, … less than 8% of households in 2007 or around 300 000 dependent children [are] exposed to tobacco smoke inside the home.

AIHW, Australia’s Health, 2008

Table 2.1  Daily smokers: proportions among those aged 12–19 years, 2007 (per cent)

<table>
<thead>
<tr>
<th>Age group</th>
<th>12–15</th>
<th>16–17</th>
<th>18–19</th>
<th>12–19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>1.5</td>
<td>4.1</td>
<td>11.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Females</td>
<td>2.5</td>
<td>7.4</td>
<td>13.7</td>
<td>6.6</td>
</tr>
<tr>
<td>Persons</td>
<td>2.0</td>
<td>5.7</td>
<td>12.6</td>
<td>5.6</td>
</tr>
</tbody>
</table>

AIHW, Australia’s Health, 2008

Source: AIHW, Australia’s Health, 2008

Figure 2.13  Daily smokers, population aged 14 years and over, 1985–2007

Chapter 2  WHAT ARE THE PRIORITY ISSUES FOR IMPROVING AUSTRALIA’S HEALTH?
Groups at risk of cancer
The groups at risk of cancer include:

- smokers
- people who are socio-economically disadvantaged
- people with high-fat, low-fibre diets
- people with a family history of cancer
- people with fair skin
- people who spend long periods of time exposed to the sun
- women who have never given birth.

The National Drug Strategy Household Survey is conducted by the Australian Institute of Health and Welfare every three years. It collects comprehensive information about people’s use of and attitudes towards tobacco, alcohol and illicit drugs; experiences of alcohol- and other drug-related harm; and physical and mental health. The extract on page 35 is from the 2007 survey and is concerned with tobacco smoking.

practical application
Tobacco smoking and cancer
In small groups, design a poster to illustrate one of the trends occurring in tobacco smoking and its contribution to the incidence of cancer. Your poster should include a:

- title
- graph labelled correctly
- short description.

Research and Review
1 Identify the three leading causes of:
   a cancer in males and females
   b cancer mortality in males and females.
2 The increase in cancer incidence has been partly attributed to improvements in detection techniques.
   a Identify the steps that are available to individuals to detect cancers at the earliest possible time.
   b Explain why some people do not take full advantage of available screening services.
   c Propose how screening services could be further promoted and utilised.
3 a There have been significant increases in melanoma (a form of skin cancer) over the last 15 years. Explain why this is so.
   b Describe the steps that have been taken to reduce the incidence of skin cancer.

Critical inquiry
1 Analyse the impact of tobacco smoking on health by investigating:
   a the extent of tobacco smoking (that is, trends)
   b risk factors and protective factors related to tobacco smoking
   c the socio-cultural, socio-economic and environmental determinants related to tobacco smoking
d groups at risk of tobacco smoking.

Diabetes
The incidence of diabetes is on the rise in Australia and across the world. Recent increases in the number of people with diabetes have led to claims that it has now risen to ‘epidemic’ proportions.

The nature of diabetes
Diabetes mellitus is a hereditary or developmental disease caused by the improper functioning of the pancreas. This results in a disturbance in the sugar levels (glucose concentration) of the blood. If there is insufficient sugar in the blood, the condition is known as hypoglycaemia. Too much sugar in the blood is known as hyperglycaemia.

Type-1 diabetes is not a lifestyle disease. It is an autoimmune disease and, as yet, cannot be prevented.

Type-2 diabetes results from a combination of genetic and environmental factors. Although there is a strong genetic predisposition, the risk is greatly increased when associated with lifestyle factors, such as high blood pressure, overweight or obesity, insufficient physical activity, poor diet and the classic ‘apple shape’ body where extra weight is carried around the waist.

Diabetes produces a high level of blood sugar if untreated. A person with diabetes has an increased risk of coronary heart disease and atherosclerosis. Diabetes is also linked to kidney failure, nerve disease in the lower limbs and blindness.
Extent of and trends in diabetes

There has been a significant increase in the number of people with diabetes in Australia over the last 20 years, and it is now a major cause of morbidity and early mortality. In 2005, there were 901 new cases of type-1 diabetes in children aged under 15 years, 788 new cases in people aged 15–39 years and a 20 per cent increase in the rate of new cases since 2000.

Source: AIHW, Australia’s Health, 2008

Figure 2.14  Trends in the prevalence of diabetes

An increase in the incidence of diabetes may play a major role in trends in diabetes prevalence. Yet the increased incidence may also result from rising awareness in the community, better detection and better survival.

A total of 11,864 deaths in Australia in 2005 were caused to some degree by diabetes. Where diabetes was the underlying cause of death, common conditions listed as associated causes included coronary heart diseases, kidney-related diseases, stroke and heart failure. There have not been major changes in the death rate from diabetes (as an underlying cause) over the last 25 years, although there have been some differences in the rates for males and females. For males, the death rate rose by an average of 0.7 per cent per year. In contrast, the rate for females fell by an average of 0.5 per cent per year.

The death rate for diabetes increases progressively with age; about 87 per cent of people who died with diabetes in 2005 were aged 65 years and over. Males are more likely to die from diabetes than are females.

More than half (56 per cent) of the people with diabetes also have a disability. Diabetes is the eighth leading cause of disease and injury in Australia. It increases the risk of coronary heart disease and stroke and, when this contribution is added, diabetes is then ranked fourth out of all diseases. It is projected that by 2023, type-2 diabetes will be the leading specific cause of disease burden for males and the second for females.

Australia has a relatively low prevalence of overall diabetes compared with other countries, ranking the third lowest in 2006. Australia’s incidence of type-1 diabetes among 0–14 year olds in the late 1990s to early 2000s was the fourth highest in the world.

Risk factors and protective factors for diabetes

Risk factors for diabetes differ by type of diabetes. There are two main types of diabetes: insulin-dependent diabetes (type 1) and non-insulin-dependent diabetes (type 2).

Insulin-dependent diabetes (type 1)

Insulin-dependent diabetes is more common in children and young adults, and is caused by the failure of the pancreas to supply sufficient amounts of insulin to convert glucose into energy. The cause of insulin-dependent diabetes is not confirmed, but is possibly linked to genetic factors and to viral infections contracted while young. It can also be caused by biological interactions and exposure to environmental agents among genetically predisposed people. Type-1 diabetes is managed by artificially supplying the body with insulin through regular injections.
Non-insulin-dependent diabetes (type 2)

Age is a risk for type-2 diabetes and genetic predisposition is shown by family history and ethnic background. Unlike type-1 diabetes, non-insulin-dependent diabetes has strong links to lifestyle. Type-2 diabetes occurs in adults, and is related to obesity, physical inactivity and an unhealthy diet. It is related to high blood pressure, the intake of too much saturated fat and refined sugar, and high alcohol consumption. As such, it is controlled through strict dietary measures and weight reduction.

The protective factors for diabetes include regularly participating in physical activity, eating a well-balanced diet, consuming no or little alcohol, limiting the intake of saturated fat and refined sugar and maintaining a healthy weight range.

Socio-cultural, socio-economic and environmental determinants

The increased incidence of non-insulin-dependent diabetes is linked to social factors, such as socio-economic status. Socio-economically disadvantaged people are less likely to engage in physical activity, are more likely to consume large amounts of alcohol, are more likely to be obese, and more likely to have diets that are high in saturated fats. The significantly higher incidence of non-insulin-dependent diabetes in Aboriginal populations results from a combination of these factors, in addition to a lack of access to education and medical care.

Another contributing factor is the social acceptance of alcohol. Dangerous levels of alcohol consumption are considered a normal part of the Australian lifestyle, despite the fact that it is a significant risk factor for conditions such as non-insulin-dependent diabetes.

An ageing population has also contributed to an increased incidence of non-insulin-dependent diabetes. As the Australian population ages, the most rapid growth will occur in the age group of 45 years and over.

Groups at risk of diabetes

Groups at risk of type-2 diabetes are:

- those aged over 65 years
- those with a family history of adult-onset diabetes
- people who are overweight
- those with high intakes of saturated fat and refined sugar
- people who frequently consume alcohol
- those who engage in little or no exercise.

Aboriginal and Torres Strait Islander peoples have markedly higher rates of diabetes (specifically type 2) compared with other Australians. Six per cent of the total Indigenous population has diabetes/high-sugar level. The prevalence of diabetes among Indigenous people is almost three times as high as that of non-Indigenous Australians. There are also higher rates of diabetes among other sections of the Australian community, namely those living in more remote areas, those with lower socio-economic status and those born overseas.
Respiratory disease

We may take breathing for granted, thinking that it is just an involuntary reflex action. But for the millions of people who suffer from respiratory disease, each breath is a major accomplishment.

The nature of respiratory disease

Respiratory disease, or chronic obstructive pulmonary disease (COPD), is a disease that destroys the lung tissue and narrows the air passages to obstruct oxygen intake, causing chronic shortness of breath. A person with COPD is prone to episodes where shortness of breath is more severe and he or she has fits of coughing with mucus. The lung damage is mainly due to the long-term inhalation of irritant gases and particles, and by far the main cause of this is cigarette smoking. Common COPDs are emphysema and chronic bronchitis.

Extent of and trends in respiratory disease

An international survey of people aged 20–44 years ranked Australia third out of 16 high-income countries in the prevalence of mild COPD. In this survey, Australia had the lowest prevalence of the identified groups considered at risk of respiratory disease. The World Health Organization (WHO) predicts that COPD will become the third leading cause of death worldwide by 2030.

Deaths due to respiratory disease were 45.2 per cent and 3.7 per cent of all deaths. The death rate among males was almost double the female rate. Overall, the death rate for COPD has fallen over the last 25 years. In males, the death rate due to COPD fell every year for the last 10 years, except in 2002. In females, the rate appeared to level off after peaking in 1997 until a small fall in 2005.

In 2004–05 fewer Australians had emphysema and/or bronchitis than in 2001. Among those aged 65 years and over, 8 per cent had emphysema and/or bronchitis compared with 3 per cent of all Australians. For people aged 65 years and over, emphysema and/or bronchitis is more common in males than in females. Influenza and pneumonia can worsen the symptoms of COPD, decrease lung function and lead to hospitalisation or even death. These risks can be reduced significantly by vaccination.

Risk factors and protective factors for respiratory disease

Tobacco smoking is the most important risk factor for COPD. Other risk factors for COPD may worsen respiratory symptoms or may contribute to the risk of developing the disease, either independently or in conjunction with tobacco smoking. These include respiratory infections and exposure to environmental (passive) tobacco smoke, indoor and outdoor air pollution, and occupational dusts and chemicals.

Socio-cultural, socio-economic and environmental determinants

Social factors that influence the risk of COPD include socio-economic status. People of low socio-economic status are more likely to smoke. Thus, children of low socio-economic status are more likely to be exposed to passive smoking in the home. Indigenous adults are twice as likely to smoke as are other Australian adults, thus increasing asthma risk for their children. The death rate from asthma is higher in rural and remote locations than in capital cities. This might reflect difficulty in accessing emergency care when a serious asthma attack occurs.
Asthma can be triggered by exposure to environmental pollutants. Children from lower socio-economic groups are more likely to live in areas close to factories or high-density housing near industrial areas. Children from low socio-economic groups might also be less likely to obtain adequate medical care regarding asthma prevention, control and treatment. Asthma might be more common in people from low socio-economic areas because they are more likely to work in hazardous jobs involving chemicals and fibres.

Groups at risk of COPD
Groups at risk of COPD are those aged over 65 years, people who smoke and people prone to allergies. Young children are at highest risk of developing asthma. In particular, Aboriginal and Torres Strait Islander peoples, people from low socio-economic areas and people from non-English speaking backgrounds are also at risk of COPD.

Injury
Injury has a major, but often preventable, impact on Australia’s health. It affects Australians of all ages, is the greatest cause of death in the first half of a person’s life and leaves many with serious disability or long-term conditions.

The nature of injuries
For the purpose of this study, ‘injuries’ are defined as those that are caused by any form of external violence. These include injuries and death suffered as a result of motor vehicle and workplace accidents, suicide, violence, drowning and poisoning. Because of the sudden nature and tragedy of deaths from injuries, such deaths are often accompanied by severe emotional trauma. There is also significant loss to the community because deaths from external violence are most likely to occur in young adults.

Extent of and trends in injuries
Injuries caused by accidents, poisonings, suicide and violence are the fourth most common cause of death in Australia. They account for approximately 7.5 per cent of all deaths. The overall injury death rate for males was almost 1.7 times that of females. Injury was the most common cause of death from early childhood through to middle age. In 2004–05, half of all deaths of persons aged 1–44 years were due to injury.

The three main causes of death through injury are self-harm or suicide, falls and transport-related injuries. Other injuries include those caused by poisoning, drowning, fires, homicide and machinery. Injury death rates are relatively low in childhood (see Figure 2.18). For those aged 1–14 years, 38 per cent of all deaths in 2004–05 were due to transport injuries (especially as car occupants and pedestrians); drowning (especially for toddlers); and fires, burns and scalds. Injury is the main cause of death in the age range during which teenagers become adults. In 2004–05, 71 per cent of all deaths at ages 15–24 years were injury deaths, mainly due to transport injuries and suicide. Suicide and transport-related injuries are also prominent causes of injury death in middle age. At older ages, fall-related injury predominates.

Overall, injury mortality has tended to decline during recent decades, largely due to a decline in road deaths. The decline in road deaths has slowed more recently. From the late 1990s, noteworthy declines occurred in drug-related deaths and in suicides.

Falls by older people commonly result in a fracture, often of the hip. Nearly one-third of hospitalised fall-related injuries for older Australians in 2005–06 involved the hip or thigh. Head injuries due to a fall were also common, particularly for males. Most injurious falls for all Australians are due to slips, trips and stumbles.
### Risk factors and protective factors for injury

For the major causes of injury there are specific sets of risk factors. Youth suicide can be linked to a number of social changes that have placed extra pressures on young people. High levels of unemployment, higher levels of illicit drug use and increased breakdown in family structure are just some factors that could possibly lead to depression and eventual suicide. Young people feeling depressed might also lack access to quality counselling and treatment. Other factors that can contribute to suicide include a mental disorder and inappropriate role modelling.

The major risk factors leading to injury through motor vehicle accidents have been clearly identified. They are speeding, alcohol, fatigue and not wearing a seat belt. Other factors that can contribute to motor vehicle injuries include overcrowding, driver inexperience, and road or environmental conditions.

Risk factors for child accidents include a lack of supervision and an unsafe environment. The reductions in transportation deaths can be attributed to improved car safety and restraining devices, along with helmet legislation and other cycling and pedestrian safety initiatives. Other initiatives such as pool fencing, electricity cut-off switches, smoke alarms and product safety standards have also contributed.

### Socio-cultural, socio-economic and environmental determinants

#### Suicide

The incidence of suicide in young males is of concern and can be linked to several social factors. Lifestyle patterns of young people have changed dramatically from those of earlier generations, and have possibly resulted in higher levels of depression.

One significant change has seen young people seeking more independence from their parents or carers at an earlier age. For some young people this independence is by choice as they desire more control over their lives and the decisions that affect them. For others, there is little choice because the extra independence and responsibility is forced upon them as they escape from a home life where they experience violence and neglect or due to family breakdown. Other young people find greater responsibility thrust upon them at an earlier age because both parents are in full-time employment.

As young people seek more independence, they can be confronted with unemployment, homelessness, an inability to develop positive relationships and the need to make decisions related to drug use. Some young people turn to drug use to cope with the extra pressures associated with their new independence and extra responsibilities. A lack of access to appropriate support networks for young people is also a contributing factor.

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**Table 2.2** Injury deaths by type of external cause, 2004–05

<table>
<thead>
<tr>
<th>External cause of injury</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Per cent</td>
</tr>
<tr>
<td>Unintentional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>1239</td>
<td>20.3</td>
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<tr>
<td>Drowning</td>
<td>174</td>
<td>2.9</td>
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<tr>
<td>Poisoning, pharmaceuticals</td>
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<td>Poisoning, other substances</td>
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</tr>
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</tr>
<tr>
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<tr>
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<tr>
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<td><strong>All external causes</strong></td>
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<td>100.0</td>
</tr>
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</table>

AIHW, Australia’s Health, 2008
Motor vehicle accidents

The media have become a very influential part of today’s society, and there is no better example of their influence than the role they have played in the reduction of road accidents. Although there are numerous factors that have contributed to this reduction, the ‘shock’ tactics used in many road safety television commercials appear to have had some impact on road-user behaviour. The increased use of community organisations involved in accident prevention has also played a part. An example of this is the Lions Club with its ‘Driver Reviver’ stops.

Deaths from motor vehicle accidents remain highest in young males. The desire to seek independence at an earlier age might contribute to this, and motor vehicle ownership is considered an integral part of this independence. For young males, motor vehicle ownership and the driving of a vehicle is also a symbol of adulthood and masculinity. For some, the desired image also involves driving a car that has been modified; for example, with ‘mag’ wheels and a turbo engine. Young males also engage in driving vehicles that are overcrowded, and this significantly increases the risk of accidents.

**practical application**

**Risk factors and protective factors for injury**

It has been suggested that the following ‘get-tough’ measures should be introduced to reduce deaths and injuries resulting from motor vehicles:

- ‘P’ plates to last a minimum of three years, and progression to a full licence to be allowed only after merit points have been earned
- all drivers to be re-tested every 10 years
- drink-driving rules to be further tightened
- lower speed limits to apply in wet weather
- road safety to be taught as part of the Higher School Certificate
- banning from the road of ‘hotted-up’ cars
- responsible attitudes to road safety to be taught in kindergarten
- jaywalking to be discouraged
- more traffic police patrols to be used
- an examination of why cars are sold with maximum speeds of 220 km/hour.

1. From the above list, identify three proposals that you believe will be most effective in lowering the number of deaths from motor vehicle injuries and suggest three proposals that will have little or no effect on road fatalities. Discuss reasons for your answer.

2. Describe how drink-driving rules can be further tightened. Is a ‘zero-tolerance’ approach to drink-driving the most effective strategy?

3. Fatigue is believed to be a major contributing factor in fatal road accidents. Discuss what measures can be taken to reduce fatigue-related road deaths.
Child accidents
Social factors that might result in child accidents include the need for both parents to be engaged in full-time employment, resulting in children being inadequately supervised. People who are socio-economically disadvantaged might not have the financial resources to provide the necessary safety devices designed to prevent child accidents (for example, electricity cut-off switches, smoke alarms and hot-water thermostats). There is also a link between child accidents and a lack of parental education.

Groups at risk of injury
Groups at high risk of injuries include:
- elderly people (mainly through falls)
- males aged 15–24 years
- drivers who speed and/or drink-drive
- young children
- workers in high-risk occupations (for example, mining or construction).

Critical inquiry
See the Practical Application task opposite.
1 Describe the difficulties that would be faced in attempting to implement these proposals.
2 Propose which groups would be likely to support the proposals and which groups might be opposed to the proposals.
3 Discuss how effective legislation is in reducing road accidents and injury.

Research and Review
1 Describe the trend in deaths from external sources. What are the three major causes of death from external sources?
2 Identify the major gender differences in deaths from external sources.
3 Discuss the measures that have contributed to reducing the incidence of injury in children from drowning, poisoning, falls and burns/scalds/fire.

The nature of mental illness
One in five Australians will experience mental illness at some stage during their lives. Mental illnesses can be categorised as psychotic or non-psychotic.

Psychotic illnesses
Psychotic illnesses are those that cause a person to lose touch with reality. Psychotic illnesses include schizophrenia and bipolar disorder (previously known as manic depression). People experiencing a psychotic illness might see, hear and feel a world that is very different from those experienced by the people around them. For the person with the illness, this world is very real. The person might display extreme emotions (ranging from joy to depression), false beliefs and, possibly, hallucinations. Medication is now available to treat psychotic illnesses effectively, and the associated societal stigma of these illnesses has decreased.

Non-psychotic illnesses
All people experience emotions. For some people these emotions can become overwhelming and interfere with their ability to cope with their day-to-day tasks, such as work and maintaining relationships. An individual with a non-psychotic mental illness experiences exaggerated feelings, such as depression, anxiety and fear. Common non-psychotic illnesses include phobias, depression and obsessive-compulsive disorder. As with psychotic illnesses, these conditions can be treated effectively. In some cases, they are more difficult to identify because the person experiencing the condition might hide the behaviour. This is commonly observed in those with anorexia or bulimia, for example.

The stigma associated with mental illness has decreased in recent years as more members of the community become aware of its existence, and become better informed about mental health issues. The stigma has not completely disappeared, however, and many people are still embarrassed or feel uncomfortable about the issue. A person with a mental illness needs the same support as someone with any other disease. These people need empathy, encouragement and care. Most people fully recover from a mental illness. They do not need to be isolated and most do not need hospitalisation.
### Extent of and trends in mental illness

A mental or behavioural disorder was recorded as the underlying cause for 579 deaths in 2005 (excluding dementia and suicide); a rate of 2.7 per 100,000 persons. The rate dropped substantially from the peak years of the mid to late 1990s, and now appears to be plateauiing (see Figure 2.20). Most cases with a mental or behavioural disorder as the underlying cause of death were due to abuse of psychoactive substances, such as alcohol and heroin.

In 2003, after cancer and cardiovascular disease, mental illness was the third highest contributor (estimated at 13 per cent) to the total burden of disease. Mental illnesses accounted for almost one-quarter (24 per cent) of the total disability burden for all diseases. Mental illness was spread across both sexes and all ages, with females accounting for 53 per cent of the burden. In females, anxiety and depression were the foremost causes, accounting for 10 per cent of the overall female burden of disease. Together, anxiety and depression ranked third (at almost 5 per cent) in the overall male burden. The burden from mental illnesses for both sexes was greater in early to mid adulthood than at other ages. Mental illnesses accounted for a relatively large proportion of overall disease burden for age groups up to middle age. Twenty-three per cent of the overall burden for children aged 0–14 years was due to mental illnesses; and the proportion was 36 per cent for the 15–44 years age group.

Of those people who had one mental disorder (including anxiety, substance use or personality disorder), 40 per cent reported having at least one other mental disorder. People with multiple mental disorders were more disabled, more distressed, had more consultations for mental health problems and had higher measured levels of neuroticism than those with only one mental disorder. There is strong evidence establishing depression as a risk factor for heart disease. There is a causal association between depression, social isolation and lack of quality social support and the onset and prognosis (likely outcome) of coronary heart disease.

![Death rates for mental and behavioural disorders](source: AIHW, Australia’s Health, 2008)

**Figure 2.20** Death rates for mental and behavioural disorders

![Mental Illnesses burden by age and sex](source: AIHW, Australia’s Health, 2008)

**Figure 2.21** Mental Illnesses burden by age and sex

### Critical inquiry

1. Explain whether mental illness has increased in incidence or is being better diagnosed.

2. If it has increased in incidence, is it valid to say that this is because life is more stressful now than it was in, say, the 1950s? If so, discuss the factors that have contributed to this increase.
Risk factors and protective factors for mental illness

There are many types of mental illnesses with varying degrees of severity. People who have a mental illness often also experience isolation and discrimination due to the stigma associated with their illness. Sometimes mental illness may develop when a person has a strong reaction to a particular drug. Illicit drug use increases the risk of developing a mental illness or making an existing mental illness worse. People who use drugs have much higher rates of mental illness than people who don't.

Psychotic illnesses

Schizophrenia

Schizophrenia is an illness that affects the mental functioning of a person and may cause changes to their personality. Schizophrenia affects people in different ways. For some, the illness might be only one brief episode, whereas for others it might be a lifetime condition. Schizophrenia might have a rapid onset over a period of weeks, or might develop over several months or years.

No single risk factor has been isolated for schizophrenia, but it is believed to occur as a result of a combination of factors. These include:

- **Genetic factors**—Schizophrenia has hereditary links; if one parent suffers from the illness, the children have a 10 per cent chance of developing the condition.
- **Biochemical factors**—Various neurotransmitters (chemicals that play a part in nerve cell function) have been implicated in schizophrenia. Abnormalities in the type and amounts of these neurotransmitters are likely to be linked to genetic factors.
- **Family relationships**—Although family relationships are not a cause of schizophrenia, relationship tension might lead to relapses. It is often unclear whether the illness contributed to the family tension, however, or the family tension preceded the illness.
- **Environment**—Stressful incidents might lead to an episode of schizophrenia but, as with family tensions (see earlier), it is often unclear whether the illness contributed to the stress or the stress preceded the illness.

Bipolar disorder

A person with bipolar disorder (previously referred to as manic depression) experiences extreme mood swings: episodes of depression alternating with episodes of abnormally heightened mood. This heightened mood is known as mania. The episodes of depression are more common and last longer than the episodes of mania, and many people develop prolonged episodes of extreme depression.

Causes of bipolar disorder include:

- **Genetic factors**—Children of parents with bipolar disorder have a greater risk of developing the disorder.
- **Biochemical factors**—A chemical imbalance in the brain might cause an episode of depression or an episode of mania. This imbalance is treated with medication.
- **Stress**—For some people, the condition can be triggered by a stressful incident, such as a relationship breakdown or unemployment.
- **Seasons**—For some unexplained reason, the likelihood of experiencing a manic episode is higher in spring and early winter.

Psychotic depression

As well as bipolar disorder (with extreme mood swings from depression to mania), some people suffer from severe psychotic depression without any manic features. People with this illness have all the characteristics of non-psychotic depression (described below), but also have psychotic features, such as severely disordered thought patterns, irrational beliefs and difficulty keeping in touch with reality. In common with other psychotic illnesses, this form of depression is probably caused by genetic and biochemical factors. An example of this type of depression is severe psychotic post-natal depression in which some women suffer a severe distortion of reality due to internal biochemical and hormonal factors after giving birth.
Non-psychotic illnesses

Non-psychotic depression

As described above, people with depression can suffer from severe psychotic symptoms in which they have difficulty keeping in touch with reality. However, depression can also occur in a less severe (but still distressing) form known as non-psychotic depression.

Depression is an emotion that all people experience at some time. For many it is a normal reaction to a life experience; for example, the loss of a loved one. However, clinical depression is a more serious condition and is not to be confused with unhappiness. Clinical depression lasts longer, is more intense and might result in anxiety, poor sleep patterns and loss of appetite.

The risk factors for depression include:

- **Genetic factors**—As with many other illnesses, the likelihood of depression is increased if there is a family history of the condition.
- **Biochemical imbalance**—Depression is believed to be due, in part, to a chemical imbalance in the brain. Significant changes in hormone levels, such as occur in menopause or after childbirth can be associated with depression in females. This can sometimes develop into severe psychotic depression.
- **Stress**—Depression is linked to stressful life episodes, such as unemployment, retirement or loss of a loved one.
- **Personality**—People with certain personality traits might be more likely to experience bouts of depression. Such people include those who are perfectionists, extremely stubborn or heavily dependent on others.

Anxiety

In common with depression, anxiety is an emotion that all people experience at some time. Some people are more deeply affected by their anxiety, however, and, in extreme cases, it can manifest itself in physical conditions, such as sweating, erratic heartbeat, headaches, nausea, muscle pain and faintness. The main types of anxiety disorders are simple phobias (for example, fear of spiders), social phobias (for example, fear of failing in the presence of others), obsessive-compulsive disorder (for example, repeated hand-washing and locking of doors), post-traumatic stress disorder (for example, flashbacks of major traumas) and panic disorders.

The risk factors for anxiety disorders are not clear. Anxiety disorders can result from unresolved problems developing into major life traumas, and may be triggered by a significant life experience.
A growing and ageing population

Australia has a growing and ageing population. Older Australians are people aged 65 years and over. This group makes up approximately 13 per cent of the population. The proportion of the population aged 65 years and over is projected to rise by between 27 per cent and 30 per cent by 2051. The ageing of the population is caused by two factors. First, Australian families are, on average, having fewer children. The second factor contributing to the ageing population is that we are living longer. With fewer babies being born, and more people living longer, it is inevitable that the population will become progressively older. With the population ageing and people living longer, there are more people, particularly those at older ages, who have a disability and are limited in their ability to participate in physical activity.

Healthy ageing

All Australians, regardless of age, should have access to appropriate employment, training, learning, housing, transport, cultural and recreational opportunities and care services that are appropriate to their diverse needs. This enables them to optimise their quality of life over their entire lifespan. Healthy ageing is concerned with quality of life, independence and lengthening the number of healthy years, not just the years of life, enjoyed by an individual. The benefits of adopting a healthy lifestyle even at an older age include the prevention of disease and functional decline, extended longevity and enhanced quality of life. The healthier an individual, the less demand that person places on health and aged care services.

Australian males aged 65 can expect to live to be 83.1 years, while 65-year-old females have an expected life span of 86.4 years. These life spans are about six years more than were experienced...
during the beginning of the twentieth century. Males and females aged 85 years can expect to live for a further 5.9 and 7.1 years, respectively, which is about two years more than for those living in the early 1900s. Most of these gains in life expectancy among older Australians occurred during the last three decades, when deaths from cardiovascular diseases (particularly heart disease and stroke) fell rapidly.

The majority of older Australians consider themselves to be in good health. Many older people have a positive view of their health, even though older age may be generally associated with increasing levels of disability and illness. Older females are more likely than older males to rate their health as excellent or very good.

**Increased population living with chronic disease and disability**

Coronary heart disease and cerebrovascular disease (particularly stroke) are the two leading causes of death among older males and females. These diseases are also major causes of disability among older Australians. Other heart diseases, which include heart failure, are also common. Lung cancer is the third most common cause of death for older males and the fifth for older females. Colorectal cancer is also high for both sexes, and prostate cancer and breast cancer are two important sex-specific causes of death. Other chronic diseases include cancer and chronic pulmonary obstructive disease, which includes emphysema.

Dementia and related disorders, such as Alzheimer’s disease, still cause many deaths among older Australians. Diabetes is the main underlying cause of death and was ranked the eighth leading cause for both older males and females. It also correlates with disability and poor quality of life. Diseases of the arteries, such as atherosclerosis and other peripheral vascular diseases, are the twelfth leading cause of death for older males and females.

The top causes of death for 65–74 year olds include pancreatic cancer, cirrhosis of the liver for males and ovarian cancer for females. At 75–84 years, deaths from dementia and related disorders are prominent, along with deaths from influenza and pneumonia. For those aged 85 years and over, influenza and pneumonia and kidney failure are among the top causes.

Other conditions with a large impact on older Australians include adult-onset hearing loss, Parkinson’s disease in males, and osteoarthritis and falls in females.

**Table 2.3** Leading causes of death in Australians aged 65 years of age and over

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<th>Females</th>
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<td>Total (all deaths 65+)</td>
<td>53 566</td>
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AIHW, Australia’s Health, 2008
Aged care crisis: a call for kindness and justice

By Tristan Ewins

… [In] light of Australia’s ageing population [who is responsible for] … the structural fiscal impact this will have on future Federal budgets? …

The crisis of aged care in Australia has many dimensions …

Charmaine Crowe, the Policy Co-ordinator of the Combined Pensioners and Superannuants Association (CPSA), … explained that … lack of trained staff comprises ‘the number one [reason] behind poor standards of care’ …

A report on the aged care workforce by the National Institute of Labour Studies at Flinders University found that (in 2008): ‘Registered nurses in aged care are reputed to earn $250 to $300 a week less than their colleagues in acute care.

Furthermore, ‘the number of registered nurses in aged care [had] reduced from 21 per cent to 16 per cent’.

Residents requiring a higher level of care often need to be ‘turned’ on a regular basis to avoid bedsores. And in case of incontinence, nurses need [to] check on the conditions of residents regularly, and must be able to assist in showering and washing residents whenever the need arises …

According to Crowe, ‘for-profit’ aged care is counter-productive. There is a contradiction, here, between an ethic of providing the greatest care and respect, and the motive of maximising profit and share-value. Ideally, there ought to be a mix of public and private providers—where private providers are run on a ‘not-for-profit’ basis—managed by charities, churches and other community organisations …

There are many dimensions to the problem: but the inability of vulnerable patients to hold their carers accountable—often because of dementia and other conditions—is a central concern …

Crowe holds that the accreditation process ‘lacks vigour’ resulting in poor quality of care. Currently, nursing home management has the option of ‘nominating the assessor’ who will conduct the accreditation review: a clear conflict of interest. Reviews need to be more thorough; without such conflicts. And more prolonged and thorough visits should be made without the generous preparation times currently allowed …

Crowe applauded the example of Denmark—whose social wage incorporates compensation schemes to ensure that the cost of care and disability are covered by the State. The principle is that the vulnerable should not be disadvantaged financially.

Denmark provides ‘rebates’ for the disabled or frail—so that such people are not disadvantaged financially.

A further option, here, is for residents of nursing homes or hostels to receive a ‘targeted supplement’. This could assist pensioners and their carers so they can afford basic goods and services …

Perhaps additional funding should be provided for a community and family advocacy group to ensure greater accountability. In Australia, there are several modes by which aged care fees are conducted … Crowe related that there are a number of modes of payment.

Often residents are expected to provide about ‘85 per cent of the full aged pension’ to meet the costs of their care (about $33 a day). Those on higher incomes may be asked to pay up to $118 a day.

Finally, low care hostels can charge a bond—at any rate they like—with the exception that residents must be left with no less than $35 500 in assets.

Importantly, those better suited to ‘low care’ should not be driven into ‘high care’ nursing homes, simply because they cannot afford the ‘low care’ option … There are many other issues pertaining to ‘quality of life’ for pensioners, including the frail and vulnerable. To begin: nursing homes rarely provide sufficient dental care. Free dental care ought to be a priority for all Australians. But in the case of the most vulnerable Australians, our duty of care is even more plain. Dentists should be regularly commissioned to visit nursing homes and hostels: and should be ‘on call’ for whenever the need for their services arises.

[Other] elements that would best be implemented to ensure quality of life for vulnerable and elderly Australians [include]:

• Residents should enjoy privacy with their own room …

• Access to the ‘simple pleasures’ of parks, gardens could potentially provide a significant improvement to residents’ quality of life.

• Food must be of the highest quality available …

• Television, music and radio should be provided … Where residents are increasingly technologically literate—there should be access to internet services as well …

• [Regular] outings, including visits to shops, churches or gardens.

• … And social interaction between residents should be facilitated where possible.

• [Therapy] services where required to maintain as much mobility as possible.

Heating and air conditioning for all nursing homes and hostels are essential …

Finally … the role of carers needs to be recognised and provided for … It is rational—and it is right—that carers’ pensions be dramatically increased. And the love of family can be such that even the most caring nursing professionals cannot provide.

On Line Opinion, 17 February 2009
Demand for health services and workforce shortages

During the last 25 years the Australian medical workforce has increased much more rapidly than has the population. Factors contributing to this have included the growing and ageing of the population. The demand for health care increases with age, and medical workforces are derived from the demand for health care. Those in the age group 55 years and older are the heaviest consumers of medical services. The rising national health expenditure is likely to be driven by a combination of factors:
- relative health price increases
- a growing population
- the ageing of the population
- non-demographic growth in health care expenditure in particular.

When older people are discharged from hospital, they are less likely than younger people to return to their usual residence, and more likely to enter residential aged care or die. In particular, a high proportion of injury-related hospitalisations for older people are followed by discharge to a residential aged care or ‘other health facility’.

Availability of carers and volunteers

Service providers that offer aged care in the community and through aged care homes include a mix of private and religious or charitable organisations, as well as state, territory and local governments.

Most older Australians prefer to stay in their own homes, so there are a number of programs available to help with daily living activities that may have become harder for these people to manage on their own. This is called ‘community care’. The Home and Community Care (HACC) program and Community Aged Care Packages (CACP) are two such programs, with services specifically designed for older Australians who would qualify for at least low-level care in an aged care home. HACC services aim to meet basic needs to maintain a person’s independence at home and in the community. They include community nursing, domestic assistance, personal care, Meals on Wheels, home modification and maintenance, transport and community-based respite care.

For the older person who can no longer live at home because of ageing, illness or disability, there are publicly-funded places in aged care homes. This is called ‘residential aged care’. There are two types of residential aged care in Australia: high-level and low-level care. High-level care provides nursing care when required, meals, laundry, cleaning and personal care, while low-level care gives the person assistance with meals, laundry and personal care. Other services includes, personal care, home helpers, home maintenance and/or modification, food delivery, transport services and community health centres.
What are the priority issues for improving Australia's health?

Chapter summary

1. The Indigenous Australian life expectancy is approximately 10 years less than the overall Australian life expectancy.
2. Death rates for Indigenous Australians are higher than for non-Indigenous Australians for every specific major cause of death.
3. People living in rural and remote areas have poorer health status than those living in cities and metropolitan areas.
4. Immigrants on arrival in Australia have better health than the Australian-born population.
5. Australia has an ageing population and it is estimated that the number of people aged over 65 years will increase by over 1 million before 2015. The most common causes of mortality in people aged over 65 years are cancer, coronary heart disease and stroke.
6. People with disability and people from low socio-economic groups experience more difficulty accessing health services, have lower life expectancy and experience poorer health across a range of areas.
7. Cardiovascular disease includes all diseases of the heart and blood vessels.
8. Cancer refers to a group of diseases that result when the process of cell division becomes uncontrolled.
9. There has been an increase in the number of people with diabetes in Australia over the last 20 years.
10. Chronic obstructive pulmonary disease is a disease that destroys the lung tissue and narrows the air passages.
11. Injuries and death result from motor vehicle and workplace accidents, suicide, violence, drowning and poisoning.
12. One in five Australians will experience a mental illness at some stage during their lives.

Extension activities

1. Discuss which groups are at risk of the following:
   a) cardiovascular disease
   b) cancer
   c) respiratory disease
   d) diabetes
   e) injury
   f) mental health problems and illnesses.
2. Describe the extent of and trends in the conditions listed in extension activity 1.
3. Discuss the risk factors and protective factors for health for each of the following groups:
   a) Aboriginal and Torres Strait Islander peoples
   b) socio-economically disadvantaged people
   c) people living in rural and remote areas
   d) overseas-born people
   e) people with disabilities
   f) the elderly.

Exam-style questions

1. Discuss how the changing nature of the lifestyle patterns of Australians has an impact on the incidence of two major causes of sickness and death. (8 marks)
2. Outline the major determinants that contribute to the incidence of two of the major causes of sickness and death in Australia. (8 marks)
3. Assess the impact that the health status of Australians has on the provision of health care facilities and services. (10 marks)
4. Account for the differences in the health status of Aboriginal and Torres Strait Islander peoples and other Australians. (6 marks)
5. Explain why the level of health of older people in Australia is different from that of other population groups in Australia. (8 marks)