



# 1 Introduction

As we enter a new millennium, Australians can expect their health and wellbeing to improve: death rates continue to fall, and access to treatment and other services is generally improving. Overall, the nature of illness and disability has dramatically shifted away from infectious diseases to chronic conditions, especially those influenced by lifestyle and behaviour. However, rates of disability in the population have remained stable.

This report—the eighth in the series of biennial reports on health in Australia produced by the Australian Institute of Health and Welfare (AIHW)—is a compilation of key health statistics and analysis based mainly on the work of the AIHW. Many of the topics covered in the report are more fully treated in separate AIHW publications, all of which are freely available on the AIHW web site ([www.aihw.gov.au](http://www.aihw.gov.au)). Also available on the AIHW web site are interactive data matrices on a range of topics, currently including hospital episodes, cancer incidence, general practice and disability services.

## 1.1 Structure and highlights of the report

The report is broadly structured along the lines of the conceptual schema for health shown in Figure 1.1. This shows health and wellbeing as the outcome of many causes and processes modified by intervention activities that are supported by human and material resources.

This first chapter discusses what health is, what determines it, and the role of health information in supporting the needs of service users, providers and administrators in the system. It also includes an overview of the Australian health system.

Chapter 2 reports on the health status of Australians and describes the major diseases and conditions that have an impact on their health. It shows the following:

- Australians enjoy one of the highest life expectancies in the world—82.1 years for females and 76.6 years for males in 2000.
- Death rates from cancer as a whole have been falling over the past 20 years, although slowly. Five-year cancer survival increased between 1982–86 and 1992–94 from 43.8% to 56.8% for males and from 55.3% to 63.4% for females.
- Despite continuing gains in life expectancy during the late twentieth century, the rate of severe or profound disability (through activity limitation) appears to have been relatively stable over the past decade.

Chapter 3 focuses on the individual and environmental factors that determine health. It highlights the important role of the so-called SNAP set of risk factors in chronic disease (i.e. smoking, poor nutrition, alcohol misuse and physical inactivity). Key findings include:

- Smoking rates have continued to decline, with less than 20% of Australians aged 14 or over smoking tobacco daily.

- Average energy intake increased by over 10% for boys and girls aged 10–15 years, and by around 4% for adults, between the mid-1980s and 1990s.
- In a new analysis of alcohol risk, the AIHW estimates that 35% of adult Australians drink at levels which are risky for short-term harm, and around 10% drink at levels which put them at risk of harm in the long term.
- Adult participation in sufficient physical activity for a health benefit declined from 62% in 1997 to 57% in 2000.
- Overweight and obesity remains a serious problem, affecting around 65% of men, 45% of women and 22% of children aged 2–17 years.

Chapter 4 discusses the health of particular population groups. It shows that although most Australians enjoy good health today, some groups in the population continue to suffer poor health, in particular Aboriginal and Torres Strait Islander peoples. Other findings in this chapter are:

- There are important differences in health status, health risk factors and health service access between urban and rural populations.
- Injury and poisoning are leading causes of child deaths, and asthma is the leading cause of disease burden among children; a concern for future health patterns is the high prevalence of tobacco smoking among young people.
- A clear trend is emerging in the analysis of age-specific fertility: among women aged less than 30 years the birth rates are in a long-term decline; this is partly offset by women in their late thirties and early forties whose birth rates are increasing.

**Box 1.1: Australia at a glance**

- 19 million people, including about 400,000 Indigenous people (2% of total)
- Average life expectancy at birth is 82 years for women, 77 for men
- Life expectancy for Indigenous people is much lower, at 63 years for women and 56 for men
- Fertility rate well below replacement level, middle-ranked among developed countries
- Climate varied but mainly continental and dry; highly urbanised, most people live in south-east seaboard region, high exposure to sun radiation
- Many cultural backgrounds, 23% of residents born overseas
- 78% of 15–19-year-olds are at school or other educational institutions
- Per capita income high, gross domestic product (GDP) 12th among 30 OECD countries
- Services sector main contributor to GDP (63%)
- Unemployment under 7% in early 2002
- Health expenditure 8.5% of GDP in 1999–00

Chapter 5 examines the cost of health services, employment in the health industry and the provision and use of health services. Highlights of this chapter include:

- In 1999–00, \$53.7 billion was spent on health services in Australia. About 71.2% was funded by governments—48.0% by the Commonwealth Government (up from 44.2% in 1996–97), and 23.2% by State, Territory and local governments (up from 23.0%).
- There were 5.9 million separations from public and private hospitals in 1999–00, and a total of 22.6 million days spent in hospital. Separation rates for private hospitals rose by 19% between 1995–96 and 1999–00, and by 1.7% for public acute hospitals.
- Medicare provided benefits for 213.9 million services in 2000–01, 3.7% more than in 1998–99. The Pharmaceutical Benefits Scheme subsidised 148.1 million community prescriptions, 18.4% more than the 125.1 million in 1989–99.

Chapter 6 outlines the need for health information for a better understanding of current and emerging health issues, and the structures and processes involved. It describes key achievements and challenges for the health information system. One achievement has been the adoption of a framework for health system performance measurement (the National Health Performance Framework) and a set of criteria for the selection of performance indicators. In the past 2 years there has also been considerable expansion in health survey capacity across the country. The National Health Survey will be conducted on a 3-yearly basis from 2001, including substantial supplementation for Aboriginal and Torres Strait Islander peoples.

Statistical tables covering a range of topics are included after chapter 6. These tables contain data on population and fertility as well as health-related information. Many of the tables provide time series information, as well as comparing Australia with other countries.

## 1.2 Health and its determinants

### What is health?

In 1946 the World Health Organization (WHO) described health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO 1946). A more recent dictionary definition of health is ‘the general condition of the body or mind with reference to soundness and vigour’ (Macquarie 1997).

Together these two definitions convey the ideas that:

- health is an important part of wellbeing, of how people feel and function, and also contributes to social and economic wellbeing
- health is not simply the absence of illness or injury, and there are degrees of good health as well as of bad health
- health should be seen in a broad social context.

In short, healthy people feel and function well in body and mind and are in a position to keep doing so for as long as possible.

Despite the longevity and status of the WHO definition, it remains a challenge to fully measure the concepts contained in it. Most of the measures that are currently used relate to ill health (e.g. deaths, hospital episodes, incidence of disease). WHO now focuses on health outcomes as much as on health problems (WHO 2001).

In the last two decades, the effort has expanded to include measuring determinants of health (factors influencing health), functioning and disability, and describing the context in which health is assessed and managed. For each aspect of health that is measured, equity issues must also be addressed.

## What determines and influences health?

Many things determine and influence health. Indeed, the dominant view presently is a 'multicausal' one, in which disease, disability and (ultimately) death are to be seen as the result of the interaction of human biology, lifestyle and environmental (including social) factors, modified by healthcare interventions.

Figure 1.1 presents a conceptual framework for health. Disability, disease and death are aspects of health and wellbeing, and all can be seen as the result of a complex interplay of many determinants described as individual or environmental. These causes and effects can be modified to various degrees by health protection, prevention and promotion, or by treatment and rehabilitation; in the end stages of life, palliation services feature. Such interventions are supported by human and material resources, including essential information via research, monitoring and evaluation.

Determinants of health include those that can be measured in an individual, although the measures of these determinants are often aggregated to population groups. Environmental factors can be physical, as in landscape and climate; biological, as in vegetation, the food supply, infectious agents and other animal life; and socioeconomic, as in politics, culture, standard of living and other economic factors, and interactions within and among communities.

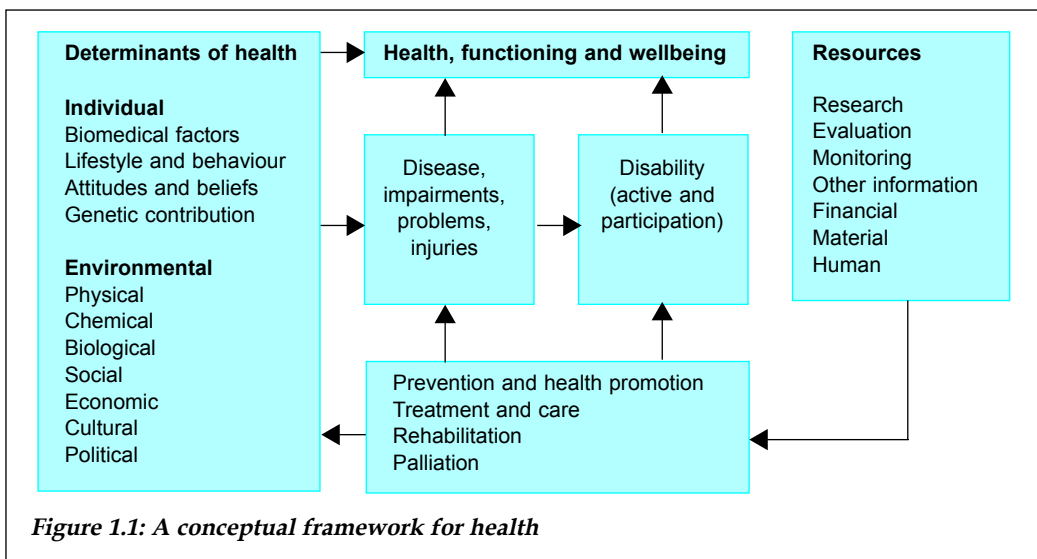


Figure 1.1: A conceptual framework for health

Environmental factors in turn overlap one another in many ways and are also influenced by the actions of individuals and groups.

In assessing interventions, the following are important:

- availability of and access to appropriate health services
- the responsiveness of the health system to a person's needs
- the quality of the services provided.

## Implications for improving health

Health interventions can occur at many levels. These can range from clinical and preventive attention to individuals through to efforts to improve the physical, social and economic environment for special groups or the community as a whole. As well as seeking to reduce people's exposure to risks, some strategies aim to help people develop personal skills to exercise more control over their own health and environments, and to make healthy choices.

Given the great range of influences on health, many major improvements require a strong partnership between public health and clinical care, and also that the health sector work with other sectors to make the best use of limited resources. This further requires that other sectors take into account the possible health impact of their decisions.

Improvements have occurred among all the major Australian socioeconomic groups, even though there are continuing large inequalities between them in their levels of health. However, to achieve the full scope of improvement also requires significant social changes such as reducing educational and economic disadvantage.

Solving these major issues often involves value judgments, and often includes political processes because of competing interests. Along with limited resources, the challenge requires choices, priority setting and trade-offs between the health sector and other sectors, between prevention and treatment services, and between the short term and longer term.

## 1.3 The role of health information

Health information is fundamental to developing effective health policies and programs, to coordinating treatment and care, and to empowering consumers.

Again using the structure of Figure 1.1, health information is about:

- quantifying the inputs to the health system
- monitoring and evaluating health programs
- extending and refining knowledge
- measuring the extent and distribution of health determinants and risk factors
- assessing the effectiveness (outcomes) of the system
- understanding the relationships among all of the above.

Australia has for the last decade given substantial attention to coordinating and structuring health information to support decision making. The National Health Information Agreement, made in 1993 between Commonwealth, State and Territory health agencies, the Australian Bureau of Statistics and the AIHW, now includes the Health Insurance Commission. A major product of this agreement is the *National Health Data Dictionary*, which is updated annually to provide standards for national health information and generally to be a guide for gathering health data.

There is also a burgeoning collection of information frameworks, indicator sets and national minimum data sets (i.e. an agreed set of data items on a particular topic that are collected in a uniform manner and collated for national reporting). Much effort in the past 2 years has gone into developing the National Health Performance Framework, under the auspices of the Australian Health Ministers' Advisory Council. This framework proposes a number of indicators to comprehensively cover aspects of performance at the organisational level and at the system level, while keeping a focus on equity issues and encompassing the role of health determinants (more detail can be found in Chapter 6).

With increasing electronic availability of clinical information, opportunities are growing to improve health information for populations and system-wide purposes. Provided personal privacy and confidentiality are properly protected richer data sets will become possible to improve health and health services.

## 1.4 The Australian health system

The Australian health system is widely regarded as being world-class, in terms of both its effectiveness and efficiency. This is largely achieved as a result of partnerships between individual Australians and families and healthcare professionals. People's decisions about lifestyle, self-care, and seeking and acting on professional help, and their participation in the development of public policy at many levels, all contribute to shaping the Australian health system. Increasingly, detailed information is available to and accessed by individuals, especially via the Internet.

The system is complex, with many types and providers of services and a range of funding and regulatory mechanisms. Those who provide services include medical practitioners, other health professionals, hospitals, and other government and non-government agencies. Funding is provided by the Commonwealth (federal) Government, State and Territory governments, health insurers, individual Australians and a range of other sources.

The Commonwealth's funding includes two major national subsidy schemes, Medicare and the Pharmaceutical Benefits Scheme. These schemes cover all Australians and subsidise their payments for private medical services and for a high proportion of prescription medications bought from pharmacies. The Commonwealth and State governments also jointly fund public hospital services so they are provided free of charge to patients. Between them, these three funding provisions aim to give all Australians, regardless of their personal circumstances, access to adequate health care at an affordable cost or no cost. These arrangements, with minor modifications, have been supported by successive governments for almost 30 years.

Many patients' first contact with the health system is through a general medical practitioner (GP). Patients can choose their own GP and are reimbursed for all or part of the GP's fee by Medicare, depending on the GP's billing arrangements. For specialised care, patients can be referred to specialist medical practitioners, other health professionals, hospitals or community-based healthcare organisations. Community-based services, some of which can also be accessed directly by patients, provide mental health, family planning and other specialised care and treatment, usually funded through Medicare or other government programs.

Patients can access public hospitals through emergency departments, where they may present on their own initiative, or via the ambulance services, or after referral from a medical practitioner. Admitted patients are charged nothing for their treatment or accommodation, unless they choose private treatment. Emergency department and outpatient services are free.

Australians may also choose to be treated in a private hospital, or be treated as private patients in a public hospital. Private patients can choose their own doctor, and they must pay for the hospital's services, with or without the support of private health insurance, or through other arrangements such as compensation. Medicare subsidises the fees charged by doctors for services provided to private patients in hospitals, and private health insurance funds also contribute towards medical fees for insured patients. No-gap or known-gap arrangements are increasingly being agreed on between hospitals and insurers.

Since the late 1990s, various Commonwealth incentives encouraged people to take up and retain private health insurance. There are virtually no employer-based health insurance schemes in Australia.

Australians also visit dentists and other private sector health professionals of their choice. Charges are met by the patients themselves, or with support of private health insurance. Limited provision of these services is available from the public sector on a needs-tested basis.

The health service system is regulated in various ways. Private hospitals are licensed by State and Territory governments. Medical practitioners and other health professionals are registered for practice in each State and Territory. The Commonwealth's regulatory roles include overseeing the safety and quality of pharmaceutical and therapeutic goods and appliances, and regulating the private health insurance industry. Commonwealth and State policies also regulate food safety and product labelling, and encourage quality across the health system.

An important addition to the services outlined above is the provision of public health services, community health services and ambulance services, largely funded by Commonwealth, State and Territory, and local governments. Public health services include:

- activities to ensure food quality
- immunisation services and other communicable disease control (including biosecurity)

- public health education campaigns (including health promotion in the areas of nutrition and physical activity)
- injury prevention activities
- programs to reduce the use of tobacco, alcohol and illicit drugs, and their harmful effects on individuals and communities
- environmental monitoring and control
- screening programs for diseases such as breast cancer.

Essential support to the health service system is given by many other agencies. Research is fostered and funded through the National Health and Medical Research Council. Statistical agencies provide the information needed for prevention, detection, diagnosis, treatment, care and associated policy. Consumer and advocacy groups contribute to public discussion and policy. Professional associations for medical practitioners and other health professionals help set professional standards and clinical guidelines. Universities and hospitals undertake training of undergraduate and postgraduate health professionals. Voluntary agencies contribute in various ways, including raising funds for research, running education and health promotion programs, and coordinating voluntary care.

Although they are not seen as part of the health system, many other government and non-government organisations play a role because of their influence on health. Departments of transport and the environment, the media and the food industry are just a few examples.

## References

The Macquarie Dictionary 1997. 3rd edn 1997. Sydney: The Macquarie Library Pty Ltd, Macquarie University.

WHO (World Health Organization) 1946. Constitution of the WHO. Reprinted in: Basic documents, 37th edn. Geneva: WHO.

WHO 2001. International Classification of Functioning, Disability and Health. Geneva: WHO.