1 Introduction

Health is not only important to individuals; the health of a nation's population also has important implications for national wellbeing and prosperity. Health and health care are consistently top interests for Australians, and more so as the population ages and as health and medical knowledge expands and then spreads within society.

While health and health care are topical and regularly covered by the electronic and print media, popular reports often portray a less than satisfactory picture. It is understandable that they tend to focus on sensational or 'new' things that can demand attention and concern. These include medical mishaps, service shortfalls and emerging epidemics, only partly balanced by the odd brilliant breakthrough. Examples of such concerns are any increases in the use of an illicit drug, long waiting lists for elective surgery, hospital adverse events, high levels of obesity and rising national health expenditure.

However, there are parallel and important good-news stories that deserve to be more widely known. They include the decline in use of most illicit drugs, the large rise in the number of surgeries undertaken, the vast number of successful hospital treatments with patients recovering well from their illnesses, the fall in mortality from major diseases such as heart disease and cancer, and the great value that people place on their health and how much they may be prepared to see paid for it (through the taxation system and out of their own pockets). There are also, of course, some disturbing facts which continue to pervade the picture. The poorer health of Australia's Indigenous population and the rise in obesity are two of these.

The role of *Australia's health*, therefore, is to put the various stories together in a rounded and balanced way and to present a much wider picture as a report card to the nation. This, the tenth biennial national report on the health of Australians, brings together key health statistics from many sources to give as comprehensive a picture as possible. It charts the progress of health in the past two decades or more, looking at the health status of the Australian population, the factors that influence that status, health services and expenditure.

This first chapter begins by summarising Australia's international standing in health and its comparative progress over recent decades. It then sets out the general Australian context before discussing what health is and broadly how it can be improved and the performance of the health system measured. The chapter next outlines the Australian health system; describes the role of national health information, how it is governed and some related information priorities; and concludes by summarising the structure of the rest of the report.

1.1 Australia compares well

Eighteen years ago in 1988, when the then Australian Institute of Health released the first *Australia's health* report, it concluded that:

> The general level of health of Australians is better than it has ever been. There have been remarkable declines in mortality from all causes and this trend has accelerated during the last 15 years. Yet Australia still lags behind other apparently comparable countries ... (AIH 1988:171).

Eighteen years on, the level of health of Australians has continued to improve. Moreover, in most aspects of health Australians no longer lag behind other comparable countries (those from the Organisation for Economic Co-operation and Development: OECD). There is now much better information in the community about health and the vast network of health services has continued to improve to provide prevention, early intervention and treatment of diseases.

Figure 1.1 shows broadly how Australia ranked in 1987 and 2002 on various aspects of health among 30 member countries of the OECD. Comparisons are made where data are available for a substantial number of countries (on average, 25 countries for each indicator) for the years 1987 and 2002, although in a few cases data relate to the years immediately preceding or following.

In 2002, Australia's life expectancy at birth had risen to be one of the highest in the world. Life expectancy at age 65 for males is second only to Japan, and for females is third behind Japan and France. Our ranking among OECD countries has improved markedly for mortality rates from coronary heart disease, stroke, lung cancer and transport accidents. Our smoking rates have continued to fall, with the ranking improving from middle third to 'best' third. The ranking for lower alcohol consumption has also improved a little. The dental health of our 12 year olds is at the top of the 'best' third, along with mortality from accidental falls. And various measures of life expectancy and mortality place Australia among the best in the world.

However, our ranking has fallen in relation to mortality from suicide, diabetes and respiratory diseases, and for infants, although our levels for these indicators remain among the middle third of the OECD countries. Our ranking for obesity has not changed and is clearly among the 'worst' third in the OECD group.

1.2 Australia at a glance

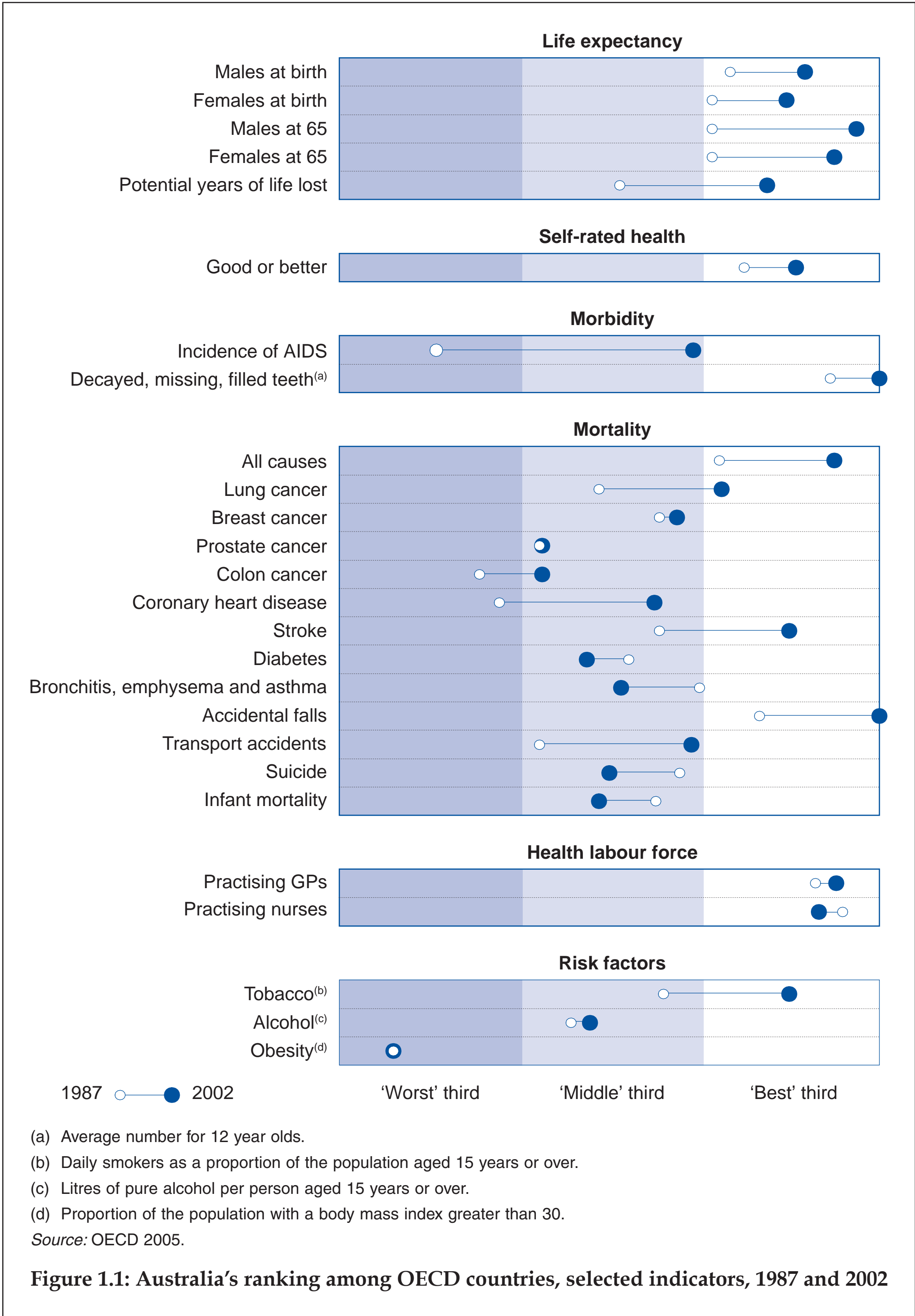
Australia is a vast continent with a relatively small population: 20.3 million people as at June 2005. The population is highly urbanised, with over 70% living in metropolitan areas and mostly near the coastline.

Australia is a nation made up mainly of migrants or their descendants; only 2.4% of the population reported Indigenous origin at the 2001 Population Census and over 50% of Australians were either born overseas or had at least one parent born overseas. The country of origin of Australia's population is diverse; migrants since World War II have come from all regions of the world (see Box 1.1).

1.3 Understanding health

What is health?

Defining the scope and boundary of health has always involved much debate. Those who propose a narrower definition often adopt a biomedical view, emphasising the presence or absence of diseases and medically measured risk factors. Those favouring a broader definition would include a wide range of social and economic determinants of health along with various aspects of wellbeing.



(a) Average number for 12 year olds.
(b) Daily smokers as a proportion of the population aged 15 years or over.
(c) Litres of pure alcohol per person aged 15 years or over.
(d) Proportion of the population with a body mass index greater than 30.
Source: OECD 2005.

Figure 1.1: Australia's ranking among OECD countries, selected indicators, 1987 and 2002

Box 1.1: Australia at a glance

- *20.3 million population at June 2005, including about 493,000 Indigenous people (2.4% of total)*
- *Climate varied but mainly dry, high exposure to sun radiation*
- *Gross domestic product (GDP) per person was $10,693 in September 2005. In 2003, Australia ranked 12th among OECD countries. Services industries are the main contributor to GDP (56% in 2004–05)*
- *Real national net disposable income per person in September 2005 was $8,973*
- *Unemployment at 5.2% in January 2006*
- *High ownership of residential housing—in 2002–03, 69% of households were outright owners or paying off a home loan*
- *14.9% of households spent 30% to 50% of their gross income on housing, and 4.7% spent more than 50%, in 2002–03*
- *Fertility rate of 1.77 births per woman in 2004, well below replacement level but relatively stable and middle-ranking among developed countries*
- *Infant mortality rate of 4.7 per 1,000 live births in 2004, middle range among developed countries; however, the rate for the Indigenous population is about 3 times this rate*
- *Average expectation of life at birth was 78.1 years for males and 83.0 for females, in 2002–04; however, estimates of Indigenous expectation of life at birth for 1966–2001 were 59.4 years for males and 64.8 years for females*
- *Life expectancy free of severe and profound disability was 72.4 years for males and 74.5 for females in 2003*
- *Number of days per year when the concentration of PM_{10} (particles with diameter of 10 microns or less) and ozone exceeded the air quality National Environmental Protection Measure standards: in 2003, Sydney PM_{10} 10 days and ozone 4 days; Melbourne PM_{10} 13 days and ozone 2 days; other cities much lower.*

The World Health Organization, in its 1946 Constitution, adopted a broad definition and defined health as a 'state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity' (WHO 1946). At that time, such a wide-ranging definition was revolutionary, in particular in the inclusion of social wellbeing into the concept of health. This definition has encouraged health researchers to broaden their scope and has given legitimacy and added emphasis to research on the determinants of health and health outcomes.

The development of health statistics has also been influenced by this broadening of the scope of health. While much of health statistics is still about ill health (mortality and diseases), there are now serious efforts in Australia and many other countries to develop statistics on the broader aspects on health. The International Classification of Diseases and Related Health Problems (now in its 10th revision), which is mainly used to measure ill health, is now complemented by the International Classification of Functioning, Disability and Health (adopted in 2001) that provides a tool for measuring the level of health functioning and outcomes.

A framework

Australia's health is based on the conceptual framework presented in Figure 1.2. It shows that Australia's levels of health and wellbeing, including diseases and disability, are influenced by a complex interplay between health determinants, interventions and resources, including systems. Health determinants can be socioeconomic, environmental, behavioural (such as alcohol use or physical activity), biomedical (such as blood cholesterol or blood pressure) and genetic factors.

These causes and their effects on health and wellbeing can be modified to various degrees by prevention and health promotion, treatment, rehabilitation and other health care. Such interventions are supported by human and material resources and associated systems, including essential information via research, monitoring and evaluation.

Where possible, these aspects of Australia's health need to be considered in terms of the features and needs of individuals, population groups and the population as a whole. Finally, Australia's health can be viewed as a reflection of the performance of both the health system and Australian society as a whole.

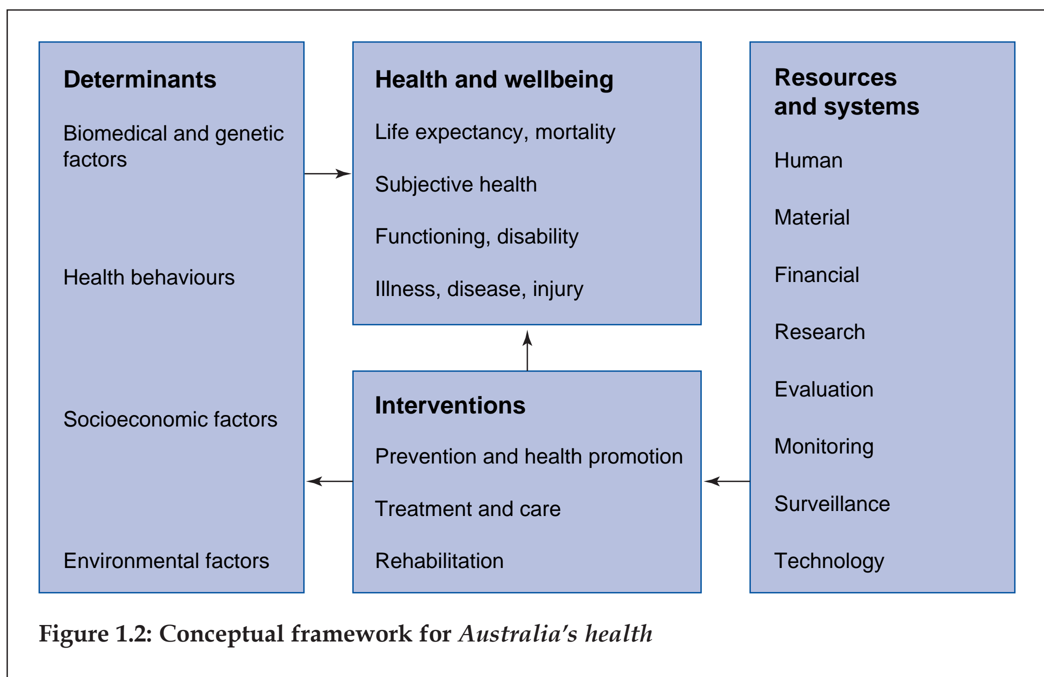


Figure 1.2: Conceptual framework for *Australia's health*

1.4 Improving health and measuring performance

Many things influence health—as further described in Chapter 3—including preventive and treatment interventions. Having a country that is socially and economically prosperous is arguably the most important factor in ensuring a good average level of

health in the population. These general influences in turn affect other major factors that interact and lead to differences among individuals and subpopulations in their health—such as their education and income levels, their choices about healthy living, and so forth. A prosperous country can also afford to spend more on health care, thereby improving the health of its population. Conversely, improving health could lead to improved education and employment which, in turn, leads to economic and social prosperity.

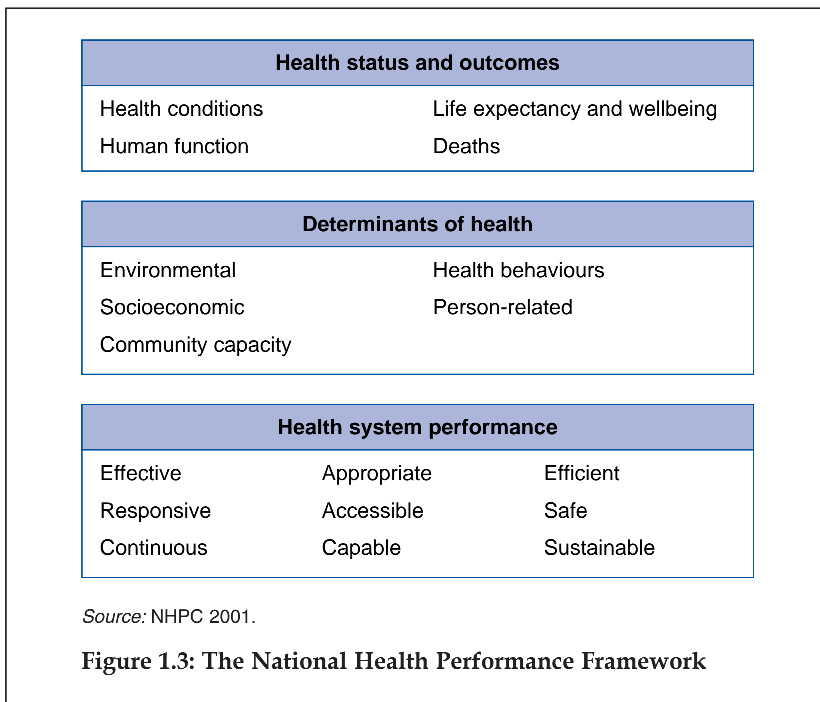
Action on broad social determinants can be seen as the widest and most far-reaching form of 'health intervention'. Such action is among the great aims of society for reasons that include health, in its narrower sense, but which go well beyond it. It follows that this involves much more than the health system. However, that system can do much in its own right and at many levels. Its activities range from clinical and preventive services and programs through to efforts to help improve the physical, social and economic environment for groups or individuals at special risk. As well as seeking to reduce people's exposure to risks, some health strategies aim to help individuals develop personal skills to exercise more control over their own environments and to make healthy choices. Other strategies may aim to enhance a community's capacity to provide culturally relevant services.

The health system's effectiveness in achieving its goals is ultimately a function of its performance as a system. In 2001, Australia's National Health Performance Committee adopted a conceptual framework specially designed for measuring that performance (NHPC 2001). This framework (Figure 1.3) is consistent with the *Australia's health* conceptual framework, and offers a structure for considering system performance. Its components include the:

- availability and accessibility of services and programs
- appropriateness or relevance of interventions
- effectiveness of interventions in achieving the desired outcome
- responsiveness of the health system to individual or population needs
- degree to which care is integrated and coordinated.

Given the great range of influences on health, many major improvements depend on a strong partnership among components of the system—such as public health and clinical care—and require that the health sector works with other sectors to make the best use of available resources. Partnerships are also vital between the health system and others involved in the lives of those using the system, such as family and friends, teachers, employers, and so on.

As in other areas of public policy, pursuing the best health for a society will often involve value judgments and include 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, between improving health overall and reducing inequalities, and between short-term and longer term objectives.



Source: NHPC 2001.

Figure 1.3: The National Health Performance Framework

1.5 The Australian health system: an outline

The Australian health system is complex, with many types of service providers and a variety of funding and regulatory mechanisms. Those who provide services include a range of medical practitioners, other health professionals, hospitals, clinics, and other government and non-government agencies. Funding is provided by the Australian Government, state and territory governments, health insurers, individual Australians and a range of other sources.

Overall coordination of major components of the health care system is the responsibility of the Australian Health Ministers' Advisory Council (AHMAC)—a committee of the heads of the Australian Government, state and territory health authorities, and the Australian Government Department of Veterans' Affairs. AHMAC advises the Australian Health Ministers' Conference on policy, resources and financial issues. Specific national bodies (currently being reviewed) have been established by AHMAC or the ministers to coordinate information, advice and program implementation, namely the:

- National Health Priorities Action Council, which oversees government activities to promote better services and achieve better results in priority health areas
- Australian Safety and Quality Commission in Health Care, which leads national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error

- National Public Health Partnership, which plans and coordinates national public health activities
- National Health Information Group (NHIG), which coordinates and directs the implementation of the National Health Information Agreement (see page 10).

Almost 70% of total health expenditure in Australia is funded by government, with the Australian Government contributing two-thirds of this and state, territory and local governments the other third. The Australian Government's major contributions include the two national subsidy schemes: Medicare and the Pharmaceutical Benefits Scheme. These schemes subsidise payments for services provided by doctors and optometrists, and for a high proportion of prescription medications bought from pharmacies. The Australian and state and territory governments also jointly fund public hospital services. Between them, these arrangements aim to give all Australians—regardless of their personal circumstances—access to adequate health care at an affordable cost or no cost. These schemes are further integrated with social welfare arrangements, with larger rebates provided for individuals or families who receive certain income support payments (such as for unemployment or disability). There are also special health care arrangements for members of the defence forces, and for war veterans and their dependants.

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 health care organisations. Community-based services—a range of which can also be accessed directly by patients—provide care and treatment in areas such as mental health, alcohol and other drugs, and family planning.

Patients can access public hospitals through emergency departments, where they may present on their own initiative, via the ambulance services, or after referral from a medical practitioner. Public hospital emergency and outpatient services are provided free of charge.

Patients admitted to a public hospital can choose to be treated as public or private patients. Public patients receive treatment from doctors and specialists nominated by the hospital, but are not charged for their care and treatment.

Patients treated in a private hospital—or as a private patient in a public hospital—can select their treating specialist, but charges then apply for all of the hospital's services (such as accommodation and surgical supplies). Medicare subsidises the fees charged by doctors, and private health insurance funds contribute towards medical fees and the hospital costs for insured patients. 'No-gap' or 'known-gap' arrangements are increasingly being agreed on between hospitals and insurers.

Australians also visit dentists and other private sector health professionals of their choice such as physiotherapists, chiropractors and natural therapists. Charges are usually met by the patients themselves or with the support of private health insurance. Emergency ambulance services are not free of charge for most Australians, but

subscription schemes are offered by the ambulance authorities or through private health insurance.

Several state and territory governments have established 24-hour telephone-based health advice services in recent years. These are staffed by health professionals who answer queries from callers about health problems, assisted by specialised reference software. The Australian Government, with the support of the Council of Australian Governments, has also decided in 2006 to establish a national call centre.

Many Australians purchase health insurance provided by health benefits organisations (more commonly known as private health insurance funds). Unlike other countries such as the United States of America and Germany, Australia has virtually no employer-based health insurance schemes. Australians have a choice of a wide range of private health insurance schemes. Hospital insurance schemes cover services in private hospitals as well as services provided in public hospitals for private patients and associated medical services. These are supplemented by additional schemes that cover a wide range of allied health and other professional services, including some alternative/complementary health services.

In response to a significant decline in health insurance membership towards the end of the last century, the Australian Government introduced various incentives to encourage uptake and retention of private health insurance, the most notable being a 30% rebate on membership fees and the introduction of lifetime cover. As of late 2005, around 8.8 million Australians (43% of the population) were covered by private health insurance for hospital treatment.

Complementing the services outlined above is the provision of public health services, which 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 and harmful effects of tobacco, alcohol and illicit drugs
- environmental monitoring and control
- screening programs for diseases such as breast cancer and cervical cancer.

The health system is regulated in various ways. State and territory governments are responsible for licensing or registering private hospitals (including free-standing day hospital facilities), medical practitioners and other health professionals; and each state and territory has legislation relevant to the operation of public hospitals. The state and territory governments are also largely responsible for industry regulations, such as for the sale and supply of alcohol and tobacco products. The Australian Government's regulatory roles include overseeing the safety and quality of pharmaceutical and therapeutic goods and appliances, managing international quarantine arrangements,

ensuring an adequate and safe supply of blood products, and regulating the private health insurance industry. There is also an established role for governments in the regulation of food safety and product labelling.

Essential support to the health service system is given by many other agencies. Research and 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 health practitioners 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 educational 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, liquor licensing authorities and the media are just a few examples.

1.6 National health information and how it is governed

Health information is fundamental to developing effective health policies and programs, to ensuring quality provision of services, to coordinating treatment and care and to empowering consumers.

In accordance with Figure 1.2, health information is about:

- assessing the level and distribution of the health of populations
- measuring the level, distribution and influence of the determinants of health
- monitoring and appraising health interventions
- measuring the inputs to the health system
- evaluating the performance of the health system
- furthering knowledge and enhancing system performance through research and statistics
- understanding the relationships among all of the above.

Increasing attention is being given to organising health information to support decision making. The National Health Information Agreement—originally made in 1993—covers the Australian Government Department of Health and Ageing, state and territory health agencies, the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW), and the Health Insurance Commission (now Medicare Australia).

A major product of the agreement is the *National health data dictionary*, which is updated annually to provide standards for national health information and to provide guidance for gathering health data. Data standards published in the dictionary are used, for example, in collecting health information to support performance monitoring of the Australian Health Care Agreements between the Australian Government and the state and territory governments.

Priorities for national health information

In 2002, AHMAC endorsed a set of 10 priorities to guide the development of health information for the period 2003–2005. Published in a document entitled *Health information development priorities* (HIDP) (NHIMG 2003), they were:

- Aboriginal and Torres Strait Islander health
- Integration of services—coordinated care
- Safety and quality in health care
- Information technology and health
- Population health
- Equity and access
- Health labour force
- Performance of the health system
- Standards and classification
- Management of health information.

The HIDP was intended to focus the health sector, over a three-year period, on data development in the areas that were lacking health information of sufficient quality and consistency to support policy development and program monitoring.

2005 was the final year of the HIDP, and the bodies responsible for implementing it are reflecting on what has been achieved, with a view to informing their priorities regarding data and information for the future.

Some of the committees responsible for segments of national health information have recently reviewed their past and future activities. For example, the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data and the National Public Health Information Working Group have each released strategic plans to guide information development in their fields during the next three years.

Later this year, the AIHW will release a publication that will review achievements in the 10 priority areas for information development in 2003–2005 and summarise the priorities announced for the period 2005–2008.

Governance arrangements for national health information

Figure 1.4 outlines the main decision-making structures for health information in Australia. Two advisory bodies—the Australian Health Information Council (AHIC) and the NHIG—were established in 2003 to provide leadership on information management and technology, and to coordinate advice to AHMAC.

The key role of AHIC is to provide independent advice on long-term directions and strategic reform issues relating to national health information. AHIC gathers views from consumers, health professionals, information technology software developers, and other private stakeholders and experts.

The NHIG was established to advise on planning and management requirements, and to manage and allocate resources for national health information projects and working groups. Membership consists of all Australian jurisdictions, the AIHW and the ABS.

Five standing committees that report to the NHIG are associated with the development of health information for statistical purposes (see Figure 1.4).

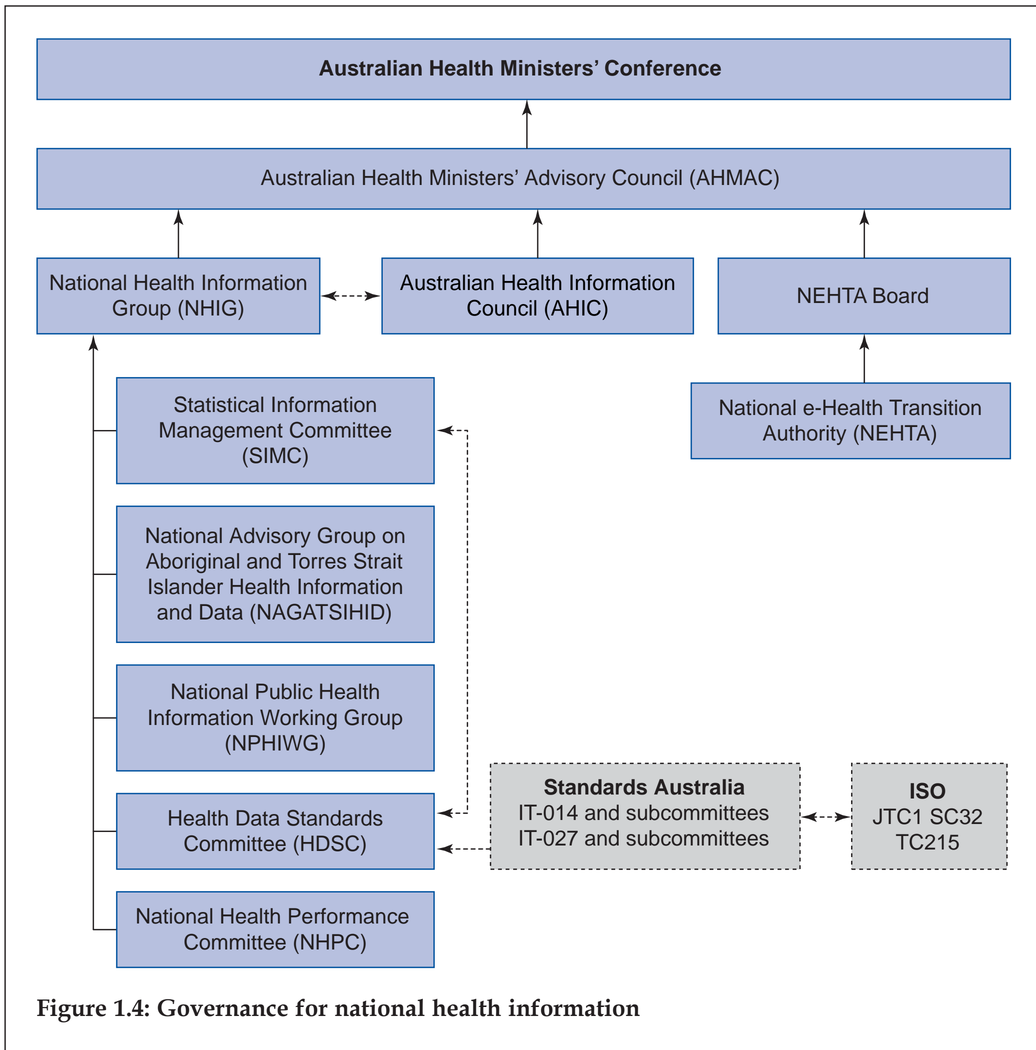


Figure 1.4: Governance for national health information

With the rapidly increasing uptake of electronic health information systems, along with community concern about personal privacy, a key challenge for the health information system is implementing a secure, effective electronic health record that will lead to better health. In 2005, the National e-Health Transition Authority (NEHTA) was incorporated to 'accelerate the adoption of e-health by supporting the process of reform in the Australian health sector'. NEHTA is governed by a board composed of the chief executive officers from each of the Australian, state and territory government health departments. It is responsible for clinical data standards; patient, provider and product identification standards; patient, provider and product directories; supply chain; consent models; secure messaging and information transfer; and technical integration standards.

Australian health ministers have established a new Australian Commission on Safety and Quality in Health Care, which commenced operations on 1 January 2006; it succeeded the Australian Council for Safety and Quality in Health Care, which operated from 2000 to 2005. A key objective of the Commission is achieving safe, effective and responsive care for consumers. This requires, among other things, the development of information about the safety and quality of care in hospitals, primary health care and other parts of the health system.

These governance arrangements are intended to enable a more coordinated, coherent governance of national health information, data collection, data standards and related information communications technology. The aim is that the clinical and statistical aspects of information management and their related standards work be brought together in a more integrated way.

At the time of writing, the structure and roles of some national information committees were under review. The publication that the AIHW will release later this year will also describe the new governance arrangements.

1.7 Structure of this report

The report is broadly structured along the lines of the conceptual framework shown in Figure 1.2.

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

Chapter 3 focuses on the determinants of health: biomedical and genetic factors, health behaviours, socioeconomic factors and environmental factors.

Chapter 4 describes the health of particular population groups and shows that some, especially Aboriginal and Torres Strait Islander peoples, do not share in Australia's generally good health.

Chapter 5 is a special chapter on the health of Australian children. It provides details on demographic trends, health conditions and disability among these young Australians.

Chapter 6 examines health system funding and expenditure, and deals with employment in the health industry. It outlines some of the challenges in resourcing a complex system.

Chapter 7 presents extensive information on health services and their use in Australia, including public health services, hospital services, and those from doctors and other health professionals.

Statistical tables covering a range of topics are included after Chapter 7. These tables contain data on population and fertility as well as health-related information. Many of the tables provide time series information. Tables have also been included for some of the graphs in the report, for the benefit of readers who may wish to examine the data in more detail.

A list of abbreviations and a glossary are given at the end of the report.

Following the Glossary are the National Health Sector Performance Indicators. These indicators are described, and referenced to tables, figures and sections in the report itself.

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