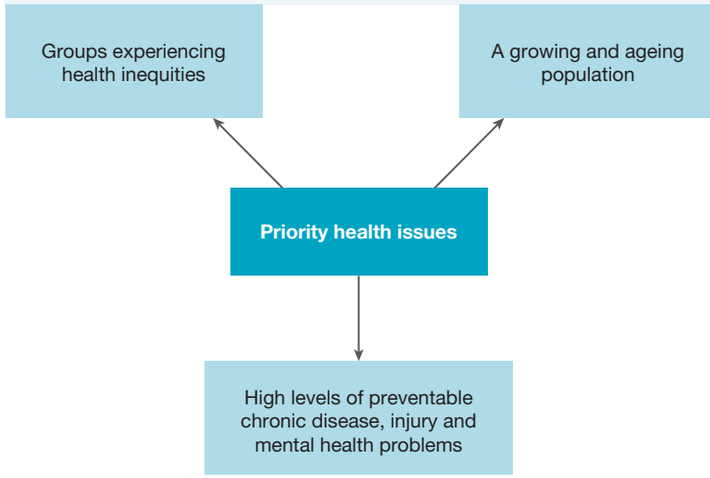
2 What are the priority issues for improving Australia's health?

Outcomes

On completion of this chapter you will be able to:

- describe the nature and justify the ~~choice~~ of Australia's health priorities (H1)
- analyse and explain the health status of Australians in terms of current trends and groups most at risk (H2)
- analyse the determinants of health and ~~health~~ inequities (H3)
- devise methods of gathering, interpreting and communicating information about health and physical activity concepts. (H16)

Figure 2.1 Priority health issues



Health authorities and governments have given priority to certain health issues in our society that impact on the health status of Australians. Priority health issues include:

- particular groups experiencing health inequities
- the high levels of preventable chronic disease, injury and mental health problems
- our growing and ageing population.

2.1 Groups experiencing health inequities

About 30 per cent of the Australian population lives in rural or remote areas. The health of people living in rural and isolated areas is poorer than that of people living in city areas. Statistics reveal higher mortality and illness rates for this group. For example, although mortality rates across all regions have fallen in the past ten years, the mortality rate for other regions has remained 10 per cent higher than the mortality rate in major cities. This does not necessarily mean that remoteness equates to poor health. There are individuals and groups within rural and remote communities who are of good health. The poorer health status of indigenous Australians is to some extent responsible for the higher rates.

Cardiovascular diseases were responsible for nearly a third of the elevated male death rates outside major cities. Compared with major cities, death rates from diabetes were 1.3 as high for men in inner regional areas and 3.7 as high in very remote areas.

~~The mortality statistics described in topic 1 appear to indicate a generally improved health status for Australians, but unfortunately this is not shared Australia-wide. There are some fundamental differences in the level of health of particular groups in our generally affluent society.~~ These differences exist in terms of:

- the unequal distribution of some illnesses or conditions throughout the population (across different cultures, geographic locations, ages and genders)
- health **inequities**; that is, the unjust impact on the health status of some groups due to social, economic, environmental and cultural factors, such as income, education, availability of transport and access to health services.

Major indicators — such as the incidence and prevalence of disease and different rates of sickness, hospitalisation and death — point to areas in which inequities exist.

Health is, to a large extent, the result of people's decisions about health behaviours (such as regular participation in physical activity) and their everyday experiences as they interact and respond to the social, physical and cultural environments in which they live. However, an individual's level of health is

determined by a broader range of factors and not just their health-related decisions. Sociocultural, socioeconomic and environmental factors play a significant role in the achievement of good health. Some factors have the potential for change, such as individuals choosing not to smoke, or governments making roads safer. Other factors, such as an individual's genetic makeup, are generally not modifiable.

Health is therefore not only the responsibility of the individual. Governments and health authorities recognise that people cannot always choose a particular lifestyle. Health promotion and illness prevention campaigns attempt to address the **determinants** that have an impact on health or affect people's ability to make good decisions about their health. These can be classified as:

2.1.1 Aboriginal and Torres Strait Islander peoples

Major inequalities exist in the health status of Aboriginal and Torres Strait Islander peoples. These indigenous people experience a much poorer level of health compared with that of non-indigenous people, they die at a younger age and are more likely to have a reduced quality of life.

Indigenous people have:

- lower life expectancy rates at birth for both males and females. Life expectancy for indigenous people is almost 10 years lower than the life expectancy of non-indigenous people.
- higher mortality rates at all ages compared with the rates for non-indigenous people. In the five states/territories with the largest indigenous populations, 62 per cent of indigenous males and 54 per cent of indigenous females who died were younger than 65 years (2016). This compares with the 21 per cent of non-indigenous males and 13 per cent of non-indigenous females who died younger than 65 years (2016).
- higher mortality rates from preventable causes compared with Australia as a whole. Death rates were almost three times as high for indigenous males and females as for the non-indigenous population.
- high death rates from cancer, diseases of the circulatory system (including heart disease and stroke), injuries (including motor vehicle crashes, homicide and suicide), respiratory diseases (including pneumonia), endocrine, metabolic and nutritional disorders (specifically diabetes), and digestive disorders.
- an infant mortality rate that is twice that for non-indigenous people.

Trends in the health status of Aboriginal and Torres Strait Islander peoples include:

- a decline in death rates from all causes for indigenous males (reflecting a similar reduction for all Australian males)
- a similar decline in death rates for indigenous females.

INQUIRY

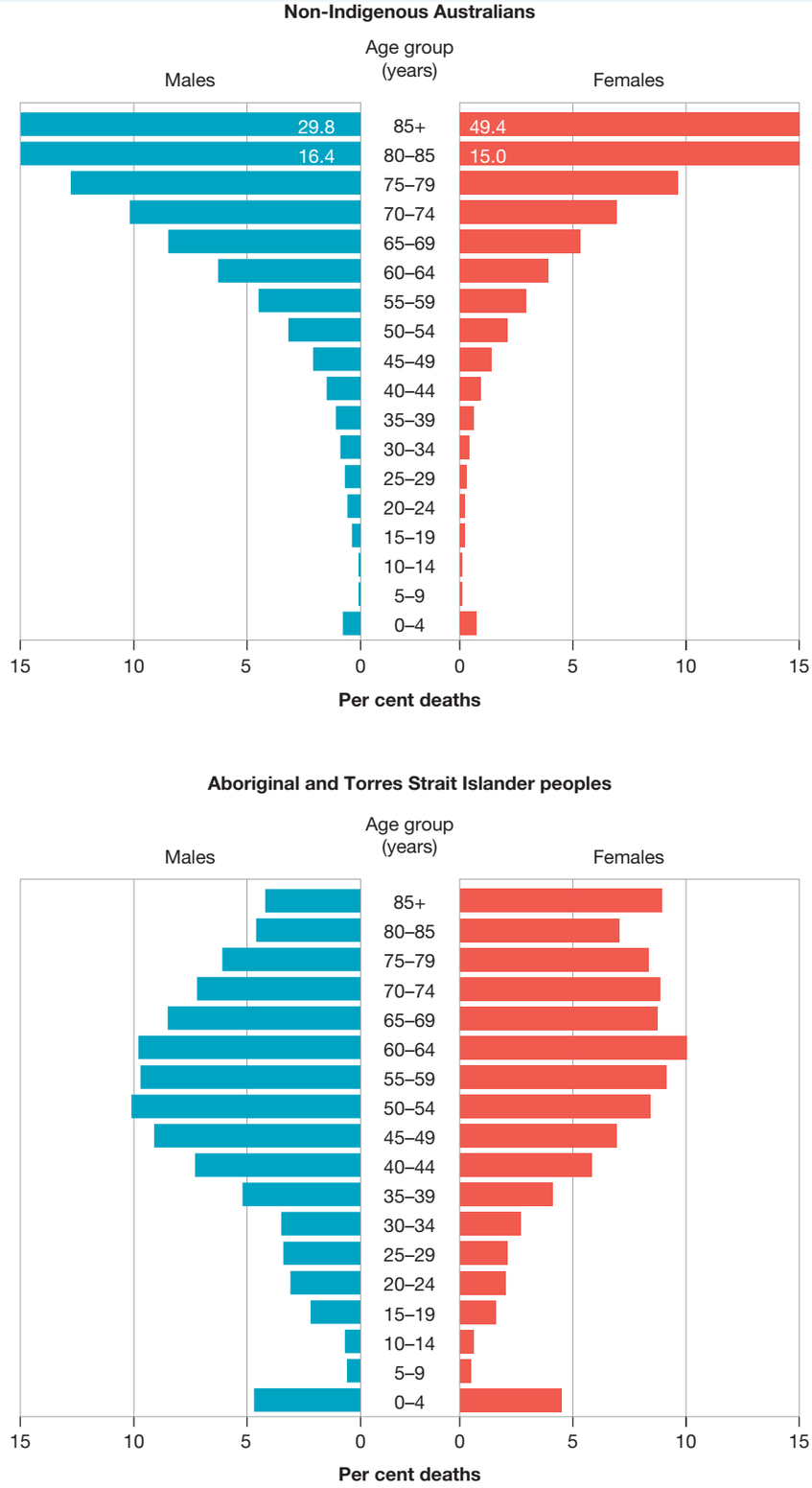
Analyse a graph

1. identify the age group that experiences the highest proportion of deaths among:
   (a) indigenous people
   (b) non-indigenous people.
2. Compare the proportions of deaths of indigenous and non-indigenous Australians in the 0–24 age groups. Suggest reasons for the differences.
3. Propose reasons for the higher proportion of deaths among indigenous people in the 25–44 years age group compared with the same age group among non-indigenous people.

Determinants of indigenous health

Health reports confirm that Aboriginal and Torres Strait Islander people are disadvantaged, compared with other Australians, based on a number of socio-economic indicators. These include lower levels of education, employment and income. These indicators are linked to higher health risk factors such as smoking, alcohol abuse, poor housing and exposure to violence. This means that the diet of residents in rural and remote areas

Figure 2.2 Proportion of deaths by age group for indigenous and non-indigenous people, 2011–15



may be affected because of insufficient access to reasonably priced fruit and vegetables (see figure 2.2). They also have poorer access to health care compared to people living in metropolitan zones due to distance, cost of fuel, and availability of transport. This lack of access is increased by a shortage and uneven distribution of medical services in rural and remote areas, compared to metropolitan areas.

Other socioeconomic and sociocultural determinants of health also play a part in the likelihood of higher health risk factors, such as the neighbourhood in which they live and the quality of social connections with family, friends and community. In some studies of indigenous communities, people who felt a lack of control over aspects of their lives, or had experienced removal from their natural family, were likely to self-assess their health as 'fair or poor'.

SNAPSHOT

Significantly higher disease burden for indigenous Australians—but improvements made

~~While Indigenous Australians face a substantially higher disease burden than non-Indigenous Australians, improvements have been seen, with more possible, according to a new report released today by the Australian Institute of Health and Welfare (AIHW).~~

~~'Indigenous Australians experienced a burden of disease that was more than twice that of non-Indigenous Australians,' said AIHW spokesperson Dr Fadwa Al-Yaman.~~

~~Chronic diseases caused 64% of the overall burden among Indigenous Australians, with mental & substance use disorders accounting for the largest proportion of the burden (19%). This was followed by injuries including suicide (15%), cardiovascular diseases (12%), cancer (9%) and respiratory diseases (8%).~~

~~Just over half (53%) of the overall burden was fatal burden, and males accounted for a greater share of the total than females (54% compared with 46%).~~

~~While the gap in disease burden between Indigenous and non-Indigenous Australians remains significant, the report shows some improvements among the Indigenous population in recent years.~~

~~'Between 2003 and 2011, total burden of disease in the Indigenous population fell by 5%, with an 11% reduction in the fatal burden,' Dr Al-Yaman said.~~

'However, over the same period, there was a 4% increase in non-fatal burden. This suggests a shift from dying prematurely to living longer with disease.'

The largest reduction in the Indigenous rate of total disease burden was for cardiovascular diseases. There were also falls in the burden caused by high blood pressure, physical inactivity and high cholesterol.

The Northern Territory and Western Australia had higher rates of Indigenous burden of disease than New South Wales and Queensland (the 4 jurisdictions for which estimates are reported). Large inequalities were also seen across remoteness areas, with *Remote* and *Very remote* areas having higher rates of disease burden than non-remote areas.

The report shows that a significant portion of the overall disease burden was preventable.

'By reducing risk factors such as tobacco and alcohol use, high body mass, physical inactivity and poor diet, over one-third of the overall burden for Indigenous Australians could be avoided,' Dr Al-Yaman said.

INQUIRY

Aboriginal health inequities

Read the snapshot 'Significantly higher disease burden for Indigenous Australians — but improvements made', then answer the following questions.

1. What does the 4 percent increase in non-fatal burden for Indigenous Australians indicate?
2. Identify the areas in the health and socioeconomic status of indigenous Australians that are:
   (a) improving
   (b) remain significantly worse compared to the general population in Australia.
3. How does Dr Al-Yaman suggest the overall burden for Indigenous Australians could be avoided?

SNAPSHOT

Indigenous smoking deaths on the rise despite people butting out

INQUIRY

Smoking amongst indigenous Australians

Read the snapshot 'Indigenous smoking deaths on the rise despite people butting out', then answer the following questions:

1. Outline the key trends revealed in the ANU report on smoking-related deaths among indigenous Australians.
2. What predictions are made by lead researcher Dr Lovatt about the number of smoking deaths in the future?
3. What strategies are suggested by Dr Lovett to address a need to reduce smoking rates?

2.1.2 Socioeconomically disadvantaged people

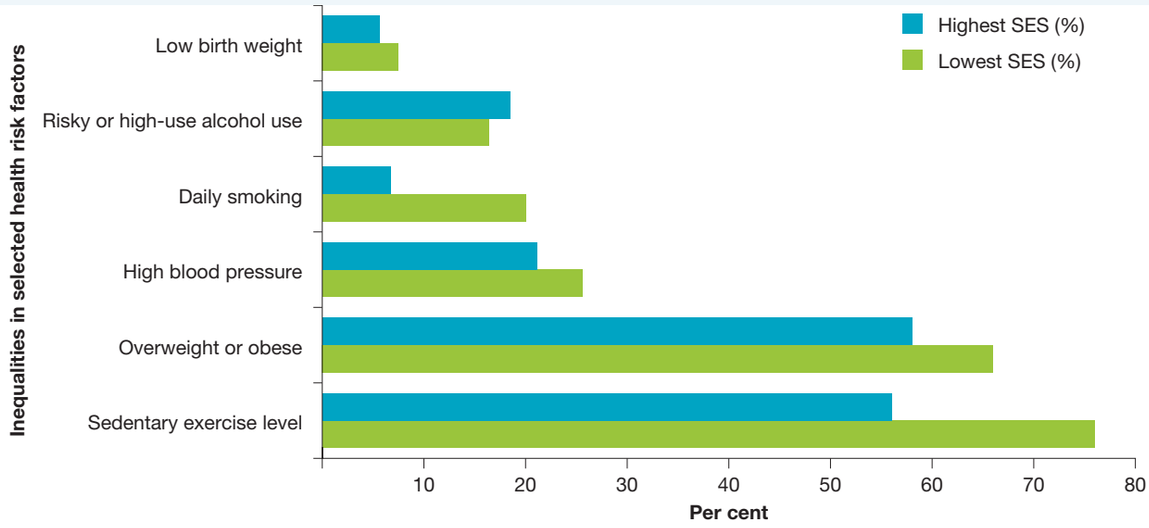
~~**Socioeconomic status** (SES) can be broadly measured by income, housing, education level and employment, and how these influence where a person fits into a society over a period of time. People or groups who are characterised by poor levels of education, low income, poor housing and unskilled work or long periods of unemployment are said to be socioeconomically disadvantaged.~~

~~There is a consistent relationship between an individual's socioeconomic status and their health. Socioeconomic disadvantage tends to be a risk factor for ill health. In all age groups, men and women from lower socioeconomic backgrounds have higher mortality and higher levels of illness than those of the more affluent groups in the population. People in the highest SES groups tend to have more choices and resources available to them and they enjoy better health outcomes.~~[1]

Studies have revealed that, in Australia:

- higher socioeconomic groups have a lower infant mortality rate

Figure 2.3 Prevalence of risk factors and disease by socioeconomic status, 2007–2008 (per cent)



- higher socioeconomic groups are better educated about their health — that is, lower education is associated with higher levels of blood pressure in both sexes, higher LDL (low-density lipoproteins) cholesterol levels in women and a higher body mass index in both sexes
- the decline in heart disease death rates is greater in higher socioeconomic groups
- smoking prevalence tends to fall as SES rises. In 2013 of those people 14 years or older, 20 per cent of people with the lowest SES smoked, daily compared with 6.7 per cent of people with the highest SES.
- people of low socioeconomic status appear to be less informed about health
- lower socioeconomic groups make less use of preventative health services such as immunisation, family planning, dental checkups and **Pap smears**
- people from low socioeconomic groups are sick more often and die younger. People from lower socioeconomic areas have higher rates of mortality overall and for most causes of death. The 20 per cent of Australians living in the lowest socioeconomic areas in 2014-15 were 1.6 times as likely to have at least two chronic health conditions, such as heart disease and diabetes.

Table 2.1 Inequalities in certain chronic conditions

	Year	LSE Group (%)	HSE Group (%)	Rate ratio: LSE/HSE
Arthritis	2014–15	19.7	12.1	1.6
Asthma	2014–15	12.8	9.8	1.3
Back problems	2014–15	18.9	15.9	1.2
Chronic kidney disease	2011–12	13.5	8.3	1.6
Coronary heart disease	2011–12	5.0	2.3	2.2
Diabetes	2014–15	8.2	3.1	2.6
Lung cancer incidence	2006–09	52.2	33.5	1.6
Mental and behavioural problems	2014–15	21.5	15.0	1.4
Oral health rated as fair or poor	2010	31.2	12.2	2.6
Stroke	2014–15	1.1	0.5	2.2

Source: AIHW, Australia's health 2016, page 184.

Health reports on rural and remote area health have identified socioeconomic and environmental determinants related to higher health risk factors. These include lower levels of education and income compared to metro-politan areas, greater exposure to injury in occupations such as farming and mining, higher risk on the road due to longer travelling distances and lower road quality, and a considerably lower percentage of water supplies that are adequately fluoridated.

People living in rural and remote areas have higher costs of living, in terms of food and fuel prices, although housing costs are lower. This means that the diet of residents in rural and remote areas may be affected because of insufficient access to reasonably priced fruit and vegetables. They also have poorer access to health care compared to people living in metropolitan zones due to distance, cost of fuel, and availability of transport. This lack of access is increased by a shortage and uneven distribution of medical services in rural and remote areas, compared to metropolitan areas.

The health of males living in rural and remote areas is comparatively worse than males living in metropolitan areas in Australia. Studies indicate that one factor is an attitude among men in rural and remote areas that injury and illness is part of normal life, and they are less likely to seek help for chronic conditions. According to surveys, they pay less attention to health-related behaviours than men in metropolitan areas.

INQUIRY

Socioeconomically disadvantaged groups

1. From Table 2.1, which condition shows the biggest difference between high and low socioeconomic status?
2. What are the reasons behind the health traits of population subgroups that have low socioeconomic status? In small groups, discuss a health issue that affects socioeconomically disadvantaged groups and list some ways to address the problem. Present your group's ideas in a short PowerPoint presentation.

2.1.3 People in rural and remote areas

About 30 per cent of the Australian population lives in rural or remote areas. The health of people living in rural and isolated areas is poorer than that of people living in city areas. Statistics reveal higher mortality and illness rates for this group. For example, although mortality rates across all regions have fallen in the past ten years, the mortality rate for other regions has remained 10 per cent higher than the mortality rate in major cities. This does not necessarily mean that remoteness equates to poor health. There are individuals and groups within rural and remote communities who are of good health. The poorer health status of indigenous Australians is to some extent responsible for the higher rates.

Figure 2.4 Rural males are less likely to seek out health advice.

Cardiovascular diseases were responsible for nearly a third of the elevated male death rates outside major cities. Compared with major cities, death rates from diabetes were 1.3 as high for men in inner regional areas and 3.7 as high in very remote areas.

'There is a strong relationship between poor health and social and economic disadvantage', said Sally Bullock, from the AIHW's Population Health Unit.

'Compared with urban areas, rural regions of Australia contain a larger proportion of people from lower socioeconomic groups. This fact, combined with the generally poorer health status of men compared with women, highlights a potential double disadvantage for men living in rural areas.'

The report also shows that men living outside major cities were more likely to have health risk factors such as daily smoking and risky or high risk alcohol use, than their counterparts in major cities. They were also more likely to have experienced a substance use–related mental disorder throughout their lifetime. Male death rates due to injury and poisoning also increased with remoteness.

- be smokers
- drink alcohol in hazardous quantities
- be overweight or obese
- be physically inactive.

Determinants of health in rural and remote areas

Health reports on rural and remote area health have identified socioeconomic and environmental determinants related to higher health risk factors. These include lower levels of education and income compared to metro-politan areas, greater exposure to injury in occupations such as farming and mining, higher risk on the road due to longer travelling distances and lower road quality, and a considerably lower percentage of water supplies that are adequately fluoridated.

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INQUIRY

Health inequities in rural and remote populations

Read the snapshot 'Men in regional and rural areas at greater health risk', then answer the following questions.

1. What is the 'double disadvantage' of men living in rural regions, according to the AIHW spokesperson?
2. Identify the health risk factors that are more common among men living outside major cities.
3. Propose why the rates of injury and poisoning are so much higher for men living in remote areas.
4. Why is distance a factor in mortality risk from cancer?
5. How is the NSW state government attempting to alleviate this difficulty?

Read the snapshot 'Facts about the inequity of cancer in rural and regional areas' then answer the following questions.

SNAPSHOT

Men in regional and rural areas at greater health risk

Men living in rural Australia are more likely to experience chronic health conditions than their urban counterparts, according to a report by the Australian Institute of Health and Welfare (AIHW). The report, *A snapshot of men's health in regional and remote Australia*, shows that male death rates increased with remoteness.

Cardiovascular diseases were responsible for nearly a third of the elevated male death rates outside major cities. Compared with major cities, death rates from diabetes were 1.3 as high for men in inner regional areas and 3.7 as high in very remote areas.

'There is a strong relationship between poor health and social and economic disadvantage', said Sally Bullock, from the AIHW's Population Health Unit.

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'The rates of injury and poisoning for men living in very remote areas were over three times as high as for men living in major cities', Ms Bullock said.

Source: AIHW media release, 14 April 2010.

SNAPSHOT

Facts about the inequity of cancer in rural and regional areas

- Cancer survivors living in rural areas have greater anxiety and distress levels and more emotional wellbeing concerns than cancer survivors living in larger cities.
- For some cancers, remote patients were up to three times more likely to die within five years of diagnosis.
- Radiotherapy often requires daily outpatient treatment for over six weeks. Rural patients need to travel and live away from home for this treatment. In some cases, people choose the type of treatment they have based not on what is needed but on the proximity to home, or worse, they refuse treatment altogether.
- Rural cancer patients are 35 per cent more likely to die within five years of diagnosis than patients in cities.
- There is a 6 per cent increase in mortality risk for each 100 km increment in distance from the nearest radiotherapy facility.
- To help bridge the gap in health outcomes between rural and urban patients in NSW, the State Government has increased allowances for travel and accommodation, to provide accommodation subsidies of $43 for single and $60 per double per night and reimbursement for car travel to 19c per kilometre.

Source: www.canassist.com.au.

Figure 2.5 Overseas-born people tend to have better levels of health than the Australian-born population.

2.1.4 ~~Overseas~~-born people

The 2016 Census showed that two thirds (28 per cent) of the Australian population were born overseas. Of the 6.1 million people born overseas, nearly one in five (18 per cent) had arrived since the start of 2012.

The highest proportion of overseas-born people were born in the United Kingdom or New Zealand, followed by China, India and the Philippines.

The health status of migrants varies, depending on their age, socioeconomic status, fluency in the English language and the~~ir~~ satisfaction with their life in Australia. It can be affecte~~d~~ by sociocultural determinants such as language barriers, stress of relocation, or ~~lack of contact with people from their original culture~~. Generally, though, migrants enjoy a higher level of health than that of the Australian-born population. Statistics reveal lower death rates, lower hospitalisation rates and a reduced incidence of lifestyle-related risk factors; for example, the mortality rate for skin cancer is very low among overseas-born Australians. Known as the 'healthy migrant effect', the main reasons appear to be that:

- people who migrate to Australia are generally willing and financially secure; sick or disabled people are less likely to apply
- the government selects migrants based on their health as well as education, language and job skills.

Studies reveal new migrants mostly maintain their traditional diet and eat as a family. As the time of residence in Australia lengthens, the more likely overseas-born Australians are to adopt the Australian lifestyle.

Given the general good health of overseas-born Australians, there are some significant inequities in health between our overseas-born population and Australian-born population, including:

- high rates of mortality from lung cancer for people from the United Kingdom and Ireland
- higher rates of diabetes and cervical cancer in the population groups of Asian origin

Figure 2.6 The elderly often have mobility problems and require additional support if they have dementia.

- markedly lower death rates for people born in China and Vietnam
- a much lower incidence of skin cancer in overseas-born Australians.

INQUIRY

Health inequities for Australians born overseas

1. Why do many new migrants tend to have good levels of health? Discuss these reasons.
2. Why would overseas-born people have lower rates of skin cancer?
3. Why would Asian migrants have higher rates of diabetes and cervical cancer?
4. Draw a web or bubble map to summarise the ways in which the Australian culture might have a negative impact on the health of some migrant groups over time.

2.1.5 Elderly people

Older Australians (65 years or older) make up a growing proportion of the Australian population. Australia has an ageing population. The population in Australia aged 65 or over increased from 1.1 million in 1971 (8 per cent of the population) to more than 3.7 million in 2016 (15.7 per cent).

Socioeconomic indicators such as higher education and income levels, and supportive social environments all contribute to a higher likelihood of elderly people maintaining good health.

Coronary heart disease is the leading cause of death among older Australians, in the older population overall. The most commonly reported health conditions for Australians aged 65–74 are vision and hearing loss, high blood pressure and related conditions, and osteoarthritis. The high levels of these conditions within this age group are often associated with some degree of disability, which places a large financial burden on the health system. The proportion of older people with disability decreased in 2015.

Dementia is another significant health condition in this age group and is more prevalent in females, mainly because they live longer. In 2016, Dementia and Alzheimer's became the leading cause of death among women. Dementia accounted for 8.3 per cent of all deaths in 2016, up from 5.3 per cent of all deaths in 2007.

SNAPSHOT

Baby boomers hitting the bottle and bongs at alarming levels, health experts warn

Young people usually get the blame for binge drinking, but Australian health experts say it's their parents and grandparents who are abusing drugs and alcohol at an alarming rate.

Key points:

- Binge drinking on the rise among those over the age of 40
- Australians over 50 also have higher rates of illicit drug use than younger people
- Researchers say new education campaigns are needed to help older drug users

In the UK and Australia, binge drinking is on the decline among all age groups — except those over the age of 40.

Researchers from the South London Maudsley NHS Foundation Trust and Flinders University in Adelaide are calling for a coordinated global approach to boozing boomers.

'Alcohol misuse in the older population may increase further as baby boomers get older because of their more liberal views towards, and higher use of, alcohol,' the researchers wrote in the British Medical Journal.

However, scientists found baby boomers were not just hitting the bottle harder than their children.

Australians over 50 also have higher rates of illicit drug use than younger people.

'In Australia, the largest percentage increase in drug misuse between 2013 and 2016 was among people aged 60 and over, with this age group mainly misusing prescription drugs,' they said.

Cannabis use among older people is also startlingly high.

'People over 50 have higher rates than younger age groups for both past year and lifetime illicit drug misuse, notably cannabis,' the researchers said.

Boomers' drug use started in teenage years.

Lead author Ann Roche, from the National Centre for Education and Training on Addiction at Flinders University, has previously found the overwhelming majority of cannabis users in this age group began using as teenagers and it continued into their older years.

She said new education campaigns were needed to help older drug users.

The number of people over 50 receiving drug and alcohol treatment is expected to treble in the United States and double in Europe by 2020.

'A lack of alcohol screening to detect risky drinking may result in a greater need for treatment, heavier use of ambulance services and higher rates of hospital admission,' they said.

Researchers said drug and alcohol services would need to improve their knowledge and skill in assessing and treating older people misusing opioid drugs, cannabis, and drugs for pain and anxiety.

'The clinical complexity of older adults with substance misuse demands new solutions to a rapidly growing problem,' the authors said.

Public health challenges 'will increase'

Professor Steve Allsop from the National Drug Research Institute at Curtin University said alcohol and other drug-related problems among older Australians were critical public health challenges that would increase in coming years.

'The increase in the proportion of Australians over the age of 50, levels of alcohol and other drug consumption, and the particular risks for ageing Australians sees this issue impact on our drug specialist and our aged care services and across our community,' he said.

Dr Terry Slevin from the Cancer Council's occupational and environmental cancer risk committee said the link between alcohol and cancer risk remained under-recognised in the community.

Alcohol consumption is known to increase a person's chances of developing cancer of the liver, mouth, bowel and breast.

Training on Addiction at Flinders University, has previously found the overwhelming majority of cannabis users in this age group began using as teenagers. It can be affected by sociocultural determinants such as language barriers, stress of relocation, or lack of contact with people from their original culture.

'Evidence from Western Australia suggests campaigns to highlight this connection are effective in encouraging older drinkers to reconsider their consumption,' Dr Slevin said

INQUIRY

Health inequities for elderly people

Read the snapshot 'Baby boomers hitting the bottle and bongs at alarming levels', then answer the following questions.

1. What trends are emerging from the latest statistics on the elderly and their use of prescription drugs?
2. Suggest reasons for these trends.
3. Use the **Ageing and health issues** weblink in your Resources tab and choose a topic that relates to a health issue for elderly Australians. Read the information and write a short report on how the health issue can be addressed to improve the health status of elderly people.

2.1.6 People with disabilities

Disability can be measured along a continuum. Components of functioning and disability reflect an interaction between the health condition of the person and his or her environment.

The disability prevalence rate in Australia has remained relatively stable over time. In 2015, 4.3 million people (18.3 per cent), or one in five Australians, reported living with a disability. The conditions that cause disability tend to increase with age. In 2015, 8.2 per cent of 15–24 year olds were affected by disability, compared to 16.4 per cent of 45–54 year olds, 37.8 per cent of 65–69 year olds and 85.4 per cent of people 90 years and over.

The actual number of people living with a disability is increasing as a result of the ageing population. Statistics reveal that the numbers of indigenous people living with severe disability are more than double that of other Australians.

People with disability have significantly worse health outcomes than the general population. The Australia's Health 2016 report refers to survey data in 2011–12 that shows that 51 per cent of people aged 15–64 with a severe or profound disability reported poor or fair health, compared with 5.6 per cent for those without disability.

By 2019, the National Disability Insurance Scheme (NDIS) will support about 460,000 Australians living with permanent and significant disability under the age of 65 years. The scheme started in July 2013 as a trial in four locations and is being introduced in stages around Australia. It aims to provide support to people with disability to build skills and capability so they can participate in the community and employment through access to appropriate services.

Determinants of health for disabled people

Disabled people in Australia have lower incomes and are more likely to live in poverty than people without a disability. This is partly due to lower education and employment levels compared to the general population. Lack of job opportunities or not having a job then limits opportunities for social connections. The health of disabled people can be affected if they are socially excluded or marginalised. They may also face violence and discrimination related to their disability.

The majority of disabled people live in households rather than accommodation establishments. They can be disadvantaged by living in poor quality housing or be affected by living in accommodation that is inappropriate for their disability.

Disabled people are generally more likely to smoke and have insufficient physical activity than non-disabled people, but have a lower incidence of alcohol misuse. People with a severe or profound disability are more likely to be overweight or obese.

SNAPSHOT

Two in five Australians over 65 years live with a disability

-
-

INQUIRY

Health inequities for disabled people

Read the snapshot 'Two in five Australians over 65 years live with a disability' then answer the following questions.

1. (a) What is the trend in Australia for:
   (i) the proportion of people living with a disability?
   (ii) the proportion of people who are severely disabled?
   (b) (i) Identify the two socioeconomic determinants of health that are compared for disabled and non-disabled people.
   (ii) Suggest how they could affect the health risk factors of people with disabilities.
2. An example of an organisation that supports people with disabilities is the Royal Institute for Deaf and Blind Children (RIDBC). Use the **RIDBC** weblink in your Resources tab and click on 'Services' to find out more about how the needs of children with hearing or vision impairment are met.

APPLICATION

Groups experiencing health inequities

1. In groups, consider Aboriginal and Torres Strait Islander peoples and one other group experiencing health inequities. For these two groups, research the:
   (a) nature and extent of their health inequities
   (b) sociocultural, socioeconomic and environmental determinants
   (c) roles of individuals, communities and governments in addressing their health inequities.
2. Share your findings with the class in a short oral presentation.

KEY TERMS

Socioeconomic status can be broadly measured by a person's level of income, education, housing and employment.

A **determinant** is a factor that can have an impact on a person's or group's health status, either positively (protective factors) or negatively (risk factors).

Sociocultural determinants of health include family, peers, media, religion and culture.

Socioeconomic determinants of health include employment, education and income.

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

Pap smears are screening tests to detect cervical cancer cells by taking a sample of cells from the cervix.

Dementia is a condition characterised by a significant loss of intellectual abilities such as memory capacity.

Disability is defined in terms of the lack of ability to perform everyday functions or activities. It refers to limitations in functional abilities.