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Chapter 1 : Mental Health Act - calendrierdelascience.com

Australia's health is the 14th biennial health report of the Australian Institute of Health and Welfare. This edition combines analytical feature articles on highly topical health issues with short statistical snapshots in the following areas: Understanding health and illness; The Australian health system; How healthy are we?;.

These are the non-communicable diseases NCDs including cancer, diabetes, cardiovascular and respiratory diseases. However, levels of excess weight and obesity in adults continue to rise and remain stubbornly at Everest-like heights for children. But losing weight on your own, for example, is notoriously hard. As a nation we have put weight on together. The tobacco epidemic would simply not exist without the tobacco industry. The biggest challenge we have is for the community to force changes in the behaviour of these unhealthy industries on the one hand, and for the best and the brightest in Australia to turn healthy food and physical activity into outstanding commercial successes on the other! If this happens then our personal and parental responsibility really can work. Inequities Sharon Friel, Professor of Health Equity, Regulatory Institutions Network and Director of the Menzies Centre for Health Policy, Australian National University Unsurprisingly, Indigenous Australians, people from lower socioeconomic groups and rural dwellers continue to have poorer health and health outcomes compared to other social group. One of the most egregious health inequities continues â€" it is incredible that an Indigenous boy born between and can expect to live more than ten years less than a non-Indigenous boy Rural and remote dwellers have less access to health services, travel greater distances to seek medical attention, and generally have higher rates of ill health and early death than people living in larger cities. In â€", people living in lower socioeconomic areas had higher rates of early death from all cancers and lower five-year survival rates than people living in wealthier areas. Why do these inequities exist and persist? The report provides a breakdown of the contribution of factors to the health inequities between Indigenous and non-Indigenous Australians: We need policy and practice that aims to address educational disadvantage, lower employment and income rates. And we need a real focus on removing the institutional racism that reinforces the health inequities between Indigenous and non-Indigenous Australians. Health costs are rising as a percentage of GDP â€" over the last decade increasing at 5. But only Dickensian characters and the occasional politician focus entirely on costs, ignoring value or benefits for increased spending. Community expectations are also increasing, both in terms of expectations about the ability of technology to address health problems and access to those technologies. The report, though, lists some important gaps in data collation: The report also presents government health expenditure data in a new way, comparing the ratio of spending to receipts. After a decade of stability where government health spending was around a fifth of government revenues, the health share increased to more than one quarter. With improved economic health, the ratio is now falling back towards a more comfortable position, at least for the Commonwealth. This makes their squeals of pain following the commonwealth budget cuts to the states even more understandable.

Chapter 2 : Women's Health - | Australian Medical Association

AIHW Australia's Health , CC BY Importantly, the AIHW report highlights that this is a revenue side issue - the share increased because of a GFC-induced fall in revenues.

Cancer is also the largest cause of illness, followed by cardiovascular disease: Burden of disease, by disease group, Australia, AIHW Chronic diseases are becoming more common, due to population growth and ageing. Half of Australians more than 11 million have at least one chronic disease. One quarter have two or more. The most common combination of chronic diseases is arthritis with cardiovascular disease heart disease and stroke: Australians have high rates of the biomedical risk factors that increase the risk of heart disease and stroke. This is the lowest level since â€" Use of methamphetamine has remained stable in recent years. However, more methamphetamine users are opting for crystal ice rather than powder speed. The bad news is Australians are still struggling with their weight. This equates to an average increase of 4. One in four children are overweight or obese. These are for adults to accumulative to minutes of moderate intensity physical activity or 75 to minutes of vigorous intensity physical activity each week. Children are advised to accumulate at least 60 minutes of moderate to vigorous physical activity every day. If we took prevention and health promotion far more seriously, we could do a lot better. The report nominates tobacco use, alcohol, high body mass and physical inactivity as the chief causes of preventable illness and the chief causes of our increasing level of chronic illnesses. Yet national investment in prevention is declining. Focus on prevention to control the growing health budget Tobacco use is rapidly declining because of really effective measures plain packaging, advertising bans and increasing price through taxes that save lives and enormous amounts of money over a lifetime for people who used to smoke. There is a gradient across society whereby the richer the area you live in, the longer you can expect to live. The difference between the highest and lowest is four years. Deaths by socioeconomic group: Children most at risk of exclusion â€" those from poor areas who experience problems with education, housing and connectedness â€" are most likely to die before they reach 15 years from potentially preventable or treatable causes. Our most glaring inequity is the ten-year life gap between Aboriginal and Torres Strait Islander Australians and others. Indigenous life expectancy is Compared with the non-Indigenous population, Indigenous Australians are: Australians living outside major cities have higher rates of disease and injury. They also live in environments that make healthy lifestyles choices harder such as more difficulties buying fresh fruit and vegetables and so their risk of chronic diseases is increased. AIHW The data on who has private health insurance coverage points to the emergence of a two-tiered health system, where those who can afford to pay receive better access and quality of care. As a result, health took up an increasing share of GDP. Spending more on health means Australia spent less on other things. This is not necessarily bad, as long as the benefits from that increased expenditure â€" such as increasing life expectancy or increased quality of life â€" are worth the increased costs. But spending above GDP growth cannot continue indefinitely. Annual growth rates in health expenditure. Commonwealth government expenditure was more or less stable over these most recent two years, declining 2. Health expenditure by area adjusted for inflation AIHW Savings to the government came from shifting costs to consumers, by slowing the growth in government subsidies to private health insurers, and also by slowing spending on pharmaceuticals. This latter slowdown was achieved through tighter controls on payments to drug manufacturers and because some big-selling drugs came off patent, resulting in falls in prices.

Chapter 3 : Australia's Health report card: experts respond | SBS News

Australia's welfare Australia's welfare is the 13th biennial welfare report of the Australian Institute of Health Our services Use down arrow to expand Our services Committees.

For example, causes of death data provide an insight into the diseases and factors contributing to life expectancy, potentially avoidable deaths, years of life lost and leading causes of death. Australia, as a member state of the World Health Organization WHO , supplies data annually to the WHO on deaths by age, sex and cause of death, as compiled from the civil registration system by the Australian Bureau of Statistics. In Australia, causes of death statistics are recorded as both underlying causes and multiple causes of death. The underlying cause is the single disease or injury which began the sequence of conditions that resulted in death. Unless stated otherwise, causes of death statistics presented by the ABS refer to the underlying cause. For further information on the way causes of death are compiled, see the Explanatory Notes in this publication. Deaths There were , deaths registered in Australia in , 5, more than the number registered in , There were more male deaths 78, registered in than female deaths 75, , resulting in a sex ratio of These accounted for over one-third of all deaths. Although the five leading causes of death were the same for males as females in , there were also key differences between the sexes. More males than females died from Ischaemic heart diseases II25 11, males; 9, females and from Cancer of the trachea, bronchus and lung C33, C34 4, males; 3, females. The diagram below shows, in order, the five leading causes of death for the total population. Each leading cause is shown to account for a proportion of all deaths calculated separately for males and females. The leading cause of death for all people, Ischaemic heart diseases II25 , accounted for one in seven male deaths and one in eight female deaths. Cancer of the trachea, bronchus and lung C33, C34 was the second leading cause for males accounting for one in 16 deaths, and was the fifth leading cause for females accounting for one in 23 deaths. Further information can be found in the Leading Causes of Death section in this publication. Leading causes as a proportion of all male and female deaths, Causes of death by age Leading causes of death vary across age groups. Among those aged 15 to 44, the leading causes of death were Intentional self-harm suicide XX84 , Accidental poisonings including drug overdoses XX49 and Land transport accidents VV Among those aged 45 to 74, the most common causes of death were Ischaemic heart diseases II25 , Cancer of the trachea, bronchus and lung C33, C34 and Chronic lower respiratory diseases JJ While a cause of death may have a lower incidence than that of another, its impact when measured in terms of premature death may be greater, as a result of that cause affecting a younger demographic. Intentional self-harm XX84 deaths accounted for 97, years of potential life lost, the highest of all leading causes in A key reason for this difference is that the median age at death for Intentional self-harm XX84 in was The median age at deaths for all causes in was Potentially Avoidable Mortality Potentially avoidable deaths comprise deaths from certain conditions that are considered avoidable given timely and effective health care. In , 26, Australians died from potentially avoidable causes of death. Among people who died between 15 and 44 years of age, The most common potentially avoidable causes for this age group were Ischaemic heart diseases II25 , Chronic obstructive pulmonary disease JJ44 and Colon, sigmoid, rectum and anus cancer CC Further information can be found in the Potentially Avoidable Mortality section in this publication. Multiple Causes of Death Multiple causes are all causes and conditions reported on the death certificate that contributed to, were associated with, or were the underlying cause of the death see the Glossary for further details. Looking at these multiple causes gives a more complete picture of the diseases and conditions affecting the health of the Australian population. In there was an average of 3. As the population ages, deaths are likely to feature chronic conditions with multiple comorbidities. Approximately two-thirds of deaths For people under 45 years of age, Deaths where the underlying cause is considered to be chronic, are generally more likely to have a greater number of conditions reported on the death certificate than deaths due to other causes. In , for deaths with an underlying cause of Type 2 diabetes E11 , there was an average of 5. Further information can be found in the Multiple Causes of Death section in this publication. Compared to the non-Indigenous population, death rates were 1. Further information can be found in the Deaths of Aboriginal and Torres Strait Islander section of this publication. In

the past year the ABS has led a process, working with coding specialists both internationally and nationally, to derive a supported method for coding an underlying cause for deaths certified using the Medical Certificate of Cause of Perinatal Death MCCPD. This has resulted in a new coding method for neonatal deaths which has been implemented by the ABS. Their continued cooperation is very much appreciated: It should be noted that a national causes of death unit record file can be obtained through the Australian Coordinating Registry at the Queensland Registry of Births, Deaths and Marriages data available on application for legitimate research purposes only. Document Selection These documents will be presented in a new window. This page last updated 27 September

Chapter 4 : Australia's health , Table of contents - Australian Institute of Health and Welfare

While there have been improvements in the health and wellbeing of Aboriginal and Torres Strait Islander Australians in recent years, some long-standing challenges remain.

Introduction All women have the right to the highest attainable standard of physical and mental health. While women and men share many health challenges, they also differ in certain patterns of illness, disease risk factors, and access to and use of health services. These differences are shaped by biological, social and cultural factors. Gender is used to describe those characteristics of women and men that are socially constructed, while sex refers to those that are biologically determined. Together, gender and sex, in interaction with socioeconomic circumstances and other determinants of health, influence exposure to health risks, access to health information and services, and health outcomes. Although women as a group have a higher life expectancy than men, they experience a higher burden of chronic disease and tend to live more years with a disability. In general, women report more episodes of ill health, consult medical practitioners and other health professional more frequently, and take medication more often. These health disparities are in turn shaped by wider social determinants such as socioeconomic status, ethnicity, age, disability, employment status, and geographic location. Women living in rural or remote areas, women with a disability, and women from migrant or refugee backgrounds also tend to experience particular health challenges and inequities. Social model of health. Addressing these underlying determinants of health requires working across various government sectors, including health, housing, education, employment, social welfare and justice. Achieving gender equity requires removing unfair, unjust and avoidable disparities in health. Health equity between women. The health status and behaviours of women may be influenced by a range of factors including income, ethnicity or Aboriginality, sexual orientation, disability, education, geographic setting, and age. Acknowledging this diversity and removing systemic discrimination in health policies and strategies is vital in securing more equitable health outcomes. A focus on prevention and upstream interventions. A life course approach to health. Strategic coordination and leadership. This includes national policy leadership to drive and support improvements across the different tiers of government. Building the knowledge base. Gender mainstreaming in health Gender plays a critical role in shaping patterns of morbidity and mortality, impacting on exposure to health risk factors, health seeking behaviour, and access to health services. Gender mainstreaming is an approach that factors these gender considerations into the design, implementation and monitoring of health-related policies. Integrating gender considerations into policy planning and delivery can therefore help to pinpoint areas of need, allocate resources and tailor interventions, and identify barriers or enablers to achieving better health outcomes. Mainstreaming gender in health does not preclude interventions that are specifically targeted to men or women, but recognises that such interventions are necessary and complimentary to broader approaches that integrate gender into health policy. The responsibility for translating gender mainstreaming into practice is system-wide and requires ongoing monitoring and accountability for outcomes. Health promotion, disease prevention and early intervention Many determinants of gender inequities in health can be influenced by health promoting measures and risk reduction strategies, ranging from interventions that enhance the knowledge and skills of women to manage their health; targeted health screening and detection programs; through to macro-policy measures that address the economic and social determinants of ill health. Health promotion strategies aimed at reducing risky behaviours, such as smoking or physical inactivity, require consideration of the social and cultural conditions within which the targeted behaviours are embedded. In addition to influencing behavioural risk factors for preventable diseases, gender can affect how women and men experience and respond to health promotion programs or activities. Cultural and language differences, levels of health literacy, and socioeconomic circumstances are also key considerations in the targeting and design of health promotion interventions. Gender considerations should inform the development, implementation, monitoring and evaluation of health promotion policies and programs. Health education and promotion should be evidence based, age-appropriate and take into account the cultural, social and economic circumstances of different groups of women, including those who experience

the most pronounced health disadvantages. Screening, health risk assessment and immunisation Screening, immunisation, and the identification of disease risk factors are key preventive health interventions. The uptake of preventive health interventions is consistently lower among women from disadvantaged backgrounds, who report greater use of hospital outpatient services and increased morbidity and mortality from preventable diseases. The allocation of funding to screening and immunisation programs should be informed by considerations around affordability, equity and access, the likely reach and size of impact, and the quality of the evidence base. Particular consideration should be given to improving the uptake of screening and immunisation interventions among women who are underscreened, at high risk of particular health conditions, or who face systemic barriers to accessing essential screening or preventive medicine interventions. The AMA supports effective interventions for the prevention, screening and treatment of cervical cancer, include routine vaccinations against the human papilloma virus HPV and a national program for cervical cancer screening. Additional measures should be adopted to improve screening rates among groups of women who experience heightened mortality rates associated with cervical cancer, including women from Aboriginal and Torres Strait Islander backgrounds. The AMA also supports and encourages HPV vaccination for boys and men as part of an effective vaccination policy to reduce the incidence of cervical carcinoma in women. An evidenced-based approach should be taken in reviewing the appropriate screening intervals, age at first screen, impact of HPV vaccination, and the role of new technologies in the national cervical screening program. Chronic disease and ageing Managing the increased burden of chronic disease and age-related disability is a fundamental public health and policy challenge, with implications for the sustainability of health care spending and the design and delivery of health services. It is important that the social context of this demographic shift, in which women and men are affected in different ways, is recognised. Men and women show differing patterns in the prevalence, manifestation and treatment of many chronic diseases, including cardiovascular disease, dementia, arthritis, osteoporosis, diabetes, and various forms of cancer. The development of chronic disease among adult and older women is shaped by the impact of risk exposures across the life cycle, and the cumulative impact of these exposures as women age. Among women from the most socioeconomically disadvantaged backgrounds, the rate of premature mortality from chronic disease is 60 per cent higher than the rate for the least disadvantaged women. Gender considerations should inform health service and workforce policy and planning in response to the convergence of population ageing and the growing burden of chronic disease. This should be supported by the incorporation of sex-disaggregated data and gender-based analysis into the monitoring of prevalence and trends of chronic disease conditions and risk factors. The AMA supports initiatives undertaken by federal and state governments that recognise and address issues relating to domestic violence within the community. The medical profession has a key role to play in early detection, intervention and provision of specialised treatment of those who suffer the consequences of domestic violence, whether it be physical, sexual or emotional. The AMA acknowledges the widespread underreporting of domestic violence perpetrated against women and by women to other women and to men. It supports ongoing programs to make reporting of such violence easier, and in so doing start processes to gain help to make domestic circumstances safer for all. The role and extent of domestic violence, as a determinant of medical and psychiatric morbidity, should be included in undergraduate curricula, postgraduate training programs, and continuing education of medical practitioners. Continuing education of the profession is also necessary to highlight the critical role of primary health care providers in the early detection of victims of domestic violence, and to support the provision of trauma-informed care. There is a need for continuing research into the emotional and social aetiology of domestic violence. Development and evaluation of intervention programs for both offenders and victims should be significant components within that research. Strategies to prevent domestic violence must incorporate recognition, understanding, and management of the underlying problems of the perpetrator, and the potential long-term impacts for victims of domestic violence or sexual assault. Mental health and suicide Mental disorders represent the leading cause of disability and the highest burden of non-fatal illness for women in Australia. Early childhood experiences play a significant role in determining future mental health. Adolescent and young women are more likely to have negative body image or body image dissatisfaction, which is inturn linked to a range of physical and psychological health concerns and risk-taking behaviours,

including the development of eating disorders, depression, self-harm and suicide. Suicide in a family affects the mental health of all members. Although men have higher rates of suicide, women are frequently left to deal with the effects on remaining family members. The AMA recommends that mental health policies should incorporate a gendered approach. Psychiatric inpatient facilities should provide areas of sex segregation and ensure safety and privacy for female inpatients. Sexual and reproductive health Access to comprehensive sexual and reproductive health services, screening, and information is critical to safeguarding and promoting the health of women. Contraception can prevent psychological distress and premature deaths of women from the consequences of unwanted pregnancies, particularly for women with a history of certain psychiatric and medical conditions. The non-availability of termination of pregnancy services has been shown to increase maternal morbidity and mortality in population studies. Access to such services should be on the basis of healthcare need and should not be limited by age, socioeconomic disadvantage or geographical location. Child and maternal health outcomes are influenced by experiences in the journey from pre-conception through to antenatal care, delivery and postnatal care. Although maternal and fetal mortality and morbidity rates are relatively low in Australia, child and maternal health outcomes for Aboriginal and Torres Strait Islander peoples and some culturally and linguistically diverse populations remain poor. Expectant mothers should have access to timely and relevant antenatal screening. Medical professionals play an important role in supporting pregnant women to make fully informed health care decisions, including the provision of advice on the risks and benefits to both the woman and the fetus of lifestyle and medical treatment options. Mental health problems, including peripartum depression, can affect the wellbeing of mothers, and their babies and partners, during a time that is crucial to the future health and wellbeing of children. It is imperative service systems and healthcare providers support early detection and intervention to improve the outcomes for mothers who experience mental health conditions. Women should have access to legal and safe abortion; reliable, safe and affordable contraception; information and services to support adoption or maintaining a pregnancy; and appropriate sexual and reproductive health and information. Critical recognition should be given to improving access to such services and information in rural and remote areas, and to ensuring that services, information and targeted programs are available and appropriate for women with limited language literacy, women with disabilities, women from cultural and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander women. Sexuality education should be implemented in schools, and include areas such as healthy relationships, negotiating sex and contraception with a partner, and risk-taking behaviour. Sexuality education should be comprehensive, evidence based, age appropriate, and accessible to all young Australians. Awareness of the underlying and gendered risk factors for infertility should be promoted. Health services and policies should support the health of women and their babies throughout pregnancy, birth, and in the post-natal period. Maternity services should be proactive in engaging all women, particularly women from disadvantaged or culturally diverse communities, early in their pregnancy and maintaining contact before and after birth. A system of clear referral pathways should also be established so that pregnant women who require additional care are managed and treated by the appropriate specialist teams when problems are identified. The detection, management and treatment of perinatal mental disorders should be supported by screening and access to appropriate services and supports. The AMA supports specific services for the management of peripartum depression and peripartum health issues, including in-patient access to mother-baby units. Addressing the needs of specific population groups Aboriginal and Torres Strait Islander women Aboriginal women have poorer physical and mental health in almost every dimension compared to non-Aboriginal and Torres Strait Islander women. Aboriginal and Torres Strait Islander women are 35 times more likely than non-Indigenous women to suffer family violence and sustain serious injuries requiring hospitalisation, and 10 times more likely to die due to family violence. Such measures should be developed in partnership with Aboriginal and Torres Strait Islander women and agencies to ensure that they are culturally and linguistically appropriate and relevant. Women from refugee and culturally and linguistically diverse backgrounds The health needs of women from culturally and linguistically diverse CALD backgrounds are shaped by a range of factors, including their cultural background, language skills, socioeconomic circumstances, education levels, pre-arrival experiences, length of time in Australia, support networks, and possible experiences of torture and

displacement. The health advantages that some immigrant women experience upon arrival in Australia often diminishes over time, and the rates of obesity, cardiovascular disease, and diabetes is disproportionately high among a number of culturally and linguistically diverse groups of women. Asylum seekers or newly arrived women from refugee backgrounds often grapple with a range of social and economic factors that impact on their health and their capacity to access health services. This includes housing insecurity, unemployment or financial insecurity, disrupted education and limited language literacy, and social isolation. Some people who have migrated may have come from social and cultural contexts in which gender roles and expectations differ from those that are widely accepted in Australia. In some instances, engaging the family may be critical in treating women from cultural backgrounds in which participation in healthcare is a family concern rather than an individual responsibility. The AMA supports measures that increase the capacity of the health system to serve the needs of women experiencing socioeconomic disadvantage and reduce inequities in access and outcomes, including reducing financial barriers and high out-of-pocket medical costs, and ensuring health information and preventive health programs are relevant. Health promotion and service delivery should be culturally safe and sensitive, and take into account the social, cultural and linguistic factors that impact on the health of women from diverse cultural and linguistic backgrounds. Health professionals should be supported in utilising interpreting services, and accredited interpreters should be used wherever possible rather than family members. Measures should be in place to support interpreter use in hospitals and community health services. Upon arrival, all women from refugee backgrounds should be given comprehensive and culturally appropriate health assessment and screening. Particular consideration should be given to strategies to increase the engagement of refugee women with sexual and reproductive health services, preventive screening, contraception and mental health services. Women from socioeconomically disadvantaged backgrounds Women experience greater rates of poverty, underemployment, and homelessness. Women who are socioeconomically disadvantaged are more susceptible to poor health, including reduced life expectancy, injury and disease prevalence, higher rates of disability, and biological and behavioural risk factors.

Chapter 5 : Australia's Health report card: experts respond

Australia's health is the 14th biennial health report of the Australian Institute of Health and Welfare. This edition combines analytical feature articles on highly topical health issues with short statistical snapshots in the following areas.

Share on Facebook Share on Twitter By Rob Moodie , University of Melbourne; Sharon Friel , Australian National University, and Stephen Duckett , Grattan Institute Australians have one the longest life expectancies in the world but are living with growing levels of lifestyle-induced chronic illness, according to the latest national health report card. But life expectancy for Indigenous and rural Australians is much lower. Almost one in five Australians But the proportion of people who never drink alcohol has increased slightly, from Coronary heart disease remains the biggest killer, followed by: On mental health, one in five Australians have had a mental health disorder in the past 12 months 3. Life expectancy continues to rise, and years lived with disability decline. These are the non-communicable diseases NCDs including cancer, diabetes, cardiovascular and respiratory diseases. However, levels of excess weight and obesity in adults continue to rise and remain stubbornly at Everest-like heights for children. But losing weight on your own, for example, is notoriously hard. As a nation we have put weight on together. The tobacco epidemic would simply not exist without the tobacco industry. The biggest challenge we have is for the community to force changes in the behaviour of these unhealthy industries on the one hand, and for the best and the brightest in Australia to turn healthy food and physical activity into outstanding commercial successes on the other! If this happens then our personal and parental responsibility really can work. Inequities Sharon Friel, Professor of Health Equity, Regulatory Institutions Network and Director of the Menzies Centre for Health Policy, Australian National University Unsurprisingly, Indigenous Australians, people from lower socioeconomic groups and rural dwellers continue to have poorer health and health outcomes compared to other social group. One of the most egregious health inequities continues â€” it is incredible that an Indigenous boy born between and can expect to live more than ten years less than a non-Indigenous boy Rural and remote dwellers have less access to health services, travel greater distances to seek medical attention, and generally have higher rates of ill health and early death than people living in larger cities. In â€”, people living in lower socioeconomic areas had higher rates of early death from all cancers and lower five-year survival rates than people living in wealthier areas. Why do these inequities exist and persist? The report provides a breakdown of the contribution of factors to the health inequities between Indigenous and non-Indigenous Australians: We need policy and practice that aims to address educational disadvantage, lower employment and income rates. And we need a real focus on removing the institutional racism that reinforces the health inequities between Indigenous and non-Indigenous Australians. Health costs are rising as a percentage of GDP â€” over the last decade increasing at 5. But only Dickensian characters and the occasional politician focus entirely on costs, ignoring value or benefits for increased spending. Community expectations are also increasing, both in terms of expectations about the ability of technology to address health problems and access to those technologies. The Report, though, lists some important gaps in data collation: The report also presents government health expenditure data in a new way, comparing the ratio of spending to receipts. After a decade of stability where government health spending was around a fifth of government revenues, the health share increased to more than one quarter. With improved economic health, the ratio is now falling back towards a more comfortable position, at least for the Commonwealth. This makes their squeals of pain following the commonwealth budget cuts to the states even more understandable. Rob Moodie has received funding from Department of Health and Ageing. Sharon Friel receives funding from the Australian Research Council. Stephen Duckett does not work for, consult to, own shares in or receive funding from any company or organisation that would benefit from this article, and has no relevant affiliations.

Chapter 6 : Australiaâ€™s Health report card: Rising costs | Grattan Institute

Australia's health A ust r al i a 's h e al t h AIHW Australia's health is the 14th biennial health report of the Australian Institute of Health and Welfare.

Here they provide their thought-provoking and insightful responses. Make population health a cross-portfolio priority for all levels of government Population health is not just about treating illness. Continue the investment in closing the life expectancy gap between Aboriginal and Torres Strait Islander peoples and all Australians All governments need to keep up the investment, but not just in the health portfolio. There is stark evidence that investing in the social determinants of health and a good education, starting at birth, are major predictors of health outcomes. Fix e-health and the PCEHR We must be able to talk to each other in the same language -general practice, hospitals public and private , public outpatients, private specialists, aged and community care. Too often the right message just does not get through. We know we are doing a good job and are very cost effective. If we embrace the move of learned colleges toward clinical audit and self-reflection we can make best practice even better. Invest in research The human papillomavirus vaccine will save millions of lives. Research delivered and refined the place of statins, also saving millions of lives. We need new ways of treating infections, perhaps more antibiotics or better ways to use the ones we already have. Professor Chris Baggoley, Australian Government Chief Medical Officer It is not easy to nominate five priority areas for action, given that there are so many deserving areas that require our ongoing attention. Of course, in my role there are a number of areas where my direct involvement is needed to help made a difference. Understanding that this list excludes other equally deserving priority areas, my list is: Australia is taking a leading role: The appearance of avian influenza H7N9 in China in , and the Middle East Respiratory Syndrome Coronavirus in , has redoubled the focus of all areas of the health system to prepare to manage emerging infectious diseases, and this must remain a focus for Public interest in the benefits of high levels of childhood immunisation was a particular feature of , especially following the National Health Performance Authority report breaking coverage down to Medicare Local and postcode areas. Vaccine-preventable diseases should be prevented, and our attention to this aspect of health care in all areas must remain a priority. While the first three areas are part of my daily work, this is not the case for dementia. Nonetheless, the case for research into the causes and prevention of dementia is apparent to all of us. Much work is underway to improve our mental health. Improved community and professional understanding and reduction in stigma will assist sufferers of mental health illness to seek help, and assist their recovery. Addressing health disparities Prime among these is the need to Close the Gap on health disparities for Indigenous Australians, but we should not forget the disparities suffered by people with mental illness, people with disabilities, the homeless, and those who are isolated, both geographically and socially. These gaps will only be closed by a broader focus on the social determinants of health through a whole-of-government approach. Reworking the healthcare workforce If we are to address the health and healthcare needs of the 21st century in a country as large and diverse as Australia, then we need an appropriate workforce and a system that enables every healthcare profession to work to full scope of practice. That means widening who can prescribe and who can work independently. The new workforce must include more Aboriginal and Community Health Workers to assist with outreach, education, care coordination and cultural sensitivity. Antibiotic resistance The growing threat of multiple resistance requires a major international effort involving the agriculture, food and health sectors and an increased focus on research to deliver solutions and new antibiotics. Developed nations like Australia must show leadership in tackling both the causes and the impacts. In the absence of government action, communities must step in to lead the way. National data collection and evaluation â€” the collection of national hospital safety and quality data is critical to monitoring the use of drugs and controlling the rise of drug-resistant infections. Information is also needed to track progress in preventive health, such as in addressing obesity. Repeated surveys, done by the same people using the same survey instruments, are needed to judge our progress. We need to tell the story of what we are achieving in health care for the tens of billions we invest in it. The community who pays deserves to hear. Health Ministers need to enunciate what the goal of providing health care is, backed by stories that

illustrate what is achieved every day in caring for people. These stories are needed to keep compassion alive in our democracy. We are 20 years behind best practice. We can see what it looks like in the US. It requires a huge investment, but the pay-off in quality is immense. Two-thirds of Australians are overweight, 16 per cent of Australians smoke, and 13 per cent drink at levels of risk. Implementing Senate recommendations on social determinants of health would revive efforts to prevent Australians, particularly the most disadvantaged, from suffering avoidable chronic illness. Ideally, any person with an ongoing health complaint would have a health plan worked out and appropriately managed to focus on right treatment in the right place, ongoing medication management, avoidance of duplicated service, and prevention of further disease. Better choice in health and aged care also needs attention, so that competition and contestability can drive improvements in financial and clinical outcomes. Health professionals and health consumers need to give new consideration to talking about, determining, and then implementing future care plans. Pastoral care for those in the final stages of life, indeed for any person dealing with significant illness, needs elevation as a priority for health and aged care providers. What I think we need is to secure the fundamentals and enhance and support sensible collaborative work practices. Embed the notion of general practice as the bedrock, not only of primary health care and all out of hospital care, but also for health care delivery across the nation. The costs of the same care out of hospital, when appropriate, are a fraction of the cost in hospital. Enhance hospitals and support the care provided there, and stop perverse penalties. Support the existing hospital infrastructure that is struggling with the burden of increased demand and expectation from patients and from governments, which absurdly see them penalised for trying their hardest to cope with this. There needs to be a move from blame to re-setting costs and targets based on realistic care need evaluations, allowing for inevitable variation. Embolden and formalise clinical leadership in health in a meaningful way. Use clinical Senates - groups of cognisant, focussed individuals suggesting and supporting innovation in health care delivery. Enhance their work by trialling and evaluating changing concepts before whole-of-system adjustments, so that unforeseen consequences are outed and adjusted for in real situations with real doctors treating real patients. Use e-health and telehealth logically in clinically safe and acceptable forms over and above the PCEHR, especially secure messaging delivery and web-based videoconferencing. Use innovative technologies in health e-health and telemedicine for clinical purposes, with clinical needs and drivers at the forefront. We do have potential technology to support and enhance but not replace trusted, proven good clinical methods. Secure email to connect information is the key element. Innovate with translational research in real clinical situations, proving concepts before rolling them out. In care settings, sequential work across disciplines and health care establishments, with clinical participants nutting out how to best to innovate. Use just one set of agreed best practice guidelines that promote translational research that have been promulgated to, and agreed by, relevant medical groups. Make sure the economics and medicine are understood: The preparation of an Advanced Care Directive when competent will bridge this gap. Lifestyle health issues â€" The genesis of many health issues are related to poor lifestyle choices which then require medical solutions. We need brave governments to implement public health interventions to de-medicalise preventive management. Prostate cancer â€" A rational evidence-based and consensus approach is needed regarding screening and management. Alcohol â€" A multifactorial societal approach is fundamental to alcohol management.

Chapter 7 : Department of Health | Australian Influenza Surveillance Report and Activity Updates â€“

The Institute's report, Australia's health , was released in Canberra today by federal Health Minister Peter Dutton. AIHW Director and CEO David Kalisch said, 'On the positive side our report shows that we have increasingly longer life expectancy, lower death rates for cancer and many other diseases, and a health system that people say they are mostly happy with.

Chapter 8 : Western Australian Legislation - Mental Health Act

Australia, as a member state of the World Health Organization (WHO), supplies data annually to the WHO on deaths by

age, sex and cause of death, as compiled from the civil registration system by the Australian Bureau of Statistics.

Chapter 9 : HIV/AIDS in Australia - Wikipedia

Australian Influenza Surveillance Report and Activity Updates - Influenza activity updates will be published outside of the seasonal period, with updates also provided during the season. A more in-depth end-of-season report is also published in Communicable Diseases Intelligence journal.