HEALTH FOR ALL AUSTRALIANS

Report of the
Health Targets and Implementation (Health for All) Committee
to Australian Health Ministers
1988

THE HEALTH TARGETS AND IMPLEMENTATION
(HEALTH FOR ALL) COMMITTEE

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Report to the Australian Health Ministers' Advisory Council and the Australian Health Ministers' Conference

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AIDS	Acquired Immune Deficiency Syndrome
AIH	Australian Institute of Health
BHC	Better Health Commission
CHF	Consumers' Health Forum
IDDM	Insulin Dependent Diabetes Mellitus
NCADA	National Campaign Against Drug Abuse
NHF	National Heart Foundation
NIDDM	Non-insullin Dependent Diabetes Mellitus
NHMRC	National Health and Medical Research Council
NISPP	National Injury Surveillance and Prevention Projects
STD	Sexually Transmitted Disease
WHA	World Health Assembly
WHO	World Health Organization

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CHAPTER 1: SUMMARY

1.1 HEALTH STATUS OF AUSTRALIANS

It should be the concern of all Australians that a nation which can claim to be one of the healthiest in the world harbours major inequalities in health status within its population.

By 1986 life expectancy at birth for males had climbed to 72.77 years, and for females, 79.13 years, placing us about one year behind the populations of Iceland and Japan which have the longest life spans (ABS 1986c). Our infant mortality rate has continuously declined from 103.6 per 1000 live births at the turn of the century to a rate of 8.8 per 1000 in 1986 (Commonwealth Bureau of Census and Statistics 1909; ABS 1987b). The world's lowest rate is in Japan: 6 deaths per 1000 live births (United Nations 1985).

Death rates from leading causes are falling, in some cases quite dramatically. Between 1972 and 1986 deaths per 100 000 population fell as follows: ischaemic heart disease - by 22 percent; stroke - by 36 percent; motor vehicle accidents - by 30 percent; other accidents by 33 percent; with all causes falling by 15 percent (see Chapter 3.1).

Declines have occurred for these causes in every relevant age group and in both sexes. In the cases of cancer, chronic obstructive airways disease, AIDS and mental disorders the rates have increased in this period.

Despite these improvements, major challenges in improving the health of all Australians persist. In particular, inequalities in health status among different groups of Australians need reducing and the prevalence of most preventable diseases remains unacceptably high.

1.2 INEQUALITIES IN HEALTH

Our national vital statistics camouflage large variations in health status within the population. Inequalities exist in the prevalence and incidence of many diseases; the distribution of major disease risk factors such as smoking, hypertension and obesity; the practice of health related behaviours such as good nutrition or having a Pap smear; and most importantly, the social and economic circumstances that predispose people to these risk factors and behaviours.

Socioeconomic differences

When different socioeconomic groups are compared, recent data show that after adjusting for differences in the size and composition of the groups for every death from any cause in a professional or executive, two deaths occur in unskilled workers or manual labourers. Smoking, the single biggest risk factor for premature death in Australia, shows a similar pattern; blue collar workers have a 34 percent higher death rate for males and a 44 percent higher rate for females when compared with white collar workers. A similar variation is found in major diseases, accidents, nutrition, immunisation rates and hypertension.

Aboriginal health

No greater contrast in the extremes of health status can be found in this country than that between Aborigines and other Australians. Any complacency about Australia's health being "good enough" is unwarranted. The health status of Aboriginal adults in 1988 appears to be worse on many standard indicators than any other population group in the world for whom records are available. The crude mortality rate for Aborigines is about four times higher than that of non-Aborigines. Aboriginal life expectancy is up to 15 to 20 years less.

Gender differences

There are also quite remarkable gender differences in health status in this country. Men in Australia die from nearly all non-sex specific leading causes at much higher rates than do women, although women consult doctors more frequently for all causes except injuries. These differences in health status largely reflect the prevalence of preventable factors.

Comment

The first target set by the World Health Organization's Regional Office for Europe in its *Regional strategy in support of Health for All* states:

"By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25 percent, by improving the level of health of disadvantaged nations and groups." (WHO 1985a:24)

The Committee agrees that this target defines the concerted effort needed in Australia to reduce the differences outlined above. Its achievement may do more to improve the health status of the population than any other action.

1.3 LEVELS OF PREMATURE DEATH AND DISEASE

Another argument against complacency is that, while by world standards our average health status may be good, in many critical areas much remains to be achieved. This is well illustrated by a brief consideration of six major problems threatening public health today.

Heart Disease

Compared with countries of similar industrialised status, Australia's heart disease death rates remain unacceptably high. Ischaemic heart disease is still our biggest killer, despite age adjusted death rates having declined by 40.4 percent between 1968 and 1986. The healthiest nation in these terms is Japan, where the male heart disease death rate is 5.6 times less than ours. Our own world rating is fifteenth.

Cancer

In Australia, cancer is the second most common cause of death after heart disease, accounting for 24.3 percent of all deaths in 1986. As life expectancy has increased due to lessening mortality from heart disease and stroke, cancer has increased in frequency as a cause of death. Death rates from cancer are rising on an age-adjusted basis.

According to the National Cancer Statistics Clearing House, in 1982 (the latest year for which data is available from all States) in terms of the number of new cases and the years of life lost before 70 years of age the five top ranking types of cancer were lung, breast, colon, prostate and melanoma (Giles, Armstrong & Smith 1987).

Cancers of the lung, skin, breast and cervix are amenable to primary or secondary preventive strategies. The post-war increase in cancer is largely due to lung cancer for which smoking is the most important preventable factor.

High Blood Pressure (Hypertension)

High blood pressure is a major risk factor for stroke and heart disease. It ranks a close second to injuries as the most common specific reason for consultation with a doctor. Fourteen percent of 25-64 year old Australians suffer from hypertension but only 8 percent are taking medication; the remaining 6 percent are unprotected. Further, of the 8 percent being treated, one quarter still have unacceptably high levels of blood pressure. The problem of inadequate treatment is more common among men than among women (National Heart Foundation 1983).

Much is achievable in the prevention of hypertension. Primary prevention should involve maintaining acceptable body weight by exercise and diet, including the reduction of salt in the diet.

Acquired immune deficiency syndrome (AIDS)

Australia has the third highest per capita incidence of AIDS in the developed world (Armstrong & Holman 1987). While total deaths do not yet place AIDS in the same league as our most prevalent diseases, deaths are increasing more quickly than for any other disease. Currently, prevention is the only effective strategy we have to contain this potential epidemic.

Osteoporosis

By the age of 70 about 15 percent of all Australian women will have suffered a fractured neck of the femur, the most serious consequence of osteoporosis. There were an estimated 14 500 hip fractures in Australia in 1984, marking the end of independent living in most cases (Wren 1988).

It is likely that osteoporosis can be reduced through a number of primary preventive measures such as increases in calcium intake by younger women and performing more weight bearing exercise like walking.

Road Crashes

Since 1980 over 24 000 people have been killed in road crashes in Australia. In 1986, 29 179 people were seriously injured on our roads (Australia Department of Transport and Communication 1987). Despite significant reductions in fatalities in recent years, the motor vehicle accident rate remains unacceptably high, with young men experiencing a greatly disproportionate burden of the road toll in terms of fatality and injury rates.

Comment

What can we conclude from all of the above? First, while by world standards our average health status may be advanced, Australia suffers an unacceptably high prevalence of some illness and injury. Second, it is apparent that in a number of key areas our health status can be improved by prevention. This Report recommends goals and targets for improvements to the health of Australians and proposes structures and programs to achieve them.

1.4 THE HEALTH TARGETS AND IMPLEMENTATION (HEALTH FOR ALL) COMMITTEE

In March 1987 the Australian Health Ministers' Advisory Council established the Health Targets and Implementation (Health for All) Committee to develop a set of health goals and targets for Australia for the year 2000.

The terms of reference for the Committee were:

(1)To determine areas in which health goals are to be set.

(2)To define specific and measurable health targets which Australia can aim to achieve within a stated period.

(3)To propose preventive strategies to achieve these targets and give some estimate of the cost of such strategies.

(4)To determine a process for the ongoing monitoring, review and evaluation of national health goals and strategies.

The Committee comprised health department representatives from each State and Territory and the Commonwealth, and an independent chairman. The Consumers' Health Forum and the Australian Institute of Health provided co-opted members of the Committee (see Appendix A).

Two underlying principles have directed the Committee's work throughout the preparation of this report: increasing the health status of all Australians and decreasing the inequalities in health status between population sub-groups.

1.5 PREVENTION

The human and financial costs of an inadequate prevention focus are high. Neglect results in preventable illness and disability and premature mortality.

International comparisons of health status indicate that modifiable factors such as diet appear overwhelmingly to explain most of the differences. Thus, where Australia's health status lags behind that of comparable countries there is great potential for improvement and prevention's effectiveness has been shown in many fields. Recent dramatic decreases in heart disease, stroke, the road toll, cigarette smoking and dental caries in children are notable examples.

The cost of doing nothing (or too little) in preventing ill health is the same as the cost of treatment and care for preventable illness and injury plus income maintenance and associated loss of productivity. Prevention is generally cheaper than treatment, although its benefits may not always accrue in the short term. The preponderence alone of preventable illness and premature mortality suggests that the potential for prevention to improve health and reduce expenditure in the long term is very great. The National Health and Medical Research Council has expressed such views and The Better Health Commission concluded that the costs of good prevention measures initially exceed benefits but that savings in averted ill-

ness, disability, premature death and health care costs are substantial. Precise predictions of savings of course need to be treated cautiously. However, preventable premature death, illness and injury exact a massive toll from Australia. Accurate costings of their burden on health services and loss of productivity are hampered by inadequate and fragmented information but estimates obtained from various sources (see Chapter 2) give some indication of their magnitude:

- motor vehicle accidents $3.5 billion
- poor nutrition $6.0 billion
- cardiovascular disease $2.0 billion
- alcohol abuse $1.5 billion

The financial case for prevention is perhaps nowhere more graphically illustrated than in AIDS where only effective health promotion and illness prevention measures stand between the community and huge increases in health expenditures. In excess of 3 000 cases are expected to be diagnosed in Australia by 1990 (NHMRC 1988) leading to major treatment and institutional costs.

A brief glance at Commonwealth and State health budgets reveals that funds explicitly for health promotion and illness prevention represent a miniscule amount of health expenditure - less than 1 percent in 1984-1985 (Australian Institute of Health 1987).

We might also enquire how prevention compares with other mechanisms for controlling demand and containing health care costs. Price mechanisms and limitations on the range of services available have a significant part to play, but they limit access to health care. Similarly, cost-capping mechanisms can have unwanted distribution effects (the poor suffer), while other controls simply redistribute liability among service providers, be they at the Commonwealth, State or non-government level. None of these mechanisms can provide the essential circuit-breaker in the sequence of demand for treatment services based on present health levels.

The ageing of our population places special demands on our society. It is predicted that between 1976 and 2021 the number of persons aged 65 and over will double, with net gains of more than fifty thousand a year. This will lead to a significant increase in the proportion of older people in the population and if they move into later life in a healthier state, the costs to the community for their health care will be less than if prevention were neglected. The alternative is a massive escalation in nursing home, drug, medical and hospital costs.

Another argument for prevention often goes unstated. It centres on an essential characteristic of a humane health and social policy - that the pursuit of high levels of efficiency notwithstanding, societies should promote and protect the ability of their citizens to live healthy and long lives. The ethical and philosophical underpinning of the four broad aims of the WHO (Europe) Health for All strategy - equity in health, adding life to years (health promotion), adding health to life (reducing morbidity) and adding years to life (reducing premature mortality) - reflects a concern for maximising human potential. This means that governments have a responsibility to maximise the opportunities individuals and communities have to live satisfying disease-free and disability-free lives for as long as possible. This is the moral claim for prevention.

1.6 PROMOTING HEALTH

Good health is a positive state of being. It is an individual and community asset of great value. The health system can play an important role in promoting the maintenance of good health; the attainment of better health; the development of improved physical, social and mental health; preventing the development of ill health and changing health damaging behaviour.

Socioeconomic arrangements are also influential determinants of health and immensely challenging social reforms in areas such as unemployment, the social and economic situation of Aborigines, incomes policy, and housing and child care lie at the heart of many desired changes.

Chpater 3 reviews the Australian evidence on inequalities in health status and shows that those with the worst health are generally those with least wealth. While these health inequalities may be reduced through policies and programs organised by health care agencies, the greatest improvements are likely to occur in concert with reductions in poverty.

Reduction of poverty is the concern of the Commonwealth and all State governments. It will constitute a major principle of the Federal Government's forthcoming National Social Justice Strategy.

The Committee was not in a position to put forward a blueprint for reducing poverty or improving the socioeconomic status of particular subgroups. Rather, we saw our task as identifying means under the control of those in the health system - those who commissioned this Report - for addressing health differentials directly and impressing on other sectors in government and the private sector the contributions they could make in addressing avoidable illness.

1.7 RECENT INITIATIVES IN HEALTH PROMOTION

The Health Targets and Implementation (Health for All) Committee's establishment followed several significant developments both nationally and internationally in public policy concerning health promotion and disease prevention. At the forefront of these developments is the World Health Organization's Health for All by the Year 2000 initiative, to which Australia is a signatory.

WHO and Health for All

In May 1977 the Thirtieth World Health Assembly agreed that the main social target of governments and WHO in the coming decades should be the attainment by all citizens, by the year 2000, of a level of health that would permit them to lead socially and economically productive lives (Resolution WHA30.43). This was termed Health for All. Health is defined by WHO as not just the absence of disease, but complete physical, social and emotional wellbeing. In November 1979 the United Nations General Assembly called on member states to support WHO. Subsequently, in 1981 WHO produced a report on the formulation of global strategies to achieve Health for All by the Year 2000 and these were adopted at the Thirty-fourth World Health Assembly.