Health Studies
Course Code: HLT315113

The main purpose of this 2015 Assessment Report is to provide feedback for candidates and teachers about performance on the examination along with suggestions to improve the examination techniques employed in future years. The examiners’ comments are not meant to be an informal expansion of the course. They do, however, comprise specific observations from individual marking examiners regarding each question and necessarily repeat and re- emphasise several previous report comments. Candidates are therefore advised to read this, and previous, reports carefully to avail themselves of the recommendations and directions given.

The total number of candidates who sat this year’s external assessment was 1180, an increase from 1046 students examined in 2014.

As in previous years it was apparent that candidates must be reminded about a number of important points. These include:

- Allocate time very carefully – follow the suggestions on the paper. Candidates must clearly differentiate between the requirements of 10, 20 and 30 minute questions.
- Read each question carefully in order to write completely relevant answers rather than everything and anything about a general topic.
- Provide accurate, up-to-date, specific information rather than broad generalisations. Phrases such as ‘and so on’ or ‘etc.’ should not appear and do not convince the examiner that knowledge extends past what is written.
- Avoid writing sexist or racist remarks or making value judgements, which are completely inappropriate and waste valuable time that should be used for writing specific content and theory. Candidates should not use personal pronouns such as ‘I, you, we’ unless their personal opinion is specifically sought.
- Do not regurgitate information prepared for different questions. The answer written must be directly relevant to the question posed.
- Choose examples carefully to make sure they are appropriate to the nature of the questions asked.
- Write something relevant, even if it is minimal, for each criterion.
- Note the criterion being assessed by the question to ensure answer addresses that particular criterion.
- Black or blue pen is preferable to the use of a pencil.
- Answers must be written in the appropriate booklet for that answer.

Candidates should also note:

- A calculator and a ruler should be taken into the exam to ensure accuracy with data.
- Re-writing the question at the start of an answer is an unnecessary waste of time.
- What is being asked and do just that. ‘Detail’ means more than list, name or mention whereas ‘list’ doesn’t involve writing several paragraphs.
- Using liquid paper, decorating answers with highlighters or ruling margins is not the wisest use of exam time.
- Notes to the examiner should not be written and neither should the student’s name.
- Numbering questions clearly is vital, especially when a choice is offered.
- Longer answers should be written using the formal register of language, for example incorporating paragraph breaks and using of capitals correctly.
- Acronyms should only be used after the term has been written in full followed by the abbreviation in brackets.

Candidates are reminded that there is a degree of sophistication expected in a pre-tertiary subject. Poor spelling, incorrect grammar and lack of punctuation continued to be a problem this year and often made it difficult for examiners to uncover the relevant detail. Some candidates used an emotional style of writing in their answers which is not appropriate.
Students who deconstructed the questions and answered each element sequentially tended to rate the highest.

**SECTION A**

**Question 1**

a) In 2013, 3.0% of the population had used methamphetamine in Tasmania in the last 12 months.

b) Tasmania is below the National level in all years from 1998 (1.6% compared to 3.7%) until 2010 (1.1% compared to 2.1%). In 2013, Tasmania’s % is higher than the national rate (3.0% Tas vs 2.1% National).

c) The overall increase in those who ever used / tried methamphetamine from 1993 (5.4%) to 2004 (9.1%). From 2004 – 2013, nationally, a decrease in those who used / tried however the 2013 % (7.0%) has not decreased to the low of 1993 (5.4%).

d) Not all users will report that they use methamphetamine therefore % could be higher than indicated. Other answers included that those surveyed lied about usage, some people using methamphetamine are homeless and would therefore not complete a household survey, u/14’s could be using and are not surveyed, questions whether regular use vs once off use constitutes accurate prevalence comparison, questions about legal ramifications about admitting use of an illegal drug.

The graph was really easy to read and understand. Students generally answered questions a, b and c very well and with detail. Those who lost marks for these questions generally failed to use adequate or accurate data. Some failed to state what units the rate was measured in. Question 1 (d) was answered in a variety of ways but the most common was “not all users would have been honest”.

The majority of the papers were 7/8 and above out of 10.

**Question 2**

This question assessed Criteria 1 and required students to:

- draw on their understanding of health and its influencing factors
- discuss ways external components (environments) impact on internal components of an individual's health
- provide supportive examples.

Markers noted that the 20 minute questions need an extra page for the answer in each booklet – many students required an extra booklet for their response to these questions.

From the papers marked there were very few who seemed confused with the terminology ‘components’ and ‘internal vs external’. This highlighted that teachers have prepared students for differing terminology that means the same thing i.e. determinants vs components. Some markers expressed concern about these terms but students seemed to cope well in general.

Most students had a brief WHO definition of health, and lots used the “absence of disease and infirmity” definition. There were many ‘B’ type answers here but also some As which used very strong examples.

A significant number of students did not identify the three environments that are specified in the syllabus (determinants). The determinants of health anticipated by the markers included the physical, socio-cultural and political environments.

Many students mentioned war torn and natural disaster affected countries and drew on the links between this physical environment scenario and the follow-on effects to individuals.

Some students mentioned personal dimensions only without linking to the external environment. Others defined all dimensions and environments but failed to give adequate examples. Many different examples linking any of the
environments and their effect on dimensions of health were successfully used. Level of detail was ultimately the determining difference between ratings.

**Question 3**

This question assessed Criteria 3 and required students to outline:

- risk taking, associated reasons and contributing factors
- benefits on development
- one personal and one community strategy to promote positive outcomes.

Answers to this question were generally good. Markers thought this was a very user-friendly question that was clearly written in a dot point format - very straightforward.

Good answers included a definition of risk taking as well as a definition of adolescence and reasons why adolescents take more risks. The frontal lobe development got a fair run. A couple of frontal ‘LOOPs’?

Individual and community strategies were quite powerful and better answers went into more depth, rather than saying simply the name of a campaign, such as “Swap It”.

A large number of students gave examples of risks to support answers but included far too much detail of the risk and consequences for the health of the individual. This question did not ask for this and therefore lengthy discussions could not be rewarded if they did not answer the question.

Many answers made brief and general comments regarding individual and community strategies, rather than detailed information on one of each.

A general weakness was the lack of ability to discuss factors which deter adolescents from risk taking behaviours e.g. connectedness, protective factors, skill building, positive role models, channelling negative behaviour to positive, protective peers, active decision making, supervision, education, harm minimization techniques.

Some students misunderstood what a risk factor is in relation to their personal health issue.

Students were quite competent at discussing strategies by individuals and communities to ensure that RT is positive. Community strategies often related to government laws and education.

**Question 4**

This question assessed Criteria 3 and required students to:

- profile a personal health issue
- discuss why it’s an issue and the associated risk factors
- include supporting evidence
- describe one preventative and one treatment/curative strategy.

Health issues varied from obesity as one of the most common, to alcohol abuse / binge drinking, sleep deprivation, smoking, eating disorders, drugs and unwanted pregnancy and STIs. Quite a few students used their NHPA and attempted to adapt it to a personal health issue, some successfully and some not so (perhaps as we tend to teach NHPA’s with a community or group focus).

This question did not seem as popular as Question 3.

Some weaknesses were evident in relation to risk factors and the understanding of what a risk factor is (not a consequence).

Some students failed to provide enough detail on the profile of the issue. Most could identify ‘why’ it is a health issue and provide adequate data. Some students discussed two preventative strategies as they found it difficult to come up with a curative/treatment strategy for issues related to risk taking behaviours such as drink driving, binge drinking and unsafe sex.
There was some mix up occasionally between prevention, treatment and cure examples, but the crossover took care of itself and it was as previously stated, generally answered well.

SECTION B – Australia’s Health

Question 5

(a) Average available beds, public hospitals, states and territories, 2009-2010 to 2013-2014
(b)(i) Tasmania, -3.3%
(b)(ii) Queensland, increase of 235 beds

Some candidates were able to identify QLD as the correct state, however were not able to receive full marks as they gave rough or inaccurate figures for supporting data. This reinforces the importance of taking and using calculators in the exam and giving exact figures wherever possible.

(c) South Australia, 3.04 beds per 1000 population

Few students were able to correctly identify South Australia as the correct answer, with many stating NT or ACT.

(d) This question was a little problematic. Some students were confused by the discrepancy between the available beds per 1000 population (2.5 beds per 1000 population in each year) and the stated average % change since 2009-2010 (-0.5), which is statistically incorrect as the initial data indicates 0% change. This was a significant disadvantage to students.

Those who simply compared the % figures (1.3% compared to -0.5%) without looking at number of beds were better able to form correct responses.

Question 6

This question assessed Criteria 3 and required students to:

- profile an NHPA, including data
- discuss appropriate preventative and treatment/cure strategies – both personal and community

Overall students answered this question reasonably well, with most demonstrating a sound understanding of one NHPA.

A small number of students were not able to correctly identify a NHPA, instead discussing Global or Personal health issues such as malaria, smoking, poor sanitation, HIV/AIDS or unsafe sex.

Students should be aware that ‘community strategy’ refers to both strategies implemented at the community level by small groups or councils (greenspaces, community cooking classes, provision of free exercise and activity sessions or equipment) and also larger government and NGO strategies implemented throughout Australia (heart foundation tick program or Swap it, Don’t Stop it). Some students seemed to think that community strategies were things that an individual could do in their community like join a gym or football club. Being able to name a specific strategy demonstrates a higher level of understanding than simply listing general options.

Many students listed ‘fun runs’, ‘Jenny Craig’ and ‘The biggest loser and Michelle Bridges’ as a community strategy for obesity prevention but lacked detailed explanations as to how these actually prevented obesity.

Correct medical terminology is essential to achieving higher ratings. For example, many students profiling Asthma used the term ‘puffer’ which is not appropriate for this level.

Better responses provided a succinct description of their NHPA as part of the profile, along with a wide range of supporting data.

Responses rated higher if student also demonstrated a more detailed knowledge of their NHPA by providing different preventative and treatment strategies, rather than a single strategy for both. For example diet or
exercise for prevention and treatment of obesity, as compared to diet and exercise for prevention and bariatric surgery for treatment.

Examples of treatment and curative strategies varied however more detail was required rather than just listing these measures.

Many candidates chose to quote old data when profiling their issue. It is recommended that the AIHW or ABS is used to research current data as opposed to an older textbook.

Question 7

This question assessed Criteria 2 and required students to outline:

- how Australia’s health care system works
- ways components of system impact on population’s health
- how system meets one of the social justice principles.

Although a smaller percentage of students answered this question, overall the responses were generally stronger when compared to question 8.

Most students were able to identify at least Medicare, PBS and Private Health as elements of the healthcare system and give an explanation of how they worked, although students generally did not show a strong overall understanding of this. Fewer students were able to extend and explicitly state how this contributed to health status of Australians or incorporate relevant data such as life expectancy. Misconceptions included Medicare pays for 30% of all treatment, Medicare provides free treatment for all services in Australia, the PBS provides free medication to all Australians. Some students are also still stating the Medicare Levy is 1.5%, however it increased to 2% from July 1st 2014.

Most students were also able to identify a Social Justice Principle although most struggled to make a clear link between how the Health Care System meets one of the SJPs.

Some students also did not address each part of the question. This may have been due to the presentation of the question – dot points would have been helpful.

A few students referred to the SJPs as ‘access, rights, participation and equity’ as opposed to ‘equity, diversity and supportive environments.’

Question 8

This question assessed Criteria 2 and required students to outline:

- inequities and health care concerns experienced by one disadvantaged group
- comparative evidence and contributing factors
- one community or government strategy and its impact.

The overall standard of responses was poor, even though this was a reasonable question.

Most students referred to the following groups: Indigenous Australians, Rural and Remote, Low Socio-Economic, the Homeless, Men or the Elderly. Responses often showed an oversimplification of factors contributing to inequalities and a poor understanding of the realities of life for groups such as Rural and Remote and Indigenous in particular. Many generalisations were also racist or derogatory in nature which was extremely disappointing. Many students referred to most or all Indigenous Australians living in rural and remote areas. This isn’t the case. The majority of the Indigenous population is located in cities or non-remote areas (75%) while only 25% live in remote areas.
Medicare, or the PBS, was discussed as a strategy by a number of students, and although appropriate to some disadvantaged groups (in particular low SES), a better choice would have been a strategy specifically targeting the group. Specific strategies or organisations are preferable to general strategies like ‘more education’.

Students who achieved higher ratings were able to provide comparative data such as differences in life expectancy, and specific morbidity and mortality rates as well as explaining a wide range of factors that contribute to these differences including references to most of the determinants of health. They also explained how the strategy worked to improve health status.

Although students were able to give some comparative data on disadvantage, less were able to indicate where progress or improvements were being made, such as a reduction in the life expectancy gap between Indigenous and Non-Indigenous.

Some students referred to outdated data, such as a 17-20 year gap in Indigenous life expectancy. Students must be aware that when ONE strategy or ONE social justice principle is requested, marks will not be given for additional strategies and they should focus on one in detail.

SECTION C – Global Health

Question 9

Answers:

a) Lesotho - 95% literacy rate
b) Uganda - birth rate of 6.4
c) South Africa - literacy rate 88%; birth rate 2.6
   Tschad - literacy rate 25%; birth rate 6.2
   - Indicating that these countries were opposites in these indicators.
d) The tendency appears to demonstrate that the higher a country’s literacy rate, the lower their birth rate and vice versa. An above 80% literacy rate correlated with a reduced birth rate in most African countries.
e) Information depended on country chosen but a common example chosen was:
   Uganda has the highest birth rate of 6.4 but only has a literacy rate of 67%.
   Students needed to identify one of the applicable countries, its rates and the reason chosen.

This question was generally answered very well using the appropriate supporting data although some students wrote “%” for birth rate.

Q9(a) posed no problems.
Q9(b) A few students claimed South Africa had the ‘lowest’ literacy rate indicating they had interpreted the graph the wrong way around.
Q9(c) Most students were able to give the comparative figures but many failed to make a comment on the difference.
Q9(d) This was answered quite well on the whole. Better responses stated there were also anomalies to the general trend and used data as an example to support.
e) Uganda and Equatorial Guinea were the most common answers. Most students stated the country and the figures but many did not make reference as to why it was not reflective of the general trend. Markers expressed concern that the key (other countries) did not match the continents listed on graph and that continents were classified as countries. It was also noted that the birth rate did not include a unit or rate such as ‘per female’.

The majority of marks ranged from 8 to 10 out of ten.
**Question 10**

This question assessed Criteria 2 and required students to:

- Outline one health issue in LDCs
- Give reasons why this is an issue
- Detail the effects of the issue on individual health.

The most common issues were malaria, HIV/AIDS, and issues related to lack of safe water and sanitation. Many chose to discuss diarrhoea, cholera or malnutrition. Other less popular issues included obstetric fistula, child soldiers, measles, war/conflict and natural disaster.

Generally, markers found this question to be answered quite poorly. Most students gave a very, very brief outline of the issue and lacked supportive statements and data as to why it’s a health issue. Better answers outlined what the issue is, how it’s contracted and spread easily and how it impacts the individual. Better answers were also able to provide some data/stats to support, stated that they contributed greatly to morbidity and mortality of LCDs, and that lack of education about prevention and access to treatment contributed to it being an issue. Some better answers also said it contributed to health indicators, e.g. life expectancy and infant mortality, and therefore impacts on an individual’s health status. Better answers also linked to PHC and MDGs saying that lack of PHC contributed to it being an issue and that being one of MDGs supports the fact it is a health issue.

The second dot point was answered poorly or not addressed at all. Students seemed to find it harder to make direct links to individual health as the health issue generally affects the whole population. Some students, justifiably, questioned the criteria and use of the word ‘individual’ health in the question. Therefore, there were quite weak attempts to cover this anomaly by saying how the 5 dimensions of health were affected. Most were able to discuss the physical impact of the disease or issue, but then went on to very loosely discuss how this would lead to individuals needing time off work and school. Some quite unsuccessful attempts at trying to link it to social, emotional and spiritual component were also made.

**Question 11**

This question assessed Criteria 1 and required students to outline:

- importance of PHC in LDCs
- the effect of PHC on major causes of mortality and morbidity in LDCs
- supporting evidence.

As with Question 10, there was some confusion with the criteria not being able to be easily assessed by the question, resulting in some students trying to apply individual health perspectives to PHC. However, overall, this question was answered quite well.

There seemed to be a few variations of the 8 components of PHC. ‘ELEMENTS’ was occasionally used as an acronym. Most students were able to identify the 8 components and briefly discuss their importance, saying what makes PHC effective in LDCs.

Better answers were able to discuss 2 or 3 components in greater detail and make strong connections to specific causes of morbidity and mortality. Some also linked to specific MDGs which also strengthened discussions.

Many answers mentioned all the components but gave weaker links to how implementing the components affected morbidity and mortality. They were more generalised answers not showing depth of understanding.

A common mistake was that many students believe there is an immunisation available for Malaria. This was a common error in answers for both question 10 and 11.

Some students also made comment on how PHC is only important for LDCs, which showed a lack of understanding of PHC.
**Question 12**

This question assessed Criteria 1 and required students to:

- profile an LDC, including five health indicators
- outline one type of aid, its provision, and its health influence in the LDC.
- Detail the effect of the chosen aid on one of the MDGs, including examples.

Overall this question was answered well.

First dot point was quite good, most able to identify 5 indicators. Better answers identified what the indicator actually was and some factors that contributed to them. Also stronger answers gave supportive data for indicators, some even able to compare to a MDC. Not necessarily required, but good.

Second and third dot point needed to make a connection between aid and a MDG. Most students were able to discuss a type of aid, mostly an NGO and identify an appropriate organisation. Better answers were able to give a brief description of what the aid is and how it works within LDCS.

Better answers chose specific initiatives that targeted specific issues in their country and how it has improved health in this area and linked to appropriate MDG. Progress of a chosen MDG was quite weak, but most said that their form of aid had contributed to improvement of a goal. Better answers gave specific targets and progress.

Other general comments made by markers were about the concerning number of students who claimed Africa is a country or chose a Millennium Development Village rather than a country. Some still referring to ‘third-world countries’ in their terminology and giving very outlandish figures to try and include data.