2025 ASSESSMENT REPORT
HLT315118 HEALTH STUDIES

General Comments

A total of 866 students were enrolled in Health Studies Level 3 in 2025, with 774 students sitting the external examination. Overall, student performance reflected a sound level of engagement with course content, with many students demonstrating a basic to competent understanding of key health concepts and the structure of the examination. Stronger responses were characterised by clear explanations, accurate use of terminology and appropriate interpretation of information. A number of positive trends were evident, including improved confidence in responding to data-based questions and an ability to identify relevant health concepts and strategies. Common areas for improvement included the need for greater depth in explanations, more consistent use of precise and culturally appropriate terminology and stronger application of evidence to support responses. Some students relied on generalised statements or provided descriptive rather than analytical responses. Teachers are encouraged to continue supporting students to read questions carefully, apply course concepts with precision and develop well-reasoned, evidence-based responses across all sections of the examination.

Section A

Question 1

Criterion 8

The data question was generally straightforward, and most students completed it with ease. Some confusion was noted in relation to the pie graph, which may have been influenced by the colour scheme or by unfamiliarity with interpreting this type of graph. The question effectively assessed basic data interpretation skills.

a. What does figure 1 represent?
   The number of young people in detention on an average night in Australia. (*will accept other answers with the same meaning)*

b. How many young people were in detention in Queensland and in New South Wales on an average night in the June quarter in 2024?
   QLD – 317
   NSW – 240

c. What percentage of young people in detention were unsentenced?
   74%

d. What proportion of young people in detention identify as First Nations?
   60%

e. What proportion of young people in detention were male and what proportion were female?
   Males – 90%
   Females – 10%

f. Which two (2) states or territories recorded the smallest difference in their detention numbers, and what is the value of that difference?
   Tasmania – 21
   ACT – 16
   The smallest difference of 5 people.

Question 2

Criterion 1

This question was generally accessible to students; however, the depth and clarity of responses varied across the sub-questions.

a. Most students demonstrated a basic understanding of the concept being assessed; however, many responses required clearer links to health. Weaker responses tended to make general statements, while stronger responses explained *how* and *why* the concept influenced health outcomes.

b. Responses were often very brief and descriptive. Many students identified relevant ideas but did not provide sufficient clarification or supporting examples. Greater depth and use of examples would have strengthened responses.

c. There was some confusion between *determinants of health* and *dimensions of health*. Some students simply listed determinants, whereas stronger responses demonstrated an understanding of how determinants influence one or more dimensions of health. A number of students either did not include examples or provided examples that were overly broad.

d. Many responses lacked specificity and did not move beyond vague statements about health impact. Stronger responses clearly explained how an issue becomes a health issue, supported by relevant explanation and examples. These responses demonstrated an understanding of factors such as the scale, severity and broader impact of the issue on the community.

Question 3

Criterion 4

This question required students to identify a leading cause of morbidity and mortality, supported by data, and to outline prevention and treatment options. While many students demonstrated a sound understanding of the selected health issue, many responses relied on broad Australian health examples rather than explicitly linking the issue to adolescent health, as required.

Accuracy in the use of statistics was also an issue with some responses including implausible or incorrect data, which reduced the credibility of otherwise sound explanations. Individual prevention or treatment actions were generally well addressed; however, responses outlining government strategies often lacked depth or clear explanation of how the strategy operates and who it targets. Stronger responses demonstrated a clear understanding of the scope and function of government programs and explained how these strategies support health outcomes for young people.

Given the consistency of Criterion 4 questions across years, which typically explicitly reference adolescents or young people, teachers are encouraged to emphasise responses that are clearly focused on this group. Students should be advised to read the question carefully, support their responses with accurate data and provide clear explanations of prevention and treatment strategies. It should also be noted that the relevance of social media-based campaigns may shift due to the introduction of age restrictions for under 16s and students should consider this when selecting and evaluating examples.

Question 4

Criterion 1 and Criterion 7

Relatively few students attempted this question, and many of those who did, found it challenging. While most responses demonstrated an understanding of health literacy, examples provided were often vague and lacked sufficient detail. Explanations of health promotion campaigns were brief and did not clearly show how these initiatives improve the wellbeing of young Australians.

Stronger responses addressed all parts of the question by:

- Explaining the purpose of health promotion and its importance for young people's wellbeing, clearly outlining how health promotion aims to empower individuals and communities to take control of their health by providing knowledge, skills and supportive environments. It is particularly important for young people as it helps prevent chronic disease, promotes mental health and encourages healthy lifestyle choices during formative years.
- Discussing why health literacy is essential and how it enables informed health decisions by identifying how health literacy ensures young Australians can understand health information, navigate services and make informed decisions about diet, exercise, mental wellbeing and risk behaviours. For example, being able to interpret food labels or knowing where to access mental health support are practical applications of health literacy.
- Providing two well-developed examples of current Australian health promotion campaigns targeting young people could include:
  - *The "Make Smoking History" campaign*, which educates young people about the risks of smoking and provides resources to quit through advertising and community initiatives.
  - *The "Towards Zero" road safety campaign*, which targets young drivers by promoting safe driving practices and reducing road fatalities through education and enforcement strategies.
  - *Headspace mental health initiatives*, which provide accessible support services and resources for young people to manage stress, anxiety and other mental health challenges.

High-quality responses included specific strategies used by campaigns (e.g., social media outreach, school-based programs, community engagement) and explained how these initiatives contribute to improving wellbeing outcomes for young Australians.

Question 5

Criterion 1 and Criterion 7

This question was attempted by most students; however, many responses lacked specificity and depth. A common issue was that students tended to regurgitate general knowledge about risk-taking rather than directly addressing the question components. The most frequent reasons provided were brain development and peer pressure, but these were often poorly explained. In particular, the role of the prefrontal cortex was frequently omitted or confused with the limbic system. Peer pressure was generally defined superficially, with limited explanation of why it is especially influential during adolescence.

Examples of risk-taking behaviours varied, with common choices including drink driving, binge drinking, unsafe sex and unsafe sun practices. Data to support the significance of these behaviours was generally well presented, which is a strength that should be encouraged. However, analysis of the potential impact on two dimensions of health was often generalised and lacked depth. Similarly, when asked to provide one way to reduce the impact, many students listed multiple strategies rather than focusing on one in detail, which weakened the quality of their responses. Campaigns such as RYDA (road safety education) and DrinkWise were frequently mentioned but lacked explanation of how they specifically reduce risk and improve health outcomes.

Stronger responses included:

- Two clear reasons for risk-taking behaviours
  For example:
  - *Biological*: The prefrontal cortex, responsible for decision-making and impulse control, is still developing during adolescence, leading to increased risk-taking.
  - *Social*: Peer pressure is heightened during adolescence due to the desire for social acceptance and identity formation, making young people more likely to engage in risky behaviours.
- One example of a risk-taking behaviour with supporting data
  For instance:
  - *Binge drinking*: According to the Australian Institute of Health and Welfare, approximately one in three young Australians aged 18–24 engages in risky drinking at least monthly, highlighting its prevalence and significance.
- Analysis of the impact on two dimensions of health and one way to reduce it
  For example:
  - *Impact*: Binge drinking can negatively affect physical health through short-term consequences such as vomiting, dehydration, alcohol poisoning and seizures, as well as increased risk of accidents and injuries. While long-term effects like liver damage are possible, they are less immediate for young people.
    It can also impact mental health, contributing to impaired judgment, heightened anxiety, depression and increased likelihood of engaging in unsafe behaviours that may lead to regret or trauma
  - *Reduction strategy*: The DrinkWise campaign uses targeted education and social media messaging to shift attitudes toward responsible drinking, aiming to reduce harm among young Australians.

Section B

Question 6

Criterion 8

Markers considered the data presented in this question to be clear and in a format that students should have encountered throughout the year. Overall performance was strong, with most students achieving a score of 7 out of 10 or higher. For those who did not, common issues included misreading or misinterpreting either the question or the table. In some cases, students provided overly detailed responses, particularly for questions worth only one mark.

a. What is the most common leading cause of death for individuals aged 45–84?
   Coronary heart disease ranked first in all groups 45–84

b. Which age group(s) in Australia rank suicide as one to the leading causes of death? Identify the specific age group(s) and provide supporting data.
   - 15–24 → Ranked 1st
   - 25–44 → Ranked 1st
   - 4–64 → Ranked 4th

c. In the 1–14 age group, what are the top three (3) causes of death, and how do they differ from the Under 1 age group?
   1. Land traffic, 2. Other ill-defined causes, 3. Perinatal and congenital conditions. In Under 1 – land traffic accidents do not rank. Other ill-defined causes remain at 2nd and perinatal and congenital conditions move from 3rd to 1st

d. How does the ranking for COVID-19 as a cause of death change across the older age groups (65–74, 75–84,85–94 and 95+)? Identify the ranks for each age group.
   In the 85–94 age bracket, COVID 19 is the 3rd leading cause of death, compared to 4th place in the others
   - 65–74 years → Ranked 4th
   - 75–84 years → Ranked 4th
   - 85–94 years → Ranked 3rd
   - 95+ years → Ranked 4th.

Observations from responses:

a. The majority of students answered this correctly.

b. Many responses missed the 45–64 age group (4th), losing 1/2 mark.

c. A lot of responses did not include SIDS, losing 1/2 mark.

d. This question required 'rankings' and the changes to COVID deaths through older age groups. Many students did not discuss the "changes" using words such as 'increased', 'fell', 'dropped to'. The changes were worth up to 2 marks out of 4.

To improve performance, it is recommended that students:

- Keep answers concise and focused on the question.
- Include data when specifically requested.
- Avoid unnecessary detail/commentary that does not contribute to the mark allocation.

This question should take no longer than 10 minutes to complete, and an average student should be able to finish within 5–6 minutes.

Question 7

Criterion 2

This group of short-answer questions was generally accessible. Students were able to achieve 4–6 marks by giving answers that demonstrated a basic level of understanding.

Observations from responses:

a. Stronger answers incorporated factors from different determinant categories.
b. Many responses referenced Medicare or the PBS without explaining how these improve access for Australians.
c. Most students recognised DALYs but did not provide an accurate definition of Burden of Disease.
d. Some listed factors were not common to major causes of morbidity and mortality (e.g., UV exposure is specific to skin cancer/melanoma).
e. Marks were lost when responses listed health problems rather than reasons for them.

Question (a) was intended to reflect understanding of health determinants, while question (d) should have focused on clearly identified risk factors for chronic disease (modifiable and non-modifiable).

Question 8

Criterion 4

Many students produced high-quality responses that demonstrated strong knowledge of their chosen health condition. Commonly selected conditions such as cardiovascular disease, diabetes, and dementia reflected leading causes of morbidity and mortality in Australia and enabled students to address the requirements of the question effectively. Stronger responses closely followed the explicit instructions in the question, addressing all required components with appropriate depth. Some students, however, selected issues that do not represent a significant burden of disease in Australia, which limited their capacity to fully meet the assessment criteria. Weaker responses often included excessive descriptive detail that was not required, reducing the depth of analysis in key areas. A common area for improvement was the identification and explanation of risk factors, with some students omitting this component, confusing risk factors with outcomes, or providing overly general statements. While data was often used effectively to demonstrate disease burden, responses were frequently weakened by limited depth in addressing all parts of the question. While Criterion 4 allows for investigation of preventative, curative and treatment strategies, this particular question required students to outline prevention and treatment options only. Teachers are encouraged to explicitly support students to read questions carefully, attend to command terms and dot points and structure responses according to the instructions provided.

Question 9

Criterion 2 and Criterion 7

Question 9 was attempted by significantly more students than Question 10 and elicited a wide range of responses. Stronger responses clearly identified health inequalities experienced by a selected population group and supported these with relevant data. These responses also demonstrated an understanding of the key factors contributing to inequality and were able to explain how government strategies work to improve health outcomes. Weaker responses often lacked data, relied on generalised statements or provided limited explanation of the underlying causes of inequality.

A recurring issue was confusion between government-led strategies and non-government or community-based supports, with some students incorrectly identifying universal services such as Medicare as targeted strategies to address inequality. Misunderstandings about refugee access to Medicare were also evident. In addition, some students struggled to clearly link strategies to Social Justice Principles or included culturally unsafe language and stereotypes, particularly when discussing First Nations Australians. Teachers and students are reminded that the term *ATSI* is outdated and inappropriate, and that correct terminology should be used, including First Nations Australians in national contexts and Tasmanian Aboriginal People when referring specifically to Tasmania (or Palawa or similar).

Confusion between rural and remote contexts also affected the accuracy of some responses. While the terms are often used together, they describe very different settings with distinct challenges. Rural areas generally refer to smaller towns with access to essential services, often requiring longer travel, whereas remote areas are highly isolated and may have limited or irregular access to healthcare, food and transport. Teachers are encouraged to avoid treating rural and remote contexts as interchangeable and to support students to interpret questions carefully, use accurate data and terminology, clearly distinguish between population contexts and explain how government strategies reflect social justice principles when addressing health inequalities.

Question 10

Criterion 2 and Criterion 7

Question 10 was attempted by fewer students than Question 9; however, those who selected this question generally produced high-quality responses. The structure of the question supported student success, with stronger responses clearly describing the main components of Australia's health care system and providing well-developed explanations rather than simple lists. High-achieving responses demonstrated an understanding of how a selected component supports people with disability and explained the role of medical technology in improving access, quality and delivery of health care in Australia.

A common area for improvement was the identification and explanation of alternative and complementary health care services. Some students demonstrated confusion in this area, incorrectly identifying Medicare or private health insurance as examples of complementary or alternative care. Weaker responses tended to be overly descriptive or lacked clear explanation of how components function within the health care system. Overall, responses indicated that when students followed the explicit instructions in the question and addressed each dot point with

appropriate depth, they were able to demonstrate strong understanding of the Australian health care system.

Section C

Question 11

Criterion 8

Question 11 was generally well-answered by most candidates. Students could correctly identify key figures such as India's projected population increase and Nigeria's ranking in 2100. However, the most common errors were technical rather than conceptual: many responses omitted units of measurement (e.g., million or billion), miscalculated totals or copied data incorrectly, which led to loss of marks. Another recurring issue was that some students described changes for individual countries rather than identifying broader trends across regions, such as the rise of African nations in global population rankings and the decline of European countries. Stronger responses included accurate calculations, clear trend analysis and correct use of data units. Looking at the data questions across all three sections, the importance of data literacy and interpretation skills in classroom practice cannot be emphasised enough. Students should be encouraged to always include correct units of measurement (e.g., million/billion) and check calculations carefully. Explicit teaching on identifying broader trends rather than focusing on isolated data points and incorporate practice tasks that require students to summarise patterns across regions or time periods, is essential.

a. What does figure 3 represent?
   A table showing rankings of the most populous countries over time. (*will accept other answers with the same meaning)*
b. Which country has the greatest projected increase in population from 1950 to 2100?
   India has the greatest projected increase in population, rising from 376 million in 1950 to 1,450 million in 2100, an increase of 1,074 million people
c. Which African country is projected to have the largest population in 2100 and what is the figure?
   Nigeria with 733 million people.
d. Identify two (2) trends that are evident in Figure 3. Use data to support your answer.
   - African countries are moving up the population rankings.
   - All listed European countries are falling down the rankings.
   - India has the greatest projected increase in population, rising from 376 million in 1950 to 1.45 billion in 2100, an increase of approximately 1.07 billion people.

All listed countries are expected to increase, with the exception of China from 2020 to 2100 where they are predicted to decrease in population.

Question 12

Criterion 3

Most students attempted all parts of this question, but responses often lacked clarity and completeness. Common issues included misinterpreting requirements, omitting units of measurement and failing to link concepts effectively. Stronger answers provided accurate definitions, clear explanations and relevant data comparisons between LDCs and MDCs.

a. Types of Foreign Aid and Negative Impacts: Most students were able to name two types of aid, such as bilateral and multilateral, but weaker responses often failed to provide a distinct negative impact for each. Some students misread the question and gave only one negative impact overall or included unnecessary explanations of aid types rather than focusing on limitations. Stronger answers clearly linked each aid type to a relevant drawback, such as political influence in bilateral aid or delays in multilateral aid delivery.
b. Political Factor and Health Impact: While most candidates identified a political factor like government instability or corruption, many responses lacked depth in explaining how this factor affects health outcomes in LDCs. Common issues included vague statements without linking to specific consequences, such as disruption of health services, vaccine delivery or increased disease spread in refugee camps. Stronger responses provided clear cause-and-effect reasoning.
c. Health Indicators and Data: Most students could identify two indicators (e.g., life expectancy, infant mortality rate), but definitions were often incomplete or incorrect, and units of measurement were frequently missing. Data use was inconsistent; some students omitted figures entirely or failed to specify which country was an LDC or MDC. Stronger responses included accurate definitions, correct units and meaningful comparisons between chosen countries.

Question 13

Criterion 4

Most students were able to identify a leading cause of morbidity and mortality in an LDC, but responses often lacked depth and completeness. Common issues included omitting treatment details, failing to provide accurate statistics and giving vague descriptions of the role of international organisations. Stronger answers followed a logical structure, used relevant data and linked impacts to broader social and economic consequences.

While many students correctly identified health issues such as malaria or diarrhoeal disease, weaker responses did not include all required components. Key statistics were sometimes missing or inaccurate, and impacts on the community were often limited to health outcomes rather than considering education, productivity or poverty. Treatment options were frequently overlooked or described as “no treatment,” and references to international organisations were broad and lacked specific examples of programs or actions. Stronger responses demonstrated clear understanding by including accurate data, feasible treatments (e.g., insecticide-treated nets, oral rehydration therapy) and naming organisations like WHO or UNICEF with details of their role in prevention and care.

Question 14

Criterion 3 and Criterion 7

Responses to this question were generally weaker compared to other long answer responses, and the majority of students attempted Question 15. While most candidates could identify social contributions of women in LDCs, economic roles were often overlooked, and links to Primary Health Care (PHC) were mostly vague or missing. Many answers lacked depth and failed to integrate theory with practical examples. Students tended to provide generic statements rather than detailed explanations supported by evidence. Organisational examples were usually listed

without clear connections to how they improved women's lives. Overall, this question highlighted gaps in understanding of PHC and the broader social and economic context of women's roles in LDCs.

Social and Economic Contributions (including PHC): Most responses focused on women as caregivers and educators but rarely discussed their economic contributions such as farming, small-scale trade or informal market work. Few students linked these roles to PHC components like health education, nutrition, maternal and child health or community participation.

Challenges: Students commonly identified barriers such as lack of education and gender inequality, but explanations were brief and lacked detail on how these challenges limit participation in society. Stronger responses explored impacts on autonomy, income and access to healthcare.

Organisational Support: While most students named organisations (e.g., UNICEF, Plan International), weaker answers simply listed names without explaining how programs improved women's lives. Stronger responses provided examples of initiatives such as education programs, maternal health services and economic empowerment projects.

Question 15

Criterion 3 and Criterion 7

This question was generally answered better than Question 14, with more students attempting it. Most candidates correctly identified two Sustainable Development Goals (SDGs) from Goals 1–6 and provided a basic description of their aims. However, responses often lacked depth when explaining how achieving these goals improves lives in LDCs. Many answers were generic and did not fully explore the flow-on effects of achieving these goals. While most students included actions taken in their chosen country, stronger responses linked these actions to measurable outcomes and supported them with data. Weaker responses were descriptive rather than analytical and missed opportunities to demonstrate understanding of the SDGs' broader impact.

Identifying Goals and Their Aims: Most students correctly named two goals and outlined their purpose, but weaker responses simply listed the goals without explaining their targets or context within the SDGs framework.

Explaining Impact on Lives in LDCs: This was the least developed part of many responses. Students often repeated the goal statement rather than explaining how achieving it would improve health, education or economic stability.

Actions Taken: Most students provided examples of programs or initiatives, such as microfinance schemes or health campaigns. Stronger responses named specific organisations or government programs and explained their relevance to the chosen goals.

Evidence of Success: Few students included data or examples to demonstrate progress. Stronger answers referenced statistics (e.g., poverty reduction rates in Bangladesh) or cited program outcomes, which added credibility and depth.