

Chapter 6

Women's Health and Wellbeing

Self-assessed health status

Self-assessed health is a commonly used measure of health status. The most recent data on the health status of Australians are available from the Australian Bureau of Statistics 2006 General Social Survey where respondents aged 18 years and over rated their own health on a five point scale ranging from poor to excellent.

Gender differences in health status

In 2006, just over half of women aged 18 years and over (57.9 per cent) considered their health status to be excellent or very good. As shown in Figure 6.1, self-assessed ratings of very good or excellent health were similar for men (57.3 per cent) and women (57.9 per cent), but men were somewhat more likely to report good health (27.3 per cent) than women (25.9 per cent) and women (16.2 per cent) were slightly more likely than men (15.4 per cent) to report poor health.

Figure 6.1: Self-assessed health by gender, Australia, 2006



Source: Australian Bureau of Statistics, 2007, *General Social Survey, 2006*, Catalogue No. 4159.0, ABS, Canberra, Tables 3 & 4

Self-assessed health by age

Ratings of self-assessed health vary by age. The percentage of women who rated their health as poor or fair increased with age, while those who considered their health to be excellent or very good peaked at ages 25 to 34 years and then declined with increasing age (Table 6.1).

Table 6.1: Women's self-assessed health status by age, Australia, 2006.

	Self-assessed health status		
	Excellent/ Very good (%)	Good (%)	Fair/Poor (%)
Age group (years)			
18-24	67.8	25.2	7.0
25-34	74.7	18.0	7.2
35-44	66.0	23.7	10.2
45-54	56.5	26.9	16.6
55-64	47.5	28.4	24.1
65-74	40.1	35.4	24.5
75-84	31.0	30.3	38.8
85 and over	20.5	37.2	42.3
Total	57.9	25.9	16.2

Source: Australian Bureau of Statistics, 2007, *General Social Survey, 2006*, Catalogue No. 4159.0, ABS, Canberra, Table 4
Some totals may not add to 100% due to rounding

Mental Health

The 2007 National Survey of Mental Health and Wellbeing (SMHWB), conducted by the Australian Bureau of Statistics, provides lifetime and 12-month prevalence estimates of mental disorders in the Australian population aged 16 to 85 years. The assessment of mental disorders is based on the definitions and diagnostic criteria of the World Health Organization's (WHO) International Classification of Diseases, Tenth Revision (ICD-10). Prevalence of mental disorders is the proportion of people in a given population who meet the diagnostic criteria of a mental disorder at a point in time. The SMHWB focuses on the more common or high prevalence classes of mental disorders: Anxiety disorders (e.g. Panic disorder); Affective disorders (e.g. Depression); and Substance Use disorders (e.g. alcohol and drug harmful use and dependence).

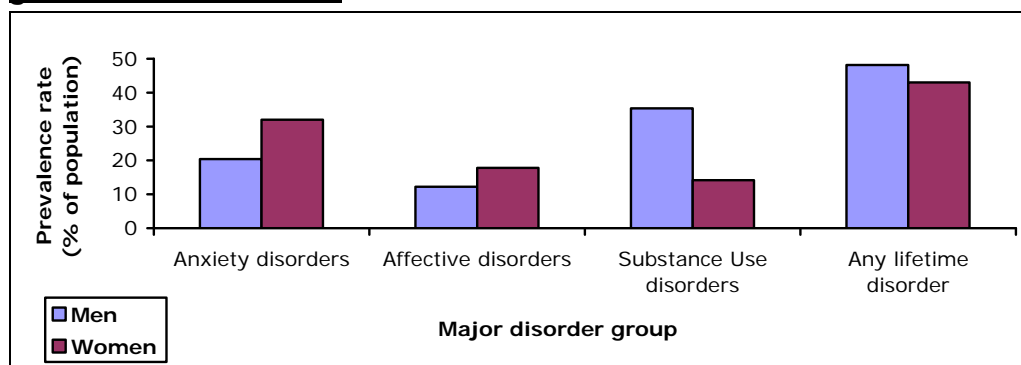
Gender differences in lifetime prevalence of mental disorder

In Australia in 2007, 48.1 per cent of men (3.8 million) had experienced mental illness at some point in their life, compared to 43 per cent of women (3.5 million).

Prevalence of the mental disorders differed by gender (see Figure 6.2). The most common diagnosis for women was an Anxiety disorder, followed by Affective disorder. For men, the most common diagnosis was Substance Use disorder, followed by Anxiety disorder. Women experienced higher rates than men of Anxiety

and Affective disorders. However, men had 2.5 times the rate of Substance Use disorders compared to women.

Figure 6.2: Lifetime mental disorders by major disorder group and gender, Australia, 2007



Source: Australian Bureau of Statistics, 2008, National Survey of Mental Health and Wellbeing 2007, Catalogue No. 4326.0, ABS, Canberra, Table 1.

Gender differences in 12-month prevalence of mental disorder

In the SMHWB, 12-month diagnoses were derived based on lifetime diagnosis and the presence of symptoms of that disorder in the 12 months prior to the survey interview.

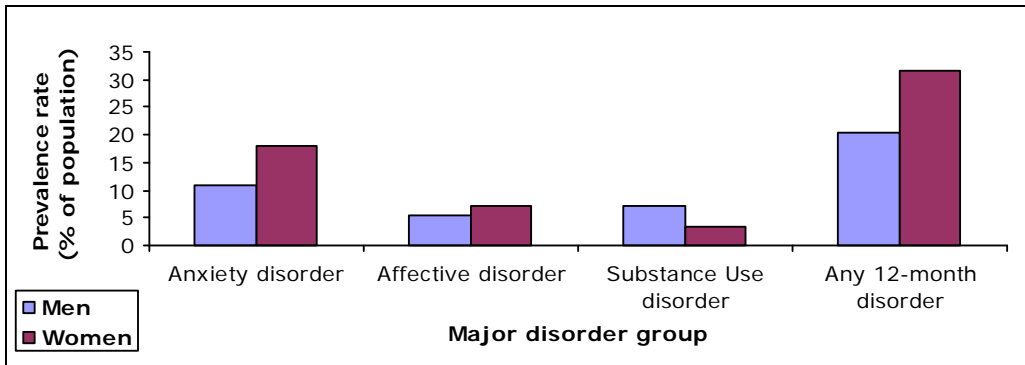
In 2007, one in five (3.2 million) Australians had a 12-month mental disorder. Contrary to lifetime prevalence of mental disorders in Australia, women experienced higher rates than men of mental disorders in the previous 12 months (See Figure 6.3).

Figure 6.3 also shows that the most common 12-month mental disorders for women were Anxiety disorders, followed by Affective disorders. Anxiety disorder was also the most common form of 12-month mental disorder for men, followed by Substance Use disorders. Although Anxiety disorders were the most common 12-month mental disorders among men and women, the prevalence rate was higher among women than men. Women also experienced higher rates than men of Affective disorders, whereas men experienced higher rates than women of Substance Use disorders.

Figures 6.4 and 6.5 show that the prevalence of 12-month mental disorders varied by age and the age variations differed by gender. Among women, 12-month Anxiety disorders had the highest prevalence across all age groups, with the prevalence remaining stable at around 21 per cent between the ages of 16 and 54 years, and then declined with age. The prevalence of Affective disorders among women remained similar between the ages of 16 and 54 years (at around 8 per cent) and then declined with age. The

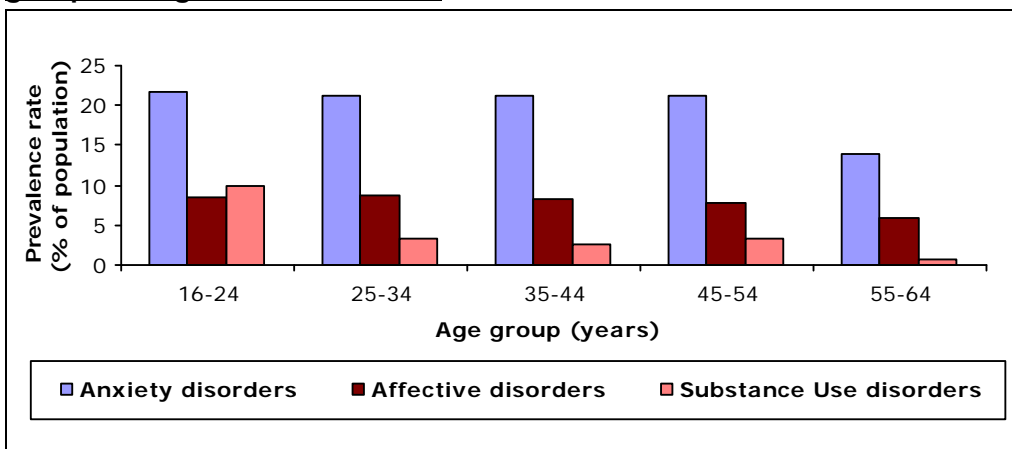
prevalence of 12-month Substance Use disorders for women was highest among those aged 16 to 24 years.

Figure 6.3: 12-month mental disorders by major disorder group and gender, Australia, 2007



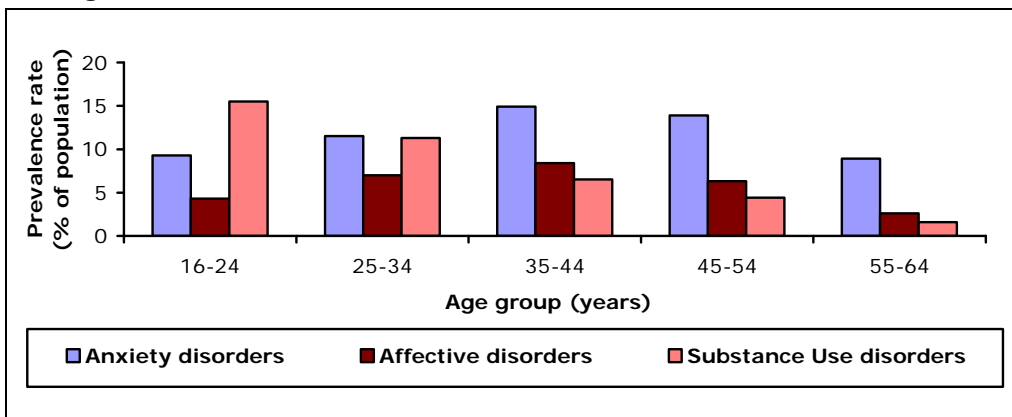
Source: Australian Bureau of Statistics, 2008, National Survey of Mental Health and Wellbeing 2007, Catalogue No. 4326.0, ABS, Canberra, Table 2.

Figure 6.4: 12-month mental disorders for women by major disorder group and age, Australia, 2007



Source: Australian Bureau of Statistics, 2008, National Survey of Mental Health and Wellbeing 2007, Catalogue No. 4326.0, ABS, Canberra, Table 3.

Figure 6.5: 12-month mental disorders for men by major disorder group and age, Australia, 2007



Source: Australian Bureau of Statistics, 2008, National Survey of Mental Health and Wellbeing 2007, Catalogue No. 4326.0, ABS, Canberra, Table 3.

Although Anxiety disorders had the highest prevalence for both men and women across most age groups, the prevalence of Anxiety disorders was higher among women than men across all age groups. Women in the 16–24 and 25–34 years of age groups experienced around twice the prevalence of 12-month Anxiety disorders compared with men in the same age groups.

The prevalence of Substance Use disorders was higher for men than for women across all age groups, especially among those aged between 25–34 years, where men experienced more than three times the prevalence of 12-month Substance Use disorders compared with women. The prevalence for 12-month Affective disorders was higher for women than for men in all age groups except in the 35–44 years of age group where prevalence rates were similar for men and women (8.4 per cent and 8.3 per cent respectively).

Causes of death

Gender differences in the leading causes of death

The top 10 causes of deaths shown in Table 6.2 accounted for 53.7 per cent of all male and 56.9 per cent of all female deaths in Australia in 2006. Table 6.2 also shows that the leading causes of death varied by gender.

Ischaemic heart diseases were the leading causes of both male and female deaths. However, there were 113 male deaths per 100 female deaths from this cause.

Trachea and lung cancer was the second leading cause of male deaths (fourth for female deaths). Lung cancer was the most common cause of cancer deaths among men and lung cancer has now overtaken breast cancer as the most common cancer death for women.¹ Breast cancer was the fifth leading cause of death among women.

There were more female than male deaths due to strokes, and Dementia and Alzheimer's disease. Heart failure is the eighth ranked cause of death among women, but it does not appear in the top 10 causes of death among men.

Other causes of death where a high proportion of deaths were female included Influenza and pneumonia (55 per cent), arthritis and musculoskeletal diseases (69 per cent), and mental health disorders (64 per cent).²

Table 6.2: Ten leading causes of death by gender, Australia, 2006

Rank	Male deaths			Female deaths		
	Cause of death	Number of deaths	% of all male deaths	Cause of death	Number of deaths	% of all female deaths
1	Ischaemic heart diseases	12,186	17.8	Ischaemic heart diseases	10,797	16.6
2	Trachea and lung cancer	4,665	6.8	Strokes	6,985	10.7
3	Strokes	4,480	6.5	Dementia and Alzheimer's disease	4,470	6.9
4	Prostate cancer	2,952	4.3	Trachea and lung cancer	2,683	4.1
5	Chronic lower respiratory disease	2,943	4.3	Breast cancer	2,618	4.0
6	Colon and rectum cancer	2,149	3.1	Chronic lower respiratory disease	2,500	3.8
7	Blood and lymph cancer	2,084	3.0	Diabetes	1,837	2.8
8	Dementia and Alzheimer's disease	2,072	3.0	Heart failure	1,778	2.7
9	Diabetes	1,825	2.7	Diseases of the kidney and urinary system	1,739	2.7
10	Diseases of the kidney and urinary system	1,453	2.1	Colon and rectum cancers	1,709	2.6
	Total (10 leading causes)	36,809	53.7	Total (10 leading causes)	37,116	56.9
	Total (all deaths)	68,556	100.0	All deaths	65,183	100.0

Source: Australian Bureau of Statistics, 2008, *Causes of Death, Australia, 2006*, Catalogue No. 3303.0, ABS, Canberra, Tables 1.2 and 1.3

Premature deaths

The potential years of life lost (PYLL) from a disease or injury is a measure of premature mortality. For example, at current average life expectancy levels in developed countries all deaths before age 75 might be considered untimely and to involve a loss of potential years of life. Thus, from this perspective, a person dying on his/her 40th birthday loses 35 potential years of life.³

Gender differences in leading causes of PYLL

Table 6.3 shows that the potential years of life lost from a disease or injury due to premature mortality in 2005 was greater for men than for women.

Table 6.3 also shows the top five leading specific causes of PYLL in 2005. Coronary heart disease was the leading cause of PYLL among male deaths and breast cancer was the highest contributor to premature mortality among women. Suicide, land transport accidents and lung cancer all feature in the top five leading specific causes of PYLL for men and women, although these causes are larger contributors to premature mortality among men than women.

Table 6.3: Five leading specific causes of potential years of life lost (PYLL), Australia, 2005

Rank	Male deaths			Female deaths		
	Cause of death	PYLL	% all causes PYLL	Cause of death	PYLL	% all causes PYLL
1	Coronary heart disease	59,795	11.1	Breast cancer	30,248	9.9
2	Suicide	52,998	9.8	Lung cancer	16,628	5.4
3	Land transport accidents	42,505	7.9	Coronary heart disease	15,515	5.1
4	Lung cancer	26,888	5.0	Suicide	13,270	4.3
5	Other heart diseases	18,215	3.4	Land transport accidents	12,678	4.1
	Total (all causes)	538,985	100.0	All deaths	306,330	100.0

Source: Australian Institute of Health and Welfare, *Australia's Health, 2008*, Catalogue No. AUS99, AIHW, Canberra, Table 2.15

Burden of disease and injury

The burden of disease and injury is measured using the 'disability-adjusted life year' (DALY). The DALY measures the years of life lost due to premature death coupled with years of 'healthy' life lost due to disability.⁴ One DALY is equivalent to one lost year of healthy life.

The total burden of disease and injury in Australia in 2003 was 2.63 million DALYs.⁵ Men accounted for more of the burden of disease and injury (1.4 million DALYs) than women (1.3 million DALYs).⁶

Table 6.4 shows gender differences in the leading specific causes of healthy life lost. Ischaemic heart disease was the leading specific cause of healthy life lost for men and anxiety and depression were the largest contributors to healthy life lost among women. Dementia, breast cancer, and asthma were in the top 10 specific causes of healthy life lost for women, but not for men. Suicide and self-inflicted injuries was ranked eighth for men, but these causes did not rank in the top 10 for women.

Major risks to health

The 14 risks to health in Table 6.5 were among the top contributors to the burden of disease and injury in Australia in 2003.⁷ The 14 risks in combination explained 35.1 per cent of the total male burden and 29.1 per cent of the total female burden.

Gender differences in the burden attributable to health risks

Table 6.5 shows that tobacco, high blood pressure, high body mass, physical inactivity and high blood cholesterol were the leading causes of both the male and female burden of disease and injury, although these risks accounted for a larger share of the male burden than the female burden. The harmful effects of alcohol, low

fruit and vegetable consumption, and illicit drugs were also larger contributors to the male burden than to the female burden. Intimate partner violence and child sexual abuse accounted for a larger proportion of the female burden than the male burden.

Table 6.4: Ten leading specific causes of burden of disease and injury (DALYs), by gender, Australia, 2003

Rank	Male burden			Female burden		
	Specific cause	Number of DALYs	% of total DALYs	Specific cause	Number of DALYs	% of total DALYs
1	Ischaemic heart disease	151,107	11.1	Anxiety and depression	126,464	10.0
2	Type 2 diabetes	71,176	5.2	Ischaemic heart disease	112,390	8.9
3	Anxiety and depression	65,321	4.8	Stroke	65,166	5.1
4	Lung cancer	55,028	4.0	Type 2 diabetes	61,763	4.9
5	Stroke	53,296	3.9	Dementia	60,747	4.8
6	Chronic obstructive pulmonary disease	49,201	3.6	Breast cancer	60,520	4.8
7	Adult-onset hearing loss	42,653	3.1	Chronic obstructive pulmonary disease	37,550	3.0
8	Suicide and self-inflicted injuries	38,717	2.8	Lung cancer	33,876	2.7
9	Prostate cancer	36,547	2.7	Asthma	33,828	2.7
10	Colorectal cancer	34,643	2.5	Colorectal cancer	28,962	2.3

Source Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD, 2007. *The burden of disease and injury in Australia 2003*. Catalogue no. PHE 82. AIHW, Canberra, Table 3.1.

Table 6.5: Burden of disease and injury (DALYs) attributable to 14 selected risk factors by gender, Australia, 2003

	Male burden (%)	Female burden (%)
Tobacco	9.6	5.8
High blood pressure	7.8	7.3
High body mass	7.7	7.3
Physical inactivity	6.4	6.8
High blood cholesterol	6.6	5.8
Harmful effects of alcohol	4.9	1.6
Low fruit and vegetable consumption	2.7	1.5
Illicit drugs	2.7	1.2
Occupational exposures and hazards	2.6	1.3
Intimate partner violence	n/a*	2.3
Child sexual abuse	0.3	1.5
Urban air pollution	0.8	0.7
Unsafe sex	0.5	0.7
Osteoporosis	<0.1	0.3
Joint effect**	35.1	29.1

Source Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD, 2007. *The burden of disease and injury in Australia 2003*. Catalogue no. PHE 82. AIHW, Canberra, Table 4.3.

*The attribution of burden to intimate partner violence for men was not calculated due to insufficient evidence on prevalence and risk among men.

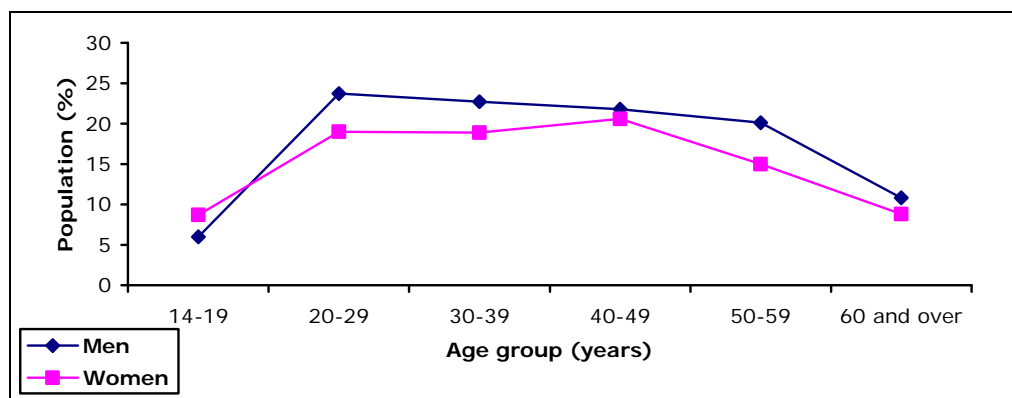
**The burden attributable to these health risks in combination is not the sum of burden from each risk. The combined effects have been expressly calculated.

Gender differences in tobacco use

In 2007, 16.6 per cent of Australians aged 14 years and over reported smoking cigarettes on a daily basis.⁸ Women were less likely (15.2 per cent) than men (18 per cent) to be daily smokers, but this was not the case across all ages - among Australians aged 14 to 19 years, female teenagers were more likely than male teenagers to smoke cigarettes on a daily basis (Figure 6.6).

Figure 6.6 also shows that for both men and women, the least prevalent age group for daily smoking was 14 to 19 years, followed by men and women in the 60 years and over age group. Between the age groups of 14-19 years and 20-29 years, daily smoking rates rose sharply for both men and women and were highest among men in this age group. Male daily smoking rates then declined with age. For women, daily smoking rates decreased between the age groups of 20-29 years and 30-39 years, but increased again at ages 40 to 49 years, where women in this age group were more likely to be daily smokers than in any other age group.

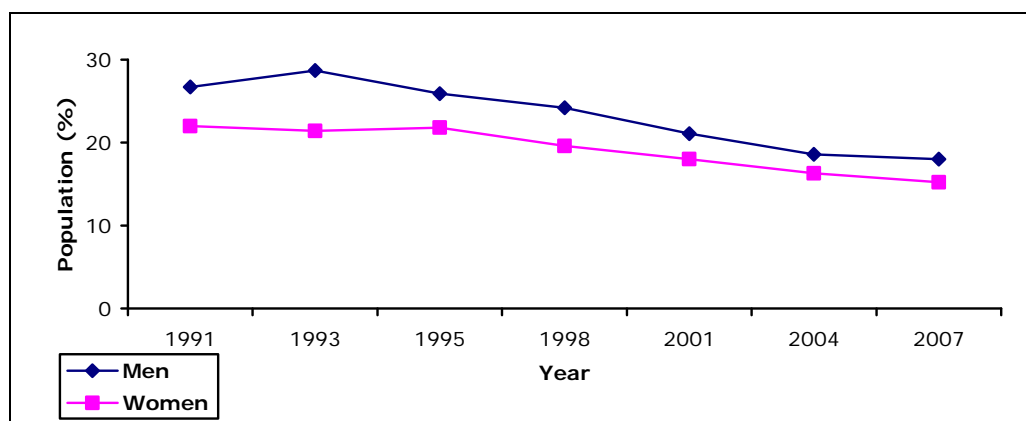
Figure 6.6: Daily tobacco smoking among men and women aged 14 years and over by age group, 2007



Source: Australian Institute of Health and Welfare, 2007 National Drug Strategy Household Survey: detailed findings, Cat. no. PHE 107, AIHW, Canberra, Table 4.1

Daily smoking rates have declined over time for both men and women, although they have declined slightly more sharply for men than for women, resulting in a steady narrowing of the gender gap in daily smoking rates (see Figure 6.7).

Figure 6.7: Trends in daily tobacco smoking among men and women aged 14 years and over, 1991 - 2007



Source: Australian Institute of Health and Welfare, 2007 National Drug Strategy Household Survey: detailed findings, Cat. no. PHE 107, Table 4.1 & Statistics on drug use in Australia, 2004, Cat no. PHE 62, Table 2.1, AIHW, Canberra

Gender differences in risk of harm from alcohol consumption

Risk of short term alcohol-related harm

The short-term risk of harm from alcohol consumption is measured by the level of consumption on any drinking occasion. 'Low risk' is defined as the consumption on any one occasion of up to six standard drinks for adult men and up to four standard drinks for adult women. For men, the consumption of seven to 10 drinks on one occasion is considered 'risky' and 11 or more drinks on one occasion is considered 'high risk'. For women, five to six standard drinks on one occasion is 'risky' and seven or more 'high risk'.⁹

Table 6.6 shows that in 2007, 38.7 per cent and 30.5 per cent of Australian men and women aged 14 years and over respectively drank in a pattern that is considered risky or high risk for alcohol-related harm in the short term. This included 9.3 per cent of men and 6.2 per cent of women who drank at risky or high risk levels at least weekly, 14.3 per cent of men and 10.9 per cent of women who drank at risky or high risk levels for harm in the short term at least monthly (but not as often as once a week), and 15.1 per cent of men and 13.4 per cent of women who consumed alcohol at risky or high risk levels once or more a year (but not as often as monthly).

Table 6.6 further shows that men were more likely than women to consume alcohol at risky or high risk levels for short term harm across all age groups, except among those aged 14 to 19 years, where nearly three in every ten young women put themselves at risk of alcohol-related harm in the short term at least once a month.

The consumption of alcohol at risky or high risk levels for short term harm peaked at ages 20 to 29 years for both men and women and then declined with age.

Table 6.6: The proportion of the population aged 14 years and over at risk of alcohol related harm in the short term by age, gender, and level and frequency of risk, Australia, 2007

Age group (years)	Abstainers*	Low risk	Risky and high risk			
			At least yearly	At least monthly	At least weekly	Total
Men						
• 14-19	29.2	33.4	12.9	15.7	8.8	37.4
• 20-29	11.1	26.1	19.0	26.6	17.2	62.8
• 30-39	10.9	40.6	21.1	17.5	10.0	48.6
• 40-49	10.8	47.0	18.9	14.5	8.7	42.1
• 50-59	9.9	59.4	12.9	9.5	8.2	30.6
• 60 and over	17.3	67.8	6.4	4.5	4.0	14.9
Total	14.0	47.2	15.1	14.3	9.3	38.7
Women						
• 14-19	28.7	30.1	12.9	18.8	9.5	41.2
• 20-29	14.8	29.2	20.7	23.1	12.2	56.0
• 30-39	13.5	46.9	19.5	13.3	6.8	39.6
• 40-49	13.9	53.4	16.2	10.2	6.3	32.7
• 50-59	18.1	62.5	10.2	4.8	4.4	19.4
• 60 and over	31.1	61.3	3.9	2.1	1.5	7.5
Total	20.1	49.3	13.4	10.9	6.2	30.5

Source: Australian Institute of Health and Welfare 2008. 2007 National Drug Strategy Household Survey: first results, Catalogue No. PHE 98. Canberra: AIHW, Table 3.12.

*Not consumed alcohol in the previous 12 months

Risk of long term alcohol-related harm

The long-term risk of alcohol related harm is estimated from regular daily patterns of consumption. For adult men, the consumption of up to 28 standard drinks per week is considered 'low risk', 29 to 42 per week 'risky', and 43 or more per week 'high risk'. For adult women, the consumption of up to 14 standard drinks per week is considered 'low risk', 15 to 28 per week 'risky' and 29 or more per week 'high risk'.¹⁰

Table 6.7 shows that in 2007, 10.1 per cent of men and 10.4 per cent of women aged 14 years and over consumed alcohol at levels that are considered risky or high risk of long term alcohol related harm. For men, the peak occurred at ages 20 to 29 years, where 9.3 per cent drank at risky levels and 6.2 per cent drank at high risk levels. For women, the peak also occurred at ages 20 to 29 years, where 11 per cent consumed alcohol at risky levels and a further 5.4 per cent consumed alcohol at high risk levels.

Across all age groups (except among those aged 60 years and over), women were more likely than men to consume alcohol at levels considered risky to health in the long term. At all ages, except for young adults aged 14 to 19 years, men were more likely

than women to consume alcohol at high risk levels for long term harm.

Table 6.7: The proportion of the population aged 14 years and over at risk of alcohol related harm in the long term by age, gender, and level of risk, Australia, 2007

Age group (years)	Abstainers*	Level of risk		
		Low risk	Risky	High risk
Men				
• 14-19	29.2	63.7	4.4	2.6
• 20-29	11.1	73.4	9.3	6.2
• 30-39	10.9	79.2	6.2	3.7
• 40-49	10.8	79.6	6.0	3.5
• 50-59	9.9	78.9	6.1	5.1
• 60 and over	17.3	75.3	4.9	2.5
Total	14.0	75.8	6.2	3.9
Women				
• 14-19	28.7	60.7	6.7	3.9
• 20-29	14.8	68.8	11.0	5.4
• 30-39	13.5	75.8	7.7	3.0
• 40-49	13.9	74.1	9.3	2.6
• 50-59	18.1	72.3	6.9	2.7
• 60 and over	31.1	63.4	4.7	0.8
Total	20.1	69.4	7.6	2.8

Source: Australian Institute of Health and Welfare 2008. 2007 National Drug Strategy Household Survey: first results, Catalogue No. PHE 98. Canberra: AIHW, Table 3.13.

*Not consumed alcohol in the previous 12 months

Gender differences in physical inactivity

According to the National Physical Activity Guidelines for Australians, adults require at least 30 minutes of moderate physical activity, on most, preferably all, days to generate sufficient health benefits.¹¹

In 2007, equal proportions of men and women reported undertaking very low levels of physical activity (less than 100 minutes) or no physical activity in the week prior to the National Survey of Mental Health and Wellbeing.¹² More women than men reported undertaking physical activity at low levels (100 minutes to less than 1,600 minutes), whereas more men than women undertook moderate/high levels of physical activity in the week prior to the survey (over 1,600 minutes) (Table 6.8).

Table 6.8: Population aged 16 to 85 years, physical activity levels by gender, Australia, 2007

Level of exercise	Men		Women	
	Number	%	Number	%
• Sedentary	1,494,200	18.8	1,484,500	18.4
• Low	3,736,300	47.0	4,921,700	61.1
• Moderate/high	2,715,300	34.2	1,654,300	20.5
Total	7,945,800	100.0	8,060,500	100.0

Source: Australian Bureau of Statistics, 2008, National Survey of Mental Health and Wellbeing 2007, Catalogue No. 4326.0, ABS, Canberra, Table 8.

Gender differences in high body mass

The body mass index, or BMI, is a measure of total body fat based on height and weight. It is calculated by dividing weight in kilograms by height in metres squared (m²). BMI values are used to classify adults into weight categories as listed in Table 6.9.

Table 6.9: Body mass index (BMI) and weight categories for adults

BMI value	Weight category
Less than 18.5	Underweight
18.5 to less than 25.0	Normal weight range
25.0 to less than 30.0	Overweight
30.0 and greater	Obese

Source: Australian Bureau of Statistics, 2008, National Survey of Mental Health and Wellbeing 2007, Catalogue No. 4326.0, ABS, Canberra.

Based on responses to questions relating to height and weight in the Australian Bureau of Statistics National Survey of Mental Health and Wellbeing in 2007, 54.2 per cent of Australia's population aged 16 to 85 years was categorised as overweight or obese.¹³

As shown in Table 6.10, a higher number and proportion of men than women were categorised as overweight, whereas a higher number and proportion of women were categorised as obese.

Table 6.10: Overweight and obese population aged 16 to 85 years by gender, Australia, 2007

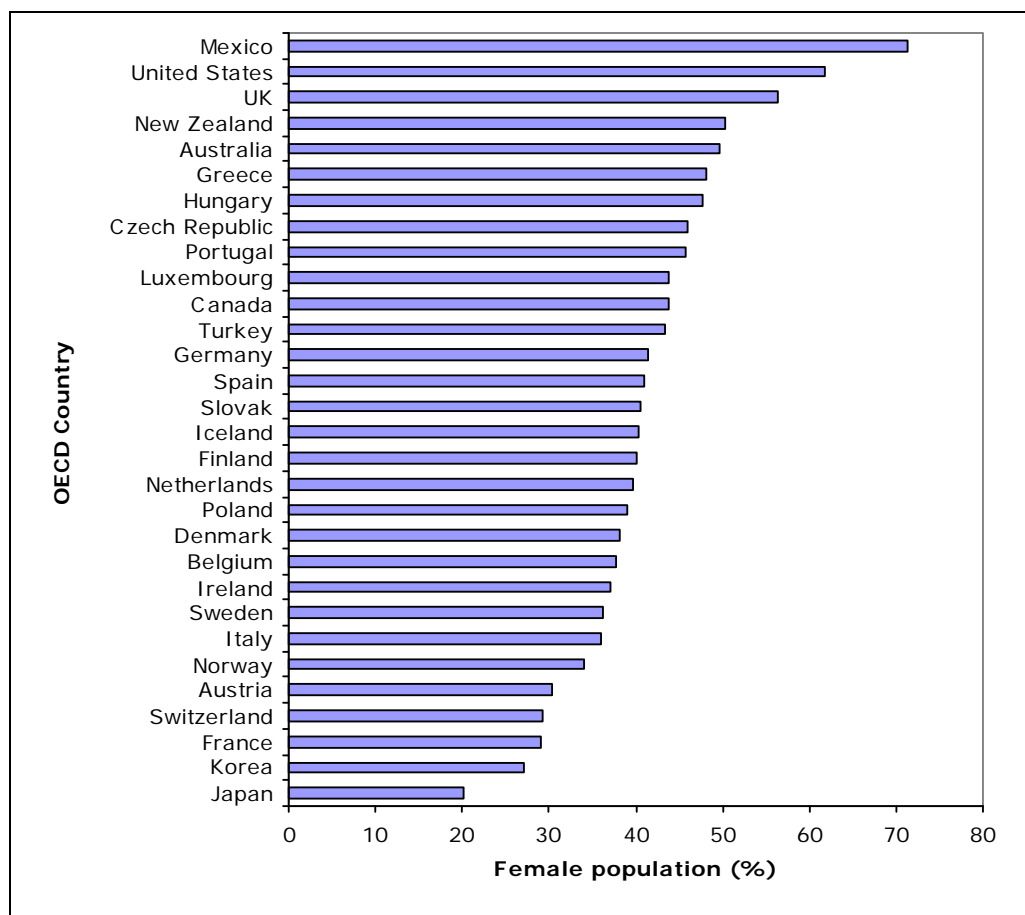
	Men		Women	
	Number	%	Number	%
Overweight	3,424,800	43.1	2,027,700	25.1
Obese	1,504,300	18.9	1,717,900	21.3
Total (overweight and obese)	4,929,100	62.0	3,745,600	46.4

Source: Australian Bureau of Statistics, 2008, National Survey of Mental Health and Wellbeing 2007, Catalogue No. 4326.0, ABS, Canberra, Table 8.

Between 1995 and 2007, the proportion of Australian women classified as overweight has increased from 21.4 per cent to 25.1 per cent. However, obesity levels among Australian women have grown at a faster rate, almost doubling from 11 per cent in 1995 to 21.3 per cent in 2007. In 1995, there were similar proportions of men and women in Australia categorised as obese. Since 2001, obesity has been more common among women than among men.¹⁴

The overweight/obesity rate among women aged 15 years and above in Australia was ranked fifth in OECD countries in 2005 at 49.6 per cent (see Figure 6.8). It was lower than for women in the United States (61.8 per cent) and the United Kingdom (56.3 per cent), but similar to women in New Zealand (50.2 per cent) and Greece (48.1 per cent).¹⁵

Figure 6.8 Overweight and obese female population aged 15 years and over in OECD countries, 2005 or latest available year



Source: Organisation for Economic Co-operation and Development 2007, OECD Factbook 2008, OECD, Paris. <http://lysander.sourceoecd.org/vl=2703422/cl=18/nw=1/rpsv/factbook/110103.htm>, viewed 21/01/2009

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- ⁵ Ibid.
- ⁶ Australian Institute of Health and Welfare, *Australia's Health 2008*, Catalogue No. AUS 99, AIHW, Canberra, 2008, p.54
- ⁷ Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez AD, 2007. *The burden of disease and injury in Australia 2003*. Catalogue no. PHE 82. AIHW, Canberra.
- ⁸ Australian Institute of Health and Welfare, *2007 National Drug Strategy Household Survey: detailed findings*, Catalogue No. PHE 107, AIHW, Canberra, 2008, Table 4.1
- ⁹ National Health and Medical Research Council, *Australian Alcohol Guidelines: health risks and benefits*, NHMRC, Canberra. The alcohol risk guidelines are currently being revised by the National Health and Medical Research Council.
- ¹⁰ National Health and Medical Research Council, *Australian Alcohol Guidelines: health risks and benefits*, NHMRC, Canberra. The alcohol risk guidelines are currently being revised by the National Health and Medical Research Council.
- ¹¹ Commonwealth Government Department of Health and Aged Care, *National physical activity guidelines for Australians*, DHAC, Canberra, 1999.
- ¹² Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Catalogue No. 4326.0, ABS, Canberra.
- ¹³ Ibid, Table 8.
- ¹⁴ Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Catalogue No. 4326.0, ABS, Canberra, Table 8 and Australian Bureau of Statistics, *National Health Survey: Summary of Results, 2004-05*, Catalogue No. 4364.0, Table 25.
- ¹⁵ Data for 25 of the 30 OECD countries is self-report survey data. Only Australia, the Czech Republic, Luxembourg, New Zealand, the United Kingdom and the United States have data in the OECD database that is based on actual measurement of weight and height. The difference in survey methodologies limits data comparability, as estimates arising from the actual measurement of weight and height are more accurate and significantly higher than those based on self-report (by around 5-6 percentage points on average). Thus, a significant influence on Australia's high ranking of 5th arises from survey methodology. The six countries using measured data are all in the top 10 countries for overweight/obesity. If Australia were to be compared on a similar methodological basis to the majority (25) of OECD countries, using self-report data from the ABS National Survey of Mental Health and Wellbeing 2007, then Australia's OECD ranking would be 7th instead of 5th. If the ABS National Health Survey 2004-05 data were used, Australia would be ranked 10th.