



Health



Main findings

- One Queensland baby in four is born by caesarean section – a higher rate than in any other state.
- 14.2% of married first-time mothers are aged 35 years or over.
- 41.3% of Queensland women aged 18 and over were classed as overweight or obese in 2001.
- Queensland women had a much higher rate of melanoma than in any other state, with 48.3 cases per 100,000 women.ⁱ
- Nearly 20% of Queensland women smoke daily – and more are dying from lung cancer.
- Women attempt suicide more than men – but men are nearly four times more likely to kill themselves.
- Fewer women now die from breast and cervical cancers.

ⁱ 1994–1998, average annual age-standardised incidence



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As education levels increase,
so does income; with that
comes better health.

Introduction

Health, education and economic status are inextricably linked.¹ As an individual's education level increases, so does income and individual health. It is thought that this is because education and employment provide the ability and opportunity for people to adopt and sustain healthy lifestyle practices. Access to health services may be influenced by physical location, transport, financial status, cultural appropriateness and education. Some health risk factors are strongly related to socio-economic status, such as housing quality, alcohol and tobacco abuse, nutrition, and exercise.²

Queensland's Indigenous women are generally in poorer health than other Queensland women. The poorer prognosis for Indigenous women could be due to barriers to access to screening, treatment and palliative care. Financial barriers and distance to health services, cultural inappropriateness of existing services and inadequate dissemination of information about services are some of those barriers.³

Australians are having children at an increasingly later age, and having fewer of them. The fertility rate is measured by the number of births per woman, but that tells only part of the story. Men too are delaying fatherhood. The median age of first-time fathers has increased from 29.4 years in 1980 to 32.3 years in 2000.

While women generally are delaying childbearing, 6.2% of all Queensland women (and 21.1% of Indigenous women) were teenage mothers in 2001. This may impact on their long-term educational, social and economic outcomes.

Screening programs are significantly improving death rates, particularly for breast cancer and cervical cancer. However, the continuing very high death rate from cervical cancers among Indigenous women suggests a need for greater access to culturally appropriate services, and education about the importance of screening, for this population.

Childbirth

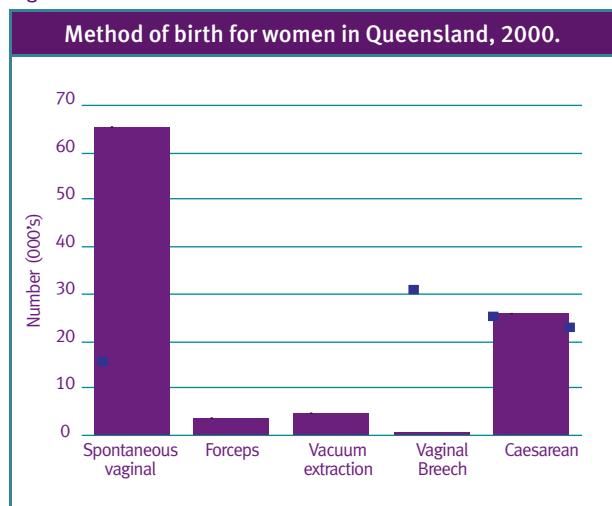
In 2002, 19.1% of the babies born in Australia were born in Queensland. 5.1% of births registered in Queensland in 2001 were to Indigenous women.

The infant mortality rate in Queensland in 2001 was 5.9: above the national average of 5.3, but below the Northern Territory on 11.7, and Tasmania on 6.2.⁴

In 2001, 6.2% of all births in Queensland were to teenage mothers. This was above the national average of 4.8% and was the third highest rate in Australia, after the Northern Territory (13.4%) and Tasmania (8.5%). In 2001, 21.1% of Indigenous women giving birth in Queensland were teenagers.⁵

In 2000, 98.5% of babies born in Queensland were born in hospital. A further 0.8% was born in a birthing centre attached to a hospital, and 0.3% at homeⁱⁱ. These are similar proportions to other states and territories.⁶

Figure 4



Source: Australian Institute of Health and Welfare National Perinatal Statistics Unit, 2003. *Australia's Mothers and Babies 2000*. AIHW, Canberra.

Queensland had the highest caesarean birth rate in Australia in 2000. The rate increased from 20.5% of births in 1991 to 25.6% in 2000 (nationally 23.3%). Caesarean rates were higher among older mothers, those having their first baby, and private patients.⁷

ⁱⁱ Details for the remaining 0.4% were unknown.

In 2001, 14.2% of married mothers in Australia having their first baby were aged 35 years or more.⁸ This is mirrored by a corresponding increase in women entering the In Vitro Fertilisation (IVF) program: 44.4% of women seeking assistance with conception through IVF were aged 35 and over. The causes of infertility are not necessarily related to the woman's ageⁱⁱⁱ. Only 26.8% of infertility problems were attributed to female causes. A further 29.7% were attributed to male fertility problems, and the remaining 43.5% were unexplained or multiple causes.⁹

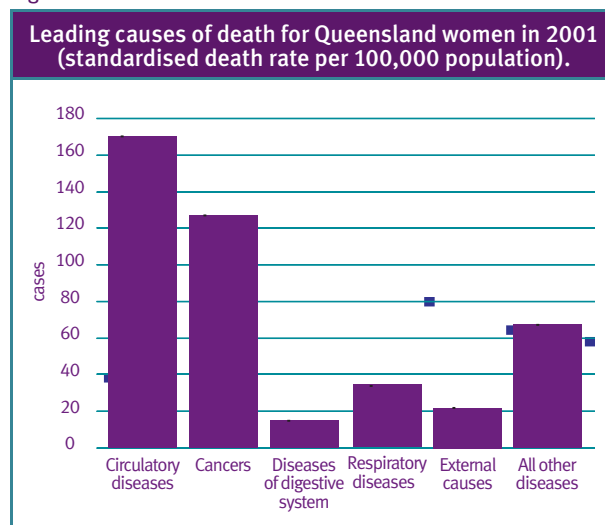
Breastfeeding

In 2000, 83.2% of Queensland babies were breastfed on their discharge from hospital, with mothers aged over 35 more likely to breastfeed (84.4%) than mothers aged under 20 years (75.3%). The more children a mother already had, the less likely she was to breastfeed her new baby: 85% of first-time mothers and 82.3% of mothers with one to four children breastfed on discharge from hospital, reducing to 72.6% of mothers with five or more previous children.¹⁰

Causes of death

Circulatory diseases, such as heart disease, stroke and heart failure, are the most common causes of death for Queensland women.

Figure 5



Source: ABS, 2002. Cat. No. 3311.3. *Demography, Queensland*.

ⁱⁱⁱ For women undertaking oocyte retrieved cycles for IVF, ICSI and GIFT.



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Of all deaths from stroke in 2001, 59.2% were women.¹¹

Women were less likely than men to die from external causes such as transport accidents and intentional self-harm.

The leading cancers causing deaths in Australian women in 2000 were breast cancer (with a death rate of 21.5 per 100,000), lung cancer (19.6), colorectal cancer (17.5), and melanoma (3).¹²

Death from breast cancer fell 25% over the five years to 2000, an annual decline of 4.5%. This can be attributed to increased levels of participation in breast screening programs, and improvements in management and treatment.¹³

Queensland has the highest incidence of skin cancer in the world, due to a predominantly Caucasian population and traditional outdoor lifestyle.¹⁴ The rate of melanoma is much higher than women in any other state, at 48.3 cases per 100,000 between 1994 and 1998 (compared to the second highest, Western Australia, at 35.3 cases).¹⁵

More Queensland women are dying from lung cancer. The death rate increased by 10.6% between 1993–1996 and 1997–2000, to 18.7 cases per 100,000. Only the ACT had a higher increase.¹⁶

Death rates^{iv} from chronic obstructive pulmonary disease (COPD) in Queensland women increased by 8.7% between 1993–1996 and 1997–2000. Only Tasmania had a higher increase.¹⁷ COPD is a serious, progressive lung disease where damage to the lungs in the form of emphysema and/or chronic bronchitis obstructs breathing. The greatest cause of COPD is cigarette smoking.

While slightly more men (50.3%) are listed on the national diabetes register as having insulin-treated diabetes, the incidence varies considerably across age groups. In the 25–44 age group, females (64.4%) strongly outnumber males. This reflects the effect of gestational diabetes on this age group. Men (57%) strongly outnumber women in older age groups (45 to 74 years).¹⁸



Cancers of the reproductive system

Cervical cancer is one of the few forms of cancer in which pre-cancerous lesions can be detected and treated before they progress to cancer. The incidence of cervical cancer in Queensland fell 48% between 1982 and 2000. The death rate from this preventable cancer fell 37% over the same period. This is largely due to increases in the availability of, and participation in, cervical screening.¹⁹

The incidence^v of cervical cancer of 12.6 cases per 100,000 Queensland women aged 20 to 69 years was the third highest in Australia in 2000, and was above the national incidence of 10.5. Queensland's higher overall rate reflects a relatively large Indigenous population. While data on the incidence of this cancer among Indigenous women is limited, the death rate from cervical cancer among Indigenous Australians was 11.4 per 100,000 women in 1998–2001, compared to the non-Indigenous death rate of 2.5.²⁰ There are indications that the rate is also particularly high in remote areas where access to preventative and primary health services are reduced.²¹

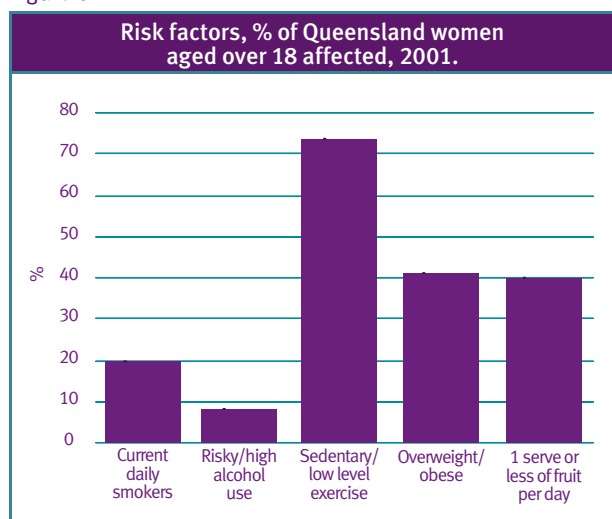
Ovarian cancer was the sixth leading cause of cancer death for Australian women in 1998. The lifetime risk of a woman developing ovarian cancer by the age of 75 is 1 in 103.²²

^{iv} Age-standardised

Risk factors for Queensland women aged 18 years and over

Particular lifestyle factors place people at greater risk of poor health. Figure 6 (below) shows the greatest risks to the health of Queensland women, by the proportion of Queensland women to whom they apply.

Figure 6



Source: ABS, 2002. Cat. No. 4364.0 National Health Survey 2001 – Companion Data. ABS, Canberra. Table 1.

Lifestyle factors – smoking, alcohol and poor diet – place women at greater risk of poor health.

People who are overweight, and particularly those who are obese, have higher rates of death and disease than people of a healthy weight. In particular, diseases such as coronary heart disease, type 2 diabetes, gall bladder disease, sleep apnoea, and some cancers are linked to being overweight or obese. Obesity can also have psychological and psychosocial consequences.²³ In Queensland, 41.3% of women aged 18 years or more were overweight or obese in 2001.²⁴

Being overweight or obese can be a result of lifestyle factors. Exercise and diet are equally important in preventing people becoming overweight or obese.²⁵

In 2001, 19.6% of Queensland women aged 18 years and over were daily smokers.²⁶ In the crucial initiation age period (14 to 19 years), the proportion of female smokers was 21.7% compared with male smokers at 14.1%.²⁷

While alcohol abuse appears to be relatively low among Australian women generally, the situation is quite different for teenage girls and young women.

In 2001, 14.6% of females aged 14 to 19 years reported alcohol consumption at a level considered risky or high risk for long-term harm (compared to 8.8% of males in the same age group).²⁸ In the same survey, 11.1% of females reported that loss of memory after drinking had occurred at least once a month over the previous 12 month period, and 29.5% reported memory loss after drinking at least once in the last 12 months (10.7% and 27.4% respectively for males in the same age group).²⁹

In 2002, females aged 15 to 17 years, in a high risk group who drank at a level that represented a risk to the health of adults according to the Australian Alcohol Guidelines³⁰, reported consumption of an average number of 8.4 standard drinks in one drinking session.³¹ As well as long-term health risks, alcohol abuse places young women at particular risk of sexual assault and other violence. More than 21% of girls allege to have experienced unwanted sexual activity after drinking.³²

^v Age-standardised



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More women than men try to kill themselves; but men are more likely to succeed.

Mental health

By 2020, depression is expected to be one of the western world's most significant health issues. Depression is most likely to occur for women aged 18 to 24 and 35 to 44.³³ It is also common for women after childbirth (10–15% of women).³⁴

In 2001, 13.8% of Queensland women 18 years and over reported experiencing high or very high levels of psychological distress, compared with 9.8% of men their age.³⁵

More women than men attempted suicide between 1998 and 2002, yet nearly four times as many men as women succeeded in killing themselves. The most common cause of death by suicide for men was hanging, and for women, self-poisoning.³⁶

Suicide death rates for widows, divorced women, and women who never married were about three times higher than for married women. This figure is consistent with patterns for men.³⁷

Women appear to be more likely than men to seek medical assistance for mental health problems. An estimated 10.2% of adult Queenslanders took pharmaceutical medication for their mental well-being in 2001. Of them, women represented 63.2%. Anti-depressants (69%) were the most common mental health medications used by women, followed by sleeping tablets or capsules for anxiety or nerves (34.1%).³⁸

Falls

With women generally living longer than men, they are also more likely to be affected by ailments of old age. Three times as many women as men aged over 65 years were hospitalised in 1998 due to accidental falls, and women in that age group had nearly a three times greater risk of sustaining fractures due to falls. 48% of accidental falls leading to hospitalisation occurred in the home.³⁹

Indigenous women's health

The leading causes of death in both the Indigenous and non-Indigenous populations are diseases of the circulatory system, cancers and external causes, such as injuries and accidents. These affect Indigenous people at younger ages than in the total Australian population. Indigenous Australians are seven to nine times more likely than non-Indigenous Australians to die from endocrine disorders (ie. thyroid disease and adrenal gland disorders) and metabolic diseases (of which 88% relate to diabetes).⁴⁰

Indigenous Australians are more likely to smoke and consume alcohol at risky levels, be exposed to violence, and be overweight or obese. All of these are significant health risk factors. The rates of these risk factors can vary between remote and non-remote areas. For example, Indigenous people living in remote areas are nearly twice as likely to consume alcohol at risky levels as those living in non-remote areas.⁴¹

Australia's^{vi} Indigenous population had a cervical cancer death rate of 11.4 per 100,000 women in 1997–2001, compared to the non-Indigenous death rate of 2.5.⁴²

In 2001, in non-remote areas, 43% of Indigenous women aged 40 years and over reported having regular mammograms, and 50% of Indigenous women aged 18 years and over reported having regular pap smear tests. In both cases, this was only slightly less than for all Queensland women (46% and 55%, respectively). No reliable data is available for Indigenous women in remote areas. However, the number of remote Indigenous women who reported never having had a mammogram (41%) or a pap smear test (19%) is significantly higher than for Indigenous women from non-remote areas (20% and 8% respectively) or non-Indigenous women (25% and 12% respectively).⁴³

vi "Australia" includes only Queensland, Western Australia, South Australia and the Northern Territory as these are the only states which have publishable data.

Rural and remote communities

Australians living in rural and remote areas have lower overall cancer survival rates than city and town dwellers. Women in metropolitan areas and large towns have a 60% relative survival rate five years after diagnosis, while their rural and remote counterparts have around a 55% relative survival rate.^{vii,44}

Women diagnosed with breast cancer and colorectal cancer who live in high socio-economic status areas (generally urban) have significantly higher relative survival rates than those living in low socio-economic areas (most rural and remote areas).⁴⁵

One possible reason for this is access to primary health care. This can be limited in rural and remote areas for geographical, socio-economic and cultural reasons. Such limitations in turn impact on the likelihood of prevention and early detection, as well as ongoing treatment. In particular, female GPs are under-represented in rural and remote areas (comprising around 30%).⁴⁶ While this is fairly similar to the metropolitan proportions, access to a female GP is obviously even more restricted in a rural area.

Health professionals

In 2001, females represented 35% of Queensland's 8,994 medical practitioners (including general practitioners and specialists). Females represented 35.8% of general practitioners, 33.8% of paediatricians, 21% of obstetricians and gynaecologists, and 8.4% of surgeons. In 2001, 87.7% of Queensland nursing workers were female.⁴⁷

vii A relative survival rate is, in this case, a comparison between survival of a person with cancer, and survival for the general population of their age and sex.



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