

## 1.1 Whole of population summary

Health status or levels of ill health and early death depend on a variety of factors or 'determinants' that surround individuals, families and communities. Factors in the socioeconomic and physical environment, as well as early childhood experiences, personal health behaviours and biology, all have a major impact on health.

For the first time in Queensland, *Health Determinants Queensland 2004* combines indicators of the major behavioural, social, economic and environmental determinants of health. This report describes the relationship between health determinants and health outcomes. In doing so, it provides: evidence for investment in population health, both in the health sector and across government; priority areas for investment; and interventions, which can most improve the health of Queenslanders.

In Queensland, as in other developed countries, the greatest burden of ill health is borne by the most disadvantaged groups. As a result, social and economic disparities are one of the major public health challenges confronting the state.

However, the risks to health are not confined to those within the population with the highest levels of health risk factors. Rather, as the level of many health risk factors increase from low to medium to high levels, the risk of ill health or premature death also increases. Key findings of this report underline the gains that can be made by intervening before people reach recognised levels of these risk factors. This is particularly so for coronary heart disease, diabetes, stroke, hip fracture and neural tube defects.

### How healthy are Queenslanders?

- The life expectancy of Queenslanders born in 1999-2001 was 76.9 years for males and 82.5 years for females, similar to that of Australia. Australia has one of the highest life expectancies in the world. In Queensland, premature mortality accounts for 56% of the burden of disease in males and 49% in females, close to that of Australia.
- By and large, Queenslanders were satisfied with their lives and their health. The vast majority of Queenslanders were satisfied with their health and rated their quality of life as good or very good and their health as excellent, very good or good.
- In comparison to Australia, Queensland had higher rates of deaths preventable through primary prevention for females, and potentially avoidable hospitalisations for males and females. Rates of death preventable through secondary and tertiary prevention were somewhat higher in Queensland than the national average. As the highest numbers of avoidable deaths were due to primary prevention, targeted efforts to reduce overweight and obesity levels, increase physical activity and improve diet among men and women would result in significant improvements in health in Queensland.
- Death rates due to coronary heart disease (CHD) in Queensland were the highest of the Australian states. Queensland also has high levels of overweight and obesity, physical inactivity and smoking. About half of the large decline in CHD in recent decades was due to a better control of risk factors: high blood cholesterol, smoking and high blood pressure.
- In recent years, more Queenslanders are experiencing diabetes. In 2000, one in four adults had diabetes or impaired glucose metabolism, which is a major risk factor for diabetes. Risk factors, which can be changed, contribute significantly to the rate of onset of diabetes and its complications.
- Health behaviours such as tobacco smoking, physical inactivity, poor nutrition, and behaviours heading to obesity and high blood pressure, contribute to a sizeable proportion of the total burden of disease.

### Key population groups

The health status of Aboriginal and Torres Strait Islanders, children, young people and older people in Queensland are fully described in the population specific chapters of *Health Determinants Queensland 2004*. Insufficient information is available to describe the health status of culturally and linguistically diverse populations in Queensland.

Indigenous status, the level of socioeconomic disadvantage, and to a lesser extent rural or remote location, all have a major effect on health. However, with current data the effect of each of these factors is unable to be separated from the effect of the other factors. This is because, Indigenous peoples most often live in areas of most socioeconomic disadvantage, and 55% live in rural and remote areas of Queensland. The result is that each of these factors combines and interacts to influence the

health of a particular population. Thus, it is important to be aware that the key health issues for the socioeconomically disadvantaged groups, and rural and remote population groups outlined below, and those for Indigenous peoples, are not independent.

## Males

- The rate of preventable deaths in Queensland males is twice as high as for females. The total burden of disease and injury in males is 17% higher than for females. CHD, stroke, lung cancer and suicide were the top four causes of burden of disease for Queensland males - most of which can be prevented by primary, secondary and tertiary measures.
- Men are more likely to die prematurely than women. In contrast to women, men are more likely to die of lung cancer, colorectal cancer, melanoma, CHD, stroke, suicide, injury and poisoning, road traffic injury, diabetes and chronic obstructive pulmonary disease (COPD).
- Men are more likely than women to have substance abuse disorders, with higher prevalence of harmful and hazardous alcohol consumption and illicit drug use. Males have more deaths and hospitalisations due to hazardous and harmful consumption of alcohol, tobacco smoking and illicit drug use.
- Men are less likely than women to consume sufficient fruits, vegetables and skim or low fat milk and are less likely to 'do the right thing' in the sun. Melanoma incidence and death rates for all Queenslanders are increasing, and men experience more melanoma than women.

## Females

- Women are more likely than men to rate their quality of life as good or very good.
- While women live longer than men, they are more likely to experience and to die from asthma, and to have arthritis, anxiety disorders, affective disorders (including depression) and psychological distress.
- Stroke, CHD, depression and breast cancer were the top four causes of burden of disease for females, much of which can be prevented by primary, secondary and tertiary prevention.
- In the last seven years, fewer women have died of breast cancer. This reduction is due to both mammography screening and improved treatment.
- The death rate due to lung cancer is increasing for women, and 20% of women currently smoke. If the rates of smoking among young women are not reduced, lung cancer rates among women will continue to climb.

## Socioeconomically disadvantaged groups

- At least 17% of the total burden of disease and injury in Australia is due to socioeconomic disadvantage. The greatest differences in burden between the least and most socioeconomically disadvantaged groups were for diabetes, intentional and unintentional injuries and mental disorders.
- On every rung up the socioeconomic disadvantage ladder, from least disadvantaged to most disadvantaged, people experience more sickness, shorter life expectancy and poorer health.
- Only 76% of Queenslanders in the most socioeconomically disadvantaged group rate their health as excellent, very good or good, compared with 82% in the least disadvantaged group.
- There were higher death rates due to lung cancer, CHD, injury and poisoning, road traffic injury, diabetes, asthma and COPD in areas of high socioeconomic disadvantage in Queensland, and similarly, these people were more likely to have arthritis.
- Socioeconomically disadvantaged people were less likely to have a functional dentition and more likely to have no natural teeth than those of lower disadvantage.
- In areas of most socioeconomic disadvantage, there were higher death and hospitalisation rates due to hazardous and harmful consumption of alcohol and tobacco smoking, as well as a higher proportion of harmful and hazardous alcohol consumption.
- People in the most socioeconomically disadvantaged areas were more likely to be overweight or obese and physically inactive.
- Women in the most socioeconomically disadvantaged areas are less likely to be screened for cervical cancer.
- People in areas of *low socioeconomic disadvantage* had a higher death rate due to illicit drugs.

## Rural and remote populations

- People living in remote areas of Queensland reported higher satisfaction with life, particularly with safety and feeling part of the community, and were more willing to help each other, compared with urban and rural areas.
- People in remote areas are more likely to die of lung cancer, CHD, stroke, suicide, injury and poisoning, road traffic injury, diabetes, asthma and COPD.
- In remote areas, there were higher death and hospitalisation rates due to hazardous and harmful consumption of alcohol and tobacco smoking, as well as a higher proportion of harmful and hazardous alcohol consumption.
- People in remote areas were more likely to be overweight or obese, and physically inactive.
- Healthy food costs more in remote areas of Queensland.
- In *accessible* areas, people were more likely to die or be hospitalised due to illicit drugs.

## Overseas-born people

- Very little is known of the health of overseas-born people in Queensland.
- People born overseas were less likely to rate their health as excellent or very good, compared with other Australians.
- People born in the South Pacific regions, the Middle East/North Africa, Southern Asia and Southern Europe were more likely to have diabetes.
- People born in Asia were less likely to be overweight or obese than the other Australians.
- Females born in Asia were less likely to smoke tobacco than other Australians.

## What are the health determinants impacting on the health of Queenslanders?

Health determinants can be broadly divided into:

- ‘upstream’ (education, employment, income, living and working conditions);
- ‘midstream’ (health behaviours and psychosocial factors); and
- ‘downstream’ (physiological and biological factors).

In this report, ‘upstream’ determinants are addressed in environmental and socioeconomic factors, and ‘midstream’ determinants in community capacity and health behaviours. The downstream effects are addressed through health behaviours.

These health determinants have short, medium and long term impacts on the overall health of individuals and populations, specifically rates of hospitalisation and death. Actions to address these determinants are described in this report. Such actions themselves will have short and long term impacts.

## Environmental factors

- Basic healthy food costs more in rural and remote areas of Queensland. In 2001, the cost of a basket of healthy food was 24% higher in the very remote areas compared with highly accessible areas of the state.
- Food safety is critical to human health and wellbeing. In 2002, 26% of food businesses in Queensland had a food safety program and 64% had adequate hand washing facilities.
- Less than 5% of Queensland people had satisfactory water fluoride levels, compared with 69% of Australians.
- Many injuries to adults and children occur in the home. Two thirds of Queensland households had smoke alarms or detectors, two thirds had a circuit breaker on the electrical system and half had adjustable hot water thermostats.
- Ambient air quality in Queensland is generally very good. In 2002, the maximum levels for carbon monoxide and nitrogen dioxide concentration were not exceeded, although ozone levels were more variable. There were a number of days where atmospheric fine particles exceeded the desired level (these mainly resulted from dust storms and bush fires).

## Socioeconomic factors

- In 2000, the weekly income of one in three men and one in two women was less than \$300. The median gross weekly income of one parent households was \$386 and was two and a half times lower than for couple-with-dependants households (\$933). Forty three percent of Queensland households reported some difficulty in making ends meet.
- There were inequalities in income in Queensland, particularly for women, people aged 15-24 years and 65 years and older, and one parent family households. Indications are that income inequality has increased in the last decade. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole.
- Forty one percent of Queenslanders had post school qualifications, compared with 44% nationally. Queenslanders with low educational attainment are more likely to be unemployed, experience socioeconomic disadvantage and, therefore, to suffer poorer health and premature death than those with high levels of education.
- Socioeconomically disadvantaged people felt less able to influence government and had lower access to transportation, including access to motor vehicles.

## Community capacity

- Generally, Queenslanders are a caring people. They report high levels of social support, willingness to help one another, caring for others, volunteerism and civic participation.
- Queenslanders with higher social capital were more likely to rate their quality of life as good or very good, their health as excellent, very good or good, to be satisfied with their health, and to have good health behaviours.
- Most Queenslanders felt in control of the decisions that affect their lives.
- One in ten Queenslanders live alone, and the average number of people in each house is expected to decrease by 2021. In 1996, 19.8% of Queensland children lived in one parent families and, by 2021 this is expected to increase to up to one in three children.
- In 2001, 24,569 people in Queensland were homeless, where 50% were less than 24 years and 10% less than 12 years of age.
- Women are less likely than men to feel safe either during the day or at home after dark.

## Health behaviours

- In 1999-2001 tobacco smoking caused 3,402 deaths (19% of all male deaths and 10% of all female deaths) and 30,453 hospitalisations each year. One quarter of males and 20% of females smoke daily. One in eight youths aged 14-17 smoke daily.
- In 2001, levels of physical inactivity increased to 55%. Rates of physical activity drop as age increases and males are more active than females. In 1999-2001, insufficient physical activity caused 646 deaths and 7,004 hospitalisations each year.
- More than half of adult Queenslanders are overweight or obese. If current trends continue, three of four Australians will be overweight or obese by 2020.
- In 1999-2001, there were 812 deaths and 20,912 hospitalisations due to hazardous and harmful alcohol consumption each year. Suicide was the leading cause of such deaths. In 2001, 28% of male and female adults, and 25% of young males and 45% of young females aged 14-17 years drank hazardous or harmful levels of alcohol.
- In 2000 in Queensland, 16% of adults had untreated and 12% treated hypertension.
- Queenslanders consume too few fruits and vegetables.
- Increasing breast and cervical cancer screening will result in immediate health gains.
- In 1999-2001, illicit drug use caused 94 deaths and 4,187 hospitalisations each year, mostly in the 15-49 year age group.

Evidence-based strategies, which address the determinants of health, have the potential to reduce the burden of ill health and premature death in the lives of all Queenslanders, particularly those who are most disadvantaged.