

5.5.4 Health behaviours

“It makes little sense to expect individuals to behave differently from their peers; it is more appropriate to seek general change in behavioural norms and in the circumstances which facilitate their adoption ”

Geoffrey Rose 1992⁸⁹

High quality risk factor data was collected in the Well Persons' Health Check (WPHC), a survey conducted in 26 rural and remote Indigenous communities between 1998 and 2000.⁶⁴ Data from this survey may be compared with that from the Australian Diabetes, Obesity and Lifestyle Study, 2000 (AusDiab).⁹⁰ This comparison is tabulated as age adjusted relative risks in Table 5.14. As an example in the interpretation of this data, the first cell shows that Aboriginal females were 1.52 times as likely to be obese (BMI > 30) than the predominantly non-Indigenous population surveyed in AusDiab.

Diabetes and obesity were more prevalent in Torres Strait Islanders than in Aborigines, while smoking was more common among Aborigines than amongst Torres Strait Islanders. For both Indigenous groups the prevalence of diabetes, obesity, dyslipidaemia, hypertension and smoking was significantly higher than in the AusDiab sample. However, prevalence of impaired glucose tolerance (IGT) in the WPHC was significantly lower than in the AusDiab sample, indicating a high conversion of people at risk to diabetes. This is similar to data presented from later in the diabetes epidemic in parts of the developing world.⁹¹

Smoking rates in the non-remote Indigenous sample of the National Health Survey of 2001 were also high (Figure 5.61). As discussed in the *Whole of population* chapter, smoking is a risk factor that has a clear social gradient, with disadvantaged people more likely to be smokers. We have also shown that Indigenous Queenslanders are more likely to be socially disadvantaged. In order to assess the extent of excess smoking prevalence that may be attributed to socioeconomic disadvantage, we applied the non-Indigenous SEIFA specific smoking prevalences to the SEIFA profile of the Indigenous population. Doing this, we calculate a predicted smoking prevalence for the Indigenous population, based on SEIFA profile, of 19.5%. This falls far short of the prevalence found in the 2001 NHS of almost 50%. This suggests that the excess smoking prevalence found in Indigenous Queenslanders cannot be solely explained by socioeconomic disadvantage.

Aboriginal and Torres Strait Islander people are less likely to be drinkers than non-Indigenous Australians. However, a high proportion of Aborigines and young Torres Strait Islanders who drink, do so at risky or high risk levels (Table 5.15, Table 5.16, Table 5.17).

The data from the ABS National Health Survey indicate that Indigenous Australians are slightly more likely to be sedentary (Figure 5.62). Fruit and vegetable consumption was low among WPHC participants, who were primarily from remote areas in Queensland. The consumption reported by the AIHW for non-remote Indigenous and non-Indigenous people were similar (Figure 5.63, Figure 5.64). The comparability of the WPHC and AIHW study methods has not been. In Australia in 1996, inadequate fruit and vegetable consumption were estimated to cause 3.0% of the total burden of disease for males and 2.4% for females.³⁵ This was based on a recommended consumption of two serves of fruit and three serves of vegetables. However the 1999 Australian Guide to Healthy Eating recommends for adults two serves of fruit (300g) and five serves of vegetables (375g) daily for optimum health benefits.⁹²

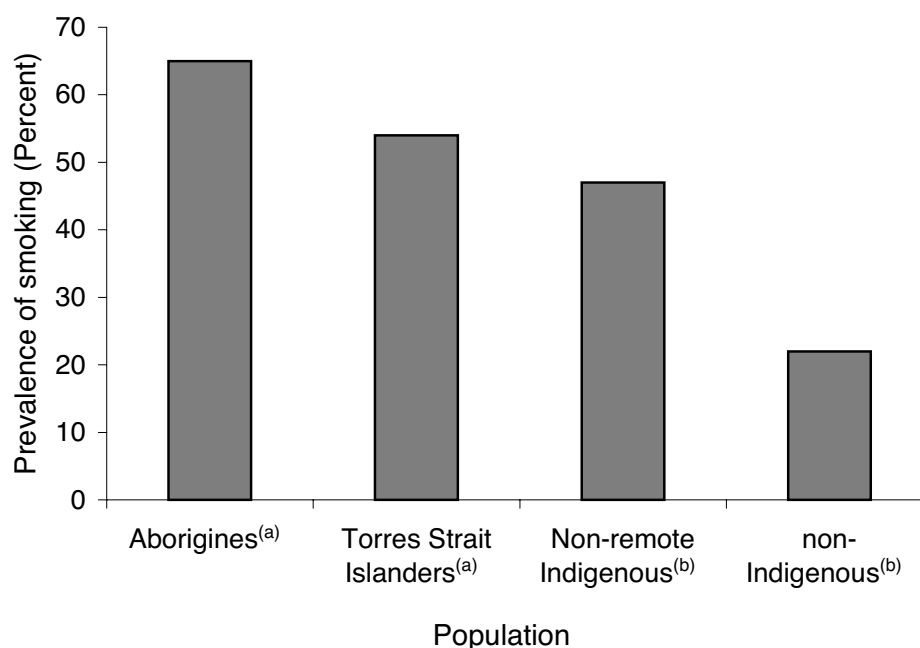
Fruit and vegetables enhance health because of their high fibre content, their micronutrient content, and because a higher intake of fruit and vegetables displace substances like saturated fat. There is very good evidence that people who regularly eat diets high in fruit and vegetables, including legumes, have substantially lower risks of CHD, stroke, several major cancers and possible hypertension, type 2 diabetes, cataract and macular degeneration of the eye.^{92,93} The risk of CHD is not confined to populations who do not consume the recommended quantity of fruits and vegetables.⁵¹ Rather, the risk of CHD decreases linearly with increasing consumption from 0.5 to 4.5 serves per day.

Self reported fruit and vegetable consumption in remote Aborigines and Torres Strait Islanders is very low. This may be related to the excess cost of fruit and vegetables in remote communities (Figure 5.53).

Table 5.14: Comparison between prevalence of risks found in the WPHC and Ausdiab, adjusted for age using Indirect Standardised Ratios (relative risks)

Risk	Aborigines		Torres Strait Islanders	
	Females	Males	Females	Males
BMI \geq 30	1.52 (1.32-1.75)	0.81 (0.65-1.36)	3.24 (2.86-3.66)	2.62 (2.27-3.19)
Diabetes	5.00 (4.23-5.87)	2.84 (2.27-4.36)	6.60 (5.50-7.85)	4.13 (3.36-5.90)
IGT	0.33 (0.20-0.51)	0.67 (0.44-0.62)	0.28 (0.14-0.50)	0.40 (0.20-0.49)
Dyslipidaemia	1.24 (1.12-1.37)	1.08 (0.97-1.23)	1.26 (1.10-1.43)	1.21 (1.08-1.35)
Hypertension	1.64 (1.87-2.13)	1.51 (1.31-1.84)	1.79 (1.51-2.11)	1.92 (1.67-2.09)
Smoking	3.75 (3.38-4.16)	3.66 (3.32-3.94)	2.91 (2.49-3.39)	2.77 (2.42-3.14)

Source: Well Person's Health Check, 1998-2001⁶⁴. Reference data source: Australian Diabetes, Obesity and Lifestyle Study, 2000⁹⁰

Figure 5.61: Prevalence of tobacco smoking, by ethnic category

Source: (a) Well Persons' Health Check, 1998-2001⁶⁴
(b) ABS National Health Survey: Aboriginal and Torres Strait Islander Results, Australia 2001⁹⁴

Table 5.15: Prevalence of alcohol consumption, by age and ethnicity.

Age group	Aborigines ^(a)	Torres Strait Islanders ^(a)	Indigenous ^(b)	Non-Indigenous ^(b)
18-24	57%	60%	61%	67%
25-34	64%	39%	55%	73%
35-44	64%	35%	63%	77%
44-54	58%	31%	54%	77%
55+	33%	12%	29%	67%

Source: (a) Well Persons' Health Check, 1998-2001⁶⁴
(b) ABS National Health Survey: Aboriginal and Torres Strait Islander Results, Australia⁹⁴

Table 5.16: Prevalence of risky or high risk alcohol consumption, by age and ethnicity.

Age group	Aborigines ^(a)	Torres Strait Islanders ^(a)	Indigenous ^(b)	Non-Indigenous ^(b)
18-24	27%	25%	6%	15%
25-34	41%	10%	19%	14%
35-44	38%	9%	23%	14%
44-54	29%	8%	28%	14%
55+	15%	1%	11%	11%

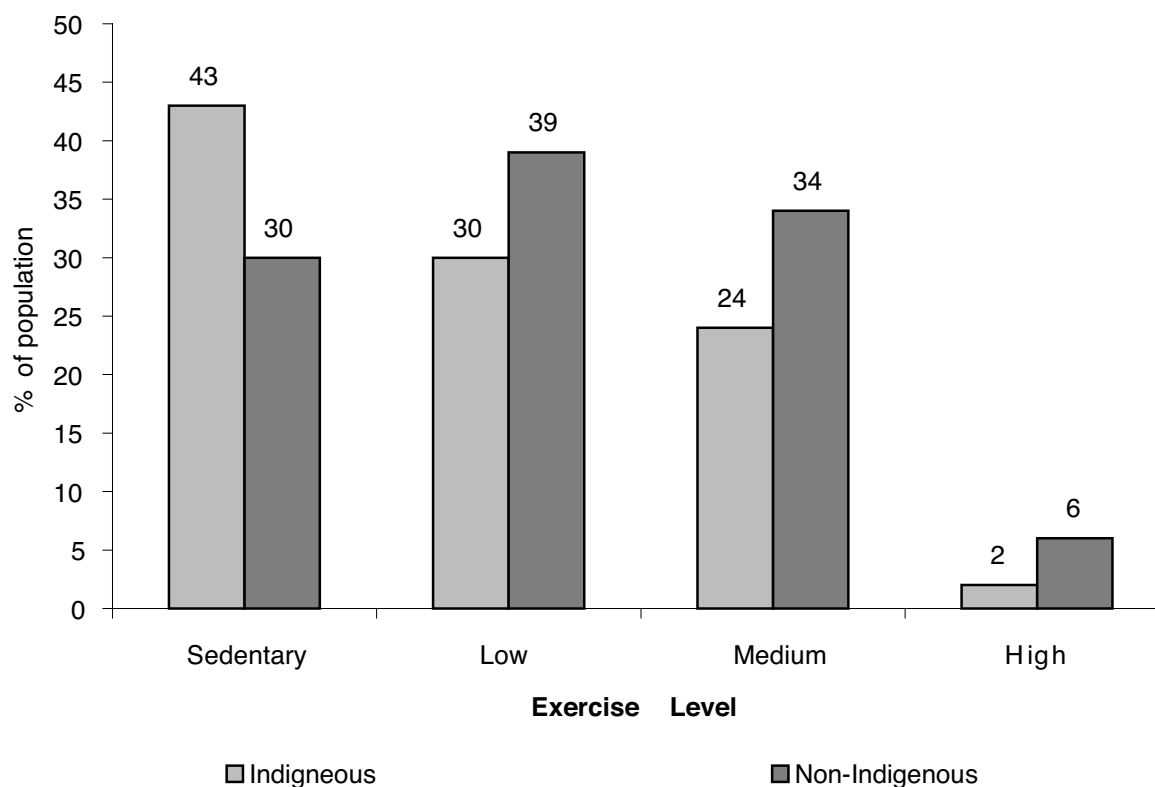
Source: (a) Well Persons' Health Check, 1998-2001⁶⁴
(b) ABS National Health Survey: Aboriginal and Torres Strait Islander Results, Australia⁹⁴

Table 5.17: Proportion of drinkers who do so at risky or high risk levels, by age and ethnicity

Age group	Aborigines (a)	Torres Strait Islanders (a)	Indigenous (b)	Non-Indigenous (b)
18-24	47%	42%	10%	22%
25-34	64%	26%	35%	19%
35-44	59%	26%	37%	18%
44-54	50%	26%	52%	18%
55+	45%	8%	38%	16%

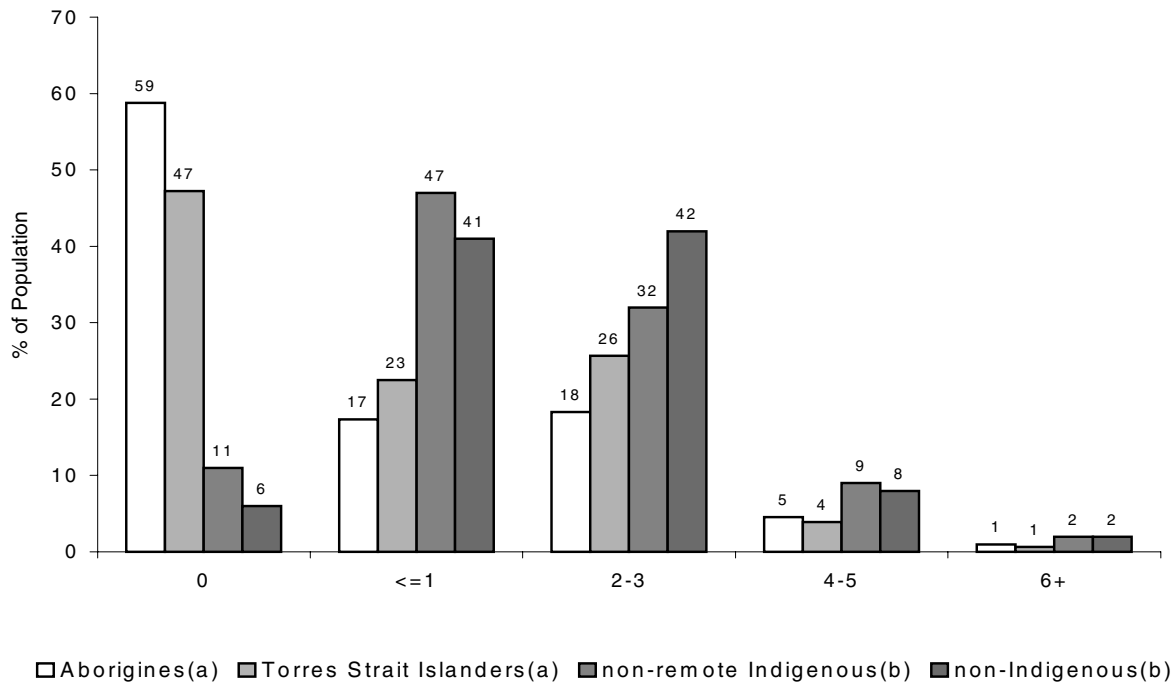
Source: (a) Well Persons' Health Check, 1998-2001⁶⁴
 (b) ABS National Health Survey: Aboriginal and Torres Strait Islander Results, Australia⁹⁴

Figure 5.62: Self reported exercise levels, by ethnicity



Source: ABS National Health Survey: Aboriginal and Torres Strait Islander Results, Australia³⁹

Figure 5.63: Self reported daily fruit consumption, by ethnicity



Source: (a) Well Persons' Health Check, 1998-2001⁶⁴
 (b) ABS The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples⁹⁵

Figure 5.64: Self reported daily vegetable consumption, by ethnicity



Source: (a) Well Persons' Health Check, 1998-2001⁶⁴
 (b) ABS The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples⁹⁵