



Men's Health in Queensland

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Key Findings

In 1994 males in Queensland experienced:

- A shorter life expectancy than females (males 75.0 years, females 80.9 years);
- Higher overall rates of hospitalisation than females (excluding complications of pregnancy, childbirth and puerperium), with the excess relating to injuries and disorders of the circulatory and respiratory systems; and
- Higher death rates than females (122 male deaths for every 100 female deaths), with the age-standardised ratio of male to female deaths being highest for injuries (2.68 - including over four times the number of female suicides), respiratory conditions (2.18), neoplasms (1.77) and circulatory conditions (1.49).

Despite the foregoing, men rate their health status higher than women as measured by the SF-36 self-perceived health questionnaire. This result highlights the paradox that exists between men's perception of superior health status and their higher morbidity and mortality. It is also a possible explanation as to why men do not seek medical advice or express interest in their own health with the same propensity as their female counterparts.

Queensland men, over 18 years of age, adopt high-risk lifestyles in regard to the major risk factors for morbidity and mortality:

- Twenty-eight per cent of men smoke - 2,300 male deaths, 17,000 hospitalisations and 11,372 years of potential life lost are attributed to smoking each year;
- Approximately one-quarter (26%) of males consume sufficient alcohol to place them at moderate to high risk of harm;
- Forty-seven per cent of males are overweight or obese, 39% have a slight pot belly and 4% a large pot belly. Just over one in four (28%) do not trim the fat off meat or chicken, while 56% and 84% eat less than the recommended amount of fruit and vegetables, respectively;
- Over one-third of men do not wear a hat in summer and almost two-thirds do not use sunscreen;
- Nearly half do not undertake moderate exercise and two-thirds do not do vigorous exercise; and
- Prevalence of high-risk lifestyles is higher in low socio-economic groups.

Men of low socio-economic status suffer poorer health (based on hospital separations) relative to other men in Queensland.

Aboriginal and Torres Strait Islander men have death rates estimated to be 2.7 times higher than the general community. Hospitalisation rates are also higher: hypertension (13 times the total Queensland male rate), followed by pneumonia and diabetes (both 6 times higher), cirrhosis of the liver (5 times higher), bronchitis, emphysema and asthma, and suicide (both 4 times higher), and alcoholism (3 times higher).

Men living in remote areas of the state have levels of hospitalisation up to 47% higher than the Queensland average (for public and private hospitals combined).

Introduction

Approximately 125 male fetuses are conceived for every 100 female fetuses, and 106 live male babies are born for every 100 female babies. Almost 33% more boys than girls die in the first year of life, and an equal sex ratio does not occur until 18, when 100 young men are alive for every 100 young women. This ratio steadily decreases so that by the age of 87, only one man is alive for every two women. For those fortunate enough to celebrate a century of life, only one man is alive for every five women (Williams, 1983¹).

These differences in male survival, from conception onwards, highlight the suboptimal nature of men's health and excess mortality from injury and accident. In almost every aspect of health, men compare unfavourably with women in terms of the adoption of a high-risk lifestyle and inadequate preventive health measures.

This document summarises the state of men's health in Queensland. Male morbidity and mortality are defined along with a look at specific men's health issues. Differences in health status among men due to socioeconomic status and place of living are identified. The major risk factors responsible for preventable disease are discussed and the health status of target groups in the men's community are addressed.

Male/Female comparisons

It has been long recognised that the health status of men and women differ². These differences, it has been proposed, may result from differences in genetics and biology as well as behavioural and occupational exposures which together lead to excess morbidity and premature death. The evidence for genetic weakness is apparent across all animal species and is supported in humans by the higher male death rates *in utero* and from Sudden Death Infant Syndrome. These early deaths occur well before gender differences in behaviour could be expected to be significant.

It is apparent that men do not seek medical advice as frequently as women, but beyond age 54 the rate of hospitalisation exceeds that of women. Psychologists³ have proposed that this propensity of men to not recognise and deal with illness until their condition is serious is related to aspects of masculinity and gender stereotyping.

Life expectancy

The life expectancy of an Australian male born in 1994 is 75.0 years whereas that of a female is 80.9 years⁴. The gap between male's and female's life expectancy increased gradually from the beginning of the century up until 1980. Since that time the gap has decreased and, in 1994, was 5.9 years (Figure 1).

It has been estimated that females have a genetic advantage of about two years of life over males⁵. The remaining differences are attributed to behavioural and lifestyle differences. The reduction in the difference in life expectancy between men and women since 1981 is attributed to reduced motor vehicle fatalities in young males and a decrease in deaths from heart disease in older males⁴.

Hospital separations

Hospital usage (morbidity) is measured by separations, which are defined as hospital discharges plus transfers and deaths. The separation rates for males during 1993/94 exceeded those of females in the 0 - 14 and 55 years and over age groups, with the greatest difference experienced by the 75 to 79 years age group where the male rates were nearly 50% higher than the females (884 and 598 separations per 1,000 population, respectively)⁶.

Females accounted for more total hospital separations than males (291 and 250 separations per 1,000 population, respectively) (Figure 2). However, excluding complications of pregnancy, childbirth and puerperium, male hospital separation rates were marginally higher than females (250 and 244 separations per 1000 population, respectively). Females still experienced higher rates between 15 to 54 years of age, but the differential was not as pronounced as when all disease classifications were included (Figure 3).

Using the standard ICD-9-CM system of classification of separations, the top five causes of hospitalisation for men, in decreasing order of importance, were diseases of the digestive system, injuries, circulatory conditions, neoplasms and respiratory conditions (Figure 4). The major conditions relating to excess hospitalisation for males were injuries, circulatory and respiratory conditions, and neoplasms.

Self-perceived general health status

A measure of self-perceived health status, used recently in Queensland, is the SF-36 questionnaire. The SF-36 measures the following eight dimensions of self-perceived health: physical functioning, role limitations due to physical problems, bodily pain, general health, vitality, social functioning, role limitations due to emotional problems, and mental health.

In the 1994 Queensland Health Status Survey, with the exception of general health, males rated higher than females for each of the health dimensions (Figure 5)⁷. This result highlights the paradox that exists between men's perception of superior health status and their higher morbidity and mortality. It is also a possible explanation as to why men do not seek medical advice or express interest in their own health with the same propensity as their female counterparts.

Deaths

In 1994, in Queensland, there were 122 male deaths for every 100 female deaths⁸. However, after age-standardising data from 1992 to 1994, this difference increased to 164 male deaths for every 100 female

deaths⁹, highlighting the higher age-specific death rates experienced by males. The age-standardised ratio of male to female deaths over this period was greatest for injuries (2.68), respiratory conditions (2.18), neoplasms (1.77) and circulatory conditions (1.49) (Figure 6). Within the injuries category, the number of males who committed suicide was more than four times the number of females.

The difference in mortality varies across the age groups, with peaks in early adulthood (over three times the female rate) and in later life when heart disease and cancer are prominent (two times the female rate)(Figure 7)⁸. Only in the 1 - 9 years age group are the death rates similar.

Causes of death⁹

The major causes of death in 0 - 4 year old males are, in decreasing order of importance, perinatal conditions, congenital abnormalities, motor vehicle accidents, drowning, diseases of the nervous system, and other accidental causes of death. Perinatal conditions and congenital abnormalities make up the bulk of deaths in this age group. Females in this age group have lower death rates from all these conditions except nervous system, where they are comparable (Figure 8).

In the 5 - 14 years age group, the male age-specific death rates are highest for motor vehicle accidents, cancer, other accidents and drowning. The former two account for most deaths. The greatest disparity between the sexes in this age group is drowning (Figure 9).

The male age-specific death rates rise dramatically in the 15 - 24 years age group. Most deaths result from motor vehicle accidents, suicide and other accidents. The female death rates for these causes are only 37%, 25% and 29% as high as their male counterparts, respectively (Figure 10).

More males in the 25 - 44 years age group die from suicide than any other cause. Cancer and diseases of the circulatory system rank next in importance, followed by motor vehicle accidents and other accidents. Females in this age group have higher death rates from cancer but, overall, their death rate is half that of the males (Figure 11).

Cancer and circulatory system diseases are the major causes of male deaths in the 45 - 64 years age group, followed by diseases of the respiratory and digestive systems. The greatest differences between men and women in this age group are seen in the death rates for suicide, and diseases of the circulatory and digestive systems (Figure 12).

In the over 65 years age group, most male deaths are caused by circulatory system disease and cancer, followed by respiratory, digestive and endocrine conditions. Female age-specific death rates for cancer and respiratory conditions are approximately half those experienced by males (Figure 13).

Exposure to risk factors

The following results are from the 1993 Queensland Regional Health Survey¹⁰, unless otherwise indicated.

Smoking

The most important exposure to a risk factor for disease in males is smoking. Overall, 28% of adult males in Queensland smoke¹⁰. A small proportion (6%) of school-aged boys have commenced smoking by age 12 and this proportion rapidly increases by age 15 (27%) (Figure 14)¹¹. The proportion of males who currently smoke peaks in the 18 - 29 years age group (33%), but declines after 30 years of age¹⁰.

By apportioning the contribution of smoking to the cause of various diseases (using aetiological fractions), it is possible to estimate the total harm which can be attributed to smoking. In 1993/94, smoking was responsible for the deaths of 2,300 Queensland males, 17,000 hospitalisations, and 11,372 years of potential life lost⁹, with the principal causes being cancer and heart disease.

Alcohol consumption

Overall, 61% of Queensland adult males drink alcohol at least once per week¹⁰. Alcohol consumption is common in school-aged boys with one-quarter of 13 year olds and one-third of 15 year olds drinking alcohol on at least a weekly basis¹¹, increasing to a maximum of 66% in the 30 - 39 years age group (Figure 15).

Just over one in four males (26%) aged 18 years or over consume sufficient alcohol to place them in the moderate to high risk of harm category as classified by the World Health Organisation Alcohol Use Disorders Identification Test. In comparison, only 7% of females are in the moderate to high risk of harm category¹⁰. Heavy drinking is most common for males aged 18 - 30 years, but then decreases with age after this.

Food habits¹⁰

- Twenty-eight per cent of males aged 18 years or over do not trim the fat off meat or chicken;
- Fifty-six per cent eat less than the recommended two pieces of fruit, on average, per day;
- Eighty-four per cent eat less than the recommended

- five serves of vegetables, on average, per day; and
- Twenty-nine per cent of males in the 1993 Regional Health Survey reported consuming takeaway food at least once on the day before the survey.

Overweight and obesity¹⁰

- Forty-seven per cent of males aged 18 years or over are overweight or obese (Figure 16); and
- Thirty-nine per cent have a slight pot belly and 4% have a large pot belly.

Sun¹⁰

- Thirty-eight per cent of men over 18 years of age do not wear a broad-brimmed hat always or often when outdoors in summer, while 56% do not in winter;
- Sixty-two per cent do not use sunscreen always or often in summer and 86% do not in winter;
- Thirty-two per cent do not regularly check their skin for any changes; and
- Fifty-four per cent had not had a skin examination by a doctor or nurse within the 12 months prior to the 1993 Regional Health Survey, including 34% who had never had a skin examination.

Exercise¹⁰

- Forty-eight per cent of men aged 18 years or over did not undertake moderate exercise in the two weeks prior to the 1993 Regional Health Survey, while 68% did not do any vigorous exercise during this period.

Specific Conditions of Males

Prostate cancer

Cancer of the prostate is one of the most common forms of cancer in men. For the four years from 1991 to 1994, there were an average of 418 deaths each year from prostate cancer in Queensland, which equated to a standardised death rate of 35 per 100,000⁹.

The Australian Health Technology Advisory Committee is reviewing the evidence on benefits, risks and costs of screening but because, at this time, it is not clear if the potential benefits outweigh the potential side effects of treatment, screening for prostate cancer is not advocated¹².

It is difficult to distinguish slow-growing prostate cancers from malignant ones, and while there has been an improvement in sensitivity of diagnostic tests recently (serology and ultrasound), treatment outcomes can be unfavourable with consequent loss of quality of life from such sequelae as incontinence and impotence. As many of the newly-diagnosed, asymptomatic cases would not

have been detected if not for improved diagnostic capabilities, the surge in the incidence of the disease may not be as great as is apparent from the figures. With the aging of the male population, we can expect the number of new cases to increase as prostatic cancer, as well as enlargement, is more common in older men¹².

HIV/AIDS

Although HIV/AIDS affects both sexes, it is a disease predominantly of men. By June 1996, there had been a total of 622 deaths from AIDS in Queensland, of which 94% (587) were male¹³.

In 1995, there were 77 male deaths from AIDS. This was the first time that the number of deaths showed a decrease from the previous year since records commenced in 1984¹³ (Figure 17).

The number of AIDS notifications first diagnosed in Queensland has remained fairly constant since 1991, although the total number of AIDS notifications continues to rise due to interstate migration, as well as Queensland residents who are initially tested and diagnosed outside of the state.

Of the 96 male AIDS notifications in 1995/96, 82% were men who had sex with men, 6% were men who had sex with men and were also injecting drug users, and 3% were either men with haemophilia or heterosexual injecting drug users. For the remaining 9%, data on the source of the infection was unavailable¹³.

Mental Health

- Men suffer from mental illness at approximately the same rate as females, although the pattern of illness is somewhat different¹⁴;
- The prevalence of serious disorders, such as schizophrenia, is similar, but differences between the sexes exist for less severe mental disorders. Conditions more common in men include alcohol and other drug abuse, and antisocial personality disorders, while women have more anxiety, depression and eating disorders^{14,15};
- In childhood, the rate of mental health problems in boys is approximately twice that of girls¹⁴;
- Homosexual and heterosexual men do not differ on mental health measures or in suicide rate¹⁴;
- Aboriginal men are at greatly increased risk of alcohol abuse and depression, but have poor utilisation of existent services¹⁶; and
- Factors that have been identified as contributing to male mental illness include unemployment, hazardous occupations, separation and divorce, homelessness and war¹⁴.

The utilisation of mental health services exhibits the same gender paradox evident for other types of ill-health. Women are more likely than men to use mental health services although the prevalence of mental illness is similar. Only for inpatient psychiatric services, for people with severe mental disorders, is the sex ratio similar.

There is little data available on the mental health status of males in Queensland. A national survey, by the Commonwealth Department of Human Services and Health, of mental health and well-being is planned for 1997. This will provide the first Australian estimates of the prevalence of the main categories of mental disorders and the amount of associated disablement. Until this information becomes available, it is necessary to rely on estimates, many of which are based on American data.

It has been estimated that each year 3% of Australians experience a serious mental illness¹⁷. This equates to about 46,000 Queensland males. Additionally, extrapolating from USA mental illness prevalence estimates, around 22% of the population experience some form of mental health problem each year¹⁸.

The self-assessed health status of Queenslanders was measured in the 1994 Queensland Health Status Survey using the SF-36 instrument⁷. For the mental health scale, adult males reported significantly better mental health than adult females (Figure 5).

Suicide is listed under "injuries" in the International Classification of Disease but is commonly considered a component of mental health.

- Males currently account for 80% of all suicide deaths in Queensland⁴;
- Suicide has been an increasing problem for young Australian males since the 1950s, while the rate for older men has decreased over this time period, stabilising in recent years¹⁹. In 1992-94 the suicide rate for Queensland males aged 20 to 24 years was 37 per 100,000, decreasing to between 23 to 30 per 100,000 for males aged 25 - 74 years⁹ (Figure 18). The suicide rates for females are much lower, around 7 per 100,000;
- Although the suicide rate is much higher for males than females, there were 25% more hospital admissions for attempted suicides for females compared to males in Queensland between 1992 and 1994⁹;
- These higher rates of female admissions for attempted suicide are due to females choosing to use poison as their most common method of suicide, which is in contrast to males who choose more aggressive means. Fifty-nine per cent of male suicides in Queensland between 1992 and 1994 were by firearms

or hanging, whereas only 23% of female suicides occurred in this manner⁹; and

- With the exception of the 15 - 24 and 75 - 79 years age groups, suicide prevalence in both sexes in 1992 - 94 was lower than in 1986 - 88. The rates for males aged over 80 years are very high, but as the population size is small, these rates are unstable⁹ (Figure 18).

Health status differences due to socioeconomic status

The Australian Bureau of Statistics (ABS) has derived five summary indexes from the 1991 Population Census to measure different aspects of socioeconomic conditions by geographic areas. Together, these indexes make up the Socioeconomic Indexes for Areas (SEIFA). The Index of Relative Socioeconomic Disadvantage is used in this publication. It is a general socioeconomic index summarising variables such as income, educational attainment, occupation and labour force status of people in households in defined areas. Areas which have low scores on this index tend to have high proportions of people with low incomes, low educational attainment and high unemployment.

Hospital separation rates for Queensland males in 1993/94, for public and private hospitals combined, increased steadily as socioeconomic disadvantage increased. This gradient was more pronounced for public hospital separations, with the least disadvantaged hospitalised 25% less than the Queensland average, and the most disadvantaged hospitalised 33% more than the average for Queensland (Figure 19).

In the 1994 Queensland Health Status Survey, using the SF-36 instrument, the following associations between socioeconomic status and health were found:

- Men whose annual household income was less than \$20,000 had the lowest perceived health status (as measured by mean scores) for all dimensions (Figure 20). As household income increased, there was an increasing trend in the perceived health status for all eight dimensions;
- Men whose highest level of education was "less than senior" had significantly lower perceived health status than those with higher levels of education for all dimensions, except role limitations (emotional) and mental health (Figure 21);
- Men who were employed (either full-time or part-time) had significantly higher perceived health status for all eight dimensions of the SF-36 compared to those who were not employed (Figure 22); and
- Men who were separated, divorced or widowed had

the lowest perceived health status for all dimensions, whereas those who had never married had the highest perceived health status for physical functioning, role limitations (physical), bodily pain, general health and vitality, and those who were married/de facto had the highest perceived health status for social functioning, role limitations (emotional) and mental health (Figure 23).

Health status differences due to rural/urban place of living

The Commonwealth Department of Human Services and Health has developed a Rural and Remote Areas (RaRA) classification system for classifying Statistical Local Areas (SLAs) across Australia to urban, rural or remote areas.

Combining information from both public and private hospitals, hospital separations for city and urban males were slightly below the Queensland average (Figure 24)⁶. Men in remote areas had higher than average separations, and these were primarily accounted for in public hospitals where separations were up to 84% higher than the Queensland average.

An examination of the major conditions and disease groups requiring admission to hospital showed that for all conditions, except cancer, the pattern of increasing hospitalisation with increasing remoteness was similar. The most remote areas had higher hospitalisation rates for cancer, but the other areas showed no obvious trends⁹.

In the 1994 Queensland Health Status Survey, using the SF-36 instrument, the following associations between rurality and health were found⁷:

- Men in the remote major area (i.e. Mt Isa) had the highest mean scores for all dimensions except for role limitations (emotional) and mental health; and
- Men in all other RaRA categories tended to have similar mean scores within each dimension (Figure 25).

Target groups among men

Aboriginal and Torres Strait Islanders

Aboriginal and Torres Strait Islander men suffer a much lower health status than other men in the Queensland community. Age-standardised death rates are estimated to be 2.7 times higher for Aboriginal and Torres Strait Islander men compared to total Queensland⁹, and hospital separation rates (discharges plus transfers and deaths) for most conditions are many times higher than the Queensland average²⁰.

Hospital separation rates for selected conditions for

indigenous people living in areas with greater than 50% Aboriginal and Torres Strait Islander population (i.e. the far north and west of the State) are presented in Figure 26. The higher likelihood of accurate identification of Aboriginal and Torres Strait Islander ethnicity in hospital records was the reason these areas of the State were chosen. Rates were highest for hypertension (13 times higher than the total Queensland male rate), followed by pneumonia and diabetes (both 6 times higher), cirrhosis of the liver (5 times higher), bronchitis, emphysema and asthma, and suicide (both 4 times higher), and alcoholism (3 times higher)⁷.

Many of the risk factors for ill-health and premature death are more prevalent among indigenous men than in the general male community. For example:

- Fifty-three per cent of Aboriginal and Torres Strait Islander men smoke²⁰ compared to 28% of the general male population in Queensland¹⁰;
- The proportion of Aboriginal and Torres Strait Islander men over 15 years of age who reported drinking alcohol within the past week (52%)²⁰ was lower than the reported rate for the general male population of Queensland aged over 18 years (73%)²¹; however,
- Twenty-three per cent and 45% of indigenous drinkers consume hazardous and harmful quantities of alcohol respectively, whereas the corresponding proportions of men who drink alcohol at these risk levels in the general Queensland population is 12% and 11%, respectively²².

There are higher rates of overweight and obesity among Aboriginal and Torres Strait Islander men than were found in the Regional Health Survey for all Queensland males (Figure 27).

- Twenty-one per cent of Aboriginal and Torres Strait Islander men consume moderate to high levels of fat, and a further 4% consume high levels of fat²⁰; and
- Thirty per cent consume moderate to high levels of sugar and a further 12% consume high levels of sugar²⁰.

Men who have sex with men

While there is currently no Queensland data to provide information about this group, a non-random longitudinal study commenced in Sydney in 1992²³ of more than 900 homosexual men suggests that:

- Men who are HIV-positive have medical checkups more regularly than other men;
- Two-thirds (66%) of HIV-positive men consider their

health to be excellent or good, compared with 76% of all men in the Regional Health Survey¹⁰;

- HIV-positive men are more likely to have previously acquired sexually transmitted diseases (Figure 28);
- The study group are more likely to use illicit drugs and more likely to smoke than the general male community; and
- They consume alcohol at the similar levels to the general male population.

However, caution needs to be exercised in extrapolating this information to similar Queensland groups, given differences in the two environments.

Men from non-English speaking backgrounds

About half of the Australian males born overseas come from countries where English is not the main language. These people represented 13% of the male population in the 1991 Census.

There have been no comprehensive studies of ethnic health in Queensland. Until recently, the only information on ethnic health relative to other Australians was from small surveys investigating specific ethnic groups. However, in 1992 the Australian Institute of Health and Welfare undertook a national review of the health of people born overseas relative to Australian-born people²⁴. The results showed that for morbidity and mortality, people born overseas enjoyed better health than people born in Australia, although their level of health became more similar to persons born in Australia the longer that they had been living in this country. The mortality rates were particularly low for Greeks, Italians, Central and South Americans, Vietnamese and Yugoslavs.

Hospitalisations for ischaemic heart disease of men from non-English speaking backgrounds were highest for those born in Egypt, Asia (other than Cambodia, Laos and Vietnam), and the Middle East²⁴.

An analysis of risk factors for cardiovascular disease found that immigrants generally had lower systolic blood pressure but higher body mass index than their Australian-born counterparts²⁵. Male migrants were more likely to smoke and undertake less physical activity than Australian-born males.

For some members of the non-English speaking population, their mental health has been affected by their experience as refugees, personal and cultural loss and as victims of torture and trauma. Cultural differences, language problems and the stigma of mental disease have

been identified as a barrier to help-seeking and service delivery²⁶.

A comprehensive study of the health status of the Vietnamese community in Brisbane, currently underway, will provide one of the few insights available into Queensland ethnic health.

Policy Implications

At the National Men's Health Conference held in Melbourne in August 1995, a focus panel on policy formulation made the following comments¹²:

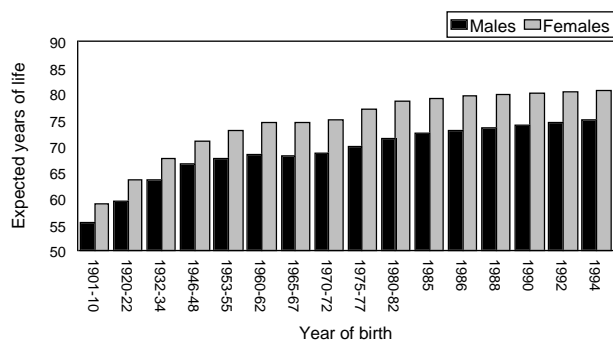
A national men's health policy must extend beyond a focus on medical conditions and address the broader social and environmental issues that impact negatively on men's health. While socialisation was identified as a particularly important issue, other social and environmental issues raised at the conference include poverty, unemployment, occupation and the structure of work, and environmental hazards. The role of the media in shaping the popular image of what it is to be a man was also identified as a significant problem needing to be addressed.

It was also strongly emphasised that particular groups such as Aboriginal and Torres Strait Islander men, men of non-English speaking backgrounds, homosexual men and "grass roots" men's groups must be involved in further work on men's health.

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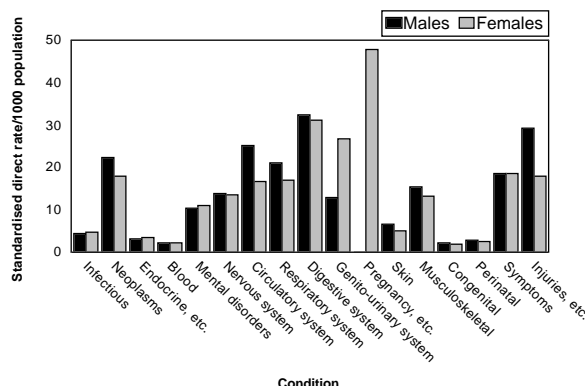
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Figure 1: Life Expectancy for Australians 1901 to 1994



Source: Australian Men & Boys: a picture of health, Fletcher R, 1992

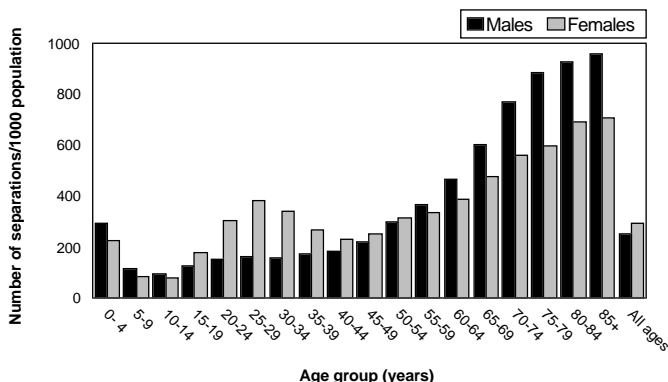
Figure 4: Age standardised separation rates* (total separations), all ages combined, by ICD chapters, Queensland, 1993/94**



* Directly standardised to Australian population 1991
 ** The international classification of diseases 9th revision clinical modification (ICD 9-CM)

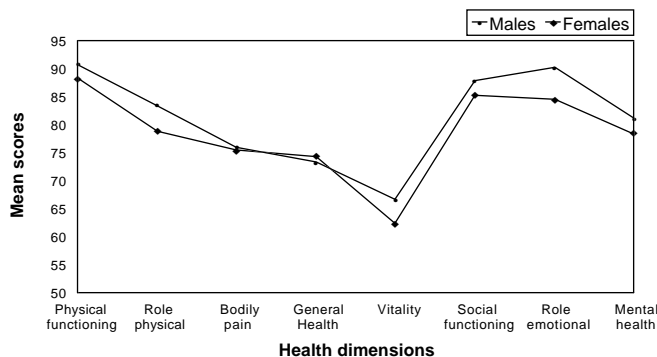
Source: Health Information Centre, Queensland Health, Information Circular No 39

Figure 2: Number of separations per 1000 population, Queensland, 1993/94 by 5 year age groups



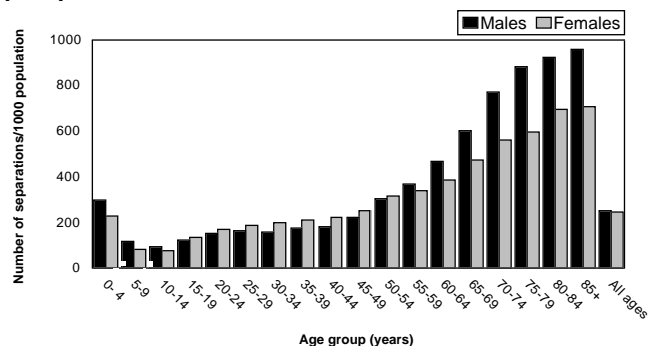
Source: Health Information Centre, Queensland Health, Info Circ 39

Figure 5: Mean SF-36 scores by gender, Queensland, 1994



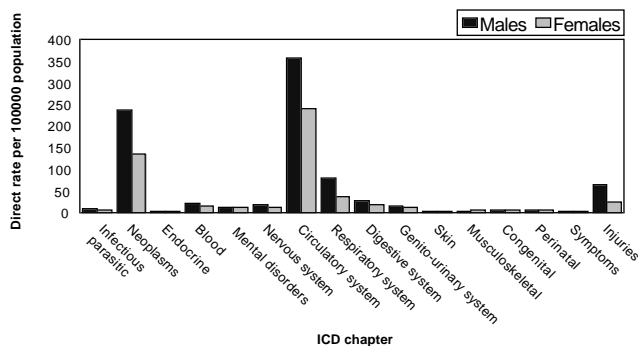
Source: Health Information Centre, Queensland Health, 1994

Figure 3: Number of separations per 1000 population, Queensland, 1993/94 by 5 year age groups: All conditions except complications of pregnancy, childbirth and puerperium



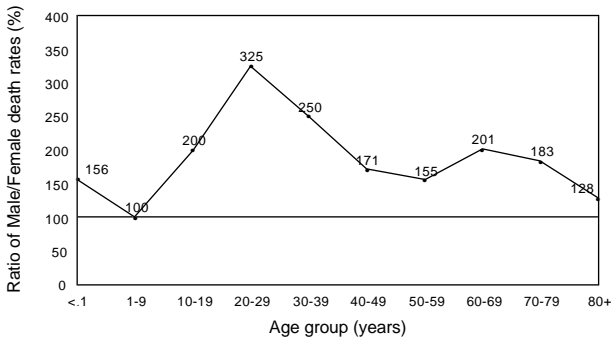
Source: Health Information Centre, Queensland Health, Info Circ 39

Figure 6: Direct standardised death rate* per 100000 population by ICD chapter, Queensland, 1992-94



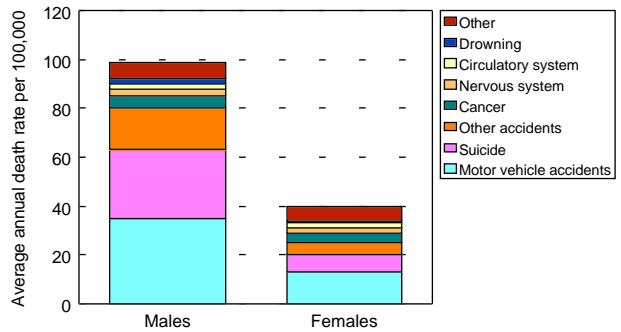
* Directly standardised to Australian population 1991
 Source: Health Information Centre, Queensland Health

Figure 7: Sex ratio of age-specific death rates, Queensland, 1994



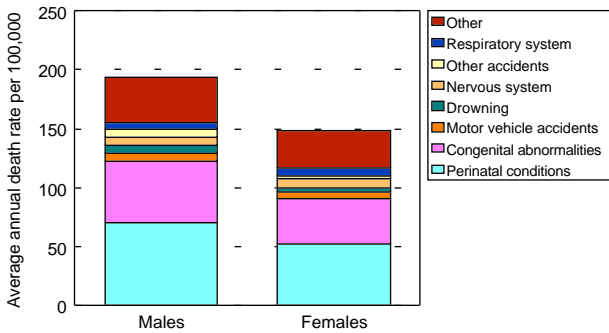
Source: Australian Bureau of Statistics, Cat 3303.0, 1994

Figure 10: Major causes of death for persons aged 15-24 years, Queensland, 1992-94



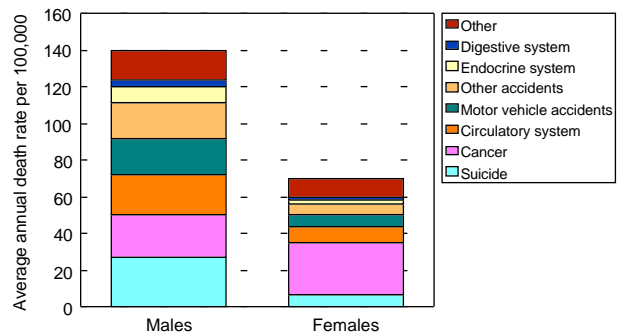
Source: Health Information Centre, Queensland Health

Figure 8: Major causes of death for persons aged 0-4 years, Queensland, 1992-94



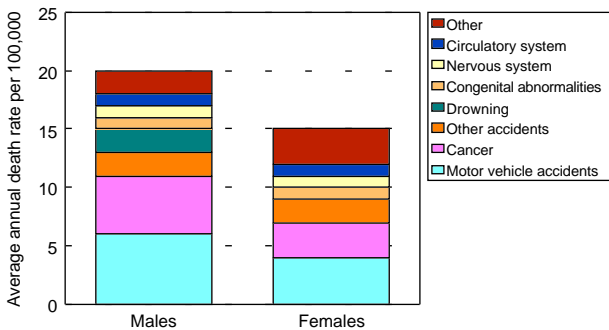
Source: Health Information Centre, Queensland Health

Figure 11: Major causes of death for persons aged 25-44 years, Queensland, 1992-94



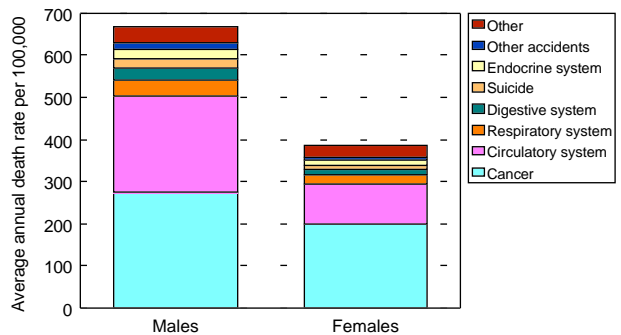
Source: Health Information Centre, Queensland Health

Figure 9: Major causes of death for persons aged 5-14 years, Queensland, 1992-94



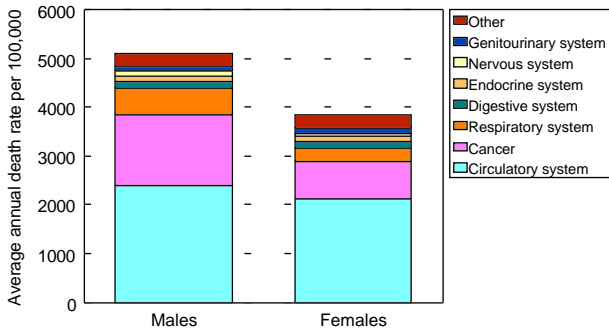
Source: Health Information Centre, Queensland Health

Figure 12: Major causes of death for persons aged 45-64 years, Queensland, 1992-94



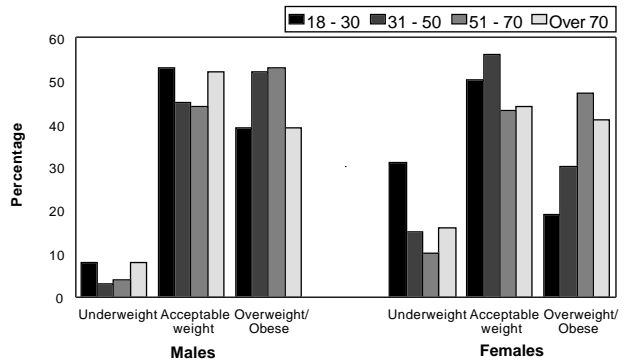
Source: Health Information Centre, Queensland Health

Figure 13: Major causes of death for persons aged 65 years and over, Queensland, 1992-94



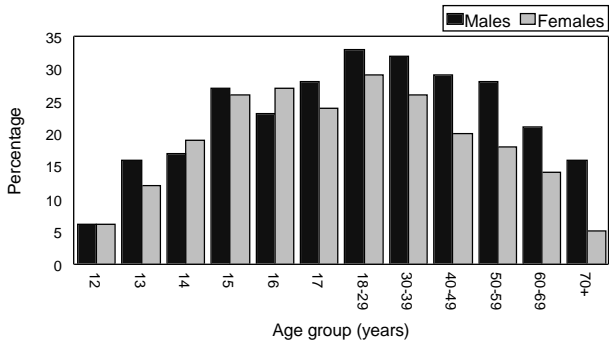
Source: Health Information Centre, Queensland Health

Figure 16: Body mass index by sex, Queensland, 1993



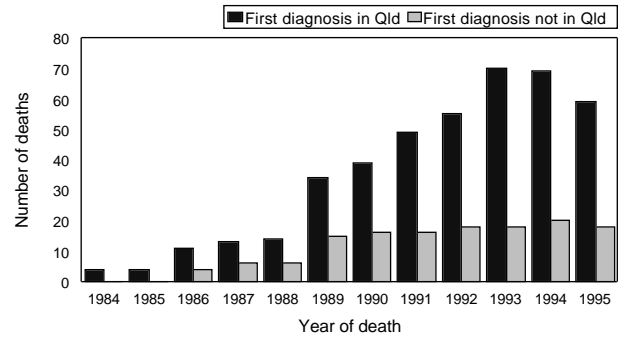
Source: Health Information Centre, Queensland Health, Regional Health Survey, 1993

Figure 14: Percentage of Queenslanders who are current smokers by age and sex, 1993



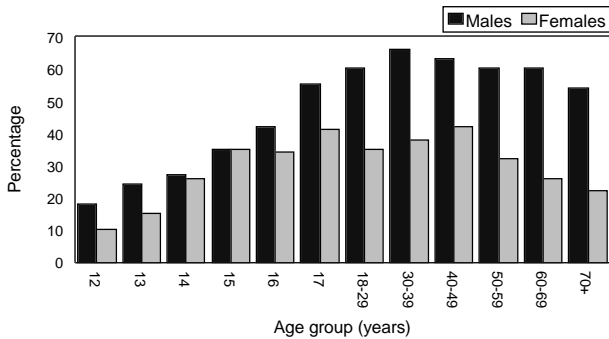
Source: Health Information Centre, Queensland Health, Regional Health Survey, 1993 (18 years and older)
Centre for Health Promotion and Cancer Prevention Research, University of Queensland, 1993 (12-17 year olds)

Figure 17: Male AIDS deaths in Queensland by year of death and place of first diagnosis



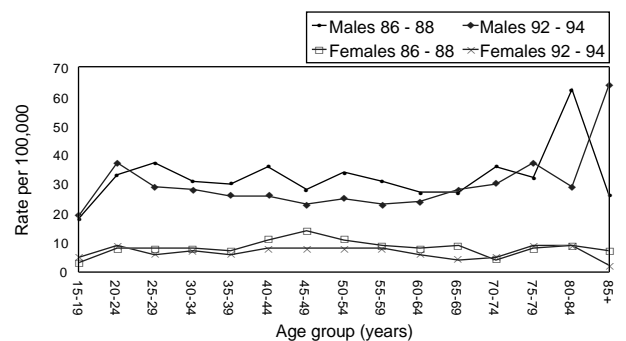
Source: AIDS Medical unit, Queensland Health, 1996

Figure 15: Percentage of Queenslanders who consume alcohol at least once per week, 1993



Source: Health Information Centre, Queensland Health, Regional Health Survey, 1993 (18 years and older)
Centre for Health Promotion and Cancer Prevention Research, University of Queensland, 1993 (12-17 year olds)

Figure 18: Suicide age-specific mortality rates per 100,000, Queensland, 1986-88 and 1992-94



Source: Health Information Centre (unpublished), Queensland Health

Figure 19: Separation ratios* for Queensland males by Index of Relative Socioeconomic Disadvantage decile#, all ages combined, 1993/94**

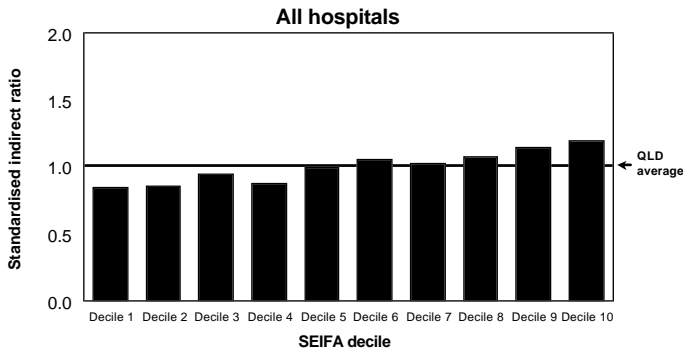
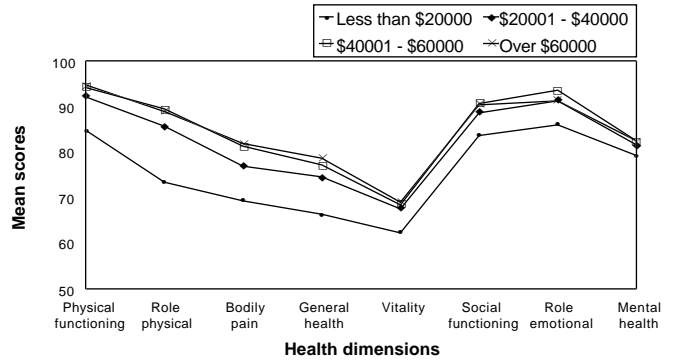


Figure 20: Mean male SF-36 scores by income level, Queensland, 1994



Source: Health Information Centre, Queensland Health, Health Status Survey, 1994

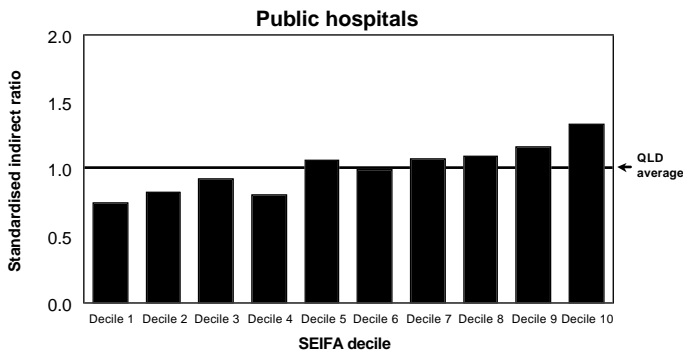
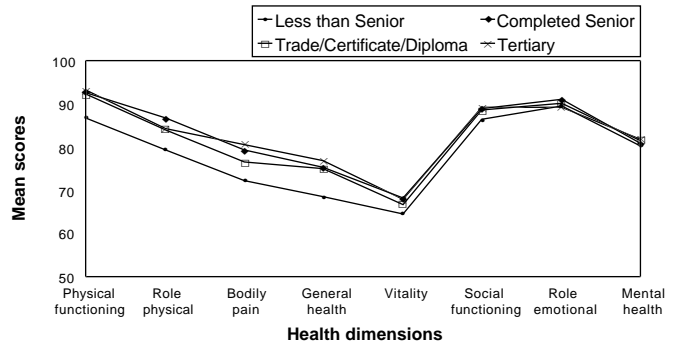
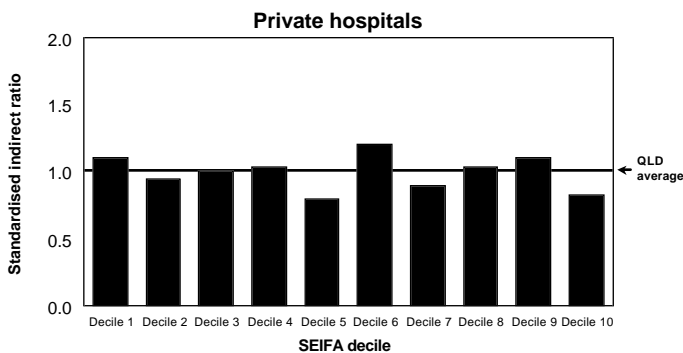


Figure 21: Mean male SF-36 scores by education level, Queensland, 1994



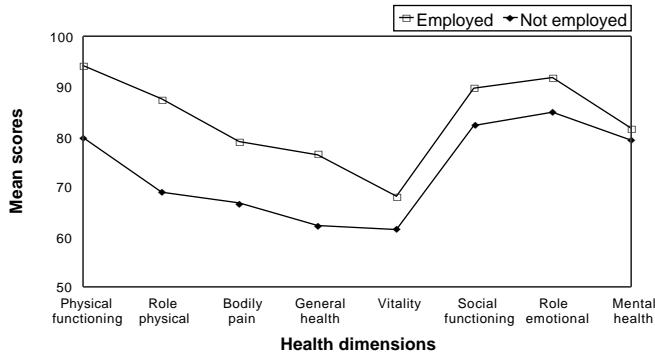
Source: Health Information Centre, Queensland Health, Health Status Survey, 1994



* Indirectly standardised to Queensland population 1993/94
 # Socioeconomic indexes for areas-information paper. ABS cat No 2912.0
 ** Decile 1=least disadvantaged, decile 10=most disadvantaged

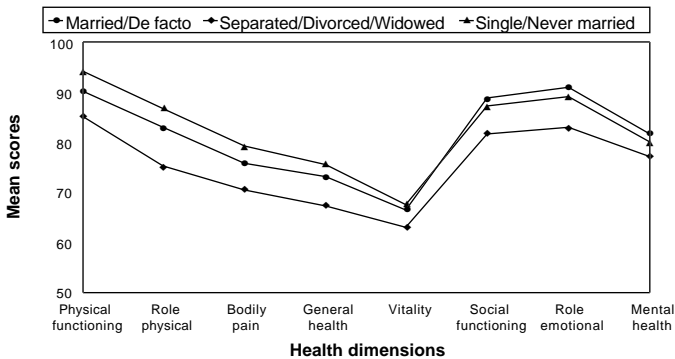
Source: Health Information Centre, Queensland Health, Information circular 39, 1996

Figure 22: Mean male SF-36 scores by employment status, Queensland, 1994



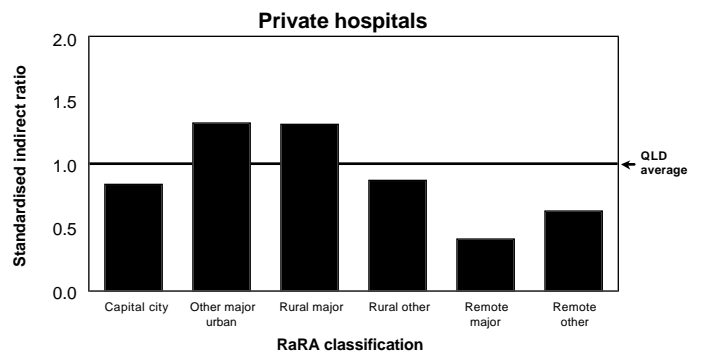
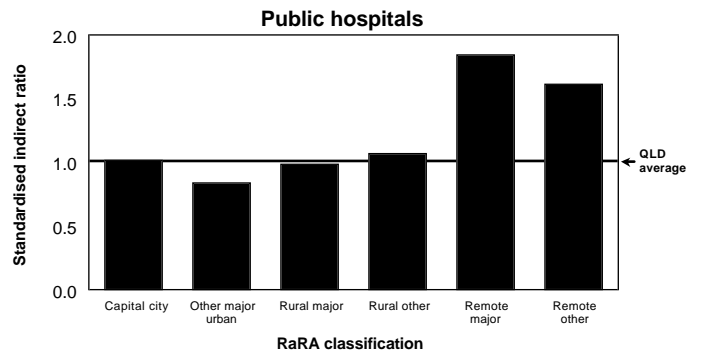
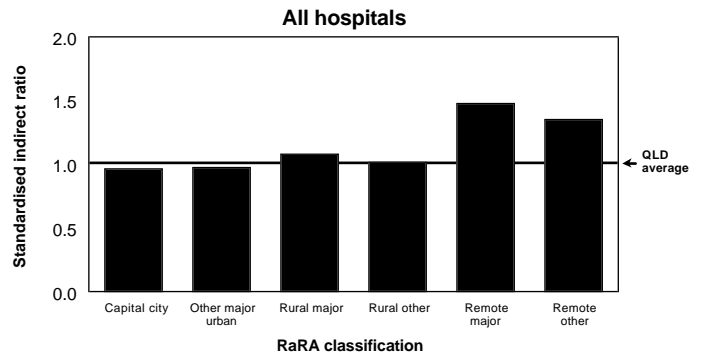
Source: Health Information Centre, Queensland Health, Health Status Survey, 1994

Figure 23: Mean male SF-36 scores by marital status, Queensland, 1994



Source: Health Information Centre, Queensland Health, Health Status Survey, 1994

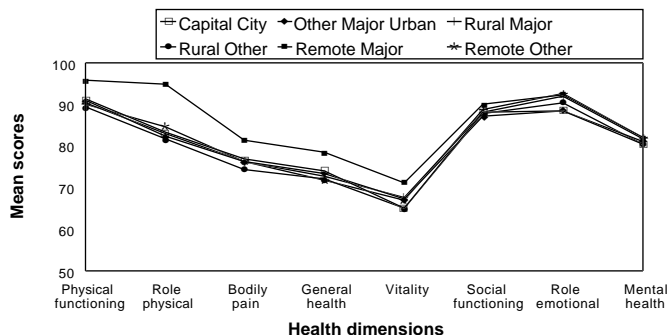
Figure 24: Separation ratios* for Queensland males, by RaRA classification, all ages combined, 1993/94**



* Indirectly standardised to Queensland population 1993/94
 ** Department of Human Services and Health, rural/remote area classification

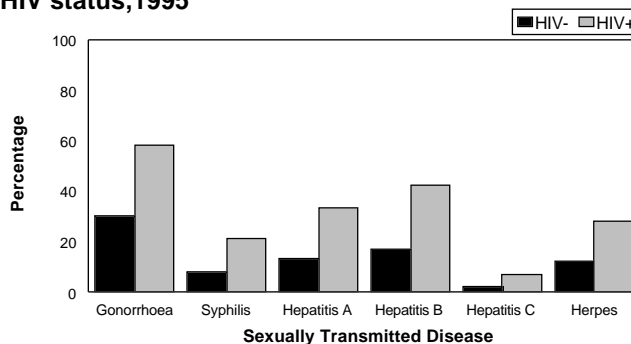
Source: Health Information Centre, Queensland Health, Information circular 39, 1996

Figure 25: Mean male SF-36 scores by RaRA classification, Queensland, 1994



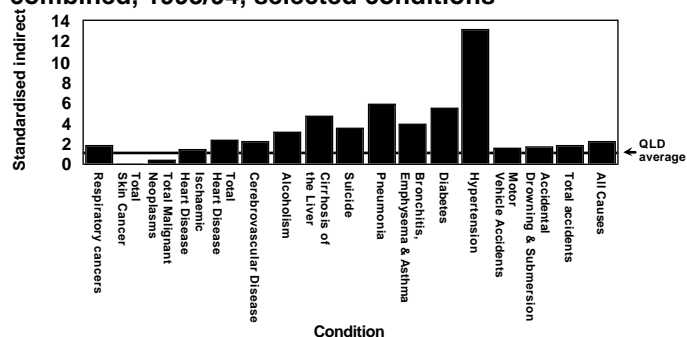
Source: Health Information Centre, Queensland Health, Health Status Survey, 1994

Figure 28: Percentage reporting ever had Sexually Transmitted Diseases, Sydney Male Homosexuals, by HIV status, 1995



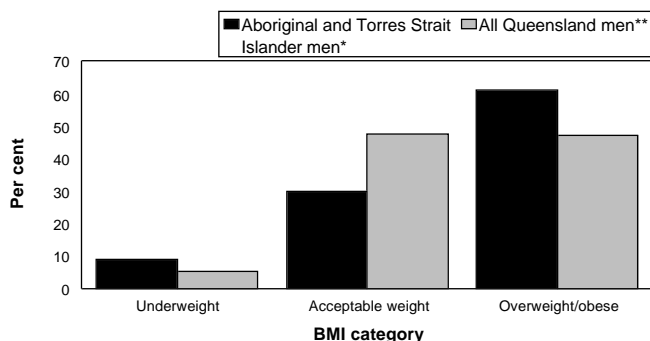
Source: HIV-positive men in the SMASH sample, HIV AIDS and Society Publications, 1995

Figure 26: Queensland separation ratios* for Aboriginal & Torres Strait Islander males resident in areas with greater than 50% indigenous population, all ages combined, 1993/94, selected conditions



* Indirectly standardised to Queensland population 1993/94
Source: Health Information Centre, Queensland Health

Figure 27: Body mass index for Queensland Aboriginal and Torres Strait Islander males (1994) and all Queensland males (1993) aged 18 years and over



Source: * ABS National Aboriginal and Torres Strait Islander survey, 1994
** Health Information Centre, Queensland Health, Regional Health Survey, 1993