The burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people 2017 (reference year 2011)

Summary report
The Queensland Government acknowledges and respects Traditional Owners and Aboriginal and Torres Strait Islander elders past and present, on whose land we work to support the provision of safe and quality healthcare.

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1 Aboriginal and Torres Strait Islander Health Branch, Queensland Department of Health

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Summary

It is well established that Aboriginal and Torres Strait Islander people have poorer health outcomes than non-Indigenous Australians. The Queensland Government is committed to closing the health gap for Queensland’s Aboriginal and Torres Strait Islander people and to achieving parity of life expectancy between Indigenous and non-Indigenous Queenslanders by 2033.

While there have been improvements in life expectancy and child mortality, Queensland’s Aboriginal and Torres Strait Islander people continue to experience poorer health than non-Indigenous Queenslanders.

Burden of disease studies produce a summary measure of population health that capture the fatal and non-fatal outcomes. Burden of disease and injury estimates are a useful descriptive epidemiological tool for describing the health of populations, but they hold most value for informing strategic planning, decision-making and resource prioritisation.

This report is the second Queensland study of the burden of disease and injury in Aboriginal and Torres Strait Islander people, the first report being released in 2014 (2007 reference year). This report describes the burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people in 2011.

This study found that Queensland’s Aboriginal and Torres Strait Islander people experience over two times the burden of disease and injury than would be expected based on Queensland non-Indigenous rates. The gap in disease and injury burden is large and concerted effort is required to close it. This study indicates that mental illness, cardiovascular disease and diabetes are the priority areas for closing the gap in disease and injury for Indigenous Queenslanders.

This summary provides a snapshot of the burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people in 2011. Understanding where the greatest potential for health gain is important to achieving the life expectancy gains outlined in the My health, Queensland’s future: Advancing health 2026. Please refer to the full report for additional details.

This forms part of the Queensland Aboriginal and Torres Strait Islander burden of disease and injury series including:

- The full report: The burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people 2017 (2011 reference year) main report
- Detailed analysis of the burden of disease and injury by Hospital and Health Service: The burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people 2017 (2011 reference year) Hospital and Health Service profiles.
Calculating the burden

Disability Adjusted Life Years (DALY)

The DALY is a summary measure of disease and injury burden, expressed as the cumulative years lost due to ill health, disability or premature death.

The DALY is derived by summing the Years Lived with a Disability (YLD) and the Years of Life Lost (YLL).

\[
DALY = YLD + YLL
\]

One DALY can be interpreted as one year of life lost due to ill health or premature death.

Years Lived with Disability (YLD)

Non-fatal burden of disease can be measured in two ways:

1. As an incidence based measure of years of life lost into the future due to new cases of disability occurring in the study year (YLD).
2. As a prevalence-based measure of the years of life lost to disability due to all cases existing in the study year (PYLD).

Both measures are useful for different reasons. YLD is primarily reported as this is the non-fatal component of the DALY calculation and is most useful for strategic planning. However, PYLD is also useful for current resource distribution and is used in the calculation of health adjusted life expectancy (HALE). Unless otherwise noted, in this report discussion of non-fatal burden refers to incident YLD.

YLD is calculated by multiplying the number of incident cases within the population (I) by the disability weight for that incident condition (DW) by the average duration of the cause until remission or death (L).

\[
YLD = I \times DW \times L
\]

One YLD can be interpreted as one year of life lost due to ill health into the future due to new cases of disease or injury occurring in the study year.

Years of Life Lost (YLL)

Fatal burden, expressed as YLL, measures the years lost between the age that a person dies and the age that they were expected to die based on the current ideal life expectancy.

YLL is calculated by multiplying the number of deaths (N) by the standard life expectancy at age of death in years (L). The estimation of fatal burden of disease weights deaths by age at death, so a death at old age contributes fewer YLL than a death at a young age.

\[
YLL = N \times L
\]

One YLL can be interpreted as one year of life lost due to premature death.
**Health Adjusted Life Expectancy (HALE)**

The HALE is a measure of the number of years a person is expected to live in perfect health from birth. The HALE differs from a standard life expectancy as it takes into account non-fatal outcomes.

The HALE deducts the years lost due to premature mortality (YLL) and the prevalent years lived with disability, illness or injury (PYLD) from the 'ideal' life expectancy (L) to provide a measure of the average population health.

One HALE can be interpreted as the number of years on average expected to be lived in ideal health.

**Understanding the burden of disease**

**DALY**
- Disability adjusted life years is a measure of disease and injury burden, expressed as the cumulative number of years lost due to ill-health, disability or premature death.

**YLD**
- Years lived with disability, illness or injury.

**YLL**
- Years of life lost due to premature mortality.

**Understanding the health adjusted life expectancy**

**HALE**
- Health adjusted life expectancy is a measure of the average number of years expected to live in ideal health.

**Life expectancy - PYLD**
- Years lived with prevalent disability, illness or injury.

**YLL**
- Years of life lost due to premature mortality.
Key findings and recommendations

Total burden: Disability Adjusted Life Years

- In 2011, the largest broad cause contributors to the Indigenous disease and injury burden were mental disorders, chronic disease and unintentional injuries. The top six contributors were responsible for more than two-thirds of the total disease and injury burden among Queensland’s Aboriginal and Torres Strait Islander people.

- At different points in the lifespan, different broad causes contributed to the burden of disease. As expected, the majority of the childhood burden (0–4 years) was due to neonatal causes, such as low birth weight. The burden of mental disorders is largely experienced during adolescence and young adulthood. In later adult life, chronic diseases such as cardiovascular disease, diabetes, cancer and chronic respiratory disease were the leading contributors to the Aboriginal and Torres Strait Islander disease and injury burden.

- More than two-thirds of Indigenous burden was carried by Aboriginal and Torres Strait Islander people aged less than 50 years old, whereas non-Indigenous Queenslanders carried two-thirds aged over 50.

- Differences in health outcomes start early in life, with Aboriginal and Torres Strait Islander infants and children aged 0–4 years carrying the largest proportion of disease and injury burden.

- Health differentials persist throughout the lifespan, with rates of disease and injury burden higher among Queensland’s Aboriginal and Torres Strait Islander people throughout adult life.

- Primary prevention of the major causes of disease burden, particularly with a focus on families and young people, will improve the health and burden profile of Queensland’s Aboriginal and Torres Strait Islander people as they age, and has the potential to impact the health of future generations.
68% of the disease burden in Queensland’s Aboriginal and Torres Strait Islander people was caused by the six leading broad cause groups.

Leading broad cause contributors to burden of disease and injury:

- Mental disorders: 20%
- Cardiovascular disease: 14%
- Diabetes: 11%
- Cancers: 9%
- Chronic respiratory disease: 9%
- Unintentional injuries: 5%

Age distribution:

- Largest proportion of Indigenous burden in infants.
- ⅔ of Indigenous burden in under 50yrs.
- ⅔ of non-Indigenous burden in over 50yrs.

Age specific rates:

- Higher rates of burden across the lifespan.

Proportion of broad cause disease and injury burden by age group:

- 99% for the 0-4 yrs age group.
- 54% for the 5-14 yrs age group.
- 41% for the 15-29 yrs age group.
- 32% for the 30-44 yrs age group.
- 36% for the 45-60 yrs age group.
- 24% for the 60-75 yrs age group.
- 22% for the 75+ yrs age group.

Bubble size represents DALYs by age and broad cause.
Fatal burden: Years of Life Lost

- In 2011, Queensland’s Aboriginal and Torres Strait Islander people experienced 2.7 times the fatal burden than expected based on the Queensland non-Indigenous rate.

- Almost three-quarters of the fatal burden in Queensland’s Aboriginal and Torres Strait Islander people was caused by the six leading broad causes groups:
  - cardiovascular disease
  - cancer
  - intentional injuries
  - diabetes
  - unintentional injuries
  - neonatal causes.

- Cardiovascular disease and cancers were the leading contributors to fatal burden for both Indigenous and non-Indigenous Queenslanders, followed by intentional injuries (such as suicide and self-harm), diabetes, unintentional injuries (such as road traffic accidents), then neonatal causes (such as low birth weight).

- Queensland’s Aboriginal and Torres Strait Islander people experienced significantly higher fatal burden from intentional injuries and diabetes than non-Indigenous Queenslanders.

- Aboriginal and Torres Strait Islander males carried significantly more fatal burden than Aboriginal and Torres Strait Islander females, especially for intentional injuries (such as self-harm and suicide) and unintentional injuries (such as road traffic accidents).

- Fatal burden in non-Indigenous Queenslanders is mainly as a result of ageing, with increasing rates with increasing age. In contrast, fatal burden among Queensland’s Aboriginal and Torres Strait Islander people is as a result of premature death, with the greatest proportion of years of life lost in infancy and mid-life.
74% of the fatal burden in Queensland’s Aboriginal and Torres Strait Islander people was caused by the six leading broad cause groups

**leading broad cause contributors to fatal burden**

- **21%** Cardiovascular disease
- **19%** Cancers
- **10%** Intentional injuries
- **9%** Diabetes
- **8%** Unintentional injuries
- **6%** Neonatal causes

**age distribution**

**sex distribution**

males more fatal burden than females

- **43%** male
- **57%** female

**expected burden**

\[
\frac{12,270 \text{ observed YLL}}{4,472 \text{ expected YLL}} = 2.7 \text{ times}
\]

higher fatal burden than expected based on Queensland non-Indigenous rate
Non-fatal burden: Years Lived with Disability

- In 2011, Queensland’s Aboriginal and Torres Strait Islander people experienced 1.7 times the non-fatal burden than expected based on Queensland non-Indigenous rates.
- Just over three-quarters of the fatal burden in Queensland’s Aboriginal and Torres Strait Islander people was caused by the six leading broad causes groups:
  - mental disorders
  - diabetes
  - chronic respiratory disease
  - cardiovascular disease
  - nervous system and sense organ disorders
  - neonatal causes.
- Mental disorders contributed more than one-third of Aboriginal and Torres Strait Islander non-fatal burden. This was the leading contributor to non-fatal burden for both Indigenous and non-Indigenous Queenslanders.
- Age related nervous system and sense organ disorders, such as dementia and adult onset hearing loss, was responsible for one-fifth of non-Indigenous non-fatal burden. However, higher chronic disease burden meant this contributed relatively less in Aboriginal and Torres Strait Islander Queenslanders (six per cent).
- Aboriginal and Torres Strait Islander females experienced more non-fatal burden than Aboriginal and Torres Strait Islander males, in part due to an increased burden of mental disorders.
- Non-fatal burden in non-Indigenous Queenslanders, while distributed across the lifespan, increases with increasing age. This is in stark contrast to Aboriginal and Torres Strait Islander Queensland non-fatal burden where 80 per cent of the non-fatal burden is carried by those aged under 50 years.
76% of the non-fatal burden in Queensland's Aboriginal and Torres Strait Islander people was caused by the six leading broad cause groups.

**Leading broad cause contributors to non-fatal burden**

- Mental disorders: 34%
- Diabetes: 12%
- Chronic respiratory disease: 12%
- Cardiovascular disease: 8%
- Nervous system and sense organ disorders: 6%
- Neonatal causes: 4%

**Age distribution**

- 80% of Indigenous YLD in under 50s
- Non-Indigenous YLD increases in later life

**Sex distribution**

- Females more non-fatal burden than males

**Expected burden**

\[
\frac{16,241}{9,287} = 1.7 \text{ times}
\]

higher non-fatal burden than expected based on Queensland non-Indigenous rate.
Burden by contributing factors

- Approximately 37 per cent of the burden experienced by Queensland’s Aboriginal and Torres Strait Islander people can be explained by the impact of a number of behavioural and environmental risk factors. This means that if exposure to these risk factors was reduced, the burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people could reduce by up to 37 per cent.

- In 2011, overweight and obesity, tobacco smoking, and insufficient physical activity were the largest single contributors to the Aboriginal and Torres Strait Islander burden.

- Some chronic diseases were strongly influenced by risk factors. Almost 75 per cent of diabetes burden, 68 per cent of cardiovascular disease burden and 50 per cent of cancer burden could be avoided through the elimination of selected behavioural and environmental risk factors.

- Disease and injury burden due to risk factor exposure is greatest in middle age (between 40–60 years), though the rate of burden attributable to risk factor exposure increases throughout life.

- Reducing the exposure to these risk factors, particularly in children and young people, is likely to have significant health benefits and reduce the burden of disease and injury for future cohorts of Aboriginal and Torres Strait Islander people in Queensland.
burden of disease and injury attributable to risk factors

<table>
<thead>
<tr>
<th>Joint effects</th>
<th>High body mass</th>
<th>Tobacco</th>
<th>Physical inactivity</th>
<th>High cholesterol</th>
<th>High blood pressure</th>
<th>Alcohol</th>
<th>Low fruit &amp; vegetable intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>37%</td>
<td>13%</td>
<td>11%</td>
<td>7%</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

burden attributable to joint risk factors by age

Proportion of burden attributable to joint risk factors

- 37% of all cause disease burden attributable to joint risk factors
- 74% of diabetes burden attributable to joint risk factors
- 68% of cardiovascular disease burden attributable to joint risk factors
- 50% of cancer burden attributable to joint risk factors
- 54% of intentional injuries burden attributable to joint risk factors
- 30% of chronic respiratory burden attributable to joint risk factors
Burden by remoteness

- Approximately half of Queensland’s Aboriginal and Torres Strait Islander people live in inner and other regional areas of the State, 30 per cent reside in major cities, and the remaining 20 per cent live in remote parts of Queensland.

- As expected, the burden of disease and injury is distributed to reflect the population distribution. However, there were significant differentials in the rate of burden of disease and injury by remoteness.

- Aboriginal and Torres Strait Islanders residing in remote areas of Queensland experienced higher rates of disease burden than their metropolitan counterparts, in particular from communicable disease, maternal and neonatal conditions and injuries.

- Based on the Queensland non-Indigenous rate, Aboriginal and Torres Strait Islander people living in remote parts of the State experienced 2.4 times the burden of disease and injury. Those living in major cities experienced relatively less burden, at 1.9 times expected burden based on the Queensland non-Indigenous rate.

- Higher rates of disease and injury burden in remote parts of Queensland are likely to be a function of environmental and geographical factors contributing to poorer access to services, medications and healthy food sources, as well as increasing disadvantage demonstrated in more remote areas.
disease and injury burden by remoteness

<table>
<thead>
<tr>
<th>Remoteness</th>
<th>Rate per 1000*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td>208</td>
</tr>
<tr>
<td>Inner/outer regional</td>
<td>251</td>
</tr>
<tr>
<td>Remote/very remote</td>
<td>297</td>
</tr>
</tbody>
</table>

*age standardised to 2001 Australian population

observed burden and gap by remoteness

<table>
<thead>
<tr>
<th>Remoteness</th>
<th>DALYs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major cities</td>
<td>7,499</td>
</tr>
<tr>
<td>Inner/outer regional</td>
<td>14,137</td>
</tr>
<tr>
<td>Remote/very remote</td>
<td>6,876</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Remoteness</th>
<th>Expected</th>
<th>Gap</th>
<th>Ratio: Observed to Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cause</td>
<td>1.9</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Communicable,</td>
<td>2.1</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Maternal and neonatal</td>
<td>2.5</td>
<td>4.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Injuries</td>
<td>1.4</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Non-Communicable</td>
<td>1.9</td>
<td>2.0</td>
<td>2.0</td>
</tr>
</tbody>
</table>

[Graphs showing disease and injury burden by remoteness and observed burden and gap by remoteness]
Change in burden 2007 to 2011

- The previous report (published 2014) described the burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people in 2007, and the current report describes the burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people in 2011.

- Between 2007 and 2011, the burden of disease and injury experienced by Queensland’s Aboriginal and Torres Strait Islander people increased by nine per cent, mainly as a result population increase.

- After accounting for differences in age structures, there was a decline in the rate of disease and injury burden in Queensland’s Aboriginal and Torres Strait Islander people.

- Despite improvements in the overall rate of disease and injury burden between 2007 and 2011, rates of disease and injury burden remain significantly higher in Queensland’s Aboriginal and Torres Strait Islander people compared to non-Indigenous Queenslanders.

- There was a significant decline in the rate of fatal burden due to cardiovascular disease, however the non-fatal burden remained the same between studies. This indicates that the health system is reducing premature death from cardiovascular disease in Queensland’s Aboriginal and Torres Strait Islander people, but not preventing the onset of disease, particularly in the younger ages.

- There was an increase in the contribution of mental disorders to the Aboriginal and Torres Strait Islander disease burden in 2011. In 2007, mental disorders contributed 16 per cent to the Aboriginal and Torres Strait Islander burden of disease and injury and this increased to 20 per cent in 2011. After adjusting for differences in age structures, the rate of mental disorders in Queensland’s Aboriginal and Torres Strait Islander people also increased between 2007 and 2011.
change in disease and injury burden in 2007 and 2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Mental disorders</th>
<th>Cardiovascular disease</th>
<th>Diabetes mellitus</th>
<th>Malignant neoplasms</th>
<th>Chronic respiratory disease</th>
<th>Unintentional injuries</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>16%</td>
<td>15%</td>
<td>9%</td>
<td>9%</td>
<td>6%</td>
<td>5%</td>
<td>30%</td>
</tr>
<tr>
<td>2011</td>
<td>20%</td>
<td>14%</td>
<td>11%</td>
<td>9%</td>
<td>9%</td>
<td>5%</td>
<td>28%</td>
</tr>
</tbody>
</table>

contribution to disease and injury burden in 2007 and 2011

<table>
<thead>
<tr>
<th>2007 Ranking</th>
<th>ASR</th>
<th>2011 Ranking</th>
<th>ASR</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cause</td>
<td>268.4</td>
<td>All Cause</td>
<td>250.7</td>
</tr>
<tr>
<td>1. Cardiovascular disease</td>
<td>58.8</td>
<td>1. Cardiovascular disease</td>
<td>49.1</td>
</tr>
<tr>
<td>2. Malignant neoplasms</td>
<td>35.0</td>
<td>2. Diabetes mellitus</td>
<td>35.3</td>
</tr>
<tr>
<td>3. Diabetes mellitus</td>
<td>33.3</td>
<td>3. Mental disorders</td>
<td>32.6</td>
</tr>
<tr>
<td>4. Mental disorders</td>
<td>27.2</td>
<td>4. Malignant neoplasms</td>
<td>32.3</td>
</tr>
<tr>
<td>5. Chronic respiratory disease</td>
<td>24.7</td>
<td>5. Chronic respiratory disease</td>
<td>22.4</td>
</tr>
<tr>
<td>7. Unintentional injuries</td>
<td>11.2</td>
<td>7. Unintentional injuries</td>
<td>8.9</td>
</tr>
<tr>
<td>8. Diseases of the digestive system</td>
<td>9.4</td>
<td>8. Diseases of the digestive system</td>
<td>8.2</td>
</tr>
<tr>
<td>10. Genitourinary diseases</td>
<td>8.7</td>
<td>10. Infectious and parasitic diseases</td>
<td>7.5</td>
</tr>
<tr>
<td>11. Infectious and parasitic diseases</td>
<td>8.3</td>
<td>11. Genitourinary diseases</td>
<td>7.4</td>
</tr>
<tr>
<td>12. Musculoskeletal diseases</td>
<td>4.9</td>
<td>12. Musculoskeletal diseases</td>
<td>4.4</td>
</tr>
<tr>
<td>14. Neonatal causes</td>
<td>4.5</td>
<td>14. Endocrine and metabolic disorders</td>
<td>3.8</td>
</tr>
<tr>
<td>15. Endocrine and metabolic disorders</td>
<td>4.1</td>
<td>15. Acute respiratory infections</td>
<td>3.5</td>
</tr>
</tbody>
</table>

ASR: Directly age standardised rate based on 2001 Australian population, per 1,000
Closing the gap in burden

- In 2011, Aboriginal and Torres Strait Islander Queenslanders could expect to live on average to 62 years of age in good health. This was almost 12 years less than the healthy life expectancy of a non-Indigenous Queenslander.

- Cardiovascular disease contributed 3.1 years to the gap in health adjusted life expectancy, and diabetes 2.5 years.

- Queensland’s Aboriginal and Torres Strait Islander people experienced more than twice the burden of non-Indigenous Queenslanders.

- There was a significant differential between Indigenous and non-Indigenous Queenslanders for communicable, maternal and neonatal causes and injuries.

- Chronic disease (such as diabetes), mental disorders and intentional injuries (predominately suicide and self-inflicted injuries) were significant contributors to the gap in disease and injury burden. These represent priority areas for improving the gap in burden of disease between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders.

- Rates of ageing related conditions such as nervous and sense organ disorders (including dementia and adult onset hearing loss) and musculoskeletal disorders (including back pain and osteoarthritis) were lower among Aboriginal and Torres Strait Islander Queenslanders than non-Indigenous Queenslanders.

- While behavioural and environmental risk factors undoubtedly contribute to the health gap, socioeconomic determinants (such as education, income, overcrowding), combined with racism and discrimination play a significant role in the difference in health between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders.
The burden of disease and injury in Queensland’s Aboriginal and Torres Strait Islander people 2017 (reference year 2011) – Summary report

**Health adjusted life expectancy**

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>DALYs</th>
<th>Observed</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular disease</td>
<td>28,511</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>13,760</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intentional injuries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal causes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

62.0 average years lived with full health

73.7 average years lived with full health

11.7 year gap in HALE*

*HALE = health adjusted life expectancy = average number of years a person can expect to live at full health

**Standardised ratio**

2.1 x more burden than expected

2.7 x more burden from communicable disease, maternal and neonatal conditions

2.3 x more burden from injuries

2.0 x more burden from non-communicable diseases

**Leading contributors to the burden of disease and injury gap**

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular disease</td>
<td>20%</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>16%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>16%</td>
</tr>
<tr>
<td>Chronic respiratory</td>
<td>9%</td>
</tr>
<tr>
<td>Intentional injuries</td>
<td>7%</td>
</tr>
<tr>
<td>Cancers</td>
<td>6%</td>
</tr>
<tr>
<td>Neonatal causes</td>
<td>5%</td>
</tr>
</tbody>
</table>