Australian Bureau of Statistics

2001

New Issue

4827.0.55.001

THE HEALTH OF OLDER PEOPLE, AUSTRALIA

EMBARGO: 11.30AM (CANBERRA TIME) WED 10 NOV 2004

CONTENTS

INQUIRIES

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NOTES

ABOUT THIS PUBLICATION

This report examines the health of older persons across a number of dimensions including demographics, health status and disability, and health service use. The data used are mainly derived from the 2001 National Health Survey (NHS), which surveyed persons in private dwellings only, and the 2003 Survey of Disability, Ageing and Carers. It is important to note that the scope of the National Health Survey excludes persons in aged care accommodation, including nursing homes.

EFFECTS OF ROUNDING

Where estimates have been rounded, discrepancies may occur between sums of the component items and the total.

ACKNOWLEDGEMENTS

Austrlian Bureau of Statistics (ABS) publications draw extensively on information provided freely by individuals, businesses, governments and other organisations. Their continued cooperation is very much appreciated. Without it, the wide range of statistics published by the ABS would not be available. Information recieved by the ABS is treated in strict confidence as required by the *Census and Statistics Act 1905*.

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Acting Australian Statistician

SUMMARY OF RESULTS

INTRODUCTION

As a developed nation Australia's demographic profile is one of a rapidly ageing population, linked to a decline in both fertility and mortality rates. Associated with this is a concern about the health of older people, and the increased costs on government and individuals associated with the deterioration in health that is a common, but not necessarily disabling, part of ageing (see Intergenerational Report 2002-03 for example). At June 2003 the number of older persons aged 65 years and over in Australia was 2.5 million people, or around 13% of the total population (ABS 2003c). A considerably smaller proportion of Australia's Indigenous population (3%) were aged 65 years and over (ABS 1998). Over time the proportion of older persons in the population is expected to increase such that by 2051, it is estimated that between 27% (Series B) and 30% (Series C) of the population will be aged 65 years and over (ABS 2003).

While older persons are defined in this paper as those aged 65 years and over, where possible analysis is conducted on sub-groups within this age category as differences are often revealed between the age groups of 65-74 years, 75-84 years and those aged 85 years and over.

HEALTH CONDITIONS

Long-term conditions

Long-term conditions have a high prevalence across the life span. Most people aged 15-64 years (86%) and nearly all (99%) persons aged 65 years and over reported one or more long-term medical conditions in 2001. However, long-term conditions vary in their effects on health. The most common long-term conditions that affected the health of older persons in 2001 included diseases of the eye, particularly long-sightedness (hyperopia 46%, and 34% with presbyopia), and short-sightedness (31%). Diseases of the eye increased consistently with age: the reported prevalence of long-sightedness was 24% and presbyopia 7% for persons aged 15-64 years in 2001. Older persons reported having osteoarthritis at a higher rate (29%) than those aged 15-64 years (6%). The reported prevalence of hypertensive disease (40% for older persons, 8% for persons aged 15-64 years), and total and partial deafness (33% for older persons, 9% for 15-64 year olds) also increased with age. In contrast, asthma was reported at a slightly lower rate for older persons (9%) compared to a rate of 12% for persons aged 15-64 years.

As females have a longer life expectancy, there are more females in the older age groups where long-term conditions are common (ABS, 2004c). Women over 65 years reported a greater incidence of hypertensive disease (44% compared to 35% of men), osteoporosis (12% compared to 2% of men), and osteoarthritis (35% compared to 21% of men) while, in contrast, men reported significantly higher rates of total and partial deafness (42% to 26% of women). The prevalence of these long-term health conditions has not changed substantially since the previous National Health Survey year of 1995.

Although associated with ageing, the incidence of all cancers in older people was relatively low at 5% (compared to around 1% for persons aged 15-64 years). There are a number of factors that may influence this estimate, including the exclusion of non-private dwellings such as hospitals and hospices from the NHS, and the mortality rates of older people from cancer.

SELECTED LONG-TERM CONDITIONS, Persons aged 65 years and over—2001

	65-74		75 AND OVER		TOTAL 65 AND OVER	
	Males	*Females*	*Males*	*Females*	*Males*	*Females*
	%	%	%	%	%	%
Diseases of circulatory system	***49.3***	***55.7***	***56.8***	***65.3***	***52.2***	***60.2***
Hypertensive disease	35.1	41.6	35.8	46.4	35.4	43.8
Ischaemic heart diseases	11.2	5.2	13.1	13.2	11.9	8.9
Cerebrovascular diseases	2.6	*1.9	*3.6	4.3	3.0	3.0
Chronic lower respiratory diseases	***13.3***	***14.9***	***16.8***	***13.9***	***14.6***	***14.4***
Asthma	8.8	10.9	5.9	8.3	7.7	9.7
Diseases of musculoskeletal system and connective tissue	***57.9***	***64.9***	***62.1***	***69.4***	***59.6***	***67.0***
Osteoporosis	*2.0	10.2	*3.2	15.1	2.5	12.5
Arthritis - Osteoarthritis	18.6	33.2	23.6	37.4	20.5	35.1
Arthritis - Rheumatoid	5.9	7.0	6.8	8.6	6.3	7.7
Diabetes mellitus	10.3	12.3	10.0	10.0	10.2	11.3
Total and partial deafness	34.0	17.5	53.4	34.8	41.6	25.6
Disorders of ocular muscles binocular movement accommodation & refraction	***92.7***	***94.2***	***91.9***	***88.6***	***92.4***	***91.6***
Short sighted/myopia	30.3	34.0	31.6	26.4	30.8	30.5
Long sighted/hyperopia	47.6	48.1	42.3	44.3	45.5	46.3
Presbyopia	30.5	32.2	37.4	36.3	33.2	34.1
Cataract	6.0	9.7	11.6	22.8	8.2	15.8
Other long-term conditions	69.1	70.2	74.4	68.8	71.2	69.6
Total with a long-term condition	***99.0***	***99.7***	***98.6***	***99.2***	***98.9***	***99.5***
Without a long-term condition	****1.0***	-	****1.4***	****0.8***	****1.1***	****0.5***
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

* estimate has a relative standard error of 25% to 50% and should be used with caution

Source: ABS, 2001 NHS

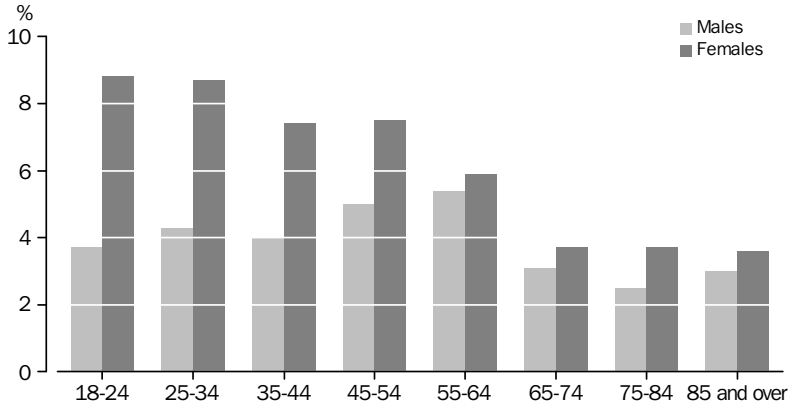
Mental health

Along with degenerative changes, other factors associated with ageing may impact on the mental health of older people, including the strain of deteriorating health and the need to care for partners. In 2001 rates of psychological distress among older persons living in private dwellings were lower than the overall population rates, with 9% of older persons (11% of females, 7% of males) reporting high to very high psychological distress compared with 13% of the population aged 18 years and over (15% of females, 10% of males) (ABS 2002c).

The 2001 NHS shows that prevalence of self-reported mood or affective disorders decreases substantially in the older age groups. This result was also evident in the 1997 Survey of Mental Health and Wellbeing of Adults, where persons aged 65 years and over reported the lowest rates of mental disorders (6% compared to 18% for all persons aged 18 years and over living in private dwellings).

Mental health continued

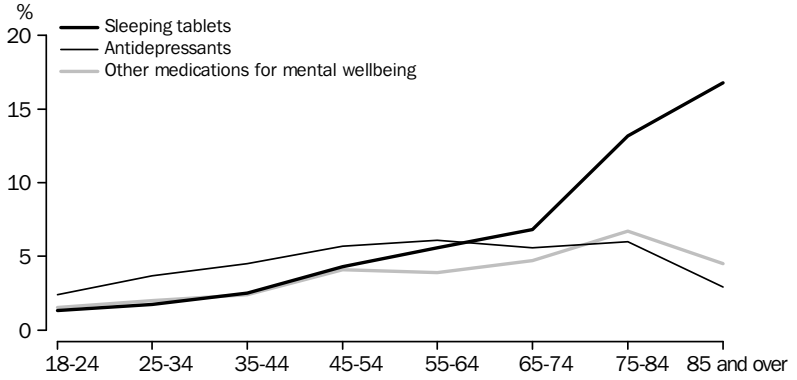
MOOD (AFFECTIVE) DISORDERS—2001



Source: ABS, 2001 NHS, data available on request.

However, the use of medications for mental wellbeing increased with age. The most commonly reported medications used for mental wellbeing were sleeping tablets (or capsules) and antidepressants. Of older persons, around 37% (40% of females, 33% of males) reported taking sleeping tablets or capsules and 15% (16% of females, 13% of males) reported taking antidepressants. The use of these medications is higher than the general population aged 18 years and over, where around 4% reported using sleeping tablets and around 5% reported using antidepressants.

SELECTED MEDICATIONS(a) FOR MENTAL WELLBEING—2001



(a) All medications other than those identified by respondents as vitamin or mineral supplements, h

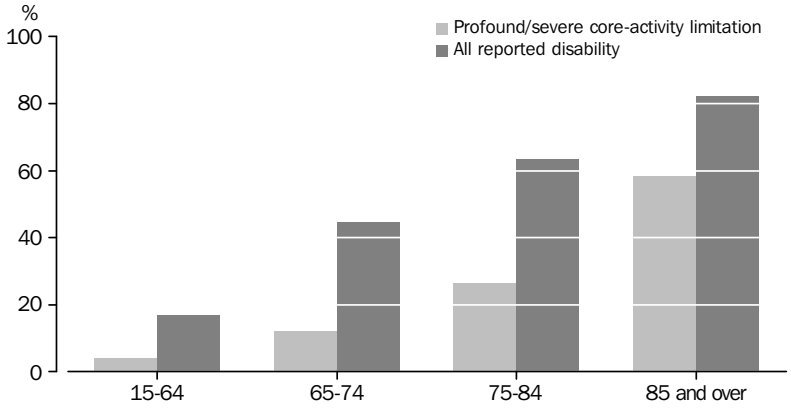
Source: ABS, 2001 NHS, data available on request.

Disability

According to the 2003 Survey of Disability, Ageing and Carers, 56% of persons aged 65 years and over had a disability. This included 23% with a profound or severe core-activity limitation, and nearly all older people in cared accommodation (97%). Those who lived in private dwellings were far less likely to have a disability (52%). Of those older persons with a profound or severe core-activity limitation, 68% lived in private dwellings, while 27% lived in cared accommodation.

Disability continued

DISABILITY STATUS—2003



Source: ABS, Survey of Disability, Ageing and Carers, 2003, data available on request.

Arthritis and related disorders were reported as being the most common main conditions in the 2003 survey (affecting an estimated 17% of older persons). Of those older persons reported to have arthritis and related disorders as their main condition, 69% had a disability and 37% of these persons were reported to have had a profound or severe core-activity limitation (see Glossary).

In 2003 there were a reported 67,300 persons aged 65 years and over with dementia and Alzheimer's disease (around 3%), most of whom reported having a disability with a profound or severe core-activity limitation (99%). Around half of these people (51%) were aged 85 years and over, and around three quarters (74%) were women. Of the 21,400 older persons who were reported to have depression and mood affective disorders as their main condition, 79% reported having a disability, of whom 66% had a profound or severe core-activity limitation.

However, older people were not just being cared for - there were some 113,200 people aged 65 years and over who were primary carers as reported in the 2003 survey, with the majority (83%) looking after their partner. A higher proportion of carers aged 65 years and over (58%) were women.

HEALTH ACTIONS

Use of hospital/medical services

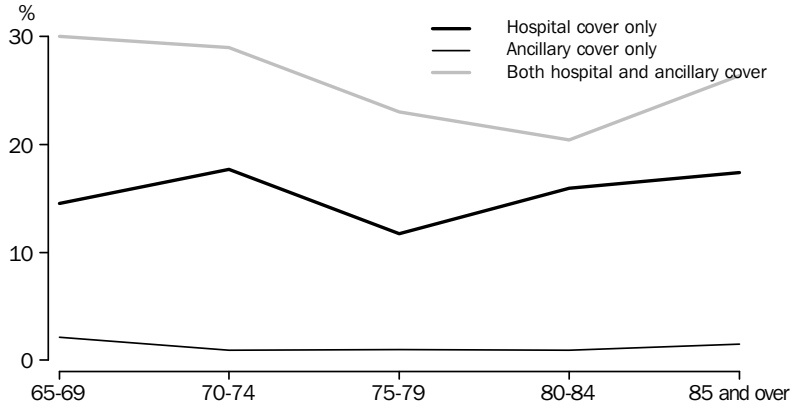
The most commonly reported use of health services were visits to a general practitioner (GP) (38% of older persons), followed by visits to specialists (10%), and dental consultations (6%). Visits to a GP increased substantially with age, such that 48% of persons aged 85 years and over had visited a GP in the two weeks prior to the interview. Older persons also reported a higher rate of hospital admissions than those aged less than 65 years in the 12 months prior to the 2001 NHS. Overall, around 21% of persons aged 65 years and over had a hospital admission during this time compared to 12% of all persons aged 15 years and over.

Private Health Insurance and Government Health Cards

Around 43% of older Australians had some form of private health insurance in 2001, less than the estimated rate of coverage for all Australians (51%). Those aged 75-84 years had the lowest rates of coverage of around 36%, in contrast to those aged 65-74 years (around 47% coverage), and 85 years and over (45%).

Private Health Insurance and Government Health Cards continued

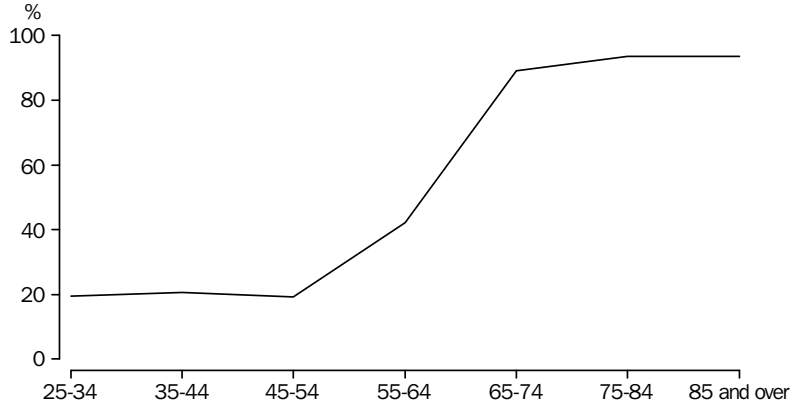
PRIVATE HEALTH INSURANCE COVER—2001



Source: ABS, 2001 NHS, data available on request.

For the 2001 NHS, Government health concession cards included Health Care Cards, Pensioner Concession Cards, Commonwealth Seniors Health Card, and treatment entitlement cards issued by the Department of Veterans' Affairs (DVA). These cards offered varying types of benefits in relation to the access of health care. In 2001, most older persons (91%) had at least one type of Government health card. The majority (73%) had a pensioner concession card, 14% had a DVA card, 13% had a Commonwealth Seniors Health Card, and 7% had a health care card.

GOVERNMENT HEALTH CARD HOLDERS—2001



Source: ABS, 2001 NHS, data available on request.

RISK FACTORS

Lifestyle behaviours such as smoking, alcohol consumption, diet and exercise can impact on a person's health and, as people age, the opportunity for these behaviours to impact negatively on health outcomes increases. The 2001 NHS results suggest that, excluding the effects of past lifestyle behaviours, the highest prevalence of risk factors for older people appear to be increased body mass, particularly for the 65-74 year olds, and decreasing levels of physical activity with age.

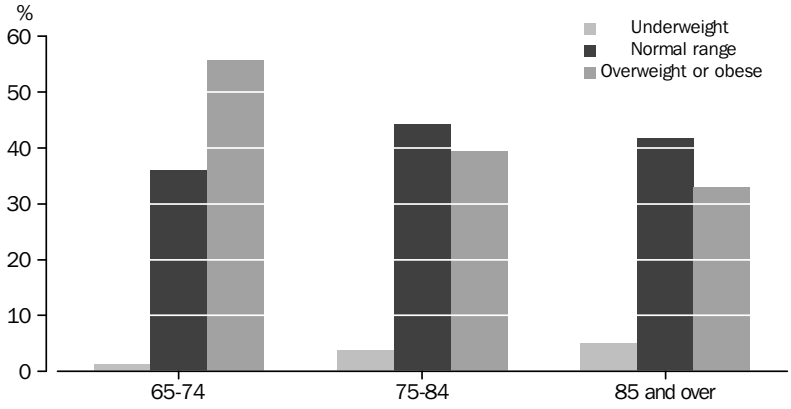
Body mass

Overweight and obesity are increasing concerns for the population in general, as the trend has been for an increase in overweight and obesity prevalence (ABS 2003). In 2001, almost half of all older persons (48%) were either overweight (34%) or obese (14%), while 39% reported being within the normal range for body mass. This represents an increase from 1995, when 39% of older persons reported being overweight or obese and

Body mass continued

46% reported being within the normal weight range. Of older people aged 65 years and over, those aged 65-74 years were more likely to be overweight or obese than older age groups. Overall in this age group, 59% of males and 52% of females were overweight or obese. The proportion of underweight persons also increases with age, and may be underrepresented by the survey as nursing homes and other supported accommodation are not included in its scope.

BODY MASS INDEX—2001



Source: ABS, 2001 NHS, data available on request.

Smoking

Around 9% of older persons were current smokers, with a lower rate for those aged 85 years and over (4%). This is considerably lower than the proportion of smokers in the general population, where in 2001, 24% of persons aged 18 years and over were current smokers (28% of males and 21% of females). However, 40% of older persons reported being ex-smokers, with considerably higher rates for males (59% compared to 24% of female ex-smokers). There is little change in the proportion of current smokers in the older population since 1995, with a decrease reported for male current smokers, from 15% in 1995 to 11% in 2001.

Alcohol consumption

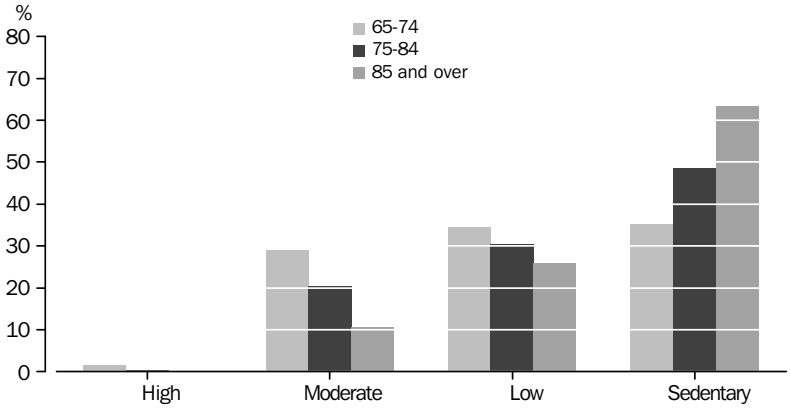
Most older people did not consume alcohol at levels considered to be high risk, and this varied little across age and sex. The majority of older people either did not consume alcohol, or consumed at low risk levels (94%). In the general population, males are more likely to drink at risky levels than females, however this difference was marginal for older persons, with 7% of males drinking at risky to high risk levels compared to 6% of females. There has been little change in alcohol consumption since the 1995 NHS.

Physical activity

Physical activity is associated with various health benefits including a reduced risk of cardiovascular disease, some cancers, and depression (WHO, 2002). In older people a lack of activity may be related to reduced cognitive functioning (Bryan & Ward, 2004). In 2001, there was a substantial difference in exercise levels between the different groups of older people. While 35% of persons aged 65-74 reported being sedentary, almost half (49%) of persons aged 75-84 years and 63% of persons aged 85 years and over reported being sedentary in the two weeks prior to the survey. There is little difference observed in physical activity levels for older persons between the 1995 and 2001 NHS.

Physical activity continued

EXERCISE LEVEL—2001



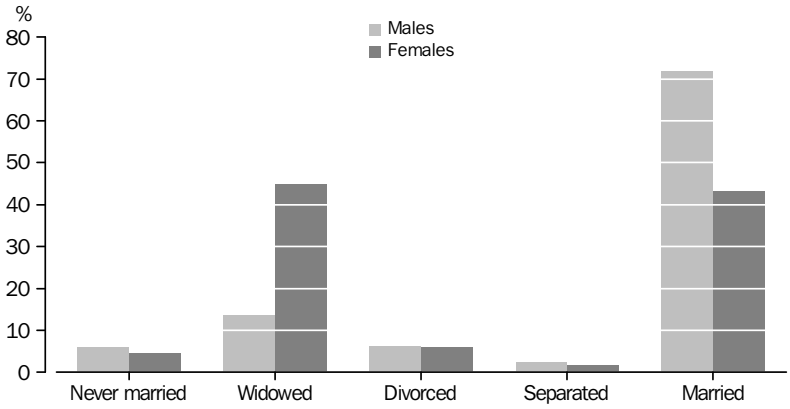
Source: ABS, 2001 NHS, data available on request.

GENERAL CHARACTERISTICS

Marital status

The greater longevity of females to males creates a distinctive pattern in marital status as people age (see section on Life Expectancy). At the 2001 Census, almost three-quarters of males aged 65 years and over were married (72%); for females in this age group, around 43% were married. This discrepancy can be explained by the considerably higher proportion of widows (45%) to widowers (14%) in this age group (ABS 2002a).

MARITAL STATUS, Persons aged 65 years and over—2001



Source: ABS, 2001 Census Basic Community Profiles.

Living arrangements

The differences in marital status for older males and females impact on living arrangements and other forms of support. Over time older people experience loss, not only of a partner, but often incremental loss of independence through disability and other factors associated with ageing.

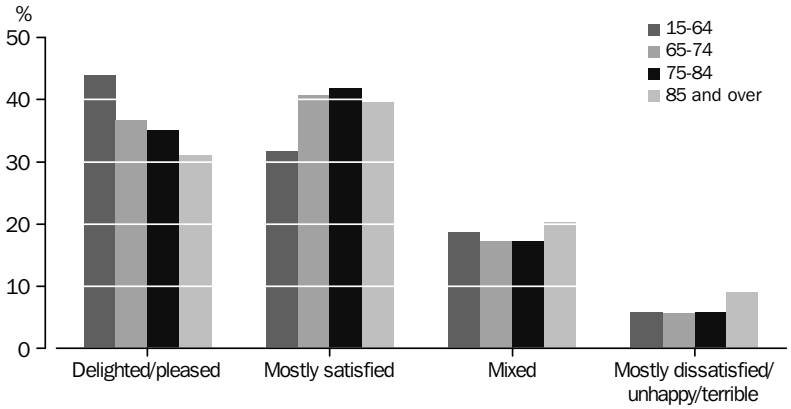
According to the 2001 Census, most older persons (92%) lived in private dwellings while around 6% lived in aged care accommodation or nursing homes. The proportion of older persons in aged care or nursing homes (non-private dwellings) increased with age, so that by 85 years and over, more than a quarter of this population (27%) lived in aged care accommodation (31% of females and 17% of males). Of those living in private dwellings, just over half (56%) of older persons lived in a couple relationship in 2001, while around 31% lived by themselves. A greater proportion of women lived alone (40%) compared to men (21%) (ABS 2001).

WELLBEING

Life Satisfaction

There does not appear to be a strong relationship between ageing and reduced life satisfaction. In 2001 most people (76%) reported being satisfied with their life, including 77% of those aged 65 years and over. This was significantly higher than the estimate for persons aged between 35-64 years (around 73%). Of the 65 years and over group, 12% reported being 'delighted', 24% were 'pleased' and 41% were 'mostly satisfied'. Although there is a decrease in the intensity of life satisfaction with ageing, only 6% of this age group reported that they felt either mostly dissatisfied, unhappy or terrible about their lives, the same estimate for the overall population.

LIFE SATISFACTION—2001



Source: ABS, 2001 NHS, data available on request.

Self-assessed health status

Self-assessed health status is considered to be a strong predictor of morbidity and mortality (Gerdtham et al 1999; McCallum et al 1994). In 2001 most older people rated their health as good (35%), and almost another third (32%) rated their health as excellent to very good. This compares to 55% of persons aged 15-64 years who rated their health as excellent to very good (including 41% of persons aged 55-64 years), and 30% who rated their health as good. The proportion of older people who reported excellent to very good health was generally lower in the older age groups.

Self-assessed health status continued

SELF-ASSESSED HEALTH STATUS—2001

	65-74	*75-84*	*85 years and over*	*Total*
	%	%	%	%
Males				
Excellent/very good	32.4	27.1	22.6	30.1
Good	36.3	33.4	49.7	36.0
Fair/poor	31.3	39.4	27.7	33.9
Total	100.0	100.0	100.0	100.0
Females				
Excellent/very good	36.0	29.4	31.3	33.1
Good	35.6	31.6	28.5	33.5
Fair/poor	28.4	39.0	40.3	33.5
Total	100.0	100.0	100.0	100.0
Persons				
Excellent/very good	34.2	28.4	28.5	31.7
Good	35.9	32.4	35.2	34.6
Fair/poor	29.8	39.2	36.3	33.6
Total	100.0	100.0	100.0	100.0

Source: ABS, NHS 2001, data available on request.

Social contacts and activities

Social contacts and activities are important as they counter the potential risk of social isolation as people age. In 2002, 94% of older persons reported having weekly contact with family or friends, including 96% of those aged 85 years and over. Only 1% reported no recent such contact. Around 71% of older people had attended selected culture and leisure venues and activities in the 12 months prior to the General Social Survey (GSS), but this attendance reduced in older age groups, to around 45% of persons 85 years and over (49% of females and 37% of males). Around one in five (21%) of older persons had attended a sporting event in the last 12 months (16% of females, 27% of males), which also declined with age to 11% of those aged 85 years and over. In a time of crisis, families were the main sources of support for older persons (82%), followed by friends (44%) and neighbours (39%). While 28% of older persons reported they had participated in unpaid voluntary work, females aged 65-74 were the most likely to have been involved in voluntary work (36%).

LIFE EXPECTANCY

Life expectancy is one of the most widely used indicators of population health. Australia has one of the highest life expectancy at birth rankings in the world at 80.4 years, with females born in 2000–2002 expected to live 82.6 years and males expected to live 77.4 years (ABS 2004b; ABS 2003a). It is more difficult to assess national trends in Indigenous life expectancy because many of the historical data are of poor quality. What is known is that Indigenous Australians do not live as long, and that the difference is marked (ABS 2004b).

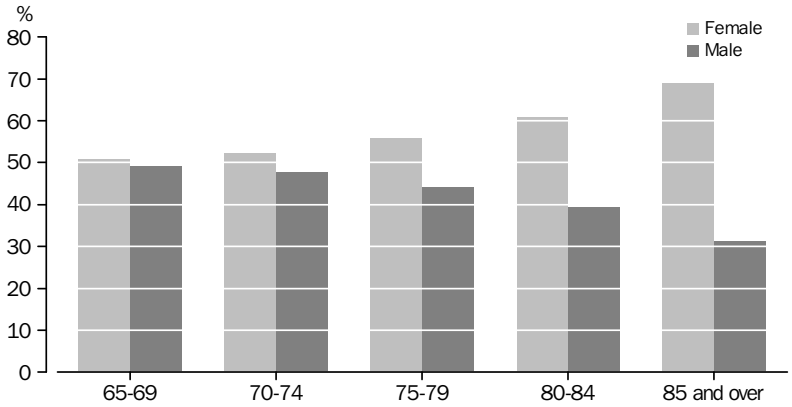
As life expectancy as an indicator of population health does not focus on quality of life, ideally a more useful indicator would simultaneously take into account the full burden of illness and disability along with life expectancy (ABS 2004b). The World Health Organisation (WHO) uses an adjusted life expectancy measure of 'healthy life expectancy' based on the expected number of years to be lived without reduced functioning. For Australians in 2002 this moderated measure estimates a healthy life expectancy of 70.9 years for males and 74.3 years for females – a ranking of fifth highest in the world (WHO

LIFE EXPECTANCY *continued*

2004). While female life expectancy is around six years longer than males, their healthy life expectancy is only three years longer, suggesting that longevity for females is currently associated with increased disability in the latter years.

Although male life expectancy is increasing at a higher rate than that for females, current trends show that as the population ages, the proportion of males to females in the population decreases due to higher life expectancy of females. While population estimates from 2002 show an almost equal proportion of males to females in the total population (50.3% females), females were over-represented in the 65 years and over population with 56% being female. In addition, 69% of the population aged 85 years and over were female (ABS 2003c).

PROPORTION OF MALES AND FEMALES IN THE POPULATION BY AGE GROUPS—2002



Source: ABS, Population by Age and Sex, cat. no. 3201.0, 2003.

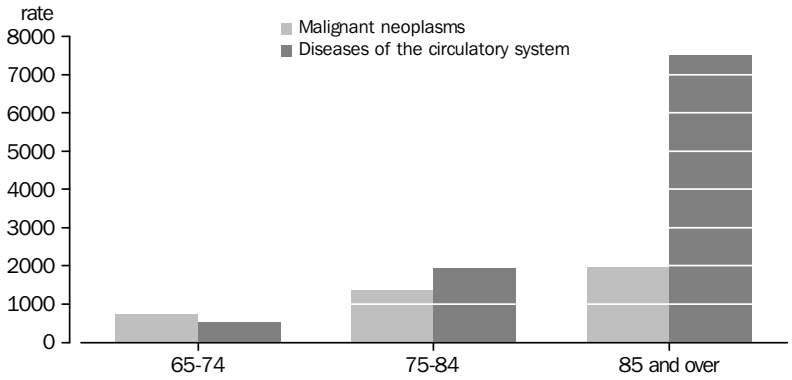
CAUSES OF DEATH

In 2002, the death rate for persons aged 65 years and over was 4,250 per 100,000 older persons, with the male death rate higher at 4,641 per 100,000 males compared with a rate of 3,939 per 100,000 females. When looking at broad groupings of causes of death, the leading causes of death for older persons in 2002 were diseases of the circulatory system and malignant neoplasms. Inevitably death rates increase with age, however the death rates for these conditions vary in the extent to which they increase with age. For persons aged 65-74 years, all malignant neoplasms (cancers) were the leading cause of death at a rate of 740 per 100,000 persons. By 75 years and over, all circulatory conditions become the leading cause of death, peaking at a rate of 7,513 per 100,000 persons for those aged 85 years and over.

CAUSES OF DEATH

continued

SELECTED CAUSES OF DEATH (a)—2002



(a) Rate per 100,000 persons.

Source: ABS, Causes of Death, 3303.0, 2002.

Alternatively, when looking at more specific causes, the leading causes of death for older males and females in 2002 were ischaemic heart diseases (angina and acute myocardial infarction), followed by cerebrovascular diseases (cerebral haemorrhage and cerebral infarction). Lung cancer was the leading cause of cancer deaths for both males and females. Prostate cancer and colorectal cancer were the next most common cancers causing death among older males, while colorectal cancer and breast cancer were among the top ten leading causes of death for females. Of note, death rates from dementia and Alzheimer's disease were much higher in older females (212 per 100,000) compared to older males (124 per 100,000). In contrast, death rates from lung cancer and chronic lower respiratory diseases such as bronchitis, emphysema, and asthma, were higher for older males (324 and 289 deaths per 100,000 respectively) than for older females (131 and 171 deaths per 100,000).

LEADING CAUSES OF DEATH, Males aged 65 years and over—2002

	Total no. of deaths	*Death rate per 100,000*	*Rank*
All causes	***51 322***	***4 641***	***n.a.***
Ischaemic heart diseases (I20-I25)	11 277	1 020	1
Cerebrovascular diseases (I60-I69)	4 452	403	2
Lung cancer (C33,C34)	3 582	324	3
Chronic lower respiratory diseases (J40-J47)	3 199	289	4
Prostate cancer (C61)	2 634	238	5
Colo-rectal cancer (C18-C21)	1 786	161	6
Cancer of lymphoid, haematopoietic and related tissue (C81-C96)	1 543	140	7
Diabetes mellitus (E10-E14)	1 414	128	8
Dementia and Alzheimer's disease (F01,F03,G30)	1 368	124	9
Influenza and pneumonia (J10-J18)	1 223	111	10

Source: ABS Causes of death collection, data available on request.

CAUSES OF DEATH

continued

LEADING CAUSES OF DEATH, Females aged 65 years and over—2002

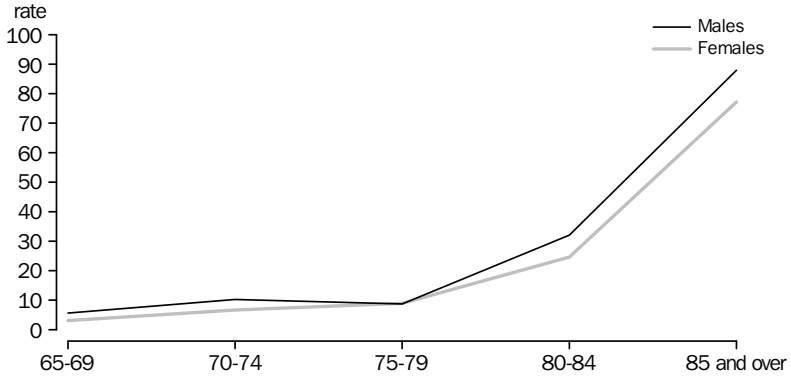
	Total no. of deaths	*Death rate per 100,000*	*Rank*
All causes	***54 553***	***3 939***	***n.a.***
Ischaemic heart diseases (I20-I25)	11 592	837	1
Cerebrovascular diseases (I60-I69)	7 232	522	2
Dementia and Alzheimer's disease (F01,F03,G30)	2 938	212	3
Chronic lower respiratory diseases (J40-J47)	2 371	171	4
Heart failure and complications and ill-defined heart diseases (I50-I51)	2 000	144	5
Lung cancer (C33,C34)	1 816	131	6
Colo-rectal cancer (C18-C21)	1 716	124	7
Influenza and pneumonia (J10-J18)	1 628	118	8
Diseases of the urinary system (N00-N39)	1 546	112	9
Breast cancer (C50)	1 457	105	10

Source: ABS, Causes of death collection, data available on request.

Falls

Another significant issue associated with ageing is the increased incidence of deaths from falls, particularly for persons aged 80 years and over. The death rate from falls for persons aged 65 years and over was 18 per 100,000 people, peaking at 81 per 100,000 for persons aged 85 years and over. Falls may be attributed to many causes including increased age, stroke and Parkinson's disease, low levels of physical activity and reduced muscle strength (National Ageing Research Institute 2004). It is also possible that the effects of particular medications such as sleeping tablets may result in reduced alertness and impaired motor coordination, increasing a susceptibility to falls and injuries (Hasan et al 2001).

DEATHS – ACCIDENTAL FALLS (a)—2002



(a) Rate per 100,000 persons.

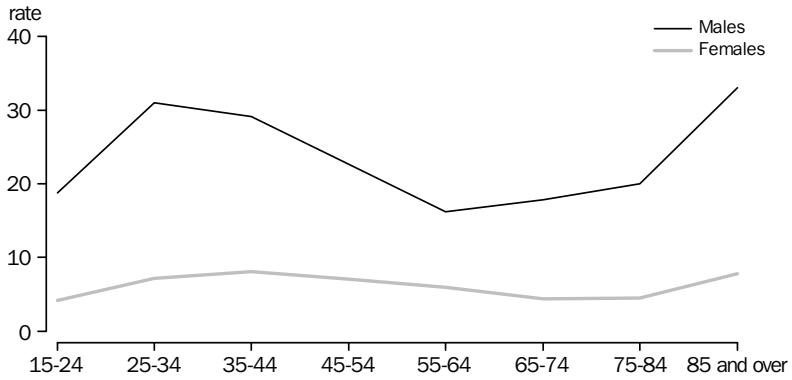
Source: ABS, Causes of Death collection.

Suicides

Although not a leading cause of death among the older population, suicide rates are vastly different between males and females, a difference that is maintained across all age groups. For older persons the male suicide rate is 4.0 times higher than the female suicide rate. The higher male suicide rate is particularly evident for males aged 85 years and over, with a rate of 33 per 100,000 population.

Suicides continued

SUICIDE RATES(a)—2002



(a)Rate per 100,000 population.

Source: ABS, Causes of Death collection.

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Alcohol risk level

Adults were classified by 'alcohol risk level' based on their estimated average daily alcohol consumption in the 7 days prior to interview. Average daily consumption in the previous 7 days was estimated using two components:

- the number of days on which the respondent reported consuming alcohol in the previous week
- the quantity consumed on the three most recent days on which they consumed alcohol in that week. For people who drank on no more than 3 days in the last week, their daily average was simply the total consumed divided by 7.

Risk levels are based on the National Health and Medical Research Council (NHMRC), 2001, *Australian Alcohol Guidelines: Health Risks and Benefits* (www.nhmrc.gov.au) risk levels for harm in the long term, and assumes the level of alcohol consumption recorded for the survey period is typical. The average daily consumption of alcohol associated with the risk levels is as follows:

ALCOHOL RISK LEVEL

	Males	*Females*
Low risk	50ml or less	25ml or less
Risky	More than 50ml, up to 75ml	More than 25ml, up to 50ml
High risk	More than 75ml	More than 50ml

Drinking status information was also collected for those who did not consume any alcohol in the 7 days prior to interview:

- Last consumed more than one week to less than 12 months ago
- Last consumed 2 months or more ago
- Never consumed.

Ancillary cover

Any cover provided by private insurance organisations for health-related services other than medical or hospital cover (e.g. physiotherapy, dental, optical, chiropractic and ambulance).

Body Mass Index (BMI)

Calculated from self-reported height and weight information, using the formula weight (kg) divided by the square of height (m).

To produce a measure of the prevalence of overweight or obesity in adults, BMI values are grouped according to the table below which allows categories to be reported against both WHO and NHMRC guidelines.

BMI RANGE

	2001
Underweight	Less than 18.5
Normal range	18.5 to less than 20.0
Normal range	20.0 to less than 25.0
Overweight	25.0 to less than 30.0
Obese	30.0 and greater

Cardiovascular conditions

See Circulatory problems/diseases.

Carer

A person of any age who provides any informal assistance, in terms of help or supervision, to persons with disabilities or long-term conditions, or older persons (i.e. aged 60 years and over). This assistance has to be ongoing, or likely to be ongoing, for at least six months. Assistance to a person in a different household relates to 'everyday types of activities', without specific information on the activities. Where the care recipient lives in the same household, the assistance is for one or more of the following activities:

- cognition or emotion
- communication

Carer *continued*

- health care
- housework
- meal preparation
- mobility
- paperwork
- property maintenance
- self care
- transport.

Circulatory problems/diseases

Covers all diseases and related problems of the circulatory system. Includes specific conditions such as hypertension, angina, tachycardia, oedema, haemorrhoids, varicose veins and cardiac murmurs.

Core-activity limitation

Four levels of core-activity limitation are determined based on whether a person needs help, has difficulty, or uses aids or equipment with any of the core activities (communication, mobility or self care). A person's overall level of core-activity limitation is determined by their highest level of limitation in these activities.

The four levels of limitation are:

- profound: the person is unable to do, or always needs help with, a core-activity task
- severe: the person
  - sometimes needs help with a core-activity task
  - has difficulty understanding or being understood by family or friends
  - can communicate more easily using sign language or other non-spoken forms of communication.
- moderate: the person needs no help but has difficulty with a core-activity task
- mild: the person needs no help and has no difficulty with any of the core-activity tasks, but
  - uses aids and equipment
  - cannot easily walk 200 metres
  - cannot walk up and down stairs without a handrail
  - cannot easily bend to pick up an object from the floor
  - cannot use public transport
  - can use public transport but needs help or supervision
  - needs no help or supervision but has difficulty using public transport.

Disability

In the context of health experience, the International Classification of Functioning, Disability and Health (ICF) defines disability as an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environment and personal factors).

In the *2003 Survey of Disability, Ageing and Carers*, a person has a disability if they report that they have a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. This includes:

- loss of sight (not corrected by glasses or contact lenses)
- loss of hearing where communication is restricted, or an aid to assist with, or substitute for, hearing is used
- speech difficulties
- shortness of breath or breathing difficulties causing restriction
- chronic or recurrent pain or discomfort causing restriction
- blackouts, fits, or loss of consciousness
- difficulty learning or understanding
- incomplete use of arms or fingers
- difficulty gripping or holding things
- incomplete use of feet or legs
- nervous or emotional condition causing restriction
- restriction in physical activities or in doing physical work

Disability *continued*

- disfigurement or deformity
- mental illness or condition requiring help or supervision
- long-term effects of head injury, stroke or other brain damage causing restriction
- receiving treatment or medication for any other long-term conditions or ailments and still restricted
- any other long-term conditions resulting in a restriction.

Equivalised income

Equivalising adjusts actual income to take account of the different needs of households of different size and composition. See equivalence scales.

Equivalence scales

Equivalence scales have been devised to make adjustments to the actual incomes of households in a way that enables analysis of the relative wellbeing of households of different size and composition. For example, it would be expected that a household comprising two people would normally need more income than a lone person household if the two households are to enjoy the same standard of living. The equivalence scale used to obtain equivalised incomes is the modified method used in studies by the Organisation for Economic Co-operation and Development (OECD). For further information, see *Household Income and Income Distribution, Australia, 2000-01* (Cat.no.6523.0), Appendix 2.

Exercise level

Based on frequency, intensity (i.e. walking, moderate exercise and vigorous exercise) and duration of exercise (for recreation, sport or fitness) in the 2 weeks prior to interview. From these components, an exercise score was derived using factors to represent the intensity of the exercise. Scores were grouped for output as follows:

EXERCISE LEVEL

	2001
Physically inactive	Less than 100 (includes no exercise)
Low	100 to less than 1,600
Moderate	1,600–3,200, or more than 3,200 but less than two hours of vigorous exercise
High	More than 3,200 and two hours or more of vigorous exercise

Government health concession cards

Includes Health Care Card, Pensioner Concession Card, Commonwealth Seniors Health Card and treatment entitlement cards issued by the Department of Veterans' Affairs.

Hospital cover

Health insurance provided by private insurance organisations to cover all or part of the costs of private accommodation in a public hospital, charges for private hospital treatment and care in a public hospital by a doctor of the patient's choice.

Hypertension

An arterial disease of which the elevation of blood pressure is the outstanding sign.

Life satisfaction

In the *2001 National Health Survey*, life satisfaction was measured by asking respondents' how they felt about their life as a whole, taking into account events of the last year and their expectations for the future. Responses were to correspond with one of the following:

1 - Delighted

2 - Pleased

3 - Mostly satisfied

4 - Mixed

5 - Mostly dissatisfied

6 - Unhappy

7 - Terrible

Long term condition

A condition which was current at the time of the survey and which, in the respondent's opinion, had lasted for 6 months or more, or which he or she expected will last for 6 months or more. Some conditions reported were assumed to be long term conditions: these included asthma, cancer, diabetes insipidus, diabetes mellitus types 1 and 2, rheumatic heart disease, heart attack and stroke.

Physical activity

Refers to exercise undertaken in the two weeks prior to interview through sport, recreation or fitness (including walking). Incidental exercise undertaken for other reasons, such as for work or while engaged in domestic duties was excluded. See exercise level.

Psychological distress

Derived from the Kessler Psychological Distress Scale 10 items (K10). This is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the 4 weeks prior to interview. The K10 is scored from 10 to 50, with higher scores indicating a higher level of distress; low scores indicate a low level of distress. In this publication scores are grouped as follows:

- Low (10 - 15)
- Moderate (16 - 21)
- High (22 - 29)
- Very high (30 - 50).

Quintile

When persons (or any other units) are ranked from the lowest to the highest on the basis of some characteristic such as their household income, they can then be divided into equal sized groups. When the population is divided into five equally sized groups, the groups are called quintiles.

Self assessed health status

Refers to respondent's general assessment of own health, against a 5 point scale from excellent through to poor.

Smoker status

Refers to the smoking status of adults at the time of the survey, and incorporates the notion of (regular) smoking, as reported by respondents.

Categories are:

- Current regular (i.e. daily) smoker
- Current smoker not regular
- Ex-regular smoker;
- Never smoked regularly.

Smoking refers to the regular smoking of tobacco, including manufactured (packet) cigarettes, roll your own cigarettes, cigars and pipes, but excludes chewing tobacco and smoking of non tobacco products.

Type of medication used for mental well-being

Refers to the type of medication reported by adult respondents as used for their mental well-being in the 2 weeks prior to interview. Includes vitamins and minerals, natural and herbal medications and the following types of pharmaceutical medications:

- sleeping tablets/capsules
- tablets/capsules for anxiety or nerves
- tranquillisers
- antidepressants
- mood stabilizers
- other medications for mental health.

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