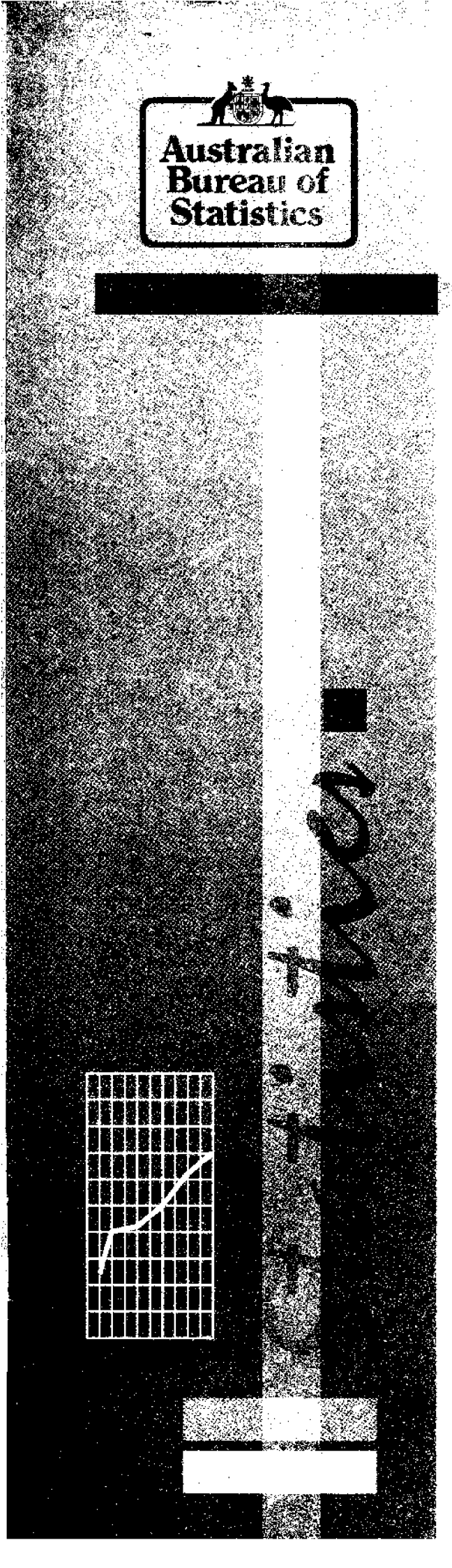
Australian Bureau of Statistics

4803.7

National Health Survey

Darwin–Palmerston and Alice Springs

Northern Territory



NEW ISSUE

National Health Survey

Darwin–Palmerston and Alice Springs

Northern Territory

Dan Black
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Northern Territory

AUSTRALIAN BUREAU OF STATISTICS

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INQUIRIES

- For information about other ABS statistics and services, please refer to the back page of this publication.
- For further information about these statistics, contact Tracey Brandrup on (08) 8943 2152.

CONTENTS

PREFACE

This publication provides a statistical overview of health-related matters of the Northern Territory's urban centres of Darwin-Palmerston and Alice Springs. Most of the information in this publication has been extracted from the Australian Bureau of Statistics' National Health Survey 1995 and the publication is designed to play a companion role to other National Health Survey publications which deal with Australia as a whole.

Information in this publication is catergorised under five broad headings of Health Status, Health-Related Factors, Health Risk Factors, Women's Health and Causes of Death. The chapters Health-Related Factors and Causes of Death contain statistics relating to child immunisation and principal causes of death which have been taken from Australian Bureau of Statistics sources other than the National Health Survey 1995.

Complete information on the nature of the National Health Survey, its objectives, content, and the concepts, methods and procedures used in the collection of data are provided in *National Health Survey: Users' Guide, 1995* (Cat. no. 4363.0).

The Australian Bureau of Statistics acknowledges the input of the Epidemiology Branch of Territory Health Services in the preparation of this publication.

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CHAPTER 1 HEALTH STATUS

SELF ASSESSED HEALTH STATUS

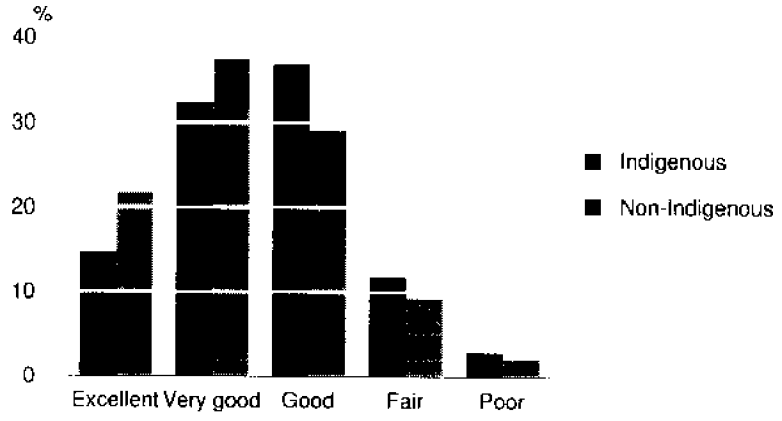
The majority of people aged 15 years and over regard themselves as being in good health with 88.1% reporting their health status as good, very good or excellent. Similar proportions were reported by males and females. The proportion of people reporting fair or poor health increased with age: only 9.1% of those aged 15–34 years reported fair or poor health compared to 23.1% of those aged 55 years and over.

1.1 PERSONS AGED 15 YEARS AND OVER: SELF ASSESSED HEALTH STATUS

	Age (years)									
	15-34		*35-54*		*55 and over*		*Males*		*Females*	
Self assessed health status	'000	%	'000	%	'000	%	'000	%	'000	%
Excellent	8.5	22.9	6.3	20.4	*1.5	*17.0	8.3	20.8	8.0	21.6
Very good	15.0	40.2	11.4	37.0	2.1	23.8	15.2	38.3	13.3	35.8
Good	10.3	27.8	9.5	30.7	3.2	36.0	11.7	29.4	11.3	30.5
Fair	3.0	8.1	3.1	9.9	*1.3	*14.7	3.7	9.2	3.7	9.9
Poor	*0.4	*1.0	*0.6	*2.0	*0.7	*8.4	*0.9	*2.3	*0.8	*2.2
Total persons	**37.2**	**100.0**	**30.9**	**100.0**	**8.8**	**100.0**	**39.8**	**100.0**	**37.1**	**100.0**

The majority of Indigenous people aged 15 years and over also reported their health status as good, very good or excellent (83.9%). However, Indigenous people were less likely than non-Indigenous people to report their health status as very good or excellent (47.1% compared with 59.3%).

1.2 PERSONS AGED 15 YEARS AND OVER: SELF ASSESSED HEALTH STATUS BY INDIGENOUS STATUS



How people rated their health was strongly related to their experience of illness. Of those people who reported having no medical condition (11.7%), 69.7% assessed their health as very good or excellent. In contrast, of those people who reported both recent and long-term conditions (57.5%), only 51.1% assessed their health as very good or excellent and 16.0% rated their health as fair or poor.

1.3 PERSONS AGED 15 YEARS AND OVER: SELF ASSESSED HEALTH STATUS BY WHETHER REPORTED RECENT AND/OR LONG-TERM CONDITION(S)

	Recent condition(s) only		*Long-term condition(s) only*		*Both recent and long-term conditions*		*No condition reported*	
Self assessed health status	'000	%	'000	%	000	%	'000	%
Excellent	2.0	29.3	4.4	26.4	7.3	16.4	2.6	28.7
Very good	3.1	44.0	6.4	38.3	15.3	34.7	3.7	41.0
Good	*1.5	*20.9	4.8	29.0	14.5	32.9	2.2	24.1
Fair	*0.4	*5.4	*1.0	*6.0	5.5	12.3	*0.5	*5.8
Poor	**	**	**	**	1.6	3.7	**	**
Total persons	**7.0**	**100.0**	**16.7**	**100.0**	**44.2**	**100.0**	**9.0**	**100.0**

RECENT CONDITIONS

Almost two-thirds (63.9%) of people experienced an illness or injury in the two weeks prior to the survey.

1.4 PERSONS REPORTING RECENT CONDITION: TYPE OF CONDITION

	Males		Females	
Type of action	'000	%	'000	%
Infectious and parasitic diseases	2.0	6.1	2.9	8.7
Neoplasms	*0.8	*2.4	*0.6	*1.9
Endocrine, nutritional and metabolic diseases and immunity disorders	3.3	10.3	3.9	11.7
Diseases of the blood and blood forming organs	**	**	*1.4	*4.1
Mental disorders	1.9	6.0	2.1	6.3
Diseases of the nervous system and sense organs	17.1	52.9	18.3	55.2
Diseases of the circulatory system	4.7	14.7	6.3	18.9
Diseases of the respiratory system	13.8	42.6	15.7	47.4
Diseases of the digestive system	5.3	16.4	5.5	16.7
Diseases of the genito-urinary system	*0.9	*2.9	3.5	10.7
Complications of pregnancy, childbirth and the puerperium	..	..	*0.3	*0.9
Diseases of the skin and subcutaneous tissue	4.3	13.3	4.8	14.4
Diseases of the musculoskeletal system/connective tissue	8.9	27.5	8.7	26.3
Congenital anomalies	**	**	**	**
Symptoms, signs and ill-defined conditions	10.2	31.7	12.7	38.3
Injuries and poisoning	4.1	12.8	3.3	9.9
Disability, not elsewhere classified	*0.6	*1.8	*0.4	*1.1
Other factors influencing health status or contact with health services	11.4	35.4	14.1	42.5
Total persons (a)	**32.3**	**100.0**	**33.1**	**100.0**

(a) Persons may have reported more than one type of action, therefore components do not add to totals.

Diseases of the nervous system and sense organs were the most commonly reported recent illness group. More than half of people (54.1%) with a recent condition reported illnesses in this group which included problems with eyesight such as long sightedness (reported by 20.0%) and short sightedness (reported by 18.5%). Diseases of the respiratory system were the second most commonly reported recent illness (45.1%) followed by diseases of the musculoskeletal system and connective tissue (26.9%) which included arthritis (11.6%) and unspecified back problems (6.0%).

LONG-TERM CONDITIONS

More than two-thirds (70.4%) of people reported having at least one condition of six months or more duration. The most commonly reported long-term conditions were diseases of the nervous system and sense organs (64.7%). Other commonly reported conditions were diseases of the respiratory system (43.8%) and diseases of the musculoskeletal system and connective tissue (27.5%).

1.5 PERSONS REPORTING LONG-TERM CONDITION: TYPE OF CONDITION

	Males		*Females*	
Type of action	'000	%	'000	%
Infectious and parasitic diseases	1.8	4.9	2.6	7.2
Neoplasms	*0.8	*2.2	*0.6	*1.7
Endocrine, nutritional and metabolic diseases and immunity disorders	4.1	11.3	4.2	11.7
Diseases of the blood and blood forming organs	**	**	*1.4	*3.8
Mental disorders	2.2	6.0	2.1	5.8
Diseases of the nervous system and sense organs	23.4	64.6	23.2	64.8
Diseases of the circulatory system	5.7	15.9	7.1	19.7
Diseases of the respiratory system	15.0	41.4	16.5	46.2
Diseases of the digestive system	4.9	13.6	4.5	12.6
Diseases of the genito-urinary system	*1.0	*2.8	3.8	10.6
Complications of pregnancy, childbirth and the puerperium	..	..	*0.3	*0.9
Diseases of the skin and subcutaneous tissue	3.6	9.8	4.0	11.2
Diseases of the musculoskeletal system/connective tissue	10.2	28.2	9.6	26.8
Congenital anomalies	**	**	*0.2	*0.6
Symptoms, signs and ill-defined conditions	9.1	25.0	11.6	32.4
Injuries and poisoning	3.1	8.4	2.6	7.3
Disability, not elsewhere classified	*0.9	*2.5	*0.5	*1.5
Other factors influencing health status or contact with health services	11.4	31.4	14.8	41.4
Total persons (a)	**36.2**	**100.0**	**35.8**	**100.0**

(a) Persons may have reported more than one type of action, therefore components do not add to totals.

HEALTH-RELATED ACTIONS

A substantial number of people (73.0%) reported taking one or more health-related action in the two weeks prior to the survey. The most common health-related action among these people was using medication (excluding vitamins and minerals and natural or herbal medications) (74.2%) while 22.9% consulted a doctor (general practitioner or specialist).

1.6 PERSONS: WHETHER TOOK HEALTH RELATED ACTION DURING THE TWO WEEKS PRIOR TO INTERVIEW BY TYPE OF ACTION

	Males		*Females*	
Type of action	'000	%	'000	%
Hospitalisation	*0.4	*1.1	*0.5	*1.3
Casualty/emergency/outpatients visit	2.3	6.3	2.3	6.1
Day clinic visit	*0.8	*2.2	*1.1	*2.9
Doctor consultation	7.4	20.1	9.7	25.6
Dentist consultation (a)	2.9	7.9	3.0	7.9
Consultation with other health professionals	4.4	12.0	5.1	13.5
Vitamin and minerals use	12.5	34.0	15.2	40.1
Natural or herbal medications use	3.3	9.0	5.7	15.0
Medication use	26.1	70.9	29.3	77.3
Days off work/school	4.5	12.2	5.6	14.8
Days of reduced activity	2.6	7.1	3.0	7.9
Other health related contact	7.0	19.0	7.8	20.6
Total persons taking action (b)	*36.8*	*100.0*	*37.9*	*100.0*
Total persons who took no action	*16.0*		*11.6*	
Total persons	**52.8**		**49.5**	

(a) Only persons aged 2 years and over. (b) Persons may have reported more than one type of action, therefore components do not add to totals.

Females were more likely to take a health-related action than males (76.5% compared with 69.7%). More than three-quarters of females who took a health-related action used medications (excluding vitamins and minerals and natural or herbal medications) (77.3%) compared with 70.9% of males while about one-quarter of females consulted a doctor (25.6%) compared with 20.1% of males. Females were also more likely than males to use vitamins and minerals (40.1% compared with 34.0%) and natural or herbal medications (15.0% compared with 9.0%).

CHAPTER 2 HEALTH - RELATED FACTORS

USE OF MEDICATIONS

During the two weeks prior to the survey, 54.2% of people used some form of medication (excluding vitamins and minerals and natural or herbal medications). The proportion of people who had taken medication was similar in Darwin–Palmerston and Alice Springs and somewhat higher for females in both centres: 50.8% of males in Darwin–Palmerston and 45.0% of males in Alice Springs had taken medication compared with 58.8% of females in Darwin–Palmerston and 60.1% of females in Alice Springs.

2.1 PERSONS: WHETHER USED MEDICATION IN THE TWO WEEKS PRIOR TO INTERVIEW BY TYPE OF MEDICATION

	Males		*Females*	
Type of medication (a)	'000	%	'000	%
Asthma medications	2.3	8.8	3.5	11.9
Medications for arthritis	*0.8	*3.1	*1.1	*3.8
Medications for cough/colds	3.2	12.3	3.3	11.3
Skin ointments/creams	4.7	18.0	5.5	18.8
Stomach medications	*1.3	*5.0	*1.2	*4.1
Medications for allergies	*1.5	*5.7	2.0	6.8
Medications for heart problems/blood pressure	2.2	8.4	1.6	5.5
Pain relievers	10.4	39.8	13.4	45.7
None of the above	**	**	**	**
Total persons who used medications (b)	*26.1*	*100.0*	*29.3*	*100.0*
Total persons who did not use medications	*26.6*		*20.3*	
Total persons	**52.8**		**49.5**	

(a) Type of medication as reported by respondents. Excludes vitamins and minerals and natural or herbal medications. (b) Persons may have reported using more than one type of medication, therefore components do not add to totals.

The most commonly used medication was pain relievers (43.0%) with more females than males using them (45.7% compared with 39.8%). Other commonly used medications included skin ointments/creams (18.2%), medications for coughs and colds (11.7%) and asthma medications (10.5%). Females were more likely than males to use asthma medications (11.9% compared with 8.8%) while males were more likely than females to use medications for heart problems/blood pressure (8.4% compared with 5.5%).

IMMUNISATION

Vaccination remains one of the single most significant means of preventing some infectious diseases. High levels of vaccine uptake are considered important by health authorities, not only to maximise individual protection but to minimise the transmission of wild virus.

The National Health and Medical Research Council (NH&MRC) recommends a 95% uptake of all vaccines, administered at the recommended age. Among children in the Territory (excluding remote and sparsely settled areas) aged 0–6 years, only 40.5% of males and 32.2% of females were fully immunised for age according to the NH&MRC guidelines at April 1995. This compared with 31.9% of males and 34.4% of females being fully immunised in Australia as a whole. At the time of the survey, the national Childhood Vaccination Schedule had recently been changed. In the Northern Territory, 48.8% of males and 58.5% of females aged 0–6 years were fully immunised under the previous Schedule, compared with 49.5% of males and 54.9% of females in Australia as a whole.

2.2 FULLY IMMUNISED CHILDREN (a): CONDITION BY SELECTED AGE GROUPS, NORTHERN TERRITORY (b), APRIL 1995

Condition	*Children aged 1 year* %	*Children aged 2 years* %	*Children aged 6 years* %
Diphtheria/Tetanus	88.9	65.4	39.1
Pertussis	85.2	65.4	**
Polio	70.4	61.5	69.6
Measles	88.9	99.9	82.6
Mumps	85.2	99.9	82.6
Rubella	81.5	99.9	78.3
Hib	70.4	46.2	43.5
All conditions (c)	*59.3	38.5	**
Total persons ('000)	**2.7**	**2.6**	**2.3**

(a) A child is classified as fully immunised against a particular condition if he or she has received the number of vaccinations for that condition appropriate to his or her age as specified in the Schedule. (b) Estimates exclude remote and sparsely settled areas. (c) 1994 schedule.
Source: *Children's Immunisation* (ABS Catalogue No. 4352.0).

In the Northern Territory (excluding remote and sparsely settled areas), the proportion of one year old children that were fully immunised for each of the vaccine-preventable diseases was comparable to national averages with the exception of polio and *Haemophilus influenzae* type b (Hib). Among one year old children, 70.4% were fully immunised against polio in the Territory compared with 86.3% nationally. Among two year old children, this gap was greater with 61.5% of Territory children fully vaccinated against polio compared with 86.9% nationally. In the Territory, 70.4% of one year old children were fully immunised against Hib compared with 62.3% nationally, but among two year old children this situation was reversed with 46.2% of Territory children fully vaccinated against Hib compared with 52.4% nationally.

CHAPTER 3 HEALTH RISK FACTORS

SMOKING

Smoking is considered by health authorities to be an important preventable cause of ill health and death. Among the population of Darwin–Palmerston and Alice Springs, 34.0% of males and 29.0% of females smoked. The rate of smoking among males in Alice Springs was higher than in Darwin–Palmerston (39.6% compared with 32.4%) and at similar levels among females in both centres (28.8% and 29.1% respectively).

3.1 PERSONS AGED 18 YEARS AND OVER: SMOKER STATUS

	Males		*Females*	
	'000	%	'000	%
DARWIN–PALMERSTON				
Smoker	9.2	32.4	7.7	29.1
Ex-smoker	8.3	29.0	6.2	23.3
Never smoked	11.0	38.6	12.7	47.6
Total persons	**28.5**	**100.0**	**26.6**	**100.0**
ALICE SPRINGS				
Smoker	3.3	39.6	2.3	28.8
Ex-smoker	2.0	23.4	1.9	23.2
Never smoked	3.1	37.0	3.9	48.0
Total persons	**8.3**	**100.0**	**8.1**	**100.0**

In the 25–64 year age group, males were more likely to smoke than females (35.3% compared with 28.2%). This situation was reversed for people in the 18–24 year age group where females were slightly more likely to smoke than males (38.6% compared with 32.1%).

The proportion of males and females in Darwin–Palmerston and Alice Springs who smoked (34.0% and 29.0% respectively) was higher than in Australia as a whole: nationally 27.3% of males and 20.3% of females were smokers. The proportion of people in these areas of the Northern Territory who had never smoked was lower than in Australia as a whole (42.8% compared with 48.9%). This difference was larger for females: almost half (47.7%) of females in Darwin–Palmerston and Alice Springs had never smoked compared with 57.1% nationally while 38.2% of males had never smoked compared with 40.4% nationally.

The proportion of males in Darwin–Palmerston and Alice Springs who were ex-smokers was lower than the proportion of males in Australia as a whole (27.7% compared with 32.4%) while the proportion of females who were ex-smokers was almost the same (23.3% compared with 22.5%).

ALCOHOL CONSUMPTION

Excess consumption of alcohol has been identified by health authorities as a major health risk factor linked to numerous health conditions such as cirrhosis of the liver as well as suicide, road injuries and social problems.

Almost two-thirds of people (63.9%) reported having consumed a drink containing alcohol in the week prior to the survey, with a slightly higher proportion of people consuming alcohol in Alice Springs than in Darwin–Palmerston (68.1% compared with 62.4%). Males were much more likely to consume alcohol than females (71.5% compared with 55.7%). People aged 35–54 years were also most likely to consume alcohol (68.9%) followed by those aged 18–34 years (62.8%). Half of those aged 55 years and over consumed alcohol (50.0%).

The majority of those persons who drank alcohol did so at levels considered to be of low risk to their health (68.1% of males and 83.4% of females). Males who drank alcohol were more likely than females to consume alcohol at medium or high risk levels (32.3% compared with 16.0%).

3.2 PERSONS AGED 18 YEARS AND OVER: ALCOHOL RISK LEVELS (a)

	Males		*Females*	
	'000	%	000	%
Low	17.9	68.1	15.6	83.4
Medium	3.9	14.8	2.1	11.2
High	4.6	17.5	*0.9	*4.8
Total persons who consumed alcohol	26.3	100.0	18.7	100.0
Total persons who did not consume alcohol	10.5		14.9	
Total persons (b)	**36.8**		**33.6**	

(a) Refer to Glossary for definition of alcohol risk levels. (b) Population total is affected by non-responses.

A much higher proportion of people in Darwin–Palmerston and Alice Springs consumed alcohol at levels considered to be of medium or high risk to their health than in Australia as a whole. In these areas of the Northern Territory, males were almost twice as likely to consume alcohol at medium risk levels than males in Australia as a whole (14.8% compared with 8.4%) while females were only slightly more likely to do so (11.2% compared with 10.7%). Consumption of alcohol at high risk levels among males and females in Darwin–Palmerston and Alice Springs was about twice the rate for Australia as a whole (17.5% compared with 7.7% for males and 4.8% compared with 2.8% for females).

EXERCISE

Participation rates in medium levels of exercise among people in Darwin–Palmerston and Alice Springs were broadly similar: about two-thirds of people in both areas reported taking part in some type of exercise for sport, recreation or fitness in the two weeks prior to interview.

While the proportions of males and females who exercised were similar (67.2% and 67.6% respectively), males were more likely than females to exercise at a high level (23.1% compared with 13.8%). About one-third (35.1%) of females reported exercising at a low level compared with 26.0% of males.

3.3 PERSONS AGED 15 YEARS AND OVER: PHYSICAL ACTIVITY INDEX

	Males		*Females*	
	'000	%	'000	%
DARWIN–PALMERSTON				
Low exercise level	8.3	39.7	9.9	51.8
Medium exercise level	5.5	26.3	5.1	26.7
High exercise level	7.1	34.0	4.1	21.5
Total persons who exercised	*20.9*	*100.0*	*19.1*	*100.0*
Total persons who did no exercise	*10.1*		9.3	
Total persons	**31.0**		**28.4**	
ALICE SPRINGS				
Low exercise level	2.1	35.6	3.2	52.5
Medium exercise level	1.7	28.8	1.8	29.5
High exercise level	2.1	35.6	*1.1	*18.0
Total persons who exercised	5.9	*100.0*	6.1	*100.0*
Total persons who did no exercise	3.0		2.7	
Total persons	**8.8**		**8.7**	

People aged 15–34 years were more likely to exercise than those aged 35–54 years (75.6% compared with 61.9%) and to exercise at a medium or high level (45.9% compared with 29.8%). While the proportion of females who exercised at a high level was similar for both age groups (16.4% of those aged 15–34 years and 13.1% of those aged 35–54 years), the proportion of males exercising at a high level dropped markedly with age from 33.7% of those aged 15–34 years to only 14.2% of those aged 35–54 years.

People in Darwin–Palmerston and Alice Springs were also slightly more active overall than Australians as a whole. While the proportion of people who did not take part in some type of exercise was similar to that nationally, people in Darwin–Palmerston and Alice Springs were more likely to exercise at medium and high levels than Australians as a whole (36.9% compared with 33.0%).

BODY MASS

Only about half of people (47.2% of males and 49.3% of females) recorded a Body Mass Index within an acceptable weight range for their height. Considerably more females were underweight than males (16.4% compared with 6.8%). Of these, the majority (70.5%) were females aged 15–34 years.

3.4 PERSONS AGED 15 YEARS AND OVER: BODY MASS INDEX (a)

	Males		*Females*	
	'000	%	'000	%
Underweight	2.7	6.8	6.1	16.4
Acceptable weight	18.8	47.2	18.3	49.3
Overweight	12.1	30.5	6.6	17.7
Obese	3.5	8.7	2.7	7.2
Not stated/not known	2.7	6.8	3.5	9.4
Total persons	**39.8**	**100.0**	**37.1**	**100.0**

(a) Refer to Glossary for definition of body mass.

Conversely, more males (39.2%) than females (24.9%) were recorded as being overweight or obese. Older people were more likely to be overweight or obese than younger people: 42.1% of people aged 55 years and over were overweight or obese compared with 23.9% of people aged 15–34 years and 39.5% of people aged 35–54 years.

People living in Alice Springs were also more likely to be overweight or obese than those living in Darwin–Palmerston: 45.4% of males and 28.4% of females in Alice Springs were overweight or obese compared with 37.4% of males and 23.8% of females in Darwin–Palmerston.

SUN PROTECTION

Most people (91.3% of males and 92.0% of females) reported that they had deliberately taken measures to protect themselves against the sun in the month preceding the survey. People aged 15–34 years and 35–54 years were more likely to take measures to protect themselves (92.0% and 90.3% respectively) than those aged 55 years and over (82.8%). Less than half (47.7%) of people always took measures to protect themselves against the sun and a further 27.7% usually took such measures.

3.5 PERSONS: WHETHER SUN PROTECTION MEASURES USED

	Males		*Females*	
	'000	%	'000	%
Yes	48.2	91.3	45.6	92.0
No	4.2	8.0	3.6	7.2
Not exposed to sun	*0.4	*0.7	*0.4	*0.7
Total persons	**52.8**	**100.0**	**49.5**	**100.0**

Females were more likely than males to report that they regularly checked their skin (or had their skin checked by a doctor) for any changes to freckles and moles (64.6% compared with 57.9%).

ACCIDENTS

A total of 15.9% of people reported having a condition as a result of an accident. Males were more likely than females to have a condition caused by an accident (19.5% compared with 12.1%).

The most common cause of conditions resulting from an accident among males was single or long-term exposure to a harmful factor (20.4%) followed by a fall (17.5%) and vehicle accident (15.5%). Among women the most common causes were a fall (25.0%) and vehicle accident and single or long-term exposure to a harmful factor (both 11.7%).

3.6 PERSONS WHO REPORTED ANY CONDITIONS AS A RESULT OF AN ACCIDENT (a): AGENT OF INJURY

	Males		*Females*	
Agent of injury	'000	%	'000	%
Single or long-term exposure to harmful factor	2.1	20.4	*0.7	*11.7
Fall	1.8	17.5	1.5	25.0
Vehicle accident	1.6	15.5	*0.7	*11.7
Hitting something or being hit by something	*1.3	*12.6	*0.5	*8.3
Attack by another person	*0.7	*6.8	*0.2	*3.3
Other/not stated	**	**	**	**
Total persons	**10.3**	**100.0**	**6.0**	**100.0**

(a) Includes accidents, exposures to harmful factors and other incidents.

CHAPTER 4 WOMEN'S HEALTH

BREAST SCREENING

Breast mammograms are currently regarded by health authorities as an effective method for the early detection of breast cancer. The current national breast screening program recommends that all women aged 50 years and over should be screened every two years. About one-third (33.2%) of women aged 50 years and over and 78.6% of women aged 18–49 years reported that they had never had a mammogram. Of these, 9.5% of women aged 50 years and over and 15.7% of women aged 18–49 years reported that not only had they not had a mammogram but they had never heard of a mammogram.

4.1 WOMEN AGED 18 YEARS AND OVER: BREAST SCREENING TESTS

	Age group (years)			
	18-49		50 and over	
	'000	%	'000	%
Whether regularly examines own breasts—				
Does not regularly examine own breasts	9.0	32.1	1.6	29.1
Regularly examines own breasts	19.0	67.6	3.8	69.1
Not stated	**	**	**	**
Whether ever had a breast examination by a doctor or medical assistant—				
Has not had breast examination	9.6	34.1	*1.2	*22.4
Has had a breast examination	18.3	65.2	4.2	76.9
Not stated	**	**	**	**
Whether ever had a mammogram—				
Has not had a mammogram	17.7	62.9	*1.3	*23.7
Has had a mammogram	5.2	18.4	3.5	64.3
Never heard of mammogram	4.4	15.7	*0.5	*9.5
Not stated	*0.8	*3.0	**	**
Total persons (a)	**28.1**	**100.0**	**5.5**	**100.0**

(a) Population total is affected by non-responses.

Regular breast examination is also considered to be important for detection of breast cancer. About one-third of women aged 18–49 years (34.1%) stated that they had never had their breasts examined by a doctor or medical assistant and 32.1% did not regularly examine their own breasts. Of women aged 50 years and over, 22.4% reported that they had never had their breasts examined by a doctor or medical assistant and 29.1% did not regularly examine their own breasts.

PAP SMEAR TESTS

The current national women's health policy recommends that all women who have ever been sexually active should commence having Pap smears between the ages of 18 to 20 years or one to two years after first sexual intercourse, whichever is later. Routine screening with Pap smears should be carried out every two years for women who have no symptoms or history suggestive of cervical pathology.

The majority of women in Darwin–Palmerston and Alice Springs have had at least one Pap smear: 88.5% of women aged 18–49 years and 85.1% of women aged 50 years and over reported that they have had a Pap smear at some time in their life.

4.2 WOMEN AGED 18 YEARS AND OVER: WHETHER EVER HAD A PAP TEST

	Age group (years)			
	18-49		50 and over	
	'000	%	'000	%
Has not had a Pap test	1.7	6.0	*0.3	*5.5
Has had a Pap test	24.9	88.5	4.7	85.1
Never heard of Pap test	*1.1	*3.8	*0.5	*8.6
Not stated	*0.5	*1.7	**	**
Total persons (a)	**28.1**	**100.0**	**5.5**	**100.0**

(a) Population total is affected by non-responses.

CONTRACEPTIVE USE

Half of the women aged 18–49 years reported that a contraceptive method was used by themselves or their partner. Of these, 63.8% used the oral contraceptive pill and 22.0% used condoms.

4.3 WOMEN AGED 18–49 YEARS: CONTRACEPTIVE USE (a) BY CONTRACEPTIVE METHOD

	Total	
	'000	%
Oral contraceptive pill	9.0	63.8
Condom	3.1	22.0
IUD	*0.9	*6.4
Other (b)	**	**
Total persons who use contraceptives	*14.1*	*100.0*
Total persons who do not use contraceptives (c)	*14.1*	
Total persons (d)	**28.1**	

(a) By self or partner. (b) Other includes natural method (includes rhythm/Billings, etc), diaphragm, withdrawal and contraceptive injection (depoprovera). (c) Includes not stated. (d) Population total is affected by non-responses.

HORMONE REPLACEMENT THERAPY

Hormone Replacement Therapy is commonly prescribed as a treatment for symptoms associated with menopause and as a preventive measure for osteoporosis. More than one-third (37.5%) of women aged 50 years and over reported using Hormone Replacement Therapy at the time of the survey.

CHAPTER 5 CAUSES OF DEATH

PRINCIPAL CAUSES OF DEATH

There were 408 deaths of Darwin–Palmerston and Alice Springs residents registered in 1995. Although Indigenous people comprised about 10% of the population of Darwin–Palmerston and Alice Springs, they accounted for 22.1% of these deaths.

The two main causes of death among non-Indigenous people were malignant neoplasms (25.8% of males and 25.7% of females) and diseases of the circulatory system (24.9% of males and 22.0% of females). External causes such as accidents and suicide were a substantial cause of death for non-Indigenous males (20.6%) but less so for females (9.2%).

5.1 DEATHS: PRINCIPAL CAUSES OF DEATH, 1995

	Indigenous		*Non-Indigenous*	
Cause of death and ICD code	Males	Females	Males	Females
Malignant neoplasms (cancer) (140-208)	7	5	54	28
Diabetes mellitus (250)	2	2	2	5
Mental disorders (290-319)	5	5	5	4
Diseases of the circulatory system (390-459)—	*10*	*11*	*52*	*24*
Ischaemic heart disease (410-414)	5	5	28	11
Other heart disease (393-398, 402, 404, 415, 416, 420-429)	5	3	10	4
Other (390-392, 400, 401, 403, 405, 417, 430-438, 440-459)	—	3	14	9
Diseases of the respiratory system (460-519)	3	5	19	11
Perinatal conditions (760-779)	—	—	6	6
All other medical conditions (Remainder of 001-799)	10	10	28	21
External causes (E800-E999)—	*11*	*4*	*43*	*10*
Motor vehicle traffic accidents (E810-E819)	6	2	12	2
Other external causes (Remainder of E800-E999)	5	2	31	8
Total	**48**	**42**	**209**	**109**

Source: Unpublished ABS data.

Amongst Indigenous people, diseases of the circulatory system were the main cause of death (20.8% of males and 26.2% of females). The proportion of deaths among Indigenous people resulting from external causes mirrored that for non-Indigenous people (22.9% of males and 9.5% of females). Other significant causes of death amongst Indigenous people included malignant neoplasms (14.6% of males and 11.9% of females), mental disorders (10.4% of males and 11.9% of females) and diseases of the respiratory system (6.3% of males and 11.9% of females).

EXPLANATORY NOTES

INTRODUCTION

1 The 1995 National Health Survey (NHS) is the second in a series of regular five-yearly population surveys designed to obtain national benchmark information on a range of health-related issues and to enable the monitoring of trends in health over time. Surveys in this series comprise a core data set which is repeated in successive surveys and a supplementary data set which can be varied from survey to survey to address key health issues of the day. The aims of the 1995 survey were to obtain information about the health status of Australians, their use of health services and facilities and about health-related aspects of their lifestyle such as smoking, alcohol consumption and exercise. The survey was conducted throughout the 12 month period February 1995 to January 1996.

SCOPE

2 The estimates contained in this publication are based on information obtained from residents of a final sample of 1,981 private dwellings (houses, flats, etc.) and non-private dwellings (hotels, motels, boarding houses, caravan parks, etc.) within the Northern Territory with a metropolitan sampling fraction of 1/30 and ex-metropolitan sampling fraction of 1/150. Nationally 28,636 private and non-private dwellings were included in the final sample selected. The estimates in this publication relate only to Darwin–Palmerston and Alice Springs.

3 At the request of the health authority, Territory Health Services, the survey sample in the Northern Territory was increased six-fold in Darwin–Palmerston and Alice Springs to enhance the reliability of estimates.

4 Households were selected at random using a stratified multi-stage area sample which ensured that persons within each State and Territory had a known and, in the main, equal chance of selection in the survey.

5 Certain groups of persons such as non-Australian diplomatic personnel, persons from overseas holidaying in Australia, members of non-Australian defence forces and their dependents stationed in Australia, students at boarding schools, and institutionalised persons (including inpatients of hospitals, nursing homes, etc.) were excluded from the survey.

METHODOLOGY

6 Trained ABS interviewers conducted personal interviews with residents of selected dwellings. Each person aged 18 years or more was interviewed personally, with the exception of persons too old or sick. Persons aged 15–17 years were interviewed with the consent of a parent or guardian; otherwise, a parent or guardian was interviewed on their behalf. For persons aged less than 15 years, information was obtained from a person responsible for the child (usually the mother).

7 In order to maximise the capacity of the survey, some sections were administered to half of the sample only. The General Health and Well-Being form (SF-36) was administered to adults in one-half of the sample, while questions on post-school educational qualifications, private health insurance, alcohol consumption and supplementary women's health issues were administered (appropriate to sex and age) to respondents in the other half of the sample. Other sections of the survey were administered across the full sample. For output, weighted estimates for all items, regardless of the particular sample in which they were included, relate to the total population of appropriate age and/or sex.

METHODOLOGY *continued*

8 Definitions for those items covered in this publication are provided in the Glossary. Comprehensive details of all the concepts, methodologies and procedures used in this survey are provided in *National Health Survey: Users' Guide, 1995* (Cat. no. 4363.0).

CLASSIFICATION OF MEDICAL CONDITIONS

9 All medical conditions (and other reasons for taking health-related actions) reported were classified to a list of selected conditions, symptoms, treatments, etc. developed for this survey. This classification is based on the International Classification of Diseases (ICD), 9th Revision[1] but was modified to take account of the type and quality of information likely to be reported in the survey. In general, broad classification groups have been used. Special codes were created for some non-illness reasons for action (e.g. check-up, preventive measures) and for some frequently reported conditions which could not be reliably coded to ICD categories because insufficient detail was provided at interview (e.g. back problems, virus, infection).

10 While the classification of conditions and the methodologies used for identifying conditions were generally similar to those used in the 1989–90 NHS, they are not identical. Changes introduced for the 1995 survey included the re-ordering of questions on illness within the questionnaire, additional actions used to prompt respondents for recent illness, expansion of the classification categories (which may have affected the counts of illness conditions) and inclusion of new questions on specific conditions. Full details of changes made between surveys, and a discussion of their implications for comparability, are contained in *National Health Survey: Users' Guide, 1995* (Cat. no. 4363.0).

ESTIMATION PROCEDURES

11 Estimates from the survey are derived using a procedure which combines response information collected in the course of the survey with independently available information concerning the underlying populations. As a result, survey estimates conform to the published population estimates at age-sex-area level. The survey was conducted over a 12 month period and estimates were made to conform to the population distribution for each quarter of the year.

12 The estimation procedure developed for the 1995 survey uses information on the patterns of response to counter known biases in target variables resulting from partial response. This information, in the form of models, was used to adjust data for differential response by class, and also to specify weighting classes for applying benchmarks. Full details of the estimation procedures used are contained in *National Health Survey: Users' Guide, 1995* (Cat. no. 4363.0).

[1] *International Classification of Diseases, Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Vol. 2*, World Health Organisation, Geneva, 1978.

RELIABILITY OF ESTIMATES

13 Since the estimates are based on a sample they are subject to sampling variability. In this publication, only estimates with relative standard errors less then 25% are considered sufficiently reliable for most purposes. However, estimates with relative standard errors 25% to 50% have been included and are preceded by an asterisk (e.g. *4.3) to indicate they are subject to a high standard error and should be used with caution. Estimates with a relative standard error over 50% have been replaced with a double asterisk (e.g. **). Such estimates are considered too unreliable for general use.

14 Sampling error occurs because a sample, rather than the entire population, is surveyed. One measure of the likely difference resulting from not including all dwellings in the survey is given by the standard error. There are about two chances in three that a sample estimate will differ by less than one standard error from the figure that would have been obtained if all dwellings had been included in the survey, and about nineteen chances in twenty that the difference will be less than two standard errors. Full details of sampling error variability are provided in *National Health Survey: Users' Guide, 1995* (Cat. no. 4363.0)

15 In addition to sampling errors, the estimates are subject to non-sampling errors. These may be caused by errors in reporting (e.g. because some answers were based on memory, or because of misunderstanding or unwillingness of respondents to reveal all details) or errors arising during processing (e.g. coding, data recording). Such errors may occur in any statistical collection whether it is a full census count or a sample survey. Every effort is made to reduce non-sampling errors in the survey to a minimum by careful design and testing of questionnaires, by intensive training and supervision of interviewers, and by efficient operating procedures.

INTERPRETATION OF RESULTS

16 Information recorded in this survey is essentially 'as reported' by respondents, and hence may differ from that which might be obtained from other sources or via other methodologies. This factor should be considered in interpreting the estimates in this publication. In particular:

- reported information on medical conditions was not medically verified, and was not necessarily based on diagnosis by a medical practitioner. Conditions which have a considerable effect on people (or which people have had for a longer time) are likely to be better reported than those which have little effect. Some people may be unaware of minor conditions, and occasionally may have serious conditions which have not been diagnosed. There may also be some instances of under-reporting as a consequence of respondents being unwilling to talk about a particular condition at an interview; and
- results of previous surveys of alcohol and tobacco consumption suggest a tendency for respondents to under-report actual consumption levels.

17 The exclusion from the survey of people currently in hospitals, nursing homes and other institutions will have affected the results.

RELATED PUBLICATIONS

18 The *1995 National Health Survey Data Reference Package* containing the NHS questionnaires, data item listings, lists of standard unpublished table sets, comparison of 1995 and 1989–90 condition codes, 1995 condition codes list and sample counts is available. Information about all the publications and other products planned for release from the 1995 NHS is contained in the brochure *National Health Survey: Guide to Products and Services* which is available free of charge from any office of the ABS.

RELATED PUBLICATIONS *continued*

Other ABS publications which may be of interest include:

Australian Health Survey, 1983 (Cat. no. 4311.0)

Census of Population and Housing, Counts by Age and Sex for Selected Areas, Northern Territory, 1996 (2018.7)

Census of Population and Housing, Selected Social and Housing Characteristics for Statistical Local Areas, Northern Territory, 1996 (2015.7)

Health Insurance Survey, Australia, June 1992 (Cat. no. 4335.0)

National Health Survey: Health Related Actions, 1989–90 (Cat. no. 4375.0)

National Health Survey: Health Risk Factors, 1989–90 (Cat. no. 4380.0)

National Health Survey: Health Status Indicators, 1989–90 (Cat. no. 4370.0)

National Health Survey: First Results, 1995 (Cat. no. 4392.0)

National Health Survey: Summary of Results, 1989–90 (Cat. no. 4364.0)

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SYMBOLS AND OTHER USAGES

ABS	Australian Bureau of Statistics
BMI	body mass index
ICD	International Classification of Diseases
NH&MRC	National Health and Medical Research Council
NHS	National Health Survey
*	relative standard error of 25% to 50%
**	relative standard error over 50%
—	nil or rounded to zero
. .	not applicable

APPENDIX

POPULATION OF DARWIN–PALMERSTON AND ALICE SPRINGS (a), 1995

	0–14	15–17	18–34	35–49	50–54	55 and over	Total
Darwin–Palmerston							
Males	9 795	2 467	12 344	10 061	2 102	3 973	40 742
Females	9 257	1 806	12 642	9 102	2 098	2 789	37 694
Persons	19 052	4 273	24 986	19 162	4 200	6 762	78 435
Alice Springs							
Males	3 198	504	3 207	3 423	668	1 036	12 036
Females	3 159	544	3 655	2 917	569	1 004	11 848
Persons	6 357	1 049	6 862	6 339	1 237	2 040	23 884
Total							
Males	12 993	2 971	15 552	13 483	2 770	5 009	52 778
Females	12 416	2 350	16 296	12 019	2 667	3 793	49 541
Persons	25 409	5 321	31 848	25 502	5 437	8 802	102 319

(a) These estimates correspond to the population benchmarks for the National Health Survey, 1995, and were derived from an average of the four mid-quarterly population estimates for the period, adjusted for the scope of the survey.

GLOSSARY

Accidents Refers to events identified by respondents which resulted in injury or other recent or long-term medical condition reported in the survey. The term accident is used in this publication to refer to events (accidents, exposures to harmful factors and other incidents) with or without intent, which resulted in injury or illness. This topic does not provide data indicating the number of accidents (either injury or otherwise) occurring over a period.

Actions taken As used in this publication this item refers to specific actions persons had taken in relation to their health, and refers to actions taken in the two weeks prior to interview. Actions covered in the survey were:

- inpatient episodes in hospital;
- visits to casualty/emergency units at hospitals;
- visits to outpatients units;
- visits to day clinics;
- doctor consultations;
- dental consultations;
- consultations with other health professionals;
- other persons/organisations consulted;
- use of natural/herbal medications;
- use of vitamins/minerals;
- use of other medications;
- days away from work/school; and/or
- other days of reduced activity.

Alcohol risk level Derived from the average daily consumption of alcohol during the week prior to interview and grouped into relative risk levels as defined by the National Health and Medical Research Council (NH&MRC) as follows:

	CONSUMPTION PER DAY	
	Males	*Females*
Relative risk	mls	mls
Low	Less than 50	Less than 25
Moderate	50–75	25–50
High	Greater than 75	Greater than 50

It should be noted that risk level as defined by the NH&MRC is based on regular consumption levels of alcohol, whereas indicators derived in the NHS do not take into account whether consumption was more, less, or the same as usual.

Body mass Based on height and weight as reported by the respondent. Persons were categorised into four groups according to their body mass, derived using the formula weight (kg) divided by the square of height (m^2). The groups used are consistent with recommendations of the NH&MRC.

	Body mass index
Underweight	Less than 20
Acceptable weight	20–25
Overweight	26–30
Obese	Greater than 30

Exercise level This item relates to exercise undertaken for sport, recreation or fitness only, and hence does not reflect the level of total physical activity. Exercise level was derived from information about the number of times exercise was undertaken in the two weeks prior to interview, the average length of each session and the intensity (i.e. vigorous, moderate or walking). The item is intended as a guide to the relative exercise levels of persons, and should not be interpreted as necessarily indicative of level of fitness.

Long-term conditions Medical conditions (illness, injury or disability) which have lasted at least six months, or which the respondent expects to last for six months or more including:

- long-term conditions from which the respondent experienced infrequent or spasmodic attacks e.g. asthma;
- long-term conditions which may be under control through use of medications or other treatment e.g. diabetes, epilepsy;
- conditions which, although present, may not be generally considered illness because they are not necessarily debilitating e.g. reduced eyesight; and/or
- long-term and permanent impairments or disabilities.

Other health professionals Includes acupuncturists, audiologists/audiometrists, chiropractors, chemists, chiropodists/podiatrists, dieticians/nutritionists, herbalists, hypnotherapists, naturopaths, nurses, opticians/optometrists, osteopaths, occupational therapists, physiotherapists, psychologists, social workers/welfare officers, speech therapists/pathologists.

Recent conditions Medical conditions (illness, injury or disability) experienced in the two weeks prior to interview. May include long-term conditions experienced in the period.

Self-assessed health status Refers to respondent's perception of their general health status.

Smoker status The topic describes smoking status (current smokers, ex-smokers and never smoked) at time of interview.

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. The topic focused on 'regular smoking', where regular was defined as one or more cigarettes (or pipes or cigars) per day on average as reported by the respondent.

Sun protection Refers to measures taken for protection from the sun, focussing on measures taken in the month prior to interview. Measures covered include sunscreen, umbrella, hat, clothing and sunglasses.

Type of conditions All reported recent and long-term medical conditions and other reasons for health-related actions were coded to a list of 134 selected conditions/reasons for action developed by the ABS. This classification was based on the Ninth Revision (1975) of the International Classification of Diseases (ICD9), but was modified to take account of the fact that information obtained is 'as reported' by respondents. Special codes were created for some non-illness reasons for action (e.g. check-up, preventive measure) and for some frequently reported conditions which could not be readily coded to ICD categories because insufficient detail was provided (e.g. back problems, virus, infection).

Type of medication Two classifications of type of medication are shown in this publication:

- Reported type of medication, which refers to type of medication as categorised by the respondent, and tends to reflect the reason(s) for using the medication, rather than the type of ingredients or actions of the medication.
- Generic type of medication, based on the World Health Organisation's Anatomical Therapeutic Chemical (ATC) Classification, and adapted for use in the survey. This classification, although based on the ATC, covered selected types of medication only. A copy of this classification is included in the *National Health Survey: Users' Guide, 1995* (Cat. no. 4363.0).

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