

Men's health and wellbeing in South Australia:

an analysis of service use and outcomes by
socioeconomic status

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Contents

Summary	xvii
Glossary	xviii
1. Introduction	1
2. Overview	5
3. Demography and socioeconomic status	9
4. Men's use of services.....	19
Community health services	20
Community mental health services	23
Child and Adolescent Mental Health Service	27
Domiciliary care services	31
Royal District Nursing Service	34
Community dental services and dental health	37
Adults aged 18 years and over, 2005/06	40
Dental health of 12 year old children: with decayed, missing or filled teeth, 2004-06.....	42
Dental health of 12 year old children: with decayed, missing or filled teeth, 2004-06.....	43
General medical practitioner services	46
45 Year Old Health Check.....	50
Accident and Emergency Department attendances.....	53
Hospital admissions	56
Hospital admissions – Total admissions.....	58
Hospital admissions – Admissions for cancer.....	61
Hospital admissions – Admissions for mental and behavioural disorders	64
Hospital admissions – Admissions for circulatory system diseases.....	67
Hospital admissions – Admissions for respiratory system diseases.....	70
Hospital admissions – Admissions for diseases of the musculoskeletal system and connective tissue ..	73
Hospital admissions – Admissions for injuries	76
Hospital admissions – Admissions for tonsillectomy	79
Hospital admissions – Aboriginal population.....	82
Indigenous admissions – total admissions	83
Indigenous admissions – diabetes mellitus.....	86
Indigenous admissions – alcohol-related conditions	89
Indigenous admissions – smoking-related conditions	92
Potentially avoidable hospitalisations.....	95
Potentially avoidable hospitalisations – all ACS conditions	96
Potentially avoidable hospitalisations – diabetes' complications	98
Potentially avoidable hospitalisations – diabetes' complications	99
5. Prevalence of selected chronic diseases	102

Mental and behavioural problems.....	103
Mood (affective) problems.....	105
Mood (affective) problems.....	106
6. Prevalence of selected risk factors.....	109
Current smokers.....	110
Overweight (not obese).....	113
Obesity.....	115
Obesity.....	116
7. Incidence of cancer.....	120
Cancer.....	121
Prostate cancer.....	123
Prostate cancer.....	124
Colorectal cancer.....	126
Colorectal cancer.....	127
Lung cancer.....	130
8. Disability.....	134
9. Premature and avoidable mortality.....	138
Premature mortality – all causes.....	140
Premature mortality – Cancer.....	143
Premature mortality – Circulatory system diseases.....	146
Premature mortality – Respiratory system diseases.....	149
Premature mortality - External causes.....	152
Premature mortality – Other causes.....	155
Avoidable mortality.....	158
10. Burden of Disease.....	162
Health-Adjusted Life Expectancy, males, 1999 to 2001.....	163
11. Correlation analysis.....	166
12. References.....	172
Appendix.....	176
Data sources.....	175
Key Maps.....	177

Table 2.1: Use of selected services, by sex, South Australia, early 2000s ¹	5
Table 2.2: Selected chronic disease, associated health risk factors and self-reported health status, by sex, South Australia, 2004/05 ¹	6
Table 2.3: Selected health status measures, by sex, South Australia, 2004/05	7
Table 3.1: Population by age and sex, South Australia, 2006	9
Table 3.2: Life expectancy, South Australia, 2004-2006	9
Table 3.3: Population projections by age and sex, South Australia, 2021	10
Table 3.4: Selected indicators of demography and socioeconomic status, by sex, South Australia, 2006.	14
Table 4.1: Community health services, clients by age and sex, Metropolitan Adelaide, 2005/06	20
Table 4.2: Community health services, male clients by Health Region, Metropolitan Adelaide, 2005/06	21
Table 4.3: Community mental health service clients by age and sex, South Australia, 2005/06	23
Table 4.4: Community mental health services, male clients by Health Region, South Australia, 2005/06	25
Table 4.5: Child and Adolescent Mental Health Service clients by age and sex, South Australia, 2004/05 to 2006/07	27
Table 4.6: Child and Adolescent Mental Health Service, male clients by Health Region, South Australia, 2004/05 to 2006/07	29
Table 4.7: Domiciliary care service clients by age and sex, Metropolitan Adelaide, 2006 ¹	31
Table 4.8: Domiciliary care services, male clients by Health Region, Metropolitan Adelaide, 2006	32
Table 4.9: Royal District Nursing Service clients by age and sex, Metropolitan Adelaide, 2005/2006 ¹	34
Table 4.10: Royal District Nursing Service, male clients by Health Region, Metropolitan Adelaide, 2005/2006	35
Table 4.11: Attendance of males, 1 to 18 years of age, at an SDS clinic by Health Region, South Australia, 2005/06	38
Table 4.12: Dental participation of males aged 18 years and over by Health Region, South Australia, 2005/06	41
Table 4.13: Dental health of 12 year old boys: with decayed, missing or filled teeth by Health Region, South Australia, 2004-06	44
Table 4.14: GP services by age and sex, South Australia, 2004/05	46
Table 4.15: GP services, males, by Health Region, South Australia, 2004/05	48
Table 4.16: 45 Year Old Health Check, by region and sex, South Australia, 2006/07 ¹	51
Table 4.17: Accident and Emergency Department attendances of males, by Health Region, Metropolitan Adelaide, 2005/06	54
Table 4.18: Hospital admissions by principal diagnosis/procedure, age and sex, South Australia, 2005/06	56
Table 4.19: Hospital admissions – Total male admissions by Health Region, South Australia, 2005/06	59
Table 4.20: Hospital admissions – Male admissions for cancer, by Health Region, South Australia, 2005/06	62
Table 4.21: Hospital admissions – Male admissions for mental and behavioural disorders, by Health Region, South Australia, 2005/06	65
Table 4.22: Hospital admissions – Male admissions for circulatory system diseases, by Health Region, South Australia, 2005/06	68

Table 4.23: Hospital admissions – Male admissions for respiratory system diseases, by Health Region, South Australia, 2005/06.....	71
Table 4.24: Hospital admissions – Male admissions for diseases of the musculoskeletal system and connective tissue, by Health Region, South Australia, 2005/06.....	74
Table 4.25: Hospital admissions – Male admissions for injury, poisoning and other consequences of external causes, by Health Region, South Australia, 2005/06.....	77
Table 4.26: Hospital admissions – Male admissions for tonsillectomy, by Health Region, South Australia, 2005/06.....	80
Table 4.27: Hospital admissions by Indigenous status, age and sex, South Australia, 2005/06-2006/07 Number and Rate.....	82
Table 4.28: Hospital admissions by Indigenous status, age and sex, South Australia, 2005/06-2006/07 Rate ratio	82
Table 4.29: Hospital admissions – Aboriginal males, all admissions, by Health Region, South Australia, 2005/06-2006/07	84
Table 4.30: Hospital admissions – Aboriginal males, diabetes admissions, by Health Region, South Australia, 2005/06-2006/07.....	87
Table 4.31: Hospital admissions – Aboriginal males, alcohol-related conditions, by Health Region, South Australia, 2005/06-2006/07	90
Table 4.32: Hospital admissions – Aboriginal males, smoking-related conditions, by Health Region, South Australia, 2005/06-2006/07	93
Table 4.33: Potentially avoidable hospitalisations ¹ by sub-category, condition and sex, South Australia, 2005/06 and 2006/07	95
Table 4.34: Potentially avoidable hospitalisations ¹ of males – all conditions, by Health Region, South Australia, 2005/06 and 2006/07	97
Table 4.35: Potentially avoidable hospitalisations ¹ – diabetes complications, by Health Region, South Australia, 2005/06 and 2006/07	100
Table 5.1: Estimates of males with mental and behavioural problems by Health Region, South Australia, 2004/05	104
Table 5.2: Estimates of males with mood (affective) problems by Health Region, South Australia, 2004/05	107
Table 6.1: Estimated current smokers, males aged 18 years and over, by Health Region, South Australia, 2004/05	111
Table 6.2: Estimated number of overweight (not obese) males aged 15 years and over by Health Region, South Australia, 2004/05.....	114
Table 6.3: Estimated number of obese males aged 15 years and over by Health Region, South Australia, 2004/05	117
Table 7.1: Incidence of cancer by type, age and sex, South Australia, 2000-05	120
Table 7.2: Incidence of cancer in males, by Health Region, South Australia, 2000-05	122
Table 7.3: Incidence of prostate cancer, males 50 years and over, by Health Region, South Australia, 2000-05	125
Table 7.4: Incidence of colorectal cancer in males, by Health Region, South Australia, 2000-05.....	128
Table 7.5: Incidence of lung cancer for males, by Health Region, South Australia, 2000-05.....	131
Table 8.1: People aged 65 years and over with a profound or severe disability and living in the community, by Health Region, South Australia, 2006	135
Table 9.1: Premature mortality 0 to 74 years, by age, sex and major cause, South Australia, 2001-2005	138

Table 9.2: Deaths of males, all causes, 0 to 74 years, by Health Region, South Australia, 2001-2005...	141
Table 9.3: Deaths of males aged 0-74 years from cancer, by Health Region, South Australia, 2001-2005	144
Table 9.4: Deaths of males aged 0-74 years from circulatory system diseases, by Health Region, South Australia, 2001-2005	147
Table 9.5: Deaths of males aged 0-74 years from respiratory system diseases, by Health Region, South Australia, 2001-2005	150
Table 9.6: Deaths of males aged 0-74 years from external causes, by Health Region, South Australia, 2001-2005	153
Table 9.7: Deaths of males aged 0-74 years from other causes, by Health Region, South Australia, 2001-2005	156
Table 9.8: Avoidable mortality, males, by Health Region, South Australia,	160
Table 10.1: Health-Adjusted Life Expectancy, by Burden of Disease (BoD) area, South Australia, 1999 to 2001	163
Table 11.1: Correlation coefficients for SLAs in Metropolitan Adelaide.....	168
Table 11.2: Correlation coefficients for SLAs in country South Australia.....	170
Table A.1: Hospital admissions for selected injury conditions, by sex and condition.....	173
Table A.2: Premature mortality 0 to 74 years, by age, sex and major cause, South Australia, 2001 - 2005.....	174
Table A.3: Project data sources.....	175

<u>List of figures</u>	<u>Page</u>
Figure 3.1: Unemployment by sex and socioeconomic status, 2006.....	17
Figure 3.2: Unemployment of 15 to 24 year olds, by sex and socioeconomic status, 2006	17
Figure 3.3: Unemployment by sex and remoteness, 2006	17
Figure 3.4: Unemployment, of 15 to 24 year olds, by sex and remoteness, 2006	17
Figure 3.5: Full time participation in secondary school education at age 16, by sex and socioeconomic status, 2006	17
Figure 3.6: Full time participation in secondary school education at age 16, by sex and remoteness, 2006.....	17
<u>Community health services</u>	
Figure 4.1: Clients, by age and sex.....	20
Figure 4.2: Clients by socioeconomic status and sex	20
<u>Community mental health services</u>	
Figure 4.3: Clients by age and sex.....	23
Figure 4.4: Clients by socioeconomic status and sex	23
Figure 4.5: Clients by remoteness and sex	23
<u>Child and Adolescent Mental Health Services (CAMHS)</u>	
Figure 4.6: Clients by age and sex.....	27
Figure 4.7: Clients by socioeconomic status and sex	27
Figure 4.8: Clients by remoteness and sex	27
<u>Domiciliary Care services</u>	
Figure 4.9: Clients by age and sex.....	31
Figure 4.10: Clients by socioeconomic status and sex	31
<u>Royal District Nursing Service (RDNS)</u>	
Figure 4.11: Clients by age and sex.....	34
Figure 4.12: Clients by socioeconomic status and sex	34
<u>Community dental services - Children 1- 18 years</u>	
Figure 4.13: By age and sex.....	37
Figure 4.14: By socioeconomic status of area and sex.....	37
Figure 4.15: By remoteness and sex	37
<u>Community dental services - Adults 18+ years</u>	
Figure 4.16: By socioeconomic status of area and sex.....	40
Figure 4.17: By socioeconomic status of area and sex.....	40
Figure 4.18: By remoteness and sex	40
<u>Dental health - 12 year old children with decayed, missing or filled teeth</u>	
Figure 4.19: By socioeconomic status of area and sex.....	43
Figure 4.20: By remoteness and sex	43
<u>General medical practitioner services</u>	
Figure 4.21: Services by age and sex	46

Figure 4.22: Services by socioeconomic status and sex.....	46
Figure 4.23: Services by remoteness and sex.....	46
<u>45 year old health check</u>	
Figure 4.24: Health check by socioeconomic status of area	50
Figure 4.25: Health check by remoteness	50
<u>Accident and emergency department attendances</u>	
Figure 4.26: Attendances by age and sex.....	53
Figure 4.27: Attendances by socioeconomic status and sex	53
<u>Hospital admissions - Total admissions</u>	
Figure 4.28: Total admissions by age and sex.....	58
Figure 4.29: Total admissions: by socioeconomic status and sex	58
Figure 4.30: Total admissions: by remoteness and sex	58
<u>Hospital admissions - Cancer admissions</u>	
Figure 4.31: Admissions by age and sex	61
Figure 4.32: Admissions: by socioeconomic status and sex.....	61
Figure 4.33: Admissions: by remoteness and sex.....	61
<u>Hospital admissions - Mental and behavioral disorder admissions</u>	
Figure 4.34: Admissions by age and sex	64
Figure 4.35: Admissions: by socioeconomic status and sex.....	64
Figure 4.36: Admissions: by remoteness and sex.....	64
<u>Hospital admissions - Circulatory system diseases admissions</u>	
Figure 4.37: Admissions by age and sex	67
Figure 4.38: Admissions: by socioeconomic status and sex.....	67
Figure 4.39: Admissions: by remoteness and sex.....	67
<u>Hospital admissions - Respiratory system disease admissions</u>	
Figure 4.40: Admissions by age and sex	70
Figure 4.41: Admissions: by socioeconomic status and sex.....	70
Figure 4.42: Admissions: by remoteness and sex.....	70
<u>Hospital admissions - Disease of the musculoskeletal system and connective tissue admissions</u>	
Figure 4.43: Admissions by age and sex	73
Figure 4.44: Admissions: by socioeconomic status and sex.....	73
Figure 4.45: Admissions: by remoteness and sex.....	73
<u>Hospital admissions - Injuries, poisoning and other consequences of external injury admissions</u>	
Figure 4.46: Admissions by age and sex	76
Figure 4.47: Admissions: by socioeconomic status and sex.....	76
Figure 4.48: Admissions: by remoteness and sex.....	76
<u>Hospital admissions - Tonsillectomy admissions</u>	
Figure 4.49: Admissions by age and sex	79
Figure 4.50: Admissions: by socioeconomic status and sex.....	79

Figure 4.51: Admissions: by remoteness and sex.....	79
<u>Aboriginal hospital admissions - Total admissions</u>	
Figure 4.52: Admissions, by age and sex	83
Figure 4.53: Admissions, by socioeconomic status.....	83
Figure 4.54: Admissions, by remoteness.....	83
<u>Aboriginal hospital admissions - Diabetes mellitus admissions</u>	
Figure 4.55: Admissions, by age	86
Figure 4.56: Admissions, by socioeconomic status and sex.....	86
Figure 4.57: Admissions, by remoteness and sex.....	86
<u>Aboriginal hospital admissions - Alcohol-related admissions</u>	
Figure 4.58: Admissions by age and sex	89
Figure 4.59: Admissions by socioeconomic status and sex.....	89
Figure 4.60: Admissions by remoteness and sex.....	89
<u>Aboriginal hospital admissions - Smoking-related admissions</u>	
Figure 4.61: Admissions, by age and sex	92
Figure 4.62: Admissions, by socioeconomic status.....	92
Figure 4.63: Admissions, by remoteness.....	92
<u>Potentially Avoidable hospitalisations - All ACS conditions</u>	
Figure 4.64: By age and sex.....	96
Figure 4.65: By socioeconomic status and sex	96
Figure 4.66: By remoteness and sex	96
<u>Potentially Avoidable hospitalisations - Diabetes complications</u>	
Figure 4.67: By age and sex.....	99
Figure 4.68: By socioeconomic status and sex	99
Figure 4.69: By remoteness and sex	99
<u>Prevalence of chronic disease - Mental and behavioral problems</u>	
Figure 5.1: By age and sex.....	103
Figure 5.2: By socioeconomic status and sex	103
Figure 5.3: By remoteness and sex	103
<u>Prevalence of chronic disease - Mood (affective) problems</u>	
Figure 5.4: By age and sex.....	106
Figure 5.5: By socioeconomic status and sex	106
Figure 5.6: By remoteness and sex	106
<u>Prevalence of chronic disease - Current smokers</u>	
Figure 6.1: By age and sex.....	110
Figure 6.2: By socioeconomic status and sex	110
Figure 6.3: By remoteness and sex	110
<u>Prevalence of chronic disease - Overweight (not obese)</u>	
Figure 6.4: By age and sex.....	113

Figure 6.5: By socioeconomic status and sex	113
Figure 6.6: By remoteness and sex	113
<u>Prevalence of chronic disease - Obese</u>	
Figure 6.7: By age and sex.....	116
Figure 6.8: By socioeconomic status and sex	116
Figure 6.9: By remoteness and sex	116
<u>Cancer incidence</u>	
Figure 7.1: Cancer by age and sex.....	121
Figure 7.2: Cancer by socioeconomic status of area and sex.....	121
Figure 7.3: Cancer by remoteness	121
Figure 7.4: Prostate cancer by age.....	124
Figure 7.5: Prostate cancer by socioeconomic status of area.....	124
Figure 7.6: Prostate cancer by remoteness	124
Figure 7.7: Colorectal cancer by age and sex.....	127
Figure 7.8: Colorectal cancer by socioeconomic status of area and sex.....	127
Figure 7.9: Colorectal cancer by remoteness and sex	127
Figure 7.10: Lung cancer by age	130
Figure 7.11: Lung cancer by socioeconomic status of area and sex	130
Figure 7.12: Lung cancer by remoteness.....	130
<u>Disability</u>	
Figure 8.1: By socioeconomic status of area and sex.....	134
Figure 8.2: By remoteness and sex	134
<u>Premature mortality - All causes</u>	
Figure 9.1: Male deaths at ages 0 to 74 years by selected causes and ages, 2001-05	139
Figure 9.2: By age and sex.....	140
Figure 9.3: By socioeconomic status of area and sex.....	140
Figure 9.4: By remoteness and sex	140
<u>Premature mortality - Cancer</u>	
Figure 9.5: By age and sex.....	143
Figure 9.6: By socioeconomic status of area	143
Figure 9.7: By remoteness	143
<u>Premature mortality - Circulatory system diseases</u>	
Figure 9.8: By age and sex.....	146
Figure 9.9: By socioeconomic status of area and sex.....	146
Figure 9.10: By remoteness and sex	146
<u>Premature mortality - Respiratory system diseases</u>	
Figure 9.11: By age and sex.....	149
Figure 9.12: By socioeconomic status of area and sex.....	149
Figure 9.13: By remoteness and sex	149

Premature mortality - External causes

Figure 9.14: By age and sex..... 152
Figure 9.15: By socioeconomic status of area and sex..... 152
Figure 9.16: By remoteness and sex 152

Premature mortality - Other causes

Figure 9.17: By age and sex..... 155
Figure 9.18: By socioeconomic status of area and sex..... 155
Figure 9.19: By remoteness and sex 155

Avoidable mortality

Figure 9.20: Avoidable mortality by age and sex, 2001-05 159
Figure 9.21: Avoidable mortality by socioeconomic status and sex..... 159
Figure 9.22: Avoidable mortality by remoteness and sex..... 159

List of maps	Page
Map 3.1: Age distribution, Metropolitan Adelaide, 2006	11
Map 3.2: Age distribution, South Australia, 2006	12
Map 3.3: Unemployment, males, Metropolitan Adelaide 2006	15
Map 3.4: Unemployment, males, country South Australia, 2006.....	15
Map 3.5: Unemployment, males 15-24 years, Metropolitan Adelaide 2006	15
Map 3.6: Unemployment, males 15-24 years, country South Australia, 2006	15
Map 3.7: Full time participation in secondary school education at age 16, males, Metropolitan Adelaide, 2006.....	16
Map 3.8: Full time participation in secondary school education at age 16, males, Adelaide, 2006.....	16
Map 3.9: Index of Relative Socio-economic Disadvantage, Metropolitan Adelaide, 2006.....	18
Map 3.10: Index of Relative Socio-economic Disadvantage, country South Australia, 2006.....	18
Map 4.1: Community health services, male clients, Metropolitan Adelaide, 2005/06.....	22
Map 4.2 and Map 4.3: Community mental health services, male clients, Metropolitan Adelaide and country SA, 2005/06	26
Map 4.4 and Map 4.5: Child and Adolescent Mental Health Service, male clients, Metropolitan Adelaide and country SA, 2005/06	30
Map 4.6: Domiciliary care services, male clients, Metropolitan Adelaide, 2006.....	33
Map 4.7: Royal District Nursing Service, male clients, Metropolitan Adelaide, 2005/2006.....	36
Map 4.8 and Map 4.9: Attendance of males, 1 to 18 years of age, at an SDS clinic, Metropolitan Adelaide and country SA, 2005/06	39
Map 4.10 and Map 4.11: Attendance of men, aged 18 years and over, at a SADS clinic, Metropolitan Adelaide and country SA, 2005/06.....	42
Map 4.12 and Map 4.13: Dental health of 12 year old boys: with decayed missing or filled teeth, Metropolitan Adelaide and country SA, 2004-06	45
Map 4.14 and Map 4.15: General medical practitioner services, males, Metropolitan Adelaide and country SA, 2004/05	49
Map 4.16 and Map 4.17: 45 Year Old Health Check, persons, Metropolitan Adelaide and country SA, 2006/2007	52
Map 4.18: Accident and Emergency Department attendances of males, Metropolitan Adelaide, 2005/06	55
Map 4.19 and Map 4.20: Hospital admissions – Total admissions of males, Metropolitan Adelaide and country SA, 2005/06	60
Map 4.21 and Map 4.22: Hospital admissions – Admissions of men for cancer, Metropolitan Adelaide and country SA, 2005/06	63
Map 4.23 and Map 4.24: Hospital admissions of males for mental and behavioural disorders, Metropolitan Adelaide and country SA, 2005/06.....	66
Map 4.25 and Map 4.26: Hospital admissions of males for circulatory system diseases, Metropolitan Adelaide and country SA, 2005/06.....	69
Map 4.27 and Map 4.28: Hospital admissions of males for respiratory system diseases, Metropolitan Adelaide and country SA, 2005/06.....	72
Map 4.29 and Map 4.30: Hospital admissions of males for musculoskeletal system and connective tissue diseases, Metropolitan Adelaide and country SA, 2005/06	75

Map 4.31 and Map 4.32: Hospital admissions of males for injury, poisoning and certain other consequences of external causes, Metropolitan Adelaide and country SA, 2005/06	78
Map 4.33 and Map 4.34: Hospital admissions of males for tonsillectomy, Metropolitan Adelaide and country SA, 2005/06	81
Map 4.35 and Map 4.36: Hospital admissions: Aboriginal males, total admissions, Metropolitan Adelaide and country SA, 2005/06-2006/07	85
Map 4.37 and Map 4.38: Hospital admissions: Aboriginal males, diabetes, Metropolitan Adelaide and country SA, 2005/06-2006/07	88
Map 4.39 and Map 4.40: Hospital admissions: Aboriginal males, alcohol-related conditions, South Australia, 2005/06-2006/07	91
Map 4.41 and Map 4.42: Hospital admissions: Aboriginal men, smoking-related conditions, 2005/06-2006/07	94
Map 4.43 and Map 4.44: Potentially avoidable hospitalisations, males, all conditions, Metropolitan Adelaide and country SA, 2005/06 and 2006/07	98
Map 4.45 and Map 4.46: Potentially avoidable hospitalisations of males, diabetes' complications, South Australia, 2005/06 and 2006/07	101
Map 5.1 and Map 5.2: Estimated number of males with mental and behavioural problems, Metropolitan Adelaide and country SA, 2004/05	105
Map 5.3 and Map 5.4: Estimated number of males with mood (affective) problems, Metropolitan Adelaide and country SA, 2004/05	108
Map 6.1 and Map 6.2: Estimated number of male current smokers (18 years and over), Metropolitan Adelaide and country SA, 2004/05	112
Map 6.3 and Map 6.4: Estimated number of overweight (not obese) males aged 15 years and over, Metropolitan Adelaide and country SA, 2004/05	115
Map 6.5 and Map 6.6: Estimated number of obese males aged 15 years and over, Metropolitan Adelaide and country SA, 2004/05	118
Map 7.1 and Map 7.2: Cancer incidence in males, Metropolitan Adelaide and country SA, 2000 to 2005	123
Map 7.3 and Map 7.4: Prostate cancer incidence, males 50 years and over, Metropolitan Adelaide and country SA, 2000-2005	126
Map 7.5 and Map 7.6: Colorectal cancer incidence for males, Metropolitan Adelaide and country SA, 2000-2005	129
Map 7.7 and Map 7.8: Lung cancer incidence for males, Metropolitan Adelaide and country SA, 2000-2005	132
Map 8.1 and Map 8.2: Men aged 65 years and over with a profound or severe disability and living in the community, South Australia	136
Map 9.1 and Map 9.2: Deaths of men aged 0-74 years, all causes, 2001 to 2005.....	142
Map 9.3 and Map 9.4: Deaths of men aged 0-74 years from cancer, 2001 to 2005.....	145
Map 9.5 and Map 9.6: Deaths of men aged 0-74 years from circulatory system diseases, 2001 to 2005	148
Map 9.7 and Map 9.8: Deaths of men aged 0-74 years from respiratory system diseases, 2001 to 2005	151
Map 9.9 and Map 9.10: Deaths of men aged 0-74 years from external causes, 2001 to 2005	154
Map 9.11 and Map 9.12: Deaths of men aged 0-74 years from other causes, 2001 to 2005	157
Map 9.13 and Map 9.14: Avoidable mortality, men aged 0-74 years, 2001 to 2005.....	161
Map 10.1 and Map 10.2: Health-Adjusted Life Expectancy for men, 1999 to 2001	164

Key 1: Key to areas mapped by Statistical Local Area, metropolitan regions, South Australia, 2006..... 180
Key 2: Key to areas mapped by Statistical Local Area, country South Australia, 2006 181

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Summary

The South Australian Department of Health (SA Health) commissioned this report to address the following question,

'Are there populations of South Australian men who underutilise a range of health services, particularly primary health care services, and, as a consequence, experience a disproportionate burden of disease?'

In response, this report provides an analysis of South Australian men's health and medical service use by age and socioeconomic status. In doing so, it highlights areas where further planning of programs and services may be required and likely directions for improving men's health across the population, through targeted public policy.

Overall, Aboriginal males continue to suffer mortality and morbidity at much higher rates than non-Indigenous males, and have a reduced quality of life and high rates of illness and premature death. This remains an area for urgent intervention and disease prevention in ways that are culturally acceptable to Aboriginal men.

There was little difference between South Australian men and women in self-assessing their health as 'fair' or 'poor' (compared to 'excellent', very good', or 'good'). However, rates of 'high' or 'very high' psychological distress (measured by the K-10) were 32% lower than those reported by women (a rate ratio of 0.68). There were 18% fewer men than women whose responses to questions in the 2006 Population Census indicated they had a profound or severe disability, but only 5% fewer who were living in the community (i.e., excluding people living in long-term residential accommodation in nursing homes, accommodation for the retired or aged (not self-contained), hostels for the disabled and psychiatric hospitals).

In terms of the health risks of males, this report reinforces that they remain concerning. Men engage in behaviours that risk their health at generally higher rates than women. Consumption of alcohol at levels considered to be of high risk to health was substantially higher among men, being more than twice the rate of that for women (a rate ratio of 2.32). Smoking rates were also markedly higher for men (a rate ratio of 1.39). These behaviours, however, cannot be seen in isolation from the social and economic contexts in which men live and work. Factors such as employment and income interact with ethnicity, sexual and cultural identity and age to influence men's health status across the life cycle. Thus, youth unemployment and lower participation in education add to men's risk of poorer health later in adult life.

Male rates for diabetes and heart, stroke and vascular disease were higher than for females (27% and 10% higher, respectively); however, rates of respiratory system diseases (including asthma) and circulatory system diseases overall were lower than for women (10%, 24% and 20% lower, respectively). Further, certain groups of South Australian men — particularly Aboriginal men and those disadvantaged by poverty and/or geographical remoteness — are at higher risk of such health problems, have specific medical needs and often poorer use of services where these are available. Throughout this report, patterns of socioeconomic disadvantage are evident in men's use of health services, risk factors for chronic disease and health status.

In terms of service use, men accessed community health services, but at a rate that was substantially lower than that of women (a rate ratio of 0.44, 56% lower). Their use of general medical practitioner and specialist medical practitioner services was also lower than that of women (rate ratios of 0.73 and 0.89, respectively; or 27% and 11% lower). Community mental health services were utilised (8%) more by men than by women (a rate ratio 1.08). Male rates of use of CAMHS by children and adolescents were higher than those for females in all but the 15 to 19 year age group; and the rate of male clients in the most disadvantaged groups was almost six times the rate in the least disadvantaged group (rate ratio 5.77). Rates of attendance at Accident and Emergency Departments were generally higher for males; and hospital admission rates of males for circulatory system diseases and injury were higher than for females, other than in the oldest age group.

Death rates for males at ages 0 to 74 years (referred to as premature deaths) were 68% higher than those for females. In South Australia:

- the premature mortality rate for males in the most socially advantaged group of the population was higher than that for females in the most socially *disadvantaged* group; and
- males in the most socially disadvantaged group had a premature mortality rate nearly double that of the most socially disadvantaged females.

The differential in deaths from avoidable causes was even greater, at 85% – this indicator comprises those causes of death (before 75 years of age) that are potentially avoidable at the present time, given available knowledge about social and economic policy impacts, health behaviours, and health care. This indicates an area where further work in disease prevention and early intervention for males is warranted.

Glossary and symbols used

Admission:

The technical term describing a completed hospital episode (i.e. the discharge, death or transfer of a patient) is a 'separation'. At the time of admission, the age, sex, address of usual residence and other personal details of the patient are recorded. At the end of the episode, at the time of separation from hospital, details of the episode itself are recorded, including the principal diagnosis (and other diagnoses), principal procedure (and other procedures), and the date, time and method (discharge, transfer or death) of separation.

Aboriginal men (and women):

In this report, all references to Aboriginal men (or women) are inclusive of Torres Strait Islanders.

Rates

All rates described as 'Rate per 100,000 (of population)' have been produced by indirect age standardisation.

SLA – Statistical Local Area

The Statistical Local Area (SLA) is generally equivalent to a local government area, with additional codes allocated to areas outside local government areas (e.g., unincorporated areas) and to local government areas which have been split for statistical purposes, largely where local government areas are very large: e.g., Playford local government area is split into five SLAs.

Socioeconomic status

To produce the socioeconomic status groupings used in this report, SLAs were ranked by their IRSD score (see next paragraph) and were then allocated to one of five groups (quintiles), each representing approximately 20% of the population of Metropolitan Adelaide, or of country South Australia. Admissions were then allocated to one of these five groups with similar socioeconomic status (referred to as quintiles of socioeconomic disadvantage of area). Rates were then calculated by quintile for each condition.

The Index of Relative Socio-economic Disadvantage (IRSD) is an area-based, summary measure of socioeconomic disadvantage and is calculated from variables in the 2006 ABS Census, including those relating to education, labour force status, occupation and Indigenous status, of individuals and families (ABS 2008). The index is expressed as a number with a base for Australia of 1000: numbers above 1000 show relatively low disadvantage, and numbers below 1000 indicate relatively high disadvantage.

Symbols used

- * Statistically significant, at the 5% confidence level
- ** Statistically significant, at the 1% confidence level