Men's health and wellbeing in South Australia:

an analysis of service use and outcomes by socioeconomic status

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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