



The health of Australia's females

Web report | Last updated: 10 Dec 2019 | Author: AIHW |

Citation

AIHW

Australian Institute of Health and Welfare 2019. The health of Australia's females. Cat. no. PHE 240. Canberra: AIHW. Viewed 24 December 2020, <https://www.aihw.gov.au/reports/men-women/female-health>

In 2018, just over half of Australia's population—51% or 12.6 million people—were female. On average, Australian females experience different health outcomes than Australian males. Compared with males, females have a higher life expectancy and experienced more of their total disease burden due to living with disease rather than from dying early from disease and injury. They are more likely than males to experience sexual violence and to have multiple chronic conditions.

To learn more about the health outcomes of males, see [The health of Australia's males](#).

Cat. no: PHE 240

Findings from this report:

- Almost half of Australian females (49%) had 1 or more of the 10 selected chronic conditions in 2017-18.
- The leading cause of death for females in 2017 was Dementia and Alzheimer disease.
- 2 in 5 women were sufficiently physically active in 2017-18.
- The leading cause of total disease burden for females in 2015 was coronary heart disease.

Last updated 25/11/2019 v17.0

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Who are Australia's females?

In 2018, there were 12.6 million females in Australia—just over half (51%) of the country's population. Overall, there were 101.6 females for every 100 males (ABS 2018a).

The typical Australian female is 38.1 years old, lives in a major city, is employed and has a non-school qualification (ABS 2018b, 2018c, 2018d, 2019a).

The female population is ageing

In 2018, most of the female population were of working age. In a group of 20 females, 4 (18%) would be girls aged 0-14 years, 13 (65%) would be women of working age (15-64 years) and 3 (17%) would be women aged 65 years and over (ABS 2018a).

Over the last 10 years, the proportion of the female population in older age groups has been increasing, particularly the 70-74 years age group, which has grown by 6.2% since 2006. In comparison, the proportion of females in the 0-4 years age group has grown by 0.2% in the same time period (ABS 2018a).

Some females are more disadvantaged than others

In 2015-16, just under 3 in 20 females (13%) were experiencing poverty, and in 2016 around 49,000 were homeless (ACOSS 2018, ABS 2018e). In 2019, there were around 3,600 Australian female prisoners in adult corrective services (ABS 2019a) and 1 in 20 females (5.3%) were unemployed (ABS 2019b).

Australian females have diverse backgrounds—3 in 10 females were born overseas

Almost one-third (29%) of Australia's females were born overseas. Of these, the most common countries of birth were England (14%), China (9.3%) and New Zealand (7.7%) (ABS 2018f).

Aboriginal and Torres Strait Islander females

In 2016, the estimated resident population of Aboriginal and Torres Strait Islander females was nearly 400,000 (3.2% of the female population) (ABS 2018a).

Indigenous females tend to be younger than non-Indigenous females. Around 3 in 10 (34%) were aged under 15, compared with around 2 in 10 (18%) non-Indigenous females (ABS 2018a).

Around 3 in 5 Indigenous females (63%) identify with a clan, tribal or language group and 1 in 5 (19%) speak an Indigenous language. They outnumber males in older age groups (122 Indigenous women for every 100 Indigenous men aged 65 or over) (ABS 2016, ABS 2018a).

Females outnumber males in *Major cities*

The density of the female population varies across the country. For example, females outnumber males in *Major cities* and *Inner regional* areas (104 and 103 females to every 100 males, respectively) and males outnumbered females in *Outer regional* areas and *Remote and very remote* areas (98 and 89 females for every 100 males, respectively) (ABS 2018b).

According to the 2016 ABS Census (ABS 2018b):

7 in 10 (71%) females live in *Major cities*

2 in 10 (18%) live in *Inner regional* areas

nearly 1 in 10 (8.3%) live in *Outer regional* areas

less than 1 in 50 (1.9%) live in *Remote and very remote* areas.

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Last updated 19/11/2019 v10.0

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Lifestyle and risk factors of Australia's females

A person's lifestyle influences how healthy they are. A lifestyle including exercise, a well-balanced diet, and maintaining a healthy body weight reduces the risk of poor health. Risk factors such as smoking tobacco, consuming alcohol and illicit substance use, or being exposed to violence, increase the likelihood of poor health.

Last updated 4/11/2019 v32.0

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Lifestyle and risk factors of Australia’s females

Physical activity

Physical activity

Low levels of physical activity are a major risk factor for chronic conditions. People who do not do sufficient physical activity have a greater risk of cardiovascular disease, type 2 diabetes and osteoporosis. Being physically active improves mental and musculoskeletal health and reduces other risk factors such as overweight and obesity, high blood pressure and high blood cholesterol. Physical activity can also be helpful in the management and treatment of many chronic conditions—by improving symptoms, and/or delaying or halting progression of the condition or the onset of associated diseases and complications (Pedersen & Saltin 2015).

Australia’s [Physical Activity and Sedentary Behaviour Guidelines](#) outline the minimum amount of physical activity required for health benefits (Department of Health 2019). These recommend that adults aged 18-64:

1. accumulate 150 to 300 minutes (2.5 to 5 hours) of moderate intensity physical activity or 75 to 150 minutes (1.25 to 2.5 hours) of vigorous intensity physical activity or an equivalent combination of both moderate and vigorous activities, each week
2. do muscle-strengthening activities on at least 2 days each week.

For adults aged 65 and over, the Guidelines recommend that older people accumulate at least 30 minutes of moderate intensity physical activity on most, preferably all, days.

The data presented in this section are for adults only. There are different guidelines for children. For information on physical activity for children and young people see [Physical activity across the life stages](#).

Physical activity in this section is based on self-reported data from the ABS 2017-18 National Health Survey (NHS) which collects data on time spent walking for fitness, recreation and sport, walking for transport, moderate exercise, vigorous exercise and workplace physical activity which is moderate to vigorous (ABS 2019b). ‘Sufficiently physically active’ refers to meeting the physical activity guideline and is operationalised here as:

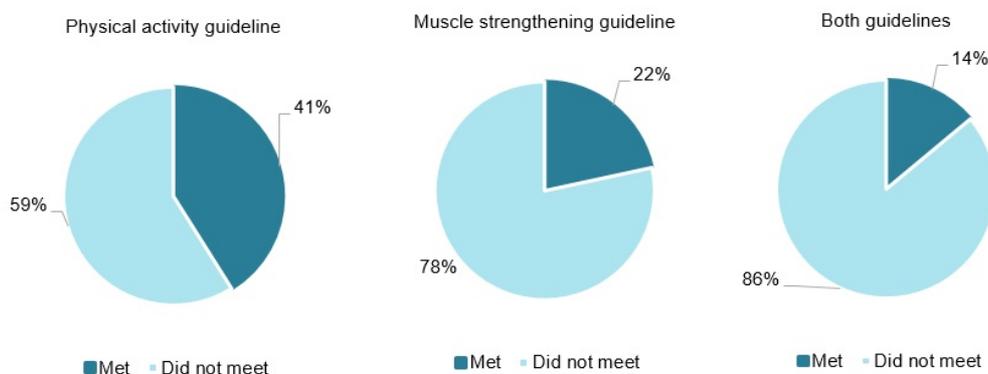
- completing 150 minutes or more of moderate to vigorous physical activity per week (where vigorous activity is multiplied by 2), and
- being active on 5 or more days per week.

2 in 5

Australian women aged 18 and over are sufficiently physically active

According to 2017-18 data, 2 in 5 (41%) women aged 18 and over were sufficiently physically active—just over 1 in 5 women (22%) did strength or toning activities on 2 or more days. Overall, 3 in 20 (14%) women were sufficiently physically active *and* met the muscle strengthening guideline (Figure 1) (ABS 2019a).

Figure 1: Proportion of women aged 18 and over who met the physical activity guideline, strength guideline and both guidelines, 2017-18



Note: Includes workplace activity

Chart: AIHW. *Source:* ABS 2019a (see [Table S1](#) for footnotes).

In 2017-18, the proportion of women who were sufficiently physically active varied by age and for some population groups (ABS 2019a):

- around 1 in 2 women aged 18-24 (52%) were sufficiently physically active compared with around 1 in 4 women aged 65 and over (26%) (Figure 2)
- after adjusting for age, 1 in 2 women (49%) living in the highest socioeconomic areas were sufficiently physically active compared with 1 in 3 women (34%) in the lowest areas.

Figure 2: Proportion of women who were sufficiently physically active, by age group (years), 2017-18

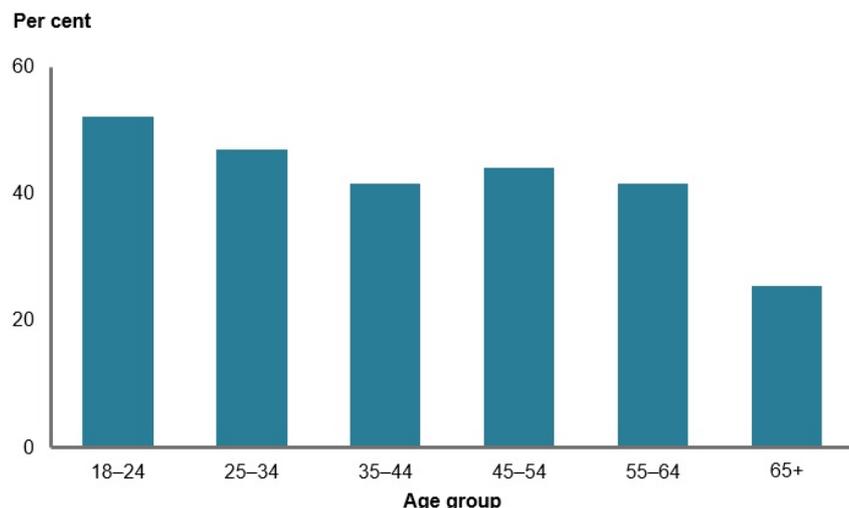


Chart: AIHW. Source: ABS 2019a (see [Table S1](#) for footnotes).

For more information, see [Insufficient physical activity](#).

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Lifestyle and risk factors of Australia's females

Diet

Fruit and vegetables

The foods and drinks we consume (our diet) play an important role in our overall health and wellbeing. A balanced diet, including sufficient fruit and vegetables, reduces a person's risk of developing conditions such as heart disease and type 2 diabetes. The 2013 [Australian Dietary Guidelines](#) recommend, for females, to consume a minimum of 2 serves of fruit and 5 serves of vegetables each day, depending on age, to ensure good nutrition and health.

Less than 1 in 10

Australian women are meeting fruit and vegetable intake guidelines

According to 2017-18 data (ABS 2019a):

- over half (56%) of women aged 18 and over met the fruit intake guideline
- 1 in 9 (11%) met the vegetable intake guideline
- 1 in 13 (7.7%) met both (Figure 3).

Figure 3: Proportion of women aged 18 and who met fruit intake guideline, vegetable intake guideline and both guidelines, 2017-18

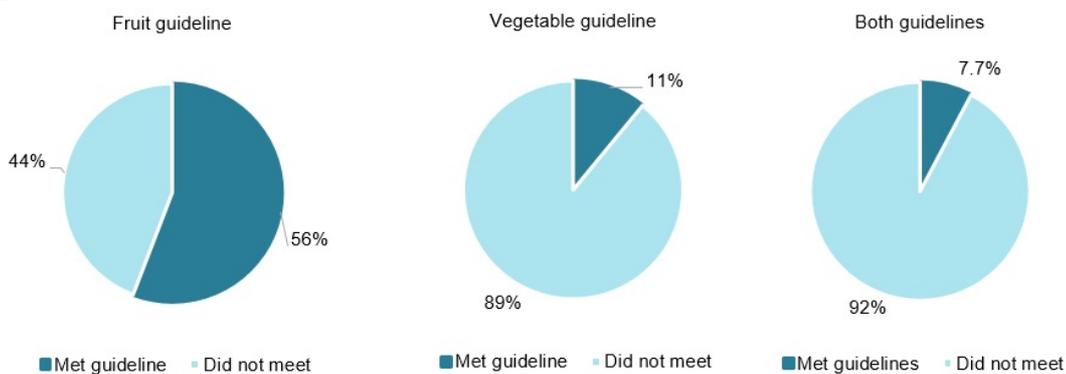


Chart: AIHW. Source: ABS 2019a (see [Table S2](#) for footnotes).

The proportion of women meeting both the fruit and vegetable intake guidelines varied by age group. For example, women aged 65-74 were 5 times as likely to meet both guidelines as women aged 18-24 (12% and 2.4%, respectively) (Figure 4).

Figure 4: Proportion of women who met the 2013 Australian Dietary Guidelines for fruit and vegetable consumption, by age group, 2017-18

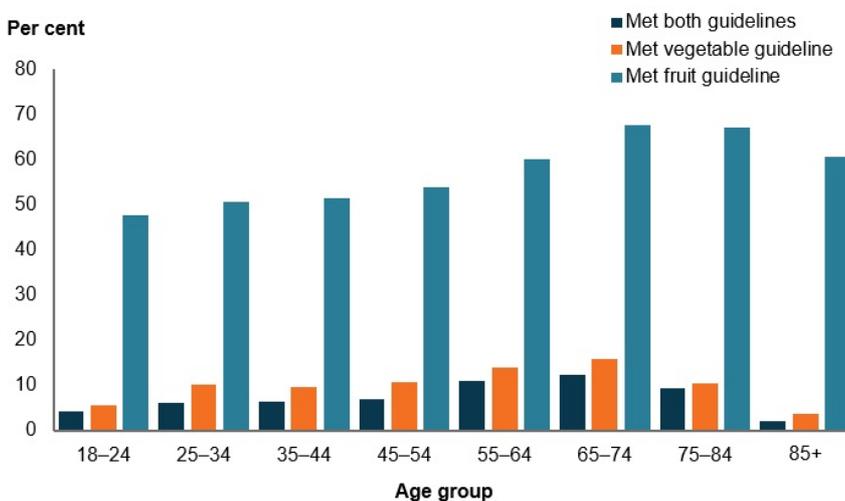


Chart: AIHW. Source: ABS 2019a (see [Table S2](#) for footnotes).

Whether women ate enough fruit and vegetables varied for some population groups. After adjusting for age (ABS 2019a):

- women living in *Inner regional* areas were 1.5 times as likely as women in *Major cities* to be eating enough vegetables (14% and 9.5%, respectively)
- women living in the highest socioeconomic areas were 1.1 times as likely to be eating enough fruit as women in the lowest socioeconomic areas (58% and 52%, respectively)
- women living in the highest socioeconomic areas were 1.4 times as likely to be eating enough vegetables as women in the lowest socioeconomic areas (12% and 8.3%, respectively).

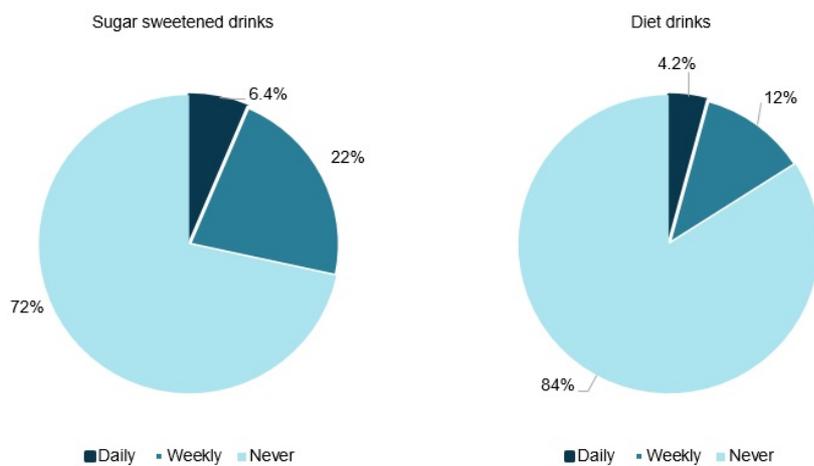
Sugar sweetened and diet drinks

Discretionary foods like sugar sweetened and diet drinks are not an essential part of a healthy diet and a limited intake of these is recommended in the [Australian Dietary Guidelines](#). Having too much of these drinks too often may lead to adverse health outcomes.

According to 2017-18 data (ABS 2019a):

- around 1 in 5 (22%) women drank sugar sweetened drinks at least once a week and around 1 in 15 (6.4%) did so daily
- around 1 in 10 (12%) women drank diet drinks at least once a week, and around 1 in 25 (4.2%) did so daily (Figure 5).

Figure 5: Proportion of women aged 18 and over who consumed sugar sweetened or diet drinks daily, weekly or never, 2017-18



Notes:

1. Sugar sweetened drinks includes soft drink, cordials, sports drinks or caffeinated energy drinks and may include soft drinks in ready to drink alcoholic beverages. Fruit juice, flavoured milk, ‘sugar free’ drinks or coffee/hot tea are excluded.
2. Totals may not add to 100% due to rounding.

Chart: AIHW. Source: ABS 2019a (see [Table S3](#) for footnotes).

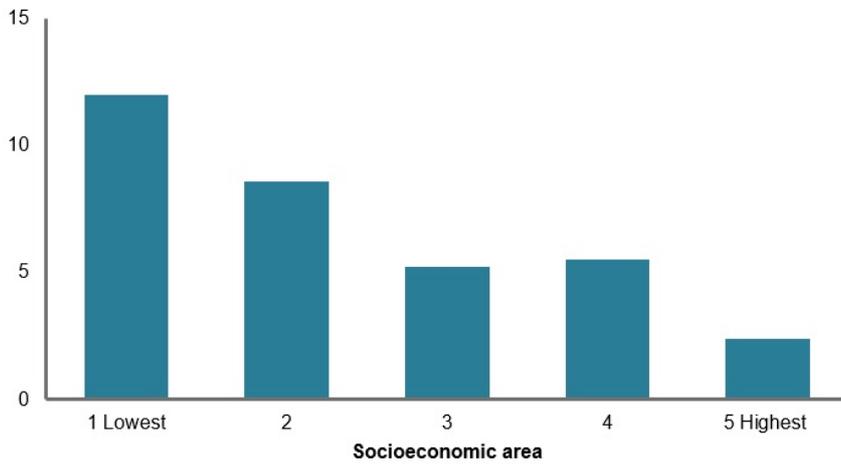
The proportion of women who consumed sugar sweetened or diet drinks daily varied by age group. For example, women aged 18-24 were 2.3 times as likely as women aged 55-64 to consume sugar sweetened drinks daily (10% and 4.4%, respectively) (ABS 2019a).

Consumption also varied for some population groups. After adjusting for age (ABS 2019a):

- women living in *Outer regional and remote* areas were almost twice as likely to drink sugar sweetened drinks daily as women in *Major cities* (10% and 5.9%, respectively)
- women living in the lowest socioeconomic areas were 5 times as likely to drink sugar sweetened drinks daily as women in the highest socioeconomic areas (12% and 2.4%, respectively) (Figure 6).

Figure 6: Proportion of women aged 18 and over who consumed sugar sweetened drinks daily, by socioeconomic area, 2017-18

Age-standardised per cent



Note: Sugar sweetened drinks includes soft drink, cordials, sports drinks or caffeinated energy drinks and may include soft drinks in ready to drink alcoholic beverages. Fruit juice, flavoured milk, 'sugar free' drinks or coffee/hot tea are excluded.

Chart: AIHW. *Source:* ABS 2019a (see [Table S3](#) for footnotes).

For more information on diet as a risk factor for poor health, see [Poor diet](#).

Dietary supplements

Dietary supplements are products defined as Complementary Medicines under the Therapeutic Goods Regulations 1990. They include products containing ingredients that are nutrients, such as multivitamin or fish oil products (ABS 2019b).

Based on 2017-18 data from the ABS NHS, around half (47%) of Australian women aged 18 and over were estimated to have taken dietary supplements in the past 2 weeks. Supplement use was more common in older age groups. Around 3 in 5 women aged 65 and over (57%) used supplements compared with around 1 in 3 women aged 18-24 (29%) (ABS 2019a).

Dietary supplement use varied for some population groups. After adjusting for age (ABS 2019a):

- women living in *Major cities* were 1.3 times as likely to be taking dietary supplements as women in *Outer regional and remote areas* (48% and 38%, respectively)
- women living in the highest socioeconomic areas were 1.4 times as likely to be taking dietary supplements as women in the lowest socioeconomic areas (52% and 38%, respectively).

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Last updated 24/12/2020 v8.0

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Lifestyle and risk factors of Australia's females

Overweight and obesity

Excess body weight, known as overweight and obesity, is a risk factor for many conditions, including cardiovascular disease, high blood pressure, type 2 diabetes, sleep apnoea and osteoarthritis. Overweight and obesity is among the leading causes of death and disability in Australia (AIHW 2019a).

Body Mass Index (BMI)

One way of measuring excess body weight at the population level is to use the body mass index (BMI)—an internationally recognised standard for classifying overweight and obesity in adults. BMI is calculated by dividing a person's weight in kilograms by the square of their height in metres. Differences in body composition may affect the appropriateness of BMI, and different BMI cut-off points may need to be considered for certain population groups such as:

- older people
- people with high muscle mass
- certain ethnic groups, including Aboriginal and Torres Strait Islander, Pacific Islander, South Asian, Chinese and Japanese populations (NHMRC 2013).

Height and body composition are continually changing for children and adolescents. A separate classification of overweight and obesity for children is used based on age and sex (Cole et al. 2000).

Information in this section relates to measures of overweight and obesity as estimated using BMI.

3 in 5

Australian women are overweight or obese

According to 2017-18 data (ABS 2018):

- 3 in 5 Australian women (60%) were overweight or obese
- 3 in 10 (30%) were overweight (but not obese)
- 3 in 10 (30%) were obese.

Overweight and obesity is more common in older age groups. Around 3 in 4 women (73%) aged 65-74 were overweight or obese, compared with 2 in 5 women (40%) aged 18-24 (ABS 2018).

The proportion of women who were overweight or obese varied for some population groups. After adjusting for age (ABS 2013, ABS 2019c):

- women living in *Outer regional and remote* areas were 1.2 times as likely to be overweight or obese as women in *Major cities* (66% and 57%, respectively)
- women living in the lowest socioeconomic areas were 1.3 times as likely to be overweight or obese as women in the highest socioeconomic areas (66% and 50%, respectively)
- in 2012-13, 7 in 10 (70%) Aboriginal and Torres Strait Islander women were overweight or obese. After adjusting for differences in age structure, the rate of overweight and obesity in Aboriginal and Torres Strait Islander women was 1.3 times the rate in non-Indigenous women (73% compared to 55%).

The proportion of females who were overweight or obese in 2017-18 differed between women and girls (ABS 2019c):

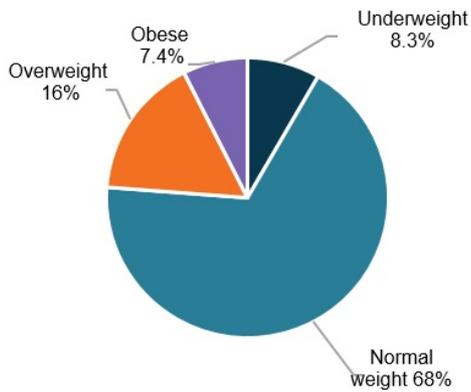
- more than half (60%) of women aged 18 and over were overweight or obese
- less than 1 quarter (24%) of girls aged 2-17 were.

Overweight and obesity among girls aged 2-17 varied for some population groups (ABS 2019c):

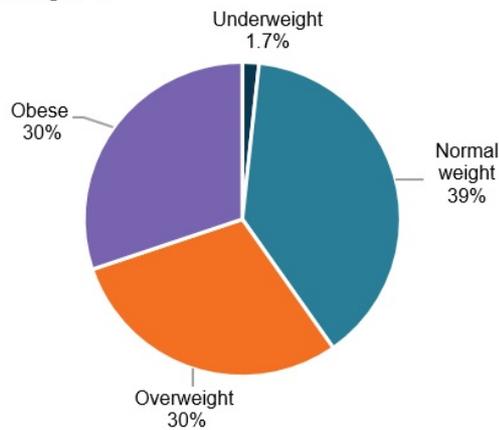
- girls living in the lowest socioeconomic areas were 1.5 times as likely to be overweight or obese as girls in the highest socioeconomic areas (31% and 21%, respectively).

Figure 7: Body mass index, girls aged 2-17 and women aged 18 and over, 2017-18

Girls aged 2–17



Women aged 18+



Note: Totals may not add to 100% due to rounding.

Chart: AIHW. Source: ABS 2018 (see [Tables S5](#) and [Table S6](#) for footnotes).

For more information see [Overweight and obesity](#).

Waist circumference

Waist circumference is another common measure of overweight and obesity. For women, a waist circumference above 80cm is associated with an increased risk of metabolic complications and above 88cm a substantially increased risk (WHO 2011).

2 in 3

Australian women have a waist circumference associated with increased or substantially increased metabolic risk

According to 2017-18 data, 2 in 3 Australian women (66%) had a high-risk waist circumference—that is, one associated with an increased or substantially increased risk of metabolic complications (Figure 8). The average waist circumference for women aged 18 and over in 2017-18 was 88 cm (ABS 2018).

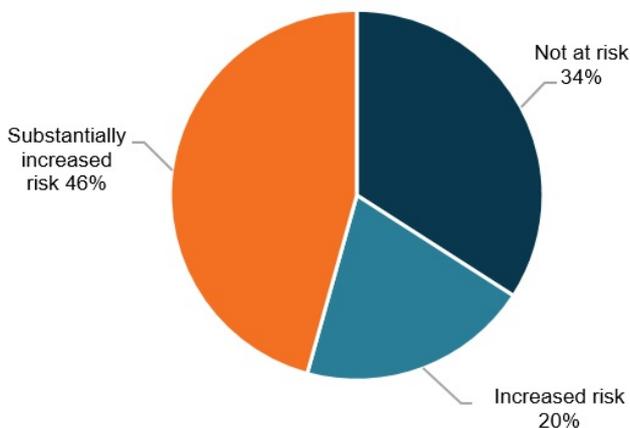
A high-risk waist circumference is more common in older women. In 2017-18 (ABS 2019):

- around 4 in 5 women aged 75 and over (84%) had a high risk waist circumference
- around 2 in 5 women aged 18-24 (37%) did.

The prevalence of high-risk waist circumference varied for some population groups. After adjusting for age (ABS 2019a):

- women living in *Inner regional* areas were 1.1 times as likely to have a high-risk waist circumference as women in *Major cities* (69% and 63%, respectively)
- women living in the lowest socioeconomic areas were 1.3 times as likely to have a high-risk waist circumference as women in the highest socioeconomic areas (71% and 56%, respectively).

Figure 8: Waist circumference, women aged 18 and over, by risk category, 2017-18



Note: Totals may not add to 100% due to rounding.

Chart: AIHW. Source: ABS 2019a (see [Table S7](#) for footnotes).

Management of overweight and obesity

While excess weight is commonly managed using dietary intervention and exercise, for those who are morbidly obese, or who are obese and have other conditions related to their excess weight, weight loss surgery may be appropriate.

Weight loss surgery (bariatric surgery) aims to help obese patients lose weight and lower the risk of medical problems associated with obesity. It restricts the amount of food a recipient can eat or alters the process of food digestion so that fewer calories are absorbed.

In 2017-18, females accounted for 80% of procedures for weight loss surgery (31,600 procedures). The rate of weight loss surgeries among females for the same year was 251 per 100,000, an increase from 2015-16 with 23,663 procedures and a rate of 194 per 100,000 (AIHW 2019b).

For more information see [Weight loss surgery in Australia 2014-15](#).

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Last updated 24/12/2020 v7.0

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Lifestyle and risk factors of Australia's females

Tobacco smoking, alcohol and illicit drugs

Tobacco

Tobacco smoking is the leading preventable cause of poor health and death in Australia (AIHW 2019a).

1 in 9

Australian women smoke daily

The main data sources reporting on tobacco smoking in Australia are:

- Australian Bureau of Statistics (ABS) [National Health Surveys \(NHS\)](#)
- ABS [National Australian Aboriginal and Torres Strait Islander Health Survey](#)
- Australian Institute of Health and Welfare (AIHW) [National Drug Strategy Household Survey \(NDSHS\)](#).

Although these surveys employ different methodologies, results for adult women were similar. Both the 2017-18 NHS and 2016 NDSHS showed that 1 in 9 (11.1%) women aged 18 or over smoked daily.

Different age groups for girls were reported in each survey. Based on the:

- 2017-18 NHS, 1.1% of girls aged 15-17 smoked daily (ABS 2018)
- 2016 NDSHS, 3.2% of girls aged 14-19 smoked daily (AIHW 2017b).

Based on the NDSHS, there has been a long-term downward trend in tobacco smoking among Australian females aged 14 and over, decreasing from 17.9% in 2001 to 10.7% in 2016.

Based on the 2017-18 NHS, smoking rates among adult women (aged 18 years and over) varied by age group, peaking in middle age and then decreasing with age, with rates being lowest in women aged 75 years and over (3.7%) (ABS 2018).

Daily smoking varied for some population groups. After adjusting for differences in age structure (AIHW 2017a, ABS 2019a):

- according to 2017-18 data, women living in *Outer regional and remote* areas were 1.6 times as likely to smoke daily as women in *Major cities* (15.9% and 9.9%, respectively)
- women living in the lowest socioeconomic areas were almost 4 times as likely to smoke daily as women in the highest socioeconomic areas (19.3% and 5.2%, respectively) (Figure 9)
- according to 2014-15 data, 39.1% of Aboriginal and Torres Strait Islander women aged 18 and over smoked daily. After adjusting for age, Indigenous women were 3 times as likely to smoke daily as non-Indigenous women.

Figure 9: Proportion of women aged 18 and over who smoked daily, by socioeconomic area, 2017-18

Age-standardised per cent

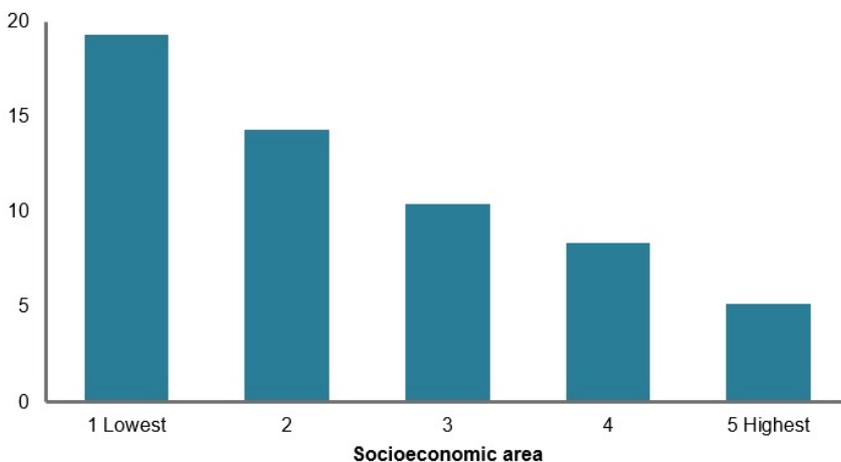


Chart: AIHW. Source: ABS 2019a (see [Table S8](#) for footnotes).

Alcohol

Excessive alcohol consumption is a major risk factor for a variety of health problems, including liver and heart conditions, and poor mental health. It also contributes to accident and injury, such as motor vehicle accidents, physical violence and homicide.

Australian women are exceeding single occasion risky drinking guidelines

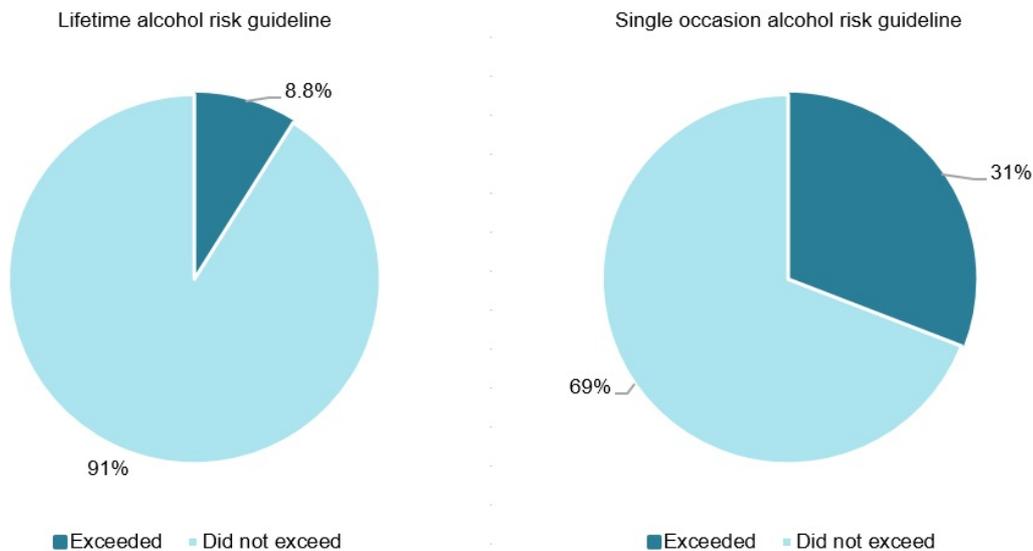
The main data sources reporting on alcohol consumption in Australia are the AIHW National Drug Strategy Household Survey (NDSHS) and the ABS National Health Survey (NHS). Although these surveys use different methodologies, they show similar results.

Based on the most recent data from the ABS NHS, in 2017-18 (ABS 2018):

- around 1 in 11 women (8.8%) aged 18 and over exceeded the lifetime risk guideline—consuming more than two standard drinks per day, on average
- around 1 in 3 women (31%) exceeded the single occasion risk guideline—consuming more than four standard drinks on any one occasion (Figure 10).

Based on the NDSHS, there has been a long-term downward trend in alcohol consumption at risky levels among Australian females, with the proportion of females aged 14 and over who were exceeding the lifetime risk guideline decreasing from 11.9% in 2007 to 9.8% in 2016. The proportion of females drinking alcohol daily has also decreased, from 5.8% in 2004 to 4.2% in 2016 (AIHW 2017b).

Figure 10: Proportion of women aged 18 and over who exceeded and did not exceed lifetime and single occasion alcohol risk guidelines, 2017-18



Note: Totals may not add to 100% due to rounding.

Chart: AIHW. Source: ABS 2019a (see [Table S9](#) for footnotes).

Lifetime risk

Exceeding the lifetime risk guideline varied by age group. According to 2017-18 data, 1 in 9 women (11%) aged 35-44 exceeded the lifetime alcohol risk guideline, compared with around 1 in 15 women (6.1%) aged 18-24 (Figure 11) (ABS 2019a).

The proportion of women exceeding the lifetime risk guideline varied for some population groups. After adjusting for differences in age structure (ABS 2013, ABS 2019a):

- according to 2017-18 data, women living in *Outer regional and remote* areas were 1.5 times as likely to exceed this guideline as women in *Major cities* (12% and 8.2%, respectively)
- women living in the highest socioeconomic areas were 1.4 times as likely to exceed this guideline as women in the lowest socioeconomic areas (9.9% and 6.9%, respectively)
- In 2012-13, 1 in 10 (10%) Aboriginal and Torres Strait Islander women exceeded the lifetime risk guideline. There was no difference in the rates of exceeding this guideline between Indigenous and non-Indigenous women (about 10%).

Figure 11: Proportion of women aged 18 and over who exceeded the lifetime alcohol risk guideline, by age group (years), 2017-18

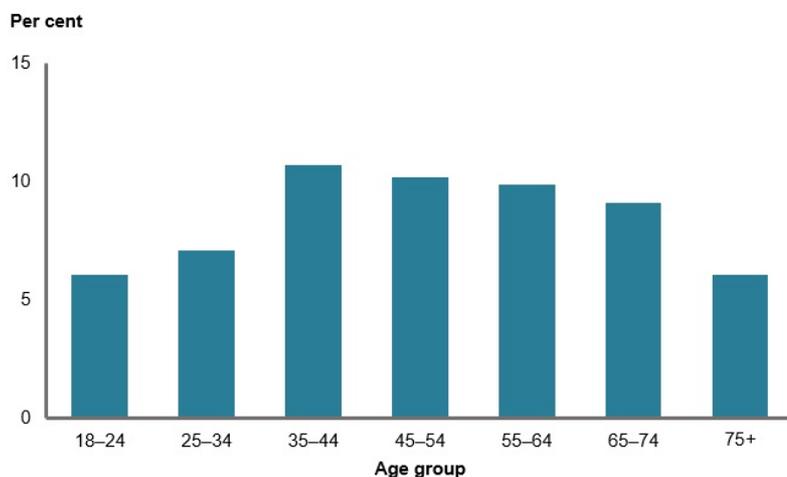


Chart: AIHW. Source: ABS 2019a (see Table S9 for footnotes).

Single occasion risk

The proportion of women exceeding the single occasion risk guideline varied by age group. According to 2017-18 data, women aged 18-24 were 5 times as likely to exceed the single occasion risk guideline as women aged 65-74 (55% and 11%, respectively) (Figure 12) (ABS 2019a).

Exceeding the single occasion guideline varied for some population groups. After adjusting for age (ABS 2019a):

- women living in *Outer regional and remote* areas were 1.2 times as likely to exceed this guideline as women in *Major cities* (38% and 31%, respectively)
- women living in the highest socioeconomic areas were 1.3 times as likely to exceed this guideline as women in the lowest socioeconomic areas (36% and 27%, respectively).

Figure 12: Proportion of women aged 18 and over who exceeded the single occasion alcohol risk guideline, by age group (years), 2017-18

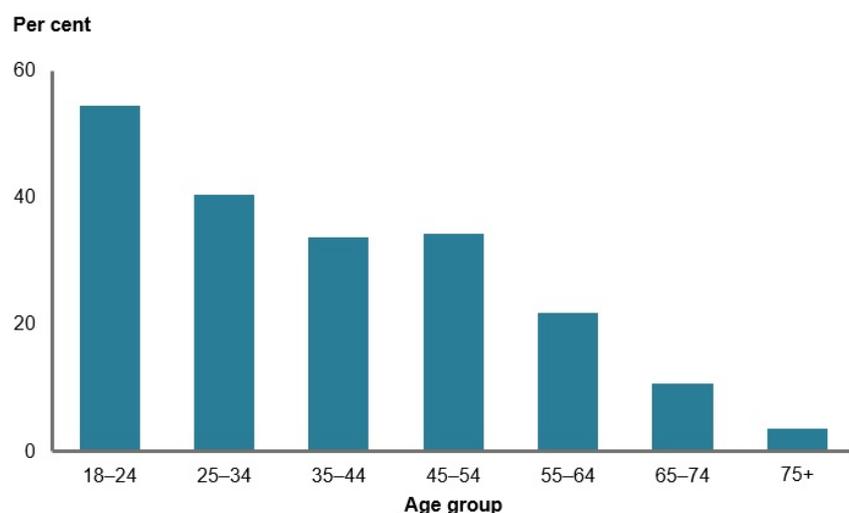


Chart: AIHW.

Source: ABS 2019a (see Table S9 for footnotes).

Illicit substances

Illicit substance use includes:

- use of illegal drugs, such as cannabis and heroin
- inappropriate use of prescription pharmaceuticals, such as sleeping pills
- inappropriate use of other substances, such as naturally occurring hallucinogens.

Illicit use of drugs can cause death and disability and is a risk factor for many diseases. The effects of short and long-term illicit drug use can be severe and can lead to poisoning, heart damage, mental illness and other adverse outcomes (AIHW 2017b). Illicit drug use is also associated with risks to users' families and friends and to the community. It contributes to social and family disruptions, violence, and crime and community safety issues. The AIHW National Drug Strategy Household Survey reports on illicit drug use in Australia.

In 2016, around 3 in 20 Australian females aged 14 and over (13%) had used an illicit drug or substance in the previous 12 months (AIHW 2017b).

The pattern of illicit drug or substance use differs by age groups—1 in 4 women aged 20-29 (25%) had used illicit drugs or substances in the previous 12 months compared with 1 in 17 women aged 60 or over (5.9%).

For more information, see [*Alcohol, tobacco and other drugs in Australia*](#).

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Last updated 9/12/2019 v8.0

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Lifestyle and risk factors of Australia's females

Violence

Violence is the intentional threat or actual use of physical force or power against oneself, another person, or a group, that results in injury, death, psychological harm, abnormal growth or deprivation.

Almost 2 in 5

Australian women have experienced violence since the age of 15.

In 2016, for women aged 18 or over (ABS 2017):

- Around 7 in 20 (37%) had experienced violence since the age of 15—of these, 3 in 10 (31%) had experienced physical violence and around 2 in 10 (18%) had experienced sexual violence.
- 1 in 20 (4.5%) had experienced violence in the last 12 months, with the highest rates among women aged 18-24 (12%) and the lowest among women aged 65 and over (1.2%).
- Around 3 in 20 (17%) had experienced partner violence since the age of 15.
- Around 3 in 20 (17%) had experienced an episode of stalking since the age of 15.
- 1 in 4 (23%) had experienced emotional abuse by a partner since the age of 15.
- Over half (53%) had experienced sexual harassment during their lifetime.

For information on family, domestic and sexual violence see *Family, domestic and sexual violence in Australia: continuing the national story 2019*.

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How healthy are Australia's females?

A person's **health status** is their overall level of health, and can be measured through self-assessed health status; presence of chronic disease and comorbidities; mental health; sexual health; life expectancy; and level of disability.

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How healthy are Australia's females?

Self-assessed health status

Self-assessed health status is a measure of health status, combining physical, social, emotional and mental health and wellbeing.

3 in 5

Australian females rate their health as excellent or very good

According to 2017-18 data, 3 in 5 females aged 15 and over (56%) rated their health as excellent or very good.

The proportion of females who rated their health as excellent or very good varied by age group. Two in 3 females aged 15-24 (67%) rated their health as excellent or very good, compared with 1 in 3 women (31%) aged 85 and over (ABS 2018a).

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Last updated 18/11/2019 v6.0

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How healthy are Australia's females?

Burden of disease

Burden of disease quantifies the health impact of disease on a population in a given year—both from dying early and from living with disease and injury. The summary measure 'disability-adjusted life years' (or DALY) measures the years of healthy life lost from death and illness.

In 2015, females experienced a smaller share of the total disease burden (47%) than males (53%). A larger proportion of the total disease burden for females was caused by living with disease. For males, the greatest proportion of total burden was caused by premature death (AIHW 2019a).

The distribution of overall burden between the sexes varied by disease group. Compared with males, females experience a greater proportion of the total burden from (AIHW 2019a):

- blood and metabolic disorders (59%)
- neurological conditions (58%)
- musculoskeletal conditions (55%).

Nearly half (44%) of the total burden of disease for females is from cancer, musculoskeletal conditions, and cardiovascular disease.

After cancer, the ranking of disease groups contributing to total burden of disease differed for females and males. For females, musculoskeletal conditions ranked second, followed by mental and substance use disorders, cardiovascular diseases and neurological conditions (AIHW 2019a).

After coronary heart disease, the specific diseases responsible for the most total burden among males and females differed. Among females, dementia ranked second, followed by back pain and problems, chronic obstructive pulmonary disease and anxiety disorders (Table 1).

For more information see [Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015](#)

Table 1: Leading 10 causes of total disease burden (DALY), by disease, females, 2015

Disease	DALY	Proportion (%)
Coronary heart disease	111,999	5.0
Dementia	110,615	5.0
Back pain and problems	98,356	4.4
Chronic obstructive pulmonary disease	91,670	4.1
Anxiety disorders	90,468	4.1
Depressive disorders	78,290	3.5
Osteoarthritis	74,902	3.4
Breast cancer	69,690	3.1
Asthma	66,796	3.0
Lung cancer	65,635	2.9

(a) DALY = Disability Adjusted Life-Year.

Chart: AIHW. Source: AIHW 2019a.

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How healthy are Australia's females?

Chronic conditions

The term 'chronic condition' encompasses a broad range of chronic and complex health conditions across the spectrum of illness. Both communicable and non-communicable diseases can become chronic, however, the monitoring of chronic conditions in developed countries focuses primarily on non-communicable disease. According to the [National Strategic Framework for Chronic Conditions](#) (Australian Health Ministers' Advisory Council 2017), chronic conditions:

- have complex and multiple causes
- may affect individuals alone or with other diseases
- usually have a gradual onset
- occur across the life cycle
- compromise quality of life and create limitations and disability
- are long-term and persistent.

Chronic conditions pose significant health problems and have a range of potential impacts on individual circumstances. Chronic conditions also have a significant impact on the health sector. Data in this section focus on 10 common chronic conditions including [arthritis](#), [asthma](#), [back problems](#), [cancer](#), [chronic obstructive pulmonary disease](#), [diabetes](#), [heart, stroke and vascular disease](#), [chronic kidney disease](#), [osteoporosis](#) and [mental health conditions](#).

Data from the 2017-18 [National Health Survey](#) (NHS) provide an estimate of the prevalence of a number of chronic conditions among the Australian population. This survey data is self-reported and is therefore likely to under-report the true prevalence of chronic conditions.

1 in 2

Australian females have 1 or more of the 10 selected common chronic conditions

According to 2017-18 data, 1 in 2 (49%) Australian females are estimated to have one or more of the 10 selected common chronic conditions. Of these females, 26% have one condition, 13% have two, and 10% have three or more.

The self-reported prevalence of these chronic conditions varies with age (ABS 2018a):

- around 4 in 5 women aged 65 and over (83%) have at least one chronic condition
- around 2 in 5 women aged 45 and under do (43%).

Table 2: Selected chronic conditions, females, 2017-18^(a)

Condition	Number	% ^(b)
Mental and behavioural problems	2,709,500	22.3
Arthritis	2,183,500	17.9
Back problems	1,978,800	16.3
Asthma	1,497,300	12.3
Chronic obstructive pulmonary disease ^(c)	250,994	5.1
Diabetes	525,200	4.3
Heart, stroke and vascular disease ^(d)	510,400	4.2
Cancer	179,700	1.5
Chronic kidney disease	120,800	1.0
Osteoporosis	749,200	6.2

Notes:

- This data is self-reported and likely under-reports the true prevalence of chronic conditions.
- Percentages related to females with at least 1 chronic condition.
- Chronic obstructive pulmonary disease (COPD) here refers to self-reported current and long-term bronchitis and/or emphysema. COPD occurs mostly in people aged 45 and over. While it is occasionally reported in younger age groups, in those aged 45 and over there is more certainty that the condition is COPD and not another respiratory condition. For this reason only people aged 45 and over are included in the line for COPD in this table.
- Includes angina, heart attack, other ischaemic heart diseases, stroke, other cerebrovascular diseases, oedema, heart failure, and diseases of the arteries, arterioles and capillaries. Estimates include persons who reported they had angina, heart attack, other ischaemic heart diseases, stroke or other cerebrovascular diseases but that these conditions were not current at the time of interview

Source: ABS 2018a, ABS 2019. See [Table S10](#) for footnotes.

For more detailed information on chronic conditions, see [Chronic conditions](#).

Cancer

[Cancer](#) describes a diverse group of several hundred diseases in which some of the body's cells become abnormal and begin to multiply out of control. Some cancers are easily diagnosed and treated, others are harder to diagnose and treat, and most can be fatal. Cancers are named by the type of cell involved or the location in the body where the disease begins.

The primary source of national cancer incidence data is the [Australian Cancer Database](#)—a data collection of all primary, malignant cancers diagnosed in Australia since 1982.

19,998

estimated new cases of breast cancer, the most common cancer among females, will be diagnosed in 2020

In 2020, it is estimated that females will account for 46% of all new cancer cases (68,535 cases). The risk for Australian females being [diagnosed with cancer](#) before their 85th birthday is 1 in 2. The most common cancer diagnosis in females is [breast cancer](#), followed by [colorectal cancer](#), [melanoma of the skin](#), and [lung cancer](#) (AIHW 2018).

The most common cancer diagnosis in females varies by age. For example, in 2019, leukaemia, colorectal cancer, lymphoma, thyroid cancer and melanoma of the skin were the most common cancers in females under 30 and breast cancer was the most common cancer for women aged over 30 (AIHW 2018).

Figure 13: Estimated age-specific incidence and mortality rate for all cancers, females, 2020

Rate per 100,000 population

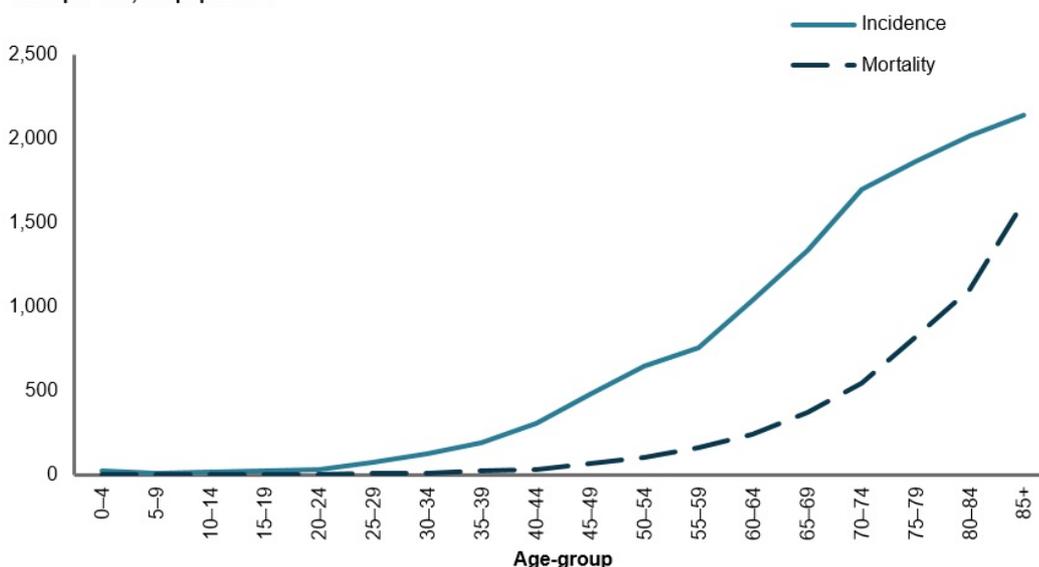


Chart: AIHW. Source: AIHW 2018 (see [Table S11](#) for footnotes).

Endometriosis

Endometriosis is a chronic condition that can be painful, affect fertility and lead to reduced participation in school, work and sporting activities. Around 1 in 9 women born in 1973-78 were estimated to have been diagnosed with endometriosis by age 40-44. Among women born in 1989-95, around 1 in 15 (6.6%) women were estimated to have been diagnosed with endometriosis by age 25-29 (AIHW 2019b).

In 2016-17, there were around 34,200 endometriosis-related hospitalisations (a rate of 281 hospitalisations per 100,000 females). Around half of these (52%) had endometriosis as the [principal diagnosis](#). Nearly 4 in 5 (79%) endometriosis-related hospitalisations were among females aged 15-44 years, which are generally regarded as a woman's reproductive years. This accounts for around 15 out of every 1,000 hospitalisations among females aged 15-44 (AIHW 2019b).

Rates of endometriosis-related hospitalisations varied by population group, after adjusting for age (AIHW 2019b):

- Females living in *Inner regional* areas had the highest rate of endometriosis-related hospitalisations (332 per 100,000 females), followed by females living in *Major cities* (296 per 100,000), *Outer regional* areas (255 per 100,000) and *Remote and very remote* areas (167 per 100,000).
- Females living in the highest socioeconomic areas had higher rates of endometriosis-related hospitalisations compared with females in the lowest areas (307 and 261 per 100,000 females, respectively).
- Non-Indigenous females had higher rates of endometriosis-related hospitalisations than Indigenous females (319 and 196 per 100,000 females, respectively).

The reasons for these differences are not known. They could reflect potential variations in access to health services or differences in health-seeking behaviour between population groups, rather than a difference in disease prevalence.

Endometriosis-related hospitalisations were more likely than all hospitalisations for females to be partly or fully funded by private health insurance (57% compared with 43%). They were also more likely than all hospitalisations for females to be in private hospitals (62% compared with 42%). These differences are likely related to the generally greater numbers of endometriosis-related hospitalisations among females living in higher socioeconomic areas.

For more information see [Endometriosis in Australia: prevalence and hospitalisations](#).

Mental health

The World Health Organization defines mental health as ‘a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community.’ Poor mental health may adversely affect any or all of these areas and has consequences for an individual, their family and society. Mental and substance use disorders are among the leading causes of disease burden for Australian women (AIHW 2019a).

More than 2 in 5

Australian women have experienced a mental health problem in their lifetime.

The most recent comprehensive national survey, the 2007 National Survey of Mental Health and Wellbeing, indicated that more than 2 in 5 (43%) females aged 16-85 had experienced a mental disorder in their lifetime (ABS 2008). The ABS has plans to begin conducting the Intergenerational Health & Mental Health Study from 2020.

More recently, the 2017-18 National Health Survey (NHS) collected data on self-reported mental health issues in Australia. The NHS showed that (ABS 2018a):

- around 1 in 5 (22%) Australian females were estimated to have a current mental or behavioural condition that had lasted, or was expected to last, 6 months or more
- the most common mental and behavioural conditions were anxiety related problems (71%) and mood (affective) disorders (54%)
- around 3 in 20 (15%) women aged 18 and over were estimated to have experienced a high or very high level of psychological distress in the last 12 months.

Other sources of administrative data show that, in 2017-18, more than 2.4 million Australian females (20%) received a mental health-related prescription (AIHW 2019g).

The 2010 Survey of High Impact Psychosis estimated that the 12-month prevalence of females aged 18-64 with a psychotic disorder in contact with public specialised mental health services in Australia to be 24,674 (3.5 cases per 1,000 persons) (Morgan et al. 2011).

The 2013-14 Australian Child and Adolescent Survey of Mental Health and Wellbeing indicated that just over 1 in 10 (11.5%) girls aged 4-17 had experienced a mental disorder in the previous 12 months (Lawrence et al. 2015).

For more information see [Mental health services](#).

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How healthy are Australia's females?

Mothers

An important life stage for many Australians is when they become a parent. For mothers, the health of a mother and baby can be affected by (Bywood, Raven & Erny-Albrecht 2015, WHO 2015):

- a mother's age
- where she lives
- the socioeconomic conditions in which she lives
- the presence of pre-existing or pregnancy-related medical conditions
- risky behaviours such as smoking and drinking alcohol during pregnancy.

Data on almost every birth in Australia are collected by midwives and other birth attendants and included in [the National Perinatal Data Collection](#) at the Australian Institute of Health and Welfare (AIHW). Among Australian women (AIHW 2019c; AIHW 2019d):

- In 2017, 301,095 women gave birth to 305,667 babies in Australia—an increase of 4% since 2007 (289,499 women).
- The rate of women giving birth decreased from 66 per 1,000 women of reproductive age (15-44 years) in 2007 to 60 per 1,000 in 2017.
- The average age of all women who gave birth continues to rise— from 29.9 years in 2007, to 30.6 years in 2017.
- 1 in 10 women (29,267 or 9.9%) who gave birth in 2017 smoked at some time during their pregnancy, a decrease from 15.4% in 2010.
- After adjusting for age, 44.3% of Indigenous women who gave birth in 2017 smoked at some time during their pregnancy. Indigenous women were 3.7 times as likely to smoke at some time during their pregnancy as non-Indigenous women.
- After adjusting for age, smoking at any time during pregnancy for Indigenous mothers declined from 49.4% in 2010 to 44.3% in 2017.
- 7 in 10 (72%) mothers received antenatal care in the first trimester in 2017 compared with 6 in 10 (63%) in 2010.
- Almost half (46%) of women who gave birth in 2017 were overweight or obese at their first antenatal visit.
- 2 in 3 mothers had vaginal births, and the remaining 1 in 3 had caesareans in 2017. Mothers aged 40 and over were almost 3 times as likely to deliver by caesarean section as teenage mothers (54% and 20%, respectively).

For more information see [Mothers and babies](#).

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How healthy are Australia's females?

Sexual health

Sexual health is a state of physical, mental and social well-being in relation to sexuality (WHO 2019a). Measures of sexual health include the prevalence of sexual difficulties and sexually transmissible infection rates.

Sexually transmitted infections

Sexually transmitted infections (STIs) are a subset of communicable diseases known to be transmitted through sexual contact. More than 30 different viruses, bacteria and parasites are known to be transmitted sexually (WHO 2019b). While some STIs can be cured, a person can have an STI without symptoms of disease. If left untreated, these infections can have serious consequences for long-term health.

In Australia, data about new cases of STIs are collected through notifiable disease monitoring systems. Data about common infections are routinely published in annual surveillance reports, including chlamydia, gonorrhoea, syphilis, hepatitis B, hepatitis C and HIV (Kirby Institute 2018).

66,449

new cases of selected notifiable STIs were reported for Australian females in 2017

In 2017, females accounted for less than half (44%) of all new STI cases (Kirby Institute 2018).

Table 3: Number, proportion and rate of sexually transmitted infection notifications, females, 2017-18

	Number of notifications	Per cent of total cases ^(a)	Rate per 100,000	Age group with highest rate
Chlamydia	52,318	52%	442	20-24
Gonorrhoea	7,282	26%	62	20-24
Hepatitis C	3,263	31%	27	25-29
Hepatitis B	2,831	46%	23	30-39
Infectious Syphilis	647	15%	5.5	15-19
HIV	108	11%	0.9	30-39

(a) Total cases excludes cases where sex was missing.

Chart: AIHW. Source: Kirby Institute 2018 (see [Table S12](#)).

Notification rates for viral hepatitis and HIV have remained stable over time in females. However, there has been an increase in rates of chlamydia, gonorrhoea and syphilis notifications. The increase in gonorrhoea and syphilis notifications are more dramatic than the increase in chlamydia, with rates of gonorrhoea in females twice as high in 2017 as in 2008 and rates of syphilis 4 times as high in 2017 as in 2008.

Figure 14: Rate per 100,000 of gonorrhoea and syphilis notifications, females, 2008-2017

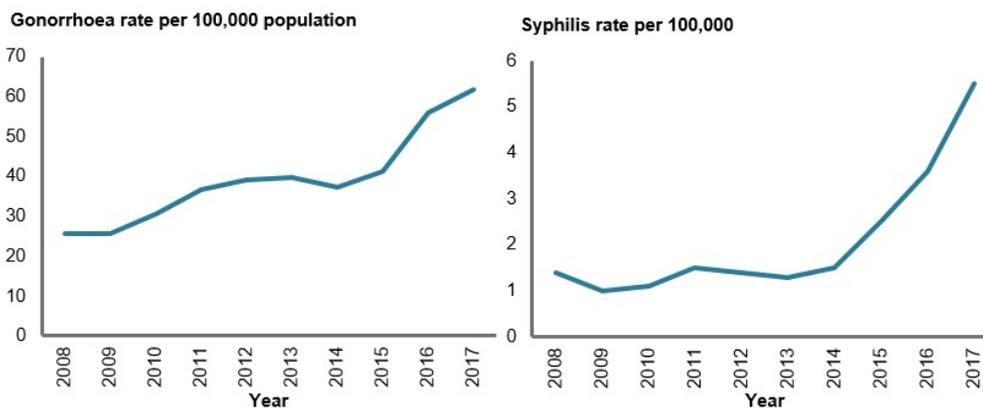


Chart: AIHW. Source: Kirby Institute 2018 (see [Table S13](#)).

For more information, see [HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2018](#)

Sexual difficulties

Around 2 in 3

Australian women experienced at least 1 sexual difficulty in the last 12 months

A sub-study of the Australian Longitudinal Study of Health and Relationships, asked 2,252 women in 2011, which indicated that 66% of women surveyed (aged 20-64) had experienced at least 1 of the following sexual difficulties in the 12 months prior to the survey (Smith et al. 2012):

- lacked interest in having sex (50%)
- unable to climax (21%)
- took too long to orgasm (21%)
- had trouble with vaginal dryness (20%)
- did not find sex pleasurable (17%)
- felt anxious about ability to perform sexually (12%)
- physical pain during intercourse (10%)
- came to orgasm too quickly (5%).

For more information, see [Sexual and reproductive health](#).

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How healthy are Australia's females?

Life expectancy and mortality

Life expectancy is expressed as either the number of years a newborn baby is expected to live, or the expected years of life remaining for a person at a given age.

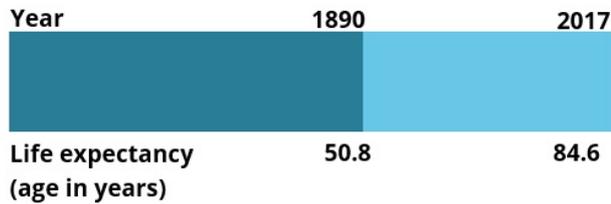


Chart: AIHW. Source: AIHW 2019b.

Australian females born in 2015-2017 can expect to live 34 years longer than females born in 1881-1890.

Life expectancy at birth in Australia has improved dramatically for both sexes in the last century, and shows some variation between population groups (ABS 2018b, AIHW 2019e, OECD 2019):

- Females born in Australia in 2015-2017 can expect to live to the age of 84.6 years on average (an increase of 0.9 years in the past 10 years).
- In 2015-2017, life expectancy at birth for Aboriginal and Torres Strait Islander females was estimated to be 75.6 years, 7.8 years less than for non-Indigenous females.
- International comparisons of life expectancy at birth projected for females in 2017, indicate that Australian females have the 7th highest life expectancy in the world. Japan ranks 1st with 87.3 years.

For more information, see: [Deaths in Australia: Life expectancy](#).

Health Adjusted Life Expectancy

Health Adjusted Life Expectancy (HALE) reflects the length of time an individual at a specific age could, on average, expect to live in full health (AIHW 2019a). It can be measured at any age but is typically reported:

- from birth (which represents the average life expectancy for a baby born that year)
- at age 65, describing health in an ageing population.

Life expectancy in Australia for females born in 2015 was 84.6 years, while the average number of healthy years (HALE) for these babies was 74.4 years. The difference between life expectancy and HALE (that is, the time expected in less than full health) was 10.2 years. This means that females could expect to spend 88% of their lives in full health.

While females born in 2015 are expected, on average, to live 4.2 years longer than males, they are also expected to have 2.9 more years of healthy life than males.

Life expectancy in 2015 for women aged 65 was 22.3 years—that is, they could expect to live to the age of 84.6. At age 65, women could expect on average, 16.8 healthy years of life and 5.5 years in less than full health.

Between 2003 and 2015, life expectancy and HALE at birth increased for females. Females gained 1.6 years in life expectancy (from 83.0 in 2003 to 84.6 in 2015) and 1.3 years in HALE (from 73.1 to 74.4 years) (AIHW 2019a).

For more information see: [Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2015](#)

Mortality

Mortality data, such as premature deaths, potentially avoidable deaths and mortality rates can help in understanding death and the fatal burden of disease in the population at a point in time.

Causes of death

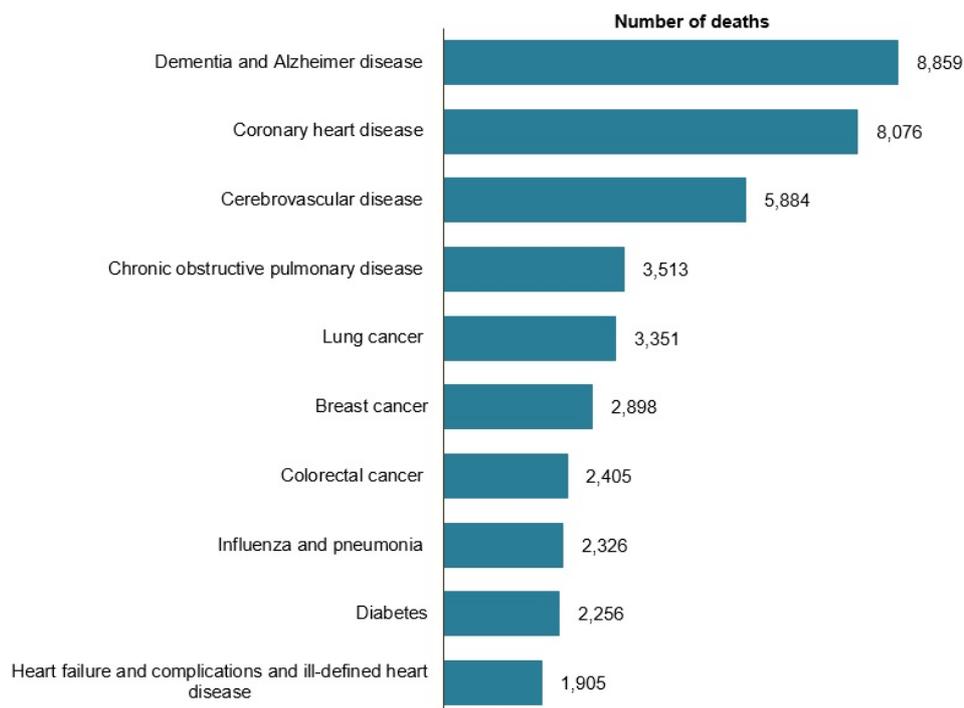
Monitoring causes of death helps to measure the health status of a population. Causes of death can be used to:

- assess the success of interventions to improve disease outcomes
- signal changes in community health status and disease processes
- highlight inequalities in health status between population groups.

In 2017, 78,051 Australian females died (AIHW 2019e). The median age at death was 85 years, and the leading cause of death was Dementia and Alzheimer disease (11%), followed by coronary heart disease (10%), and cerebrovascular disease (7.5%) (Figure 15). Leading causes of death for females varied by age group (Figure 16).

For more information see *Deaths in Australia: Life expectancy*.

Figure 15: Leading causes of death for females, 2017



Notes:

1. Data are based on year of registration of death; deaths registered in 2017 are based on the preliminary version of cause of death data and are subject to further revision by the ABS.
2. Leading causes of death are based on underlying causes of death and classified using an AIHW-modified version of Becker et al. 2006. International Statistical Classification of Diseases and Related Health Problems, 10th (ICD-10) codes presented in parentheses.

Chart: AIHW. Source: AIHW 2019e (see [Table S14](#)).

Figure 16: Leading causes of death for females, by age group (years), 2017

Age group (years)	1st	2nd	3rd
Under 1	Perinatal and congenital conditions	SIDS	Influenza and pneumonia
1–14	Perinatal and congenital conditions	Land transport accidents	Brain cancer
15–24	Suicide	Land transport accidents	Accidental poisoning
25–44	Suicide	Accidental poisoning	Breast cancer
45–64	Breast cancer	Lung cancer	Colorectal cancer
65–74	Lung cancer	COPD	Coronary heart disease
75 and over	Dementia and Alzheimer disease	Coronary heart disease	Cerebrovascular disease

Note: Disease rankings exclude ‘other’ residual conditions from each disease group; for example, ‘other musculoskeletal conditions’.

Chart: AIHW. Source: AIHW 2019e (see [Table S15](#)).

Premature and potentially avoidable deaths

In 2017, females accounted for around 2 in 5 (38%) of premature deaths. Mortality rates varied between population groups (AIHW 2019f):

- Females in *Very remote* areas had a higher percentage of potentially avoidable deaths, with 3 in 5 (62%) premature deaths being potentially avoidable, compared with less half (46%) in *Major cities*.
- The median age at death for females decreased with increasing remoteness: from 85 years in *Major cities* to 69 years in *Very remote* areas.
- Females in the lowest socioeconomic areas had twice the rate of potentially avoidable deaths per 100,000 population compared with females in the highest socioeconomic areas (105.5 and 48.1 per 100,000, respectively).
- The median age at death for females decreased with decreasing socioeconomic area: from 85 years in the highest area to 83 in the lowest.

For more information see: [Mortality Over Regions and Time](#).

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How do Australia's females access health care?

The Australian health system provides a wide range of preventive, treatment and palliative health care services. Monitoring people's health needs, their help-seeking behaviours, and their patterns of health service use helps government and health service providers to identify inequalities in access and predict future health care needs.

Last updated 5/11/2019 v33.0

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How do Australia's females access health care?

Medicare services

The Medicare Benefits Schedule (MBS) is a listing of services that qualify for a benefit under the *Health Insurance Act 1973*. The associated MBS claims data comprise information on MBS services that qualify for a Medicare Benefit, for which a claim has been processed (including bulk billed services). The data also include demographic information about patients. Medicare services include medical practitioner attendances, diagnostic and therapeutic procedures, and diagnostic and pathology services. They exclude services to public inpatients and public outpatients of hospitals, and services covered by the Department of Veterans' Affairs National Treatment Account, or provided under other public funded programs. People who live in Australia and are Australian or New Zealand citizens or hold a permanent visa are eligible for Medicare enrolment.

In 2018-19, Australia's females claimed more than 245 million services through Medicare, and received an average of 19.5 Medicare services per person in that year. By comparison, males claimed 14 Medicare services per person (Department of Health 2019).

The average number of services claimed by females varies by age group. In 2018-19, those aged (Department of Health, 2019):

- under 45 claimed fewer than 12 services per person
- 75 and over claimed more than 43 services per person.

Figure 17: Average number of Medicare services claimed by females, per person, by age group (years), 2018-19

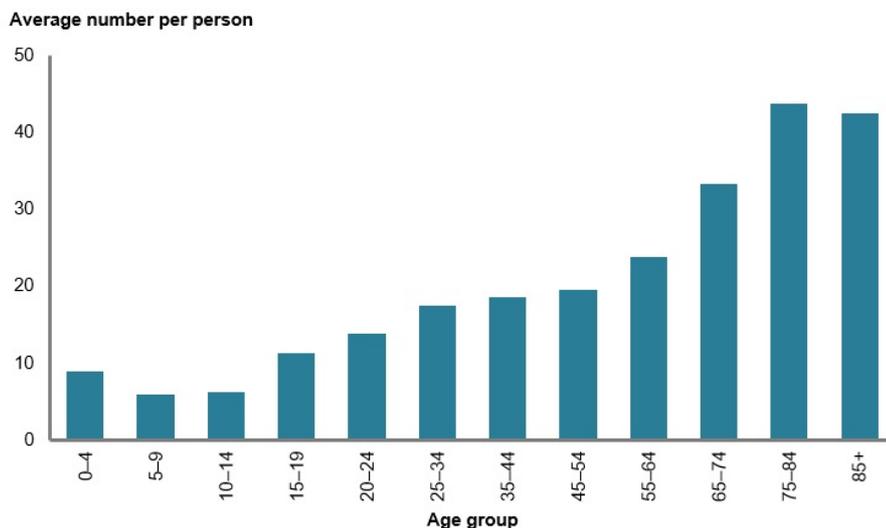


Chart: AIHW. Source: Department of Health 2019 (see [Table S16](#)).

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Last updated 19/11/2019 v8.0

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How do Australia's females access health care?

Primary health care

In Australia, primary health care is usually a person's first encounter with the health system when they have a health concern. Primary health care broadly encompasses health care not related to a hospital visit.

9 in 10

Australian females visited a general practitioner in the previous 12 months

Based on the ABS Patient Experiences Survey, in 2018-19, 88% of females aged 15 and over were estimated to have visited their general practitioner (GP) in the last 12 months (ABS 2019).

Barriers to accessing health services may impede the best possible health outcomes for women. In 2018-19, among females aged 15 and over (ABS 2019):

- more than 1 in 5 (21%) waited longer than they felt acceptable to get an appointment with a GP
- 1 in 25 (4.0%) delayed seeing, or did not see, a GP when needed because of cost reasons at least once in the past 12 months
- almost 1 in 10 (8.1%) delayed getting, or did not get prescribed medication, because of cost.

Based on the 2016 Survey of Health Care, of Australian women aged 45 and over who had at least 1 GP visit in the 12 months between November 2014 and November 2015 (ABS 2017):

- 1 in 4 (26%) had spoken to their GP about their emotional and psychological health
- almost half (49%) indicated they received care from a health professional other than their GP or specialist doctor or nurse for their physical health (for example, physiotherapist, podiatrist, dietitian)
- 1 in 9 (11%) indicated that they received care from a health professional other than their GP or specialist doctor or nurse for their emotional or psychological health (for example, psychologist, counsellor or social worker)
- more than 8 in 10 (84%) were currently taking at least 1 medication on a regular and ongoing basis
- almost 8 in 10 (79%) indicated they were always or usually involved in making decisions about their medications for their own health.

References

ABS (Australian Bureau of Statistics) 2017. Survey of Health Care, Australia, 2016. ABS cat. no. 4343.0. Canberra: ABS.

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AIHW (Australian Institute of Health and Welfare) 2019a. Emergency Department care 2017-18: Australian hospital statistics. Health services series no. 89. Cat. no. HSE 216. Canberra: AIHW.

AIHW 2019b. Admitted patient care 2017-18: Australian hospital statistics. Health services series no. 90. Cat. no. HSE 225. Canberra: AIHW.

Department of Health 2019. Annual Medicare Statistics - Financial Year 1984-85 to 2018-19. Canberra: Department of Health.

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How do Australia's females access health care?

Private health insurance

In Australia, private health insurance is available for those who wish to fully or partly cover the costs of being admitted to hospital as a private patient and/or the costs of other ancillary health services.

Based on the 2017-18 ABS Patient Experience Survey, more than half of Australian females (57%) had some form of private health insurance (ABS 2018). Of these:

- around half (46%) had both hospital and extras cover
- 3 in 50 (6%) had hospital cover only
- 1 in 20 (5%) had extras only cover.

References

ABS (Australian Bureau of Statistics) 2017. Survey of Health Care, Australia, 2016. ABS cat. no. 4343.0. Canberra: ABS.

ABS 2019. Patient Experiences in Australia: Summary of Findings, 2018-19. ABS cat. no. 4839.0. Canberra: ABS.

AIHW (Australian Institute of Health and Welfare) 2019a. Emergency Department care 2017-18: Australian hospital statistics. Health services series no. 89. Cat. no. HSE 216. Canberra: AIHW.

AIHW 2019b. Admitted patient care 2017-18: Australian hospital statistics. Health services series no. 90. Cat. no. HSE 225. Canberra: AIHW.

Department of Health 2019. Annual Medicare Statistics - Financial Year 1984-85 to 2018-19. Canberra: Department of Health.

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How do Australia's females access health care?

Hospital care

Emergency department care

Hospital emergency departments provide care for patients who present for urgent medical attention.

In 2017-18, there were 3.9 million emergency department presentations among Australian females, accounting for 50% of all presentations (AIHW 2019a). Among adult females, rates of emergency department presentations were highest in those aged 75-84 and 85 years and older (524 and 750 per 1,000 population respectively).

For more information see [Emergency department care](#)

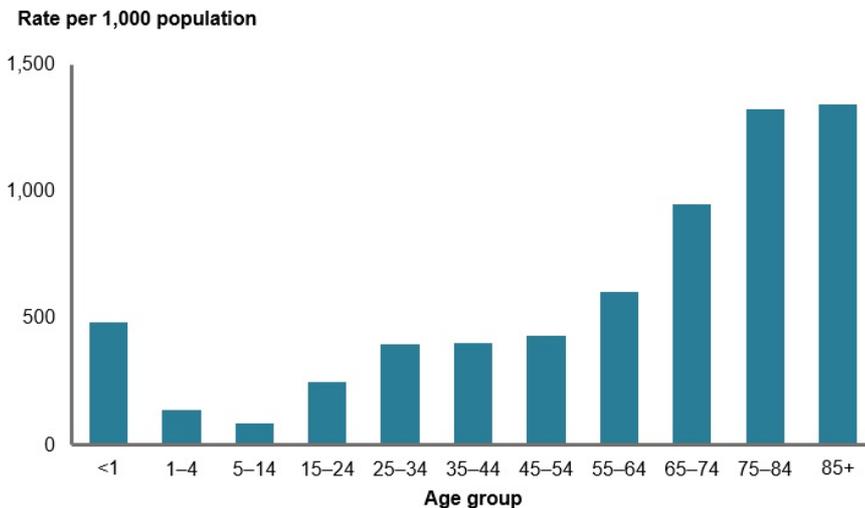
Admitted patient care

Admitted patient care refers to care provided by public and private hospitals to admitted patients. A hospitalisation is an episode of hospital care that starts with the formal admission process and ends with the formal [separation](#) process.

In 2017-18, there were 5.9 million hospitalisations among Australian females, accounting for 52% of all hospitalisations (AIHW 2019b).

Hospitalisation rates generally increase with age, and are highest among women aged 85 and over (Figure 18).

Figure 18: Hospitalisations per 1,000 population, females, by age group (years), 2017-18



Note: See Box 1.1, and appendixes A and B of [Admitted patient care, 2017-18](#) for notes on data limitations and methods.

Chart: AIHW. *Source:* AIHW 2019b (see [Table S17.1](#) and [Table S17.2](#)).

For more information see [Admitted patient care](#).

References

ABS (Australian Bureau of Statistics) 2017. Survey of Health Care, Australia, 2016. ABS cat. no. 4343.0. Canberra: ABS.

ABS 2019. Patient Experiences in Australia: Summary of Findings, 2018-19. ABS cat. no. 4839.0. Canberra: ABS.

AIHW (Australian Institute of Health and Welfare) 2019a. Emergency Department care 2017-18: Australian hospital statistics. Health services series no. 89. Cat. no. HSE 216. Canberra: AIHW.

AIHW 2019b. Admitted patient care 2017-18: Australian hospital statistics. Health services series no. 90. Cat. no. HSE 225. Canberra: AIHW.

Department of Health 2019. Annual Medicare Statistics - Financial Year 1984-85 to 2018-19. Canberra: Department of Health.



How does the health of females and males compare?

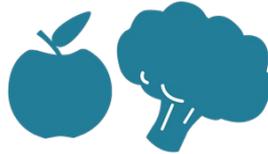
Physical activity, diet and body weight

Physical activity



In 2017-18, **5 in 10 men** and **4 in 10 women** were sufficiently physically active. ^(a)
50% of men and 41% of women

Fruit and vegetable intake



In 2017-18, fewer than **1 in 30 men** and **1 in 15 women** ate enough fruit and vegetables. ^(a)
3.0% of men and 7.7% of women

Sugar sweetened drinks



In 2017-18, men were almost **twice as likely** as women to drink sugar sweetened drinks daily. ^(a)
12% of males and 6.4% of females were daily consumers

Overweight and obesity



In 2017-18, **7 in 10 men** and **6 in 10 women** were overweight or obese. ^(b)
75% of men and 60% of women

Tobacco smoking and alcohol

Daily smoking



In 2017-18, men were **1.5 times** as likely to smoke daily as women. ^(a)
16.5% of men and 11.1% of women

Alcohol



In 2017-18, **1 in 4 men** and **1 in 11 women** were consuming alcohol at levels placing them at lifetime risk of an alcohol-related disease or injury. ^(a)
24% of men and 8.8% of women

Other risk factors

Work



In 2016-17, **9 in 10** people killed at work were men. ^(c)
176 of 190 people killed at work were men

Physical violence



In 2016, **4 in 10** men and **3 in 10** women had experienced physical violence since the age of 15. ^(d)
41% of men and 31% of women

Sexual violence



In 2016, **1 in 20** men and **4 in 20** women had experienced sexual violence since the age of 15. ^(d)
4.7% of men and 18% of women

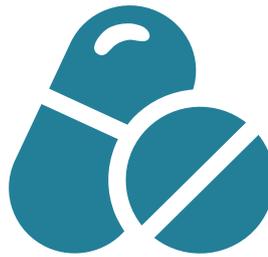
How healthy are males and females?

Self-assessed health status



In 2017-18, males and females were **equally likely** to rate their health as excellent or very good. ^(b)
57% of males and 56% of females

Chronic conditions



In 2017-18, around **1 in 2** males and females had at least 1 of the 10 selected common chronic conditions. ^(b)
46% of males and 49% of females

Multiple chronic conditions



In 2017-18, around **1 in 6** males and **1 in 4** females had more than 1 of the 10 selected chronic conditions. ^(b)
18% of males and 23% of females

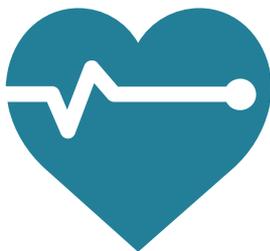
Sexually transmitted infections



In 2017, rates of new STI cases were **up to 8 times higher** in males than females for all STIs except chlamydia. ^(f)

Burden of disease

Causes of total burden



In 2015, males experienced a higher proportion of their total burden (DALY) from **dying early due to disease and injury (55%)** while females experienced more of their burden from **living with disease (56%)**. ^(e)

Leading cause of disease burden



In 2015, the leading cause of total disease burden in both males and females was coronary heart disease. ^(e)
8.6% of total burden in males and 5.0% of total burden in females

Life expectancy and mortality

Life expectancy



Life expectancy at birth for males born in 2015-17 was **80.5 years**, and females born in the same period have a life expectancy at birth of **84.6 years**.^(g)

Primary health care

Barriers to seeing a GP



In 2018-19, **1 in 25 females** and **1 in 40 males** delayed seeing, or did not see, a GP when needed because of cost reasons at least once in the previous 12 months.^(h)

2.7% of males and 4.0% of females

- a. ABS (Australian Bureau of Statistics) 2019a. Microdata: National Health Survey, 2017-18, detailed microdata, DataLab. ABS cat. no. 4324.0.55.001. Canberra: ABS. Findings based on AIHW analysis of ABS microdata.
- b. ABS 2018. National Health Survey: First results 2017-18. ABS cat. no. 4364.0.55.001. Canberra: ABS.
- c. Safe Work Australia 2018. Work-related Traumatic Injury Fatalities, Australia 2016. Safe Work Australia: Canberra.
- d. ABS 2017. Personal Safety Survey, Australia, 2016. ABS cat. no. 4906.0. Canberra: ABS.
- e. AIHW (Australian Institute of Health and Welfare) 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease series no.19. Cat. no. BOD 22. Canberra: AIHW.
- f. Kirby Institute 2018. HIV, viral hepatitis and sexually transmissible infections in Australia: annual Surveillance report 2018. Sydney: Kirby Institute.
- g. AIHW 2019. Deaths in Australia. Cat. no. PHE 229. Canberra: AIHW.
- h. ABS 2019. Patient Experiences in Australia: Summary of Findings, 2018-19. ABS cat. no. 4839.0. Canberra: ABS.

Causes of death



In 2017, the leading cause of death for males was **coronary heart disease** (10,514 deaths) and for females it was **Dementia and Alzheimer disease** (8,859 deaths).^(g)

Last updated 9/12/2019 v7.0

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Notes

Amendments

21 Mar 2019 - Data tables: Male and female data tables: S2 Weight: Table S2: BMI, children and adults by sex, 2014-15

- The data in the Males (%) column was presented in the incorrect order

5 Aug 2019 - Text in section 'How do Australia's females access health care?' incorrectly stated '...more than 8 in 10 (8.6%) delayed getting, or did not get prescribed medication, due to cost'. This has been corrected to state '...about 1 in 12 (8.6%) delayed getting, or did not get prescribed medication, due to cost'.

Last updated 27/07/2020 v1.0

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Data

Data tables: [Male and female supplementary tables](#)

Download Data tables: [Male and female supplementary tables](#). Format: [XLSX 174Kb](#) [XLSX 174Kb](#)

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Related material

Resources

[ABS National Health Survey](#)

[View](#)

Related topics

- [Chronic disease](#)
 - [Risk factors](#)
-

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