

The health of Australia's males

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Latest edition

In 2018, just under half of Australia's population—49%, or 12.4 million people—were male. On average, Australian males experience different health outcomes to Australian females. They are more likely than females to engage in risky health behaviours and to die prematurely. They are also more likely to be homeless or in custody. Compared with females, males experienced more of their total disease burden due to dying early from disease and injury than from living with disease.

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

Cat. no: PHE 239

Findings from this report:

- More than half of Australian men exceeded the single occasion risk drinking guideline in 2017-18
- Around 1 in 2 Australian males had 1 or more of the 10 selected chronic conditions in 2017-18
- 1 in 2 men were sufficiently physically active in 2017-18
- The leading cause of death for males in 2017 was coronary heart disease

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Who are Australia's males?

In 2018, there were 12.4 million males in Australia—just under half (49%) of the country's population. Overall, there are 98.4 males for every 100 females (ABS 2018a).

The typical Australian male is 36.4 years old, lives in a major city, is employed, has a non-school qualification, and is married (ABS 2017, 2018b, 2018c, 2018d, 2019a).

The male population is ageing

In 2018, the majority of Australian males were of working age. In a group of 20 males, 4 (20%) would be boys aged 0-14 years, 13 (66%) would be males of working age (15-64 years) and 3 (15%) would be men aged 65 years and over (ABS 2018a).

Over the last 10 years, the proportion of the total male population in older age groups has been increasing, particularly the 70-74 age group, which has grown by 6.3% since 2006. In comparison, the 0-4 year age group has grown by 0.2% in the same time period (ABS 2018a).

Some males are more disadvantaged than others

In 2015-16, more than 1 in 8 males (13%) were experiencing poverty, and in 2016 around 67,400 were homeless (around 18,400 more than females) (ACOSS 2018, ABS 2018e). In 2019, there were around 39,800 male prisoners in adult corrective services custody (around 11 times as many as females) (ABS 2019b) and around 1 in 20 males (5.4%) were unemployed (ABS 2019a).

Australian males have diverse backgrounds—1 in 3 were born overseas

Almost one-third (29%) of Australian males were born overseas. Of these, the most common countries of birth were England (15%), India (8.4%) and New Zealand (8.3%) (ABS 2018g).

Aboriginal and Torres Strait Islander males

In 2016, the estimated resident population of Aboriginal and Torres Strait Islander males was nearly 400,000 (3.2% of the male population) (ABS 2018a). Indigenous males tend to be younger than non-Indigenous males—around 1 in 3 (35%) are aged under 15, compared with around 1 in 5 (20%) non-Indigenous males (ABS 2018f).

Around 1 in 6 (17%) Indigenous males speak an Indigenous language and 3 in 5 (61%) identify with a clan, tribal or language group. They are outnumbered by females in older age groups (82 Indigenous men for every 100 Indigenous women aged 65 or over) (ABS 2016, 2018a).

Males outnumber females in *remote* areas

The density of the male population varies across the country. For example, in *Remote and very remote* areas, there are 113 males for every 100 females (ABS 2018b), compared with 97 males for every 100 females in *Major cities*.

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

7 in 10 (71%) Australian males live in *Major cities*

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

fewer than 1 in 10 (8.7%) live in *Outer regional* areas

1 in 50 (2.2%) live in *Remote and very remote* areas (ABS 2018b).

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Lifestyle and risk factors

A person's lifestyle influences how healthy they are. A lifestyle including, physical activity, a well-balanced diet, a safe occupation and maintaining a healthy body weight reduces the risk of poor health. Risk factors such as smoking tobacco, alcohol consumption, using illicit substances or being exposed to violence, increase the likelihood of poor health.

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Lifestyle and risk factors

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 the risk of and helps control 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 is 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 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:

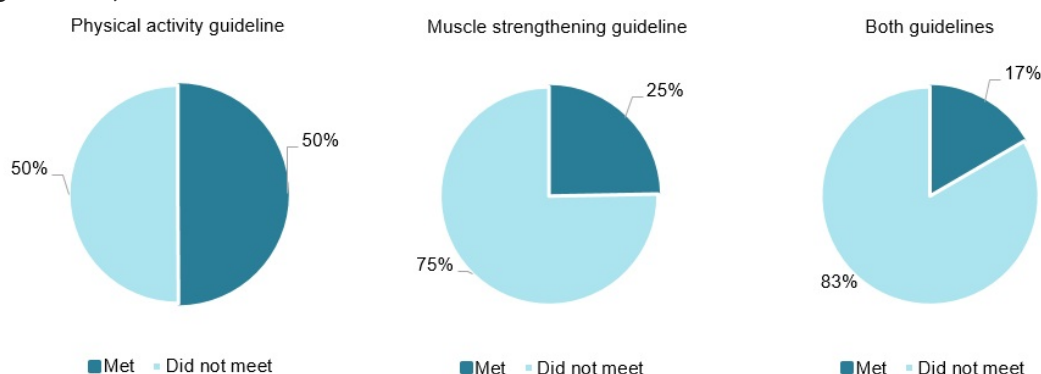
- completing 150 minutes or more of moderate to vigorous physical activity per week (where vigorous activity is multiplied by 2), and
- being active on 5 or more days per week.

1 in 2

Australian men are sufficiently physically active

In 2017–18, 50% of men aged 18 and over were sufficiently physically active and 1 in 4 men (25%) did strength or toning activities on 2 or more days. Overall, just under 1 in 5 (17%) were sufficiently physically active *and* met the muscle strengthening guideline (Figure 1) (ABS 2019a).

Figure 1: Proportion of men 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 men who were sufficiently physically active varied by age and for some population groups (ABS 2019a):

- 3 in 5 (59%) men aged 18–24 were sufficiently physically active, compared with 3 in 10 (31%) aged 65 and over (Figure 2)
- after adjusting for age, around 3 in 5 men (56%) living in the highest socioeconomic areas were sufficiently physically active, compared with around 2 in 5 men (42%) living in the lowest socioeconomic areas.

Figure 2: Proportion of men aged 18 and over who were sufficiently physically active, by age group (years), 2017–18

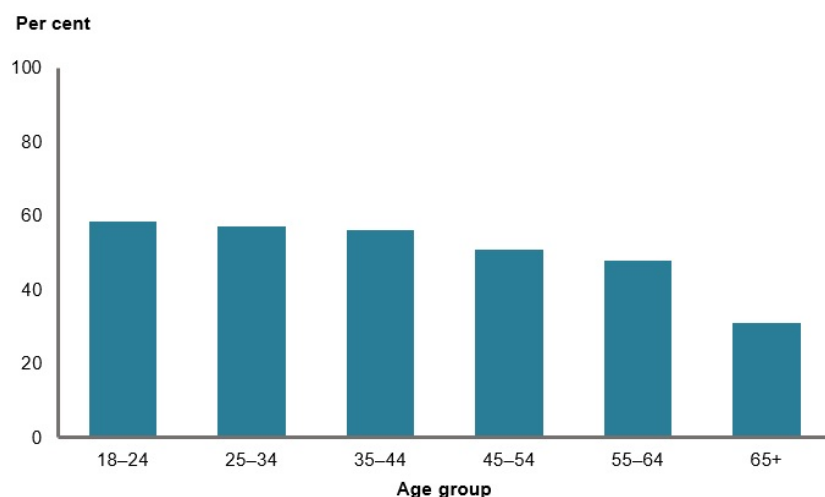


Chart: AIHW. Source: ABS 2019a (see [Table S1](#) for footnotes).

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

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Lifestyle and risk factors

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 males, consuming a minimum of 2 serves of fruit and 5 to 6 serves vegetables each day, depending on age, to ensure good nutrition and health.

Less than 1 in 30

Australian men are meeting fruit and vegetable intake guidelines

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

- around half (47%) of men aged 18 and over met the fruit intake guideline
- 1 in 25 (4.1%) met the vegetable intake guideline
- less than 1 in 30 (3.0%) met both (Figure 3).

Figure 3: Proportion of men aged 18 and over meeting fruit intake guideline, vegetable intake guideline and both guidelines, 2017-18

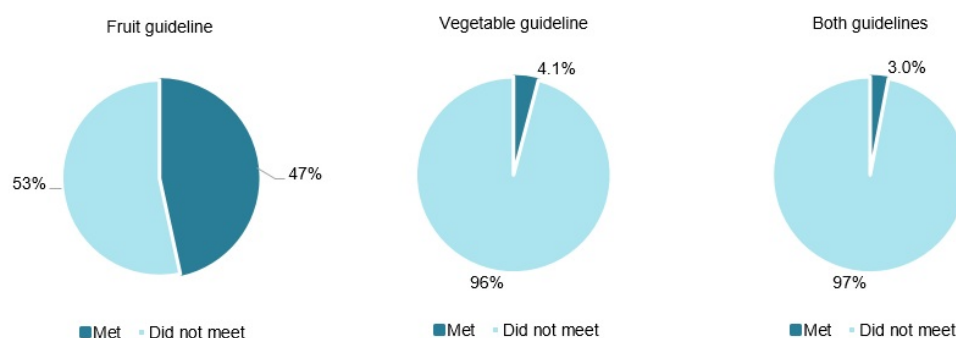


Chart: AIHW. Source: ABS 2019a (see [Table S2](#) for footnotes).

The proportion of men meeting both fruit and vegetable intake guidelines varied by age group. For example, men aged 75-84 were 9 times as likely to meet both guidelines as men aged 25-34 (10% and 1.1%, respectively) (Figure 4).

Figure 4: Proportion of men aged 18 and over who met the 2013 Australian dietary guidelines for fruit and vegetable consumption, by age group (years), 2017-18

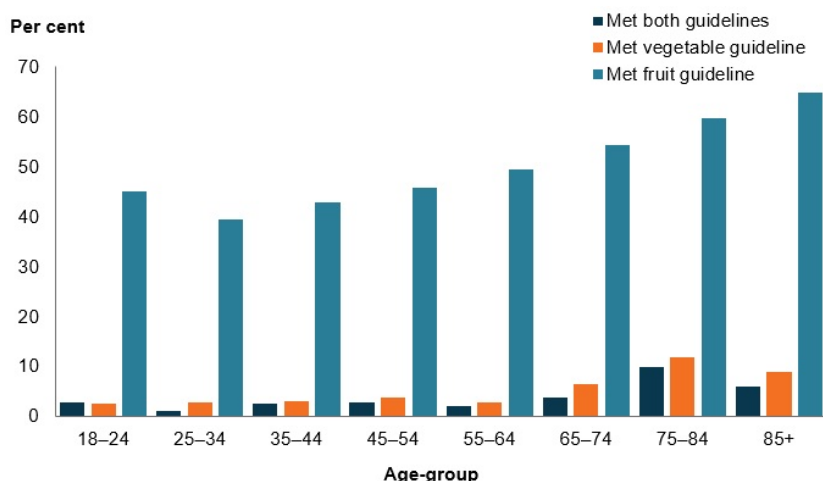


Chart: AIHW. Source: ABS 2019a (see [Table S2](#) for footnotes).

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

- men living in the highest socioeconomic areas were 1.2 times as likely to be eating enough fruit as men in the lowest areas (51% and 43%, respectively)
- the proportion of men eating enough vegetables was low (around 4%) across all remoteness areas
- the proportion of men eating enough vegetables was low across all socioeconomic areas (between 3% and 5%).

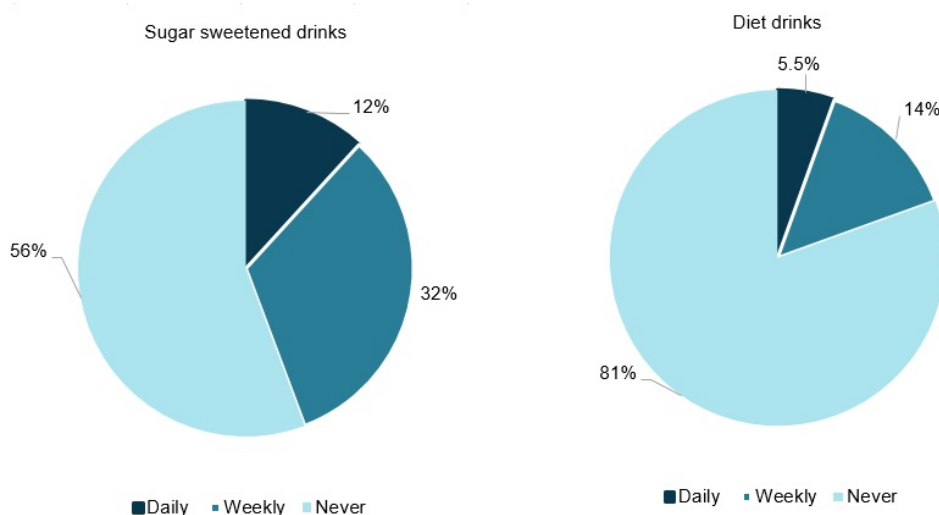
Sugar sweetened and diet drinks

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):

- 1 in 3 (33%) Australian men drank sugar sweetened drinks at least once a week, and around 1 in 8 (12%) did so daily
- 1 in 7 men drank diet drinks at least once a week (14%), and around 1 in 20 did so daily (5.5%) (Figure 5).

Figure 5: Proportion of men 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)

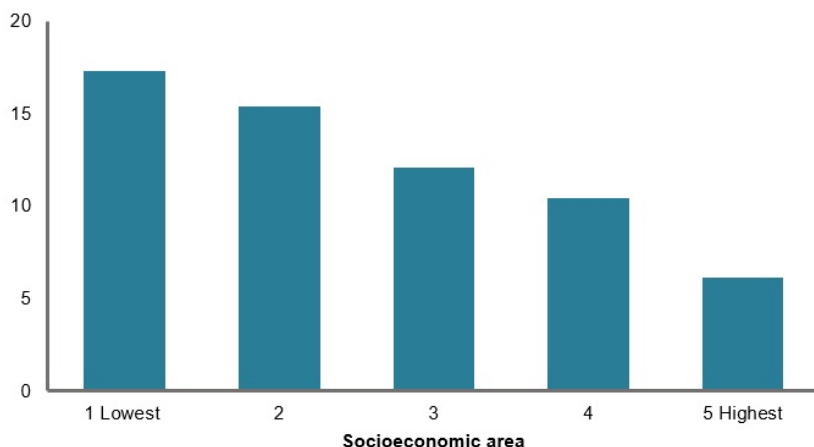
The proportion of men who consumed sugar sweetened or diet drinks daily varied by age group. For example, men aged 18-24 were almost 3 times as likely as men aged 65-74 to consume sugar sweetened drinks daily (17% and 5.8%, respectively).

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

- men living in *Outer regional and remote* areas were almost twice as likely to drink sugar sweetened drinks daily compared with men in *Major cities* (18% compared with 11%)
- men living in the lowest socioeconomic areas were almost 3 times as likely to drink sugar sweetened drinks daily as men in the highest socioeconomic areas (17% and 6.1%, respectively) (Figure 6).

Figure 6: Proportion of men aged 18 and over consuming 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 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 1 in 3 (32%) men aged 18 and over were estimated to have taken dietary supplements in the last 2 weeks. Supplement use was more common in older age groups. Around 2 in 5 (41%) men aged 65-74 used supplements compared with 1 in 4 men aged 18-24 (25%).

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

- men living in *Major cities* areas were 1.3 times as likely to be taking dietary supplements as men in *Outer Regional and remote* areas (34% and 26%, respectively)
- men living in the highest socioeconomic areas were 1.4 times as likely to be taking dietary supplements as men in the lowest socioeconomic areas (36% and 26%, respectively).

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Lifestyle and risk factors

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 2019b).

Body mass index

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 4

Australian men are overweight or obese

According to 2017-18 data (ABS 2018):

- 3 in 4 Australian men (75%) were overweight or obese
- 2 in 5 (42%) were overweight (but not obese)
- 3 in 10 (33%) were obese.

Overweight and obesity is more common in older age groups, around 4 in 5 men aged 55-64 were overweight or obese (84%), compared with 1 in 2 men aged 18-24 (52%) (ABS 2019c).

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

- men living in the lowest socioeconomic areas were slightly more likely to be overweight or obese as men living in the highest socioeconomic areas (77% and 73%, respectively)
- in 2012-13, the overall rate of overweight and obesity was the same for Aboriginal and Torres Strait Islander men and non-Indigenous men (70% for both). For obesity alone, 39% of Indigenous men were obese in 2012-13, compared with 27% of non-Indigenous men.

The proportion of males who were overweight or obese in 2017-18 differed between men and boys (ABS 2019c):

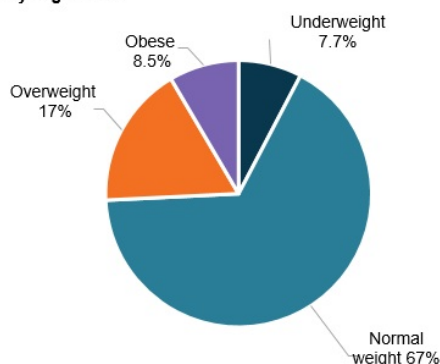
- 3 in 4 (75%) men aged 18 and over were overweight or obese
- 1 in 4 (25%) boys aged 2-17 were.

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

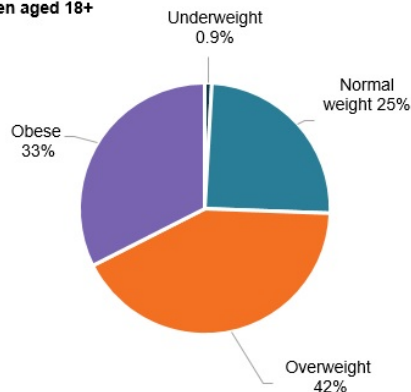
- boys living in *Inner regional* areas were 1.3 times as likely to be overweight or obese as boys in *Major cities* (30% and 24%, respectively)
- boys living in the second-lowest socioeconomic areas were 1.4 times as likely to be overweight or obese as boys in the highest socioeconomic areas (30% and 21%, respectively)
- boys living in the lowest socioeconomic areas were 3 times as likely to be obese as boys in the highest socioeconomic areas (11% and 3.4%, respectively).

Figure 7: Body mass index, boys aged 2-17 and men aged 18 and over, 2017-18

Boys aged 2–17



Men aged 18+



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

Chart: AIHW. Source: ABS 2018 (see Table 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 men, a waist circumference above 94 cm is associated with an increased risk of metabolic complications and a waist circumference above 102cm is associated with substantially increased metabolic risk (WHO 2011).

3 in 5

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

According to 2017-18 data, 3 in 5 (60%) Australian men have 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 men aged 18 in over in 2017-18 was 98cm (ABS 2018).

High-risk waist circumference was more common in older men (ABS 2019a):

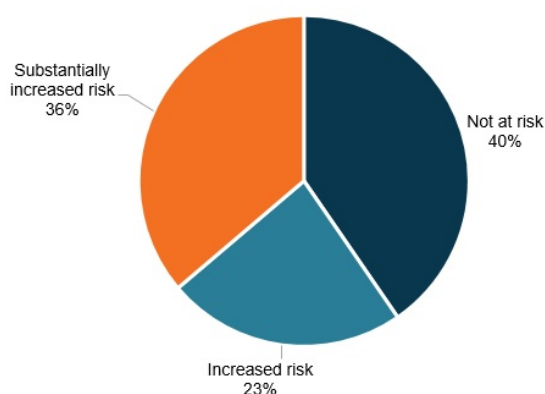
- 8 in 10 men aged 65-74 (81%) had a high-risk waist circumference
- 3 in 10 men aged 18-24 did (29%).

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

- men living in *Outer regional and remote* areas were 1.1 times as likely as men in *Major cities* to have a high-risk waist circumference (61% and 58%, respectively)
- men living in the lowest socioeconomic areas were 1.2 times as likely as men in the highest socioeconomic areas to have a high-risk waist circumference (62% and 53% respectively).

Figure 8: Waist circumference of men, by risk category, 2017-18

Men aged 18 and over



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 fewer calories are absorbed.

In 2017-18, males accounted for 20% of procedures for weight loss surgery (7,900 procedures). The rate of weight loss surgeries among males for the same year was 64 per 100,000, an increase from 2015-16 with 6,000 procedures and a rate of 50 per 100,000 (AIHW 2019a).

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

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Lifestyle and risk factors

Tobacco smoking, alcohol and illicit drugs

Tobacco

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

Around 1 in 6

Australian men 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 \(NDSHS\)](#).

Based on the:

- 2017-18 ABS NHS, 16.5% of men aged 18 or over and 2.4% of boys aged 15-17 years smoked daily (ABS 2018)
- 2016 AIHW NDSHS, 14.6% of men aged 18 or over and 2.7% of males aged 14-19 smoked daily (AIHW 2017b).

Based on the NDSHS, there has been a long-term downward trend in tobacco smoking in Australia amongst males aged 14 and over, decreasing from 20.9% in 2001 to 13.8% in 2016. Younger males are starting smoking later, with the average age when a male had their first full cigarette increasing from 15.1 years in 2001 to 16.6 years in 2016 (AIHW 2017b).

In general, smoking rates among adult men (aged 18 years and over) varied by age-group, peaking during middle age and decreasing with increasing age, with rates lowest among men aged 75 and over (5.1%) (ABS 2018).

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

- according to 2017-18 data, men living in *Outer regional and remote* areas were 1.5 times as likely to smoke daily as men in *Major cities* (23.5% and 15.7%, respectively)
- men living in the lowest socioeconomic areas were 3 times as likely to smoke daily as men in the highest areas (26.4% and 8.7%, respectively) (Figure 9)
- according to 2014-15 data, 43.9% of Aboriginal and Torres Strait Islander men aged 18 and over smoked daily. After adjusting for age, Indigenous men were 2.5 times as likely to smoke daily as non-Indigenous men.

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

Age-standardised per cent

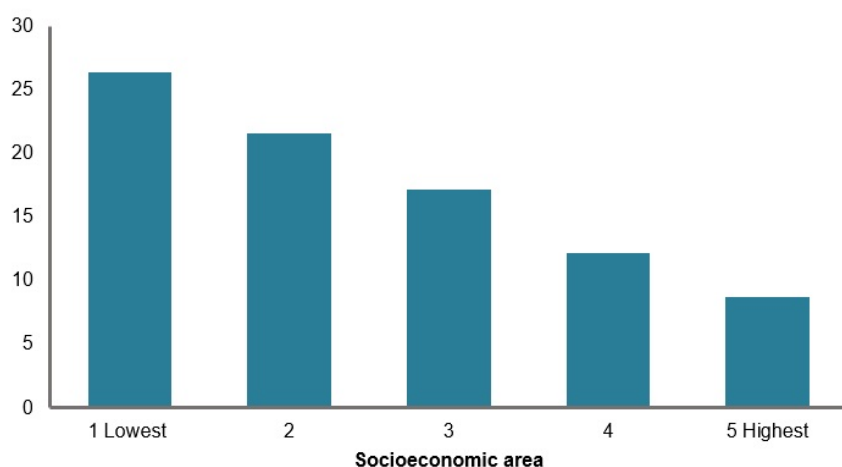


Chart: AIHW. Source: ABS 2019a see [Table S8](#) for footnotes).

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.

1 in 2

Australian men are exceeding single occasion risky drinking guidelines

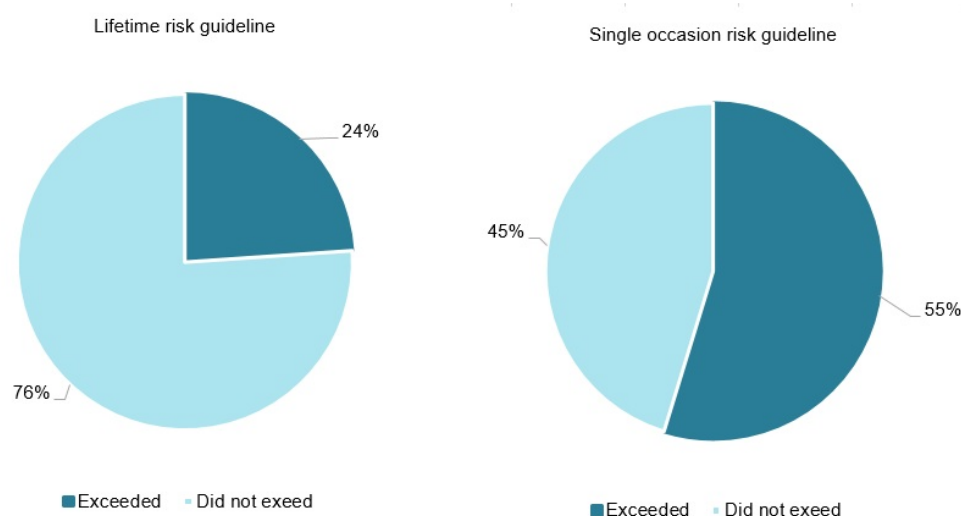
The main data sources reporting on alcohol consumption in Australia are the AIHW *National Drug Strategy Household Survey* and the ABS *National Health Survey*. Although these surveys use different methodologies, they show similar results.

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

- 1 in 4 men aged 18 and over (24%) exceeded the lifetime risk guideline—consuming more than two standard drinks per day, on average.
- more than 1 in 2 men (54%) exceeded the single occasion risk guideline—consuming more than four standard drinks on any one occasion (Figure 10) (ABS 2019a).

Based on the NDSHS, there has been a long-term downward trend in alcohol consumption at risky levels in Australia amongst men, with the proportion of males aged 14 and over who exceeded the lifetime risk guideline decreasing from 30% in 2007 to 25% in 2016. The proportion of men drinking alcohol daily has also decreased from 12% in 2004 to 7.6% in 2016 (AIHW 2017b).

Figure 10: Proportion of men aged 18 and over who exceeded and did not exceed lifetime and single occasion risk alcohol 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

The proportion of men exceeding the lifetime risk guideline varied by age group. According to 2017-18 data from the ABS NHS, 3 in 10 men aged 55-64 (29%) exceeded the lifetime risk guideline compared with 3 in 20 men aged 18-24 (15%) (Figure 11) (ABS 2019a).

The proportion of men who exceed 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, men living in *Outer regional and remote* areas were 1.6 times as likely to exceed lifetime alcohol risk guideline as men in *Major cities* (37% and 22%, respectively)
- In 2012-13, 29% of Aboriginal and Torres Strait Islander men exceeded the lifetime alcohol risk guideline. This was the same proportion as for non-Indigenous males.

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

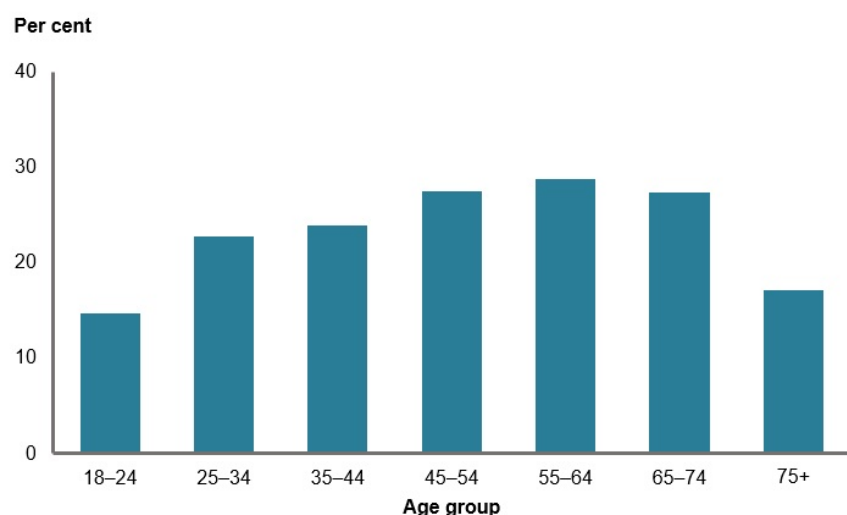


Chart: AIHW. Source: ABS 2019a (see [Table S9](#) for footnotes)

Single occasion risk

The proportion of men exceeding the single occasion risk guideline varied by age group. According to 2017-18 data, men aged 18-24 were 4 times as likely to exceed the single occasion risk guideline as men 75 and over (67% and 16%, respectively) (Figure 12) (ABS 2019a).

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

- men living in *Inner regional* areas were 1.3 times as likely to exceed this guideline as men in *Outer regional and remote* areas (66% and 53%, respectively)
- men living in the highest socioeconomic areas were 1.3 times as likely to exceed this guideline as men living in the lowest socioeconomic areas (61% and 48%, respectively).

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

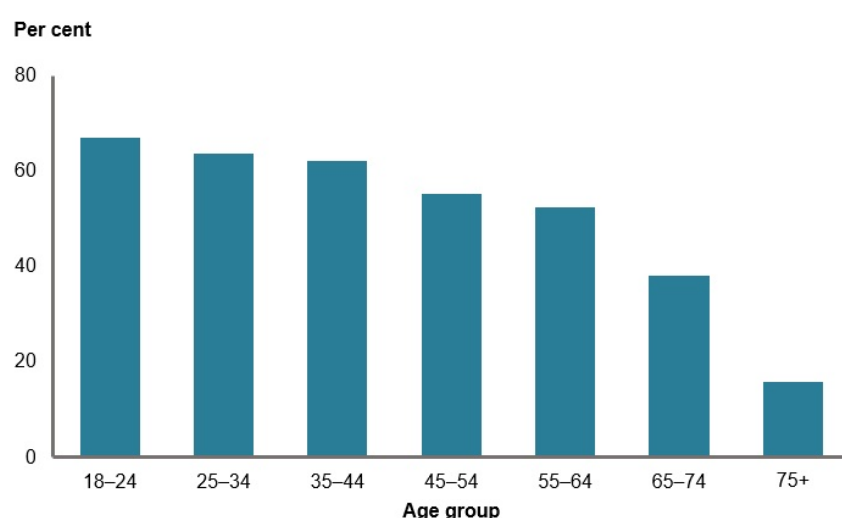


Chart: AIHW. Source: ABS 2019a (see [Table S8](#) for footnotes).

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

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 1 in 5 (18%) of Australian males aged 14 years and over 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—around 1 in 3 men aged 20-29 (32%) had used illicit drugs or substances in the previous 12 months, compared with around 1 in 13 men aged 60 or over (7.9%).

For more information, see *Alcohol, tobacco & other drugs in Australia*.

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Lifestyle and risk factors

Work

The type of work a person does can influence their health and wellbeing.

More than 9 in 10

People killed at work in Australia are men

According to 2016-17 data, 93% of people killed at work are men (176 of 190 total fatalities). However, the rate of men killed at work has been declining, from 5 deaths per 100,000 workers in 2007 to 2.7 per 100,000 workers in 2017 (Safe Work Australia 2018a).

A serious claim is one accepted by workers' compensation for an incapacity resulting in a total absence from work of 1 working week or more. Men accounted for more than half (64%) of serious claims in 2016-17. Of these, 9 in 10 (91%) arose from injury and musculoskeletal disorders, and the remaining 1 in 10 arose from diseases (9%). The number of serious claims for work-related injuries were highest among males aged 45-49 (Safe Work Australia 2018b).

The rate of serious claims was highest in men working in:

- road transport (22 claims per 1,000 employees)
- agriculture, forestry and fishing (21 claims per 1,000)
- manufacturing (18 claims per 1,000).

The most common types of work place injuries in men were:

- traumatic joint, ligament and muscle and/or tendon injury (41% of serious claims in 2016-17)
- wounds, lacerations, amputations and internal organ damage (19%)
- musculoskeletal and connective tissue diseases (14%).

For more information see [Safe Work Australia](#).

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Lifestyle and risk factors

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.

More than 2 in 5

Australian men have experienced violence since the age of 15

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

- around 2 in 5 (42%) had experienced violence since the age of 15—41% had experienced physical violence and 4.7% had experienced sexual violence
- around 1 in 20 (6%):
 - had experienced violence in the last 12 months (6%), with the highest rates among men aged 18-24 (11%), and the lowest among men aged 65 and over (1.4%)
 - had experienced cohabiting partner violence since the age of 15 (6.1%)
 - had experienced an episode of stalking since the age of 15 (6.5%)
- around 1 in 6 had experienced emotional abuse by a partner since the age of 15 (16%)
- 1 in 4 (25%) 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 males?

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

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How healthy are Australia's males?

Self-assessed health status

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

3 in 5

Australian males rated their health as excellent or very good in 2017-18

According to 2017-18 data, 3 in 5 (57%) males (aged 15 and over) rated their health as excellent or very good (ABS 2018a).

The proportion of males who rated their health as excellent or very good varied by age group. Two in 3 (69%) males aged 15-24 rated their health as excellent or very good compared with 1 in 3 (31%) men aged 85 years and over (ABS 2018a).

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How healthy are Australia's males?

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, males experienced a greater share of the total disease burden (53%) than females (47%). A larger proportion of the total disease burden for males was from dying prematurely. For females, the greatest proportion was from living with disease (AIHW 2019a).

The distribution of overall burden between the sexes varied by disease group. Males experienced almost three-quarters (69%) of the total burden from injuries and a greater proportion from cardiovascular diseases (59%). Nearly half (46%) of the total burden of disease in males is from cancers, cardiovascular diseases, and mental and substance use disorders.

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

After coronary heart disease, the specific diseases responsible for the most total burden among males and females differed. Among males, suicide and self-inflicted injuries ranked second, followed by back pain and problems, chronic obstructive pulmonary disease and lung cancer (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, males, 2015

Disease group	DALY ^(a)	Per cent of total
Coronary heart disease	216,774	8.6
Suicide	100,882	4.0
Back pain and problems	97,862	3.9
Chronic obstructive pulmonary disease	92,367	3.7
Lung cancer	91,850	3.6
Dementia	69,188	2.7
Stroke	62,511	2.5
Anxiety disorders	59,446	2.4
Type 2 diabetes	58,968	2.3
Depressive disorders	57,742	2.3

(a) DALY = Disability Adjusted Life-Year.

Chart: AIHW. Source: AIHW 2019a.

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How healthy are Australia's males?

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.

Around 1 in 2

Australian males have 1 or more of the 10 selected chronic conditions

According to 2017-18 data, around 1 in 2 (46%) males are estimated to have one or more of the 10 selected common chronic conditions. Of these males, 28% have one, 11% have two, and 7.1% have three or more (ABS 2018a).

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

- 3 in 4 men aged 65 and over (76%) have at least one chronic condition
- 2 in 5 men aged 45 and under do (38%).

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

Condition	Number	% ^(b)
Mental and behavioural problems	2,135,000	17.9
Back problems	1,973,900	16.5
Arthritis	1,440,600	12.1
Asthma	1,213,500	10.2
Diabetes	657,300	5.5
Heart, stroke and vascular disease ^(c)	643,500	5.4
Chronic obstructive pulmonary disease ^(d)	208,077	4.5
Cancer	250,900	2.1
Osteoporosis	147,200	1.5
Chronic kidney disease	116,100	1.0

Notes:

- This data is self-reported and likely under-reports the true prevalence of chronic conditions.
- Percentages relate to males with at least one chronic condition.
- 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
- 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 for the COPD line of this table.

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

For more detailed information about 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 all 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.

19,401

estimated new cases of prostate cancer, the most common cancer among males, will be diagnosed in 2020

In 2020, it is estimated males will account for more than half (54%) of all new cancer cases (79,421 cases). The risk for Australian males of being [diagnosed with cancer](#) before their 85th birthday is 1 in 2. The most common cancer diagnosis in males is [prostate cancer](#), followed by [colorectal cancer](#), [melanoma of the skin](#), and [lung cancer](#) (AIHW 2018).

The most common cancer diagnosis in males varies by age. For example, in 2019, leukaemia and testicular cancer were the most common cancers in males aged under 35 and melanoma of the skin, prostate cancer and colorectal cancer were the most common cancers in men aged over 35 (AIHW 2018).

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

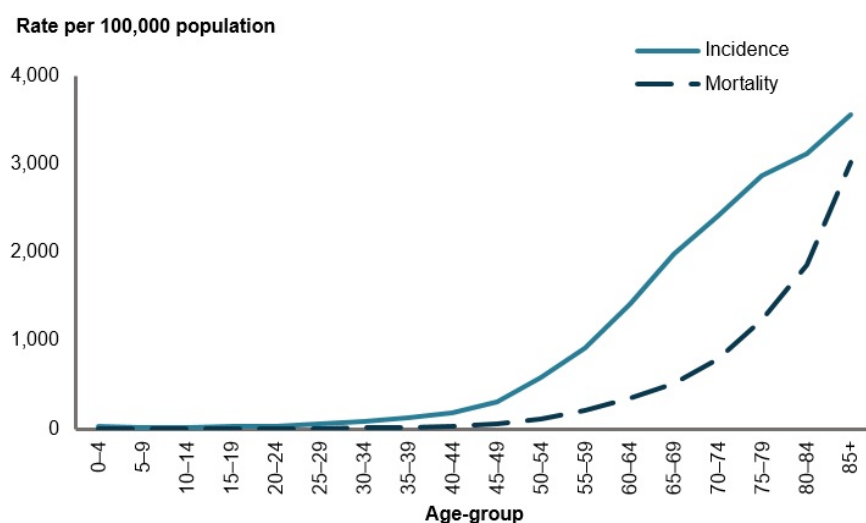


Chart: AIHW. Source: AIHW 2018 see [Table S11](#) for footnotes).

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 men (AIHW 2019a).

Nearly 1 in 2

Australian males 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 Australian males (18%) 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 (62%) and mood (affective) disorders (56%)
- around 1 in 10 men aged 18 years and over (11%) 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 1.6 million Australian males (14%) received a mental health-related prescription in 2017-18 (AIHW 2019d).

The 2010 Survey of High Impact Psychosis estimated that the 12 month prevalence of males aged 18-64 with an psychotic disorder in contact with public specialised mental health services in Australia was 38,859 (5.4 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 under 1 in 5 (16.3%) boys aged 4-17 had experienced a mental disorder in the previous 12 months (Lawrence et al. 2015).

For more information of the mental health of Australians, see [Mental health services](#).

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How healthy are Australia's males?

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).

84,436

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

In 2017, males accounted for more than half (56%) of all new STI cases (Kirby Institute 2018).

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

STI	Number of notifications	Per cent of total cases ^(a)	Rate per 100,000	Age group with highest rate
Chlamydia	48,335	48%	395	20-24
Gonorrhoea	21,010	74%	174	25-29
Hepatitis C	7,256	70%	60	25-29
Infectious Syphilis	3,733	85%	31	25-29
Hepatitis B	3,256	53%	27	30-39
HIV	846	88%	7.1	30-39

(a) Total excludes cases where sex was missing

Chart: AIHW. Source: Kirby Institute, 2018.

Notification rates for viral hepatitis and HIV have remained stable over time in males. However, there has been an increase in rates of chlamydia, gonorrhoea and syphilis notifications. Compared with 2008, rates of these infections in 2017 for males were:

- 4 times as high for gonorrhoea
- 3 times as high for syphilis
- almost twice as high for chlamydia.

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

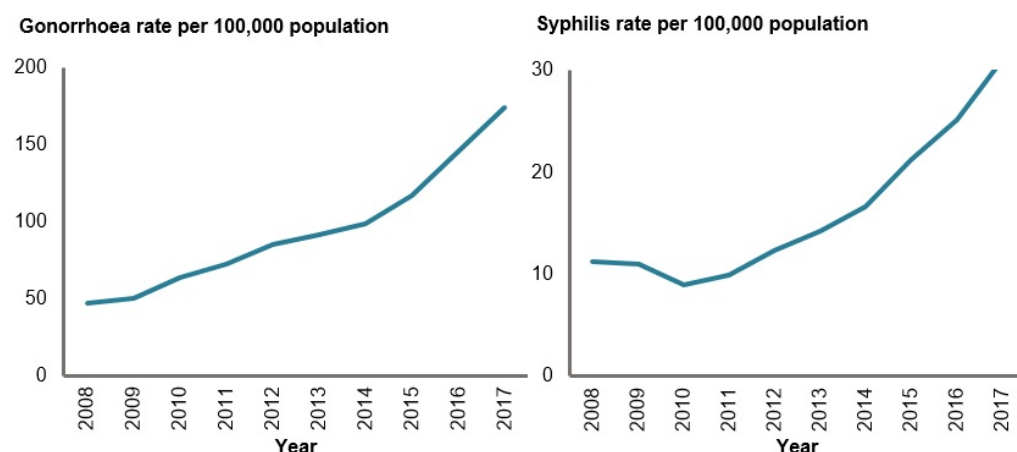


Chart: AIHW. Source: Kirby Institute 2018. [See Table S13.](#)

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

Sexual difficulties

More than 1 in 2

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

According to self-reported data, more than half (54%) of men aged 18-55 had experienced some sexual difficulty lasting at least 3 months in the last 12 months. Of these men (Schlichthorst et al. 2016):

- around 2 in 5 (37%) reported 'reaching climax too quickly'
- around 1 in 5 (17%) 'lacked interest in having sex'.

'Reaching climax too quickly' was the most common issue across all age groups (between 32% and 39%).

Other types of sexual difficulty differed by age:

- 'did not reach climax or took a long time' was the next most common issue in men aged 18-24
- 'lacking interest in having sex' was most common among men of other age groups (25-34, 35-44 and 45-55).

Table 4: Type of sexual difficulty experienced by men aged 18-55 who experienced at least 1 sexual difficulty^(a) in the past 12 months, 2013-14

Type of sexual difficulty (SD)	Total yes (%)	95% CI
At least one SD over the past 12 months	54.2	53.3-55.1
Reached climax too quickly	37.2	36.4-38.1
Lacked interest in having sex	17.3	16.6-17.9
Did not reach climax or took a long time	15.0	14.3-15.6
Had trouble getting or keeping an erection	13.7	13.1-14.3
Felt anxious during sex	10.9	10.4-11.5
Lacked enjoyment in sex	10.1	9.6-10.6
Felt no excitement or arousal during sex	6.0	5.5-6.4
Felt physical pain as a result of sex	3.7	3.4-4.0

(a) Sexual difficulty experienced for at least three months in the 12 months before the study.

Note: 95% CI = 95% confidence interval. We can be 95% confident that the true value is within this confidence interval.

Chart: AIHW.

Source: Schlichthorst et al. 2016.

For more information on male sexual health, see [Healthy Male Australia](#).

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How healthy are Australia's males?

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.

Life expectancy

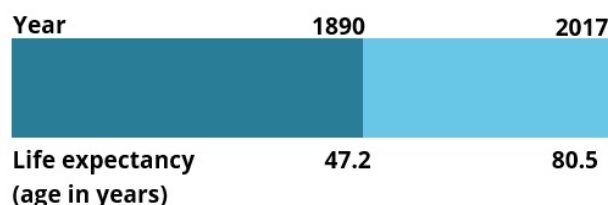


Chart: AIHW. Source: AIHW 2019b.

Australian males born in 2015-2017 can expect to live 33 years longer than males 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 2019b, OECD 2019):

- Males born in Australia in 2015-2017 can expect to live to the age of 80.5 years on average (an increase of 1.5 years in the past 10 years).
- In 2015-2017, life expectancy at birth for Aboriginal and Torres Strait Islander males was estimated to be 71.6 years, 8.6 years less than for non-Indigenous males (80.5 years).
- International comparisons of life expectancy at birth projected for males in 2017 indicate that Australian males have the 9th highest life expectancy in the world (80.5 years). Switzerland is ranked 1st with 81.6 years.

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

Health Adjusted Life Expectancy (HALE)

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. 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 males born in 2015 was 80.4 years, while the average number of healthy years (HALE) for these babies was 71.5 years. The difference between life expectancy and HALE (that is, the time expected in less than full health) was 8.9 years. This means that males could expect to spend 89% of their lives in full health.

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

Life expectancy in 2015 for men aged 65 was 19.6—that is, they could expect to live to the age of 84.6. At age 65, men could expect on average 15 healthy years of life and 4.6 years in less than full health.

Between 2003 and 2015, life expectancy and HALE at birth increased for males. Males gained 2.3 years in life expectancy (from 78.1 years in 2003 to 80.4 in 2015) and 2.0 years in HALE (from 69.5 to 71.5 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

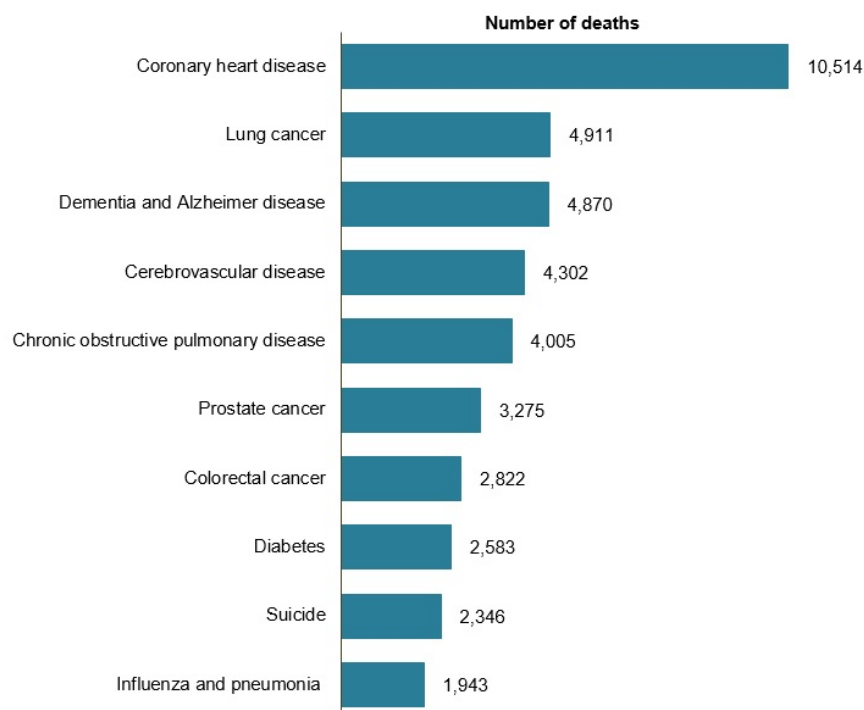
Monitoring causes of death helps to measure the health status of a population. Causes of death can be used to:

- 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, 82,858 Australian males died (AIHW 2019b). The median age at death was 78 years and the leading cause of death was coronary heart disease (12.7%), followed by lung cancer (5.9%) and Dementia and Alzheimer disease (5.9%). Causes of death varied by age group (Figure 17) (AIHW 2019b).

For more information see *Deaths in Australia*.

Figure 15: Leading causes of death for males, 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 Disease and Related Health Problems, 10th revision (ICD-10) codes are presented in parentheses.

Chart: AIHW. Source: AIHW 2019b (see Table S14).

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

Age group (years)	1st	2nd	3rd
Under 1	Perinatal and congenital conditions	SIDS	Accidental threats to breathing
1–14	Land transport accidents	Brain cancer	Perinatal and congenital conditions
15–24	Suicide	Land transport accidents	Accidental poisoning
25–44	Suicide	Accidental poisoning	Land transport accidents
45–64	Coronary heart disease	Lung cancer	Suicide
65–74	Coronary heart disease	Lung cancer	COPD
75–84	Coronary heart disease	Lung cancer	Dementia and Alzheimer disease
85 and over	Coronary heart disease	Dementia and Alzheimer disease	Cerebrovascular disease

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

Chart: AIHW. *Source:* AIHW 2019b (see [Table S15](#) for footnotes).

Premature and potentially avoidable deaths

In 2017, males accounted for 3 in 5 (62%) premature deaths. Mortality rates varied between population groups (AIHW 2019c):

- Males in *Very remote* areas had a higher percentage of potentially avoidable deaths, with 3 in 5 (62%) premature deaths being potentially avoidable, compared with 1 in 2 (50%) in *Major cities*.
- The median age at death for males decreased with increasing remoteness: from 79 in *Major cities* to 68 in *Very remote* areas.
- Males in lower socioeconomic areas had twice the rate of potentially avoidable deaths per 100,000 population compared with males in higher socioeconomic areas (187 and 87 per 100,000 respectively).
- The median age at death for males decreased with decreasing socioeconomic group: from 81 in the highest areas to 77 in the lowest areas.

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

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How do Australia's males 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 governments and health service providers to identify inequalities in access and predict future health care needs.

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How do Australia's males 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 males claimed more than 178 million services through Medicare and received an average of 14 Medicare services per person in that year. By comparison, females claimed 19.5 Medicare services per person (Department of Health, 2019).

The average number of services claimed by males varies by age group (Figure 17). In 2018-19, those aged (Department of Health, 2019):

- under 45 claimed fewer than 8 services per person on average
- 75 and over claimed 48 services per person on average.

Figure 17: Average number of Medicare services claimed, per person, males by age group, 2018-19

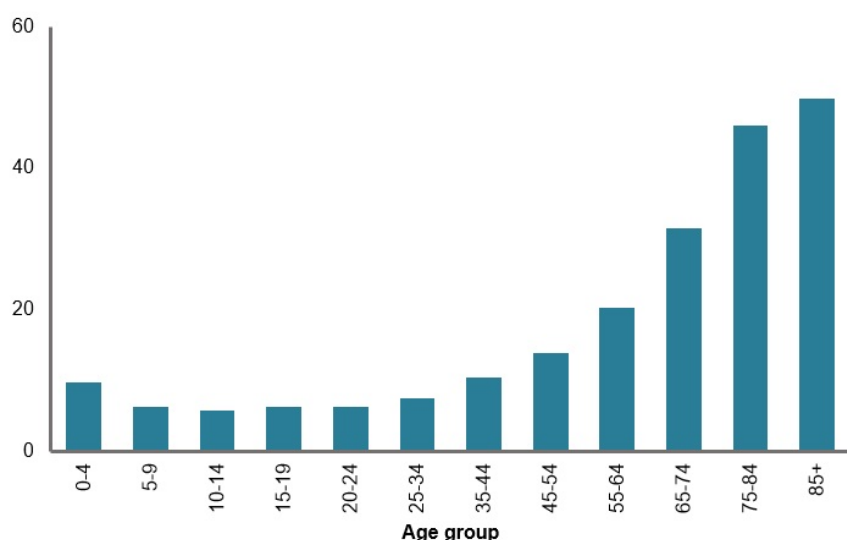


Chart: AIHW.

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

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How do Australia's males 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 that is not related to a hospital visit.

8 in 10

Australian men visited a GP in the past 12 months

Using the ABS Patient Experience Survey, in 2018-19, 78% of males aged 15 and over 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 men. In 2018-19, among males aged 15 and over (ABS 2019):

- almost 1 in 5 (16.5%) waited longer than they felt acceptable to get an appointment with a GP
- more than 1 in 40 (2.7%) delayed seeing, or did not see, a GP when needed because of cost at least once in the past 12 months
- 1 in 20 (5.0%) delayed getting, or did not get, prescribed medication because of cost.

Nearly 1 in 10

Australian men in 2013-14 (8%) were unable to access health care when needed in the last 12 months

The Ten to Men Australian Longitudinal Study on Male Health also captures self-reported information on the primary health care habits of Australia's men (Schlichthorst et al. 2016).

According to this study, the proportion of men (aged 18 and over) visiting a GP varied by age and health status. In 2013-14 (Schlichthorst et al. 2016):

- the odds of visiting a GP increased with age and decreased with remoteness
- men with 3 or more health conditions were 4 times as likely to visit a GP in the last 12 months as those without an underlying health condition.

Nearly 1 in 5

Australian men aged 45 and over spoke to their GP about their emotional and psychological health in 2014-15

Using data from the Survey of Health Care 2016, of Australian men aged 45 and over who had at least one GP visit in the 12 months between November 2014 and November 2015 (ABS 2017):

- almost 1 in 5 (18%) had spoken to their GP about their emotional and psychological health
- nearly 2 in 5 (39%) 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 or dietitian)
- almost 1 in 10 (8%) 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)
- nearly 8 in 10 (79%) were taking at least 1 medication on a regular and ongoing basis
- almost 3 in 4 (73%) indicated they were always or usually involved in making decisions about their medications for their own health.

For more information see: [Primary health care](#).

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How do Australia's males access health care?

Private health insurance

In Australia, private health insurance is available for those wanting 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 data from the 2017-18 ABS Patient Experience Survey, more than half of Australian males (57%) had some form of private health insurance, of these (ABS 2018):

- 47% had both hospital and extras cover
 - 6% had hospital cover only
 - 4% had extras cover only.
-

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How do Australia's males 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 4 million emergency department presentations among Australian males, accounting for 50% of all presentations. Among adult males, rates of emergency department presentations were highest in those aged 75-84 and 85 years and older (599 and 923 per 1,000 population respectively) (AIHW 2019a).

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

Admitted patient care

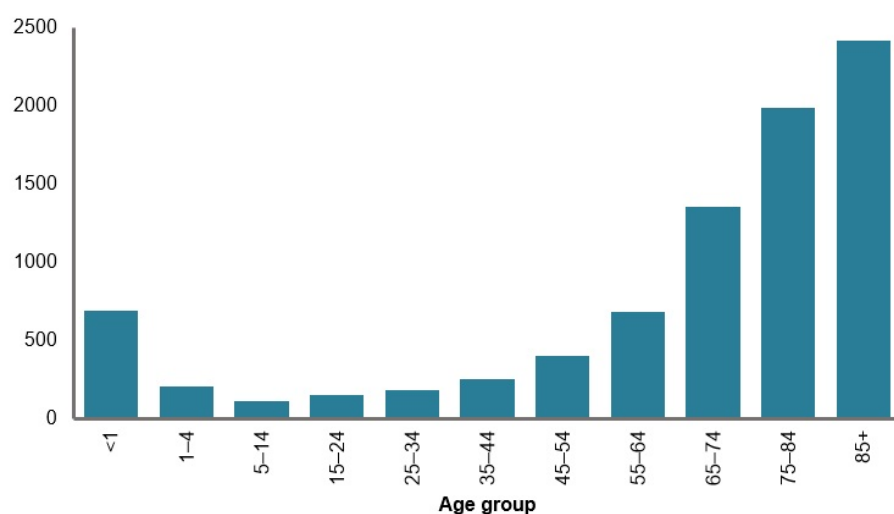
Admitted patient care refers to care provided by public and private hospitals to admitted patients. A hospitalisation is an episode of hospital care that starts with the formal admission process and ends with the formal [separation](#) process.

In 2017-18, there were 5.3 million hospitalisations among Australian males, accounting for 48% of all hospitalisations.

Hospitalisation rates generally increase with age, and are highest among men aged 85 and over (Figure 18) (AIHW 2019b).

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

Separations per 1,000 population



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](#)).

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

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How does the health of females and males compare?

This section brings together data from the male and female health reports on a number of key risk factors and health outcomes that apply to both males and females. For more detailed information on each of these risk factors and outcomes, see the main reports for [males](#) and [females](#).

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)
Life expectancy and mortality

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



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.
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- 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)

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

Lifestyle and risk factors of Australia's males: Overweight and obesity

- 28% changed to 29%. The proportion who are overweight or obese differs between boys and men—7 in 10 (71%) men aged 18 years and over are overweight or obese, compared with 3 in 10 (29%) boys aged 5-17.

19 Jul 2019 - Under the Life expectancy and mortality section a mistakenly inserted graph was replaced.

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Data

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

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

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Related material

Resources

[ABS National Health Survey](#)

[View](#)

Related topics

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

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