4364.0.55.001 - Australian Health Survey: First Results, 2011-12

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ABOUT THIS PUBLICATION

This publication contains first results from the 2011-13 Australian Health Survey, including health risk factors (such as alcohol consumption, tobacco smoking and Body Mass Index); long-term health conditions; mental health and well-being; and physical activity. Information is presented for Australia and the states and territories. The survey was designed to obtain national benchmarks on a wide range of health issues, and to enable changes in health to be monitored over time.

Explanatory Notes provide information about the survey design and methodology, the quality and interpretation of results, and information about the range of publications and other data services available or planned.

Brian Pink
Australian Statistician

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Physical Measurements
Includes: **Height and weight, Waist circumference and Blood pressure**

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 KEY FINDINGS

General health

- In 2011-12 over half (55.6%) of all Australians aged 15 years and over considered themselves to be in very good or excellent health, while 4.0% rated their health as poor.

Long-term health conditions

Of the National Health Priority Areas, the top Long-term health conditions experienced in Australia in 2011-12 were
- arthritis - 3.3 million people (14.8%)
- mental and behavioural condition - 3.0 million people (13.6%)
- asthma - 2.3 million people (10.2%)
- heart disease - 1.0 million people (4.7%)

Health risk factors

Tobacco smoking
- Rates of daily smoking have continued to drop to 2.8 million people (16.3%) aged 18 years and over in 2011-12 from 18.9% in 2007-08 and 22.4% in 2001.

Alcohol consumption
- The proportion of people aged 18 years and over who consumed more than two standard drinks per day on average, exceeding the National Health and Medical Research Council lifetime risk guidelines decreased to 19.5% in 2011-12 from 20.9% in 2007-08.
- 44.7% of people aged 18 years and over consumed more than four standard drinks at least once in the past year, exceeding the National Health and Medical Research Council single occasion risk guidelines.

Overweight and obesity
- Prevalence of overweight and obesity in adults aged 18 years and over has continued to rise to 63.4% in 2011-12 from 61.2% in 2007-08 and 56.3% in 1995.
- However the prevalence of overweight and obesity in children aged 5-17 has remained stable at 25.3% in 2011-12.

Physical measurements

Average height and weight
- In 2011-12, the average Australian man (18 years and over) was 175.6 cm tall and weighed 85.9 kg. The average Australian woman was 161.8 cm tall and weighed 71.1 kg.
- Between 1995 and 2011-12 the average height increased by 0.8 cm for men and 0.4 cm for women.
- Between 1995 and 2011-12 the average weight increased by 3.9 kg for men and 4.1 kg for women.

Waist circumference
- In 2011-12, 60.3% of men aged 18 years and over had a waist circumference that put them at an increased risk of developing chronic disease, while 66.6% had an increased level of risk.
- On average, men had a waist measurement of 97.9 cm while women had a waist measurement of 87.7 cm

Blood pressure
- In 2011-12, just over 3.1 million people (21.5%) aged 18 years and over had measured high blood pressure (systolic or diastolic blood pressure equal to or greater than 140/90 mmHg).

ABOUT THE AUSTRALIAN HEALTH SURVEY

The 2011-13 Australian Health Survey (AHS) is the largest and most comprehensive health survey ever conducted in Australia. This survey, conducted throughout Australia, was designed to collect a range of information from Australians about health related issues, including health status, risk factors, actions, and socioeconomic circumstances. In 2011-13, the AHS collected new information on nutrition and physical activity, as well as the first national biomedical information collection.

These new components in the health survey have been made possible by additional funding from the Australian Government Department of Health and Ageing as well as the National Heart Foundation of Australia, and the contributions of these two organisations to improving health information in Australia through quality statistics are greatly valued.

Results presented in this publication include:

- general health status measures;
- health related aspects of lifestyle and other health risk factors; and
- long term health conditions.

The statistics presented in this first release are indicative of the extensive range of data available from the survey and demonstrate some of the analytical potential of the survey results.

Further results will be released progressively through 2012-14 and will cover topics such as:

- health service use and other actions people had recently taken for their health;
- detailed information on dietary intake;
- comprehensive information on physical activity and sedentary behaviour;
- information on biomedical health measures; and
- representative results for the Aboriginal and Torres Strait Islander population.

The 2011-13 AHS was developed with the assistance of an advisory group comprised of experts in health issues. Members of this advisory group were drawn from Commonwealth and state/territory government agencies, non-government organisations and relevant academic institutions. The valuable contributions made by members of the survey advisory group are greatly appreciated.
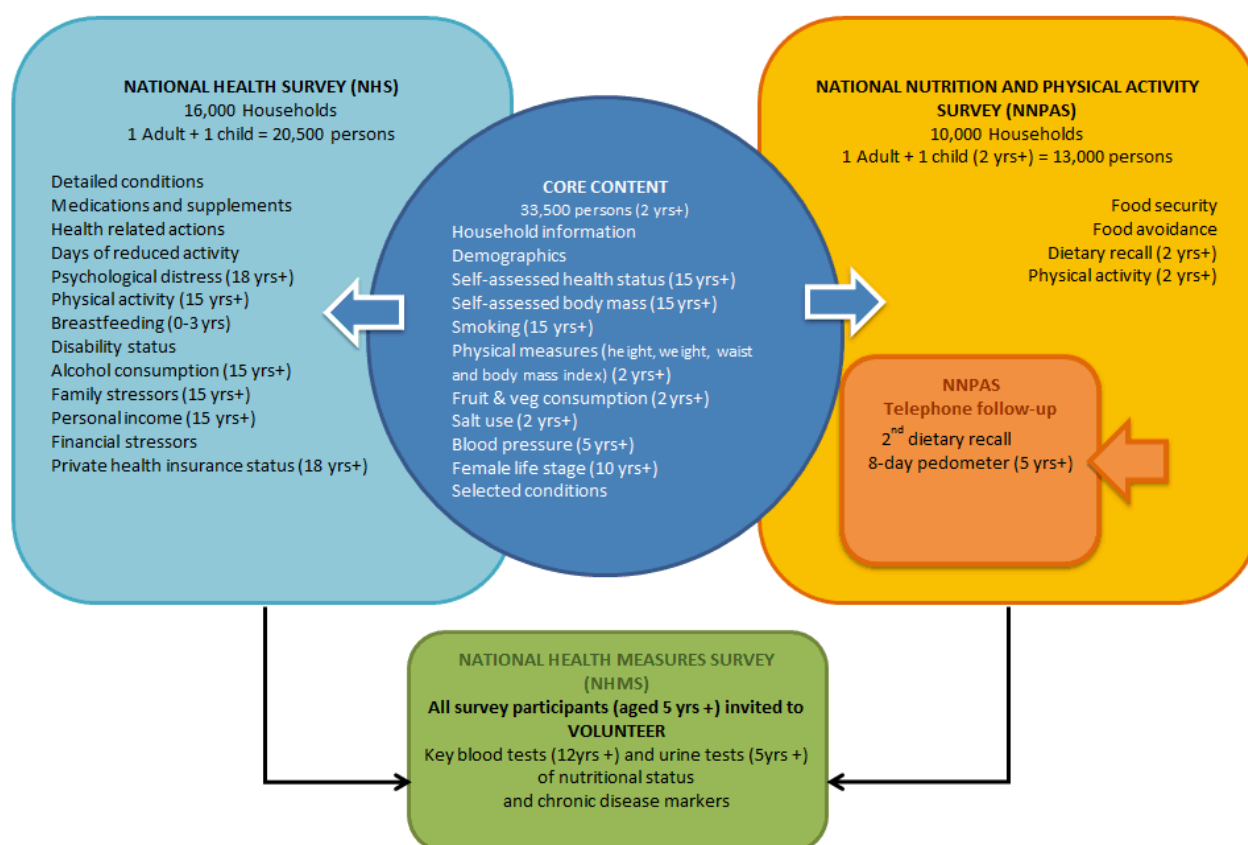
Finally, the success of the 2011-13 AHS was dependent on the very high level of cooperation received from the Australian public. Their continued cooperation is very much appreciated; without it, the range of statistics published by the ABS would not be possible. Information received by the ABS is treated in strict confidence as required by the **Census and Statistics Act 1905**.

THE STRUCTURE OF THE AUSTRALIAN HEALTH SURVEY

This publication is the first of several ABS releases of results from the 2011-13 Australian Health Survey (AHS). The AHS is the largest, most comprehensive health survey ever conducted in Australia. It combines the existing ABS National Health Survey (NHS) and the National Aboriginal and Torres Strait Islander Health Survey together with two new elements - a National Nutrition and Physical Activity Survey (NNPAS) and a National Health Measures Survey (NHMS).

The following diagram shows how the various elements combine to provide comprehensive health information for the overall Australian population. The content for each component survey is listed along with the ages of respondents for which topics were collected.

STRUCTURE OF THE 2011-13 AUSTRALIAN HEALTH SURVEY

NATIONAL HEALTH SURVEY (NHS)
16,000 Households
1 Adult + 1 child = 20,500 persons

Detailed conditions
Medications and supplements
Health related actions
Days of reduced activity
Psychological distress (18 yrs+)
Physical activity (15 yrs+)
Breastfeeding (0-3 yrs)
Disability status
Alcohol consumption (15 yrs+)
Family stressors (15 yrs+)
Personal income (15 yrs+)
Financial stressors
Private health insurance status (18 yrs+)

CORE CONTENT
33,500 persons (2 yrs+)
Household information
Demographics
Self-assessed health status (15 yrs+)
Self-assessed body mass (15 yrs+)
Smoking (15 yrs+)
Physical measures (height, weight, waist and body mass index) (2 yrs+)
Fruit & veg consumption (2 yrs+)
Salt use (2 yrs+)
Blood pressure (5 yrs+)
Female life stage (10 yrs+)
Selected conditions

NATIONAL NUTRITION AND PHYSICAL ACTIVITY SURVEY (NNPAS)
10,000 Households
1 Adult + 1 child (2 yrs+) = 13,000 persons

Food security
Food avoidance
Dietary recall (2 yrs+)
Physical activity (2 yrs+)

NNPAS
Telephone follow-up
2nd dietary recall
8-day pedometer (5 yrs+)

NATIONAL HEALTH MEASURES SURVEY (NHMS)
All survey participants (aged 5 yrs +) invited to VOLUNTEER
Key blood tests (12yrs +) and urine tests (5yrs +) of nutritional status and chronic disease markers

As shown in the above diagram, the AHS is made up of 3 components:

- the National Health Survey (NHS);
- the National Nutrition and Physical Activity Survey (NNPAS); and
- the National Health Measures Survey (NHMS)

All people selected in the AHS were selected in either the NHS or the NNPAS, however data items in the core were common to both surveys and therefore information for these data items is available for all persons in the AHS. All people were then invited to participate in the voluntary NHMS.

As indicated in the diagram, 20,500 people participated in the NHS, answering questions about items such as detailed health conditions, health risk factors and medications as well as all items in the core content. For the NHS component (those items collected only in the NHS and not the core), the sample size is similar to that of previous National Health Surveys and therefore the results are comparable. However for those items collected in the core, the sample size (33,500 people - results for which will

be published in mid 2013) is approximately 1.5 times that in the past and therefore the estimates for core items such as smoking and Body Mass Index are expected to be more accurate in particular at finer disaggregations than in previous surveys.

INFORMATION FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The AHS also includes an additional representative sample of around 13,000 Aboriginal and Torres Strait Islander people which commenced in May 2012. This is a separate collection of Aboriginal and Torres Strait Islander people living in remote and non-remote areas, including discrete communities. The structure is the same as outlined above, comprised of the National Aboriginal and Torres Strait Islander Health Survey component, the National Aboriginal and Torres Strait Islander Nutrition and Physical Activity component and the National Aboriginal and Torres Strait Islander Health Measures Survey component.

For more information on future releases see Release schedule.

RELEASE SCHEDULE

Results from the National Health Survey (NHS), the National Nutrition and Physical Activity Survey (NNPAS) and the National Health Measures Survey (NHMS) for the overall Australian population will be released progressively throughout 2012-13. Results for the Aboriginal and Torres Strait Islander population will be released progressively from late 2013. The following table contains details of upcoming publications.

AUSTRALIAN HEALTH SURVEY, Release schedule

Publication	Date	Description
Australian Health Survey: First Results (cat. no. 4364.0.55.001)	29 October 2012	Focus on long-term health conditions and health risk factors
Australian Health Survey: Health service usage and health-related actions (cat. no 4364.0.55.002)	February 2013	Focus on health service usage, health-related actions and medication use
Australian Health Survey: Updated Results (cat. no 4364.0.55.003)	May 2013	Focus on key items from the core based on the full AHS sample. Will include new estimates for those indicators published in the First Results publication.
Australian Health Survey: Physical activity	June 2013	Focus on physical activity data from NNPAS
Australian Health Survey: Health Measures	June 2013	Focus on high level results from the biomedical measures collected in the NHMS
Australian Health Survey: Nutrition First results	September 2013	Focus on high level results from the nutrition components of NNPAS. Similar to the 'Selected highlights' release from the 1995 National Nutrition Survey.
Australian Health Survey: Aboriginal and Torres Strait Islander First Results	Late 2013	--
Australian Health Survey: Aboriginal and Torres Strait Islander Nutrition and Physical Activity Results	June 2014	--
Australian Health Survey: Aboriginal and Torres Strait Islander Health Measures Results	Late 2014	--

This First Results publication presents information on long-term health conditions and health risk factors from the NHS sample (i.e. 20,500 people). Information on use of health services and actions people take for their health (for example, medication use) is scheduled for release in February 2013.

Results from the AHS core sample (the full 33,500 people) will be released in May 2013. This will include new estimates for some data items published in this First Results publication. It is expected that prevalence rates for these indicators at a broad level are unlikely to change, however sampling error associated with the estimates from the core sample is expected to be lower than the estimates from the NHS sample (due to the larger sample size).

Survey questionnaires and the full list of data items for the general population will be progressively made available in the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

GENERAL HEALTH

Information about the general health of Australians is important and used by a wide variety of people, including Commonwealth and state/territory government bodies as well as medical professionals, researchers and academics.

General health information collected in the Australian Health Survey included asking respondents to assess their own health and also to answer questions aimed at assessing levels of psychological distress. This information complements that on long-term health conditions, health risk factors and physical measures, contributing to a broad picture of the overall health of Australians in 2011-12.

SELF-ASSESSED HEALTH STATUS

Self-assessed health status is a commonly used measure of overall health. While it may not always be equivalent to health status as measured by a medical professional, it does reflect a person's perception of his or her own health at a given point in time. Therefore, it is a useful measure of a person's current health status, as well as providing a broad picture of a population's overall health.

In 2011-12, over half of all Australians aged 15 years and over considered themselves to be in very good or excellent health (55.6%), while 4.0% rated their health as poor. There was no significant change in the way Australians rated their overall health between 2007-08 and 2011-12.

Older Australians generally rated themselves as having poorer health than younger people, with persons aged 75 years and over recording the highest proportion of poor health (10.5%). Men and women showed no differences in the way they assessed their overall health in 2011-12.

Self-assessed health status(a), 2011-12
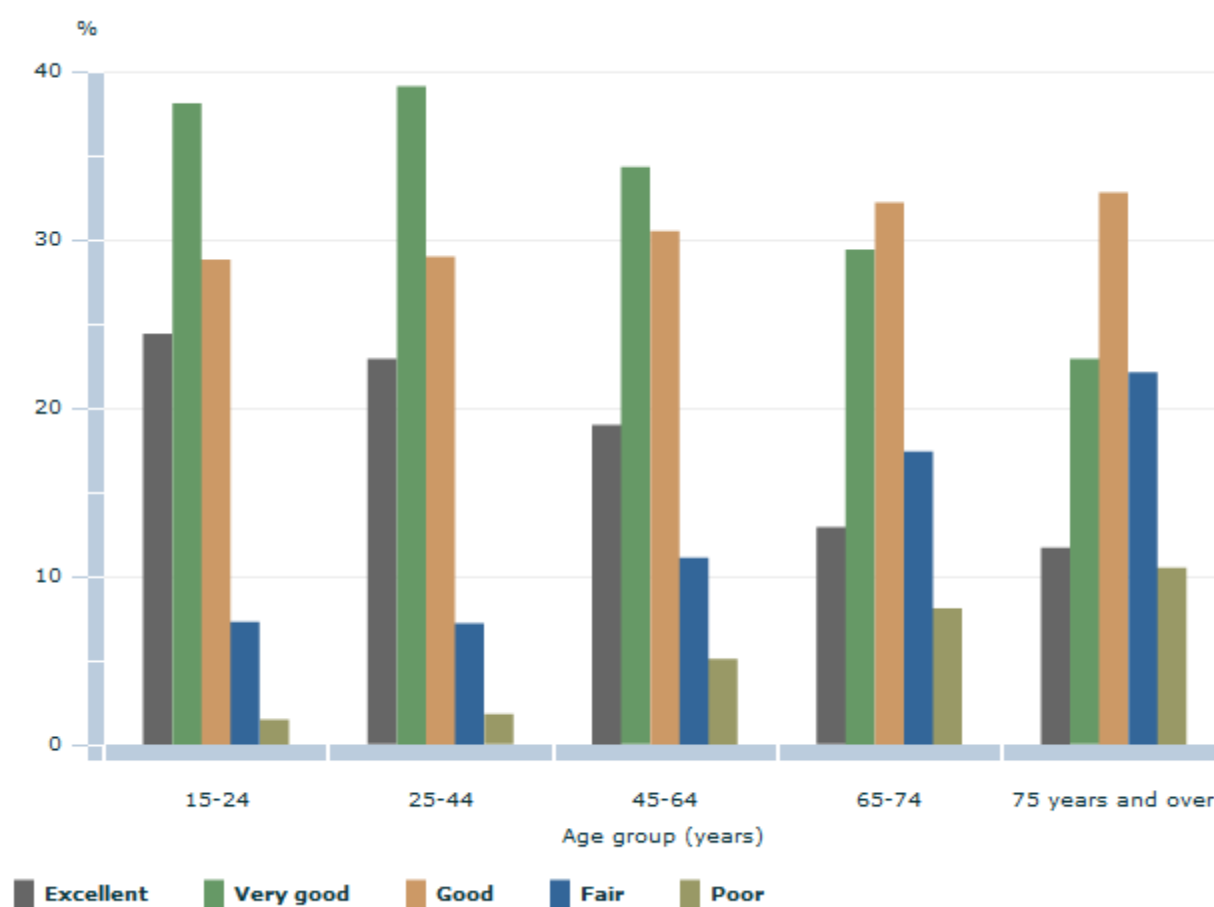
(a) Persons aged 15 years and over.

PSYCHOLOGICAL DISTRESS

Good mental health is fundamental to the wellbeing of individuals, their families and the population as a whole. One indication of the mental health and wellbeing of a population is provided by measuring levels of psychological distress using the Kessler Psychological Distress Scale (K10). The K10 questionnaire was developed to yield a global measure of psychosocial distress, based on questions about people's level of nervousness, agitation, psychological fatigue and depression in the past four weeks **[1]**.

In 2011-12, 70.1% of Australians (or 11.9 million people) aged 18 years and over experienced a low level of psychological distress according to the K10. Around one in ten adults (10.8%, or 1.8 million people) experienced high or very high levels of psychological distress, down from 12.0% in 2007-08 and 12.6% in 2001.

Proportionally more females than males experienced high or very high psychological distress in 2011-12 (12.7% and 8.8% respectively), while in general, high and very high levels of psychological distress decreased slightly with age.

For more information on the Kessler Psychological Distress Scale see Psychological distress in the Glossary.

Level of psychological distress(a), 2011-12
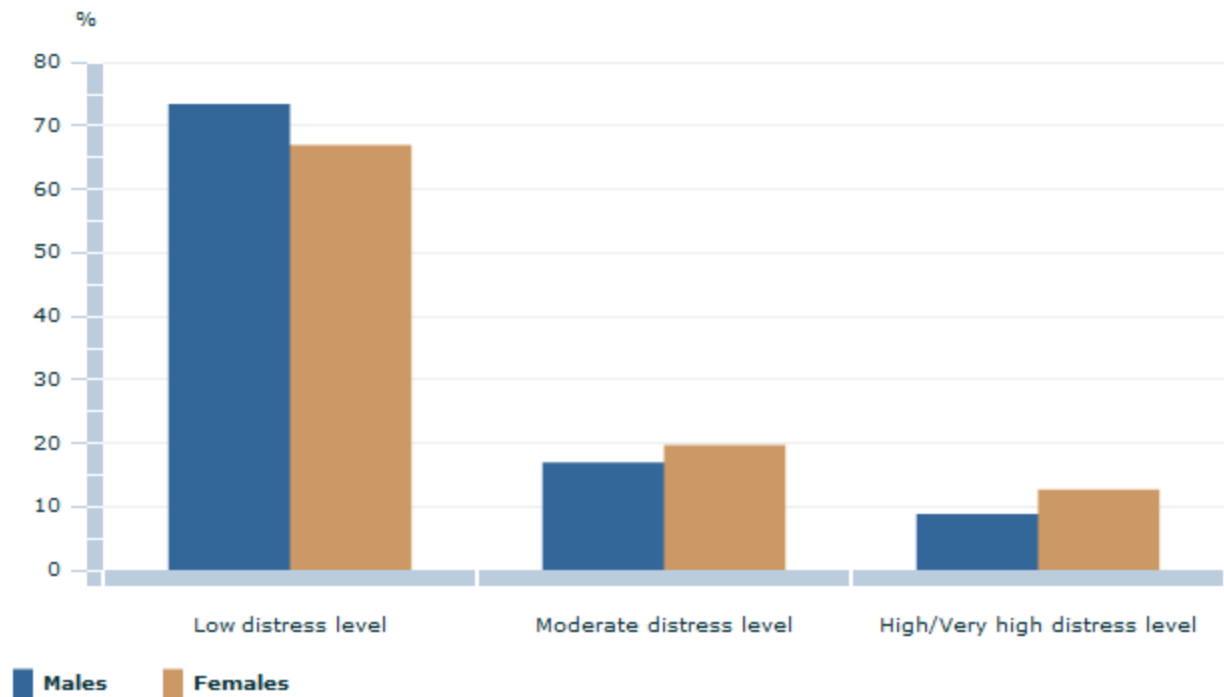
(a): Persons aged 18 years and over

Endnote(s): [1] Coombs, T. (2005) 'Australian Mental Health Outcomes and Classification Network; Kessler -10 Training Manual', NSW Institute of Psychiatry.

LONG-TERM HEALTH CONDITIONS

Information about the prevalence and types of long-term health conditions in Australia is important for healthcare planning, including assessing the effect of health prevention initiatives, as well as future planning and funding.

In the Australian Health Survey, respondents were classified as having a long-term health condition if they had:

- ever been told by a doctor or nurse that they had a particular health condition; and
- the condition was current at the time of the survey; and
- the condition had lasted at least six months or more, or the respondent expected it to last for six months or more.

ARTHRITIS AND OSTEOPOROSIS

Musculoskeletal conditions, of which arthritis and osteoporosis are the most common, are one of the major causes of chronic pain and disability in Australia.

Arthritis

Arthritis is a musculoskeletal condition in which a person's joints become inflamed, which may result in pain, stiffness, disability and deformity. The symptoms often have a significant impact on everyday life.

In 2011-12, 14.8% of Australians (or around 3.3 million people) had arthritis, with prevalence higher amongst women than men (17.7% compared with 11.8%).

Of persons with arthritis, more than half (55.9%) had osteoarthritis, 13.6% had rheumatoid arthritis, and 37.3% had an unspecified type of arthritis. Note that as it is possible to have more than one type of arthritis, proportions add to more than 100%.

The prevalence of arthritis increased with age, from less than 1% of people aged under 25 years to 52.1% of people aged 75 years and over. Women aged 45 years and over were considerably more likely to have arthritis than men. In particular, at ages 75 years and over, 59.9% of women had arthritis compared with 42.3% of men.

**Proportion of persons with arthritis, 2011-12**
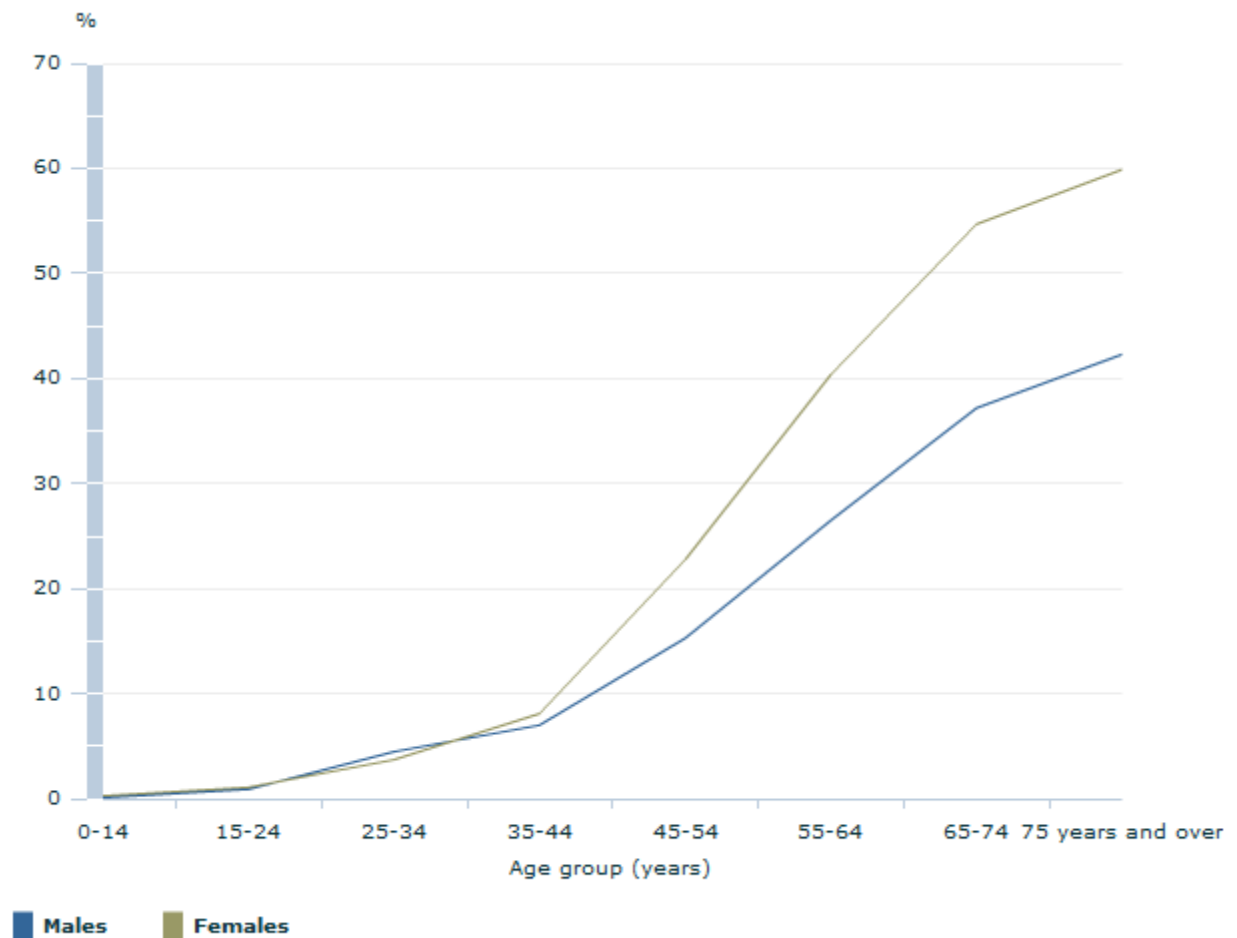
Osteoporosis

Osteoporosis is a condition of the musculoskeletal system in which a person's bones become fragile and brittle, leading to an increased risk of fractures. Fractures can lead to chronic pain, disability and loss of independence.

In 2011-12, 3.3% of Australians (or around 726,000 people) had osteoporosis. Over the last decade, the proportion of Australians with osteoporosis has increased (up from 1.6% in 2001) but has remained stable since 2007-08.

Osteoporosis was more common amongst women than men, affecting more than twice the proportion of females (5.3% compared with 1.2% of males).

Similar to arthritis, osteoporosis is more common at older ages, with over 1 in 5 women (22.8%) over the age of 65 years having osteoporosis, compared with around 1 in 20 men (5%).

**Proportion of persons with osteoporosis, 2011-12**
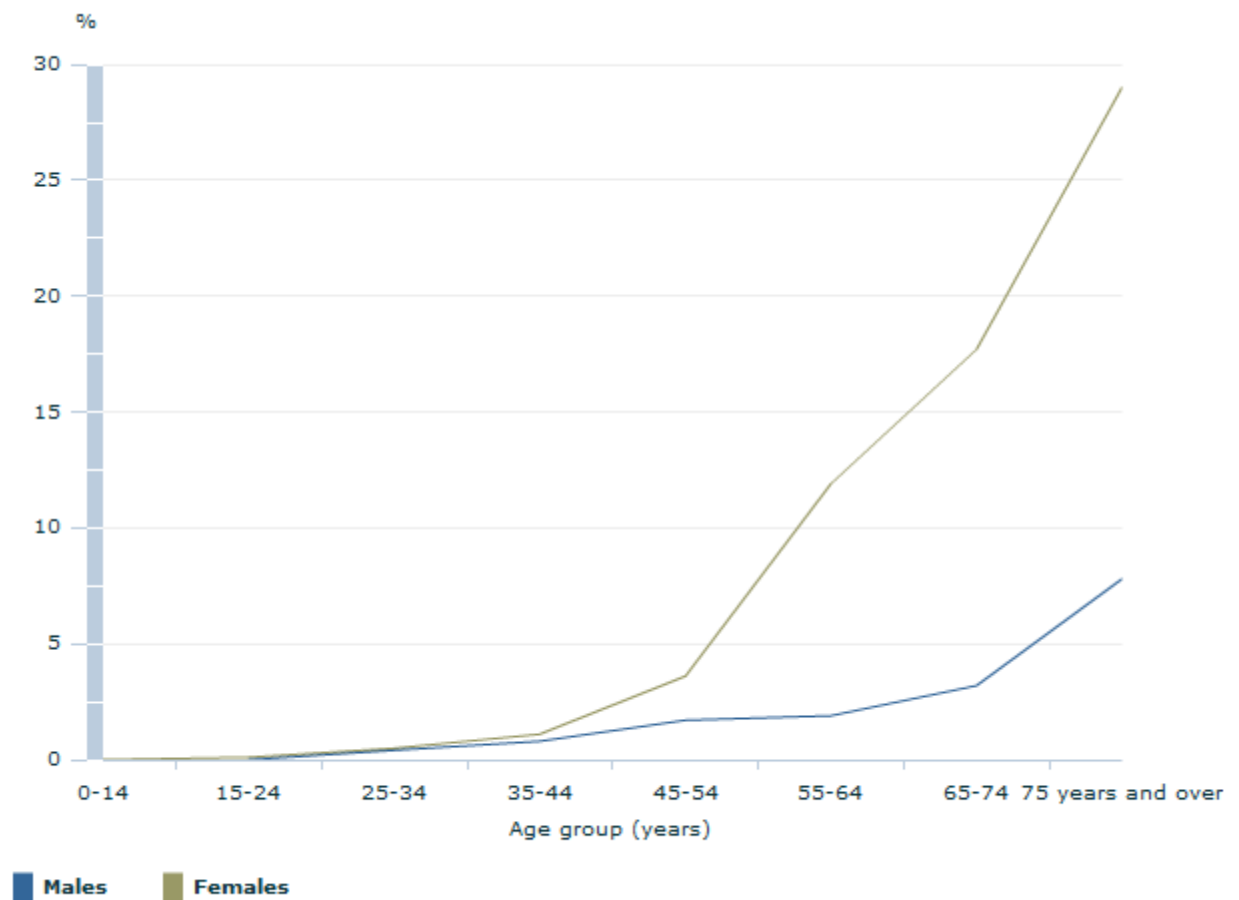
ASTHMA

Asthma is a respiratory condition affecting the airways of the lungs, causing episodes of wheezing, breathlessness and chest tightness due to the narrowing of the airways. Asthma affects people of all ages and can usually be managed through effective treatment.

In 2011-12, 10.2% of Australians (or around 2.3 million people) had asthma. Overall, males and females reported similar rates of asthma (9.5% of males and 10.9% of females), however, rates of asthma across age groups show a different pattern.

Amongst children aged 0-14 years, males had a higher rate of asthma (11.4%) than did females (7.2%). However, from 15 years asthma is more common in women than men.

Proportion of persons with asthma, 2011-12
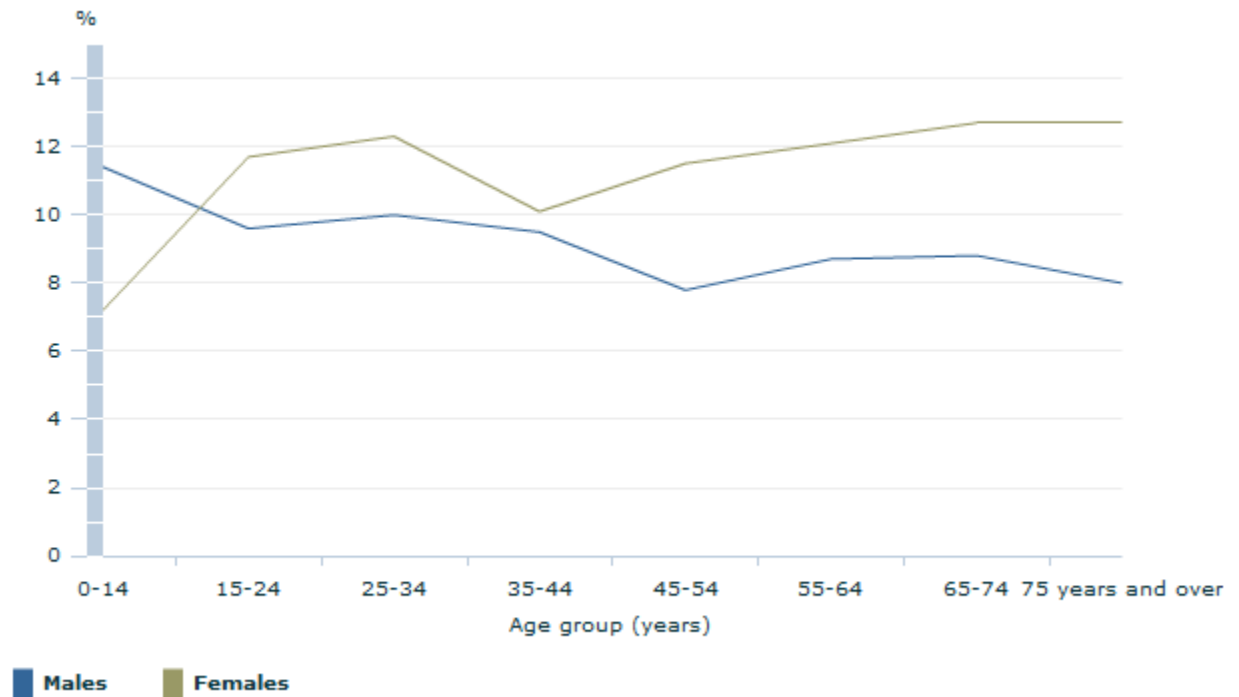
CANCER

Cancer is a condition in which the body's cells grow and spread in an uncontrolled manner. A cancerous cell can arise from almost any cell, and therefore cancer can be found almost anywhere in the body.

In 2011-12 there were 326,600 persons who had cancer, or around 1.5% of the Australian population. This reflects little change from 2007-08 (1.6%).

Cancer was more common amongst men (1.8%) than women (1.2%), and more common at older ages. The highest rate of cancer for men and women was for 75 years and over (11.1%, and 4.4% respectively).

Of all persons with cancer, nearly 1 in 3 people (32.6%) had skin cancer, making this the most common type of cancer.

The prevalence of cancer increased with age, with 7.4% of people aged 75 years and over having cancer compared with 1.2% of people aged 45-54 years.

Proportion of persons with cancer, 2011-12
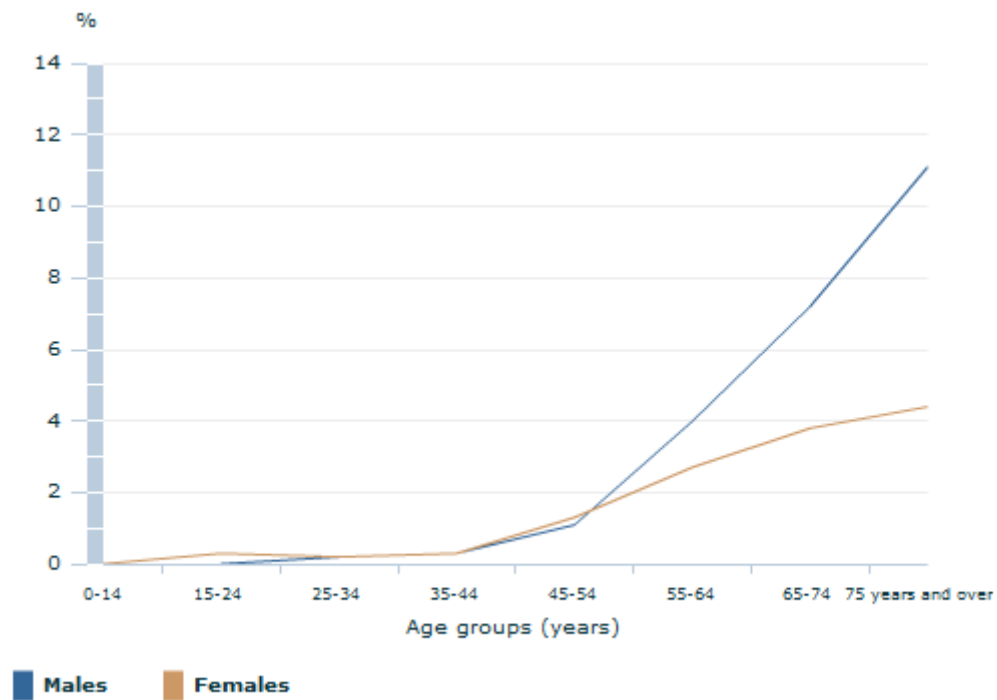
When interpreting data from the 2011-12 Australian Health Survey it should be noted that the survey excluded persons in hospitals, nursing and convalescent homes and hospices. These exclusions are expected to have a greater effect on data for cancer rates than for most other conditions, as a high proportion of people with cancer may be receiving treatment in these facilities.

DIABETES MELLITUS

Diabetes mellitus is a chronic condition where insulin, a hormone that controls blood glucose levels, is no longer produced or not produced in sufficient amounts by the body. It significantly affects the health of many Australians and can result in a range of complications, including serious damage to the nerves and blood vessels. If left undiagnosed or poorly managed, diabetes can lead to coronary heart disease, stroke, kidney failure, limb amputations or blindness.

> **Data source and definitions**
>
> Data on diabetes refers to persons who reported having been told by a doctor or nurse that they had diabetes and that it was current and long-term; that is, their diabetes was current at the time of interview and had lasted, or was expected to last, 6 months or more. There were a further 111,500 persons who reported they had diabetes but that it was not current at the time of interview.
>
> More accurate information on the number of people with diabetes based on measured blood sugar levels will be available upon release of results from the National Health Measures Survey in 2013.

In 2011-12, 4.0% of the Australian population (875,400 people) reported having some type of diabetes (excluding persons with gestational diabetes). The prevalence of diabetes remained stable between 2007-08 and 2011-12 (both 4.0%).

Of persons who reported diabetes, the majority had Type 2 diabetes (85.3%), while 12.4% had Type 1 diabetes and the remainder had an unspecified type of diabetes (2.3%).

More men reported having diabetes than women (4.3% of all men compared with 3.6% of all women) and as with many health conditions, the rate of diabetes increased with age. People aged 65-74 years had the highest rate of diabetes (16.0%).

Proportion of persons with diabetes, 2011-12
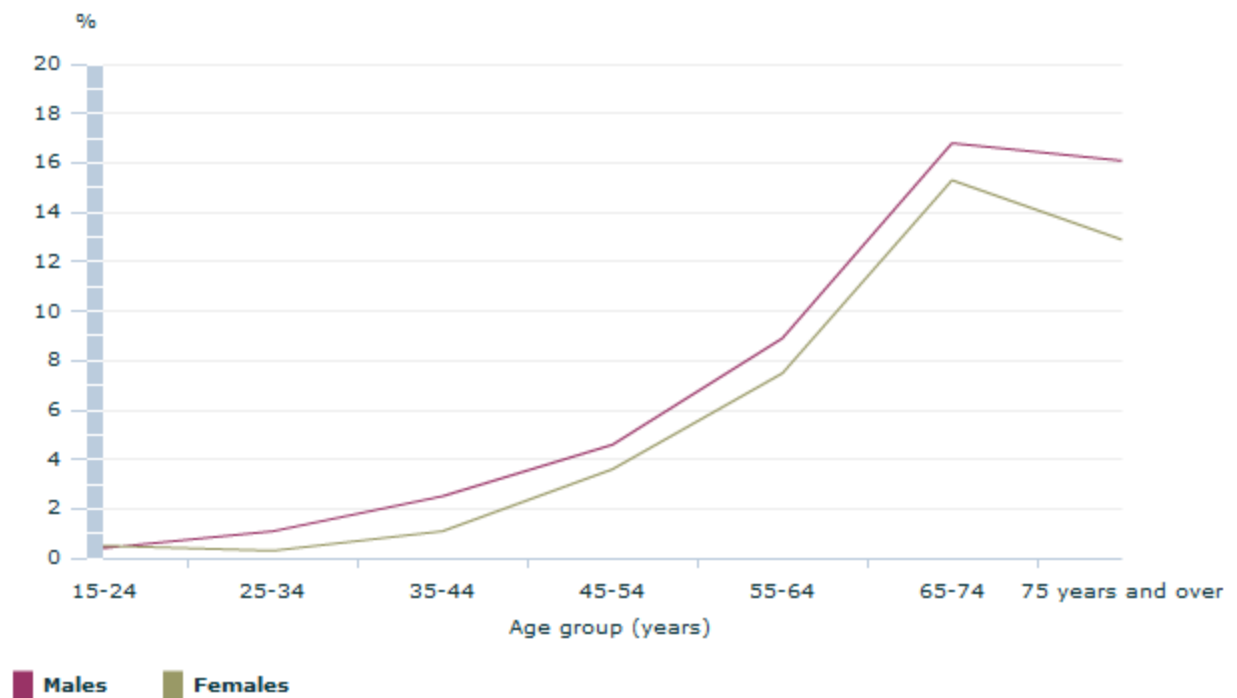
HEART, STROKE AND VASCULAR DISEASE

Heart, stroke and vascular disease encompasses a range of circulatory conditions including ischaemic heart diseases, cerebrovascular diseases, oedema, heart failure, and diseases of the arteries, arterioles and capillaries. Most commonly this group of conditions is referred to under the broader term of 'heart disease' (or 'cardiovascular disease'). Heart disease remains one of the leading causes of death worldwide, and therefore an emphasis has been placed around preventing its onset through modifying risk factors such as healthy eating, exercise and avoidance of smoking.

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Data source and definitions

Data on heart disease refers to persons who reported having been told by a doctor or nurse that they had any of a range of circulatory conditions including ischaemic heart diseases, cerebrovascular diseases, oedema, heart failure, and diseases of the arteries, arterioles and capillaries and that it was current and long-term; that is, their condition was current at the time of interview and had lasted, or was expected to last, 6 months or more.

More accurate information on the number of people with heart disease based on measured levels of blood lipids such as total cholesterol will be available upon release of results from the National Health Measures Survey in 2013.

In 2011-12, 4.7% of Australians (1.0 million people) reported they had heart disease, a decrease from 2007-08 where 5.2% of Australians (1.1 million people) had heart disease.

The proportion of people with heart disease increased steadily with age, with more than one quarter (27.7%) of all Australians aged 75 years and over having heart disease, and is more common amongst men (5.1%) than women (4.3%).

Proportion of persons with heart disease(a), 2011-12
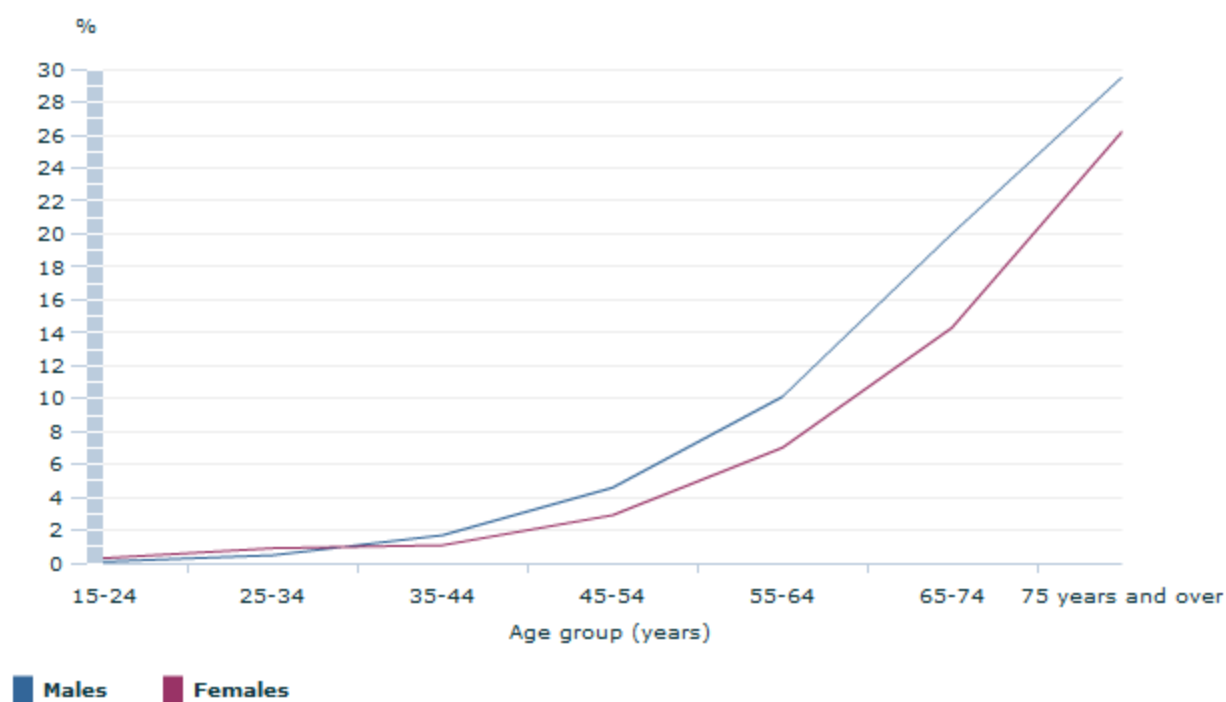
(a) Includes ischaemic heart disease, cerebrovascular disease, oedema, heart failure, and diseases of the arteries, arterioles and capillaries.

For information on measured blood pressure in the Australian Health Survey, see Blood pressure.

MENTAL AND BEHAVIOURAL CONDITIONS

Mental and behavioural conditions in the Australian Health Survey comprise a range of organic and psychological conditions such as dementia, depression, substance use and anxiety disorders.

In 2011-12 there were 3.0 million Australians (13.6%) who reported having a mental and behavioural condition, an increase from 11.2% in 2007-08 and 9.6% in 2001. Mood (affective) problems, which include depression, were most prevalent (2.1 million people or 9.7% of the population) followed by anxiety related problems (850,100 people or 3.8%).

Mental and behavioural conditions continued to be more common amongst women than men (15.1% compared with 12.0% respectively).

Information on psychological distress was also collected from adult respondents in the Australian Health Survey using the Kessler Psychological Distress Scale (K10). See Psychological distress.

Proportion of persons with a mental & behavioural condition, 2001 to 2011-12
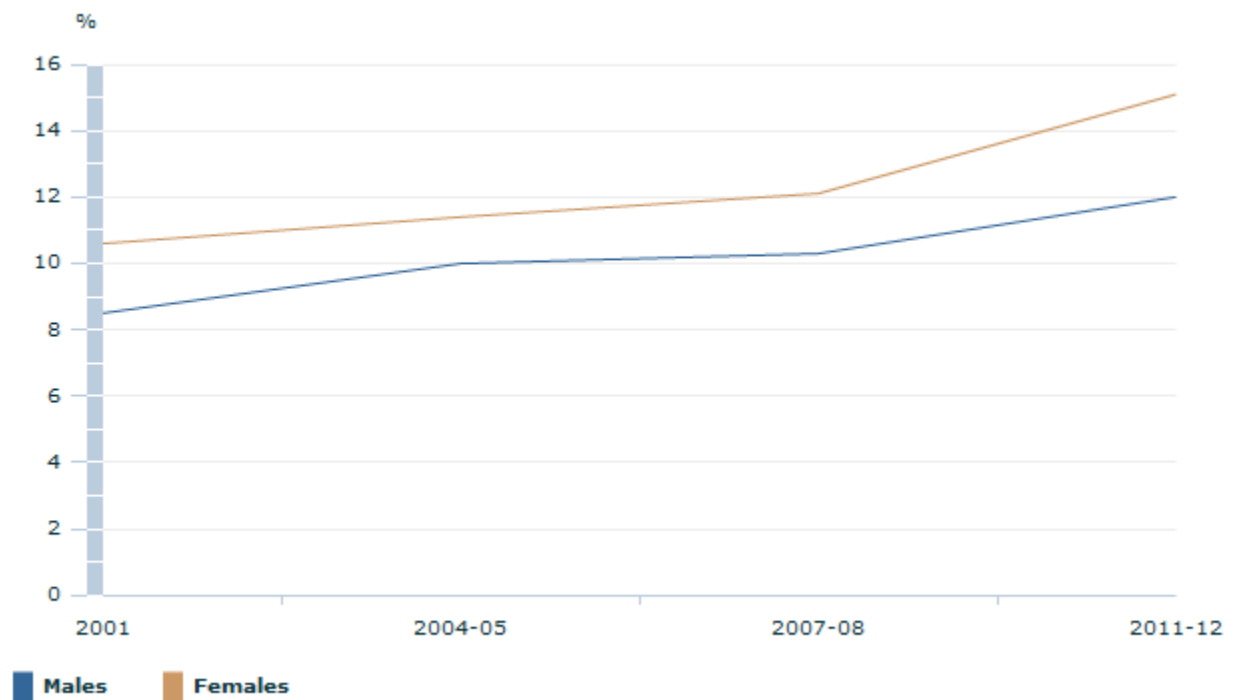
KIDNEY DISEASE

Kidney disease is a chronic disease in which a person's kidney function is reduced or damaged. This affects the kidney's ability to filter blood and therefore control the body's water and other hormone levels, leading to increased fluid and waste within the body. The increase in these fluids can cause high blood pressure, anemia, and uremia. Kidney disease is associated with several other chronic diseases such as diabetes and cardiovascular disease, and is a significant cause of mortality in Australia.

Data source and definitions

This data on kidney disease refers to persons who reported having been told by a doctor or nurse that they had kidney disease and that it was current and long-term; that is, their kidney disease was current at the time of interview and had lasted, or was expected to last, 6 months or more.

Kidney disease has a number of stages, ranging in severity from Stage 1 to Stage 5, with early kidney damage usually showing no symptoms. An individual's kidney function can improve or regress during the early stages of the disease but once Stage 5 is reached, known as end stage kidney disease, kidney function is unlikely to improve. A person with end stage kidney disease is reliant on kidney replacement therapy in the form of dialysis or kidney transplant.

More accurate information on the number of people with kidney disease based on measured levels of creatinine and albumin will be available upon release of results from the National Health Measures Survey in 2013. This information will also allow breakdown into the stages of kidney disease.

Kidney disease in the 2011-13 AHS was collected using a new separate 'kidney disease' module. In previous years kidney disease was collected as part of the 'long-term conditions' module, therefore 2011-12 data is not directly comparable to earlier years due to a change in collection methodology.

In 2011-12, 0.8% of the Australian population (181,900 people) reported having kidney disease. There was no difference in the rate of kidney disease for men and women (0.8% and 0.9% respectively).

Kidney disease, as with many health conditions, increases in prevalence across older ages. In 2011-12, people aged 75 years and above had the highest rate of kidney disease (3.7%)

Proportion of persons with kidney disease, 2011-12

Males   Females
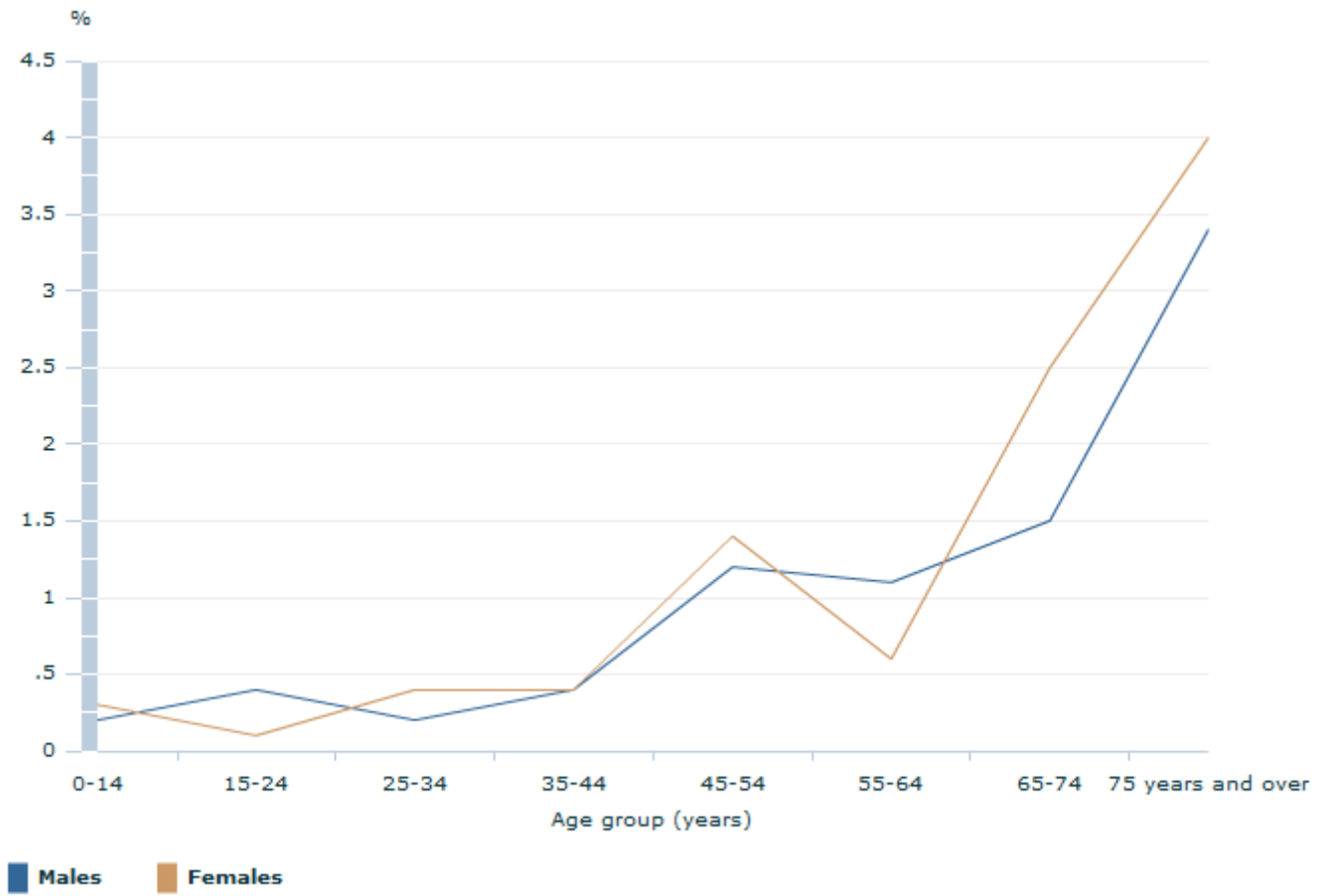
HEALTH RISK FACTORS

A range of genetic, social, economic and environmental factors are recognised as increasing the risk of developing a particular health condition. Specific lifestyle and related factors which have been identified as negatively impacting health include:

- being overweight or obese;
- smoking and excessive alcohol consumption;
- poor diet and nutrition; and
- lack of physical activity.

Information about health risk factors and behaviours can be used along with information about other health and population characteristics to enable a better understanding of Australia's overall health and how it can be improved.
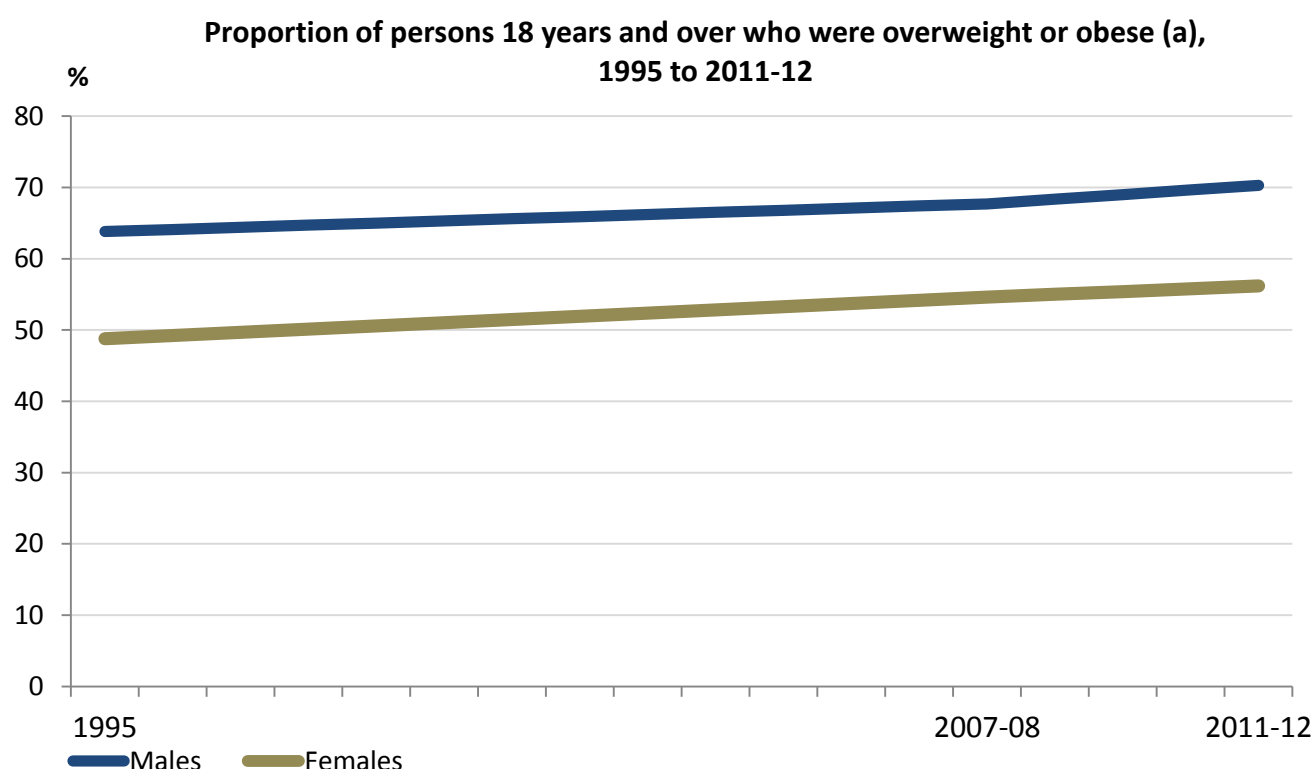
OVERWEIGHT AND OBESITY

Being overweight or obese increases a person's risk of developing cardiovascular disease, high blood pressure and/or Type 2 diabetes. Body Mass Index (BMI) is a common measure for defining whether a person is underweight, normal weight, overweight or obese.

In the Australian Health Survey, measured height and weight were collected to determine a person's Body Mass Index. BMI based on measured height and weight is considered to be more accurate than self-reported height and weight. See the Glossary for cut-offs for BMI.

In 2011-12, 63.4% of Australians aged 18 years and over were overweight or obese, comprised of 35.0% overweight and 28.3% obese. A further 35.2% were of normal weight and 1.5% were underweight.

The prevalence of overweight and obesity has increased in Australia over time, from 61.2% in 2007–08 and 56.3% in 1995.

Proportion of persons 18 years and over who were overweight or obese (a), 1995 to 2011-12

(a) Based on Body Mass Index for persons whose height and weight was measured.

In 2011-12, more men were overweight or obese than women (70.3% compared with 56.2%). Rates for both men and women have increased since 2007–08 (67.7% for men and 54.7% for women).

Overweight and obesity varies with age, with 74.7% of adults aged 65-74 years being overweight or obese, compared with 38.4% of persons aged 18-24 years.

Proportion of persons who were overweight or obese(a), 2011-12
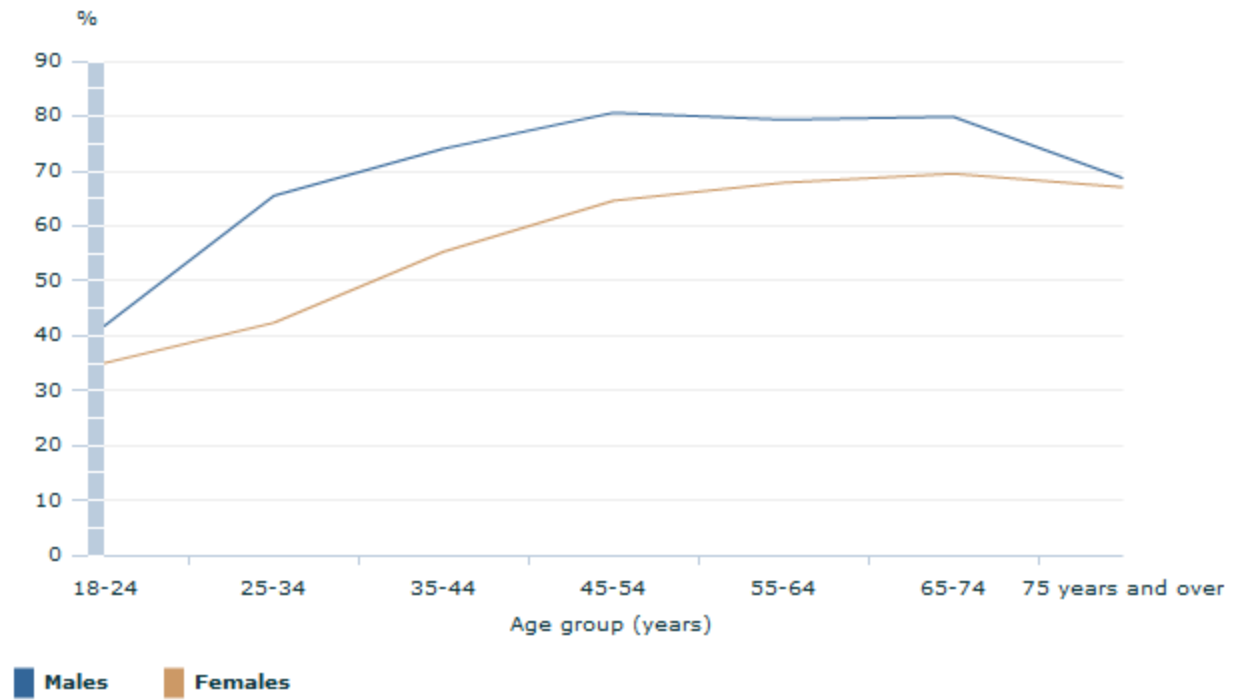
(a) Based on Body Mass Index for persons whose height and weight was measured.

Note that BMI was only calculated for persons for whom height and weight was measured. In 2011-12, 16.3% of persons aged 18 years and over did not have their height, weight or both measured.

TOBACCO SMOKING

Smoking is a significant risk factor for chronic disease. It is important to monitor rates of smoking in the population to identify high risk groups, and recognise patterns in smoking behaviour.

Persons 18 years and over

In 2011-12, there were 2.8 million Australians aged 18 years and over who smoked daily (16.3%). This rate has decreased consistently over the past decade, from 18.9% in 2007-08 and 22.4% in 2001. Decreases in smoking rates have occurred across all age groups, and particularly amongst people aged under 45 years.

Proportion of persons who were current daily smokers, 2001, 2007-08 & 2011-12
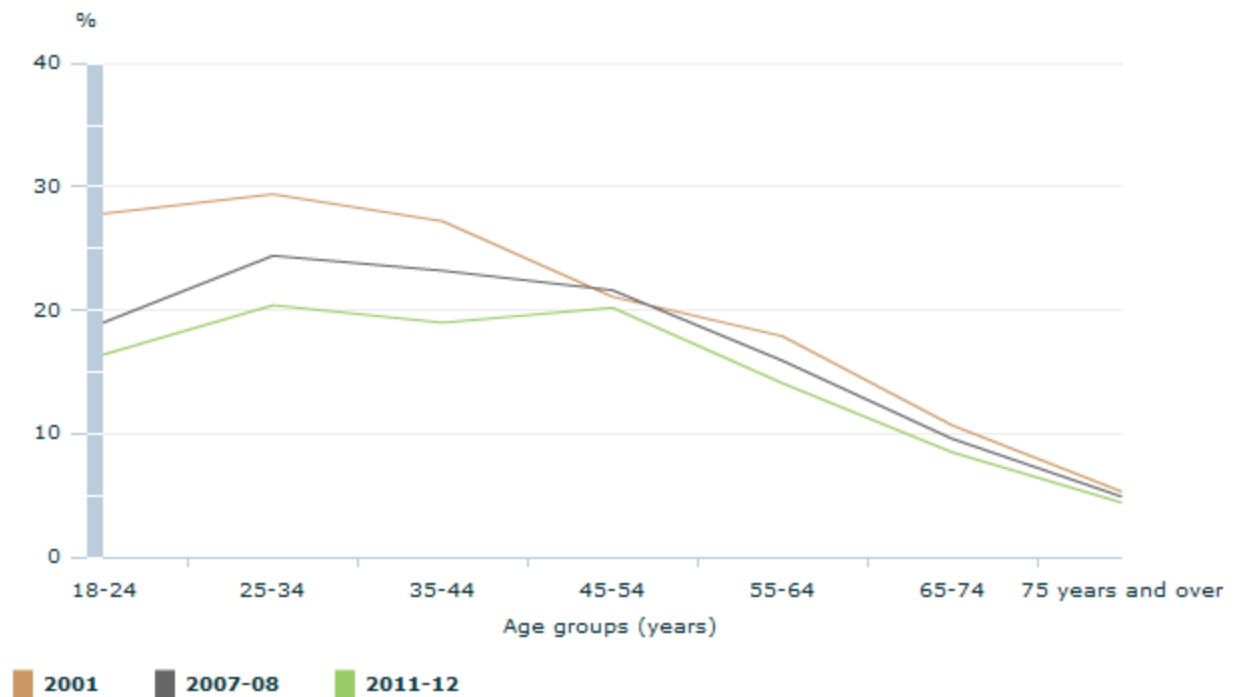
Around 50.9% of adults reported that they had never smoked, 31.0% were ex-smokers and the remaining 1.8% smoked, but less often than daily.

Men were more likely to smoke daily than women in 2011-12 (18.2% compared with 14.4%). These rates have decreased since 2001, when 25.4% of men and 19.5% of women smoked daily.

The Northern Territory had the highest rate of daily smokers (23.9%) followed by Tasmania (21.8%), while the Australian Capital Territory had the lowest rate (13.4%).

Persons 15-17 years

In 2011-12, smoking data was also collected for persons aged 15-17 years. Of people in this age group, 4.4% were daily smokers, 2.2% smoked less often than daily, 4.1% were ex-smokers, and 89.3% reported that they had never smoked.

Some under-reporting of persons identifying as current smokers may have occurred due to social pressures, particularly in cases where other household members were present at the interview. The extent to which under-reporting may have occurred is unknown. In the 2011-12 survey, interviewers were given the opportunity to indicate whether a parent was present at the time of the interview with respondents aged 15-17 years. Further analysis of the effect of this will be undertaken at a later date.

ALCOHOL CONSUMPTION

Alcohol occupies a significant place in Australian culture and is consumed in a wide range of social circumstances. In general, alcohol is consumed in Australia at levels of low immediate risk. However, some people drink at levels that increase their risk of alcohol-related injury, as well as their risk of developing health problems over the course of their life.

In 2011-12, 82.4% of Australians aged 18 years and over had consumed alcohol in the past year. A further 7.5% had consumed alcohol 12 or more months ago, 9.0% had never consumed alcohol and 1.1% did not know when they last consumed alcohol. Of all males, 87.6% had consumed alcohol in the past year while for females the proportion was lower (77.3%).

Lifetime risk

The 2009 National Health and Medical Research Council (NHMRC) guidelines for reducing health risks associated with the consumption of alcohol state that, for healthy men and women, 'drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury' [1].

In 2011-12, 19.5% of adults consumed more than two standard drinks per day on average, exceeding the lifetime risk guidelines. This was a decrease from 2007-08, when 20.9% of Australian adults exceeded the guidelines.

Proportion of persons 18 years & over who exceeded lifetime risk alcohol guidelines(a), 2001 to 2011-12

(a) More than two standard drinks per day on average.

29
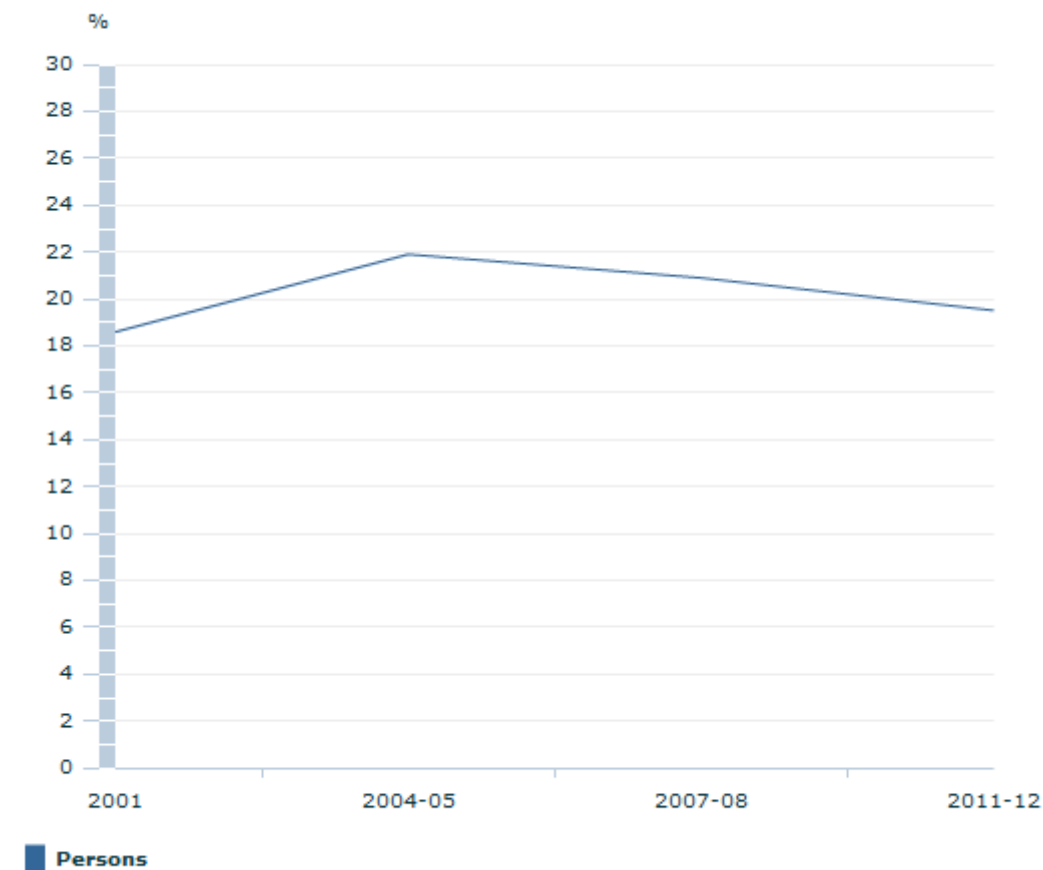
Overall, Australian men were almost three times more likely to exceed the guidelines than women (29.1% compared with 10.1%, respectively). Amongst men, those aged 55-64 years were most likely to exceed the guidelines while those aged 75 years and over were least likely. A similar pattern was apparent for women.

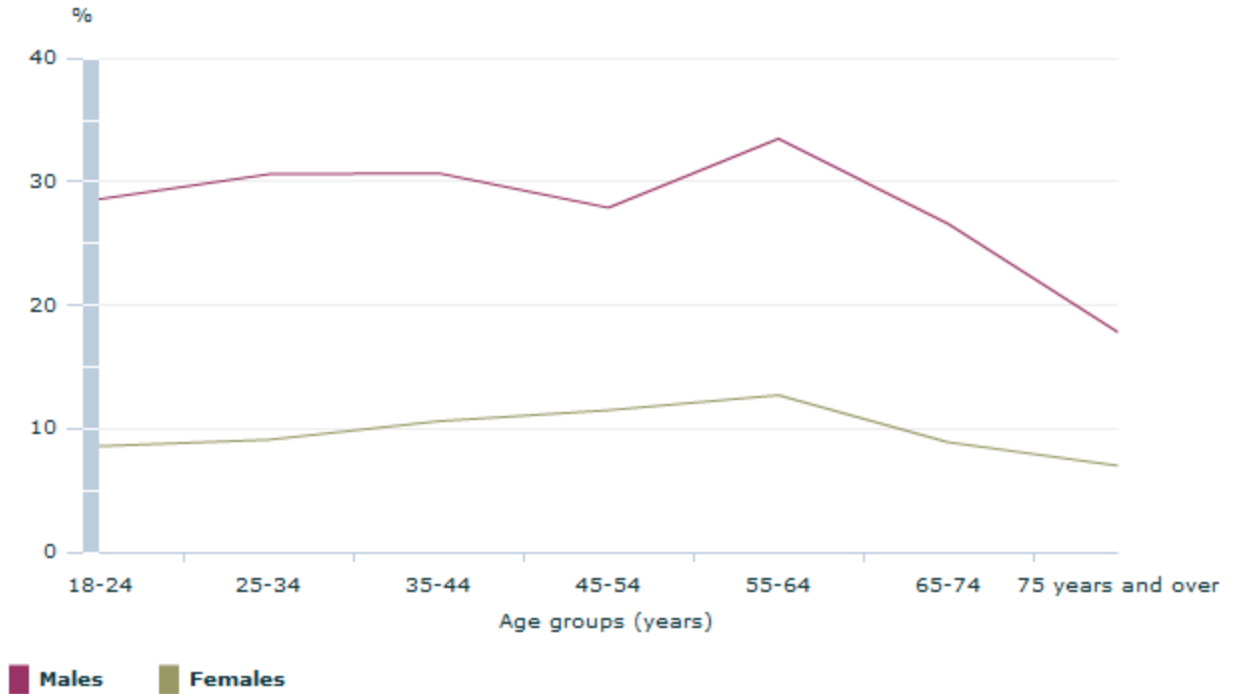**Proportion of persons who exceeded lifetime risk alcohol guidelines(a), 2011-12**

(a) More than two standard drinks per day on average.

Western Australia had the highest proportion of adults who consumed more than two standard drinks of alcohol per day on average (25.4%), and Victoria had the lowest (17.6%).

Single occasion risk

The 2009 NHMRC guidelines also advise that on a single occasion of drinking, the risk of alcohol-related injury increases with the amount consumed. For healthy men and women, 'drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion' **[1]**. A single occasion of drinking refers to a person consuming a sequence of drinks without their blood alcohol concentration reaching zero in between.

According to this guideline, 44.7% of Australians aged 18 years and over exceeded the single occasion risk threshold of consuming more than 4 standard drinks at least once in the past year, with the Northern Territory having the highest proportion (54.6%) and New South Wales the lowest (42.5%).

Proportion of persons who exceeded single occasion risk alcohol guidelines(a), 2011-12
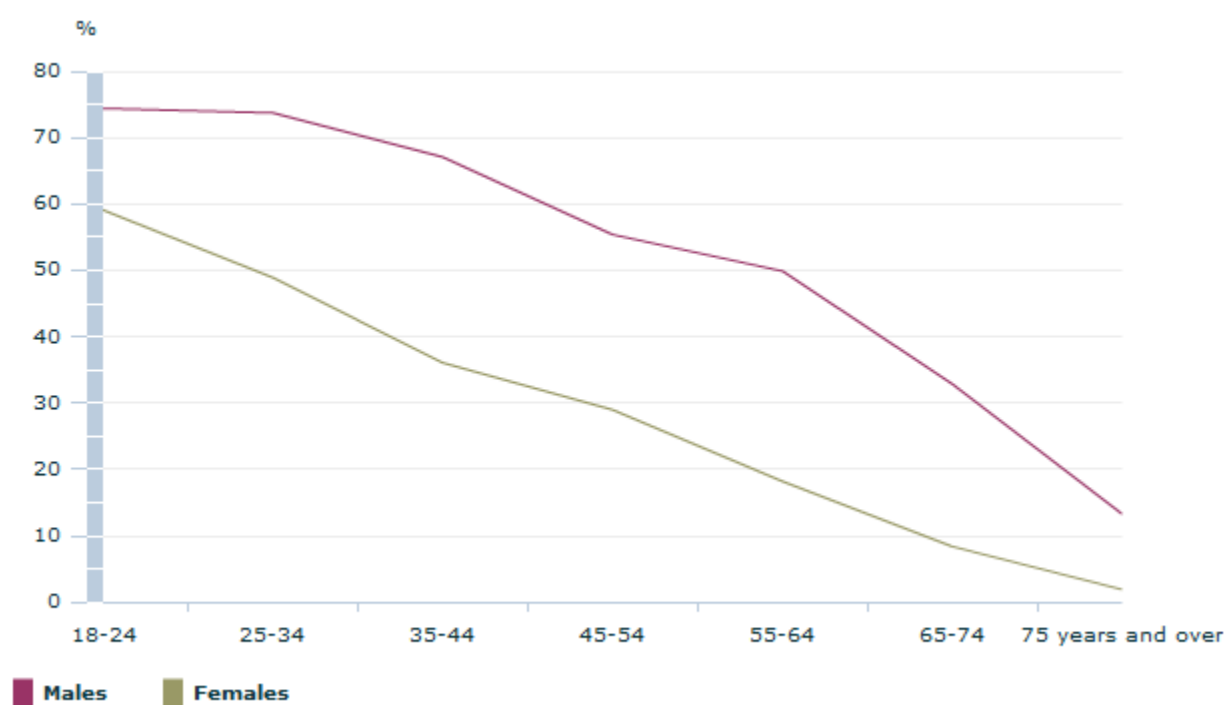
(a) More than four standard drinks at least once in the past year.

It is not possible to assess change over time using the 2009 NHMRC single occasion risk guidelines, as questions on the frequency of consumption of more than 4 standard drinks were not asked of males in the 2007-08 and earlier ABS National Health Surveys. However, applying the previous (2001) NHMRC short-term risk guidelines suggests that there was little change between 2004-05 and 2011-12 in the proportion of adults drinking at risky/high risk levels in the short term.

For more information on NHMRC guidelines for the consumption of alcohol, and an explanation of the method used to measure alcohol consumption in ABS health surveys, see Alcohol Consumption in Australia: A Snapshot, 2007-08 (cat. no. 4832.0.55.001).

Endnote(s): [1] National Health and Medical Research Council (NHMRC), 2009. Australian guidelines to reduce health risks from drinking alcohol, Canberra: NHMRC.
Available from http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf

DAILY INTAKE OF FRUIT AND VEGETABLES

The National Health and Medical Research Council (NHMRC) recommends that adults eat a minimum of 2 serves of fruit and 5 serves of vegetables a day to ensure good nutrition and health.

Data source and definitions

Usual daily intake of fruit and vegetables in the Australian Health Survey is based on self-reported data for the number of serves of fruit and vegetables that people usually ate each day.

A serve of vegetables was defined as half a cup of cooked vegetables, one medium potato or one cup of salad vegetables (approximately 75 grams). Tomatoes were included as a vegetable rather than a fruit, and legumes were excluded.

A serve of fruit was defined as one medium piece or two small pieces of fresh fruit, one cup of diced fruit, a quarter of a cup of sultanas, or four dried apricot halves (approximately 150 grams of fresh fruit or 50 grams of dried fruit). Fruit juices were not considered to be fruit.

More detailed information on the consumption of fruit and vegetables based on 2 separate days of dietary recall will be available upon release of results from the National Nutrition and Physical Activity Survey in 2013.

In 2011-12, 48.3% of Australians aged 18 years and over reported that they usually met the guideline for daily fruit intake, while 8.3% met the guideline for daily vegetable intake.

Taking both guidelines into account, only 5.6% of Australian adults had an adequate usual daily intake of fruit and vegetables. Women were more likely to meet both guidelines than men (6.6% and 4.5% respectively).

In general, older Australians were more likely to meet the guidelines than younger adults, with 9.6% of persons aged 65-74 years consuming the recommended intake of fruit and vegetables, compared with 3.0% of persons aged 25-34 years.

Usual daily intake of fruit(a), 2011-12
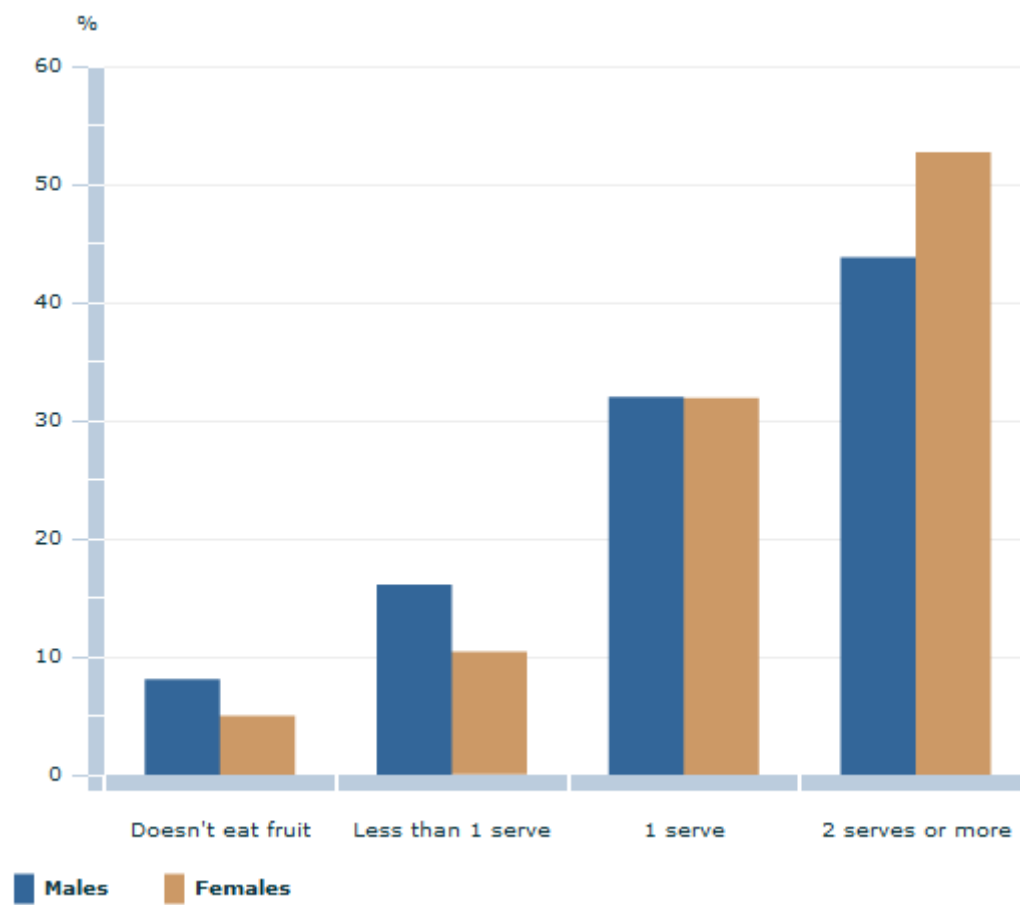
(a) Persons aged 18 years and over.

Usual daily intake of vegetables(a), 2011-12
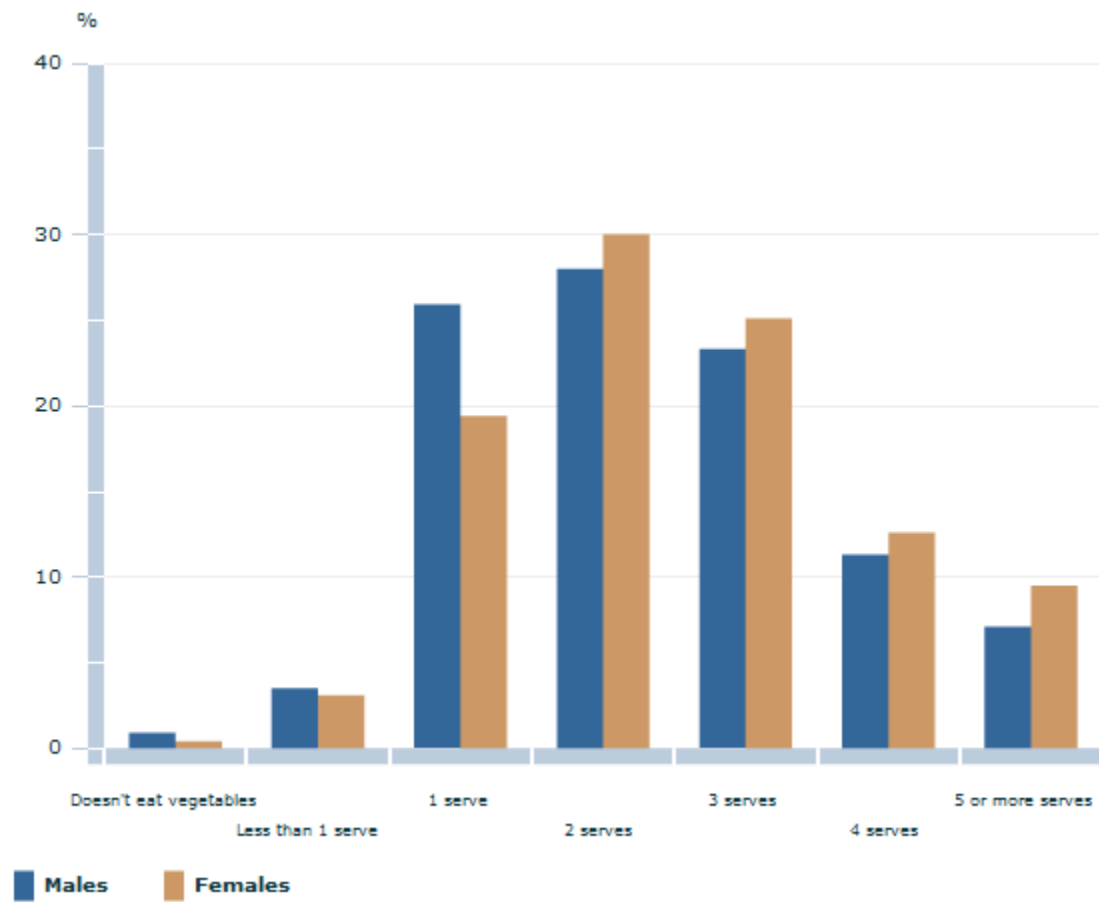
(a) Persons aged 18 years and over.

EXERCISE

Physical activity is an important factor in maintaining good overall health and wellbeing, and can help in the prevention of long-term health conditions such as heart disease, stroke and high blood pressure.

Data source and definitions

Types of exercise covered in the Australian Health Survey were walking, moderate and vigorous exercise for sport, recreation or fitness. Moderate exercise consists of activity undertaken for fitness, recreation or sport that causes a moderate increase in heart rate or breathing, while vigorous exercise causes a large increase in a person's heart rate or breathing. Level of exercise is determined based on the frequency, intensity and duration of exercise.

More detailed information on exercise based on 8 days of pedometer readings and more detailed physical activity questions will be available upon release of results from the National Nutrition and Physical Activity Survey in 2013.

In 2011-12, while most Australians aged 15 years and over had undertaken exercise in the last week, the overall level of this activity was low. Taking into account the intensity, duration and frequency of individuals' physical activity, 66.9% of Australians were either sedentary or had low levels of exercise in the week prior to interview (comprised of 35.4% sedentary and 31.5% low levels of exercise). However, this is a decrease from 2007-08 when the proportion of people who were sedentary or had low levels of exercise was 71.6%.

Older people did less exercise than younger people, with 56.9% of people aged 75 years and over being sedentary and 25.8% having low levels of exercise.

Levels of exercise differ for men and women, with men generally more active than women. In particular, young males (15-17 year olds) were three times more likely to undertake high levels of exercise than women (31.2% compared with 11.8% respectively) and women aged 15-17 years were nearly twice as likely than men to be sedentary (28.7% compared to 14.5% respectively).

Level of exercise(a)(b), 2011-12
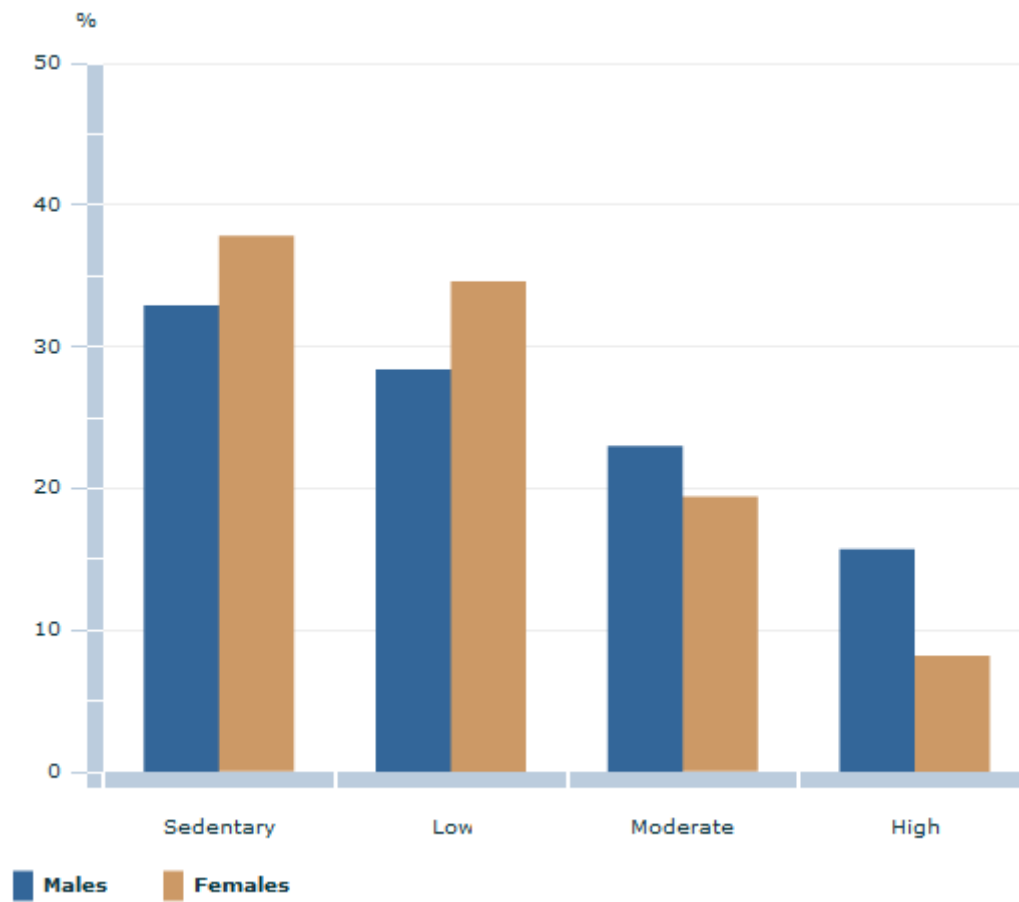
(a) Level of exercise undertaken for fitness, recreation or sport in the last week.
(b) Persons aged 15 years and over.

CHILDREN'S RISK FACTORS

Healthy habits formed early in life can follow on throughout childhood, adolescence and into adulthood. Conversely, less than healthy habits established in childhood may continue into adulthood, increasing a person's associated health risks such as cardiovascular disease, high blood pressure and Type 2 diabetes. The following commentary discusses risk factors for children aged 5-17 years.

In 2011-12, 25.3% of children aged 5-17 years were overweight or obese, comprised of 17.7% overweight and 7.6% obese. The proportion of girls who were overweight or obese was higher than that of boys (27.1% compared with 23.6%). There has been no change in the proportion of children who were overweight or obese between 2007-08 and 2011-12.

Body Mass Index(a), children aged 5-17 years, 2011-12
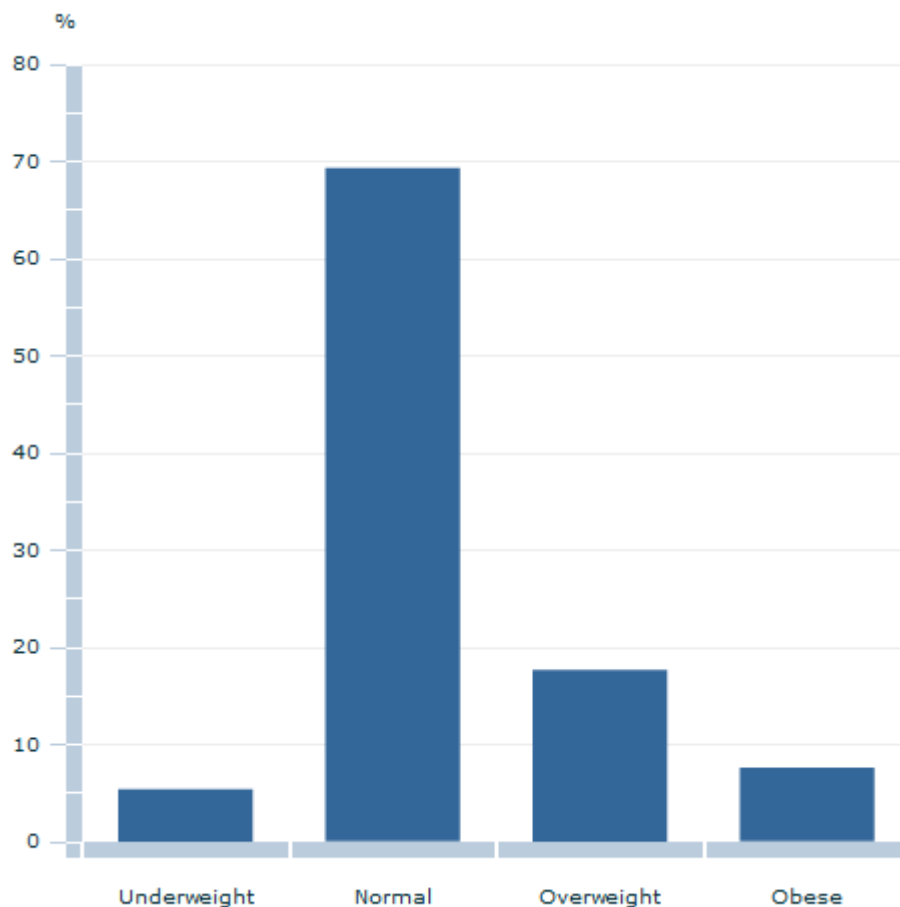
(a) Based on Body Mass Index for children whose height and weight was measured.

Good nutrition can have many positive health benefits. In 2011-12, 95.3% of children aged 5-11 years were reported to usually meet their recommended daily intake of 1 serve of fruit, compared to only 20.3% of children aged 12-17 years (for whom 3 serves of fruit per day are considered adequate).

Younger children were also more likely to meet the age-specific guidelines for vegetable intake than older children: 56.1% of children aged 5-7 years met the recommended intake of at least 2 serves per day, 30.8% of children aged 8-11 years met the recommended intake of at least 3 serves while 15.2% of children aged 12-17 years met the recommended intake of at least 4 serves of vegetables.

Milk is an excellent source of vitamins and minerals, particularly calcium, which is important for forming strong and healthy bones. In 2011-12, almost all children (97.9%) aged 5-17 years consumed milk; the majority of children consumed cow's milk (95.7%), followed by soy milk (1.7%).

PHYSICAL MEASUREMENTS

The 2011-13 Australian Health Survey collected physical measurements for people aged 2 years and over, including height, weight, waist circumference and blood pressure.

Information on physical measurements is particularly important for assessing health risk factors such as:

- the proportion of Australians who are overweight or obese (using measured height and weight to calculate Body Mass Index); or
- the proportion of people who have high blood pressure at the time of interview.

HEIGHT AND WEIGHT

In 2011-12, the average Australian man (18 years and over) was 175.6 cm tall and weighed 85.9 kg. The average Australian woman was 161.8 cm tall and weighed 71.1 kg.

On average, Australians are growing taller and heavier over time. Between 1995 and 2011-12, the average height for men increased by 0.8 cm and for women by 0.4 cm, while the average weight for men increased by 3.9 kg and for women by 4.1 kg.

In general, older people are shorter than younger people with the average male aged 75 years and over (169.7 cm) being 8.1 cm shorter than one aged 18-24 years (177.8 cm). Women aged 75 years and over (155.7 cm) were also 8.1 cm shorter than women aged 18-24 years (163.8 cm) on average.

Average height, 1995 & 2011-12
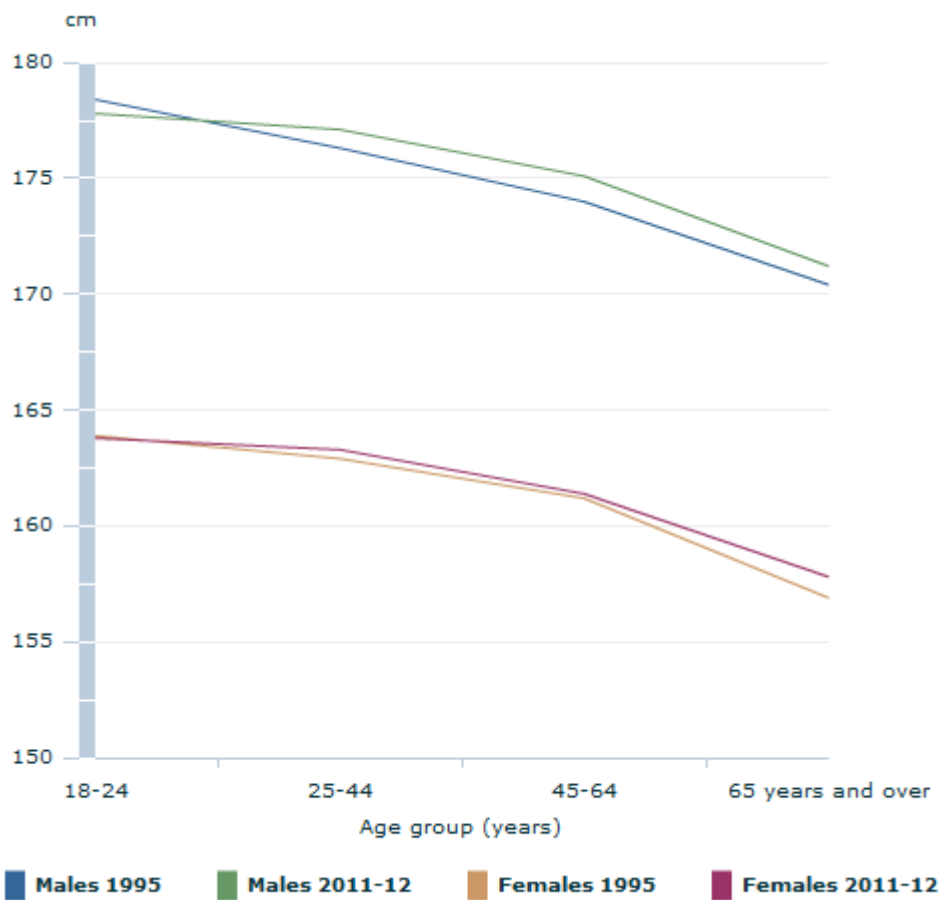
People aged 45-54 years had the highest average weight: 89.2 kg for men and 73.4 kg for women.

Average weight, 1995 & 2011-12

kg

| | Males 1995 | Males 2011-12 | Females 1995 | Females 2011-12 |

Age group (years)
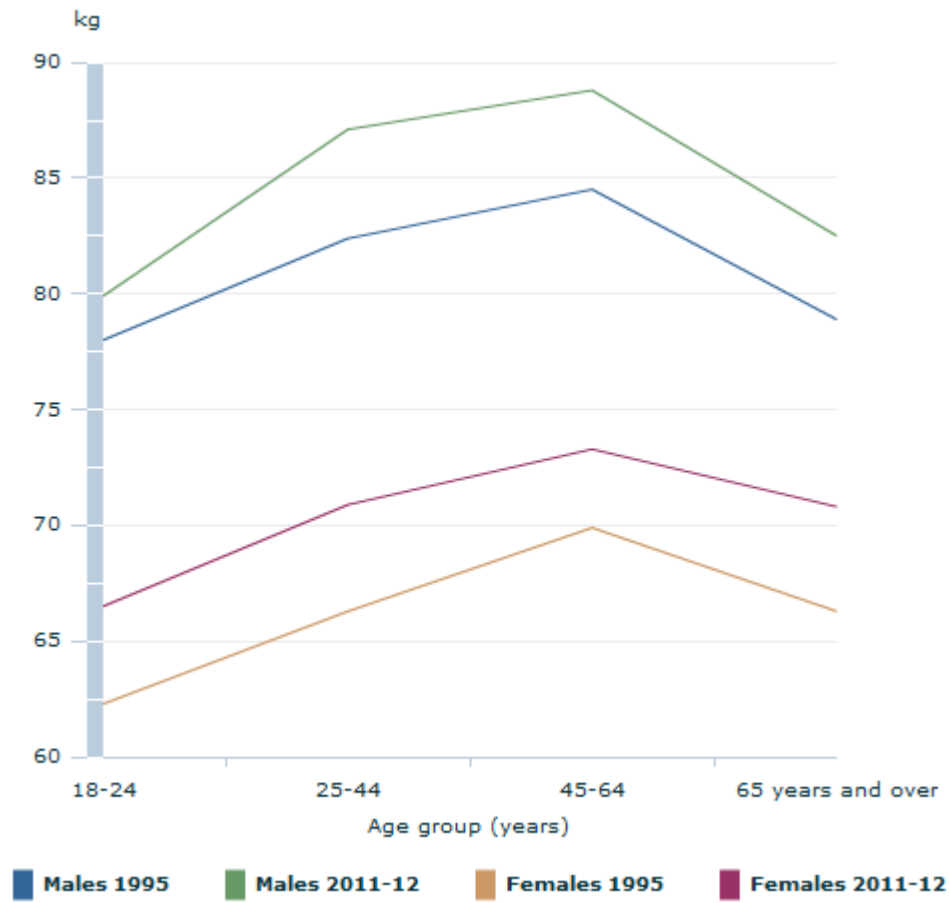
WAIST CIRCUMFERENCE

Waist circumference is widely accepted as an indicator of potential risk of developing chronic diseases such as heart disease, Type 2 diabetes and high blood pressure. According to National Health and Medical Research Council guidelines, a waist measurement of 94 cm or more (for men) or 80 cm or more (for women) is an indicator of increased risk.

In 2011-12, 60.3% of men aged 18 years and over had a waist circumference that put them at an increased risk of developing chronic diseases, while 66.6% of women had an increased level of risk. Between 2007-08 and 2011-12 there was a significant increase in the proportion of men and women with a waist circumference that put them at increased level of risk.

These increases correspond with the increasing trend in the proportion of Australians who are overweight or obese as measured using Body Mass Index. See Overweight and Obesity.

On average, men aged 18 years and over had a waist measurement of 97.9 cm, while women had a waist measurement of 87.7 cm. Between 2007-08 and 2011-12, average waist measurements increased by 1.7 cm for men and 1.9 cm for women.

The proportion of men and women with a waist circumference that put them at risk of developing chronic diseases generally increased with age.

Proportion of males with increased risk waist measurement(a), 2007-08 & 2011-12

(a) A waist measurement of 94cm or more.

41
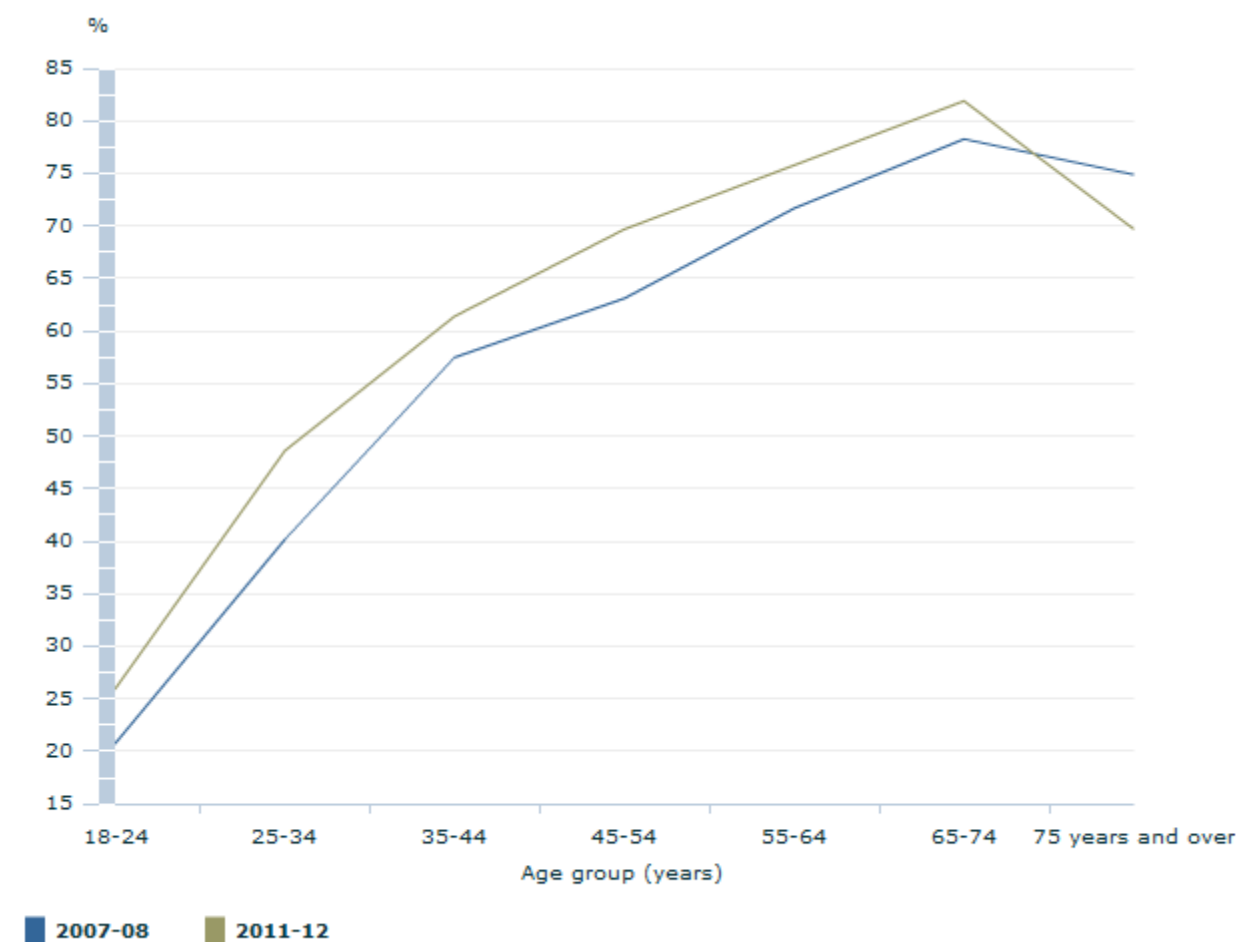
Proportion of females with increased risk waist measurement(a), 2007–08 & 2011–12
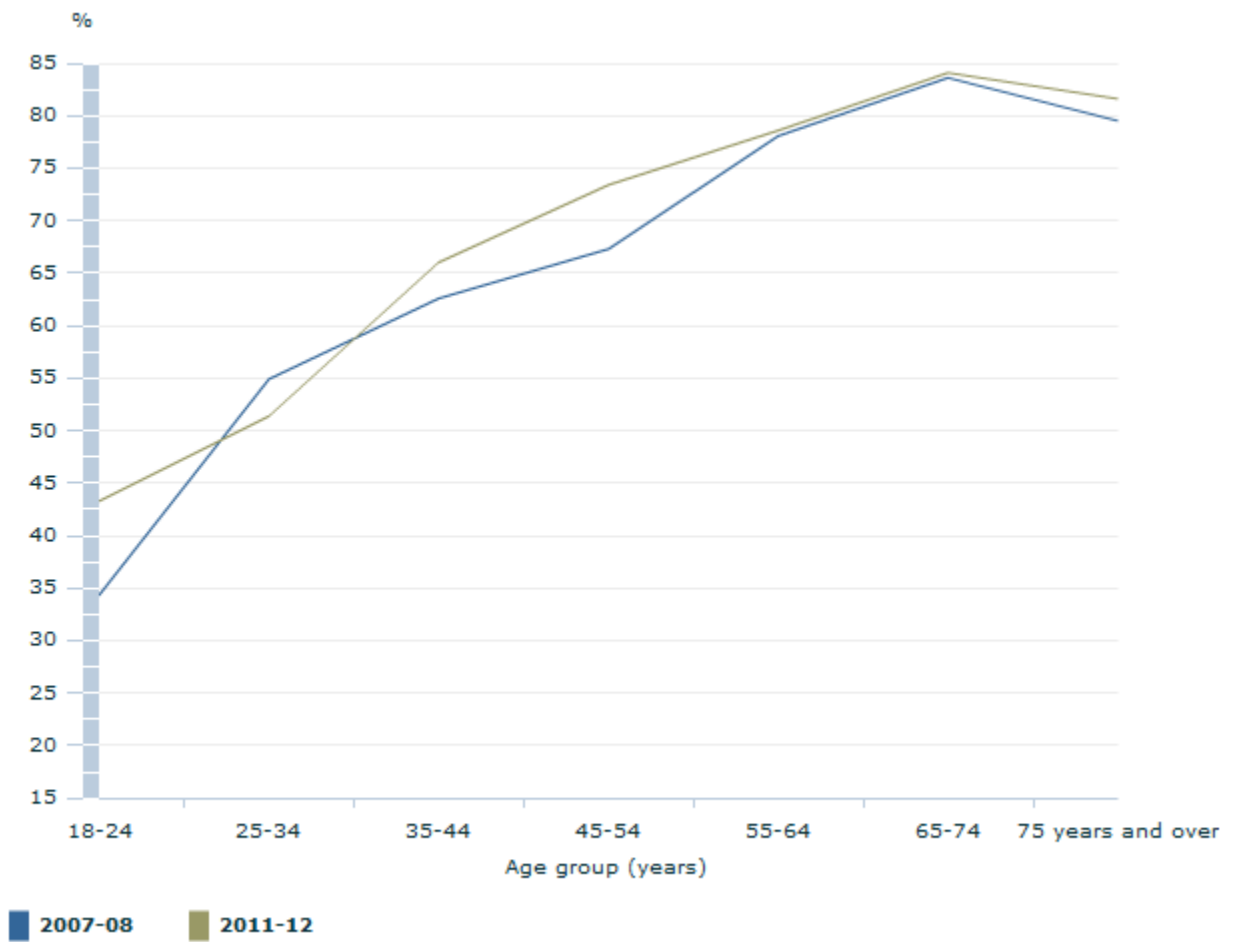
(a) A waist measurement of 80cm or more.

BLOOD PRESSURE

High blood pressure is an important risk factor for heart disease, stroke and other cardiovascular diseases.

According to WHO guidelines, a person is defined as having high blood pressure if their systolic or diastolic blood pressure is equal to or greater than 140/90 mmHg.

The results below refer to measured blood pressure only, and do not include people who might otherwise have high blood pressure but are managing their condition through the use of blood pressure medications or other actions.

In 2011-12, just over 3.1 million people aged 18 years and over (21.5%) had measured high blood pressure.

Overall, men were more likely to have high blood pressure than women (23.6% and 19.5% respectively), while the proportion of Australians with high blood pressure increased with age. Around 42.5% of persons aged 65 years and over had measured high blood pressure, compared with 6.0% of people aged 18-24 years.

Proportion of persons with high blood pressure(a), 2011-12
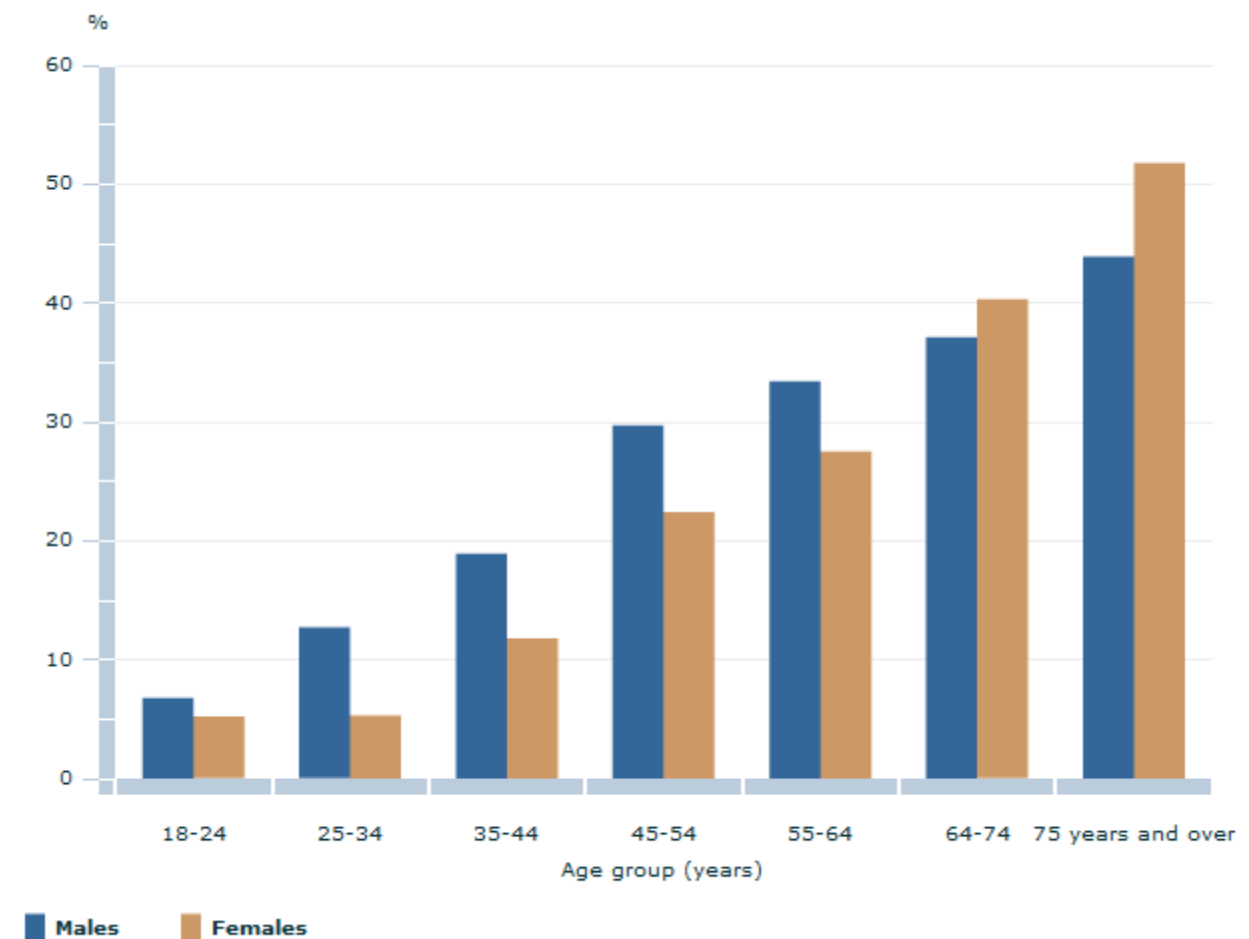
(a) Measured blood pressure of 140/90 mmHg or more.

EXPLANATORY NOTES

INTRODUCTION

1 This publication presents first results from the 2011-13 Australian Health Survey (AHS).

2 For more information on the structure of the AHS, see The structure of the Australian Health Survey. The following information focuses on the National Health Survey (NHS) component of the survey only.

3 The 2011-12 NHS was conducted throughout Australia from March 2011 to March 2012. This is the sixth in a series of Australia-wide health surveys conducted by the ABS; previous surveys were conducted in 1989-90, 1995, 2001, 2004-05 and 2007-08. Health surveys conducted by the ABS in 1977-78 and 1983, while not part of the NHS series, also collected similar information.

4 The 2011-12 NHS collected information about:

- the health status of the population, including long-term health conditions experienced;
- health-related aspects of people's lifestyles, such as smoking, Body Mass Index, diet, exercise and alcohol consumption;
- use of health services such as consultations with health practitioners and actions people have recently taken for their health; and
- demographic and socioeconomic characteristics.

5 The statistics presented in this publication are only a selection of the information collected in the NHS. Information on the use of health services and actions people take for their health will be available in early 2013. A broad release schedule for the Australian Health Survey is outlined in Release schedule while the list of data items available from the survey can be found in the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

SCOPE OF THE SURVEY

6 The NHS was conducted from a sample of approximately 15,600 private dwellings across Australia.

7 Urban and rural areas in all states and territories were included, while Very Remote areas of Australia and discrete Aboriginal and Torres Strait Islander communities (and the remainder of the Collection Districts in which these communities were located) were excluded. These exclusions are unlikely to affect national estimates, and will only have a minor effect on aggregate estimates produced for individual states and territories, excepting the Northern Territory where the population living in Very Remote areas accounts for around 23% of persons.

8 Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. This may affect estimates of the number of people with some long-term health conditions (for example, conditions which may require periods of hospitalisation).

9 Within each selected dwelling, one adult (aged 18 years and over) and one child were randomly selected for inclusion in the survey. Sub-sampling within households enabled more information to be collected from each respondent than would have been possible had all usual residents of selected dwellings been included in the survey.

10 The following groups were excluded from the survey:

- certain diplomatic personnel of overseas governments, customarily excluded from the Census and estimated resident population;
- persons whose usual place of residence was outside Australia;
- members of non-Australian Defence forces (and their dependents) stationed in Australia; and
- visitors to private dwellings.

DATA COLLECTION

11 Trained ABS interviewers conducted personal interviews with selected residents in sampled dwellings. One person aged 18 years and over in each dwelling was selected and interviewed about their own health characteristics. An adult, nominated by the household, was interviewed about one child in the household. Selected children aged 15-17 years may have been personally interviewed with parental consent. An adult, nominated by the household, was also asked to provide information about the household, such as the income of other household members.

SURVEY DESIGN

12 Dwellings were selected at random using a multistage area sample of private dwellings. The initial sample selected for the survey consisted of approximately 21,100 dwellings. This was reduced to a sample of approximately 18,400 after sample loss (for example, households selected in the survey which had no residents in scope of the survey, vacant or derelict buildings, buildings under construction). Of those remaining dwellings, 15,565 (or 84.8%) were fully or adequately responding, yielding a total sample for the survey of 20,426 persons.

APPROACHED SAMPLE, FINAL SAMPLE AND RESPONSE RATES

	New South Wales	Victoria	Queensland	South Australia	Western Australia	Tasmania	Northern Territory	Australian Capital Territory	Australia
Households approached (after sample loss)	3 269	3 051	2 907	2 285	2 385	1 635	1 307	1 516	18 355
Households in sample	2 736	2 516	2 457	1 962	2 144	1 469	975	1 306	15 565
Response rate (%)	83.7	82.5	84.5	85.9	89.9	89.8	74.6	86.1	84.8
Persons in sample	3 602	3 287	3 244	2 508	2 847	1 909	1 304	1 725	20 426

13 More information on response rates is available in the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

14 To take account of possible seasonal effects on health characteristics, the sample was spread randomly across a 12-month enumeration period. Between August and September 2011, survey enumeration was suspended due to field work associated with the 2011 Census of Population and Housing.

WEIGHTING, BENCHMARKING AND ESTIMATION

15 Weighting is a process of adjusting results from a sample survey to infer results for the in-scope total population. To do this, a weight is allocated to each sample unit; for example, a household or a person. The weight is a value which indicates how many population units are represented by the sample unit.

16 The first step in calculating weights for each person was to assign an initial weight, which was equal to the inverse of the probability of being selected in the survey. For example, if the probability of a person being selected in the survey was 1 in 600, then the person would have an initial weight of 600 (that is, they represent 600 others). An adjustment was then made to these initial weights to account for the time period in which a person was assigned to be enumerated.

17 The weights are calibrated to align with independent estimates of the population of interest, referred to as 'benchmarks', in designated categories of sex by age by area of usual residence. Weights calibrated against population benchmarks compensate for over or under-enumeration of particular categories of persons and ensure that the survey estimates conform to the independently estimated distribution of the population by age, sex and area of usual residence, rather than to the distribution within the sample itself.

18 The NHS was benchmarked to the estimated resident population living in private dwellings in non-Very Remote areas of Australia at 31 October 2011. Excluded from these benchmarks were persons living in discrete Aboriginal and Torres Strait Islander communities, as well as a small number of persons living within Collection Districts that include discrete Aboriginal and Torres Strait Islander communities. The benchmarks, and hence the estimates from the survey, do not (and are not intended to) match estimates of the total Australian resident population (which include persons living in Very Remote areas or in non-private dwellings, such as hotels) obtained from other sources.

19 Survey estimates of counts of persons are obtained by summing the weights of persons with the characteristic of interest. Estimates of non-person counts (for example, number of conditions) are obtained by multiplying the characteristic of interest with the weight of the reporting person and aggregating.

RELIABILITY OF ESTIMATES

20 All sample surveys are subject to sampling and non-sampling error.

21 Sampling error is the difference between estimates, derived from a sample of persons, and the value that would have been produced if all persons in scope of the survey had been included. For more information refer to the Technical Note. Sampling error in this survey is measured by Relative Standard Errors (RSEs). In this publication, estimates with an RSE of 25% to 50% are preceded by an asterisk (e.g. *3.4) to indicate the estimate should be used with caution. Estimates with an RSE over 50% are indicated by a double asterisk (e.g. **0.6) and are considered too unreliable for most purposes.

22 Non-sampling error may occur in any data collection, whether it is based on a sample or a full count such as a census. Non-sampling errors occur when survey processes work less effectively than intended. Sources of non-sampling error include non-response, errors in reporting by respondents or in recording of answers by interviewers, and occasional errors in coding and processing data.

23 Non-response occurs when people cannot or will not cooperate, or cannot be contacted. Non-response can affect the reliability of results and can introduce a bias. The magnitude of any bias depends on the rate of non-response and the extent of the difference between the characteristics of those people who responded to the survey and those who did not.

24 The following methods were adopted to reduce the level and impact of non-response:

- face-to-face interviews with respondents;
- the use of interviewers, where possible, who could speak languages other than English;
- follow-up of respondents if there was initially no response; and
- weighting to population benchmarks to reduce non-response bias.

25 By careful design and testing of the questionnaire, training of interviewers, and extensive editing and quality control procedures at all stages of data collection and processing, other non-sampling error has been minimised. However, the information recorded in the survey is essentially 'as reported' by respondents, and hence may differ from information available from other sources, or collected using different methodology. For example:

- information about medical conditions was self-reported and while not directly based on diagnosis by a medical practitioner in the survey, respondents were asked whether they had ever been told by a doctor or nurse that they had a particular health condition. Conditions which have a greater effect on people's wellbeing or lifestyle, or those which were specifically mentioned in survey questions, are expected in general to have been better reported than others; and
- results of previous surveys have shown a tendency for respondents to under-report alcohol consumption levels.

CLASSIFICATIONS

26 Long-term health conditions described in this publication are classified to a classification developed for use in the NHS (or variants of that classification), based on the International Classification of Diseases (ICD). The classification of data from the 2001, 2004-05, 2007-08 and 2011-12 surveys is based on the 10th revision of the ICD.

27 Country of birth was classified to the Standard Australian Classification of Countries (cat. no. 1269.0).

28 Main language spoken at home was classified according to the Australian Standard Classification of Languages (cat. no. 1267.0).

29 Descriptions for data items such as Body Mass Index and the Kessler Psychological Distress Scale (K10) are included in the Glossary to this publication.

RESULTS OF THE SURVEY

30 Summary results of previous National Health Surveys were published separately in National Health Survey: Summary of Results, Australia, 1989-90, 1995, 2001, 2004-05 and 2007-08 (cat. no. 4364.0).

31 While some changes between estimates from different reference periods can be attributed at least in part to conceptual, methodological and/or classification differences, there are some instances where the degree or nature of the change suggests other factors are contributing to the movements, including changes in community awareness or attitudes to certain conditions, changes in common terminology affecting how characteristics are reported/described by respondents, improvements in diagnosis or management of conditions, etc. The degree of change attributable to all these factors relative to the actual change in prevalence cannot be determined from information collected in this survey.

32 Further information about the comparability of data between surveys is in the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

CONFIDENTIALITY

33 The **Census and Statistics Act, 1905** provides the authority for the ABS to collect statistical information, and requires that statistical output shall not be published or disseminated in a manner that is likely to enable the identification of a particular person or organisation. This requirement means that the ABS must take care and make assurances that any statistical information about individual respondents cannot be derived from published data.

34 Some techniques used to guard against identification or disclosure of confidential information in statistical tables are suppression of sensitive cells, random adjustments to cells with very small values, and aggregation of data. To protect confidentiality within this publication, some cell values may have been suppressed and are not available for publication but included in totals where applicable. As a result, sums of components may not add exactly to totals due to the confidentialisation of individual cells.

ROUNDING

35 Estimates presented in this publication have been rounded. As a result, sums of components may not add exactly to totals.

36 Proportions presented in this publication are based on unrounded figures. Calculations using rounded figures may differ from those published.

ACKNOWLEDGEMENTS

37 ABS publications draw extensively on information provided freely by individuals, businesses, governments and other organisations. Their continued cooperation is very much appreciated; without it, the wide range of statistics published by the ABS would not be available. Information received by the ABS is treated in strict confidence as required by the **Census and Statistics Act, 1905**.

PRODUCTS AND SERVICES

38 Summary results from this survey, compiled separately for Australia and each state and territory, are available in spreadsheet form from the 'Downloads' tab in this release.

39 For users who wish to undertake more detailed analysis of the survey data, Survey Table Builder will also be made available in 2013. Survey Table Builder is an online tool for creating tables from ABS survey data, where variables can be selected for cross-tabulation. It has been developed to complement the existing suite of ABS microdata products and services including Census TableBuilder and CURFs. Further information about ABS microdata, including conditions of use, is available via the Microdata section on the ABS web site.

40 Special tabulations are available on request. Subject to confidentiality and sampling variability constraints, tabulations can be produced from the survey incorporating data items, populations and geographic areas selected to meet individual requirements. A list of data items is available from the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

RELATED PUBLICATIONS

41 Other ABS publications which may be of interest are shown under the 'Related Information' tab of this release.

42 Current publications and other products released by the ABS are listed on the ABS website <www.abs.gov.au>. The ABS also issues a daily Release Advice on the website which details products to be released in the week ahead.

GLOSSARY

The definitions used in this survey are not necessarily identical to those used for similar items in other collections. Additional information about the items is contained in the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

Adult

A respondent aged 18 years or over.

Age standardisation

Age standardisation is a way of allowing comparisons between two or more populations with different age structures, in order to remove age as a factor when examining relationships between variables. For example, the age structure of the population of Australia is changing over time. As the prevalence of a particular health condition (for example, arthritis) may be related to age, any increase in the proportion of people with that health condition over time may be due to real increases in prevalence or to changes in the age structure of the population over time or to both. Age standardising removes the effect of age in assessing change over time or between different populations.

Note that proportions quoted in commentary in this publication are not age-standardised, however, those presented in datacube Table 1 include age standardised rates for all years and both age standardised and non-age standardised rates for 2011-12. Data in this table is age standardised to the 2001 Australian population.

Alcohol consumption risk level

Alcohol consumption risk levels in this publication have been assessed using the 2001 and 2009 National Health and Medical Research Council (NHMRC) guidelines for the consumption of alcohol.

Risk in the longer term (2001 guidelines) and lifetime risk (2009 guidelines) was assessed using average daily consumption of alcohol for persons aged 15 years and over, derived from the type, brand, number and serving sizes of beverages consumed on the three most recent days of the week prior to interview, in conjunction with the total number of days alcohol was consumed in the week prior to interview.

Risk in the short term (2001 guidelines) and single occasion risk (2009 guidelines) was assessed using questions on the number of times in the last 12 months a person's consumption exceeded specified levels.

2001 NHMRC GUIDELINES(a)

	Low risk	Risky	High risk
Level of risk			
Minimising risk in the longer term			
Males	up to 4 standard drinks	5–6 standard drinks	7 or more standard drinks
Females	up to 2 standard drinks	3–4 standard drinks	5 or more standard drinks
Minimising risk in the short term			
Males	up to 6 standard drinks	7–10 standard drinks(b)	11 or more standard drinks(b)
Females	up to 4 standard drinks	5–6 standard drinks(b)	7 or more standard drinks(b)

(a) One standard drink contains 12.5 mLs of alcohol.
(b) On at least one occasion in the last 12 months.

2009 NHMRC GUIDELINES(a)(b)

	Level of risk	
	Does not exceed guideline	**Exceeds guideline**
Guideline 1 - Lifetime risk	up to and including 2 standard drinks	more than 2 standard drinks
Guideline 2 - Single occasion risk	up to and including 4 standard drinks	more than 4 standard drinks(c)

(a) One standard drink contains 12.5 mLs of alcohol.
(b) Guidelines relate to both males and females.
(c) On at least one occasion in the last 12 months.

Alcohol consumption status information was also collected for persons who did not consume any alcohol in the 7 days prior to interview, categorised as:

- Last consumed more than one week to less than 12 months ago;
- Last consumed 12 months or more ago; and
- Never consumed.

For more detailed information on the 2001 NHMRC guidelines, see the Australian Alcohol Guidelines: Health Risks and Benefits and for the 2009 guidelines, see the Australian Guidelines to Reduce Health Risks from Drinking Alcohol and Frequently Asked Questions.

For a detailed explanation of the method used to measure alcohol consumption in ABS health surveys, see Alcohol Consumption in Australia: A Snapshot, 2007-08 (cat. no. 4832.0.55.001).

Arthritis

Arthritis is characterised by an inflammation of the joints often resulting in pain, stiffness, disability and deformity.

Asthma

A chronic disease marked by episodes of wheezing, chest tightness and shortness of breath associated with widespread narrowing of the airways within the lungs and obstruction of airflow. To be current, symptoms of asthma or treatment for asthma must have occurred in the last 12 months.

Back pain/problems, disc disorder

Includes back pain or other back problems, such as sprains, strains or joint pain, as well as disc disorders, such as slipped discs or disc degeneration. Excludes arthritis and osteoporosis (as they are reported in their own separate classification), and also excludes sciatica, curvature of the spine and soft tissue disorders.

Blood pressure

See High blood pressure, Diastolic blood pressure and Systolic blood pressure.

Bodily pain

Indication of the severity of any bodily pain that the respondent had experienced (from any and all causes) during the last 4 weeks. This is a self-assessment from the SF36 international instrument. Data was collected from respondents aged 18 years and over.

Body Mass Index (BMI)

Body Mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify underweight, normal weight, overweight and obesity. It is calculated from height and weight information, using the formula weight (kg) divided by the square of height (m). To produce a measure of the prevalence of underweight, normal weight, overweight or obesity in adults, BMI values are grouped according to the table below which allows categories to be reported against both the World Health Organization (WHO) and National Health and Medical Research Council (NHMRC) guidelines.

BODY MASS INDEX, Adults

Category	Range
Underweight	Less than 18.50
Normal range	18.50 —19.99
	20.00 — 24.99
Overweight	25.00 — 29.99
Obese	30.00 or more

Separate BMI classifications were produced for children. BMI scores were created in the same manner described above but also took into account the age and sex of the child. There are different cutoffs for BMI categories (underweight/normal combined, overweight or obese) for male and female children. These categories differ to the categories used in the adult BMI classification and follow the scale provided in Cole TJ, Bellizzi MC, Flegal KM and Dietz WH, **Establishing a standard definition for child overweight and obesity worldwide: international survey**, BMJ 2000; 320. For a detailed list of the cutoffs used to calculate BMI for children see the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

Child

A person aged 0-17 years.

Chronic obstructive pulmonary disease (COPD)

Chronic obstructive pulmonary disease (COPD), a serious long-term lung disease, is the occurrence of chronic bronchitis or emphysema, a pair of commonly co-existing diseases of the lungs in which airways become narrowed. It mainly affects older people and is often difficult to distinguish from asthma.

Conditions

See long-term medical condition.

Current daily smoker

A current daily smoker is a respondent who reported at the time of interview that they regularly smoked one or more cigarettes, cigars or pipes per day. See also Smoker status.

Deafness

Includes partial or total loss of hearing.

Diabetes mellitus

A chronic condition in which blood glucose levels become too high due to the body producing little or no insulin, or not using insulin properly.

Diastolic blood pressure

Measures the pressure in the arteries as the heart relaxes before the next beat. It is the lower number of the blood pressure reading.

Dietary guidelines

As specified by the National Health and Medical Research Council (NHMRC) for fruit and vegetable consumption. See Usual intake of fruit and Usual intake of vegetables.

Disability status

A disability or restrictive long term health condition exists if a limitation, restriction, impairment, disease or disorder, has lasted, or is expected to last for six months or more, and restricts everyday activities.

It is classified by whether or not a person has a specific limitation or restriction. Specific limitation or restriction is further classified by whether the limitation or restriction is a limitation in core activities or a schooling/employment restriction only.

There are four levels of core activity limitation (profound, severe, moderate and mild) which are based on whether a person needs help, has difficulty, or uses aids or equipment with any of the core activities (self care, mobility or communication). A person's overall level of core activity limitation is determined by their highest level of limitation in these activities.

Employed

Persons aged 15 years and over who had a job or business, or who undertook work without pay in a family business for a minimum of one hour per week. Includes persons who were absent from a job or business. See also Unemployed and Not in the labour force.

Exercise level

Based on frequency, intensity (that is, walking, moderate exercise or vigorous exercise) and duration of exercise (for fitness, recreation or sport) in the one week prior to interview. From these, an exercise score was derived using factors to represent the intensity of the exercise.

For more information see the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

Fat content of milk

An indication of intake of fat. Categorised as:

- Whole/full cream (3% fat or more);
- Reduced fat (around 1 or 2%);
- Skim (less than 1%);
- Does not drink milk; and
- Does not know fat content.

Family stressors

Any of the following events or circumstances which the person considers have been a problem for themselves or someone close to them in the last 12 months:

- Serious illness;
- Serious accident;
- Death of a family member or close friend;
- Mental illness;
- Serious disability;
- Divorce or separation;
- Not able to get a job;
- Alcohol or drug related problems;
- Witness to violence;
- Abuse or violent crime;
- Trouble with the police;
- Gambling problem; or
- Other.

Hayfever and allergic rhinitis

An allergic inflammation of the nasal airways occurring when an allergen, such as pollen or dust, is inhaled by an individual with a sensitised immune system. When caused specifically by grass pollens it is known as 'hayfever'.

Heart disease (Heart, stroke and vascular conditions)

A subset of reported long-term conditions comprising the following:

- Angina and other ischaemic heart disease;
- Cerebrovascular disease;
- Heart failure;
- Oedema; and
- Diseases of arteries, arterioles and capillaries.

Health risk factors

Specific lifestyle and related factors impacting on health, including:

- Tobacco smoking;
- Alcohol consumption;
- Exercise;
- Body mass;
- Dietary behaviour; and
- Blood pressure.

High blood pressure

A measured blood pressure reading of 140/90 mmHg (millimetres of mercury) or higher. Data on high blood pressure in this publication refer to measured blood pressure only, and do not take into account whether people who might otherwise have high blood pressure are managing their condition through the use of blood pressure medications.

Household

A household is defined as one or more persons, at least one of whom is at least 15 years of age, usually resident in the same private dwelling. In this survey, only households with at least one adult (aged 18 years and over) were included.

Household structure

Refers to the composition of the household to which the respondent belonged. In this publication households are categorised as persons living alone, couple only, couple with child(ren), and other households.

High Sugar Levels

High sugar levels in blood or urine.

Hypertensive disease

Also known as hypertension or high blood pressure, hypertensive disease is a chronic medical condition in which the blood pressure in the arteries is elevated, requiring the heart to work harder than normal to circulate blood through the blood vessels. Hypertension is a major risk factor for strokes and myocardial infarction (heart attacks) as well as several other medical conditions.

Index of Relative Socio-Economic Disadvantage

This is one of four Socio-Economic Indexes for Areas (SEIFA) compiled by ABS following each Census of Population and Housing. The indexes are compiled from various characteristics of persons resident in particular areas: the Index of Relative Socio-Economic Disadvantage summarises attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations. A lower Index of Relative Socio-Economic Disadvantage quintile (e.g. the first quintile) indicates relatively greater disadvantage and a lack of advantage in general. A higher Index of Relative Socio-Economic Disadvantage (e.g. the fifth quintile) indicates a relative lack of disadvantage and greater advantage in general. For further information about SEIFA see the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

Ischaemic heart disease

A disease of the blood vessels supplying the heart muscle.

Kidney disease

A subset of symptoms including: problems or complaints about the kidneys, renal pain and renal colic (kidney stones).

Long sightedness

Long sightedness (or hyperopia/hypermetropia) is a common condition of the eye where the light that comes into the eye focuses behind the retina, causing the image of a close object to be out of focus, but that of a distant object to be in focus. Glasses, contact lenses and laser techniques are used to correct long sightedness.

Long-term medical condition (or Long-term health condition)

A medical condition (illness, injury or disability) which has lasted at least six months, or which the respondent expects to last for six months or more. Some reported conditions were assumed to be long-term, including asthma, arthritis, cancer, osteoporosis, diabetes, sight problems, rheumatic heart disease, heart attack, angina, heart failure and stroke. Rheumatic heart disease, heart attack, angina, heart failure and stroke were also assumed to be current.

Mental health problems

Equivalent to Mental and behavioural problems. Includes anxiety related problems such as phobias, mood (affective) problems such as depression, substance abuse such as alcohol and drug problems, as well as other psychological, emotional and behavioural conditions.

Moderate exercise

Exercise for fitness, recreation, or sport which caused a moderate increase in heart rate or breathing.

Neoplasm

A neoplasm is a new growth of abnormal tissue (a tumour). Tumours can be either benign (non-cancerous) or malignant (cancer). Cancer refers to several diseases and can affect most types of cells in various parts of the body.

Not in the labour force

Persons who are not employed or unemployed as defined, including persons who:

- Are retired;
- No longer work;
- Do not intend to work in the future;
- Are permanently unable to work; or
- Have never worked and never intend to work.

Osteoporosis

A condition that thins and weakens bone mineral density, generally caused by loss of calcium, which leads to increased risk of fracture. Data was collected from persons aged 15 years and over plus younger respondents who reported having gout, rheumatism or arthritis.

Psychological distress

Derived from the Kessler Psychological Distress Scale (K10). This is a scale of non-specific psychological distress based on 10 questions about negative emotional states in the past 30 days. The K10 is scored from 10 to 50, with higher scores indicating a higher level of distress; low scores indicate a low level of distress. In this publication, scores are grouped as follows:

- Low levels of distress (10-15);
- Moderate levels of distress (16-21);
- High levels of distress (22-29); and
- Very high levels of distress (30-50).

Data was collected from respondents aged 18 years and over.

Self-assessed health status

A person's general assessment of their own health against a five point scale from excellent through to poor. Data was collected from respondents aged 15 years and over.

Short sightedness

Short sightedness (or myopia) is a common condition of the eye where the light that comes into the eye does not directly focus on the retina but in front of it, causing the image of a distant object to be out of focus, but that of a close object to be in focus. Glasses, contact lenses and laser techniques are used to correct short sightedness.

Smoker status

The extent to which a respondent was smoking at the time of interview, and refers to regular smoking of tobacco, including manufactured (packet) cigarettes, roll-your-own cigarettes, cigars and pipes, but excludes chewing tobacco and smoking of non-tobacco products. Categorised as:

- Current daily smoker - a respondent who reported at the time of interview that they regularly smoked one or more cigarettes, cigars or pipes per day;
- Current smoker - Other - a respondent who reported at the time of interview that they smoked cigarettes, cigars or pipes, less frequently than daily;
- Ex-smoker - a respondent who reported that they did not currently smoke, but had regularly smoked daily, or had smoked at least 100 cigarettes, or smoked pipes, cigars, etc at least 20 times in their lifetime; and
- Never smoked - a respondent who reported they had never regularly smoked daily, and had smoked less than 100 cigarettes in their lifetime and had smoked pipes, cigars, etc less than 20 times.

Data was collected from respondents aged 15 years and over.

Standard drink

Refers to a standard drink of alcohol, defined as containing 12.5 mLs of alcohol.

Systolic blood pressure

Measures the pressure in the arteries as the heart pumps blood during each beat. It is the higher number of the blood pressure reading.

Type of conditions

All reported long-term medical conditions were coded to a classification developed by the ABS for use in the 2001 National Health Survey, which is based on the tenth revision of the International Classification of Diseases and Health Related Problems (ICD-10). Further information can be found in the Australian Health Survey: Users' Guide, 2011-13 (cat. no. 4363.0.55.001) scheduled for release in November 2012.

Type of milk

Main type of milk usually consumed, including cow's milk, soy milk, evaporated and condensed milk, and other unspecified types of milk.

Unemployed

Persons aged 15 years and over who were not employed and actively looking for work in the four weeks prior to the survey, and were available to start work in the week prior to the survey.

Usual daily intake of fruit

Refers to the number of serves of fruit (excluding drinks and beverages) usually consumed each day, as reported by the respondent. A serve is approximately 150 grams of fresh fruit or 50 grams of dried fruit. The National Health and Medical Research Council (NHMRC) has recommended a minimum of two serves of fruit per day for adults and three serves of fruit for children aged 12-17 years and one serve for children aged 5-11 years.

Usual daily intake of vegetables

Refers to the number of serves of vegetables (excluding drinks and beverages) usually consumed each day, as reported by the respondent. A serve is approximately half a cup of cooked vegetables or one cup of salad vegetables - equivalent to approximately 75 grams. The National Health and Medical Research Council (NHMRC) has recommended a minimum of five serves of vegetables per day for adults and four serves of vegetables for children aged 12-17 years, three serves for 8-11 years and two serves for children aged 5-7 years.

Vigorous exercise

Exercise for fitness, recreation or sport which caused a large increase in heart rate or breathing.

Waist circumference

Waist circumference is associated with an increased risk of metabolic complications associated with obesity. The World Health Organisation (WHO) and National Health and Medical Research Council (NHMRC) approved the following guidelines for Caucasian men and women:

WAIST MEASUREMENT GUIDELINES, Adults

	Men	Women
Not at risk	Waist circumference less than 94 cm	Waist circumference less than 80 cm
Increased risk	Waist circumference more than or equal to 94 cm	Waist circumference more than or equal to 80 cm
Greatly increased risk	Waist circumference more than or equal to 102 cm	Waist circumference more than or equal to 88 cm

ABBREVIATIONS

The following symbols and abbreviations are used in this publication:

. .	not applicable
AATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
ABS	Australian Bureau of Statistics
AHS	Australian Health Survey
ASGC	Australian Standard Geographical Classification
BMI	Body Mass Index
cm	Centimetre
COPD	Chronic Obstructive Pulmonary Disease
HSL	high sugar level in blood and/or urine
ICD	International Classification of Diseases
K10	Kessler Psychological Distress Scale
kg	kilogram
mL	millilitre
mmHg	millimetre of mercury
na	not available
NATSIHMS	National Aboriginal and Torres Strait Islander Health Measures Survey
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NATSINPAS	National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey
nec	not elsewhere classified
NHMRC	National Health and Medical Research Council
NHMS	National Health Measures Survey
NHS	National Health Survey
NNPAS	National Nutrition and Physical Activity Survey
np	not available for publication but included in totals where applicable, unless otherwise indicated
RSE	relative standard error
SE	standard error
SEIFA	Socio-Economic Indexes for Areas
WHO	World Health Organization

TECHNICAL NOTE

RELIABILITY OF THE ESTIMATES

1 Two types of error are possible in an estimate based on a sample survey: sampling error and non-sampling error. The sampling error is a measure of the variability that occurs by chance because a sample, rather than the entire population, is surveyed. Since the estimates in this publication are based on information obtained from occupants of a sample of dwellings they are subject to sampling variability; that is they may differ from the figures that would have been produced if all dwellings had been included in the survey. One measure of the likely difference is given by the standard error (SE). There are about two chances in three that a sample estimate will differ by less than one SE from the figure that would have been obtained if all dwellings had been included, and about 19 chances in 20 that the difference will be less than two SEs.

2 Another measure of the likely difference is the relative standard error (RSE), which is obtained by expressing the SE as a percentage of the estimate. The RSE is a useful measure in that it provides an immediate indication of the percentage errors likely to have occurred due to sampling, and thus avoids the need to refer also to the size of the estimate.

$$RSE\% = \left(\frac{SE}{estimate}\right) \times 100$$

3 RSEs for the published estimates and proportions are supplied in the Excel data tables, available via the Downloads page.

4 The smaller the estimate the higher is the RSE. Very small estimates are subject to such high SEs (relative to the size of the estimate) as to detract seriously from their value for most reasonable uses. In the tables in this publication, only estimates with RSEs less than 25% are considered sufficiently reliable for most purposes. However, estimates with larger RSEs, between 25% and less than 50% have been included and are preceded by an asterisk (eg *3.4) to indicate they are subject to high SEs and should be used with caution. Estimates with RSEs of 50% or more are preceded with a double asterisk (eg **0.6). Such estimates are considered unreliable for most purposes.

5 The imprecision due to sampling variability, which is measured by the SE, should not be confused with inaccuracies that may occur because of imperfections in reporting by interviewers and respondents and errors made in coding and processing of data. Inaccuracies of this kind are referred to as the non-sampling error, and they may occur in any enumeration, whether it be in a full count or only a sample. In practice, the potential for non-sampling error adds to the uncertainty of the estimates caused by sampling variability. However, it is not possible to quantify the non-sampling error.

STANDARD ERRORS OF PROPORTIONS AND PERCENTAGES

6 Proportions and percentages formed from the ratio of two estimates are also subject to sampling errors. The size of the error depends on the accuracy of both the numerator and the denominator. For proportions where the denominator is an estimate of the number of persons in a group and the numerator is the number of persons in a sub-group of the denominator group, the formula to approximate the RSE is given below. The formula is only valid when x is a subset of y.

$$RSE\left(\frac{X}{Y}\right) = \sqrt{RSE(X)^2 - RSE(Y)^2}$$

COMPARISON OF ESTIMATES

7 Published estimates may also be used to calculate the difference between two survey estimates. Such an estimate is subject to sampling error. The sampling error of the difference between two estimates depends on their SEs and the relationship (correlation) between them. An approximate SE of the difference between two estimates (x-y) may be calculated by the following formula:

$$SE(x - y) = \sqrt{[SE(x)]^2 + [SE(y)]^2}$$

8 While the above formula will be exact only for differences between separate and uncorrelated (unrelated) characteristics of sub-populations, it is expected that it will provide a reasonable approximation for all differences likely to be of interest in this publication.

SIGNIFICANCE TESTING

9 For comparing estimates between surveys or between populations within a survey it is useful to determine whether apparent differences are 'real' differences between the corresponding population characteristics or simply the product of differences between the survey samples. One way to examine this is to determine whether the difference between the estimates is statistically significant. This is done by calculating the standard error of the difference between two estimates (x and y) and using that to calculate the test statistic using the formula below:

$$\frac{|x - y|}{SE(x - y)}$$

10 If the value of the statistic is greater than 1.96 then we may say there is good evidence of a statistically significant difference at 95% confidence levels between the two populations with respect to that characteristic. Otherwise, it cannot be stated with confidence that there is a real difference between the populations.

	MEDIA RELEASE	
29 October 2012	Embargo: 11:30 am (Canberra Time)	167/2012

Health survey shows we drink and smoke less, but we've packed on the kilos

First results from the Australian Health Survey have some good and bad news; smoking rates continue to fall, as do rates of drinking at risky levels, but the number of people who are overweight and obese continues to rise.

First Assistant Statistician at the Australian Bureau of Statistics, Dr Paul Jelfs, said the 2011-12 Australian Health Survey was the largest checkup on the nation's health ever undertaken.

"Compared to four years ago the proportion of overweight adult Australians has increased by more than two percentage points, meaning that nearly two-thirds (63 per cent) of the population are now classified as overweight or obese," Dr Jelfs said.

"Men were more likely to be overweight or obese (70 per cent) than women (56 percent) while one-quarter (25 per cent) of our children are overweight or obese.

He added that while Australians are not winning the battle of the bulge, the good news is we are smoking and drinking less.

"Smoking rates are down across all age groups, particularly for people aged under 45," he said.

"Men are still more likely to smoke than women - the rate is about one in five men compared to one in seven women.

"Just over 16 percent of adult Australians smoke daily, a fall of nearly three percentage points over the last four years.

"On a state basis, there were more smokers in the Northern Territory (23.9 per cent) and Tasmania (21.8 per cent) and the fewest in the Australian Capital Territory (13.4 per cent).

"Australians are also drinking less, with a drop of 1.4 percentage points in the number of people drinking more than two standard drinks on average per day," Dr Jelfs said.

Results released today from the Australian Health Survey are the first in a series of results that will be released progressively over the next 18 months.

Further information is available in *Australian Health Survey: First Results, 2011-12* (cat. no. 4364.0.55.001).

Media note:

- When reporting ABS data you must attribute the Australian Bureau of Statistics (or the ABS) as the source.
- Overweight and obesity are classified according to Body Mass Index, calculated by dividing weight in kilograms by height in metres squared.

More than two standard drinks a day exceeds the 2009 National Health and Medical Research Council guidelines for reducing the risk of alcohol-related harm over a lifetime.