Social Determinants of Women's Health and Wellbeing in the Australian Capital Territory

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Executive Summary

This report presents a range of data previously not made publically available from the Australian Bureau of Statistics *National Health Survey 2004-05*. The focus of the report is on women's health in the Australian Capital Territory (ACT), particularly women who are socioeconomically disadvantaged. Women's Centre for Health Matters Inc. commissioned this research with the specific purpose of responding to the knowledge deficit on the health and wellbeing of ACT women, in order to support government and community to make evidenced based policy and service provision decisions. The report is informed by the social determinants of health research, which identifies that social and economic inequalities negatively impact on the health and wellbeing of individuals and their communities.

Subpopulations of ACT women focused on in the report include women who are socioeconomically disadvantaged, women from culturally and linguistically diverse backgrounds, and women with mental health and wellbeing issues. Socioeconomic status is a measure that takes account of the major causes of health inequalities, including income, educational level and literacy, occupation or employment status, social status within the community. Women from culturally and linguistically diverse backgrounds and women with mental health and wellbeing issues are identified as specific subpopulations at increased risk of socioeconomic disadvantage and health inequalities, as a result of decreased access to resources and opportunities, and social isolation.

Women's health and wellbeing are measured using a variety of statistical tools in three broad categories, including: health indicators; risk behaviours; and health related actions. Health indicators describe various aspects of the population's health, and include self assessed health status, long term health conditions, and levels of psychological distress. Examination of ACT women's health according to self assessed health status shows that the distribution of poor health followed a social gradient, with more than five times as many women with low incomes reporting fair or poor health as women with high incomes. High or very high levels of psychological distress also significantly increased the frequency of women's fair or poor health. The highest rates of fair or poor health were reported by women who mainly speak a language other than English at home. Increased prevalence of long term health conditions and mental health and wellbeing issues also shared a relationship with low socioeconomic status.

Health risk factors like tobacco smoking, alcohol consumption, diet and exercise are affected by social, economic, and environmental determinants. Tobacco smoking, for example, has twice the prevalence amongst women with low household incomes compared with women with high household incomes. Women with poor social and emotional wellbeing reported the highest rates of tobacco consumption with more than a quarter of women in the subpopulation affected. Women from culturally and linguistically diverse backgrounds reported a below average frequency of tobacco consumption. Both levels of physical activity and dietary intake were negatively affected by both socioeconomic determinants and mental health issues. Conversely, socioeconomic disadvantage, culturally and linguistically diverse backgrounds, and poor mental health correlated with a below average frequency of risky or high risk alcohol consumption.

Actions taken by respondents to care for their health are also an important element of understanding the health of a population and health care systems. Women with mental health issues reported a higher frequency of consultations with health care professionals in all categories than the average for ACT women. Divergently, women with low

household incomes were more likely to rely on a GP for health care, where women in all other household income quintiles relied more equally on both doctors and other health care professionals. Similarly, women who mainly speak a language other than English at home primarily relied on their GP for health care. Women born overseas who mainly spoke English at home were more likely to access a variety of health care professionals.

1 Introduction

Globally, women have a greater life expectancy than men. However for many women, social and economic factors result in poorer health outcomes and a lower quality of life. The World Health Organisation cites unequal access to health information and health care, roles women perform within their communities, rates of violence, and discrimination on the basis of sex as factors that contribute negatively to women's health and wellbeing.[1] Despite Australia's relative affluence and strong health outcomes, many women living in Australia experience socioeconomic disadvantage, and poor health and wellbeing. According to the social determinants of health model, individual and community health and wellbeing are sensitive to social and economic factors.[2] That is, illness and disease are not exclusively the result of biomedical, behavioural and environmental factors, but have a correlative relationship with socioeconomic and political conditions.

Currently, there is inadequate knowledge on the health and wellbeing of ACT women, particularly women who are disadvantaged in the broader community. This knowledge deficit has implications for policy and program development in government and non-government sectors. As such, the aim of this report is to collate, analyse, and disseminate quantitative data previously not made publically available on ACT women's health and wellbeing, to support government and community to make evidenced based policy and service provision decisions that will specifically target and support women's needs. This report is a companion to *Marginalised and Isolated Women in the Australian Capital Territory: Risk Prevalence, and Service Provision* (2008), which presents a range of data aimed at providing estimates of the number of ACT women who are at risk of, or are experiencing marginalisation and isolation.

The primary data source for this report is unpublished data from the Australian Bureau of Statistics *National Health Survey 2004-05*. This source delivers robust data on ACT women's health and wellbeing. However, it does not collect information on a variety of demographic and health and wellbeing factors, including: disability; homelessness; drug dependencies (other than alcohol); experiences of violence; and Aboriginal and Torres Strait Islander backgrounds. While there are other surveys that collect data on health and wellbeing for some of these groups, for example the *National Aboriginal and Torres Strait Islander Health Survey*, the data collected is not consistent with the *National Health Survey*.

As such, despite the limitations of the *National Health Survey* data, to ensure that the information presented in this report is consistent, the focus is on the subsets of women within the ACT population included in the *National Health Survey*. The demographic and health and wellbeing factors reported on include:

- socioeconomic disadvantage;
- mental health and wellbeing; and
- culturally and linguistically diverse backgrounds.

As a result of the focus of this report, the health and wellbeing of many subsets of ACT women is not provided. However, the data presented on the total population of ACT women, and the specific populations of women listed above serves to provide a baseline

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[1] World Health Organisation, "10 Facts About Women's Health", (6 March 2008).
[2] Michael Marmot, "Introduction," in *Social Determinants of Health*, ed. Michael Marmot and Richard G. Wilkinson (Oxford and New York: Oxford University Press, 2006), 1.

for future research, and emphasises ACT women as a heterogeneous group with heterogeneous health and wellbeing needs. More comprehensive data needs to be collected and disseminated on health and wellbeing by demographic, and health and wellbeing factors on a national and state/territory level to ensure all women are supported.

Section one outlines the methodological framework of the report, providing both an overview of the social determinants of health model, and the analytical tools, categories, and measures used to quantify women's health and wellbeing.

Section two examines the socioeconomic status and health and wellbeing of the total population of ACT women. This section situates ACT women's health and wellbeing in relation to the health and wellbeing of ACT men, and women and men nationally. It also provides a basis to establish the relative inequalities of ACT women who are socioeconomically disadvantaged, have mental health and wellbeing issues, and are from culturally and linguistically diverse backgrounds. This section is of great importance with view to the significance of the socioeconomic factors of both the individual and their community in determining health and wellbeing.

Section three examines health and wellbeing of the total population of ACT women by household income, and Index of Relative Socioeconomic Disadvantage. This section compares the health and wellbeing of women with low household incomes and women who are socioeconomically disadvantaged with the health and wellbeing of the total ACT women population. It illustrates the strong relationship between poor health and socioeconomic disadvantage. It also highlights that health risk behaviours and health related actions are influenced by socioeconomic factors.

Section four examines the health and wellbeing of ACT women with high or very high levels of psychological distress, and women who reported diagnosed mental and behavioural health conditions. This section compares the health and wellbeing of women with poor social and emotional wellbeing and mental and behavioural health conditions with the health and wellbeing of the total ACT women population. It illustrates a strong relationship between poor social and emotional wellbeing, poor physical health, and socioeconomic disadvantage. It highlights that tobacco smoking, diet and nutrition, and physical activity levels are affected negatively by mental health. It also shows that women with mental health issues have higher consultation rates with all health care professionals than the territory average for women.

Section five examines the health and wellbeing of ACT women born overseas, and women who mainly speak a language other than English in their home. This section shows that ACT women from culturally and linguistically diverse backgrounds reported poor health outcomes across all health indicators, with women who speak a language other than English in their home reporting the poorest health. Women from culturally and linguistically diverse backgrounds reported lower rates of tobacco smoking and risky or high risk alcohol consumption, but marginally higher rates of inadequate physical activity. Diet was also affected by background, with women from culturally and linguistically diverse backgrounds reporting a lower frequency of inadequate fruit consumption, but a higher rate of inadequate vegetable consumption than the average. In line with trends for socioeconomically disadvantaged women, women from culturally and linguistically diverse backgrounds tended to rely on their GP for health care.

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2 Methodology

The social determinants of health research theoretically underpin both this report and the work of the Women's Centre for Health Matters Inc. In order to assess ACT women's health according to the social determinants of health, this report presents a range of largely unpublished data from the Australian Bureau of Statistics. As such, the quantitative tools used to measure ACT women's health and wellbeing are those employed in the *National Health Survey, 2004-05*. Both the social determinants of health and *National Health Survey* measurement tools are outlined below.

2.1 Social determinants of health

Social inequalities negatively impact on the health and wellbeing of individuals and their communities. According to the social determinants of health, key factors that impact negatively on health and wellbeing include: housing; income and its distribution; food security; education and literacy; unemployment and employment security; early life development; Indigenous status; social safety nets; social exclusion; and access to quality health care services.[3] As recognised by the World Health Organisation, health is more than an absence of disease or infirmity; it is "a complete state of physical, mental and social wellbeing".[4] As such, in order to understand and achieve health, social and environmental determinants must be addressed in tandem with biological and medical factors. By extension, the social determinants of health argue that while certain biomedical factors have been identified as increasing risk of illness and mortality, the causes of these biomedical factors are socially determined; that is, there are "causes of the causes" that follow a social gradient.[5]

2.1.1 Socioeconomic determinants and the social gradient of disease

Socioeconomic status refers to the factors that affect the position of an individual or group within society. There are many factors that can contribute to inequalities in socioeconomic status, such as income, educational level and literacy, occupation or employment status, and social status within the community. According to the Australian Institute of Health and Welfare, socioeconomically disadvantaged people are "more likely to have shorter lives, higher levels of disease risk factors and lower use of preventive health services".[6] High socioeconomic status is linked to ready access to resources and opportunities, high levels of social inclusion and decision making capacity, whereas low socioeconomic status is the contrary.

One example of how socioeconomic determinants relate to health outcomes is illustrated in socioeconomic distribution of access to quality, affordable and safe housing and its impacts on health. As a primary determinant of health, standards of housing significantly impact individual and community health. Poor quality housing is associated with an increase of infectious disease rates, poor mental health, and the development of chronic respiratory problems and allergies due to dust mites, mould, asbestos, insufficient

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[3] Michael Marmot and Richard G. Wilkinson, eds., *Social Determinants of Health* (Oxford and New York: Oxford University Press, 2006).
[4] World Health Organisation, "Constitution of the World Health Organisation", (2006).
[5] Marmot, "Introduction," 3.
[6] Australian Institute of Health and Welfare, *Australia's Health 2008*, AIHW Cat. No. AUS 99 (Canberra: Australian Institute of Health and Welfare, 2008), xiii.

heating, damp, overcrowding, high noise levels, and lack of privacy.[7] The populations that are most vulnerable to poor accommodation standards are those with a low socioeconomic status as they have a reduced access to the resources and opportunities that would facilitate access to quality housing.

Socioeconomic determinants form a social gradient, with people of higher socioeconomic status generally enjoying better health and longer lives than people with a lower socioeconomic status.[8] The social gradient is not limited to communities in absolute poverty, but extends throughout the social hierarchy. This finding indicates that health and wellbeing are experienced relative to the surrounding community or society and, as such, a higher standard of living on average does not result in consistently higher health outcomes.[9] Within Australia the social gradient of disease is most clearly demonstrated between Indigenous and non-Indigenous communities. For example, while non-Indigenous Australian women have one of the lowest maternal mortality rates in the world, Indigenous Australian women have one of the highest, with five times the rate of deaths during or shortly after pregnancy than women nationally.[10] This discrepancy is indicative of the relatively poor socioeconomic position of Aboriginal and Torres Strait Islander women within the Australian community.

The social gradient of disease is of particular importance when considering populations like the ACT. While on average, the ACT experiences socioeconomic advantage, with the highest average income, lowest unemployment rate, and highest secondary education rate of all Australian states and territories, there is also a significant population within the community that does not share this standard of living. With such encouraging statistics on the social and economic position of the ACT population at large, it would be easy to overlook the ACT residents who are relatively disadvantaged. However, the social determinants of health research illustrates that the comparatively high standard of living experienced by the majority of the ACT population results in greater health inequalities for those experiencing socioeconomic disadvantage.

2.1.2 Gender and health

The relationship between gender and health is complex, but is fundamentally based in women's social and economic position within the community. Just as the distribution of labour, resources, and opportunities within society follows gendered lines, health too is gendered because it is shaped by the conditions of women's experiences. Gender-based discrimination is a major cause of health inequalities, and is expressed through the division of labour and resources, experiences of violence, and levels of social inclusion.[11]

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[7] Mary Shaw, Danny Dorling, and George Davey Smith, "Poverty, Social Exclusion, and Minorities," in *Social Determinants of Health*, ed. Michael Marmot and Richard G. Wilkinson (Oxford and New York: Social Determinants of Health, 2006), 201.
[8] Eric Brunner and Michael Marmot, "Social Organisation, Stress, and Health," in *Social Determinants of Health*, ed. Michael Marmot and Richard G. Wilkinson (Oxford and New York: Oxford University Press, 2006), 6.
[9] Ibid.
[10] Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, ABS Cat. No. 4704.0, AIHW Cat. No. IHW 21 (Canberra: Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008), 82.
[11] Nancy Kreiger, "Discrimination and Health," in *Social Epidemiology*, ed. Lisa F. Berkman and Ichiro Kawachi (New York: Oxford University Press, 2000).

One of the ways in which health inequalities are gendered is in women's increased frequency of long term health conditions. Possibly the most publically quoted statistic on gender and health is on the longer life expectancy of women within Australian society, with women's life expectancy at birth 83.5 years, and men's life expectancy 78.7 years (a gender variation of 4.8 years).[12] However, women's longer life expectancy is offset by higher rates of long term health conditions and disabilities.[13] In 2004-05, 78.4% (7,753,700) of women nationally and 75.0% (7,338,900) of men reported at least one chronic health condition, a gender variation of 3.4%. Further, women reported a greater frequency of chronic health conditions in each category of illness. This health inequality on the basis of gender is attributed to the role that women play within society, and illustrates the extension of the social gradient of disease to gender.

Violence against women is a clear example of gender-based discrimination and is a major source of women's decreased health and wellbeing. In the course of their lives, 40% (3,100,000) of Australian women over 15 years experience one or more incidences of domestic violence or sexual assault.[14] Women's experience of violence can have significant long term health and wellbeing impacts, including physical injuries, long term psychological and physiological health conditions, reduction in life expectancy, and changes to employment status and community involvement.[15] Collectively, these experiences result in differential health outcomes on the basis of gender.

2.1.3 Culturally and linguistically diverse backgrounds and health

People from culturally and linguistically diverse backgrounds within Australian society are at risk of poorer heath than people born in Australia who speak English as a first language. This is not as a result of biological dispositions towards poorer health, but of the social and economic conditions in which they live. Key factors that negatively influence health outcomes of many migrants, refugees, and 'minority' ethnic groups are both their socioeconomic position within society, and experiences of discrimination and social isolation.[16] Occupation and employment conditions are a key source of reduced health and wellbeing, as is the social isolation inherent in the migrant and refugee experience.

Occupation and conditions of employment are an area in which people from culturally and linguistically diverse backgrounds are at increased risk of poor health outcomes. Occupation and employment environment are a significant source of exposure to a host of physical and psychosocial factors that can impact negatively on health and wellbeing. Manual and low-skilled jobs are associated with an increased risk of poor health, disability and mortality when compared with the health impacts of managerial or professional occupations.[17] This inequality is attributed to different levels of risk from exposure to physical hazards, and to the psychosocial effects of employment. For example, workplaces high in psychosocial stressors, including a lack of autonomy at

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[12] In 2004-2006, the ACT reported the highest life expectancies at birth nationally for both women (83.9 years) and men (80.0 years). See Australian Bureau of Statistics, *Deaths, Australia*, ABS Cat. No. 3302.0 (Canberra: Australian Bureau of Statistics, 2007), 8.

[13] Kreiger, "Discrimination and Health," 37.

[14] Australian Bureau of Statistics, *Australian Social Trends*, ABS Cat. No. 4102.0 (Canberra: Australian Bureau of Statistics, 2007), 195.

[15] Ibid., 200.

[16] Shaw, Dorling, and Smith, "Poverty, Social Exclusion, and Minorities," 198.

[17] Australian Institute of Health and Welfare, *Australia's Health 2008*, 127.

work or social support, increase a worker's risk of cardiovascular diseases.[18] There is evidence to suggest that discrimination on the basis of ethnicity and fluency in the English language affects particularly newly arrived unskilled migrant and refugee employment opportunities and, as such, workers may be forced to participate in informal or 'blue collar' sectors that increase their risk of health hazards at work.[19] Further, an Australian study of work-related accidents also found that migrant workers had an increased susceptibility to occupation related fatalities as a result of their duration of residency in Australia and language barriers.[20]

Mental health and wellbeing also form a significant area of health inequality for people from culturally and linguistically diverse backgrounds. Mental health and wellbeing issues can both arise from conditions inherent in the migrant and refugee experience, and from social isolation within their new community. Experiences of war or conflict, and the disruption of moving to a new country in which an individual has limited or no social support networks can be a significant source of psychological distress.[21] Similarly, social isolation is a factor that increases risk of reduced health outcomes. Research into the experiences of maternal depression for culturally and linguistically diverse women in Melbourne indicates that there is significant prevalence of maternal depression for women who are under 25 years of age, have short residency in Australia, speak little or no English, have migrated for marriage, have no relatives in the area or no friends to confide in, have physical health problems, and/or baby feeding problems.[22] The major identified cause of women's maternal depression was social isolation.

2.1.4 Mental health and wellbeing

Social exclusion and reduced access to resources and opportunities impact negatively on individual and community mental health and wellbeing in line with the impact of socioeconomic factors on physical health. Poor mental health follows a social gradient in so far as socioeconomic factors, such as income, occupation and employment status, environmental stressors, and level of social inclusion have a significant impact on mental health and access to support services.

Social and psychological circumstances and environmental stressors can have serious negative impacts on long term physical health and wellbeing. Studies on social organisation, stress, and health show a correlation between the circumstances under which people live and work, their position within the social hierarchy, their level of social inclusion, and their health outcomes. Brunner and Marmot argue that "chronic anxiety, insecurity, low self-esteem, social isolation, and lack of control over work appear to undermine mental and physical health".[23] In addition to the psychosocial and emotional impacts of poor mental health, there are also significant physical health costs, including

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[18] Jeffrey Johnson et al., "Long-Term Psychosocial Work Environment Exposure and Cardiovascular Mortality among Swedish Men," *American Journal of Public Health* 86, no. 3 (1996). Also see Dorothy H. Broom et al., "The Lesser Evil: Bad Jobs or Unemployment? A Survey of Mid-Aged Australians," *Social Science and Medicine* 63 (2006).

[19] Kevin White, *The Sage Dictionary of Health and Society* (London, Thousand Oaks and New Delhi: Sage Publications, 2006), 74.

[20] C.F. Corvalan, T.R. Driscoll, and J.E. Harrison, "Role of Migrant Factors in Work-Related Fatalities in Australia," *Scandinavian Journal of Work, Environment and Health* 20, no. 5 (1994).

[21] Australian Institute of Health and Welfare, *Australia's Health 2008*, 92.

[22] Rhonda Small, Judith Lumley, and Jane Yelland, "Cross-Cultural Experiences of Maternal Depression: Associations and Contributing Factors for Vietnamese, Turkish and Filipino Immigrant Women in Victoria, Australia," *Ethnicity and Health* 8, no. 3 (2003).

[23] Brunner and Marmot, "Social Organisation, Stress, and Health," 28.

increased susceptibility to infection, diabetes, high blood pressure, heart attack and stroke.[24]

2.1.5 Health related actions

In addition to the socioeconomic factors that have been identified as impacting negatively on health and wellbeing, health related actions such as tobacco smoking and poor diet correlate with reduced health outcomes. Health related actions share a relationship with socioeconomic status, with the socioeconomically disadvantaged most at risk.

Tobacco smoking follows a socioeconomic gradient, with a greater prevalence of people with lower socioeconomic status smoking than higher status people. The importance of understanding 'unhealthy' behaviours as linked to socioeconomic factors is well illustrated in an assessment of the high prevalence of tobacco smoking amongst mothers with low incomes. Low income mothers isolated with young children were found to report above average rates of tobacco smoking. Smoking prevalence was attributed to the strains of caring responsibilities and material disadvantages, as "cigarettes may provide the only moment when the struggle for financial survival can be suspended and they can join a world of personal consumption that most adults take for granted".[25] Shaw expands on this link between low autonomy, caring, and low income, and suggests that women compromise their own health in order to feel "better equipped to cope with the care of their children and families".[26] Increased rates of tobacco smoking are also linked to unemployment and poor mental health.[27]

Similarly, diet is a principal determinant of health and wellbeing and, as such, availability and access to quality affordable food have the potential to significantly reduce the burden of ill health, especially amongst the relatively poor.[28] The socioeconomically disadvantaged are at a significantly increased risk of poor nutrition as a result of insecure or low incomes, which may increase the likelihood of insecure food supplies, and food supplies that are lacking in essential nutrients.[29] Nutrition is a major determinant of cardiovascular disease, type II diabetes, oral diseases, and cancers. Further, poor diet reduces resistance to infection, and increases the frequency of congenial abnormalities. As Robertson et al. illustrate, lower socioeconomic groups are inclined to have a lower intake of fruit and vegetables and a higher intake of meats, fats, salts, and sugars than higher socioeconomic groups, dietary patterns that are risk factors in the diseases listed above. Significantly, women in lower socioeconomic groups are at the greatest risk of poor nutrition and its related health and wellbeing outcomes.[30]

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[24] Ibid.

[25] See Shaw, Dorling, and Smith, "Poverty, Social Exclusion, and Minorities," 201.

[26] Ibid.

[27] Martin Jarvis and Jane Wardle, "Social Patterning of Individual Health Behaviours: The Case of Cigarette Smoking," in *Social Determinants of Health*, ed. Michael Marmot and Richard G. Wilkinson (Oxford and New York: Oxford University Press, 2006), 225.

[28] Aileen Robertson, Eric Brunner, and Aubrey Sheiham, "Food Is a Political Issue," in *Social Determinants of Health*, ed. Michael Marmot and Richard G. Wilkinson (Oxford and New York: Oxford University Press, 2006), 172.

[29] Ibid., 177.

[30] Ibid., 179.

2.2 Measures of socioeconomic status

Women's socioeconomic status is measured using two statistical tools: household income; and Index of Relative Socioeconomic Disadvantage. In addition, this report uses data on gender and cultural and linguistic background to assess the impacts of socioeconomic determinants on ACT women's health.

Data on the measures described in section 2.2 is taken from the *National Health Survey 2004-05: Users' Guide*.[31] For further information, please refer to this publication.

2.2.1 Household Income

Income is obtained for respondents who are 15 years and over, and relates to primary or recurring cash income only. Sources of income include employee cash income, unincorporated business cash income, government cash pensions and allowances, including allowances for students and the unemployed, Centrelink pensions for the aged and persons with a disability, other government cash pensions and allowances, and other cash income, including property cash income, superannuation/annuities, transfers from private organisations, and transfers from other households.

Household income is derived from the income details reported for each person aged 15 years and over in the household, and takes into account household types and compositions and their requirements in the application of equivalence scales. Household income is expressed relatively using quintiles, in which Australian household incomes are distributed evenly over five brackets, with the lowest in the first income quintile and the highest in the fifth income quintile.

This measure is affected by the respondent's knowledge of the incomes of each household member, and assumes that resources are distributed evenly within a household.

2.2.2 Index of Relative Socioeconomic Disadvantage

The Index of Relative Socioeconomic Disadvantage is one of the Socioeconomic Indexes for Areas indicators, and focuses on low income earners, relatively lower educational attainment and high unemployment. This measure assesses socioeconomic disadvantage on a population basis, and refers to the area in which a respondent lives, not their individual socioeconomic status. An area's socioeconomic status is represented in quintiles, with the proportion of population who are classified as socioeconomically disadvantaged in the lower quintiles and the advantaged in the higher quintiles.

2.2.3 Gender

Gender refers to male or female as reported by the respondent.

2.2.4 Country of birth and main language spoken at home

This measure collects data on a respondent's country of birth and main language spoken at home, and is an indicator of cultural and linguistic diversity. Information on country of birth is categorised into respondents born in Australia, those born in other main English speaking countries (including New Zealand, England, Scotland, Wales, Northern Ireland, Channel Islands, Isle of Man, Ireland, Canada, United States of

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[31] Australian Bureau of Statistics, *National Health Survey, 2004-05: Users' Guide*, ABS Cat. No. 4363.0.55.001 (Canberra: Australian Bureau of Statistics, 2006), 125-54.

America and South Africa), and all other countries. Respondents born overseas is a measure of cultural diversity.

The main language spoken at home was obtained for respondents over 18 years, and is used to measure linguistic diversity.

2.3 Measures of health and wellbeing

Women's health and wellbeing are measured for the purposes of this report using a variety of statistical tools in three broad categories, including: health indicators; risk behaviours; and health related actions. These measures are designed to gather information on a broad range of health and wellbeing issues, both in terms of the burden of illness experienced by the population, and the social determinants of health.

Health indicators aim to describe various aspects of the population's health, and include: self assessed health status; long term health conditions; and levels of psychological distress. In line with the social determinants of health, a range of social, economic, and environmental factors are recognised as affecting health and wellbeing. As such, information is collected on lifestyle issues and related indicators that impact on health and wellbeing. The health risk factors that are used in this report include: tobacco smoking; alcohol consumption; diet and nutrition; and physical activity. Actions taken by respondents to care for their health are also an important element of understanding the health of a population and health care systems. Health related actions covered in this report include consultations with health care professionals.

Data on the measures described in section 2.3 is taken from the *National Health Survey 2004-05: Users' Guide*.[32] For further information, please refer to this publication.

2.3.1 Self assessed health status

Self assessed health status refers to an individual's general assessment of their own health using a five-point scale from poor to excellent. This is a subjective measure that may be influenced by a number of factors not directly related to health. These factors may include a person's assessment of their health on the grounds of momentary or short term feelings rather than usual circumstances, variation in ideas about what constitutes health, or the conditions of the interview itself like the presence of a family member. While not without its faults, this measure can also be powerful. Where measures of health that are considered to be objective focus strongly on the presence or absence of illness, this measure allows for a more holistic assessment of a person's experience of health and wellbeing.

2.3.2 Long term health conditions

Long term health conditions are defined as an illness, injury or disability that was present at the time of interview and had either been present for six months prior to interview, or was expected to last for at least six months. Conditions reported have not necessarily been diagnosed by a health professional, but it is reasonable to assume that in most cases conditions that have lasted for at least six months have been diagnosed. The accuracy of this measure may be affected by differences in the terminology respondents used to express their health conditions. Data on mental and behavioural health has the propensity to be less accurate than that for other long term health conditions. This

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[32] Ibid., 30-124.

variation is accounted for by an increased likelihood that the respondent will give subjective information. Terminology used to describe the condition is more likely to be non-medical and, due to mental health often being understood as more personal or sensitive, there are issues around whether conditions are reported at all.

For assessment purposes, long term health conditions are separated into categories of illness. Categories incorporated into this report include: circulatory system diseases; respiratory system diseases; endocrine, nutritional and metabolic diseases; musculoskeletal system and connective tissue diseases; eye and adnexa diseases; and mental and behavioural problems. Examples of long term health conditions may include asthma, cancer, anxiety, allergies, high blood pressure, epilepsy, migraine, rheumatic heart disease, anaemia, emphysema, diabetes, depression, osteoporosis, arthritis, and eyesight difficulties. A respondent may report more than one long term health condition.

2.3.3 Levels of psychological distress

Levels of psychological distress is a measure based on the Kessler Psychological Distress Scale, and assesses non-specific psychological distress in the anxiety-depression spectrum based on ten questions about negative emotional states in the four weeks prior to interview. The measure is intended as an indicator of social and emotional wellbeing, and includes questions on levels of nervousness, feelings of hope or hopelessness, restlessness, and depression. For each question there is a five-point scale based on the amount of time that a respondent experienced the particular problem. Each of the items is scored from one for none to five for all of the time. A score between 10 and 15 indicates little or no psychological distress, where a score between 30 and 50 indicates high levels of psychological distress. Based on research from other population studies, a high or very high level of psychological distress may indicate a need for professional help, but does not necessarily indicate mental illness.

2.3.4 Tobacco smoking

Tobacco smoking includes use of manufactured (packet) cigarettes, roll-your-own cigarettes, cigars and pipes, but excludes chewing tobacco and smoking of non-tobacco products by respondents 18 years and over. This measure records whether a respondent is a current smoker (daily or other), whether they are an ex-smoker, or if they have never smoked regularly. It is expected that tobacco smoking may be under-reported as a result of its decreasing social acceptability. For the purposes of this report, current smokers will refer to both smokers who consume tobacco daily and smokers who consume tobacco on a less than daily basis.

2.3.5 Alcohol consumption

This measure refers to consumption of alcoholic drinks by respondents 18 years and over, with a focus on both intake and frequency. Data on intake of alcohol is derived from information about the types and quantities of alcoholic drinks consumed on the three most recent days in the week prior to interview on which alcohol was consumed. Amounts are defined in terms of 'standard drinks', where an Australian Standard Drink contains 10 grams (equivalent to 12.5 milliliters) of alcohol. The intake of alcohol in the week prior to interview refers to the quantity of alcohol contained in the drinks consumed, not the quantity of the drinks themselves. In addition to the quantity of alcohol consumed, information on frequency of consumption is used to assess whether a respondent has consumed 'at risk' amounts of alcohol in the previous 12 months. A respondent is only considered 'at risk' if they have consumed alcohol in the seven days

prior to interview. The health risk of respondent's consumption is categorised as 'low', 'risk' or 'high risk'. For women, two or less Australian Standard Drinks per day was classified as low risk, between two and four drinks was classified as risky, and greater than four was considered high risk. It is expected that both quantity and frequency of alcohol consumption may be under-reported.

2.3.6 Diet and nutrition

This measure covers selected dietary indicators that relate to usual intake of fruit and vegetables. According to national dietary guidelines, it is recommended that a person consumes a minimum of two serves of fruit and five serves of vegetables per day. If a respondent reports consumption less than these recommendations, they are considered to have inadequate fruit or vegetable consumption. There are some difficulties in accurately measuring diet and nutrition in this manner, as it is dependent on the respondent understanding what constitutes fruit and vegetables (legumes, for example, are excluded), how large a serve is, and their ability to accurately conceptualise and report on total consumption levels in an average day.

2.3.7 Physical activity

Rates of physical activity are measured according to exercise undertaken for recreation, sport or fitness purposes during the two weeks prior to interview, and walking for transport on the day prior to interview. This measure excludes physical activity undertaken for other reasons, like in the workplace or at home. As such, the data aims to represent the physical activity undertaken for health purposes, not overall levels of activity or fitness. Levels of physical activity are categorised based on frequency, duration and intensity of the exercise on a continuum from sedentary to high. Sedentary refers to very little or no physical activity, low indicates some but insufficient physical activity, moderate indicates regular but not vigorous physical activity, and high indicates regular and vigorous exercise.

2.3.8 Access to health care professionals

The access to health care professionals' measure is used to assess respondents' health related actions. The measure records the consultation frequency and types of health care professionals accessed two weeks prior to interview, excluding professionals accessed through hospitals and clinics. For the purposes of the National Health Survey, health care professionals are grouped into three categories: doctors, dental health professionals, and other health care professionals. Doctors include general practitioners, and specialists such as surgeons, pathologists, gynaecologists, radiologists, and psychiatrists. Dental health care professionals include dental surgeons, orthodontists, dental nurses, dental technicians, and dental mechanics. Other health care professionals include Aboriginal health workers, accredited counsellors, acupuncturists, alcohol and other drug workers, audiologists, audiometrists, chiropractors, chemists (for advice only), chiropodists, podiatrists, dieticians, nutritionists, herbalists, hypnotherapists, naturopaths, nurses, opticians, optometrists, osteopaths, occupational therapists, physiotherapists, hydrotherapists, psychologists, social workers, welfare officers, and speech therapists and speech pathologists.

As people access some health care professionals less frequently than others, this affects the reliability of the data. For example, dental health care is often less frequent than general health care and, as such, the data gathered on dental health care may not be representative of the usage of dental services.

3 ACT Women

This section gives an overview of total ACT women according to socioeconomic status, health indicators, health risk behaviours and health related actions. Its aim is to situate ACT women in relation to women nationally, ACT men, and men nationally. It is also used as a baseline against which subpopulations of ACT women are compared.

3.1 Socioeconomic status

Access to economic resources has a significant impact on the health and wellbeing of an individual and their community, as it strongly influences many of the goods and services consumed in people's lives. Measurement of ACT women's economic resources according to household income indicates that more ACT women experience economic advantage than the national average (Figure 1).[33] In 2004-05, 30.8% (39,900) of ACT women were in the highest household income quintile, with a further 46.5% (60,200) of women in the second, third and fourth income quintiles. Despite an above average proportion of ACT women experiencing relatively high household incomes, 11.1% (14,300) of women reported household incomes in the lowest income quintile, indicating relative household economic disadvantage.[34]

Figure 1: Household income by quintile (over 15 years), ACT women, 2004-2005
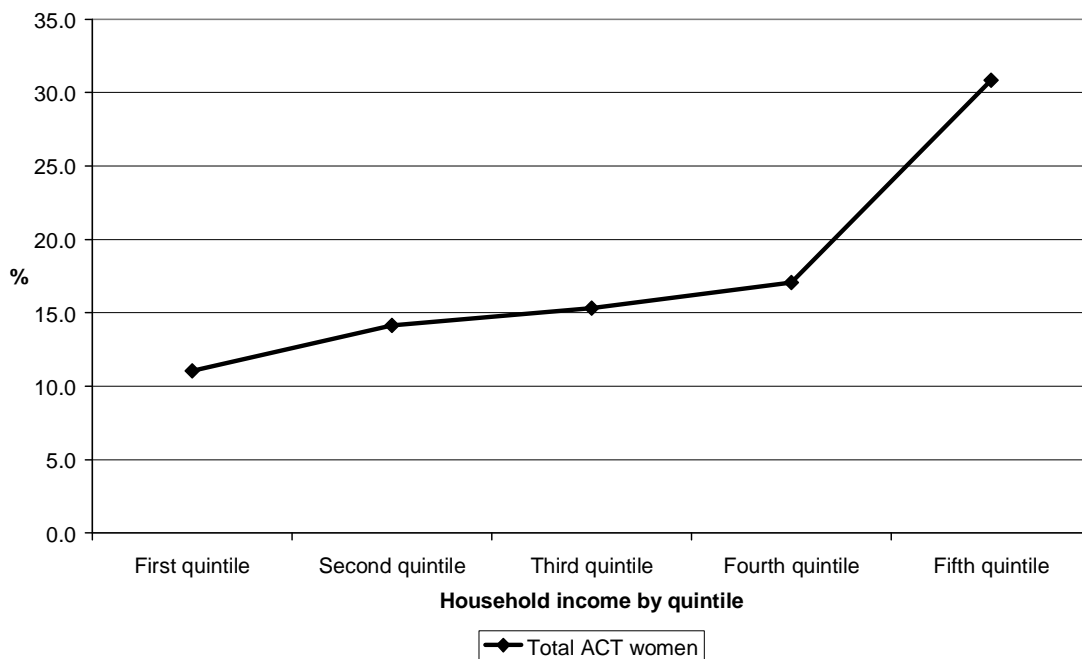
Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

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[33] This measure equally distributes household incomes across five brackets, with the lowest in the first quintile and the highest in the fifth quintile. The national average shows 20% of households in each household income quintile. As illustrated in Figure 1, ACT women reported household incomes that are unevenly distributed across the quintiles, with a bias towards incomes in the higher quintiles. This distribution indicates relative economic advantage. See section 2.2.1 for further information.

[34] Percentages listed do not total 100%, as the household income question is optional. Percentages are a proportion of total ACT women over 15 years, not a proportion of women who answered the question.

While access to economic resources has a significant impact on the health and wellbeing of an individual and their community, it does not give a full picture of the relative socioeconomic advantage or disadvantage of a community. The Index of Relative Socioeconomic Disadvantage assesses the capacity of individuals and communities within an area to access economic and social resources, by considering education and employment status in addition to income. Measurement of ACT women's access to socioeconomic resources according to the Index of Relative Socioeconomic Disadvantage indicates that ACT women are relatively socioeconomically advantaged (Figure 2). For 2004-05, 54.3% (70,200) of ACT women were considered in the fifth Index of Relative Socioeconomic Disadvantage quintile, with 92.9% (120,200) of ACT women in the top three quintiles. The concentration of women in the upper quintiles indicates relative social and economic advantage on a population basis. However, 7.2% (9,300) of ACT women were placed in the first and second quintiles, indicating a high level of disadvantage for a number of women within the ACT population.

Figure 2: Index of Relative Socioeconomic Disadvantage by quintile (over 15 years), ACT women, 2004-2005

Data Source: Australian Bureau of Statistics, National Health Survey 2004-05 (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

3.2 Health indicators

3.2.1 Self assessed health status

The majority of ACT women consider themselves to be in very good or excellent health, in line with women nationally (Table 1). In 2004-05, 58.5% (75,700) of ACT women reported their health to be very good or excellent. A further 28.0% (36,200) of ACT women reported their health to be good, while 13.6% (17,600) reported their health as fair or poor.

While ACT women were marginally more positive about their health than women nationally, contrary to national trends for self assessed health status by gender, ACT men reported higher rates of excellent and very good health than ACT women.

Table 1: Self assessed health status by gender (over 15 years), ACT and Australia, 2004-2005

Self assessed health status	ACT (%)		Australia (%)	
	Women	Men	Women	Men
Excellent	19.8	26.4	21.6	20.4
Very Good	38.7	33.0	36.5	34.3
Good	28.0	27.4	26.9	28.8
Fair/Poor	13.6	13.3	15.1	16.5
Total	**100.0**	**100.0**	**100.0**	**100.0**

Data source: Australian Bureau of Statistics, *National Health Survey 2004-05, Australian Capital Territory State Tables,* (Canberra: Australian Bureau of Statistics, 2006), table 3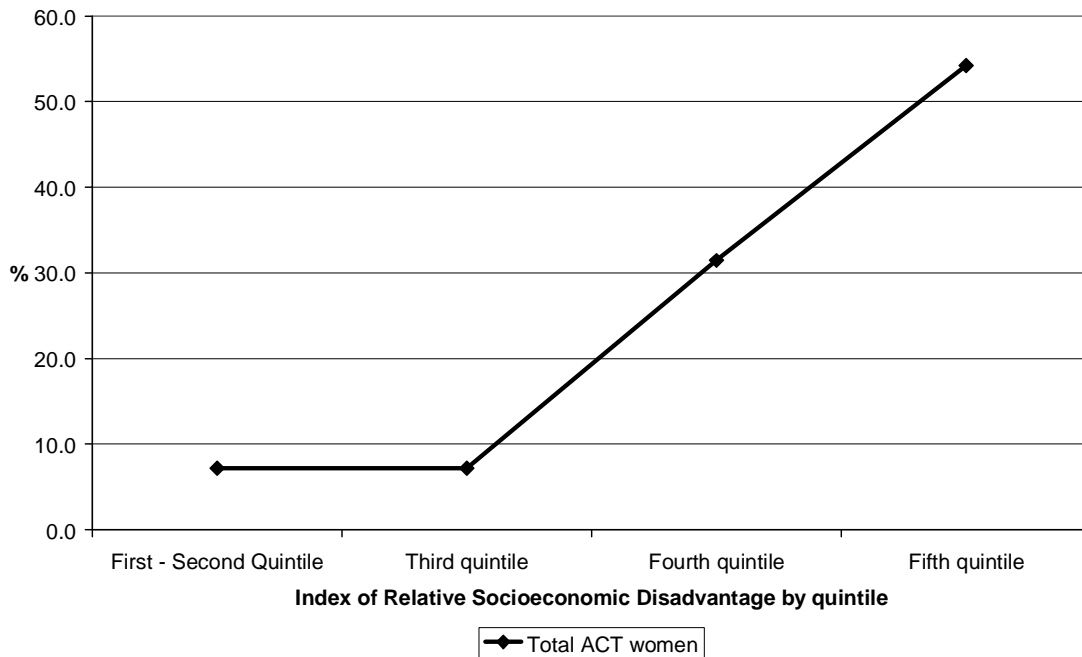; Australian Bureau of Statistics, *National Health Survey 2004-05,* (Canberra: Australian Bureau of Statistics, 2006), 18.

3.2.2 Long term health conditions

Long term health conditions affect most women in the ACT, in line with national trends for both men and women (Table 2). While on a territory and national level, both men and women are significantly more likely to experience a long term health condition than not, there are subtle differences in the proportion of each group affected.

In 2004-05, 81.4% (130,300) of ACT women reported at least one long term health condition with many women reporting more than one condition. In the same year, 77.2% (120,800) of ACT men reported at least one long term health condition, 4.2% less than ACT women. Nationally, 78.4% (7,753,700) of women and 75.0% (7,338,900) of men reported at least one long term health condition, a gender variation of 3.4%. While both ACT men and ACT women reported higher rates of long term health conditions than men and women nationally, the greatest variation in frequency of long term health conditions was between ACT women and men.

The types of long term health conditions that had the highest frequency amongst ACT women included: disease of the eye and adnexa; respiratory system diseases; musculoskeletal system and connective tissue diseases; and circulatory system diseases (Table 2). ACT women most frequently reported long term health conditions that affected eyesight, with 58.6% (93,800) of women reporting a disease of the eye and adnexa. Respiratory system diseases had the second highest frequency amongst ACT women, with 34.8% (55,600) of women reporting a health condition in this category. Long term health conditions of the musculoskeletal system and connective tissue affected 30.9% (49,400) of women, and 22.2% (35,500) of women reported circulatory system diseases.

ACT women reported higher rates of all long term health conditions by category than ACT men. Where long term health conditions of the eye and adnexa affected 58.6% (93,800) of ACT women, 50.9% (79,600) of ACT men reported conditions in the same category. Similarly, where long term health conditions of the circulatory system affected 22.2% (35,500) of ACT women, 15.4% (24,100) of ACT men reported conditions in the same category. Rates of musculoskeletal system and connective tissue diseases,

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endocrine, nutritional and metabolic diseases, mental and behavioural problems, and respiratory system diseases were between three and five percent higher for ACT women than ACT men.

Compared with women nationally, ACT women reported higher rates of long term health conditions in every category, with the exception of musculoskeletal system and connective tissue diseases.

Table 2: Selected long term health conditions by gender, ACT and Australia, 2004-2005

Long term health conditions	ACT (%)		Australia (%)	
	Women	Men	Women	Men
Circulatory system diseases	22.2	15.4	19.9	16.0
Respiratory system diseases	34.8	31.4	31.3	26.9
Endocrine, nutritional and metabolic diseases	14.2	9.6	12.7	10.8
Musculoskeletal system and connective tissue diseases	30.9	25.7	32.6	29.3
Eye and adnexa diseases	58.6	50.9	56.0	47.7
Mental and behavioural problems	15.4	12.1	11.4	10.0
Total with long term health condition(s)	84.1	77.2	78.4	75.0
Total without a long term health condition	15.9	22.8	21.6	25.0
Total population ('000)	**160.0**	**156.5**	**9893.1**	**9788.4**

Data source: Australian Bureau of Statistics, *National Health Survey 2004-05, Australian Capital Territory State Tables* (Canberra: Australian Bureau of Statistics, 2006), table 4; Australian Bureau of Statistics, *National Health Survey 2004-05,* (Canberra: Australian Bureau of Statistics, 2006), 20-23.

3.2.3 Levels of psychological distress

The majority of ACT women reported low levels of psychological distress, indicating that most women experience positive social and emotional wellbeing. However, ACT women reported a below average frequency of low levels of psychological distress when compared with ACT men and both men and women nationally (Table 3).

ACT women reported a lower frequency of very high levels of psychological distress than women nationally. While this is encouraging, ACT women reported double the frequency of very high levels of psychological distress reported by ACT men (Table 3). Specifically, where 75% of ACT residents with very high levels of psychological distress were women, the gendered distribution of poor social and emotional wellbeing was more even nationally, with women comprising 59% of the population who reported very high levels of psychological distress.[35]

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[35] Australian Bureau of Statistics, *National Health Survey, 2004-05: Summary of Results, Australia*, ABS Cat. No. 4364.0 (Canberra: Australian Bureau of Statistics, 2006), 8.

Table 3: Levels of psychological distress by gender (over 18 years), ACT and Australia, 2004-2005

Level of psychological distress	ACT (%)		Australia (%)	
	Women	Men	Women	Men
Low (10-15)	56.2	65.8	59.1	66.6
Moderate (16-21)	29.2	24.9	25.7	22.4
High (22-29)	11.0	8.1	10.8	7.5
Very High (30-50)	3.7	1.3	4.3	3.3
Total population ('000)	**122.8**	**118.3**	**7603.7**	**7359.4**

Data source: Australian Bureau of Statistics, *National Health Survey 2004-05, Australian Capital Territory State Tables*, (Canberra: Australian Bureau of Statistics, 2006), table 14; Australian Bureau of Statistics, *National Health Survey 2004-05*, (Canberra: Australian Bureau of Statistics, 2006), 35.

3.3 Health related actions

3.3.1 Alcohol and tobacco consumption

ACT women reported higher rates of risky or high risk alcohol consumption than women nationally. For 2004-05, 12.6% (19,000) of ACT women reported a pattern of alcohol consumption considered risky or high risk, where 11.7% (889,600) of women nationally reported similar alcohol consumption patterns. Similarly, ACT men reported higher rates of risky or high risk alcohol consumption than men nationally (Table 4).

Table 4: Tobacco and alcohol consumption by gender (over 18 years), ACT and Australia, 2004-2005

Tobacco and alcohol consumption	ACT (%)		Australia (%)	
	Women	Men	Women	Men
Current tobacco smoker	14.7	20.5	20.0	26.3
Ex-tobacco smoker	29.0	36.7	25.4	35.0
Never smoked tobacco	56.3	42.7	54.6	38.6
Low risk alcohol consumption	47.6	59.3	42.7	55.4
Risky alcohol consumption	9.1	8.9	8.5	7.4
High risk alcohol consumption	3.5	7.2	3.2	8
Consumed alcohol 1 week to 12 months ago	24.6	16.1	23.9	17.8
Consumed alcohol over 12 months or more	15.1	8.5	20.2	10.6
Total population ('000)	**122.8**	**118.3**	**7603.7**	**7359.4**

Data source: Australian Bureau of Statistics, *National Health Survey 2004-05, Australian Capital Territory State Tables*, (Canberra: Australian Bureau of Statistics, 2006), table 17; Australian Bureau of Statistics, *National Health Survey 2004-05*, (Canberra: Australian Bureau of Statistics, 2006), 38-39.

Conversely, ACT women reported lower rates of tobacco consumption than women nationally, and men on a territory and national basis. For 2004-05, 14.7% (18,100) of ACT women reported being current tobacco smokers, where 20.0% (1,520,700) of women nationally reported tobacco consumption. Similarly, ACT men reported lower rates of tobacco consumption than men nationally (Table 4).

3.3.2 Physical activity

The majority of Australians reported sedentary or low exercise levels. Women more frequently reported their exercise levels as sedentary or low; however, ACT women reported higher rates of physical activity than women nationally (Table 5). For 2004-05, 69.9% (85,800) of ACT women reported sedentary or low exercise levels, with only 30.1% (37,000) of women reporting exercise levels categorised as moderate or high, indicating very high rates of inadequate physical activity.

Table 5: Physical activity level by gender (over 18 years), ACT and Australia, 2004-2005

	ACT (%)		Australia (%)	
Physical activity level	**Women**	**Men**	**Women**	**Men**
Sedentary	24.5	20.0	34.6	33.4
Low	45.4	37.0	39.1	33.4
Moderate	25.0	20.4	22	24.9
High	5.1	4.2	4.2	8.3
Total population ('000)	**122.8**	**118.3**	**7603.7**	**7359.4**

Data source: Australian Bureau of Statistics, *National Health Survey 2004-05, Australian Capital Territory State Tables*, (Canberra: Australian Bureau of Statistics, 2006), table 17; Australian Bureau of Statistics, *National Health Survey 2004-05*, (Canberra: Australian Bureau of Statistics, 2006), 38-39.

3.3.3 Dietary indicators

Inadequate intake of fruit and vegetables is a significant health concern for Australians, with on average four in ten people reporting inadequate intake of fruit, and nine in ten people reporting inadequate intake of vegetables (Table 6). For 2004-05, 39.6% (48,600) of ACT women reported an inadequate intake of fruit, with most ACT women and the total Australian population consuming one serve. Similarly, 89.3% (109,600) of ACT women reported an inadequate intake of vegetables, with most ACT women and the total Australian population consuming three serves.

Table 6: Selected dietary indicators by gender (over 18 years), ACT and Australia, 2004-2005

	ACT (%)		Australia (%)	
Selected dietary indicators	**Women**	**Men**	**Women**	**Men**
Inadequate vegetable intake	89.3	89.7	83.7	87.6
Inadequate fruit intake	39.6	53.6	39.9	52.4
Total population ('000)	**122.8**	**118.3**	**7603.7**	**7359.4**

Data source: Australian Bureau of Statistics, *National Health Survey 2004-05, Australian Capital Territory State Tables*, (Canberra: Australian Bureau of Statistics, 2006), table 17; Australian Bureau of Statistics, *National Health Survey 2004-05*, (Canberra: Australian Bureau of Statistics, 2006), 38-40.

ACT women had comparable intake of fruit to women nationally; however, ACT women's intake of vegetables was 5.6% lower than the national average for women. Both in the ACT and nationally, women reported a lower frequency of inadequate intake of fruit than men. Contrary to the national trend, however, ACT men and women reported similar frequencies of inadequate intake of vegetables.

3.3.4 Consultations with health care professionals

ACT women reported higher frequency of consultations with GPs or specialist physicians than ACT men, but a lower consultation rate than the national average for women (Table 7). In 2004-05, 23.7% (37,900) of ACT women reported consultations with a GP or specialist physician. This was a higher consultation rate than reported by ACT men, 15.7% (24,500) of whom reported consulting a GP or specialist physician. While ACT women had higher rates of consultations with GPs and specialist doctors than ACT men, women reported lower consultation rates than the national average for women of 25.7% (2,542,500).

In line with access patterns for GPs and specialist physicians, ACT women reported marginally higher rates of consultations with dental health care professionals than ACT men (Table 7). For 2004-05, 6.4% (10,300) of ACT women reported access to a dental health care professional, where 5.9% (9,200) of ACT men reported accessing similar services. ACT women's access to dental health care professionals was equal to women's access to the same services nationally.

Access to other health care professionals was similar for ACT women as for women nationally, with 15.4% (24,600) of ACT women reporting consultations. In line with the health care service access trend, ACT men reported lower rates of consultations with other health care professionals, with 11.9% (18,900) of men reporting access to similar services (Table 7).

Table 7: Consultation with health care professionals by gender, ACT and Australia, 2004-2005

	ACT (%)		Australia (%)	
Type of health care professional	Women	Men	Women	Men
General Practitioner/specialist physician	23.7	15.7	25.7	19.9
Dental health care professional	6.4	5.9	6.4	5.4
Other health care professional	15.4	11.9	15.7	11.2
Total population ('000)	**160.0**	**156.5**	**9893.1**	**9788.4**

Data source: Australian Bureau of Statistics, *National Health Survey 2004-05, Australian Capital Territory State Tables*, (Canberra: Australian Bureau of Statistics, 2006), table 35; Australian Bureau of Statistics, *National Health Survey 2004-05*, (Canberra: Australian Bureau of Statistics, 2006), 59.

3.4 Summary of findings

On average, women and men in the ACT have higher household incomes and experience relative socioeconomic advantage when compared to the total Australian population. However, the higher household incomes, higher rates of employment, and higher educational attainment of ACT women do not appear to translate into considerably better health and wellbeing than for women nationally. ACT women reported a marginally higher frequency of very good or excellent self assessed health status than women nationally; however, ACT women reported a higher frequency of long term conditions than women nationally, despite a younger age distribution.

Encouragingly, ACT women reported higher rates of physical activity and lower rates of tobacco consumption than women nationally. However, ACT women reported higher rates of risky or high risk alcohol consumption than the national average for women.

While, ACT women reported a comparable intake of fruit, they reported lower intake of vegetables than women nationally.

As an indication of health related actions and access to health care, ACT women reported a lower frequency of consultations with GPs and specialist physicians than women nationally.

The reported frequency of very high levels of psychological distress in the ACT was telling in terms of the socioeconomic and gendered distribution of the population's health and wellbeing. While ACT women reported a lower frequency of very high levels of psychological distress than women nationally, three in four ACT residents with very high levels of psychological distress were women.

4 Women who are socioeconomically disadvantaged

Socioeconomic status is recognised as directly affecting the health and wellbeing of an individual and their community. The measures used in the assessment of ACT women's socioeconomic disadvantage are household income, and Index of Relative Socioeconomic Disadvantage. Household income measures women's income on a household basis, and is broken into five income brackets for assessment purposes. Index of Relative Socioeconomic Disadvantage measures women's social and economic advantage on a community basis, and takes account of income, educational attainment, and employment status (for further information see page 8). According to data availability, health indicators, health risk factors, and health related actions will be measured according to one or both of the measures.

4.1 Socioeconomic status

Assessment of ACT women's socioeconomic status by household income estimates that women's incomes are concentrated in the upper income quintiles, with 30.8% (39,900) women in the fifth household income quintile, and a further 46.5% (60,200) of women in the second through fourth quintiles. Despite the economic advantage experienced by the majority of ACT women, 11.1% (14,300) of ACT women are in the lowest income quintile, indicating relative economic disadvantage.[36]

Assessment of ACT women's socioeconomic status by Index of Relative Socioeconomic Disadvantage estimates that 54.3% (70,200) of ACT women are in the highest quintile, with 92.9% (120,200) of ACT women in the top three quintiles. This assessment indicates that more than nine in ten women in the ACT community experience relative social and economic advantage. However, despite the relative socioeconomic advantage of the vast majority of ACT, 7.2% (9,300) of ACT women were placed in the lowest and second quintiles, indicative of their relative disadvantage.

While it is encouraging that such a relatively small number of ACT women are estimated to be disadvantaged with the ACT population, the social determinants of health model demonstrates that a large gap between the wealthy and the poor within a community results in increased health inequalities. That is, because 92.9% (120,200) of ACT women have been assessed as being in the top three Index of Relative Socioeconomic Disadvantage quintiles, the 7.2% (9,300) of ACT women assessed as being in the first and second quintiles are at risk of much poorer health in the community than if there was a smaller difference between the advantaged and the disadvantaged.

4.2 Health indicators

4.2.1 Self assessed health status

ACT women's self assessed health status shows a strong relationship between low income and fair or poor health, with women in the fifth household income quintile reporting significantly lower rates of poor health than women with household incomes in the first quintile. For 2004-05, 63.9% (25,500) of ACT women in the highest income

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[36] As previously noted, percentages listed do not total 100%, as questions on household income are optional, and only 88.4% of ACT women gave a response to the question. Percentages are as a proportion of the total number of women in the ACT over 15 years, not a proportion of women who answered the question.

quintile reported their health status as either excellent or very good, where 42.7% (6,100) of women in the lowest income quintile reported their health as either excellent or very good. Similarly, where 5% (2,000) women in the highest income quintile reported their health as fair or poor, 27.3% (3,900) of women in the lowest income quintile reported their health as fair or poor (Figure 3). That is, proportionally six times as many women in the lowest household income quintile reported fair or poor health than women in the highest quintile.

Figure 3: Fair or poor self assessed health status by household income quintile, ACT women (over 15 years), 2004-2005
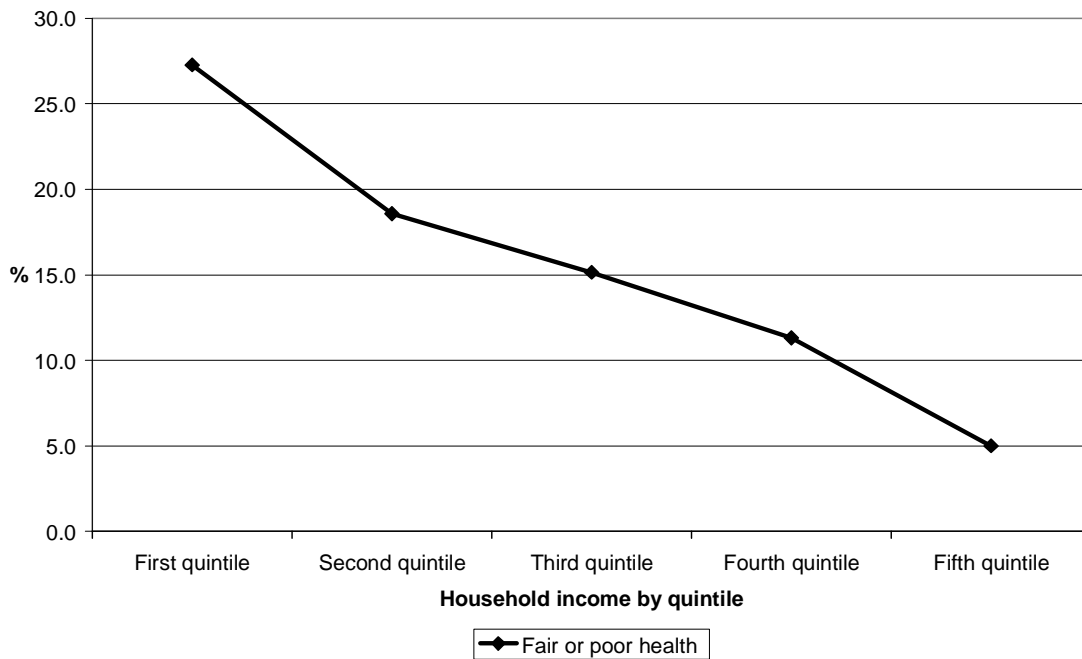
Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

Similarly, a strong relationship between socioeconomic disadvantage and fair or poor health is demonstrated by ACT women's reported self assessed health status by Index of Relative Socioeconomic Disadvantage. For 2004-05, 59.7% (71,800) of women in the upper three quintiles of the Index of Relative Socioeconomic Disadvantage reported their health to be very good or excellent. The percentage of women who reported their health to be very good or excellent in the first and second quintiles was significantly lower, with 41.9% (7,500) of women reporting this health status. Equally, where 13.2% (15,900) of women in the upper three quintiles reported their health to be fair or poor, 18.3% (1,700) in the lowest two quintiles reported this health status.

4.2.2 Long term health conditions

There is a strong relationship between the presence of selected long term health conditions and lower household income. In all categories of long term health conditions, with the exception of diseases of the respiratory system, ACT women in the lowest household income quintile were significantly more likely to report long term illness than ACT women in the higher household income quintiles.

Long term health conditions of the circulatory system, and musculoskeletal system and connective tissue were reported by a higher proportion of ACT women in the lowest income quintile than ACT women in any other income bracket (Table 8). Where 45.5% (6,500) of ACT women in the lowest income quintile reported long term health conditions of the circulatory system, on average 23.7% (23,400) of women in the second through fifth income quintiles reported conditions in the same category. Similarly, where 58% (8,300) ACT women in the lowest income quintile reported long term health conditions of the musculoskeletal system and connective tissue, on average 36.1% (34,700) of women in the second through fifth income quintiles reported conditions in the same category. Interestingly, where there was a very significant difference in the proportion of women who reported these long term health conditions between the first income quintile and all other income quintiles, there was minimal variation between the top four income quintiles.

There was a relationship between increased rates of long term endocrine, nutritional and metabolic health conditions and lower household income (Table 8). Where 32.9% (4,700) of women in the first household income quintile reported long term endocrine, nutritional and metabolic health conditions, women in the fifth household income quintile reported similar health conditions at a quarter the rate, with 8.3% (3,300) of women reporting long term endocrine, nutritional and metabolic health conditions.

Similarly, long term health conditions of the eye and adnexa affected 81.8% (11,700) ACT women in lowest income quintile compared with 65.4% (53,800) in the top three income quintiles, almost a fifth less than those women with low household incomes (Table 8). The frequency distribution of long term mental and behavioural health conditions shows a similar trend, with 22.4% (3,200) of women in the lowest income quintile reporting long term mental and behavioural health conditions, where 16.6% (13,900) of women in the top three income quintiles reported mental and behavioural problems (Table 8).

Table 8: Selected long term health conditions by household income quintile, ACT women (over 15 years), 2004-2005

Long term health conditions	Household income quintiles				
	First	Second	Third	Fourth	Fifth
Circulatory system diseases	45.5	26.8	25.3	19.9	22.8
Respiratory system diseases	26.6	37.7	35.4	45.2	39.8
Endocrine, nutritional and metabolic diseases	32.9	24.6	18.2	14.5	8.3
Musculoskeletal system and connective tissue diseases	58.0	42.6	34.3	38.5	29.1
Eye and adnexa diseases	81.8	75.4	69.2	59.3	67.7
Mental and behavioural problems	22.4	21.9	15.2	16.3	18.3
Total population ('000)	**14.3**	**18.3**	**19.8**	**22.1**	**39.9**

Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

Contrary to the overall frequency distribution of long term health conditions, ACT women in the first income quintile reported the lowest rates of long term health conditions of the respiratory system of all ACT women (Table 8). Where 26.6% (3,800) of women in the

first income quintile reported health conditions of the respiratory system, on average 39.5% (39,800) of women in the second through fifth income quintiles reported similar conditions.

4.2.3 Levels of psychological distress

High or very high levels of psychological distress had a complex relationship with socioeconomic disadvantage. Levels of psychological distress according to household income showed that women in the first quintile reported the highest frequency of high or very high levels of psychological distress, with 17.5% (2,500) of women affected. Equally, women in the fifth quintile reported the lowest frequency of high or very high levels of psychological distress, with 11.5% (4,600) of women affected. However, while these two quintiles show a relationship between low income and high or very high levels of psychological distress, the overall trend across the population does not necessarily reflect a direct relationship between income and social and emotional wellbeing (Figure 4).

Figure 4: High or very high level of psychological distress by household income quintile, ACT women (over 18 years), 2004-2005
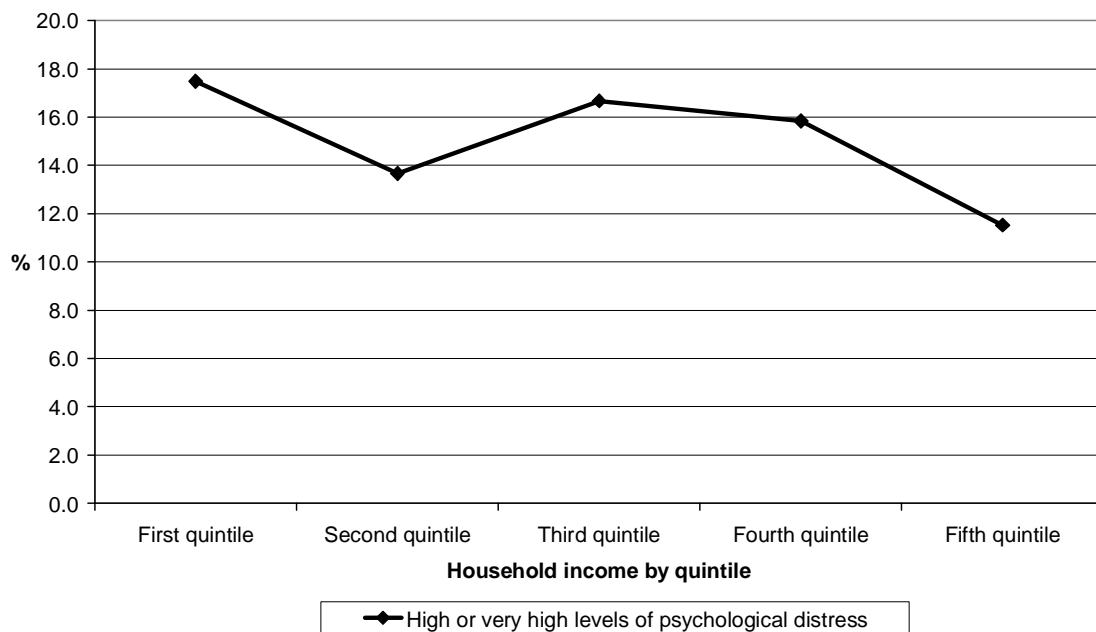
Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

Similarly, a complex relationship is shown between high or very high levels of psychological distress and Index of Relative Socioeconomic Disadvantage quintile. Where 21.5% (2,000) of women in the first quintile reported high or very high levels of psychological distress, 13.2% (9,300) of women in the fifth quintile reported high or very high levels of psychological distress. However, the lowest frequency of psychological distress was reported by women in the third quintile. As such, while the upper and lower quintiles show a relationship between socioeconomic disadvantage and high or very high levels of psychological distress, the overall data trend does not necessarily reflect this finding (Figure 5).

Figure 5: High or very high level of psychological distress by Index of Relative Socioeconomic Disadvantage quintile, ACT women (over 18 years), 2004-2005
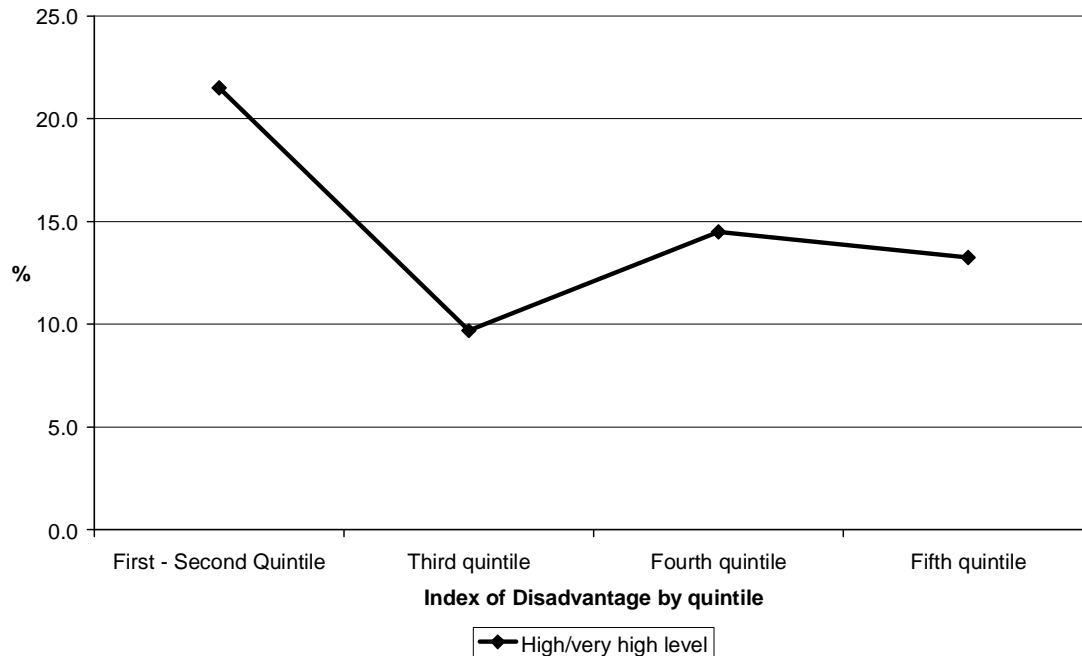
Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

4.3 Health related actions

4.3.1 Alcohol and tobacco consumption

Women with incomes in the first household income quintile reported almost half the rate of risky or high risk alcohol consumption than women in higher income quintiles. Where 7% (1,000) of women in the first income quintile report risky or high risk alcohol consumption levels, an average of 14.2% (13,300) of women in the second through fifth income quintiles reported similar consumption levels (Figure 6). The highest reported rate of risky or high risk alcohol consumption was in the third income quintile.

Rates of tobacco consumption by income quintile show that women with low to middle incomes report higher rates of tobacco smoking than women with higher incomes. Where 16.8% (2,400) of women in the first income quintile reported being current tobacco smokers, 8.5% (3,400) of women in the fifth income quintile reported being current smokers (Figure 6). Women in the third household income quintile, however, reported the highest rate of tobacco smoking.

Figure 6: Tobacco and alcohol consumption by household income quintile, ACT women (over 18 years), 2004-2005
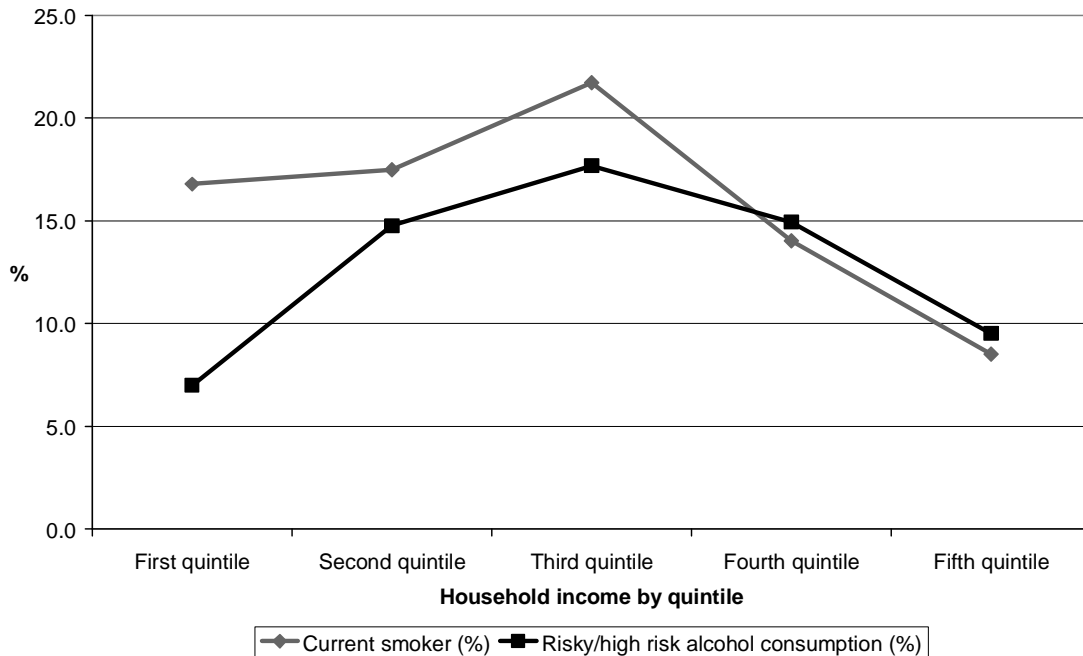
Alcohol consumption levels by Index of Relative Socioeconomic Disadvantage similarly demonstrated that women who reported risky or high risk drinking were more likely to be socioeconomically advantaged. Where 10.8% (1,000) of women in the first and second Index of Relative Socioeconomic Disadvantage quintiles reported alcohol consumption levels considered to be risky or high risk, 13.1% (9,200) of women in the fifth quintile reported similar alcohol consumption levels.

Tobacco consumption by Index of Relative Socioeconomic Disadvantage demonstrated that women who reported being current smokers were more likely to be socioeconomically disadvantaged. Where 19.4% (1,800) of women in the first and second quintiles reported being current smokers, an average of 14.0% (18,100) of total ACT women over 18 years reported tobacco consumption.

4.3.2 Physical activity

Physical activity by Index of Relative Socioeconomic Disadvantage demonstrated that women who reported low sedentary exercise levels were more likely to be socioeconomically disadvantaged. Where 73.1% (6,800) of women in the first and second quintiles reported low or sedentary exercise levels, 69.1% (82,000) in the third through fifth quintiles reported similarly low physical activity levels (Figure 7). Lack of physical activity is a key issue for all ACT women, and women who are socioeconomically disadvantaged are particularly at risk.

Figure 7: Sedentary or low physical activity by Index of Relative Socioeconomic Disadvantage, ACT women (over 15 years), 2004-2005
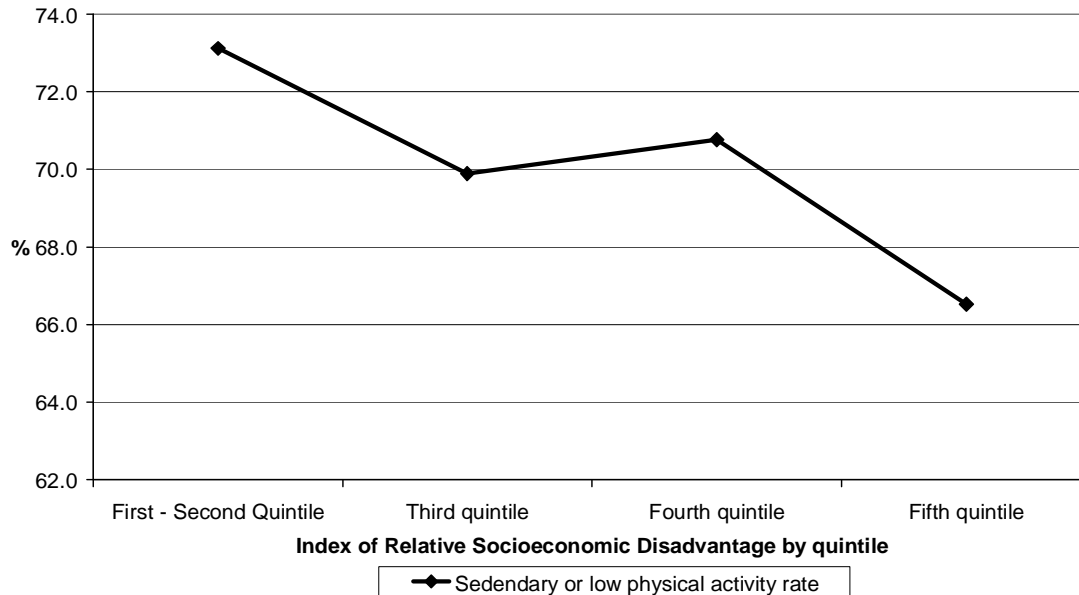
4.3.3 Dietary indicators

There was a relationship between rates of inadequate fruit consumption and socioeconomic disadvantage, with more than twice as many women in the lower Index of Relative Socioeconomic Disadvantage quintiles reporting inadequate fruit consumption than women in the fifth quintile. Where 58.1% (5,400) of women in the first and second quintiles reported inadequate intake of fruit, 25.2% (35,900) of women in the fifth quintile reported inadequate consumption.

Similarly, there was a relationship between rates of inadequate vegetable consumption and socioeconomic disadvantage. Where 95.7% (8,900) of women in the first and second Index of Relative Socioeconomic Disadvantage quintiles reported inadequate intake of vegetables, on average 88.3% (107,200) of women in the third, fourth, and fifth quintiles reported inadequate consumption.

4.3.4 Consultations with health care professionals

Women in the first household income quintile reported higher consultation rates with GPs and specialist physicians than women in higher quintiles (Figure 8). Where 37.1% (5,300) of women in the first household income quintile reported at least one consultation with a GP or specialist, 25.3% (10,100) of women in the fifth quintile reported consultations with health care professionals in the same category. Women in the third quintile reported the lowest consultation rates for GPs or specialists, with 21.7% (4,300) of women in this quintile reporting consultations.

Women in the lowest household income quintile, however, reported lower rates of access to other health care professionals, including allied health and dental health care professionals, than ACT women on average (Figure 8). Where 19.6% (2,800) of women

in the first household income quintile reported at least one consultation with a health care professional other than a GP or specialist, on average, 22.7% (21,900) of women in the second through fifth quintiles reported consultations with similar health care professionals. Women in the fourth quintile reported the highest frequency of consultations with health care professional other than a GP or specialist, with 30.8% (6,800) of women reporting at least one consultation. Women in the fifth quintile reported the lowest frequency of consultations with health care professional other than a GP or specialist, with 17.5% (7,000) of women reporting at least one consultation.

Figure 8: Consultations with health care professionals by household income quintile, ACT women (over 15 years), 2004-2005
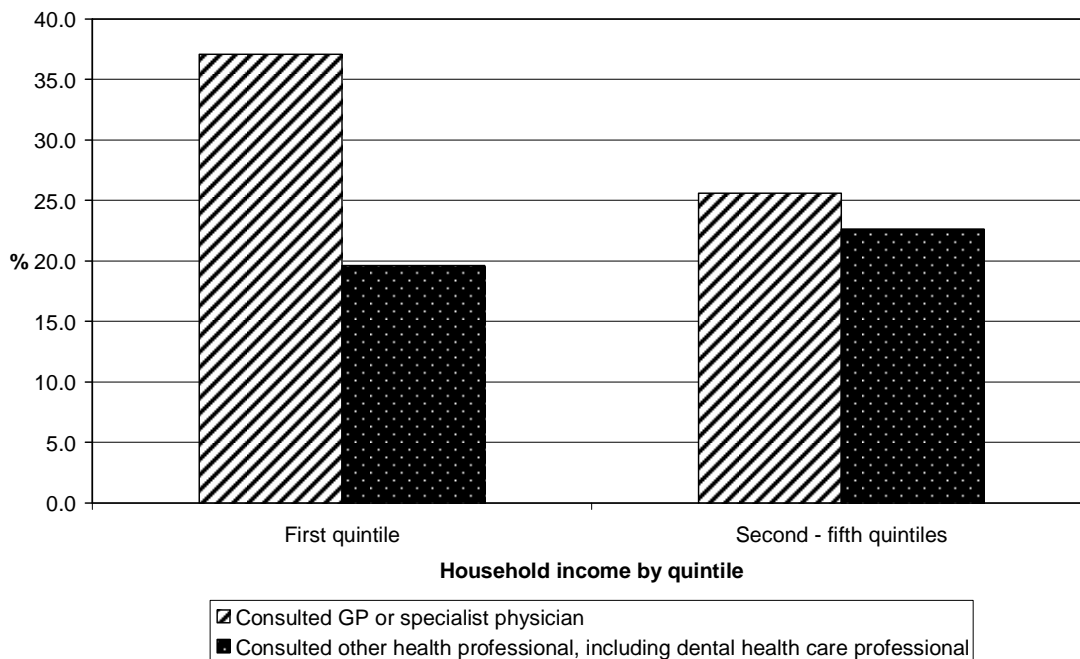
Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

Similarly, women in the first Index of Relative Socioeconomic Disadvantage quintile reported higher consultation rates with GPs and specialist physicians than women in higher household income quintiles (Figure 9). Where 35.5% (3,300) of women in the first Index of Relative Socioeconomic Disadvantage quintile reported at least one consultation with a GP or specialist, 20.5% (14,400) of women in the fifth quintile reported consultations with health care professionals in the same category.

Figure 9: Consultations with GP or specialist physician by Index of Relative Socioeconomic Disadvantage quintile, ACT women (over 15 years), 2004-2005
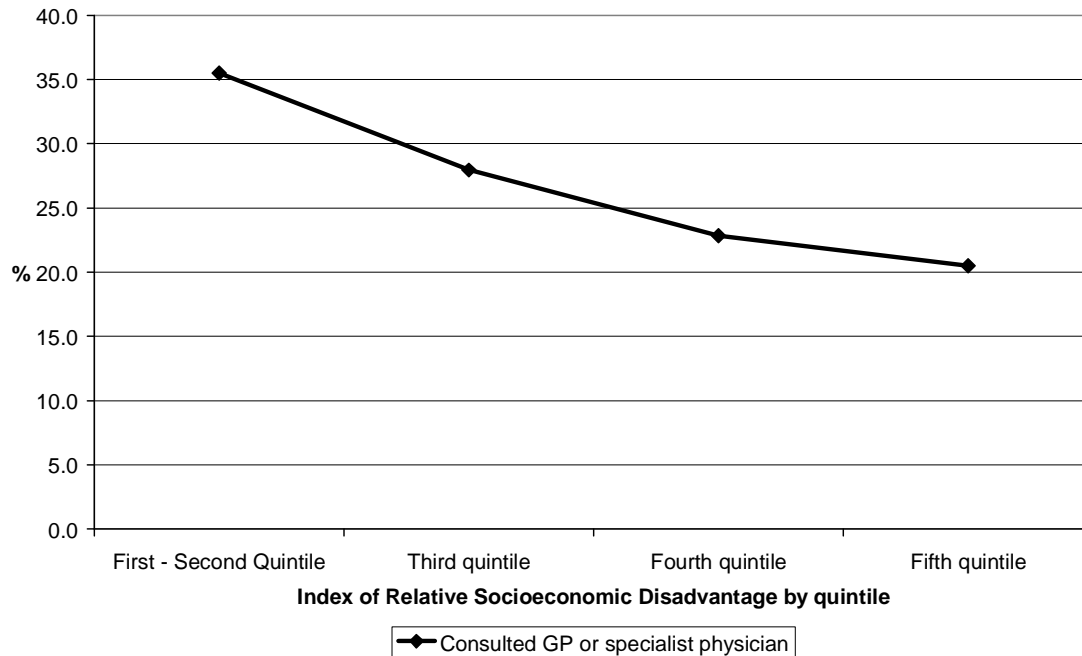
Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

4.4 Summary of findings

Health indicators including self assessed health status, long term health conditions, and levels of psychological distress all showed a relationship between poor health and wellbeing and low socioeconomic status. Women who reported household incomes in the lowest quintile reported six times the rate of fair or poor health reported by women in the highest quintile. Similarly, more than twice as many women in the lowest household income quintile reported long term health conditions of the circulatory system than women in all other quintiles. Women's experiences of poor social and emotional wellbeing were also significantly impacted by both household income and socioeconomic status, but a linear relationship was not demonstrated.

Alcohol consumption had the highest prevalence amongst ACT women from middle-income households. Women with lower socioeconomic status reported the highest rates of tobacco smoking. Both levels of physical activity and dietary intake were negatively affected by socioeconomic determinants.

Women's access patterns to health care professionals were impacted by socioeconomic determinants. Women with household incomes in the lowest quintile were significantly more likely to rely on their GP for health care, where women in all other household income quintiles relied more equally on both doctors and other health care professionals. This finding has implications for health care delivery to socioeconomically disadvantaged women.

5 Women with mental health and wellbeing issues

Women with mental health and wellbeing issues are at increased risk of socioeconomic disadvantage and poor physical health. The measures used in the assessment of women's mental health and wellbeing include the Kessler Psychological Distress Scale, and long term mental and behavioural health conditions. The Kessler Psychological Distress Scale measures women's social and emotional wellbeing based on questions about levels of nervousness, feelings of hope or hopelessness, restlessness, and depression in the four weeks prior to interview. Long term mental and behavioural health conditions measure rates of diagnosed mental and behavioural health conditions (for further information see pages 9-10). According to data availability, health indicators, health risk factors, and health related actions will be measured according to one or both of the measures.

Assessment of ACT women's mental health and wellbeing by level of psychological distress estimates that most women in the ACT experience low levels of psychological distress, an indication of positive social and emotional wellbeing. In 2004-05, 56.2% (69,000) of ACT women reported low levels of psychological distress, and a further 29.2% (35,800) of ACT women reported moderate levels of psychological distress. However, for the same period 11.0% (13,500) ACT women reported high levels of psychological distress, and 3.7% (4,500) of ACT women recorded very high levels of psychological distress. Research based on other populations indicates that while high or very high levels of psychological distress do not necessarily point to the presence of mental illness, this may signify the need for professional help.[37]

Assessment of ACT women's mental health and wellbeing by frequency of long term mental and behavioural health conditions estimates that 17.8% (23,000) of ACT women experience diagnosed mental or behavioural health conditions. Long term mental and behavioural health conditions include mood (affective) disorders, anxiety related conditions, alcohol and other drug dependencies, problems of psychological development, behavioural and emotional problems, organic mental problems, and symptoms involving cognition, perceptions, emotional state and behaviour.

5.1 Socioeconomic status

Women's decreased social and emotional wellbeing had a strong relationship with low household income (Table 9). Women who reported high or very high levels of psychological distress were over-represented in the lowest income quintile, with 13.9% (2,500) of women with reduced social and emotional wellbeing in the lowest income quintile, above the territory average for women of 11.1% (14,300). Equally, women who reported high or very high levels of psychological distress were under-represented in the highest income quintile, with 25.6% (4,600) of women with reduced social and emotional wellbeing in the highest income quintile, below the territory average for women of 30.8% (39,900).[38]

Divergently, while women who reported diagnosed mental and behavioural health conditions were over-represented in the lowest and second income quintiles compared with the territory average for women, they were also over-represented in the highest

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[37] Australian Bureau of Statistics, *National Health Survey, 2004-05: Summary of Results, Australia*, 8.

[38] Percentages listed do not total 100%, as questions on household income are optional. Percentages are as a proportion of the total number of women in the ACT over 15 years, not a proportion of women who answered the question.

income quintile (Table 9). Household income quintiles three and four had proportionally less women with diagnosed mental and behavioural health conditions.

Table 9: Household income quintile by high or very high level psychological distress and mental and behavioural health status, ACT women (over 18 years), 2004-2005

Income quintile	ACT women with high or very high levels of psychological distress (%)	ACT women with mental and behavioural issues (%)	Total ACT women (%)
First quintile	13.9	13.9	11.1
Second quintile	13.9	17.4	14.1
Third quintile	18.3	13.0	15.3
Fourth quintile	19.4	15.7	17.1
Fifth quintile	25.6	31.7	30.8
Total population ('000)	**18.0**	**23.0**	**129.4**

Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

5.2 Health indicators

5.2.1 Self assessed health status

Women who reported high or very high levels of psychological distress were more than twice as likely to report fair or poor health status as ACT women on average. Equally, women who reported high or very high levels of psychological distress were almost three times less likely to report excellent health status (Table 10). That is, where 7.2% (1,300) of women who reported high or very high levels of psychological distress reported excellent health, 19.8% (25,600) of total ACT women reported excellent health. Conversely, 29.4% (5,300) of women who reported high or very high levels of psychological distress reported fair or poor health, 13.6% (17,600) of total ACT women reported fair or poor health.

Similarly, women who reported diagnosed mental and behavioural health conditions were significantly more likely to report fair or poor health status as ACT women on average. Where 23.5% (5,400) of women who reported diagnosed mental and behavioural health conditions reported fair or poor health, 13.6% (17,600) of total ACT women reported fair or poor health. In line with this finding, women who reported diagnosed mental and behavioural health conditions were more than three times less likely to report excellent health status, with only 6.1% (1,400) of women reporting this health status (Table 10).

Table 10: Self assessed health status by high or very high level psychological distress and mental and behavioural health status, ACT women (over 18 years), 2004-2005

Self assessed health status	ACT women with high or very high levels of psychological distress (%)	ACT women with mental and behavioural issues (%)	Total ACT women (%)
Excellent	7.2	6.1	19.8
Very good	25.0	32.2	38.7
Good	38.3	38.3	28.0
Fair/poor	29.4	23.5	13.6
Total population ('000)	**18.0**	**23.0**	**129.4**

Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

5.2.2 Long term health conditions

There was a strong relationship between high or very high levels of psychological distress and increased frequency of long term health conditions. In all categories of long term health conditions ACT women who reported high or very high levels of psychological distress were significantly more likely to report long term illnesses than ACT women with low or moderate levels of psychological distress (Table 11).

The greatest variation in the frequency distribution of long term health conditions between total ACT women and the subpopulation of ACT women who reported high or very high levels of psychological distress was in endocrine, nutritional and metabolic diseases (Table 11). Where 25% (4,500) of women who reported high or very high levels of psychological distress reported endocrine, nutritional and metabolic diseases, 17.5% (22,700) of total ACT women reported chronic conditions in the same category.

Women who reported high or very high levels of psychological distress also reported an increased frequency of conditions of the circulatory system (Table 11). Where 36.7% (6,600) of ACT women who reported high or very high levels of psychological distress also reported long term health conditions of the circulatory system, 26.3% (34,000) of total ACT women reported conditions in the same category.

Similarly, there was an increased frequency of chronic conditions of the musculoskeletal system and connective tissue amongst women who reported high or very high levels of psychological distress (Table 11). Where 49.4% (8,900) of ACT women who reported high or very high levels of psychological distress also reported long term health conditions of the musculoskeletal system and connective tissue, 37.7% (48,800) of total ACT women reported conditions in the same category.

Table 11: Selected long term health conditions by psychological distress status, ACT women (over 18 years), 2004-2005

Long term health conditions	ACT women with high or very high levels of psychological distress (%)	Total ACT women (%)
Circulatory system diseases	36.7	26.3
Respiratory system diseases	43.3	37.9
Endocrine, nutritional and metabolic diseases	25.0	17.5
Musculoskeletal system and connective tissue diseases	49.4	37.7
Eye and adnexa diseases	72.2	69.7
Total women ('000)	**18.0**	**129.4**

Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

5.3 Health related actions

5.3.1 Alcohol and tobacco consumption

Women who reported high or very high levels of psychological distress reported lower rates of risky or high risk alcohol consumption than ACT women on average (Figure 10). Where 10.6% (1,800) of women who reported high or very high levels of psychological distress also reported alcohol consumption considered risky or high risk, 12.1% (15,600) of total ACT women reported similar consumption levels.

Conversely, women who reported diagnosed mental and behavioural health conditions reported an increased frequency of risky or high risk alcohol consumption when compared with the territory average for women (Figure 10). Where 14.3% (3,300) of women who reported diagnosed mental and behavioural health conditions reported risky or high risk alcohol consumption, 12.1% (15,600) of total ACT women reported similar consumption levels.

Women who reported high or very high levels of psychological distress reported double the rate of tobacco consumption than ACT women on average, indicating a strong relationship between poor social and emotional wellbeing and tobacco smoking (Figure 10). Where 27.2% (4,900) of women who reported high or very high levels of psychological distress reported being current smokers, 14.0% (18,100) of ACT women reported being current smokers. In line with this trend, women who reported diagnosed mental and behavioural health conditions also reported a higher than average frequency of tobacco smoking, with 20.0% (4,600) of this group reporting being current smokers (Figure 10).

Figure 10: Tobacco and alcohol consumption by high or very high level psychological distress and mental and behavioural health status, ACT women (over 18 years), 2004-2005
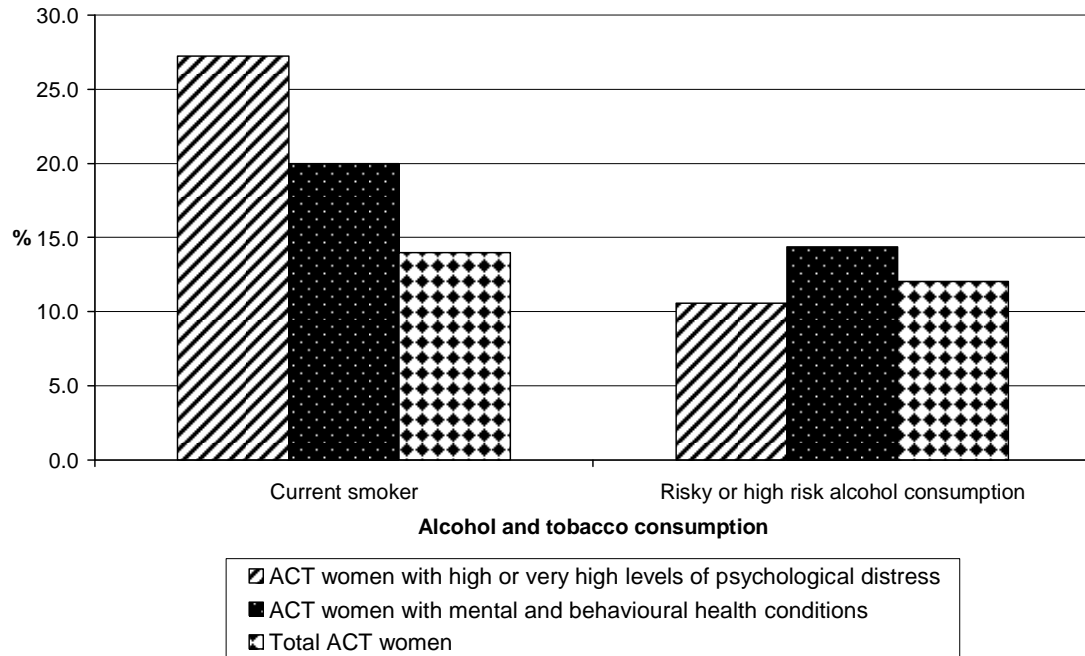
Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

5.3.2   Physical activity

Both women who reported high or very high levels of psychological distress and women who reported diagnosed mental and behavioural health conditions reported a marginally higher frequency of low or sedentary exercise levels than the average for ACT women. While 68.6% (88,000) of total ACT women reported inadequate physical activity, 69.4% (12,500) of women who reported high or very high levels of psychological distress, and 70.4% (16,200) of women who reported diagnosed mental and behavioural health conditions reported low or sedentary exercise levels.

5.3.3   Dietary indicators

Both women experiencing high or very high levels of psychological distress and women who reported diagnosed mental and behavioural health conditions reported a higher frequency of inadequate intake of fruit and vegetables than ACT women on average. ACT women experiencing high or very high levels of psychological distress reported the highest frequency of inadequate fruit consumption with 56.1% (10,100) of women affected. Women who reported diagnosed mental and behavioural health conditions also reported an above average frequency, with 43.9% (10,100) of women reporting inadequate fruit consumption. Similarly, 95.0% (17,100) of ACT women experiencing high or very high levels of psychological distress reported inadequate vegetable consumption, and 91.3% (21,000) of women who reported diagnosed mental and behavioural health conditions reported similar dietary patterns. Both measures show a relationship between poor mental health and wellbeing and inadequate dietary intake.

5.3.4 Consultations with health care professionals

Both women who reported high or very high levels of psychological distress and women who reported diagnosed mental and behavioural health conditions reported a higher frequency of consultations with all types of health care professionals than ACT women overall (Table 12). Both women who reported high or very high levels of psychological distress and women who reported diagnosed mental and behavioural health conditions reported double the consultation rate for specialist physicians and other health care professionals than total ACT women. Consultation rates for GPs were between 11.6% and 13.4% higher for women who reported high or very high levels of psychological distress and women who reported diagnosed mental and behavioural health conditions respectively than for total ACT women.

Table 12: Consultations with health care professionals by high or very high level psychological distress and mental and behavioural health status, ACT women (over 18 years), 2004-2005

Type of Practitioner	ACT women with high or very high levels of psychological distress (%)	ACT women with mental and behavioural issues (%)	Total ACT women (%)
GP	33.9	35.7	22.3
Specialist	15.6	12.2	7.0
Dentist	7.2	7.0	6.1
Other health care professional	35.0	33.0	16.4
Total women ('000)	**18.0**	**23.0**	**129.4**

Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

5.4 Summary of findings

There is a strong relationship between poor social and emotional wellbeing and low household income, with women who reported high or very high levels of psychological distress reporting a significantly increased frequency of low income than the average. Women who reported long term mental and behavioural health conditions were both over-represented in the lower household income quintiles and the highest household income quintile, indicating a more complex relationship between mental health and income.

Health indicators show that women with poor social and emotional wellbeing were significantly more likely to experience reduced health outcomes. More than twice as many women who reported high or very high levels of psychological distress also reported fair or poor health status as ACT women on average. Equally, women who reported high or very high levels of psychological distress were almost three times less likely to report excellent health status. A similar pattern was reported by women with long term mental and behavioural conditions.

In line with this trend, there was a relationship between poor social and emotional wellbeing and increased frequency of long term health conditions, with women who reported high or very high levels of psychological distress reporting an increased

frequency of long term health conditions in every category. The greatest frequency variation was reported in long term health conditions of the endocrine, nutritional and metabolic systems, circulatory system, and musculoskeletal system and connective tissue.

Women with high or very high levels of psychological distress reported a lower frequency of risky or high risk alcohol consumption than the average for ACT women. Conversely, women with mental and behavioural health conditions reported an increased frequency of alcohol consumption considered risky or high risk. Both women with high or very high levels of psychological distress and women with mental and behavioural health conditions reported a significantly increased frequency of tobacco smoking. Similarly, women who reported long term mental and behavioural health conditions and women with high or very high levels of psychological distress reported a marginally higher frequency of low or sedentary exercise levels and a higher frequency of inadequate fruit and vegetable consumption than the average for ACT women.

As an indication of health related actions, an above average frequency of consultations with health care professionals in all categories was reported by both women with long term mental and behavioural health conditions and women with high or very high levels of psychological distress.

6 Women from culturally and linguistically diverse backgrounds

Women from culturally and linguistically diverse backgrounds are at increased risk of socioeconomic disadvantage and poor health within the community. The measures used to assess cultural and linguistic diversity include country of birth and main language spoken at home (for more information see page 5).

6.1 Socioeconomic status

There was a relationship between culturally and linguistically diverse backgrounds and low household income. Women born overseas reported a higher frequency of low income than the territory average for women, comprising almost half of all women in the ACT in the lowest household income quintile (Figure 11). Where 17.6% (6,200) of women born overseas were in the lowest household income quintile, 11.1% (14,300) of women ACT were in the same quintile. Equally, women born overseas reported a lower frequency of high incomes, with 26.7% (9,400) of women born overseas reporting incomes in the fifth household income fifth quintile, below the territory average for women of 30.8% (39,900).

Figure 11: Culturally and linguistically diverse status by household income quintile, ACT women (over 15 years), 2004-2005
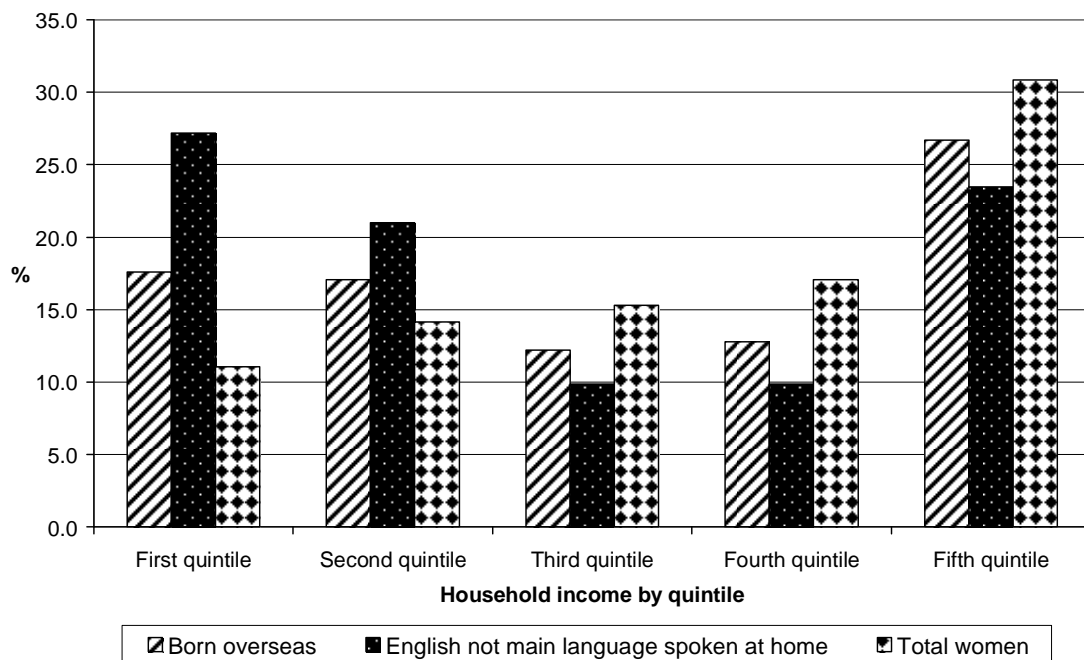
Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

The highest frequency of household income in the first quintile was reported by women who speak a language other than English in their home (Figure 11). In 2004-05, 27.2% (2,200) of women who speak a language other than English in their home reported household incomes in the first quintile, almost three times the frequency of the territory average for women. Equally, women who speak a language other than English in their

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home were under-represented in the highest income quintile, with 25.3% (1,900) of women in the highest income quintile, proportionally below both women born overseas and total ACT women.

6.2 Health indicators

6.2.1 Self assessed health status

There was a relationship between culturally and linguistically diverse backgrounds and fair or poor self assessed health status. ACT women born overseas were one and a half times more likely to report fair or poor health status than ACT women on average (Table 13). While this variation in frequency distribution is concerning, of greater concern is the difference in frequency of poor health between total ACT women and women who speak a language other than English in their home. Women who reported speaking a language other than English in their home were almost two and a half times more likely to report fair or poor health status than ACT women on average (Table 13).

Table 13: Culturally and linguistically diverse status by self assessed health status, ACT women (over 15 years), 2004-2005

Self assessed health status	ACT women born overseas (%)	ACT women who speak a language other than English at home (%)	Total ACT women (%)
Excellent	17.9	11.1	19.8
Very good	33.0	18.5	38.7
Good	29.0	37.0	28.0
Fair/poor	20.2	32.1	13.6
Total women ('000)	**35.2**	**8.1**	**129.4**

Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

6.2.2 Long term health conditions

There was a relationship between culturally and linguistically diverse backgrounds and selected long term health conditions, with women who speak a language other than English in their home reporting the highest frequency of all long term health conditions, with the exception of conditions of the respiratory system.

The largest variation in the frequency distribution of long term health conditions was in conditions of the circulatory system, musculoskeletal system and connective tissue, and eye and adnexa (Table 14). Where 46.9% (3,800) of women who speak a language other than English in their home reported long term health conditions of the musculoskeletal system and connective tissue, 45.2% (15,900) of women born overseas, and 37.7% (48,800) of total ACT women reported conditions in the same category. Similarly, where 42.0% (3,400) of women who speak a language other than English in their home reported long term health conditions of the circulatory system, 29.8% (10,500) of ACT women born overseas, and 26.3% (34,000) of total ACT women reported conditions in the same category. Long term conditions of the eye and adnexa also affected 81.5% (6,600) of women who speak a language other than English in their

home, compared with 79.3% (27,900) of women born overseas, and 69.7% (90,200) of total ACT women.

Table 14: Selected long term health conditions by culturally and linguistically diverse status, ACT women (over 15 years), 2004-2005

Long term health conditions	ACT women born overseas (%)	ACT women who speak a language other than English at home (%)	Total ACT women (%)
Circulatory system diseases	29.8	42.0	26.3
Respiratory system diseases	31.3	27.2	37.9
Endocrine, nutritional and metabolic diseases	19.3	21.0	17.5
Musculoskeletal system and connective tissue diseases	45.2	46.9	37.7
Eye and adnexa diseases	79.3	81.5	69.7
Mental and behavioural problems	18.8	21.0	17.8
Total women ('000)	**35.2**	**8.1**	**129.4**

Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

6.2.3 Levels of psychological distress

The majority of ACT women born overseas, and ACT women who speak a language other than English in their home reported low levels of psychological distress, an indication of positive social and emotional wellbeing. However, women from culturally and linguistically diverse backgrounds reported an above average frequency of high or very high psychological distress (Figure 12). Where on average 13.9% (18,000) of ACT women reported high or very high levels of psychological distress, 14.5% (5,100) of ACT women born overseas reported similar distress levels. Women who speak a language other than English in their home were at most risk of poor social and emotional wellbeing, with 23.5% (1,900) of women reporting high or very high levels of psychological distress. This variation in frequency distribution indicates a strong relationship between social and emotional wellbeing and main language spoke at home.

Figure 12: High/very high psychological distress by culturally and linguistically diverse status, ACT women (over 15 years), 2004-2005
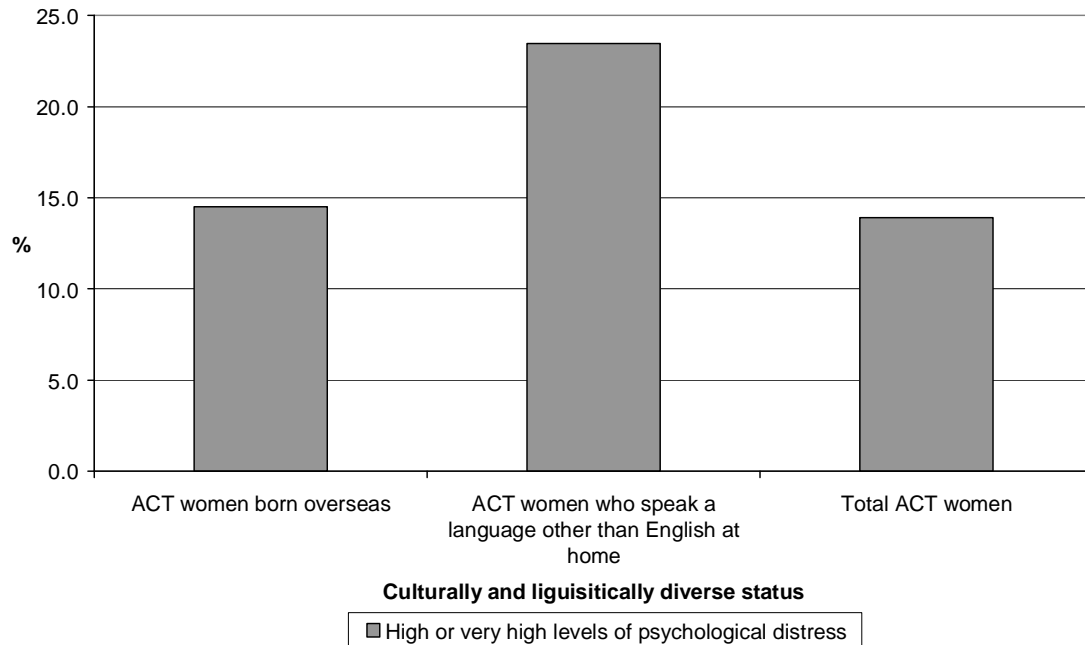
Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

6.3 Health related actions

6.3.1 Alcohol and tobacco consumption

ACT women born overseas reported a relatively low frequency of risky or high risk alcohol consumption, with 8.5% (3,000) of women born overseas reporting alcohol consumption patterns considered risky or high risk, compared with an average of 12.2% (15,600) for total ACT women. Similarly, ACT women born overseas reported a below average frequency for tobacco smoking, with 8.8% (3,100) of women born overseas reporting being current smokers, compared with an average of 14.1% (18,100) for total ACT women.

6.3.2 Physical activity

Women born overseas and women who speak a language other than English in their home reported a marginally higher frequency of sedentary or low physical activity levels than ACT women on average. Where on average 68.6 % (88,800) of ACT women reported sedentary or low physical activity levels, 69.9% (24,600) of women born overseas did so. Women who speak a language other than English in their home reported the highest frequency of sedentary or low physical activity levels, at 77.8% (6,300).

6.3.3 Dietary indicators

Both women born overseas and women who speak a language other than English in their home reported a lower frequency of inadequate intake of fruit, and a higher

frequency of inadequate intake of vegetables than ACT women on average. Where 12,300 (34.9%) of ACT women born overseas, and 22.0% (1,800) of women who speak a language other than English in their home reported inadequate fruit consumption, 39.6% (48,600) of total ACT women reported similar dietary patterns. Conversely, where 89.3% (109,600) of ACT women reported inadequate vegetable consumption, 92.9% (32,700) of ACT women born overseas, and 95.1% (7,700) of women who speak a language other than English in their home reported similar dietary patterns.

6.3.4 Consultations with health care professionals

Both women born overseas and women who speak a language other than English in their home reported a higher frequency of consultations with their GPs, and a lower frequency of consultations with specialist physicians and other health care professionals than ACT women overall (Table 15).

Consultation rates for GPs were between 3.8% and 3.6% higher for women from culturally and linguistically diverse backgrounds than for total ACT women. Conversely, where ACT women born overseas reported a consultation frequency 0.5% and 3.3% lower than total ACT women for specialist physicians and other health care professionals respectively, ACT women who speak a language other than English in their home reported a consultation frequency twice as low for other health care professionals, and six times lower for specialist physicians.

ACT women who speak a language other than English in their home reported the highest consultation frequency for dental health care professionals.

Table 15: Consultations with health care professionals by culturally and linguistically diverse status, ACT women (over 18 years), 2004-2005

Types of health practitioner	ACT women born overseas (%)	ACT women who speak a language other than English at home (%)	Total ACT women (%)
GP	26.1	25.9	22.3
Specialist physicians	6.5	1.2	7.0
Dental health care professionals	5.4	9.9	6.1
Other health care professionals	13.1	8.6	16.4
Total women ('000)	**35.2**	**8.1**	**129.4**

Data Source: Australian Bureau of Statistics, *National Health Survey 2004-05* (Canberra: Australian Bureau of Statistics, 2006), unpublished data.

6.4 Summary of findings

ACT women from culturally and linguistically diverse backgrounds experience poorer health than ACT women on average, with women who speak a language other than English in their home reporting the poorest health outcomes. Women's self assessed health status, for example, showed that women born overseas were one and a half times more likely to report fair or poor health status than ACT women on average, and women who reported speaking a language other than English in their home were almost two and a half times more likely to report fair or poor health status. Similarly, while women from culturally and linguistically diverse backgrounds reported poorer social and emotional

wellbeing than ACT women on average, the highest frequency of high or very high psychological distress was reported by women who speak a language other than English in their home.

Health risk behaviours were also affected by cultural and linguistic background, though not in a linear fashion. Women from culturally and linguistically diverse backgrounds reported lower rates of smoking and risky or high risk alcohol consumption, but marginally higher rates of inadequate physical activity. Diet was also affected by background, with women from culturally and linguistically diverse backgrounds reporting a lower frequency of inadequate fruit consumption, and a higher frequency of inadequate vegetable consumption.

The patterns in women's access to health care professionals were similar to those for socioeconomically disadvantaged women. Both women born overseas and women who speak a language other than English in their home reported a higher frequency of consultations with GPs than ACT women on average. Divergently, however, while women born overseas reported a marginally lower frequency of consultations with other health care professionals than the average, women who speak a language other than English in their home were six times less likely to consult with specialist physicians and twice less likely to consult with other health care professionals.

Recommendations

It is recommended that:

1. Both qualitative and quantitative research into women's health and wellbeing are made a priority of research institutions and government, including investigation and data collection on socioeconomically disadvantaged women.

2. Women's Centre for Health Matters Inc. undertakes health promotion initiatives and consultation with government and non-government sectors in order to work towards supporting socioeconomically disadvantaged ACT women's health and wellbeing outcomes, with a focus on management of long term health conditions, and social and emotional wellbeing.

3. Women's Centre for Health Matters Inc. undertakes health promotion initiatives and consultation with government and non-government sectors in order to work towards supporting socioeconomically disadvantaged ACT women to make positive health and wellbeing decisions, particularly in relation to physical activity levels, diet and nutrition, and tobacco smoking.

4. Women's Centre for Health Matters Inc. undertakes health promotion initiatives and consultation with government and non-government sectors in order to work towards ensuring socioeconomically disadvantaged ACT women are able to access health care and health information according to their needs and preferences.

5. Women's Centre for Health Matters Inc. evaluates any recommendations implemented as a result of this report within six months.

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