



Health Status of Women in the ACT

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KEY ISSUES

The following key issues identify demographic and health status characteristics of ACT women that will contribute to their health service needs.

- The ACT female population is increasing most rapidly in the 50 to 69 year age group. During the ten years from 1996 to 2006 the size of this age group increased by 5.3% per annum compared with an overall population increase of 0.9% per annum.
- The ACT fertility rate has been increasing in recent years. There is also a trend towards older women giving birth.
- Women are traditionally over-represented in the lower socio-economic groups (low wages, single parents). ACT women had lower average earnings than men. One in ten ACT females reported that they had times when food ran out and there was no money to buy more.
- The most common causes of female mortality were heart disease and cerebrovascular disease. For younger women aged 15-44 years the most common causes of death were intentional self-inflicted injury and accidental injury. For women aged 45-64 years the most common causes of death were breast and lung cancers and for women aged 65 years and over the most common causes of death were heart disease and cerebrovascular disease.
- Breast cancer was the most common cancer diagnosed in ACT women followed by colorectal cancer and skin melanoma. The most common causes of death from cancer among women were breast cancer, colorectal cancer and lung cancer.
- Notification rates of chlamydia infections for women have increased since 2000. The rate of notifications in the ACT has been higher than the Australian rate since 2001.
- Arthritis, asthma, chronic obstructive pulmonary disease and cardiovascular disease were the most prevalent chronic health conditions reported by ACT women.
- Women were more likely than men to report having a mental health condition such as depression and anxiety. They were also more likely to report high to very high levels of psychological distress. An ACT study found that one in ten women had postnatal depression at eight weeks post partum and 17.3% had postnatal depression over a six months post partum follow-up.
- Women were less likely to smoke or consume alcohol at risky levels than men. However, women were more likely to be obese and to have insufficient levels of physical activity. Only one in ten women consumed sufficient vegetables to meet nutritional guidelines.
- ACT women were most likely to require hospitalisation for obstetrics, gynaecology and orthopaedics than for other causes.
- The rate of caesarean section births has increased from 21.7% in 2000 to 28.9% in 2005. However, the ACT percentage remains lower than that of Australia as a whole.
- Almost one third of outpatient occasions of service provided to women were for obstetrics in 2006-07, followed by radiology, oncology and endocrinology.
- Participation of ACT women in the National Cervical Screening Program in 2004-05 was 65.5%, significantly higher than the Australian participation rate.
- BreastScreen Australia aims to achieve 70% participation in breast screening for women aged 50 to 69 years. The participation rate for ACT women in 2004-05 was 55.2% (Australia 56.2%).

- Half of female ACT Aboriginal and Torres Strait Islander residents reported being current smokers (49.4%). Almost half of ACT Aboriginal and Torres Strait Islander women reported that they smoked during pregnancy (42.9%).
- The percentage of low birth weight babies was significantly higher for Aboriginal and Torres Strait Islander women compared with non-Aboriginal women.
- Almost one third of people with a disability had problems accessing service providers, compared with 14.2% of ACT residents without a disability. This includes problems accessing transport.
- There is limited information available about specific populations in our community such as Aboriginal and Torres Strait Islander women, culturally and linguistically diverse women, women with disabilities, women in same sex relationships, women experiencing homelessness and women who have experienced violence. It is important that attempts are made to understand the needs of these groups in order to reduce the barriers in accessing services.

1 ACT Women's Health Profile

1.1 Introduction

In 2006, there were 140,317 women aged 12 years and over in the ACT, comprising 85.4% of the female ACT population.¹

This report provides a profile of the health status of women in the ACT, together with health service utilisation, demographic trends and the planning and policy context of women's health. The purpose of this report is to profile women's health issues in order to guide health planning activities proposed by the ACT Women's Health Plan Steering Committee.

The ACT Government is committed to the development, implementation and evaluation of a comprehensive plan that reflects a whole of health plan for women.

The plan will be embedded in a policy and service plan context that is underpinned by:

- universal access for all ACT women; and
- strong, positive partnerships across a whole of women's health continuum.

1.2 Australian government policy context

At the federal level, the Australian Labor Party recommended a range of health initiatives to support its vision for women's health policy and to encourage the health system to be more responsive to the needs of women (October 2007). The Labor Party has pledged to "shift the focus of our health system towards a greater focus on preventative health, enhanced health promotion and greater attention to monitoring and managing Australia's escalating burden of chronic disease²". Funding commitments were made to:

- Support waiting lists for hip, knee and hernia procedures;
- Develop GP super clinics which will bring health professionals together in the one place thereby improving the accessibility and convenience of health services for women and their families;
- Combat postnatal depression with the introduction of routine screening of mothers, together with the provision of better support and treatment for mothers, both in the lead up to birth and in the early weeks and months following the birth;
- Implement the National Cancer Plan and provide additional funding towards the National Centre for Gynaecological Cancers;
- Develop comprehensive Aboriginal and Torres Strait Islander child and maternal health services and provide accommodation for Aboriginal and Torres Strait Islander women who travel from remote to urban and regional centre to have their babies; and
- Enhance national maternity services planning to ensure a range of birthing options and support services – such as community nurses and midwives, are available across Australia so that women have appropriate care both in the antenatal and postnatal period.

1.3 ACT government policies and strategic context

Women's health services in the ACT are not under the umbrella of a single service. In practice, they are a collection of services provided in different contexts and through different organisations that overlap with a range of other services. Planning and implementation is complex, however with commitment to a strategic vision by all stakeholders, high quality outcomes are achievable.

A national focus of women's health policy in the early 2000's had been on illness prevention through programs such as breast and cervical screening, however the focus is now being broadened to include health promotion by supporting healthy lifestyles with increasing physical activity and adopting healthy eating habits.

1.3.1 ACT Women's Plan

The ACT Government developed the *ACT Women's Plan* in 2004, which sets out the ACT Government's vision for working with the community to improve the status of all women and girls. It provides a shared approach for working towards this vision across ACT Government agencies. The two strategic areas in the ACT Women's Plan for action relevant to health services include:

- Accessible services; and
- Supporting healthy lifestyles.

ACT Health's performance targets in the ACT Women's Plan include:

- Reducing the gap in life expectancy between Aboriginal and Torres Strait Islander women and ACT Women in general;
- Increasing women's participation in sport and physical activity across the lifespan;
- Increasing women's satisfaction with health and hospital services;
- Improving services for women in the criminal justice system;
- Reducing the number of incidences of self inflicted harm for women and girls;
- Reducing the prevalence of smoking by women and girls; and
- Reducing the proportion of women and girls consuming alcohol at levels considered risky or high risk.

A yearly Action Plan³ articulates the specific actions that each agency will work towards to progress the objectives of the plan. The 2005-06 Action Plan focuses on the areas of Mental Health, Alcohol and Drug, Midwifery Services, Women from marginalised groups and DCALB, Domestic Violence.

The following health related programs for women were listed in the 2006-07 and 2007-08 Budget papers to be maintained, enhanced or strengthened:

2006-2007

- Perinatal and Infant Care – a program to enhance links between maternal and child care, child and family services and mental health;
- ACT Primary Health Care Strategy – a program to support home visiting for families with children at risk and who have complex needs, and a program to reduce smoking in pregnancy;
- Increase the scope of maternal and child health services through Winnunga Nimmityjah Aboriginal Health Service;
- Maintain services for younger women at the Junction Youth Health Service;
- Targeted education and clinical sessions for women from diverse cultural and linguistic backgrounds;
- Women and Mental Health reference group;
- Child and Family Centres in Tuggeranong and Gungahlin; and
- Ongoing support of the Domestic Violence Crisis Service and Canberra Rape Crisis Centre.

2007-2008

- Women and Children Detox program;
- Targeted support for at-risk children and families; and
- Implementation of the Human Papillomavirus (HPV) Vaccination program in the ACT.

1.3.2 Access Health

In August 2007, the ACT Government released its *Access Health* strategy to enhance the high standard of health enjoyed by people living in the ACT. Target areas are:

- Timely Access to Care
- Aged Care

- Mental Health
- Chronic Disease Management
- Early childhood and vulnerable families
- Aboriginal and Torres Strait Islander Health

1.3.3 ACT Health Corporate Plan

The *ACT Health Corporate Plan* shares its vision of good health for all by targeting the following key performance areas and objectives relevant to the delivery of services to women:

- *Community and Consumers*
 - a) Improving population health outcomes;
 - b) Providing better access to services;
 - c) Promoting the independence of consumers and their carers; and
 - d) Providing comprehensive information to consumers and actively involving them in decision-making.
- *Safety and Quality Care*
 - a) Improving patient safety and quality of care;
 - b) Managing environmental risks to ensure the safety of all people on ACT Health premises; and
 - c) Improving care options and the continuity of care across the care spectrum.
- *Partnerships*
Forming key partnerships with key stakeholders.
- *Accountability and Internal Systems*
 - a) Delivering efficiency through information management and technology systems; and
 - b) Improving consumer access to health services via technology.
- *Our people*
Building ACT Health capacity and valuing our staff.

1.3.4 The ACT Primary Health Care Strategy

The ACT Primary Health Care Strategy 2006-2009 sets the direction in primary health care services. It is the interface between the different elements of the primary health care system from diagnosis to management of health, prevention to early detection. The overarching aims of the strategy are to adopt a population based, person centred, continuity and quality of health care approach for improving the health of the population. Some of the proposed actions that target women's health include:

- Introducing a program to reduce smoking in pregnancy, especially in Aboriginal and Torres Strait Islander women;
- Introducing a program to further develop and expand programs to increase the proportion of babies breastfed for six months or more;
- Collaborating with the Australian Department of Health and Ageing to map ACT Health services that are supported by the Australian Government and develop methods of improving coordination where necessary; and
- Working in partnership with other key stakeholders to explore opportunities for collaboration in research and evaluation.

1.4 ACT Health planning context

Figure 1: ACT Health planning and policy context for the ACT Women's Health Services Plan

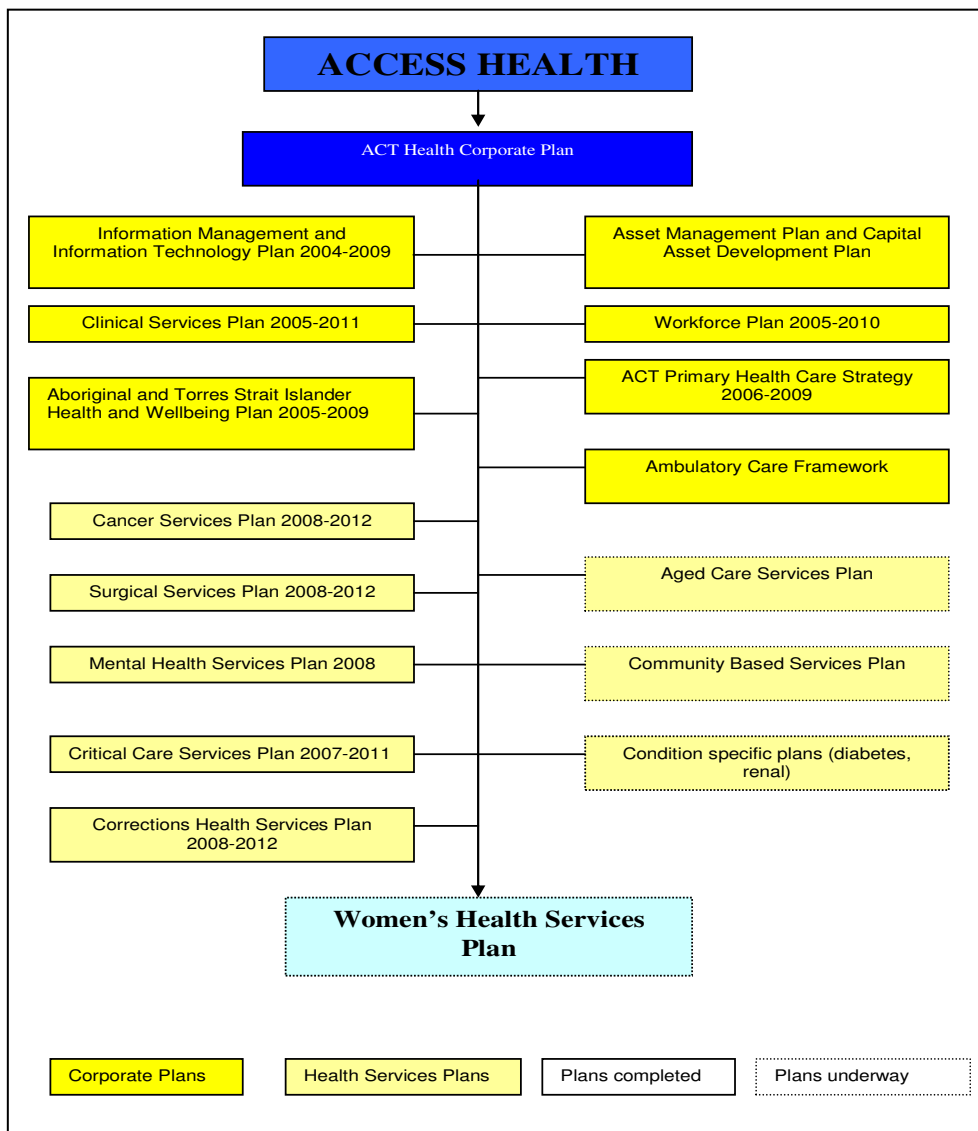


Figure 1 shows the planning and policy context for the ACT Women's Health Services Plan. It includes plans that are being implemented and plans that are currently being developed. All plans developed by ACT Health take account of:

- Patient safety and quality;
- Policy priorities;
- Efficiency and affordability;
- Feasibility and appropriateness;
- Having equity;
- Being evidence based and professional;
- Being innovative and systematic;
- Ensuring client participation; and
- Being accessible

The **Clinical Services Plan (2005-2011)** provides the framework for the development and provision of public hospital and community health services for the people of the ACT. The plan articulates current services and projects service need to 2011. It is projected that overall obstetric and gynaecology activity will remain essentially unchanged, with marginal growth in episodes of care expected by 2011. The plan also projects that average lengths of stay are expected to decrease slightly.

The key strategic aim of the **ACT Surgical Plan (2008-2012)** is to lay the foundation for the ACT to manage the expected growing demand for surgery in the Territory and surrounding region in a sustainable way. To improve access to services, the plan articulates actions to proactively identify, test and implement strategies to minimise the overall growth in surgical presentations through appropriate prevention and/or avoidance strategies, and to ensure, where possible, equitable access to surgery. The plan projects demand for surgical services including gynaecology and obstetric related services.

The **Mental Health Services Plan (2008-2020)** articulates the vision and the strategic directions for the development of public sector mental health services and acknowledges the role of primary care, the private sector and other key services and agencies. It recognises the importance of fostering key partnerships and linkages to enhance mental health care for all people in the ACT. The plan is aligned with the *National Action Plan for Mental Health 2006-2011* which identifies promotion, prevention and early intervention; integrating and improving care delivery including care coordination; improving participation in the community, including education and housing; and developing workforce capacity as priorities.

ACT Health has committed to a '*four life stages developmental model*', which focuses on developmental and life milestones to determine the most appropriate point of service. The four life stages identified are:

- Children's Mental Health Service (0 -11 years)
- Youth Mental Health Service (12 – 24 years)
- Adult Mental Health Service (25 –64 years)
- Older Persons Mental Health Service (65 + years).

The **Cancer Services Plan (2008 - 2012)** sets out the following three main priorities:

- Developing an integrated and comprehensive patient centred cancer service for the ACT and region;
- Implementing priorities of national and local policies, strategies and frameworks; and
- Embracing advances in pharmaceuticals and in clinical and information technology.

The plan does not have a specific analysis on the impact of cancer on women but discusses breast cancer as the most common cause of female cancer and the most common cause of female cancer death.

There is an existing Breast Cancer Treatment Group comprising members of the multidisciplinary team involved in the treatment of breast cancer in the ACT and SE NSW and consumer representatives. The group examines data on treatment and outcomes for patients with breast cancer collected as part of the Breast Cancer Treatment Quality Assurance project to inform improvements in treatment of breast cancer in the ACT and surrounding region.

The draft **Diabetes Services Plan (2007 - 2010)** provides a framework for diabetes care and prevention that addresses primary and secondary disease prevention. It identifies the creation of an Acute and Complex Care Diabetes Service that is complemented by an independent diabetes service, the Diabetes Care Centre.

The target populations for diabetes services identified in the plan include adult, children and young people, Aboriginal and Torres Strait Islander people and other population subgroups.

The **Adult Corrections Health Services Plan (2008 - 2012)** identifies a framework to sustain and improve the health of remandees and prisoners in detention by providing and coordinating effective, holistic and efficient health services. The plan defines the role of ACT Health in providing for the health needs of prisoners; identifies key health needs of the expected populations of the prison; identifies the services required to appropriately meet these needs; provides an outline for providing high quality health care to prisoners; and proposes key performance indicators to monitor its implementation.

2 Demography of the ACT

2.1 Demographic trends for women

Between 1996 and 2006 the number of women living in the ACT increased from just over 150,000 women to just over 164,000 women (Table 1), an increase of 0.9% per annum. Women comprised 50.7% of the total ACT population in 2006.⁴ There were 140,317 women aged 12 years and over in 2006, comprising 85.4% of the female ACT population.⁴

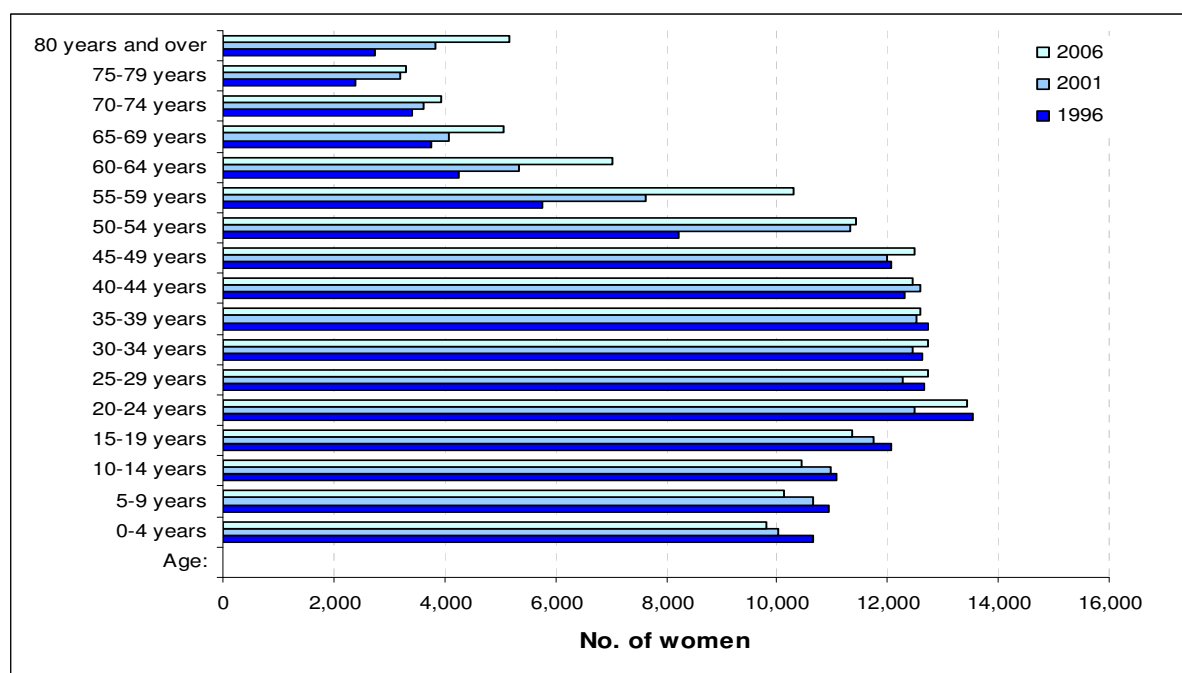
Table 1: Number of ACT resident women by age group, ACT, 1996, 2001 and 2006

	1996	2001	2006
Age:			
0-4 years	10,646	10,022	9,817
5-9 years	10,939	10,666	10,121
10-14 years	11,062	10,956	10,450
15-19 years	12,044	11,732	11,375
20-24 years	13,538	12,488	13,443
25-29 years	12,667	12,259	12,747
30-34 years	12,629	12,448	12,740
35-39 years	12,744	12,522	12,589
40-44 years	12,310	12,593	12,435
45-49 years	12,064	12,005	12,478
50-54 years	8,231	11,330	11,423
55-59 years	5,763	7,625	10,287
60-64 years	4,242	5,360	7,016
65-69 years	3,777	4,094	5,070
70-74 years	3,428	3,626	3,938
75-79 years	2,385	3,214	3,293
80 years and over	2,747	3,825	5,157
Total	151,216	156,765	164,379

Source: ABS, 2006 Census Tables, Cat. No. 2068.0, ACT

Changes to the size and composition of the ACT female population over time will have implications for health service planning, policy and service utilisation.

Figure 2: ACT resident female population by age, 1996, 2001 and 2006



Source: ABS, 2006 Census Tables, Cat. No. 2068.0, ACT

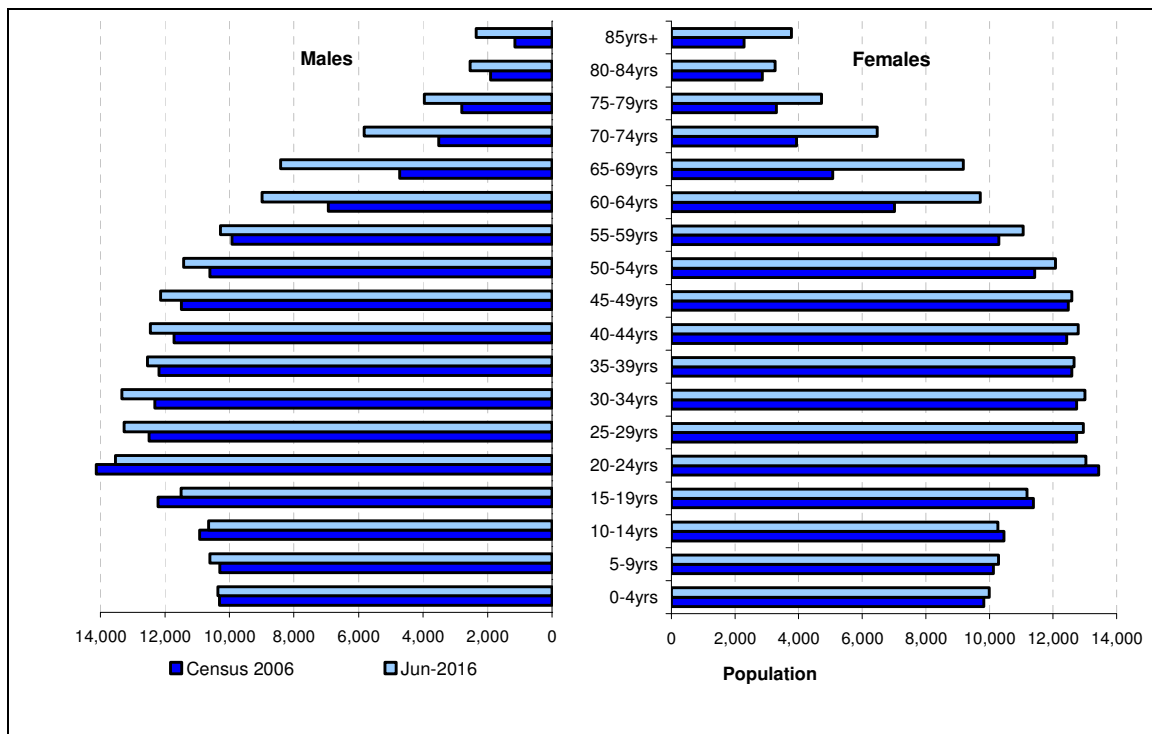
Population growth has not occurred uniformly across age groups (Figure 2). During 1996 to 2006, the number of women aged less than 20 years in the ACT has declined and the number of women aged over 40 years has increased (Figure 2), particularly in the 50 to 69 year age group. The population growth for this older age group between 1996 and 2006 was 53.2% or 5.3% per annum.

2.1.1 Population projections

The overall ACT population is expected to grow by a further 9% over the next ten years to 353,186 by 2016. Over this period, most of the growth is expected to continue in older age groups (Figure 3). The percentage of the ACT population aged 65 years or more is projected to increase from 9.7% to 14.3% of the population between 2006 and 2016. At the same time, projections suggest there will be a decrease in the number of people aged 10 to 24 years in the population. The overall proportion of females in the ACT population is not expected to change.

An important implication of the shift towards an older population is an expected increase in the number of people with age-related chronic disease.

Figure 3: ACT usually resident census population, 2006, and ACT projected population 2016, by sex and age group



Source: ABS 2006⁵; 2007⁴

2.2 Fertility trends

The total fertility rate represents the number of children a woman would give birth to during her lifetime given current age specific fertility rates. The rate for the ACT increased slightly from a low of 1.5 in 2001 to 1.8 in 2006.

The ACT and Australia are experiencing an ongoing shift toward fertility at older ages and it is worth noting that the shift towards older age at first birth artefactually reduces the fertility rate. However, the shift toward older age at first birth has a biological limit and once it is reached the fertility rate may increase in the short term. The ACT continues to lead the increase in older age at first birth, and it would therefore be expected that the ACT would be first to reach this biological limit. This may explain the recent increase in the ACT fertility rates.⁶

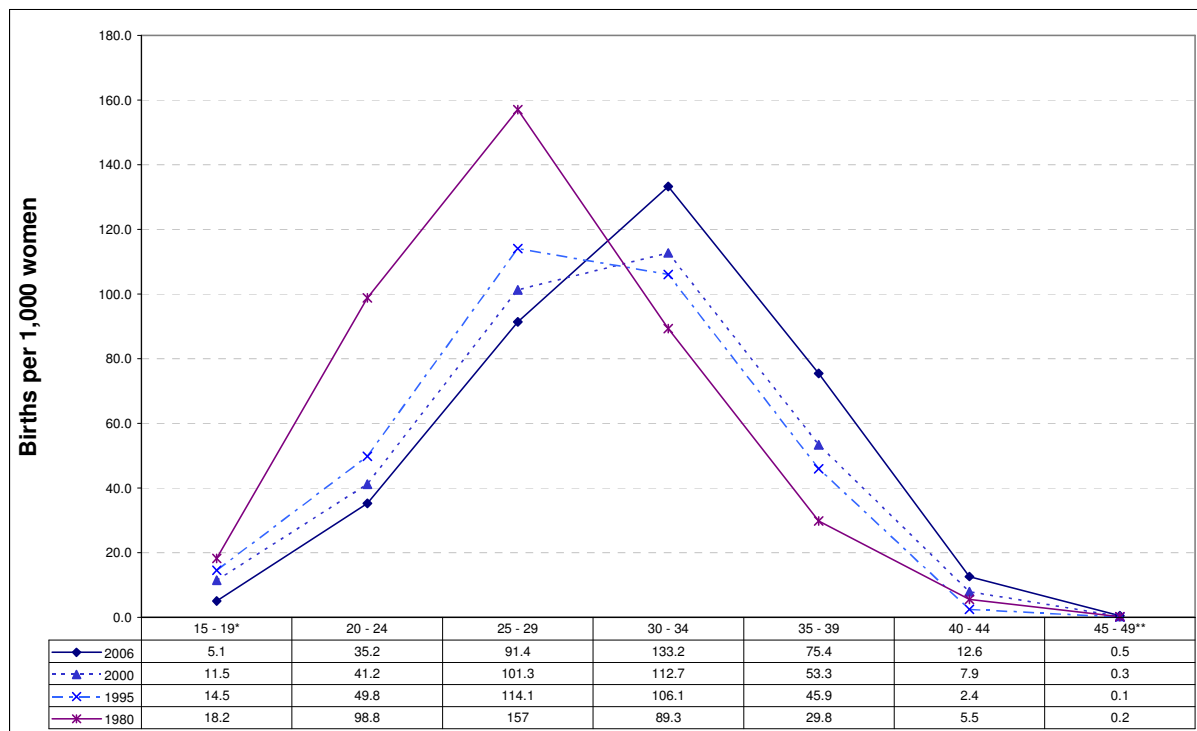
Table 2: Number of births, age specific fertility rates and total fertility rates for all live births, ACT residents, 2004-2006

Age Group	2004		2005		2006	
	No.	ASFR	No.	ASFR	No.	ASFR
15 - 19*	107	9.1	114	9.9	59	5.1
20 - 24	451	32.9	470	34.8	483	35.2
25 - 29	1,086	86	1,110	87.3	1,194	91.4
30 - 34	1,521	118	1,566	122.1	1,655	133.2
35 - 39	758	62.2	830	67.5	931	75.4
40 - 44	154	12.1	150	11.9	157	12.6
45 - 49**	9	0.7	6	0.5	6	0.5
Total	4,086	321.0	4,246	333.9	4,485	353.4
TFR births per woman	1.6		1.7		1.8	

Notes: *By definition, all births for women aged less than 15 years are included in the 15 to 19 age group.
 **Births for women aged 50 years and over are included in the 45 to 49 age group.
 2006 data is preliminary. Fourteen records where maternal age was 'not stated' have been excluded.
 Source: ACT Maternal Perinatal Data Collection and Estimated Residential Population by sex and age, ABS Cat. No: 3201.0

The shift in ACT age specific fertility rates is demonstrated in Figure 4, with fertility peaking in 25 to 29 year old women in 1980 and 1995 and in 30 to 34 year old women in 2000 and 2005. The fertility rate for women aged over 35 years in 2005 is approximately double the rate in 1980. Consistent with the shift in age specific fertility rates, average maternal age increased significantly from 29.2 years in 1997 to 30.5 years in 2005 ($p < 0.05$).

Figure 4: Age specific fertility rates, ACT 1980, 1995, 2000 and 2006



Notes: *By definition, all births for women aged less than 15 years are included in the 15 to 19 age group.
 **Births for women aged 50 years and over are included in the 45 to 49 age group.
 2006 data is preliminary. Fourteen records where maternal age was 'not stated' have been excluded.
 Source: ACT Maternal Perinatal Data Collection and Estimated Residential Population by sex and age, ABS Cat. No: 3201.0

ACT resident women who were born overseas were more likely to have a higher fertility rate than those born in Australia.⁷ Women who were born in the Middle East and North Africa, Africa and Oceania had the highest fertility. The lowest fertility was for women from Europe, North-East Asia and the Americas.⁷

2.3 Social factors that influence health

Social and economic factors such as income and education levels impact on the health burden.⁸ Social disadvantage is associated with potentially avoidable poor health outcomes, and in the ACT, indicators of material disadvantage have been linked to poor health status, lower levels of service utilisation and service access.^{9,10} The factors that explain the interrelationships between the social environment and health are not always clear, but are important in population health status assessment for policy and planning purposes. From the indicators outlined below, it can be seen that the ACT has a high socio-economic profile.

It is important to note that, those who are disadvantaged (low/no wages, poor education etc) can be difficult to identify (the 'hidden poor') and can experience a wider gap between opportunities available, even in an area of high advantage. This is compounded by the fact that, in the ACT, government and low cost housing is spread throughout most suburbs, reducing the possibility of identification and targeted assistance. Females have traditionally been over-represented in the lower socio-economic levels (low wages, single parents, etc.).

2.3.1 Income

The ACT enjoys a high level of economic prosperity, so income levels are generally higher than income levels nationally. In May 2007, the average weekly ordinary time earnings (AWOTE) for adults in full-time employment in the ACT was 18% higher (\$1,288 per week) than that for Australia (\$1,088).¹¹ Females had an AWOTE of \$1,171 compared to \$1,384 for males.

2.3.2 Labour force

Labour force participation is an important social factor that can affect an individual's ability and/or opportunity to make healthy choices. As at 30 June 2006, the ACT had the highest labour force participation rate in Australia, at 73.1%.¹² Of those employed in the ACT at 30 June 2006, three quarters (75.2%) were employed full-time.¹³

During 2006-07 females comprised 48% of the total people employed. Sixty five per cent of these females worked full-time compared to 85% of males.¹¹

The most frequently reported occupations for females were professionals (27%), intermediate clerical, sales and service workers (26%), associate professionals (15%), and managers and administrators (13%).⁹

2.3.3 Marital status

In 2006, of the 120,225 ACT females over the age of 14 years, 47.8% were in registered marriages, 9.6% were in de facto marriages (including same sex) and 42.6% were not married.¹¹ There were slightly more females than males (39.8%) who were single.

2.3.4 Education

The ACT has higher education attainment levels than other jurisdictions. Most of the population completes their secondary school education, with only 19.0% of people aged 15 to 64 years not completing Year 12 in 2005, compared to 31.2% nationally.¹⁴

School retention rates (from year 7/8 to year 12) continue to be higher in the ACT compared to nationally, although there is a slight trend towards a decline over the past five years.¹⁵ Female ACT students, with a retention rate of 86.5%, surpassed males (84%) in 2007.

In the ACT, post school qualification rates are high. In 2006, for instance, 59.2% of females and 64.9% of males aged 25-64 years had a certificate, diploma, bachelors degree or higher degree.¹⁶

2.3.5 Language

The ability to communicate easily impacts on quality of life and access to social and employment opportunities.

Of Australian born ACT people, 581 females (595 males) reported that they did not speak English well or at all.¹⁶

Of the 70,371 ACT people born overseas before 2006, 51.5% were female. Half of these spoke only English. Of the 18,003 females who spoke another language, 14.5% reported not speaking English well (or not at all). This compares to 11.1% of males unable to speak proficiently or at all. Females from China (393), Viet Nam (339), Italy (197) and Greece (135) reported lack of proficiency in English in higher numbers than for other countries.

2.3.6 Housing

In 2006, there were approximately 117,000 households in the ACT.¹⁶ Projections suggest the ACT will experience a growth in the number of households to between 158,000 and 167,000 by 2026, a growth of between 31% and 39%.¹⁷ This increase is largely due to a projected increase in one-person households over time. Census results show that in 2006, 23.2% of all occupied private dwellings in the ACT were lone person households, up from 22.2% in 2001.¹⁶

The Supported Accommodation Assistance Program (SAAP), supported by the Australian and state and territory governments, aims to assist people who are homeless or at risk of becoming homeless. In 2005-06, there were an estimated 1,900 SAAP clients in the ACT.¹⁸ Just under half (47.2%) were female. After lone males over 25 years (27%), females with children (20%) and lone females over 25 years (18%) were the next most frequent groups seeking assistance. The mean age of female clients was 26.3 years, compared to 33.7 years for males.

The Home and Community Care (HACC) program assists people living at home with special needs (eg. respite care, centre-based day care, personal care). Females comprised 66.6% of HACC clients in 2004-05.¹¹

2.3.7 Social capital

The 2005 ACT General Health Survey included questions about neighbourhood safety and trust. Overall, the survey shows the ACT has a high level of social capital.

However, results indicated that females were slightly more likely than their male counterparts to feel they had control over life decisions (92.4%; males 91.5%), but less likely to feel that their neighbourhood was safe (87.4%; males 92.2%), that their home was safe (95.4%; males 97.6%), or that they could trust people in their neighbourhood (77.3%; males 81.0%). Females had slightly more transport problems when going to health appointments, visiting people, shopping, schools etc. Females reported more frequently than males that they had times when food ran out and there was no money to buy more (10.7%; males 6.9%). They were also considerably more stressed by this situation (18.2%; males 8.8%).

With the exception of popular music concerts, ACT females aged 15 years and older attended cultural venues and events slightly more than their male counterparts (92% compared to 88%).¹¹ Cinema attendance was the most common activity.

2.3.8 Transport

Survey data show that the ACT has a high number of passenger vehicles per capita.¹⁴ Most people are able to get to places when required, although this is an issue for a small proportion of the population.¹⁹

In 2006, 85.7% of females (83.7% of males) travelled to work by motor vehicle with a further 7.7% (6.4% of males) travelling by bus and 6.1% (8.9% of males) using a bicycle or walking.

2.3.9 Volunteering

In 2006, females volunteered for an organisation or group more than males. Twenty four per cent of females volunteered consistently over the age ranges above 15 years. For males, 19% volunteered between the ages of 15 and 54, but this increased in the older age ranges to 24%.¹⁶

3 Health Status

Females in the ACT are generally a healthy population, however a sizeable proportion suffer from health conditions that can affect their participation in daily activities and general quality of life.

This section presents statistics relating to mortality, chronic disease and risk factors in ACT females.

3.1 Mortality

In 2005, there were 748 deaths registered for ACT females and a similar number was registered for males (743). The all cause mortality rate was lower for females (4.9 per 1,000 population) than males (6.6 per 1,000 population) and the median age of death was seven years older for females (82 years) compared to males (75.3 years).

Premature mortality and avoidable mortality were also lower for females than males. Average life expectancy in the ACT now exceeds 80 years and deaths that occur at less than 80 years of age are defined as 'premature'.

Table 3: Selected mortality characteristics of ACT residents, by sex, 2005

Number of deaths	
Males	743
Females	748
Persons	1491
All-cause mortality rate (deaths per 1,000 population)	
Males	6.6
Females	4.9
Persons	5.6
Median age at death (years)	
Males	75.3
Females	82.0
Persons	78.5
Premature mortality rate (deaths per 1,000 population aged less than 80 years)	
Males	2.8
Females	2.0
Persons	2.4
Avoidable mortality rate (a) (deaths per 1,000 population aged less than 80 years)	
Males	1.6
Females	1.0
Persons	1.3

(a) Avoidable mortality has been defined using method in Page et al 2006²⁰, but is based on death registrations at age less than 80 years, rather than age <75 years. Causes defined using ICD-10 codes.

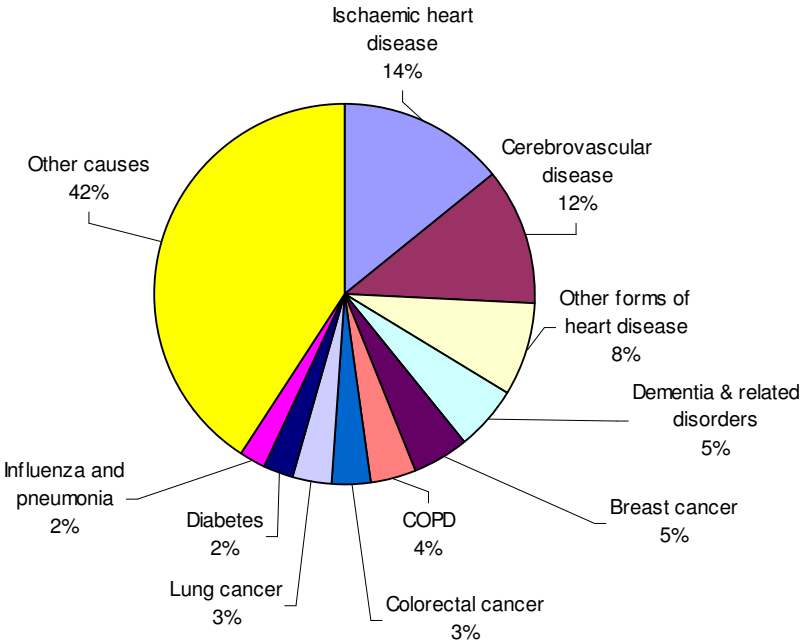
Source: Australian Bureau of Statistics, ACT Causes of Death, Confidentialised Unit Record File, 2005

The level of avoidable mortality in a population indicates the theoretical scope for future health gain through disease prevention and management. An avoidable death is defined here as a death at age less than 80 years, that could have been avoided given current understanding of causation, prevention strategies and disease management. Conditions included in the avoidable mortality rate include ischaemic and hypertensive heart disease, diabetes mellitus, breast cancer, cervical cancer, tuberculosis, HIV/AIDS etc.²⁰

3.2 Causes of death

During the period 2001 to 2005, the most common causes of death for ACT females were vascular related, with ischaemic heart disease (14%), cerebrovascular disease (12%) and other forms of heart disease (8%) contributing to 34% of all female deaths in total. Dementia (5%), breast cancer (5%) and chronic obstructive pulmonary disease (COPD; 4%) were also common causes of death for ACT females.

Figure 5: Common causes of death for ACT females, all ages, 2001-2005



Source: Australian Bureau of Statistics, ACT Causes of Death, Confidentialised Unit Record File, 2001-2005

Over the period 2001 to 2005, 80% of female deaths occurred for those aged 65 years and over, 13.7% occurred for those aged 45 to 64 years and 4.7% occurred for those aged 15 to 44 years.

Table 4 shows the six most common causes of death for ACT females in these different age groups over the period 2001-2005 compared with the percentage of male deaths in the same categories. It should be noted that this table does not necessarily show the most common causes of male deaths.

Injury that was intentionally self-inflicted, accidental or due to road accidents contributed in total to around one-third (32.5%) of all deaths in females and almost one half (43.6%) of all deaths in males aged between 15-44 years. For males aged 15-44 years, ischaemic heart disease was another common cause of death (6.4%).

For females aged 45-64 years, cancer of the breast, lung, colorectal and ovaries contributed in total to one-third (33.3%) of all deaths in this age-group, whereas heart disease was the predominant cause of death for males. For females aged 65 years and over, 38.2% of deaths were attributable to diseases of the cardiovascular and cerebrovascular system, similar to the percentage of male deaths attributed to those diseases (33.6%).

Table 4: Six most common causes of death for ACT females, 15 years and over by age group compared with percentage of male deaths in these categories, 2001-2005

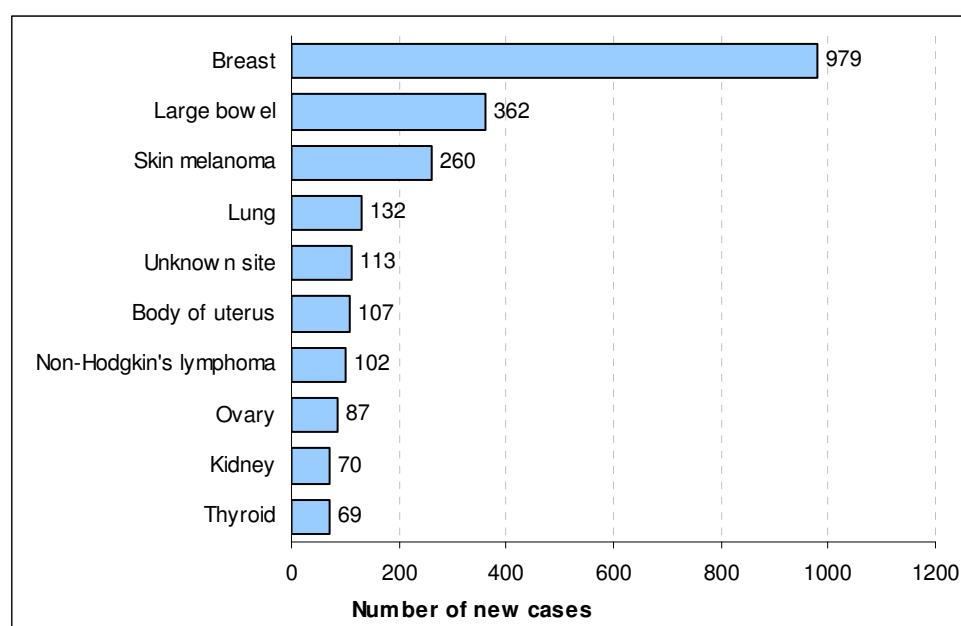
15-44 years	ICD-10 Classification	Females		Males	
		No	%	No	%
	Intentional self-inflicted injury	21	12.9	89	25.9
	Accidental injury	17	10.4	25	7.3
	Road accidents	15	9.2	40	11.6
	Breast cancer	13	8.0	0	0.0
	Cerebrovascular disease	7	4.3	9	2.6
	Other forms of heart disease	6	3.7	13	3.8
45-64 years					
	Breast cancer	77	16.2	0	0.0
	Lung cancer	35	7.4	45	6.5
	Ischaemic heart disease	27	5.7	124	17.8
	Colorectal cancer	24	5.1	40	5.8
	Cerebrovascular disease	22	4.6	29	4.2
	Ovarian cancer	22	4.6	0	0.0
65 years and over					
	Ischaemic heart disease	442	16.1	486	19.8
	Cerebrovascular disease	370	13.4	201	8.2
	Other forms of heart disease	239	8.7	137	5.6
	Dementia & related disorders	180	6.5	64	2.6
	COPD	116	4.2	128	5.2
	Colorectal cancer	85	3.1	77	3.1

Source: Australian Bureau of Statistics, ACT Causes of Death, Confidentialised Unit Record File, 2001-2005

3.3 Cancer

The five most common cancers among women living in the ACT during 2000-2004 were breast cancer, colorectal cancer (large bowel), melanoma, lung cancer and cancer of unknown primary sites. More detailed analysis of cancers diagnosed frequently in ACT women and female specific cancers is contained in the Appendix.

Figure 6: Common cancers diagnosed in women, ACT, 2000-2004

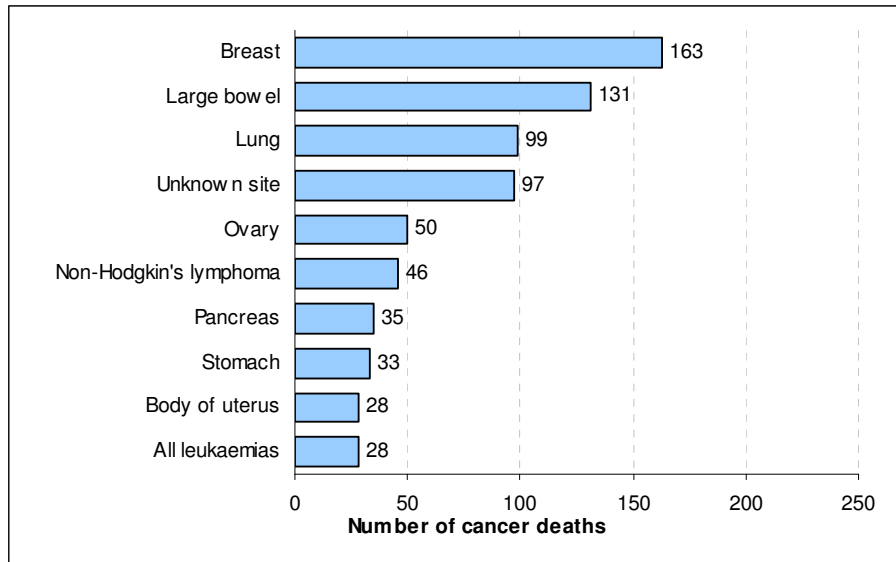


Source: ACT Cancer Registry 2000-2004, confidentialised unit record file

3.3.1 Causes of cancer related death for women in the ACT

The five most common causes of death from cancer among women in the ACT during 2000-2004 were breast cancer, colorectal cancer (large bowel), lung cancer, cancer of unknown primary sites and ovarian cancer.

Figure 7: Causes of cancer related deaths in women, ACT, 2000-2004.

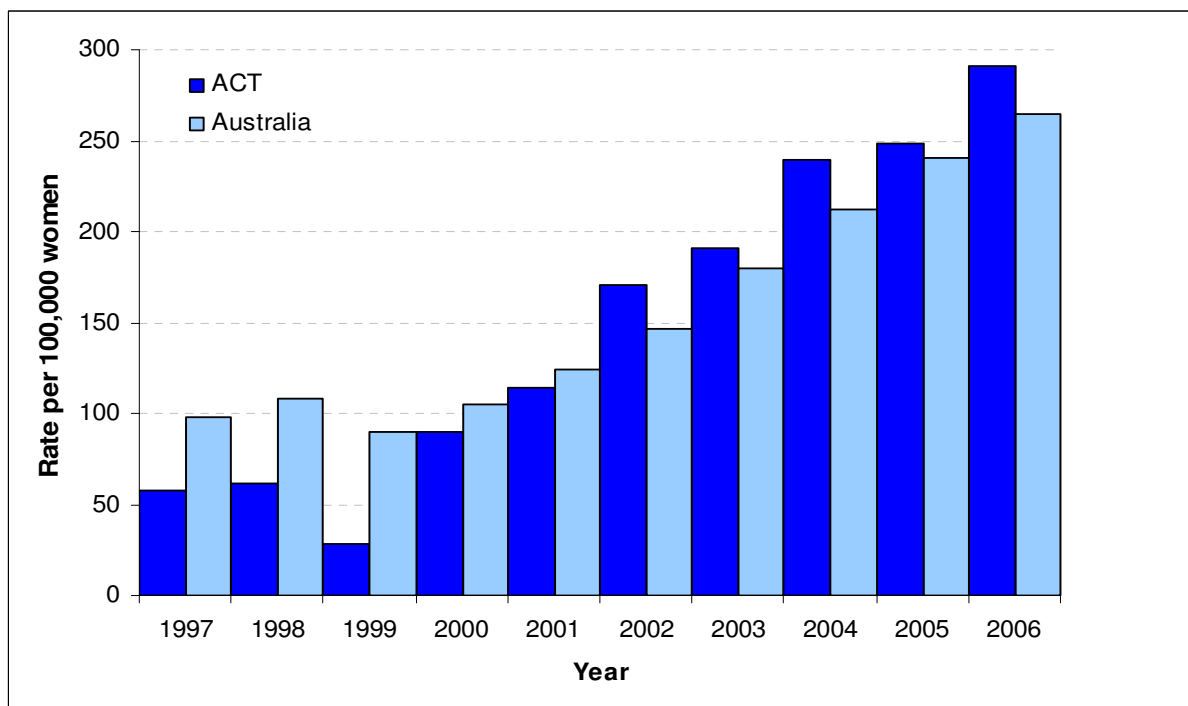


Source: ACT Cancer Registry 2000-2004, confidentialised unit record file

3.4 Sexually transmissible infections

Sexually transmissible infections (STI) are infections whose primary mode of transmission is through sexual contact with an infected partner. Sexually active individuals are at risk of a range of STIs, of which chlamydia is the most prevalent infection. Among the range of STIs, women are mostly affected by chlamydia. Other STIs such as gonorrhoea and syphilis only have a few cases in women each year in the ACT.

Figure 8: Chlamydia notification rates, females, ACT and Australia, 1997-2006

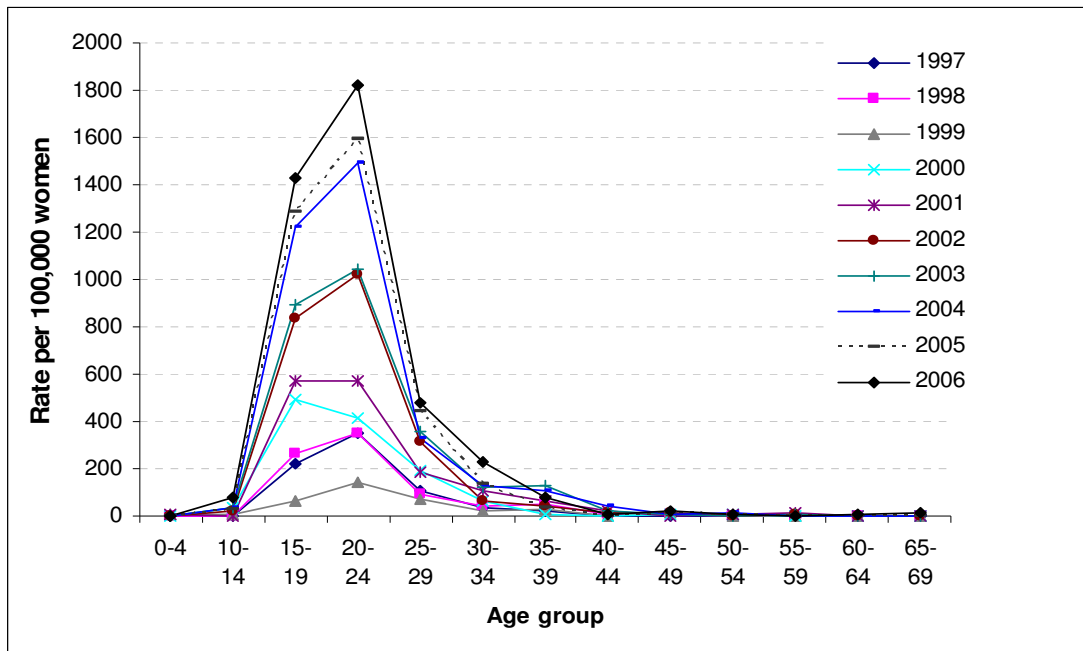


Source: ACT data from the Communicable Disease Section, ACT Health; Australian data from National Notifiable Diseases Surveillance System, DoHA

The notification rate of chlamydial infections of the genital tract has increased since 2000 (Figure 8). Chlamydia affects almost all age groups in women. However, the highest rate was observed in young women in the 15-24 year age group (Figure 9). Women in 25-34 year age group also experienced a high notification rate.

ACT rates have increased above national and NSW rates since 2001, most likely as a result of increased awareness of, and testing for, the disease in the ACT, compared to other jurisdictions. Research has demonstrated an increase of nearly 50% in the number of tests for chlamydia performed in the ACT over the six-year period to 2004 and that the proportion of positive tests increased by 40.5%.²¹ Programs focusing on outreach for diagnosis and treatment should eventually reduce the transmission of chlamydia in the community.

Figure 9: Chlamydia notification rates by year of onset and age group, females, ACT, 1997-2006



Source: ACT data from the Communicable Disease Section, ACT Health

3.5 Bloodborne viruses

A number of viruses whose primary mode of transmission is via blood and body fluids are notified to ACT Health. These include Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV). These viruses are of public health concern as their occurrence is associated with risk taking behaviours such as unprotected sexual intercourse and the sharing of needles and syringes. Transmission of bloodborne viruses (BBV) can also occur from body piercing or tattooing where unsterilized equipment has been used.

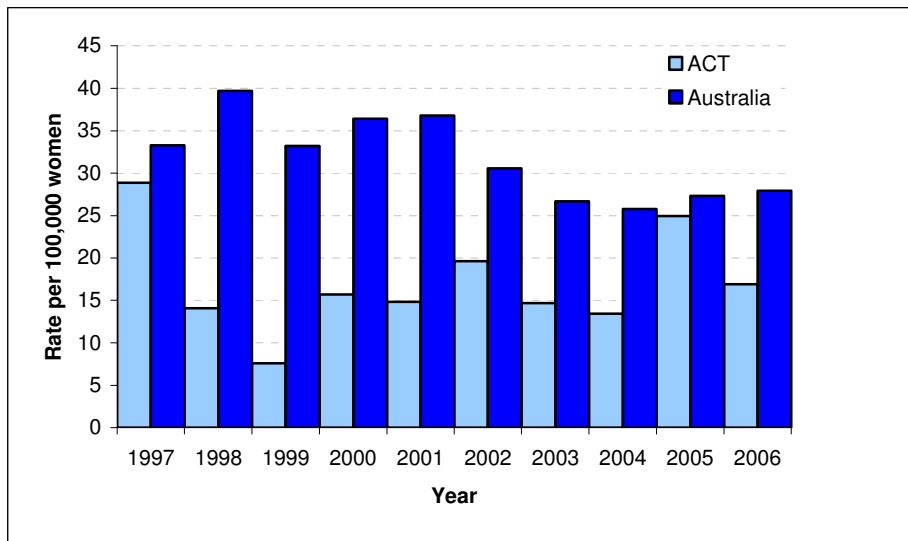
3.6 Hepatitis B

Hepatitis B (HBV) is caused by a virus that targets the liver. Infection can be mild and often goes undetected. Most people who become infected will clear the virus, but some become chronically infected (infected for the rest of their life). In some cases HBV can cause cirrhosis (scarring) of the liver, liver cancer, liver failure and death.

When a HBV notification is known to be from a recent infection, it is regarded as “incident HBV”. Those who have antibodies from a past infection of HBV are regarded as having “unspecified HBV”. In this report both incident and unspecified cases were combined into one category since ACT had a low number of incident HBV in females each year (minimum: 0 case per year; maximum: 3 cases per year).

The ACT has a stable rate of HBV in women. The crude rates (number of cases per 100,000 women) of HBV in women are much lower than the national rates. Most HBV notifications in the ACT occurred in the 20-49 year age group during the last decade (Figure 10).

Figure 10: Hepatitis B (incident and unspecified) notification rates, females, ACT and Australia, 1997-2006



Source: ACT data from the Communicable Disease Section, ACT Health
 Australian data from National Notifiable Diseases Surveillance System, DoHA

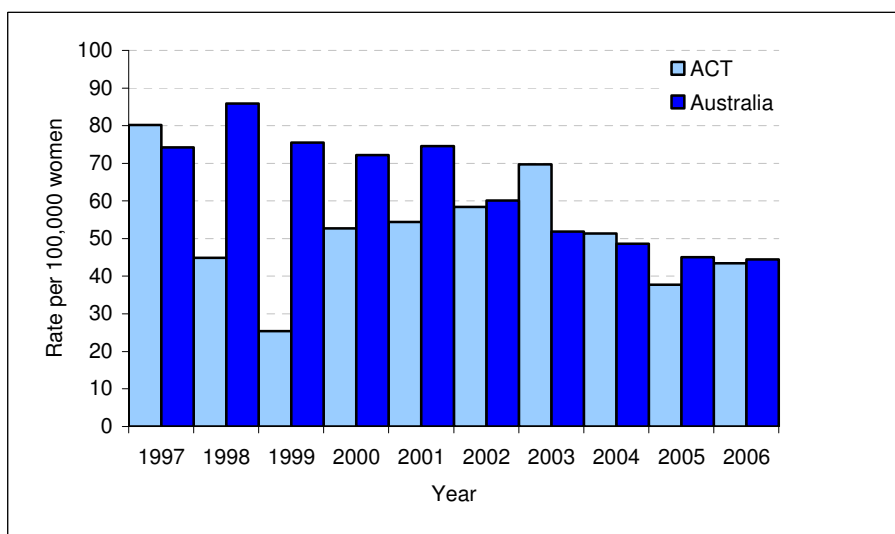
3.7 Hepatitis C

Hepatitis C (HCV) is caused by an infection with a virus first identified in 1989. Infections with HCV are frequently asymptomatic, however, the infection may result in chronic carriage of the virus in 50% of cases and some of these will go on to develop liver cirrhosis (scarring) and possibly liver cancer.

When the HCV notification is known to be from a recent infection, it is regarded as “incident HCV”. Those who have antibodies from a past infection of HCV are regarded as “unspecified HCV”. In this report both incident and unspecified cases were combined into one category as the ACT had a low number of incident HCV in females each year (minimum: 3 cases per year; maximum: 12 cases per year).

The ACT has a stable rate of Hepatitis C in women. The crude rates (number of cases per 100,000 women) of HCV in women are slightly lower than the national rates (Figure 11). There has been a decline in the number of cases notified in the ACT since 2004. Most HCV notifications in the ACT occurred in the 20-49 year age group during the last decade. In the ACT, the main risk factors for acquiring HCV in 2006 were intravenous drug use and sharing of needles and injecting equipment (71%).²²

Figure 11: Hepatitis C (incident and unspecified) notification rates, females, ACT and Australia, 1997-2006



Source: ACT data from the Communicable Disease Section, ACT Health
 Australian data from National Notifiable Diseases Surveillance System, DoHA

3.8 Human Immunodeficiency Virus

Human Immunodeficiency Virus (HIV) can severely damage the immune system, resulting in Acquired Immune Deficiency Syndrome (AIDS). AIDS is a disease in which the body's immune system breaks down and is unable to fight off certain infections, known as "opportunistic infections", and other illnesses that the body could previously fight.

HIV is transmitted from person to person through sexual contact, sharing of HIV contaminated injecting equipment, transfusion of infected blood and blood products or transplantation of infected tissue and organs. In the ACT, transmission of HIV occurred primarily through sexual contact of homosexual men (64%) or heterosexual men (18%) during 2001-2006.²³

There has been a steady decline of new HIV cases since the mid 1990s. Between 2004 and 2006, there was an average of seven new cases of HIV each year in the ACT, compared to an average of 20 cases per year during 1994-1996. Among these new cases of HIV diagnoses, women accounted for zero to three cases each year during 1997-2006.

3.9 Prevalence of Chronic Conditions

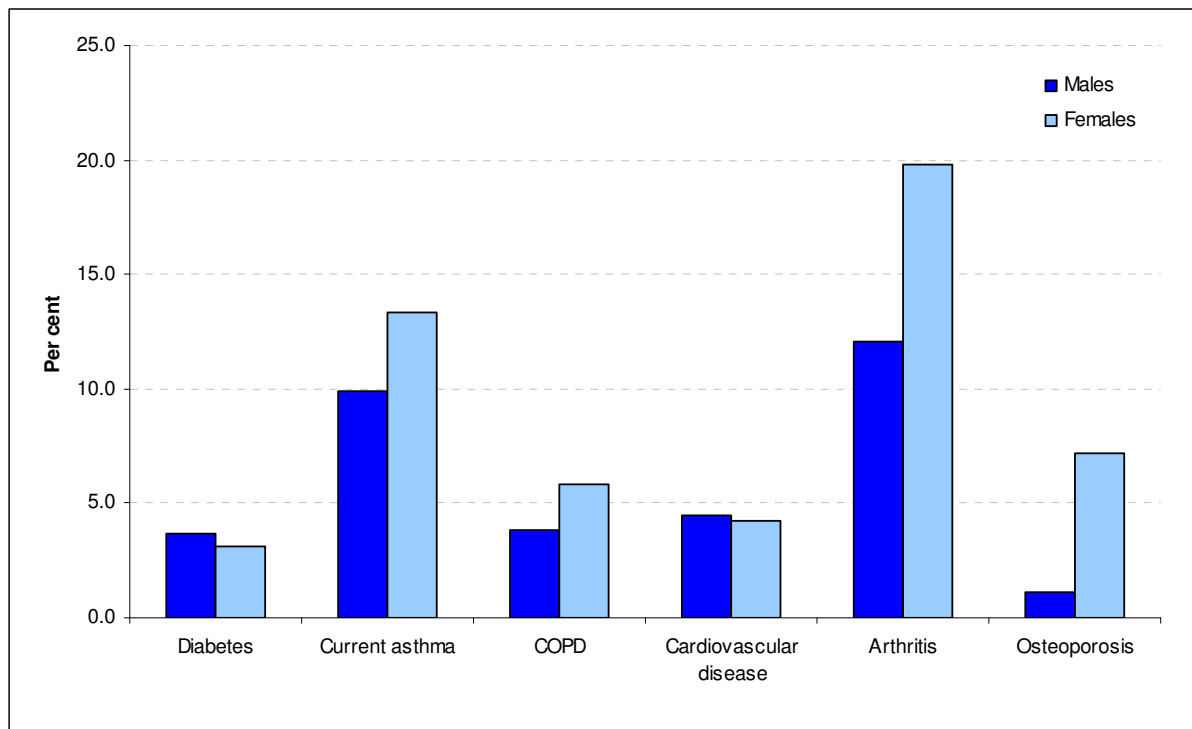
Chronic diseases are characterised by complex pathways and risk factors, prolonged illness leading to impairment and often disability.²⁴

Respondents to the 2005 ACT General Health Survey were asked whether they had ever been diagnosed with a range of chronic conditions. Results from the survey (Figure 12) show that arthritis was the most common condition (19.8%) reported by women with significantly more women reporting this condition than men.

Of those who reported being diagnosed with arthritis, osteoarthritis was the most common form of arthritis reported by both females (65.5%) and males (51.8%). This was followed by rheumatoid arthritis for 16.1% of females and 11.2% of males. Almost one in three males (30.9%) and one in five females (17%) reported not knowing what type of arthritis they had.

Asthma was the second most common condition reported by females (13.3%), followed by Chronic Obstructive Pulmonary Disease (5.8%; COPD) and cardiovascular disease. Differences between males and females in the prevalence of these conditions were not statistically significant.

Figure 12: Percentage of respondents reporting selected chronic conditions, aged 18 years and over, by sex, ACT, 2005



Note: COPD refers to Chronic Obstructive Pulmonary Disease
 Source: ACT General Health Survey, ACT Health, 2005

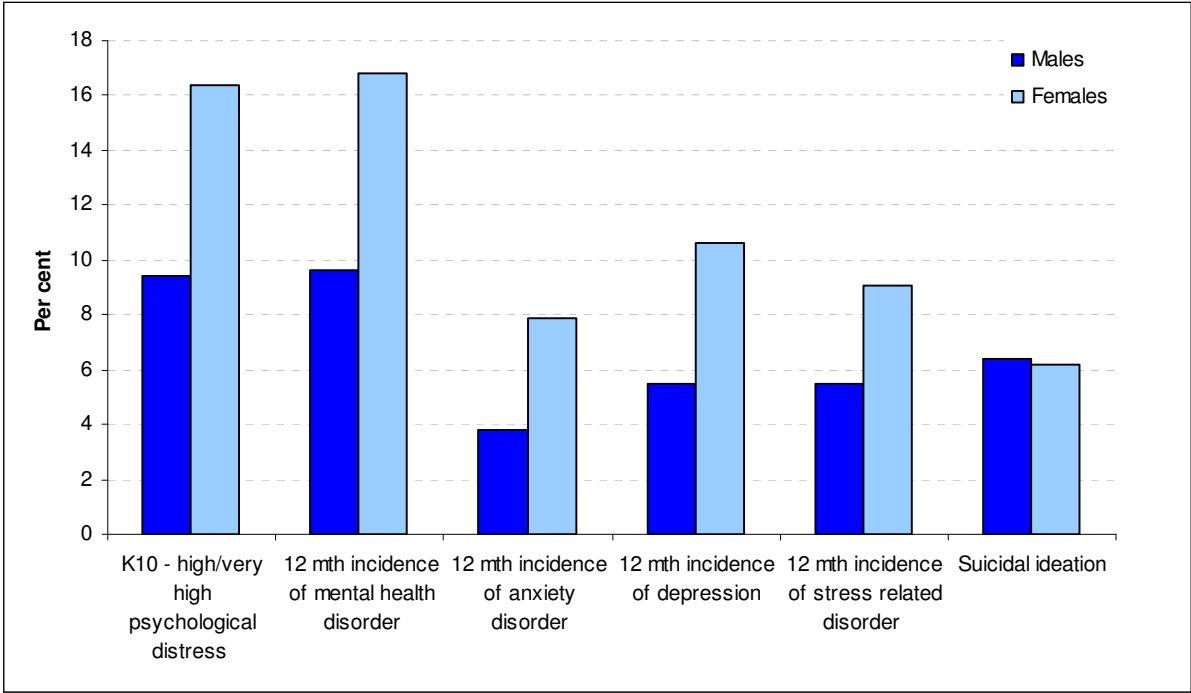
3.10 Mental health

Mental health problems and disorders can have profound effects on people’s lives. Females are generally more likely than males to be diagnosed with a mental health condition, particularly in relation to disorders affecting mood.²⁵ However, it is unclear whether this difference is due to a greater prevalence of these disorders in females or instead a higher tendency for women to seek medical attention and diagnosis.

Figure 13 shows the percentage of males and females reporting mental health conditions in the ACT General Health Survey. Levels of psychological distress were measured using the Kessler 10 (K10) instrument. This instrument is considered appropriate to estimate the needs of the population for community mental health services.²⁶

Results of the K10 indicated that 1 in 6 (16.4%) ACT females aged over 18 years reported high to very high psychological distress (Figure 13). This is almost double the proportion of males reporting this (9.4%). In addition, females (16.8%) were more likely than males (9.6%) to report having a mental health condition in general. A similar pattern was evident in relation to depression (females 10.6%; males 5.5%) and anxiety (females 7.9%; males 3.8%). These differences were all statistically significant ($p < .05$). Females (6.2%) were just as likely to report suicidal ideation as males (6.4%).

Figure 13: Percentage of respondents reporting mental health conditions, aged 18 years and over, by sex, ACT, 2005



Source: ACT General Health Survey, ACT Health, 2005

3.11 Major life events

Major life events significantly impact on people’s lives and may lead to substantial psychological distress. The most frequently reported major life events for ACT women aged 18 years and over were pregnancy and childbirth (28.0%); commencing a new job (23.9%); a family member or friend having an illness (22.1%); having a surgical operation (21.1%); or the death of somebody close to them (18.6%) (Table 5).

Table 5: Major life events experienced by ACT respondents, ACT, 2005

In the last 12 months have you personally been affected by the following:	Male %	Female %
Birth/pregnancy	18.4	28.0 *
New job	18.8	23.9
Illness in family member/friend	15.9	22.1 *
Surgical operation	27.7	21.1 *
Death of somebody close to you	19.4	18.6
Family issues/problems	13.3	13.7
Moved house	8.6	12.9 *
Financial stress (includes farming)	6.2	12.3 *
Serious illness	5.6	9.5 *
Marriage/relationship breakdown	5.4	9.2 *
Discrimination	4.6	8.3 *
Mental illness / severe mental disturbance - family member	6.4	6.7
Serious injury	3.9	4.5
Unplanned loss of job?	3.7	4.5
Family or domestic violence	2.4	4.4
Robbed or home burgled	4.5	3.5
None	7.4	13.7 *

*Significantly different at p<0.05.

Source: ACT General Health Survey, ACT Health, 2005

Women were significantly more likely than men to report being affected by childbirth and pregnancy, illness in family member or friend, moving house, experiencing financial stress, experiencing a serious illness, having a marriage or relationship breakdown, or having a family member with a mental illness. Men were significantly more likely to report being affected by a surgical procedure.

3.12 Antenatal and postnatal depression

Antenatal and postnatal depression is a serious public health issue with figures estimating that one in seven women who experience pregnancy, childbirth and new parenthood will experience some level of antenatal or postnatal depression.²⁷

There is little data available on the prevalence of postnatal depression in the ACT however results from a prospective cohort study²⁸ revealed that in 1997, 10.3% of women surveyed (n=1,252) had a score greater than 12 (indicating depression) on the Edinburgh Postnatal Depression Scale (EPDS), at eight weeks postpartum. The cumulative proportion of ACT women who scored more than 12 on the EPDS over the six months postpartum follow up was 17.3%.

3.13 Behavioural determinants

Behavioural determinants influence the likelihood of developing chronic disease and illness and can also affect the degree of progression or decline in disease. Table 6 presents results from the ACT General Health Survey in relation to selected behavioural determinants. In general, females fare better than males on several behavioural determinants, including smoking, alcohol consumption and fruit and vegetable consumption with these differences being statistically significant (p<.05).

However, females rate more poorly than males in relation to their levels of obesity and achieving sufficient levels of physical activity for good health. These differences were also statistically significant. No differences between males and females were found in relation to having high blood pressure and cholesterol treatment and testing in the 12 months prior to the survey.

Table 6: Selected behavioural determinants, by sex, ACT residents 18 years and over, 2005

	Males	Females
Currently has or is being treated for high blood pressure	13.2	18.5*
Had blood pressure checked in last 12 months	67.7	78.9
Currently has or is being treated for high cholesterol	10.4	11.2
Had cholesterol checked in last 12 months	41.8	44.5
Daily smoker	17.8	13.1*
Risky/high risk in short term of harm due to alcohol	38.7	26.2*
Risky/high risk in long term of harm due to alcohol	7.0	3.6*
Weight status		
Underweight <18.5	2.0**	5.7
Normal weight 18.5-24.99	42.6	45.6
Overweight 25-29.99	40.1	27.2*
Obese 30+	15.3	21.5*
Sufficient physical activity (at least 150 mins over at least five occasions)	49.3	42.2*
Consumes at least 5 serves of vegetables each day (a)	5.0	11.5*
Consumes at least 2 serves of fruit each day (a)	39.6	51.7*

*Statistically significant at p<0.05.

**The relative standard error for this estimate was greater than 25%, therefore the estimate should be interpreted with caution.

(a) Fruit consumption includes persons aged 19 years and over.

Source: 2005 ACT General Health Survey confidentialised unit record file, ACT Health

The health benefits of breastfeeding for infants and mothers are well established. ACT results from Wave 1 of the Longitudinal Study of Australian Children (LSAC) show that 91.2% of ACT infants and 94.9% of ACT four year olds were reported to have been breastfed at least once.²⁹ The average duration of breastfeeding for ACT respondents was 10.5 months, significantly longer than the duration of breastfeeding reported by respondents from other states and territories (8.2 months, p<0.05).

4 Health Service Utilisation

4.1 Hospital service use

There were over 40,000 episodes of hospital care provided to ACT resident women aged 12 years and over during the 2006-07 financial year, and the average length of stay was 3.6 days. The most frequent reasons for hospitalisation during 2006-07 were obstetrics (13.0%), renal dialysis (12.3%), gynaecology (9.1%), and orthopaedics (7.2%). The most frequent reasons for hospitalisation have remained similar since 2002-03.

Table 7: Hospital separations for female ACT residents aged 12 years and over by Service Related Group (SRG 4.2), 2004-05 to 2006-07

	2004-05		2005-06		2006-07	
	No.	%	No.	%	No.	%
Obstetrics	4,958	13.6	5,175	12.9	5,411	13.0
Dialysis	3,579	9.8	3,993	9.9	5,116	12.3
Gynaecology	3,902	10.7	4,217	10.5	3,810	9.1
Orthopaedics	2,989	8.2	3,000	7.5	3,016	7.2
Non sub-speciality surgery	1,346	3.7	1,654	4.1	1,807	4.3
Chemotherapy	1,601	4.4	1,890	4.7	1,676	4.0
Psychiatry	1,548	4.3	1,443	3.6	1,632	3.9
Diagnostic gastrointestinal endoscopy	1,401	3.8	1,421	3.5	1,519	3.6
Non sub-speciality medicine	1,230	3.4	1,390	3.5	1,460	3.5
Plastic surgery	1,319	3.6	1,380	3.4	1,445	3.5
Gastroenterology	914	2.5	1,157	2.9	1,282	3.1
Neurology	971	2.7	1,184	2.9	1,261	3.0
Cardiology	921	2.5	1,279	3.2	1,193	2.9
Ophthalmology	1,126	3.1	1,193	3.0	1,143	2.7
Respiratory medicine	853	2.3	987	2.5	899	2.2
Ear, nose and throat	456	1.3	622	1.5	842	2.0
Upper gastrointestinal tract surgery	700	1.9	746	1.9	811	1.9
Rehabilitation	473	1.3	650	1.6	646	1.5
Immunology and infectious diseases	544	1.5	613	1.5	601	1.4
Haematology	587	1.6	705	1.8	580	1.4
Urology	494	1.4	494	1.2	537	1.3
Drug and alcohol	372	1.0	509	1.3	531	1.3
Breast surgery	436	1.2	430	1.1	435	1.0
Interventional cardiology	521	1.4	474	1.2	430	1.0
Neurosurgery	354	1.0	414	1.0	429	1.0
Endocrinology	320	0.9	380	0.9	391	0.9
Vascular surgery	363	1.0	373	0.9	361	0.9
Maintenance	119	0.3	122	0.3	343	0.8
Colorectal surgery	315	0.9	344	0.9	312	0.7
Medical oncology	320	0.9	375	0.9	279	0.7
Non-acute geriatric	7	0.0	79	0.2	276	0.7
Dentistry	381	1.0	304	0.8	234	0.6
Renal medicine	209	0.6	241	0.6	203	0.5
Rheumatology	139	0.4	184	0.5	186	0.4
Palliative care	172	0.5	205	0.5	171	0.4
Head and neck surgery	123	0.3	128	0.3	124	0.3
Dermatology	58	0.2	124	0.3	106	0.3
Pain management	104	0.3	111	0.3	89	0.2
Cardiothoracic surgery	81	0.2	73	0.2	80	0.2
Tracheostomy	42	0.1	35	0.1	36	0.1
Unallocated	41	0.1	35	0.1	36	0.1
Extensive burns	2	0.0	8	0.0	6	0.0
Total	36,391	100.0	40,141	100.0	41,745	100.0

Source: ACT Admitted Patient Care Dataset, Confidentialised Unit Record File

Between 2002-03 and 2005-06 there were 11,076 hospital separations coded as renal dialysis. These were repeat procedures provided to 90 ACT resident women. These hospital separations have been excluded from the following analysis.

Between 2002 and 2007, the average age of women who had a hospital separation was 49.9 years (males 54.7 years). The number of hospital separations for female ACT residents peaked among women aged 25-34 years and again among women aged 75 years and over. These peaks correspond to the age groups with highest fertility (25-34 years) or illness preceding end of life (75 years or more).

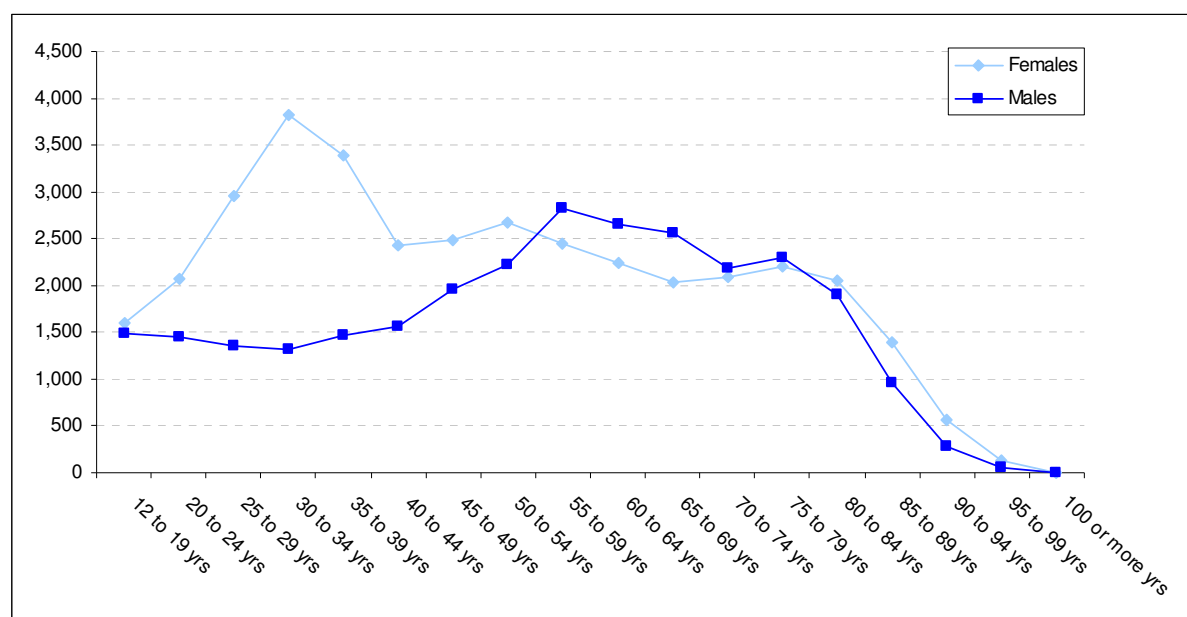
Table 8: Hospital separations by age group, ACT female residents, 2002-03 to 2006-07

	2002-03		2003-04		2004-05		2005-06		2006-07	
	No.	%	No.	%	No.	%	No.	%	No.	%
12 to 24 yrs	3,061	10.5	3,384	9.8	3,214	9.8	3,781	10.5	3,682	10.1
25 to 34 yrs	6,026	20.7	6,485	18.7	6,462	19.7	6,837	18.9	6,771	18.5
35 to 44 yrs	4,352	14.9	5,173	14.9	5,452	16.6	5,873	16.3	5,810	15.9
45 to 54 yrs	4,193	14.4	5,444	15.7	4,559	13.9	4,837	13.4	5,173	14.1
55 to 64 yrs	3,766	12.9	4,870	14.0	4,260	13.0	4,963	13.8	4,692	12.8
65 to 74 yrs	3,186	10.9	3,986	11.5	3,565	10.9	3,758	10.4	4,117	11.2
75 yrs or more	4,548	15.6	5,342	15.4	5,237	16.0	6,043	16.7	6,364	17.4
Total	29,132	100.0	34,684	100.0	32,749	100.0	36,092	100.0	36,609	100.0

Note: Excludes renal dialysis.
Source: ACT Admitted Patient Care Dataset, Confidentialised Unit Record File

The peak in hospital separations related to child birth is also evident in the number of hospital separations for males and females by age group (Figure 14). The number of hospital separations for females is substantially higher in the 20 to 39 year age groups, whereas males have a higher number of hospital separations in the 55 to 69 year age groups. The number of hospital separations for older women was slightly higher than the number for men.

Figure 14: Hospital separations by age group and sex, ACT residents, 2006-07



Note: Excludes renal dialysis.
Source: ACT Admitted Patient Care Dataset, Confidentialised Unit Record File

4.2 Maternal services

Childbirth or pregnancy related conditions were the most frequent reasons for hospital admission for women during each financial year between 2002-03 and 2006-07 (Table 7). The number of ACT resident women giving birth has increased in recent years from 4,103 in 2000³⁰ to 4,485 in 2006.³¹ Preliminary data suggests that the number of women giving birth has continued to increase in 2007.

In 2005, there were 4,995 women who gave birth in ACT hospitals (Table 9), the majority of these women were ACT residents (84.5%). There has been a decrease in the percentage of women giving birth in public hospitals from 73.6% in 2000³⁰ to 61.7% in 2005. A small percentage of women give birth at home (2005, 0.2%) or before arrival at hospital (2005, 0.3%) each year.

Table 9: Number of women giving birth by place of birth by state of residence, 2003-2005

		2003		2004		2005	
		No.	%	No.	%	No.	%
ACT residents	TCH Delivery Suite	1,350	33.3	1,352	33.6	1,315	31.2
	TCH Birth Centre	273	6.7	232	5.8	243	5.8
	Calvary Public	979	24.1	961	23.9	1,042	24.7
	Public Hospitals	2,602	64.2	2,545	63.3	2,600	61.6
	Calvary Private	576	14.2	581	14.5	612	14.5
	Calvary John James	860	21.2	860	21.4	982	23.3
	Private Hospitals	1,436	35.4	1,441	35.9	1,594	37.8
	Homebirths	5	0.1	25	0.6	10	0.2
	Born before arrival	11	0.3	7	0.2	17	0.4
Total	4,054	100.0	4,018	100.0	4,221	100.0	
Non ACT residents	TCH Delivery Suite	330	45.2	345	44.2	331	42.8
	TCH Birth Centre	31	4.2	36	4.6	31	4.0
	Calvary Public	117	16.0	112	14.3	120	15.5
	Public Hospitals	478	65.5	493	63.1	482	62.3
	Calvary Private	56	7.7	68	8.7	76	9.8
	Calvary John James	192	26.3	220	28.2	216	27.9
	Private Hospitals	248	34.0	288	36.9	292	37.7
	Homebirths	<5	*	0	0.0	0	0.0
	Born before arrival	<5	*	0	0.0	0	0.0
Total	730	100.0	781	100.0	774	100.0	
Total	TCH Delivery Suite	1,680	35.1	1,697	35.4	1,646	33.0
	TCH Birth Centre	304	6.4	268	5.6	274	5.5
	Calvary Public	1,096	22.9	1,073	22.4	1,162	23.3
	Public Hospitals	3,080	64.4	3,038	63.3	3,082	61.7
	Calvary Private	632	13.2	649	13.5	688	13.8
	Calvary John James	1,052	22.0	1,080	22.5	1,198	24.0
	Private Hospitals	1,684	35.2	1,729	36.0	1,886	37.8
	Homebirths	6	0.1	25	0.5	10	0.2
	Born before arrival	14	0.3	7	0.1	17	0.3
Total	4,784	100.0	4,799	100.0	4,995	100.0	

Source: ACT Maternal Perinatal Data Collection

The majority of women who gave birth in the ACT had a normal birth (Table 10). An increase in the percentage of caesarean section births occurred between 2000 (21.7%)³⁰ and 2005 (28.9%) (Table 10). However, the ACT percentage remains lower than the percentage of caesarean section births for Australia (30.3%).³² The percentage of women having an instrumental birth decreased slightly from 14.0% in 2003 to 12.3% in 2005.

Table 10: Method of birth by state of residence, ACT, 2003-2005

		2003		2004		2005	
		No.	%	No.	%	No.	%
ACT residents	Normal birth	2,449	60.4	2,379	59.2	2,504	59.3
	Vaginal Breech	31	0.8	19	0.5	19	0.5
	Instrumental birth	576	14.2	575	14.3	524	12.4
	Caesarean Section	998	24.6	1,045	26.0	1,174	27.8
	Total	4,054	100.0	4,018	100.0	4,221	100.0
Non ACT residents	Normal birth	414	56.7	409	52.4	408	52.7
	Vaginal Breech	15	2.1	4	0.5	9	1.2
	Instrumental birth	93	12.7	119	15.2	89	11.5
	Caesarean Section	208	28.5	249	31.9	268	34.6
	Total	730	100.0	781	100.0	774	100.0
Total	Normal birth	2,863	59.8	2,788	58.1	2,912	58.3
	Vaginal Breech	46	1.0	23	0.5	28	0.6
	Instrumental birth	669	14.0	694	14.5	613	12.3
	Caesarean Section	1,206	25.2	1,294	27.0	1,442	28.9
	Total	4,784	100.0	4,799	100.0	4,995	100.0

Source: ACT Maternal Perinatal Data Collection

The majority of ACT resident women who gave birth in 2005 were aged between 20 and 34 years (74.3%; Aust 75.9%)³². A small percentage was aged less than 20 years (2.7%; Aust 4.6%) and

23.0% were aged over 35 years (Aust 19.6%). Fourteen per cent (13.8%) of women who gave birth in 2005 reported that they smoked during pregnancy. Smoking during pregnancy for ACT residents has been previously found to be significantly higher among younger women (aged less than 25 years) and to be associated with low birthweight babies.³³

Table 11: Maternal characteristics, ACT residents, 2005

		2005	
		No.	%
Maternal age group	Under 20 yrs	114	2.7
	20-34 yrs	3,136	74.3
	Over 35 yrs	971	23.0
	Total	4,221	100.0
Smoked during pregnancy	Smoker	584	13.8
	Non smoker	3,637	86.2
	Total	4,221	100.0
Aboriginal and Torres Strait Islander Status	Aboriginal and Torres Strait Islander	79	1.9
	Non Aboriginal	4,142	98.1
	Total	4,221	100.0
Multiple birth	Singleton	4,163	98.6
	Multiple birth	58	1.4
	Total	4,221	100.0

Source: ACT Maternal Perinatal Data Collection

Two per cent of ACT resident women who gave birth during 2005 identified as Aboriginal and Torres Strait Islander. The percentage of ACT resident women having a multiple birth in 2005 was 1.4% slightly lower than the Australian percentage (1.7%).³²

4.3 Emergency department use

There were approximately 35,000 ACT emergency department presentations for ACT residents during the 2005-06 financial year (Table 12). Almost one quarter (22.6%) of these presentations were for women aged between 20 to 29 years. Four in ten emergency department presentations were classified into the triage category "emergency" or "urgent" and less than one per cent of ACT women presenting to an emergency department required resuscitation.

Table 12: ACT emergency department presentations by age group and triage category, female ACT residents, 2004-05 to 2005-06

		2004-05		2005-06	
		No.	%	No.	%
Age group	12 to 19 yrs	4,529	13.8	4,830	13.8
	20 to 29 yrs	7,278	22.2	7,918	22.6
	30 to 39 yrs	5,585	17.1	5,851	16.7
	40 to 49 yrs	4,167	12.7	4,499	12.9
	50 to 59 yrs	3,816	11.7	4,082	11.7
	60 to 69 yrs	2,383	7.3	2,499	7.1
	70 to 79 yrs	2,332	7.1	2,351	6.7
	80 to 89 yrs	2,172	6.6	2,349	6.7
	90 or more yrs	481	1.5	593	1.7
	Total	32,743	100.0	34,972	100.0
Urgency	Resuscitate	217	0.7	194	0.6
	Emergency/urgent	12,503	38.2	13,846	39.6
	Semi/Non-urgent	20,022	61.1	20,932	59.9
	Not stated	1	0.0		
	Total	32,743	100.0	34,972	100.0

Source: ACT Emergency Department Information System data, 2004/05 – 2005/06

The most frequent reasons for ACT resident women to present to an emergency department in 2005-06 were for symptoms, signs and abnormal clinical and laboratory findings, injury and poisoning and factors influencing health status (Table 13). The most common diagnostic category within symptoms and signs was unspecified abdominal and chest pain. Diagnoses within the injury and poisoning chapter were evenly distributed with very small numbers in each diagnostic group.

Table 13: ACT emergency department presentations by ICD Chapter, ACT female residents, 2005-06

ICD chapter	2005/06	
	No.	%
Symptoms, signs and abnormal findings	6,869	19.6
Injury and poisoning	6,533	18.7
Factors influencing health status, contact with health status	4,678	13.4
Musculoskeletal and connective tissue diseases	3,081	8.8
Digestive system diseases	2,060	5.9
Genitourinary system diseases	1,926	5.5
Respiratory system diseases	1,813	5.2
Circulatory system diseases	1,309	3.7
Mental & behavioural disorders	1,295	3.7
Infectious and parasitic diseases	1,188	3.4
Pregnancy, childbirth and puerperium	991	2.8
Skin & subcutaneous tissue diseases	872	2.5
Nervous system diseases	792	2.3
Eye and adnexa diseases	536	1.5
Ear and mastoid process diseases	327	0.9
Endocrine, nutritional and metabolic diseases	283	0.8
External causes of morbidity and mortality	207	0.6
Blood & blood forming organs diseases	110	0.3
Neoplasms	88	0.3
Congenital malformations, deformations and chromosomal abnormalities	14	0.0
Total	34,972	100

Note: ICD-10 classification.
Source: ACT Emergency Department Information System data, 2005-06

The majority of women who presented to ACT emergency departments completed their episode of care and departed (64.9%), and one quarter required hospital admission (26.6%, Table 14). Seven per cent (7.2%) of women did not wait to be attended by a health care professional.

Table 14: ACT emergency department presentations by departure status, ACT female residents, 2005-06

Departure status	2005-06	
	No.	%
Episode complete and departed	22,706	64.9
Admitted to this hospital	9,292	26.6
Did not wait to be attended by a health care professional	2,507	7.2
Referred to another hospital for admission	277	0.8
Left at own risk after being seen, before episode completed	171	0.5
Died in Emergency Department as a non-admitted patient	17	0.0
Dead on arrival, not treated in Emergency Department	2	0.0
Total	34,972	100.0

Source: ACT Emergency Department Information System data, 2005-06

4.4 Outpatient clinic use

There were over 70,000 outpatient occasions of service provided to women in 2006-07 (Table 15). This represents an increase of 18.0% since 2002-03. The obstetrics clinics provided almost a third of outpatient occasions of service (30.0%) in 2006-07, followed by radiology (10.4%), oncology (8.2%) and endocrinology (6.5%).

In 2006-07, ACT Health implemented the ACT Patient Administration System to record outpatient occasions of service. This may have resulted in activity being counted or coded differently and may explain the decrease in the number of occasions of service seen in 2006-07.

Table 15: Outpatient occasions of service provided to women by ACT Health clinic, 2002-03 to 2006-07

UNIT	2002-03		2003-04		2004-05		2005-06		2006-07	
	No.	%	No.	%	No.	%	No.	%	No.	%
Obstetrics	20,840	34.1	21,911	33.4	21,269	31.2	23,080	31.1	21,768	30.0
Radiology	5,034	8.2	6,271	9.5	6,765	9.9	7,243	9.8	7,572	10.4
Oncology	4,645	7.6	5,001	7.6	5,367	7.9	5,682	7.7	5,984	8.2
Endocrinology	4,429	7.2	4,187	6.4	4,034	5.9	4,528	6.1	4,693	6.5
Gynaecology	4,296	7.0	4,699	7.2	3,818	5.6	4,366	5.9	3,933	5.4
Gastroenterology	2,138	3.5	2,393	3.6	3,264	4.8	3,785	5.1	3,690	5.1
Respiratory	2,480	4.1	2,865	4.4	3,048	4.5	3,454	4.7	3,277	4.5
Orthopaedics	2,286	3.7	2,145	3.3	2,545	3.7	3,013	4.1	3,114	4.3
Cardiology	2,764	4.5	2,718	4.1	3,452	5.1	3,501	4.7	3,085	4.3
General surgery	2,522	4.1	2,709	4.1	2,952	4.3	3,365	4.5	2,965	4.1
Renal	1,405	2.3	1,946	3.0	2,034	3.0	2,462	3.3	2,320	3.2
Haematology	1,631	2.7	1,625	2.5	1,491	2.2	1,395	1.9	1,502	2.1
Radiation oncology	880	1.4	930	1.4	966	1.4	1,452	2.0	1,265	1.7
Plastic surgery	520	0.9	462	0.7	571	0.8	666	0.9	921	1.3
Immunology	530	0.9	780	1.2	787	1.2	856	1.2	890	1.2
Neurology	104	0.2	451	0.7	519	0.8	522	0.7	771	1.1
Vascular surgery	837	1.4	783	1.2	771	1.1	632	0.9	636	0.9
Infectious diseases	512	0.8	545	0.8	600	0.9	626	0.8	622	0.9
Anaesthetics	822	1.3	810	1.2	1,112	1.6	547	0.7	562	0.8
Rheumatology	435	0.7	416	0.6	451	0.7	484	0.7	552	0.8
Geriatrics	391	0.6	475	0.7	461	0.7	542	0.7	504	0.7
Genetics	340	0.6	304	0.5	360	0.5	348	0.5	426	0.6
Psychiatry	125	0.2	136	0.2	106	0.2	195	0.3	261	0.4
Neurosurgery	0	0.0	25	0.0	0	0.0	92	0.1	254	0.4
Urology	209	0.3	312	0.5	394	0.6	252	0.3	209	0.3
Ear, nose and throat	260	0.4	232	0.4	425	0.6	401	0.5	206	0.3
Rehabilitation	278	0.5	140	0.2	223	0.3	171	0.2	194	0.3
Cardiac surgery	132	0.2	111	0.2	137	0.2	143	0.2	134	0.2
Paediatrics	133	0.2	110	0.2	90	0.1	147	0.2	109	0.2
Dermatology	70	0.1	116	0.2	121	0.2	117	0.2	89	0.1
Neonatology	20	0.0	34	0.1	33	0.0	7	0.0	31	0.0
Paediatric surgery	1	0.0	5	0.0	6	0.0	6	0.0	23	0.0
Ophthalmology	48	0.1	42	0.1	37	0.1	21	0.0	3	0.0
Total	61,117	100.0	65,689	100.0	68,209	100.0	74,101	100.0	72,565	100.0

Notes: There were 131 occasions of service coded to "unknown" in 2006-07, these have been excluded from the table. Radiology occasions of service represents attendances at radiology, not the number of tests performed during the visit.
 Radiation oncology occasions of service includes appointments with the doctor only, not the number of treatments provided.
 Surgical preadmission clinic occasions of service are included in general surgery.
 Podiatry occasions of service are included in the Endocrinology clinic.
 The neurosurgery outpatient clinic commenced in March 2006.

Source: ACT Health, Caresys data 2002-03 to 2005-06; and ACT Health, Patient Administration System, 2006-07, preliminary data

4.5 Community Health Services

Community Health provides a range of community-based health services across the ACT to many people with chronic conditions and primary health care needs as well as providing valuable pre and post-hospital care responses.³⁴

Community Health provides primary health care services to the ACT community, the two remand centres and the juvenile detention centre as well as allied health services to The Canberra Hospital. These include maternal, infant and child health services, women's health services, health interpreters, immunisation clinics, diabetes services, alcohol and drug services, dental health clinics, podiatry clinics, social work services, nutrition and dietetic services, counselling, physiotherapy, psychology, neuropsychology, occupational therapy, speech pathology and community nursing services.

The Continuing Care Program of Community Health provides health care and support for people with acute, post-acute, long-term and terminal illnesses. During 2007-08, approximately 50,000 direct occasions of service were provided to ACT resident women aged 12 years or more (Table 16). Three quarters of these occasions of service were provided by nurses (77.2%), followed by physiotherapy (8.7%), podiatry (6.5%) and occupational therapy (3.6%).

The majority of occasions of service provided to women by the Continuing Care Program were for women aged 65 years and over (56.3%).³⁵

Table 16: Direct occasions of service for the Continuing Care Program, ACT resident females 12 years and older, 2004-05 to 2007-08

Discipline	2004-2005		2005-2006		2006-2007		2007-2008	
	No.	%	No.	%	No.	%	No.	%
Nursing	45,834	74.3	43,018	75.1	40,475	74.3	38,326	77.2
Physiotherapy	5,598	9.1	5,373	9.4	4,799	8.8	4,328	8.7
Podiatry	3,134	5.1	3,124	5.5	3,115	5.7	3,246	6.5
Occupational Therapy	3,253	5.3	2,428	4.2	3,804	7.0	1,764	3.6
Nutrition	1,426	2.3	1,284	2.2	417	0.8	920	1.9
Social Work/Psychology	1,742	2.8	1,584	2.8	717	1.3	730	1.5
Other	661	1.1	459	0.8	1,130	2.1	310	0.6
Total	61,648	100.0	57,270	100.0	54,457	100.0	49,624	100.0

Notes: Occasions of Service include only "direct" activity (ie. Direct contact with the client either face to face or via the phone as entered by the clinician. It should be noted that the ACT Health definition of direct occasion of service came into effect in February 2006 and has improved data quality. Only contacts that have occurred have been counted. Planned contacts are not included. Data has been sorted into broad categories based on the specialty team in ACTPAS. Data that is not related to current Community Health services has been excluded from this table (eg. Aged Care Assessment Team and Aged Care Day Care).

The "Other" category includes occasions of service that had occurred but did not match the broader categories used for each program.

Source: ACT Health, Patient Administration System (ACTPAS)

The Child, Youth and Womens Program provides post-natal and early childhood parenting support, lactation advice, home-visiting, immunisation, asthma education and health checks to children, youth and families. They also provide health interpreters and cultural awareness training; medical treatment and counselling for children where there is suspicion of abuse or where abuse has occurred; health care for women, including Pap smears; and counselling and medical services for women affected by violence.

During 2007-08, the Child Youth and Women's Program provided just over 33,000 occasions of service to ACT resident women aged 12 years and over (Table 17). In 2007-08, over half of occasions of service were provided by nursing (52.7%), followed by disciplines other than those grouped in the main categories (14.5%), Women's Health Service Counsellors (10.6%) and Women's Health Service Nurses (8.7%). This pattern has been consistent over time since 2004-05 (Table 17).

Over two thirds of occasions of service provided by the Child, Youth and Women's Program were to women aged between 25 and 39 years.³⁵

Table 17: Direct occasions of service for the Child, Youth and Women's Program, ACT resident females 12 years and older, 2004-05 to 2007-08

Discipline	2004-2005		2005-2006		2006-2007		2007-2008	
	No.	%	No.	%	No.	%	No.	%
Nursing	16,859	58.0	21,298	59.5	22,623	60.7	17,526	52.7
Other	3,394	11.7	3,628	10.1	2,942	7.9	4,819	14.5
WHS Counsellor	3,216	11.1	3,296	9.2	4,020	10.8	3,522	10.6
WHS Nurse	2,757	9.5	2,560	7.1	2,525	6.8	2,882	8.7
Social Worker	1,286	4.4	1,604	4.5	1,788	4.8	1,824	5.5
WHS Health Medical Officer	1,064	3.7	1,038	2.9	1,107	3.0	809	2.4
Interpreter	14	0.0	1,141	3.2	885	2.4	728	2.2
Physiotherapy	0	0.0	554	1.5	730	2.0	671	2.0
Nutrition	393	1.4	384	1.1	411	1.1	293	0.9
Medical Officer	13	0.0	59	0.2	71	0.2	51	0.2
Paediatrician	4	0.0	63	0.2	79	0.2	41	0.1
IMPACT	0	0.0	0	0.0	0	0.0	35	0.1
Asthma Educator	70	0.2	134	0.4	32	0.1	18	0.1
Psychologist	0	0.0	66	0.2	87	0.2	14	0.0
Total	29,070	100.0	35,825	100.0	37,300	100.0	33,233	100.0

Note: WHS refers to Women's Health Service
Source: ACT Health, Patient Administration System (ACTPAS)

The Alcohol and Drug Program provides alcohol and drug information, education, assessment, referral, treatment, counselling, detoxification and opioid treatment. During 2007-08, this program provided approximately 4,000 direct occasions of service (Table 18). In 2007-08, half of occasions of service (50.1%) were for counselling, followed by opioid treatment (23.6%), diversion (14.5%) and consultation and liaison (7.2%). Almost three quarters (72.9%) of occasions of service provided to women by the Alcohol and Drug Program in 2007-08 were for women aged between 20 to 44 years.³⁵

Table 18: Direct occasions of service for the Alcohol and Drug Program, ACT resident females 12 years and older, 2004-05 to 2007-08

Discipline	2004-2005		2005-2006		2006-2007		2007-2008	
	No.	%	No.	%	No.	%	No.	%
Counselling	1,564	37.4	1,290	34.4	1,767	41.2	1,910	50.1
Opioid Treatment	1,158	27.7	1,120	29.9	829	19.3	902	23.6
Diversion	810	19.4	932	24.9	1,309	30.5	553	14.5
Consultation & Liaison	177	4.2	160	4.3	324	7.6	275	7.2
Other	159	3.8	0	0.0	4	0.1	94	2.5
Detox	309	7.4	245	6.5	58	1.4	82	2.1
Total	4,177	100.0	3,747	100.0	4,291	100.0	3,816	100.0

Note: Alcohol and Drug program occasions of service excludes periods where paper-based recording occurred with no back entry into ACTPAS.
Source: ACT Health, Patient Administration System (ACTPAS)

The Acute Support Program is comprised of seven clinical service teams, supporting the ACT community via preventative health education, acute care, post acute care and counselling support services. There are six allied health teams and the Diabetes Service, based at The Canberra Hospital, which contribute to and provide health care for people while inpatients of the hospital. Short term follow up following discharge, and specialist outpatient services are also provided to facilitate discharge from the hospital, maintain individuals in the community and prevent admission to hospital.

The Diabetes service community based team also provides education and support to community based patients in the Health Centres and home based if required.

Services from Acute Support Program are also provided into the Aged Care and Rehabilitation Stream (Nutrition at The Canberra Hospital), Canberra Regional Cancer Service (Allied Health at The Canberra Hospital and Cancer Psychosocial Service) and Calvary Hospital (Speech Pathology and partnership support arrangements with Diabetes).

During 2007-08, there were approximately 20,000 occasions of service provided by the Acute Support Program to ACT resident women aged 12 years and over (

Table 19), this was a slight increase from 2006-07. In 2007-08, the Aboriginal Liaison service provided just over one third of occasions of service (36.3%), followed by the Diabetes service (31.1%), Nutrition (11.8%), Occupational Therapy (8.2%) and Physiotherapy (5.9%).

During 2007-08, the number of occasions of service provided by the Acute Support Program peaked for women aged 30 to 39 years, most likely reflecting the peak in hospital admissions for women in this age group due to childbirth.

Table 19: Direct occasions of service for the Acute Support Program, ACT resident females 12 years and older, 2006-07 to 2007-08

Discipline	2006-2007		2007-2008	
	No.	%	No.	%
Diabetes	7,418	44.1	7,083	36.3
Physiotherapy	4,468	26.6	6,079	31.1
Social Work	2,092	12.4	2,308	11.8
Occupational Therapy	618	3.7	1,591	8.2
Psychology	1,079	6.4	1,149	5.9
Nutrition	904	5.4	837	4.3
Speech Pathology	221	1.3	316	1.6
Aboriginal Liaison	21	0.1	158	0.8
Total	16,821	100.0	19,521	100.0

Notes: Acute Support Program Allied Health commenced using ACTPAS in September 2006, data prior to this was not available for publication.

Acute Support Program data includes inpatient and outpatient activity.

Source: ACT Health, Patient Administration System (ACTPAS)

The Child and Youth Dental Health Program provides children and young people with comprehensive assessment, oral health plans based on individual needs, general preventative and restorative treatment, emergency treatment and health promotion. The service is provided in community based clinics. Community Health's Adult Dental Service provides a range of dental treatment to ACT residents who are the primary holder of a current ACT Centrelink issued Pension Concession or Healthcare card. Adult Dental Services include general restorative care, the ACT Denture Scheme which provides a range of denture services, oral health promotion and emergency dental services.

During 2007-08, the Dental Health Program provided a minimum of 666 initial occasions of service to ACT resident women aged 12 years and over. This figure represents their first appointment only and does not include subsequent appointments.

Table 20: Occasions of service for the Dental Health Program, ACT resident females 12 years and older, 2004-05 to 2007-08

Year	Occasions of Service
2004-2005	909
2005-2006	754
2006-2007	669
2007-2008	666

Source: ACT Health, EXACT Dental

Mental Health Services

There were over 80,000 occasions of service provided by Adult Mental Health Services to ACT resident females in 2006-07. The majority of female clients of Adult Mental Health Services had an ICD-10-AM diagnosis of mood or affective disorders (36.2%)(Table 21). Just over one in five clients had a diagnosis of schizophrenia, schizotypal and delusional disorders (22.6%), however these clients received over one third of service contacts (35.9%). Just over ten per cent of clients had a diagnosis of neurotic or stress related disorders or personality and behaviour disorders.

Table 21: Number of clients by primary diagnosis at time of service, ACT resident females 12 years and older, ACT 2004-2005 to 2006-2007

ICD-10-AM Adult Mental Health Service	2004-2005		2005-2006		2006-2007	
	No.	%	No.	%	No.	%
Mood (affective) disorders	415	32.8	428	34.3	509	36.2
Schizophrenia, schizotypal and delusional disorders	325	25.7	306	24.5	318	22.6
Neurotic, stress related and somatoform disorders	146	11.5	157	12.6	188	13.4
Disorders of adult personality and behaviour	176	13.9	171	13.7	163	11.6
Mental and behavioural disorders due to psychoactive substance abuse	81	6.4	53	4.3	100	7.1
Behavioural syndromes associated with physiological disturbances and physical factors	55	4.3	57	4.6	50	3.6
Mental retardation	25	2.0	29	2.3	35	2.5
Behavioural emotional disorders with onset usually occurring in childhood or adolescence	16	1.3	20	1.6	15	1.1
Organic, including symptomatic, mental disorders	13	1.0	14	1.1	14	1.0
Disorders of psychological development	14	1.1	12	1.0	13	0.9
Total	1,266	100.0	1,247	100.0	1,405	100.0
Older Persons Mental Health Service	No.	%	No.	%	No.	%
Mood (affective) disorders	84	34.1	78	27.1	89	34.4
Organic, including symptomatic, mental disorders	64	26.0	85	29.5	62	23.9
Schizophrenia, schizotypal and delusional disorders	49	19.9	52	18.1	52	20.1
Neurotic, stress related and somatoform disorders	39	15.9	60	20.8	41	15.8
Mental and behavioural disorders due to psychoactive substance abuse	8	3.3	8	2.8	11	4.2
Disorders of adult personality and behaviour	<5	*	<5	*	<5	*
Mental retardation	0	0.0	0	0.0	<5	*
Behavioural syndromes associated with physiological disturbances and physical factors	<5.	*	<5	*	0	0.0
Total	246	100.0	288	100.0	259	100.0
Child and Adolescent Mental Health Service	No.	%	No.	%	No.	%
Mood (affective) disorders	100	31.5	119	36.2	128	39.9
Neurotic, stress related and somatoform disorders	88	27.8	90	27.4	83	25.9
Behavioural emotional disorders with onset usually occurring in childhood or adolescence	48	15.1	43	13.1	42	13.1
Behavioural syndromes associated with physiological disturbances and physical factors	35	11.0	37	11.2	28	8.7
Disorders of adult personality and behaviour	14	4.4	13	4.0	11	3.4
Schizophrenia, schizotypal and delusional disorders	8	2.5	6	1.8	10	3.1
Disorders of psychological development	12	3.8	10	3.0	10	3.1
Mental and behavioural disorders due to psychoactive substance abuse	<5	*	7	2.1	5	1.6
Mental retardation	6	1.9	<5	*	<5	*
Organic, including symptomatic, mental disorders	<5	*	<5	*	<5	*
Total	317	100.0	329	100.0	321	100.0

Notes: Diagnoses have been classified according to ICD-10-AM categories
Cells with fewer than five persons have been suppressed to maintain confidentiality.
Source: MH-ACT - MHAGIC (Mental Health Assessment Generation Information Collection) database

The most frequent diagnostic groups have remained similar for each service between 2004-05 and 2006-07 (Table 21).

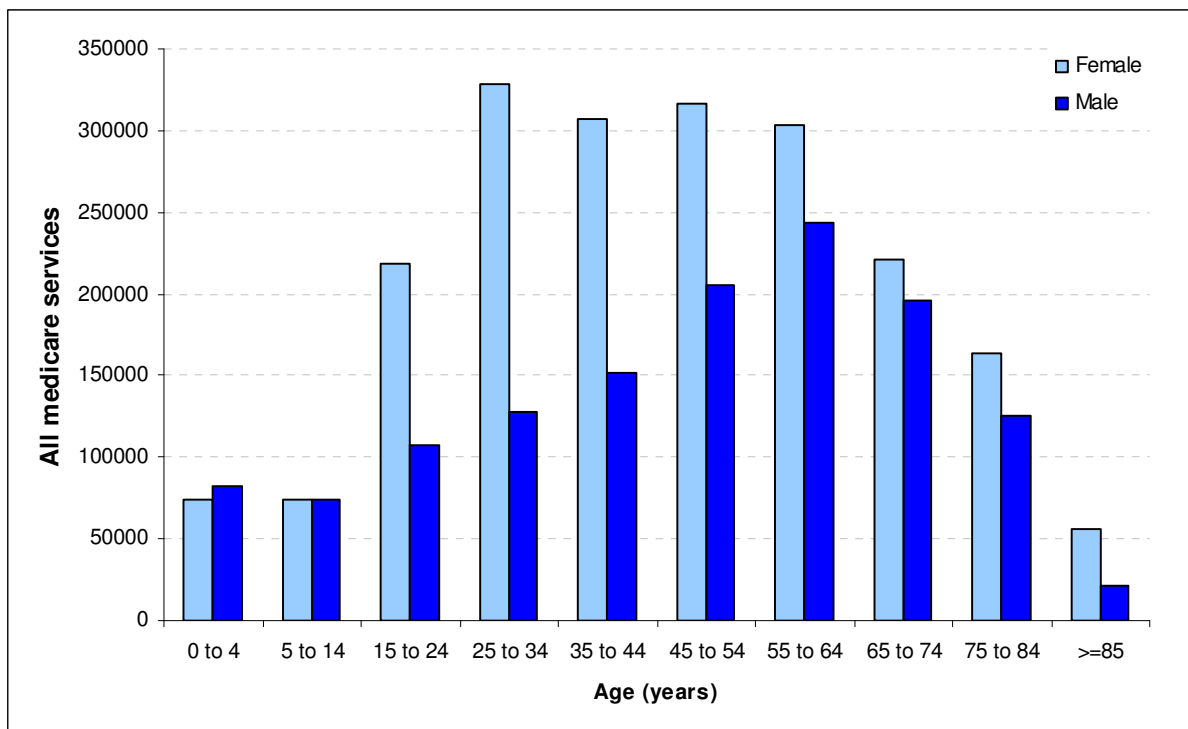
Just over one in three female clients of the Older Person's Mental Health Service in 2006-07 had a diagnosis of mood or affective disorders (34.4%) and almost one quarter (23.9%) had a diagnosis of organic mental disorder (Table 21). This diagnostic category includes dementia and other mental disorders due to brain injury and dysfunction. One in five female clients of the Older Person's Mental Health Service were diagnosed with schizophrenia, schizotypal and delusional disorders and one in six were diagnosed with neurotic or stress related disorders.

Four in ten female clients aged 12 years and over of Child and Adolescent Mental Health Services were diagnosed with mood disorders (39.9%) (Table 21). One quarter of female clients in this age group were diagnosed with neurotic, stress related and somatoform disorders (25.9%) and just over one in ten had a diagnosis of behavioural or emotional disorder with onset during childhood or adolescence (13.1%).

4.6 Medicare Australia services

During 2006-07, there were 3,398,337 services recorded by Medicare for the ACT. These services include professional attendances, diagnostic procedures and investigations, therapeutic procedures, oral and maxillofacial procedures, diagnostic imaging services, pathology services and cleft lip/palette services. Sixty per cent (60.7%) of these services were provided to females. Females had a higher number of services recorded by Medicare Australia across all age groups over 15 years of age, particularly in the 15 to 64 year age groups (Figure 15).

Figure 15: Medicare Australia services provided to ACT residents, 2006-07



Notes: The figures in the report include only those services that are performed by a registered provider, for services that qualify for Medicare Benefit and for which a claim has been processed by Medicare Australia. They do not include services provided by hospital doctors to public patients in public hospitals or services that qualify for a benefit under the Department of Veterans' Affairs National Treatment Account.
State/Territory is determined according to the address (at the time of claiming) of the patient to whom the service was rendered.
Month is determined by the date the service was processed by Medicare Australia, not the date the service was provided.

Source: Medicare Australia, Health Statistics³⁶

Professional attendances (1.6 million attendances) and pathology services (1.2 million services) were the most frequently used Medicare Australia services by ACT residents.³⁶

4.7 Cancer screening participation

There are two national cancer screening initiatives that target women exclusively, these are the National Cervical Screening Program and BreastScreen Australia.

The major objective of the National Cervical Screening Program is to reduce morbidity and mortality from cervical cancer by detecting treatable pre-cancerous lesions before their progression to cancer.

Through increased participation, more women with pre-cancerous abnormalities can be detected and treated before progression to cervical cancer, thus reducing morbidity and deaths. In addition, increased participation will lead to the detection of early stage cancer, where treatment can reduce mortality, in more women. The Program, through a variety of recruitment initiatives, focuses on women in the age group 20–69 years. The recommended screening interval for women in this target age group who have been sexually active at any stage in their lives is two years.³⁷

The participation rate for ACT resident women in the National Cervical Screening Program was significantly higher than the participation rate for all Australia between 1996 and 2005 (Table 22). Participation increased significantly from 1996-97 to 2004-05 for ACT resident women from an age-standardised rate of 63.5% in 1996-97 to 65.5% in 2004-05 (Table 22).

Table 22: Participation of women aged 20–69 years in the National Cervical Screening Program, 1996-1997 to 2004-2005

24-month period	ACT		Australia	
	AS rate	95% CI	AS rate	95% CI
1996-97	63.5	62.8 - 63.7	61.0	60.9 - 61.1
1998-99	65.7	65.1 - 66.2	63.4	63.4 - 63.5
2000-01	62.8	62.3 - 63.4	61.0	60.9 - 61.1
2002-03	62.7	62.2 - 63.3	60.7	60.6 - 60.8
2004-05	65.5	65.0 - 66.0	61.0	60.9 - 61.0

Notes: Age-standardised rates (AS rate) (standardised to the Australian 2001 population) with 95% confidence intervals. Rates are expressed as the percentage of the eligible female population and age-standardised to the Australian 2001 population.
In the 2002–2003 and 2004–2005 reporting periods the ACT registry only registered women with an ACT address respectively.
Since the National Cervical Screening Program commenced, the ACT has only registered women with an ACT address.

Source: AIHW 2007³⁷

The BreastScreen Australia Program commenced in 1991. It aims to reduce mortality and morbidity from breast cancer by actively recruiting and screening women aged 50-69 years, using mammography for early detection of the disease. Women aged 40-49 years and 70 years and over may also be screened.³⁸

The participation rate is the percentage of women in the population screened through the BreastScreen Australia Program in a 24-month period by five-year age groups for women aged 40 years and over and for the target age group 50-69 years. One of the objectives of the BreastScreen Australia Program is to achieve a 70% participation in the National Program by women in the target group (50-69 years).³⁹ It should be noted that these participation rates do not include women who had a mammogram with a private provider.

Fifty five per cent (55.2%) of ACT resident women in the target age group participated in the BreastScreen program during 2004-05 (Table 23). This is a significant decrease in ACT participation rates from 1999-2000 (58.2%) and is also significantly lower than the participation rate for all of Australia (56.2%). The decrease in ACT participation may be explained by a known increase in the population size in the target age group.

During 2004-05, 20,893 ACT women participated in BreastScreen with 18,152 of these women being in the target group aged 50 to 69 years.³⁸

Table 23: Participation of ACT resident women aged 50-69 years in BreastScreen Australia, 1999-00, 2002-03 and 2004-05

	ACT		Australia	
	AS rate	95% CI	AS rate	95% CI
1999-00	58.2	57.3 - 59.1	55.9	55.8 - 56.0
2002-03	55.7	54.9 - 56.5	56.2	56.1 - 56.3
2004-05	55.2	54.4 - 56.0	56.2	56.1 - 56.3

Notes: Rates are the number of women screened as a percentage of the eligible female population and age-standardised to the Australian 2001 population.
Source: AIHW 2008⁴⁰

5 Specific Populations

5.1 Aboriginal and Torres Strait Islander women

There were 1,942 ACT women who identified as Aboriginal and Torres Strait Islander in the 2006 Census, representing 1.2% of the ACT female population. It should be noted that there was a significant number of women who did not respond to this question and the 2006 Census data is yet to be adjusted to account for this.

Aboriginal and Torres Strait Islander people living in the ACT continue to experience poorer health outcomes than non-Aboriginal ACT residents.⁴¹

In 2004-05, 82.3% of ACT Aboriginal and Torres Strait Islander people reported at least one long term health condition with the rates being similar for males and females. Just over half (51.6%) of Aboriginal people who responded to the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) reported having three or more long term conditions.⁴¹ The most frequently reported long term conditions were eye/sight problems (37.9%) and asthma (18.0%).

Half of female ACT Aboriginal and Torres Strait Islander respondents to NATSIHS reported being current smokers (49.4%).³⁹ Almost half (42.9%) of ACT Aboriginal and Torres Strait Islander women who gave birth during 2000 to 2004 reported that they smoked during pregnancy, significantly higher than the percentage of non-Aboriginal ACT women who gave birth (13.8%, $p < 0.05$).⁴¹ Seven in ten Aboriginal women who smoked during pregnancy reported that they smoked 10 or more cigarettes per day (70.9%).⁴²

Thirty nine per cent (38.6%) of ACT Aboriginal and Torres Strait Islander women reported being overweight or obese. ACT Aboriginal women were significantly less likely to be overweight or obese than ACT Aboriginal men.³⁹

During 2000-04, 240 Aboriginal and Torres Strait Islander women gave birth to 246 babies. Aboriginal and Torres Strait Islander women are giving birth at younger ages than non-Aboriginal women. The percentage of low birth weight babies (less than 2,500 grams) born during 2000 to 2004 was significantly higher for Aboriginal and Torres Strait Islander women when compared with non-Aboriginal women. The average birthweight for babies of Aboriginal and Torres Strait Islander women who smoked during pregnancy was significantly lower than for Aboriginal women who did not smoke.⁴³

The most frequent reasons for hospitalisation of ACT Aboriginal and Torres Strait Islander people included pregnancy and birth, digestive system disorders, factors influencing health status, injury and poisoning and mental and behavioural disorders. Aboriginal and Torres Strait Islander people are requiring hospital treatment for many conditions at significantly younger ages than non-Aboriginal people in the ACT.⁴¹

5.2 Culturally and linguistically diverse women

There were 14.9% of ACT women who reported that they did not speak English at home in the 2006 Census (Table 24). Just over a quarter of ACT women reported that they were not born in Australia (27.1%).⁴⁴

Table 24: Culturally and linguistically diverse women, ACT, 2006

Census 2006 question	% (n)
ACT women who do not speak English at home	14.9% (n=24,494)
ACT women not born in Australia	27.1% (n=44,497)

Source: ABS 2006⁴²

5.3 Older women

There were 17,433 ACT women aged over 65 years in the 2006 Census representing 10.6% of the ACT female population. The number of ACT women aged 65 years or over has increased from 12,337 in 1996, an increase of 41.5%.⁴⁵

The proportion of women aged 65 years and over is expected to increase to 14.3% of the population by 2016.⁴⁶ This will have a considerable impact on demand for health services.

5.4 Women with disabilities

In 2003, it was estimated that around 6% of ACT women (9,600 women) had a profound or severe core activity limitation.⁴⁵ Seventeen per cent of ACT women were reported to have a disability (Table 25).

Table 25: ACT women with a disability, ACT, 2003

	% (n)
ACT women with a profound or severe core-activity limitation	6% (n= 9,600)
Total ACT women with a disability	16.9% (n=27,040)

Source: ABS, 2003⁴⁷

In the ACT, 75% of ACT women with a disability that resulted in core-activity limitation were over 45 years of age.⁴⁸ In 2006, 19.9% of people in the ACT with a core-activity limitation reported that they had contact with family or friends living outside the household every day.⁴⁷ Seven per cent (7.4%) did not feel they could get support from persons outside the household in a time of crisis.⁴⁹

In terms of service access, 8.4% of people with a core-activity limitation could not, or had difficulty getting to the places they needed to go, compared with 1.4% of the population without a disability, and 29.3% of people with a core-activity limitation had problems accessing service providers, while this figure was only 14.2% for ACT residents without a disability or long-term health condition.⁴⁷

5.5 Women in same-sex de facto relationships

Same-sex couples are defined by the ABS as persons of the same sex living together in the same household and reporting a de facto relationship.⁵⁰ Examination of same-sex data from the 2001 Census has some limitations, including reluctance to identify as being in a same-sex de facto relationship and lack of knowledge that same-sex relationships would be counted as such in the census. The Census data also does not identify homosexual women who were not in a de facto relationship at the time of the enumeration; therefore the following figures underestimate the true number of homosexual women in the ACT.

In the ACT, 570 women reported that they were in a same-sex de facto relationship.⁵⁰ This represents 0.4% of ACT men and women who were in a married or de facto relationship at the time of the 2001 Census. Nationally, there were 17,063 women who reported that they were in a same-sex de facto relationship.⁵⁰ The median age of Australian women in same-sex de facto relationships increased from 35.7 years in 1996 to 37.9 years in 2001. Children were present in 19.2% of female same-sex de facto "married" households compared with 42.2% of opposite-sex de facto married and 59.0% of registered married households. Only 4.6% of male same-sex de facto "married" households included children.

5.6 Women experiencing homelessness

In 2001 it was estimated that around 100,000 people nationally were homeless, 42% of whom were women.⁵¹ While the ACT had the lowest rate of homelessness nationally, around 47% of the people who experience homelessness in the ACT each year are women.

Table 26: ACT women's homelessness as a proportion of total ACT homelessness, ACT, 2001

Homelessness Category	% Total ACT	% Women's ACT
Primary	6 (n=74)	2.3 (n=29)
Secondary	89 (n=1094)	48.6 (n=532)
Tertiary	5 (n=61)	1.4 (n=17)
Total	100 (n=1229)	47 (n=578)

Notes: Primary homelessness includes all people without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings or using cars or railway carriages for temporary shelter⁴⁸
 Secondary homelessness includes people who move frequently from one form of temporary shelter to another⁴⁸
 Tertiary homelessness refers to people who live in boarding houses on a medium to long-term basis, operationally defined as 13 weeks or longer.⁴⁸

Source: AIHW, 2006⁴⁹

The Supported Accommodation Assistance Program (SAAP) is a joint Commonwealth and State funded program designed to respond, through the provision of support, to the needs of people who are homeless, escaping family violence, or at risk of homelessness. In 2005-06, 83.5% of ACT women who accessed SAAP services were Australian-born and 11.4% were from an Aboriginal or Torres Strait Islander background. Of the ACT women born overseas who accessed SAAP services, 13.4% were from a non-English speaking background.⁵²

5.7 Women who have experienced violence

Information on women who have experienced violence is not disaggregated to a state and territory level. In a national survey on personal safety conducted in 2005, 5.8% of Australian women reported that they had experienced physical or sexual violence in the 12 months prior to the survey.⁵³ There is no evidence to suggest that the ACT experience would be different.

In 1996, 2.6 million (38%) of Australian women reported that they had experienced one or more incidents of violence after the age of 15 years.⁵⁴ Of these women, 2.2 million reported that they had experienced physical violence, and 1.2 million reported sexual violence.⁵¹

Women's feelings of safety in their home and local area after dark is a measure that can be used to report on perceptions of crime levels in their vicinity, previous experience as a victim of assault or household break-in, relationships with people living nearby, sense of their own strength and capacity to be in control, and their level of trust in their local community. In 2006, 7.9% of all women in the ACT reported feeling unsafe or very unsafe in their home after dark, and 30.1% of all ACT women reported feeling unsafe or very unsafe in their local area after dark.⁵⁵ These figures were highest for women under 25 with 10.7% reported feeling unsafe or very unsafe at home after dark, and 37.0% reported feeling unsafe or very unsafe in their local area after dark.⁵²

5.8 Women in custody

As at February 2008, there were five ACT women prisoners in custody and by the time of commissioning of the prison (projected by mid 2008), it is estimated that there will be ten women prisoners.⁵⁶

Prisoners in detention are a highly stigmatised group, characterised by social and psychological disadvantage. Poor educational attainment, unemployment, social isolation, interpersonal conflicts, financial dependence and substance abuse are defining characteristics of these populations. The health of prisoners in detention is poor when compared to that of the general community and they also have a high prevalence of communicable diseases, mental illness and health risks related to drug dependence and other dependencies.

Although information specific to ACT female inmates is not available, the 2001 NSW Inmate Health Survey found that 58% of women regularly used clinics, primarily to pick up medications, with methadone supply being the most common reason for regularly visiting the clinic (70% of women). The survey also found that the majority of men and women had

consulted a doctor in prison about their health during the previous six months. Most prisoners also indicated that their last dental health visit occurred while in prison (64% of women).

The most prevalent conditions reported by women were:

- Hepatitis C (64%)
- Asthma (44%)
- Back problems (37%).

The survey results also indicated high levels of chronic illness amongst prisoners.

APPENDIX: CANCER

5.9 Breast cancer

Breast cancer is the most common cancer occurring in females, and the highest cause of female cancer death in the ACT. According to the most recent cancer statistics during 2000-2004, one in every 1,748 men and one in every ten women in the ACT developed breast cancer before the age of 75 years.

Risk factors for breast cancer include family history, reproductive factors, body size/obesity, alcohol, physical activity, exogenous hormones (oral contraceptives, hormonal replacement therapy), and possibly diet.⁵⁷ The number of reproductive cycles a woman has appears to be related to breast cancer development, with early onset of menstrual cycle, late menopause, never experiencing childbirth and late age at first full-term pregnancy being possible risk factors.⁵⁷ Perhaps because some of these factors are more common in women of high socio-economic status, breast cancer is more common in the ACT than in other parts of Australia.

Female breast cancer is more common in countries in Northern Europe, Western Europe, North America (Caucasians) and Australasia than elsewhere. It is less common in Asian and African countries.

Time trends

The most recent age standardised incidence rate of breast cancer (2000-2004) increased by 58% from 1985-1989 (Table 27). The most notable increase was between 1990-1994 and the subsequent two five-year periods. This was the result of the uptake of the BreastScreen program in 1993 for women between 50-69 years. Incidence of breast cancer has increased since cancer notifications became mandatory in 1994. This increase was statistically significant using linear regression with single indicator year for the incidence rate ($p < 0.005$).

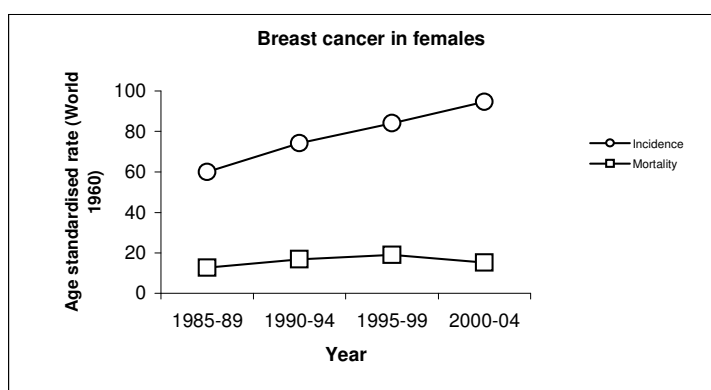
Improved treatment options, together with the population screening program have contributed to the fall in mortality from breast cancer in 2000-2004 compared with the previous two five-year periods (Table 27). The age standardised incidence rates of female breast cancer have become more stable since 2001 (Figure 16). Despite the ACT having an increasing trend of age standardised incidence rate of female breast cancer, the standardised mortality rate is the second lowest compared to other jurisdictions and lower than the national figure in 2000-2004 (ACT 23.4 per 100,000 population; Australia 24.9 per 100,000 population).⁵⁸

Variation with age

As with most cancers, incidence and mortality rates increased with age. Diagnosis of breast cancer occurs at an earlier age than most other cancers (Figure 18), however diagnosis before the age of 30 is rare. Female breast cancer occurs mostly (75%) in middle and older ages (40-69 years), however rates begin to increase for women in their thirties. Age specific incidence fell after 75 years. Age specific mortality rates continued to rise over all ages.

In the ACT, breast cancer screening is recommended for women 50-69 years. However, data from the cancer registry show that a notable proportion (25 percent in 1995-1999; 22 percent in 2000-2004) of women are diagnosed with breast cancer between 40-49 years of age.

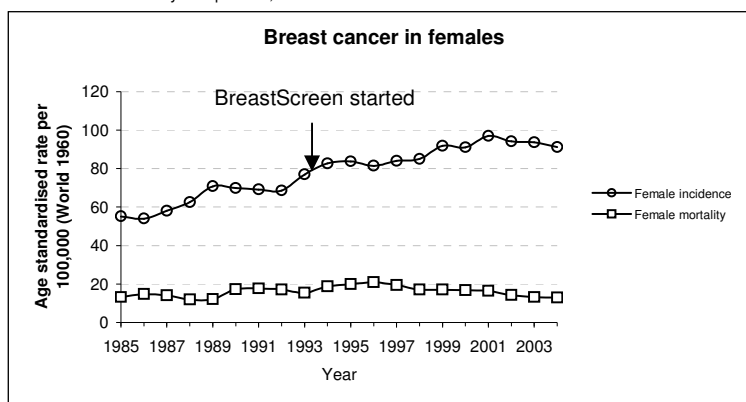
Figure 16: Breast cancer, females, age standardised incidence and mortality rates, ACT, 1985-2004



Note: Age standardised incidence/mortality rate per 100,000 women.
Source: ACT Cancer Registry, confidentialised unit record file

Figure 17: Breast cancer, females, age standardised incidence and mortality rates, ACT, 1985-2004 (3-year moving average)

Note: Age standardised incidence/mortality rate per 100,000 women.



Source: ACT Cancer Registry, confidentialised unit record file

Table 27: Breast cancer, incidence and mortality, females, ACT, 1985-2004

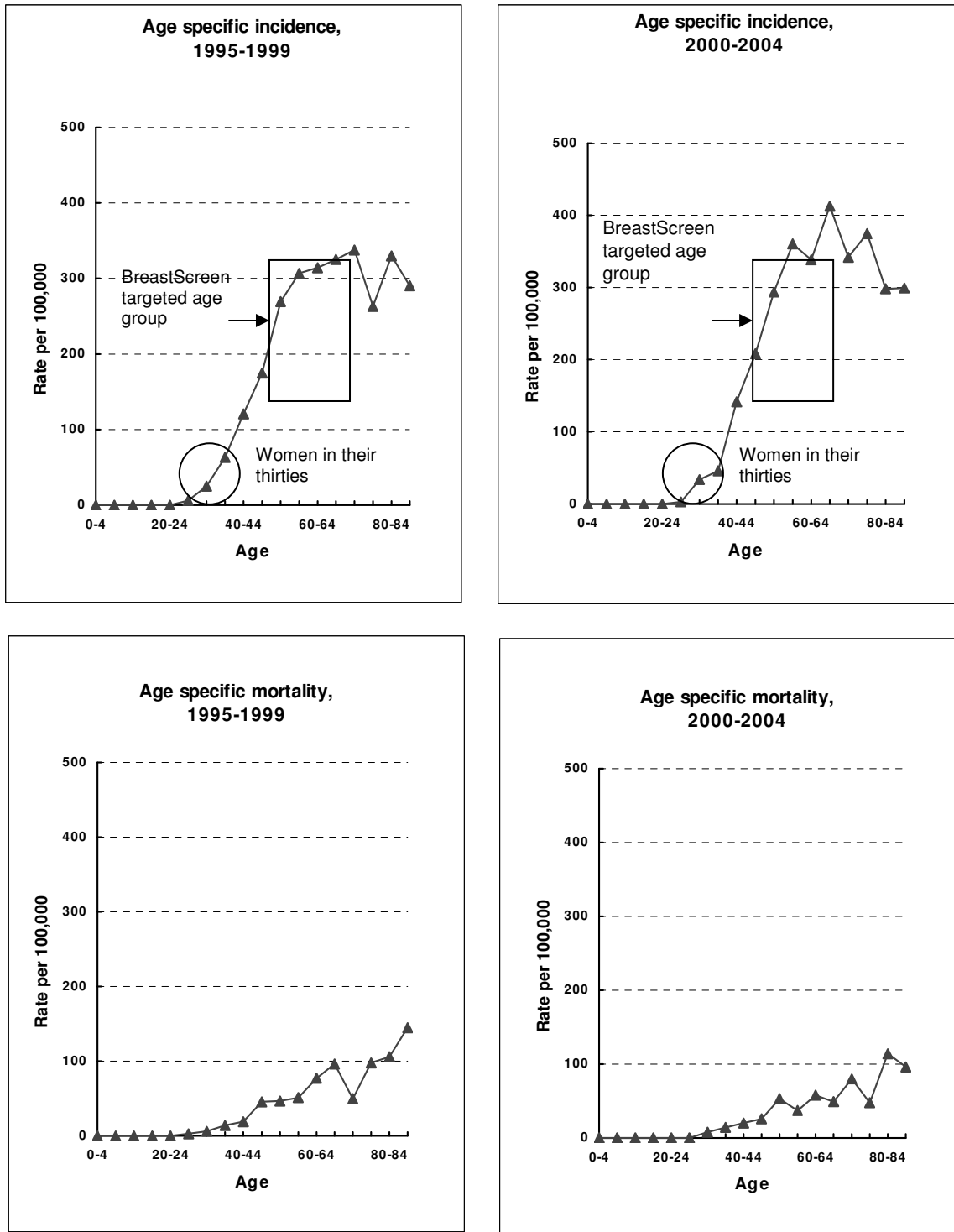
Breast	1985-1989	1990-1994	1995-1999	2000-2004
Incidence				
Number of cases	376	551	745	979
Percent of all cancers	25.5	30.5	32.3	35.2
Crude incidence rate	56.8	75.0	95.7	120.7
ASR (World 1960)	60.0	74.2	84.1	94.7
Cumulative Risk*	1 in 16	1 in 12	1 in 11	1 in 10
Mortality				
Number of deaths	80	128	170	163
Percent of all deaths	15.4	19.9	19.4	18.1
Crude mortality rate	12.1	17.4	21.8	20.1
ASR (World 1960)	12.6	16.8	19.0	15.2
Cumulative Risk*	1 in 77	1 in 57	1 in 49	1 in 58

Note: * Cumulative risk refers to a directly standardised rate with equal weights in each age group of interest and zero weight otherwise. It is calculated from the age-specific rates.

Crude incidence/mortality rate and age standardised rate (ASR) per 100,000 women.

Source: ACT Cancer Registry, Confidentialised unit record file

Figure 18: Breast cancer, age specific incidence and mortality, females, ACT, 1995-2004



Source: ACT Cancer Registry, Confidentialised unit record file

5.10 Cancer of uterus

Cancer of uterus¹ was the seventh most common cause of female cancer, and the tenth most common cause of female cancer death in the ACT. According to the most recent cancer statistics during 2000-2004, one in 76 women in the ACT developed cancer of uterus before the age of 75 years.

Cancer of uterus is more common in Caucasian women. Risk factors include age (over 50 years), obesity, family history of uterine cancer or colorectal cancer, past history of ovarian tumour, polycystic ovarian syndrome or endometrial hyperplasia, women who have never given birth, early onset of menstrual cycle or delayed menopause, hormonal replacement therapy in post-menopausal women and use of tamoxifen for breast cancer.⁵⁹

This cancer is more common in Israel, North America and many European countries and is less common in most Asian countries.⁶⁰

Time trends

Compared to 1985-1989, the latest age standardised rates (2000-2004) rose in incidence (8.2 per 100,000 women in 1985-1989; 10.7 per 100,000 women in 2000-2004) and mortality (1.1 per 100,000 women in 1985-1989; 2.7 per 100,000 women in 2000-2004) (Table 8).

Graphically, the age standardised rates in incidence and mortality both showed a slight upward trend over the twenty years period (Figure 19 and Figure 20).

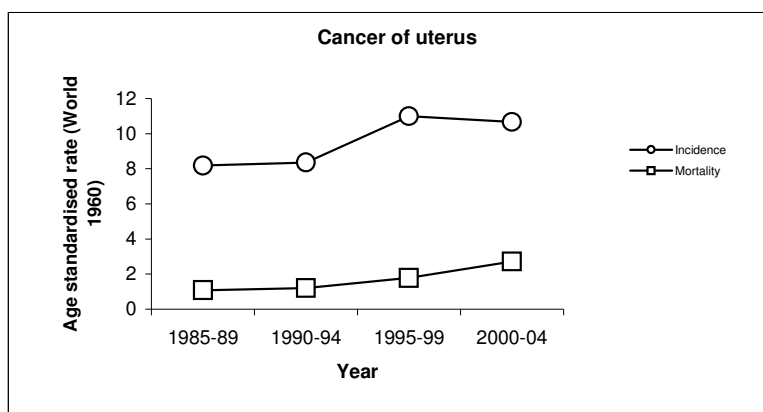
In the calculation of age standardised rates, no adjustment has been made for the number of women who had a hysterectomy and therefore were not at risk of developing uterine cancer. Therefore, the age standardised rates presented could potentially be an underestimate.

Variation with age

As for most cancers, incidence and mortality rates increased with age, in this case, from the age of 50 years. Both age specific incidence and mortality rates peaked at around 70-80 years (Figure 21). The fluctuation of rates after that age group is due to small numbers of new cases or deaths in the relevant age groups.

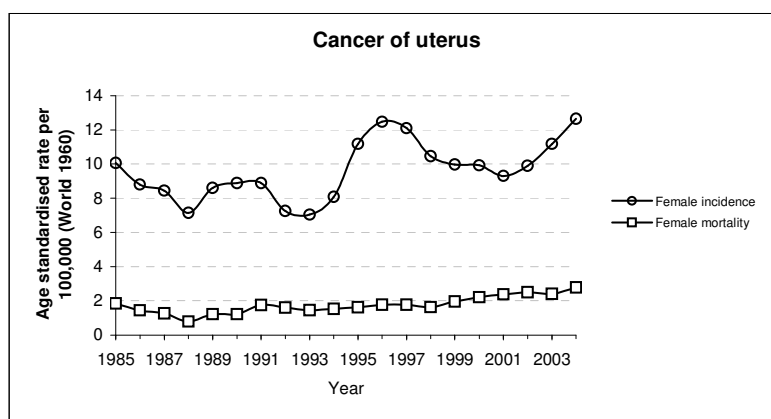
¹ It should be noted that, in this analysis, cancer of uterus (ICD 10 code: C54) and cancer of uterus not otherwise specified (ICD 10 code: C55) were grouped together, in order to be consistent with coding practice in the earlier period of data. In the earlier period of data collection, it is thought that most cases of cancer of uterus not otherwise specified (ICD 10 code: C55) were of the uterus.

Figure 19: Cancer of uterus, age standardised incidence and mortality, ACT, 1985-2004



Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 20: Cancer of uterus, age standardised incidence and mortality, ACT, 1985-2004 (3-year moving average)



Source: ACT Cancer Registry, Confidentialised unit record file

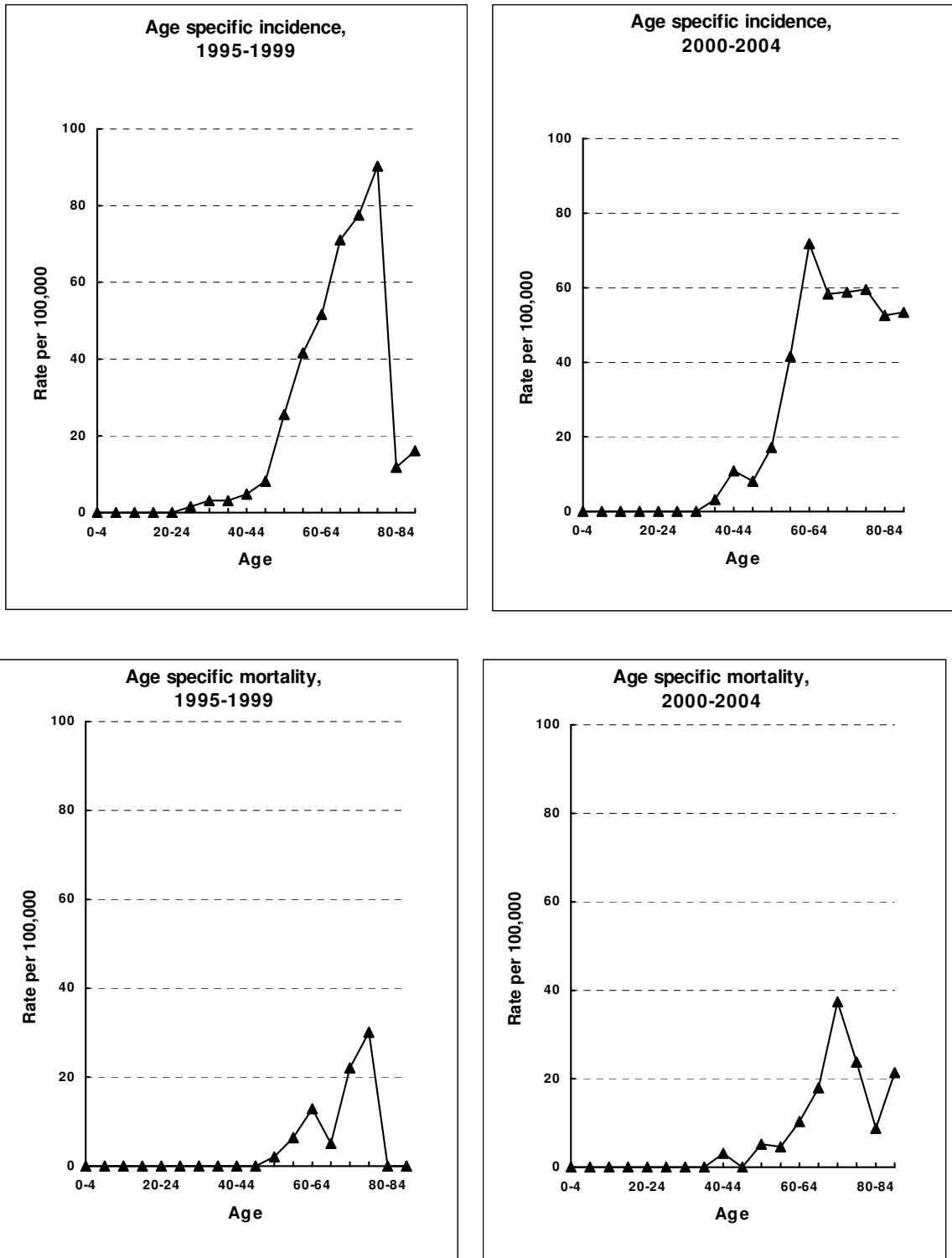
Table 28: Cancer of uterus, incidence and mortality, ACT, 1985-2004

Cancer of uterus	1985-1989	1990-1994	1995-1999	2000-2004
Incidence				
Number of cases	47	58	92	107
Percent of all cancers	3.2	3.2	4.0	3.8
Crude incidence rate	7.1	7.9	11.8	13.2
ASR (World 1960)	8.2	8.4	11.0	10.7
Cumulative Risk*	1 in 91	1 in 100	1 in 70	1 in 76
Mortality				
Number of deaths	6	9	15	28
Percent of all deaths	1.2	1.4	1.7	3.1
Crude mortality rate	0.9	1.2	1.9	3.5
ASR (World 1960)	1.1	1.2	1.8	2.7
Cumulative Risk*	1 in 773	1 in 714	1 in 411	1 in 255

Note: *Cumulative risk refers to a directly standardised rate with equal weights in each age group of interest and zero weight otherwise. It is calculated from the age-specific rates.

Source: ACT Cancer Registry, Confidentialised unit record file

Figure 21: Cancer of uterus, age specific incidence and mortality by sex, ACT, 1995-2004



Source: ACT Cancer Registry, Confidentialised unit record file

5.11 Ovarian cancer

Ovarian cancer was the ninth most common cause of female cancer, and the fifth most common cause of female cancer death in the ACT. According to the most recent cancer statistics during 2000-2004, one in 104 women in the ACT developed ovarian cancer before the age of 75 years.

Risk factors for ovarian cancer include age (over 50 years), family history of ovarian cancer, breast cancer or colorectal cancer, past history of breast cancer, no children (the greater the number of pregnancies, the lower the risk for developing ovarian cancer), people of Jewish descent, hormonal replacement therapy in post-menopausal women and use of infertility drugs.⁶¹

Other risk factors may include high fat diet, and using talcum powder around the genital area.⁶¹ The link between these factors and ovarian cancer has not been proved as yet.

Ovarian cancer is more common in Caucasian women who live in Western countries with a high standard of living. Ovarian cancer is more common in Israel, North America and many European countries and is less common in most Asian countries.⁶⁰

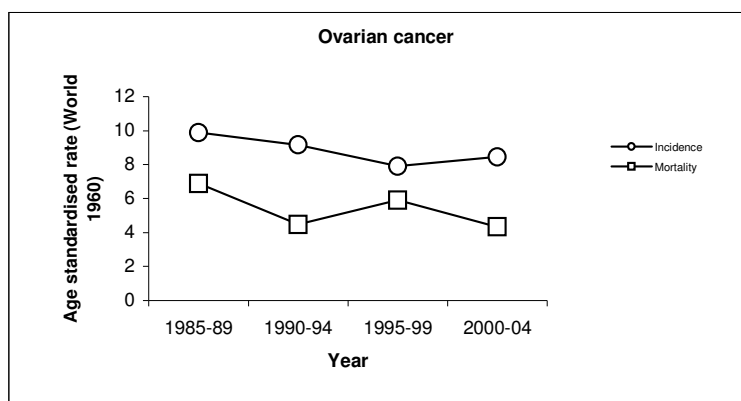
Time trends

Compared to 1985-1989, the latest age standardised rates (2000-2004) fell by 14 percent in incidence and 38 percent in mortality (Table 30). The age standardised rates in incidence and mortality (Figure 22 and Figure 23) did not show any notable trend over the twenty year period.

Variation with age

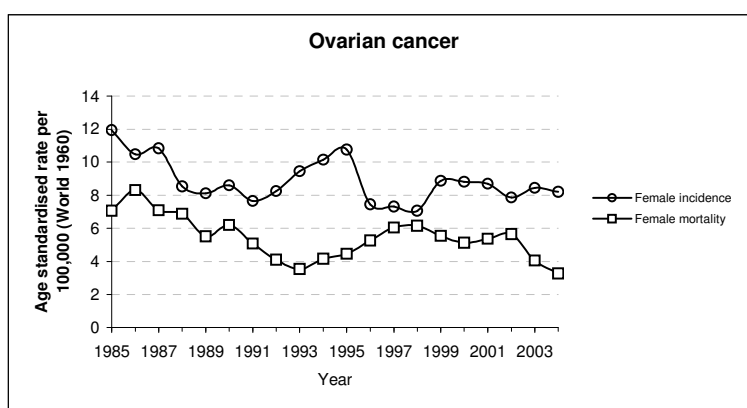
As for most cancers, incidence and mortality rates increased with age. However, ovarian cancer began at the age of 25-29 years (Figure 24), earlier than for most of other cancers. Age specific incidence and mortality rates of ovarian cancer increased from 45 to 74 years. The fluctuation of age specific rates in incidence and mortality is due to small number of cases or deaths in each age group.

Figure 22: Ovarian cancer, age standardised incidence and mortality rates, ACT, 1985-2004



Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 23: Ovarian cancer, age standardised incidence and mortality rates, ACT, 1985-2004 (3-year moving average)



Source: ACT Cancer Registry, Confidentialised unit record file

Table 29: Ovarian cancer, incidence and mortality, ACT, 1985-2004

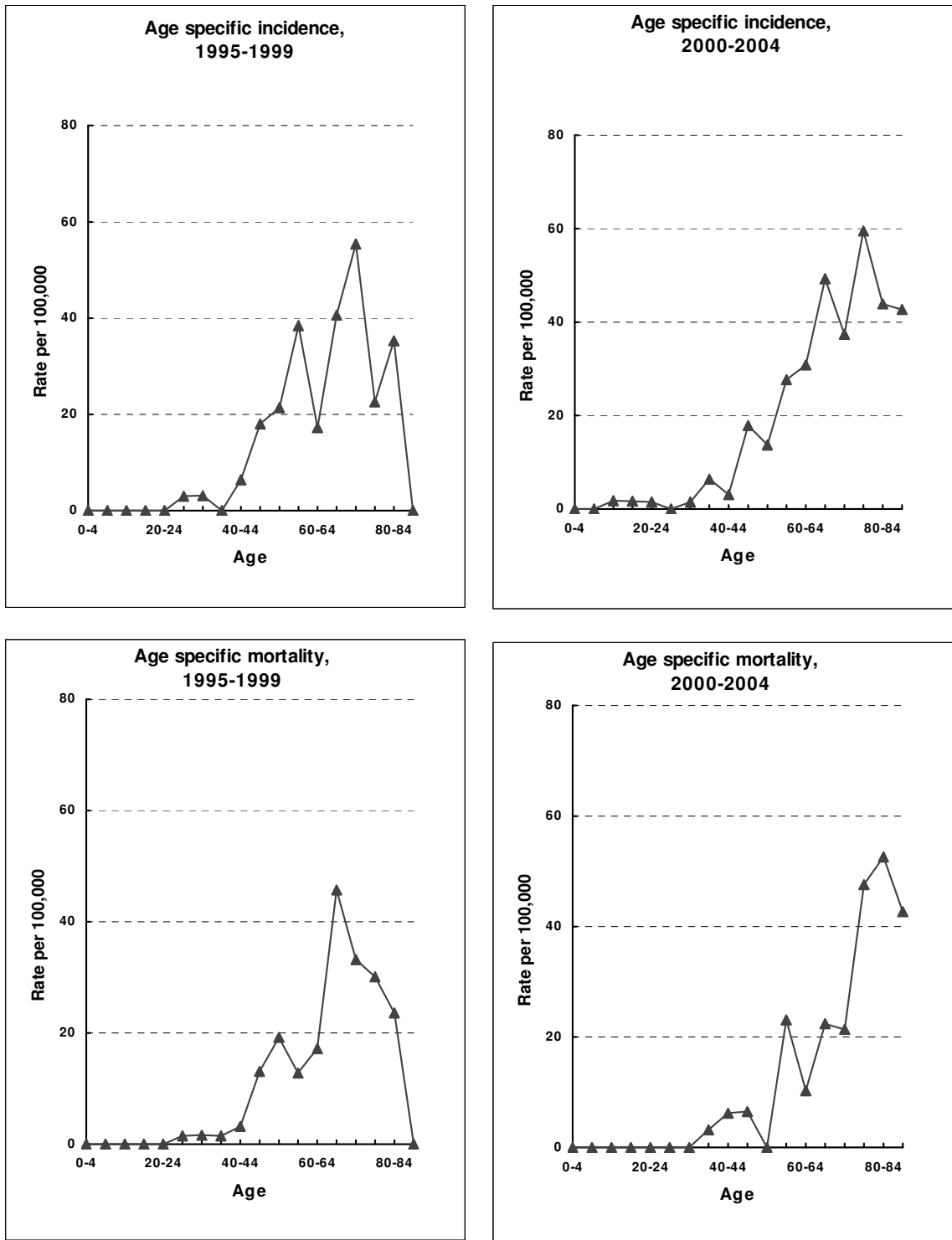
Ovarian cancer	1985-1989	1990-1994	1995-1999	2000-2004
Incidence				
Number of cases	59	68	69	87
Percent of all cancers	4.0	3.8	3.0	3.1
Crude incidence rate	8.9	9.3	8.9	10.7
ASR (World 1960)	9.9	9.2	7.9	8.5
Cumulative Risk*	1 in 90	1 in 98	1 in 99	1 in 104
Mortality				
Number of deaths	39	32	51	50
Percent of all deaths	7.5	5.0	5.8	5.6
Crude mortality rate	5.9	4.4	6.6	6.2
ASR (World 1960)	6.9	4.5	5.9	4.3
Cumulative Risk*	1 in 116	1 in 194	1 in 135	1 in 215

Note: *Cumulative risk refers to a directly standardised rate with equal weights in each age group of interest and zero weight otherwise. It is calculated from the age-specific rates.

Crude incidence/mortality rate and age standardised rate (ASR) per 100,000 women.

Source: ACT Cancer Registry, Confidentialised unit record file

Figure 24: Ovarian cancer, age specific incidence and mortality, ACT, 1995-2004



Source: ACT Cancer Registry, Confidentialised unit record file

5.12 Cervical cancer

Cervical cancer was the 13th most common cause of female cancer, and the 18th most common cause of female cancer death in the ACT. According to the most recent cancer statistics during 2000-2004, one in 188 women in the ACT developed cervical cancer before the age of 75 years.

Risk factors for cervical cancer include human papillomavirus infection, HIV infection, chlamydial infection, long term oral contraceptive use, multiple pregnancies, use of a hormonal drug called Diethylstilbestrol (DES), family history, low socio-economic status and smoking.⁶²

Cervical cancer is more common in women who live in Gambia, Mali, Uganda, Zimbabwe, Brazil, India, the Philippines, South Korea, Taiwan, Vietnam and Thailand.⁶⁰

Two cervical cancer vaccines have recently been developed which is a breakthrough in the prevention of cervical cancer. The National Immunisation Program for cervical cancer was launched in 2007. The Gardasil vaccine has been available free from July 2007 until June 2009 for females aged 12-26. Young females under 18 years will receive their vaccinations through a school-based program.

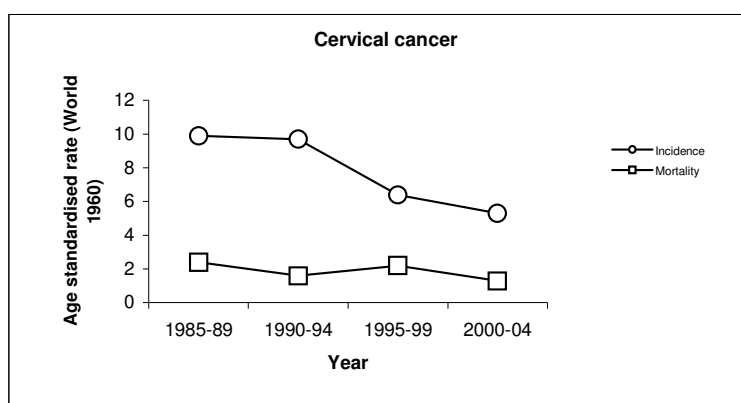
Time trends

Compared to 1985-1989, the latest age standardised rates (2000-2004) fell by 46 percent in incidence and 46 percent in mortality (Table 30). Caution must be taken to interpret the changes in rates because of the small numbers of cases. In this case, the fall of incidence rate was due to the change from 67 cases in 1985-1989 to 53 cases in 2000-2004; the fall in mortality rate was due to the change from 16 deaths in 1985-1989 to 12 deaths in 2000-2004. The age standardised rate in mortality (Figure 25 and Figure 26) did not have a clear trend over the twenty years period.

Variation with age

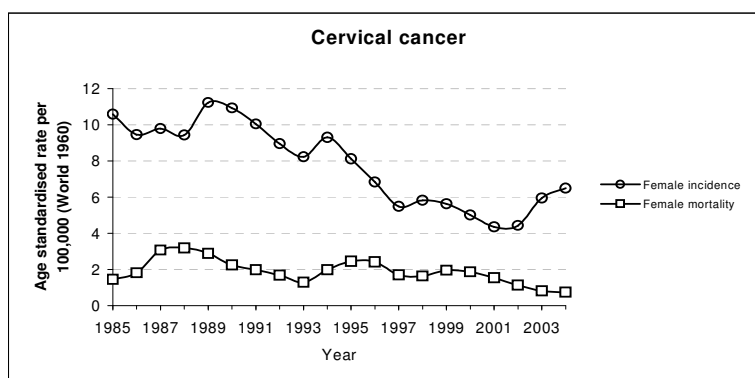
Cervical cancer incidence first occurs in the 25-29 year age group (Figure 27), earlier than for most of other cancers. Age specific incidence and mortality rates of cervical cancer increased from 65 to 74 years. The fluctuation of age specific rates in incidence and mortality is due to small number of cases or deaths in each age group.

Figure 25: Cervical cancer, age standardised incidence and mortality rates, ACT, 1985-2004



Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 26: Cervical cancer, age standardised incidence and mortality rates, ACT, 1985-2004 (3-year moving average)



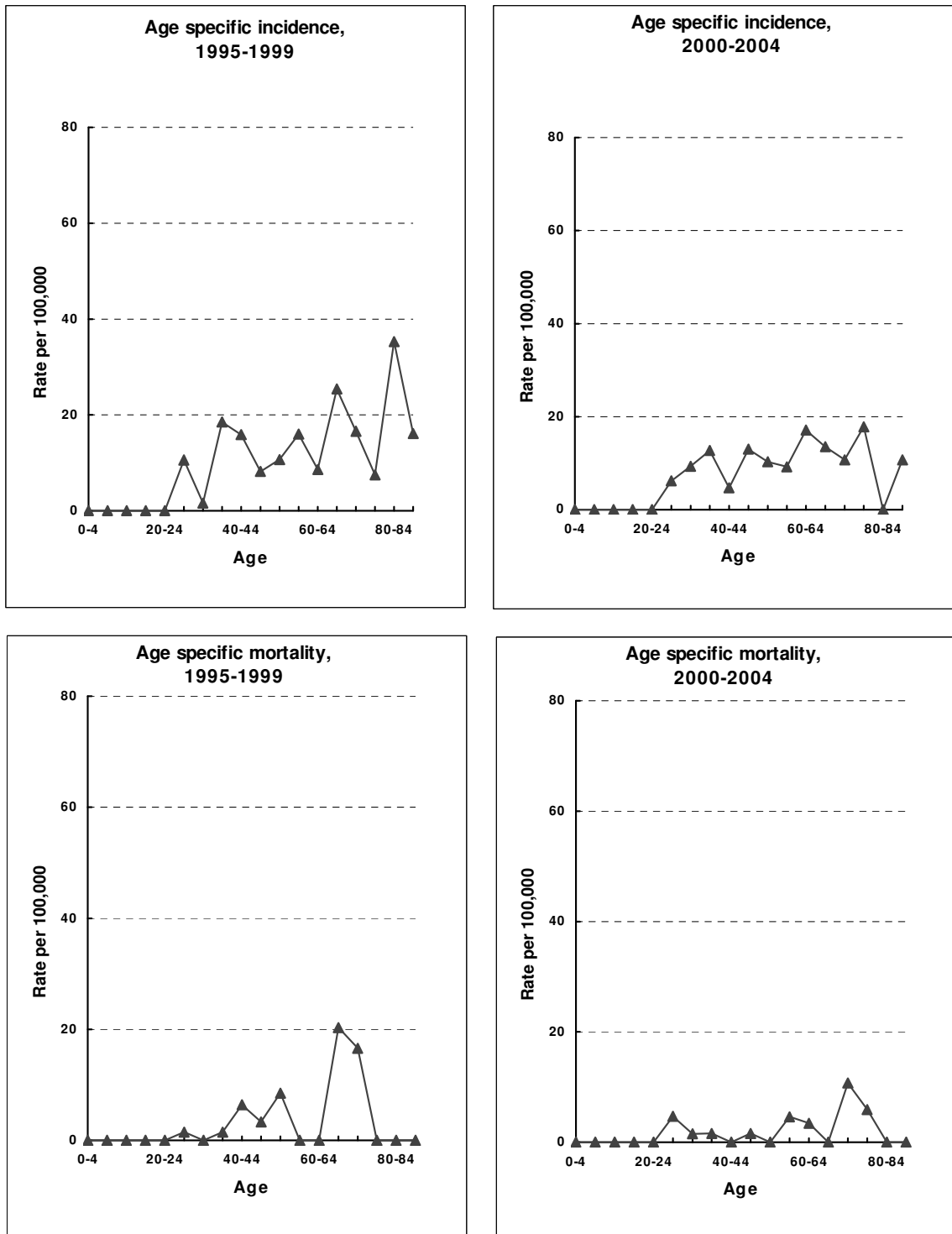
Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Table 30: Cervical cancer, incidence and mortality, ACT, 1985-2004

Cervical cancer	1985-1989	1990-1994	1995-1999	2000-2004
Incidence				
Number of cases	67	75	60	53
Percent of all cancers	4.5	4.2	2.6	1.9
Crude incidence rate	10.1	10.2	7.7	6.5
ASR (World 1960)	9.9	9.7	6.4	5.3
Cumulative Risk*	1 in 94	1 in 89	1 in 152	1 in 188
Mortality				
Number of deaths	16	11	19	12
Percent of all deaths	3.1	1.7	2.2	1.3
Crude mortality rate	2.4	1.5	2.4	1.5
ASR (World 1960)	2.4	1.6	2.2	1.3
Cumulative Risk*	1 in 390	1 in 674	1 in 344	1 in 711

Note: *Cumulative risk refers to a directly standardised rate with equal weights in each age group of interest and zero weight otherwise. It is calculated from the age-specific rates.
Crude incidence/mortality rate and age standardised rate (ASR) per 100,000 women.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 27: Cervical cancer, age specific incidence and mortality, ACT, 1995-2004



Source: ACT Cancer Registry, Confidentialised unit record file

5.13 Colorectal cancer (large bowel)

Colorectal cancer is the second most common cancer and the second most common cause of cancer death for women in the ACT. According to the most recent cancer statistics during 2000-2004, one in 27 women in the ACT developed colorectal cancer before the age of 75 years.

Countries in North America, Western Europe and Australasia have the highest incidence of colorectal cancer in the world. While most countries in Asia have a relatively low incidence of colorectal cancer, westernised countries such as Japan, Singapore and Hong Kong, have as high an incidence of the disease, being comparable to the incidence reported in America or Western Europe.⁶⁰

Differences in geographical distribution of colorectal cancer are thought to be due to dietary factors, as it has been suggested that meat and animal fat increase the risk of colorectal cancer, while a high-fibre diet may decrease the risk.⁶³ Other risk factors include genetic syndromes such as familial adenomatous polyposis, family history of colon cancer, past history of large intestine polyps, ethnicity (persons of Jewish descent from Eastern Europe). Life style factors that may increase the risk of developing the disease include obesity, lack of exercise, smoking and heavy alcohol consumption.

Time trends

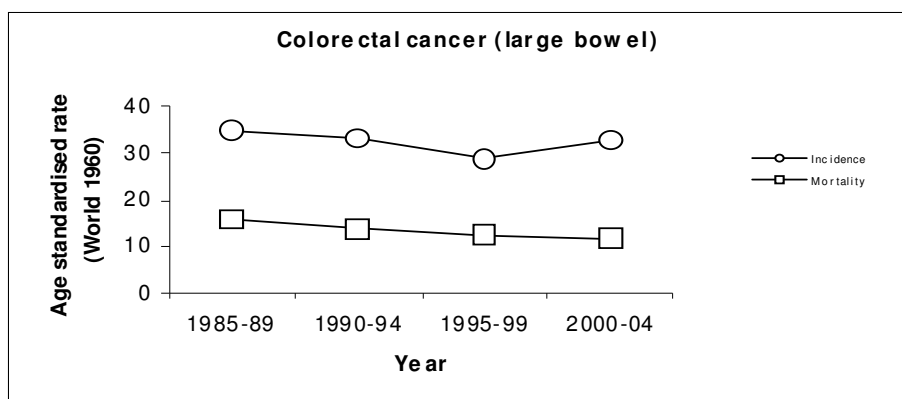
Compared to 1985-1989, the most recent age standardised incidence rates of colorectal cancer in 2000-2004 (Table 31) did not show a clear trend over time.

The age standardised mortality rates showed a slight decrease over time, from 15.9 in 1985-1989 to 11.6 per 100,000 women in 2000-2004 (Table 31).

Variation with age

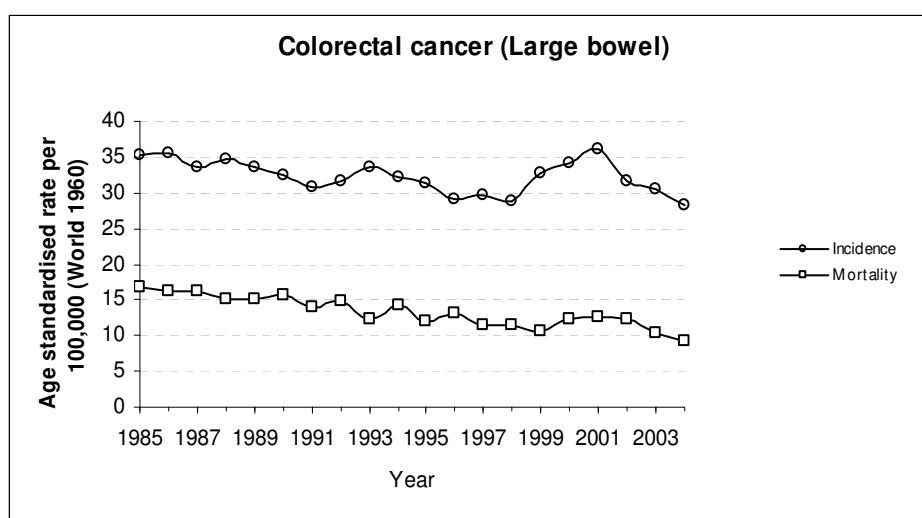
As for most cancers, incidence and mortality rates increased with age. Colorectal cancer is rare under the age of 30.

Figure 28: Colorectal cancer (large bowel), age standardised incidence and mortality rates in women, ACT, 1985-2004



Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 29: Colorectal cancer (large bowel), age standardised incidence and mortality rates in women, ACT, 1985-2004 (3-year moving average)



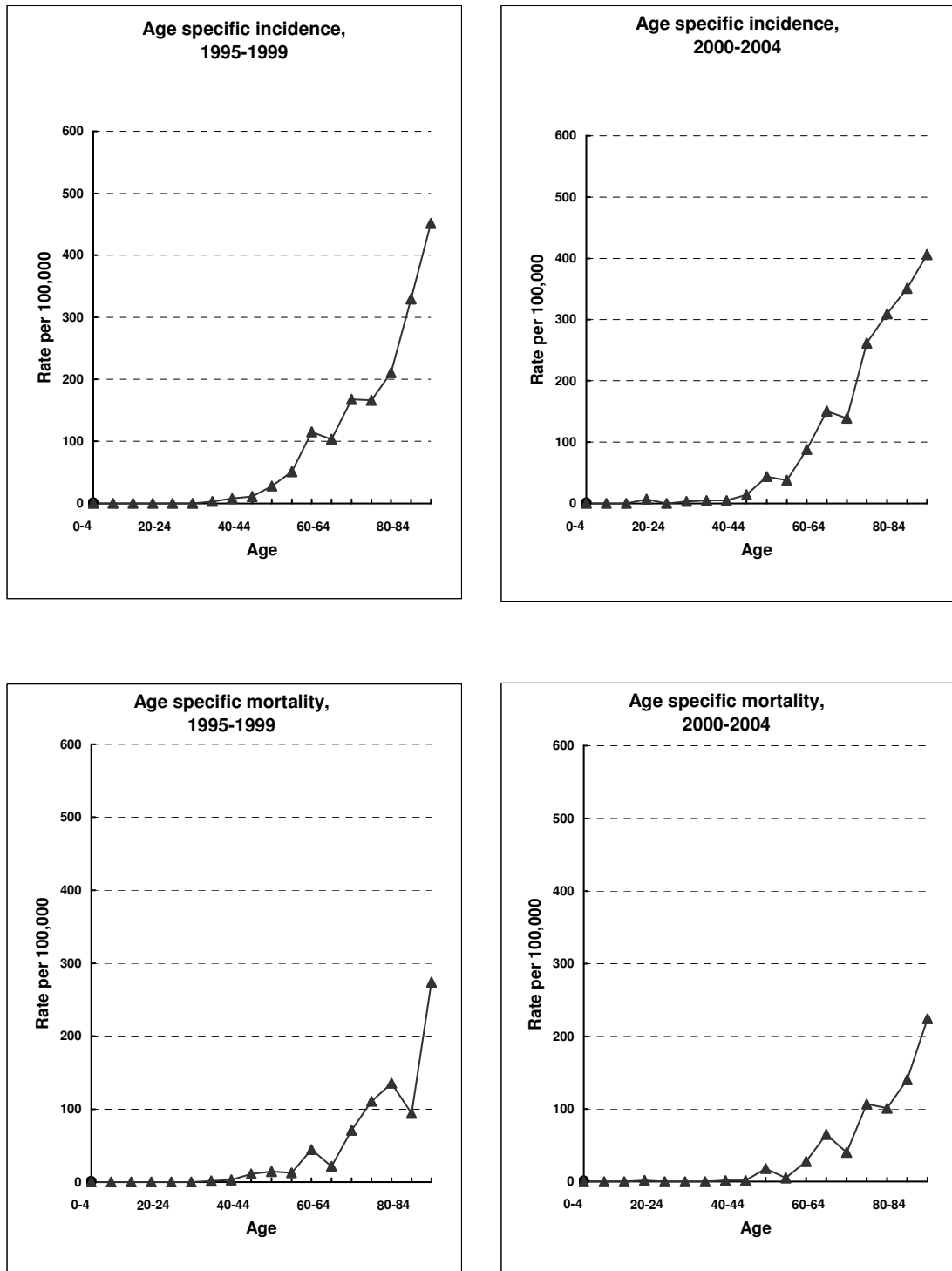
Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Table 31: Colorectal cancer (large bowel), incidence and mortality in women, ACT, 1985-2004

Colorectal (Large bowel)	1985-1989	1990-1994	1995-1999	2000-2004
Incidence				
Number of cases	209	246	262	362
Percent of all cancers	14.2	13.6	11.4	13.0
Crude incidence rate	31.5	33.5	33.7	44.6
ASR (World 1960)	34.8	33.0	28.6	32.6
Sex ratio (F:M=1:x)	1.1	1.2	1.4	1.2
Cumulative Risk*	1 in 26	1 in 25	1 in 31	1 in 27
Mortality				
Number of deaths	93	104	121	131
Percent of all deaths	18.0	16.2	13.8	14.6
Crude mortality rate	14.0	14.2	15.5	16.1
ASR (World 1960)	15.9	13.7	12.7	11.6
Sex ratio (F:M=1:x)	1.0	1.1	1.1	1.1
Cumulative Risk*	1 in 58	1 in 63	1 in 69	1 in 75

Note: *Cumulative risk refers to a directly standardised rate with equal weights in each age group of interest and zero weight otherwise. It is calculated from the age-specific rates.
Crude incidence/mortality rate and age standardised rate (ASR) per 100,000 women.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 30: Colorectal cancer (large bowel), age specific incidence and mortality in women, ACT, 1995-2004



Source: ACT Cancer Registry, Confidentialised unit record file

5.14 Melanoma of skin

Melanoma of skin was the third most common cancer diagnosed in females in the ACT. According to the most recent cancer statistics during 2000-2004, one in 40 women in the ACT developed melanoma of skin before the age of 75 years.

The difference in incidence between males and females is lower than the difference in mortality (sex ratio in Table 32). This may be due to the fact that men tend to seek medical attention in the later course of the disease more than women, therefore decreasing their chances of survival.

Risk factors for melanoma include pale-coloured skin, the presence of many skin moles, and excessive exposure to the sun.⁶⁴ Oceanic countries including Australia, New Zealand and Hawaii (Caucasians) have the highest incidence of melanoma of skin in the world.^{64,65} Australian incidence rates are about twice as high as North America, eight times higher than the United Kingdom and about 60 times higher than China, Japan and Korea.⁶⁰

Evidence of association between sun exposure and melanoma were reported in Australia⁶⁶ and overseas.^{66,67,68} Significant increased risk was found to be associated with severe sunburn before age 15, sunbathing, boating and vacations spent in the sun.⁶⁷ Despite evidence suggesting the risk of sun exposure for melanoma of skin, the results of the 2005 ACT Secondary Student Drug and Health Risk Survey showed a significant reduction in sun protection behaviours by ACT secondary school students.⁶⁹

Time trends

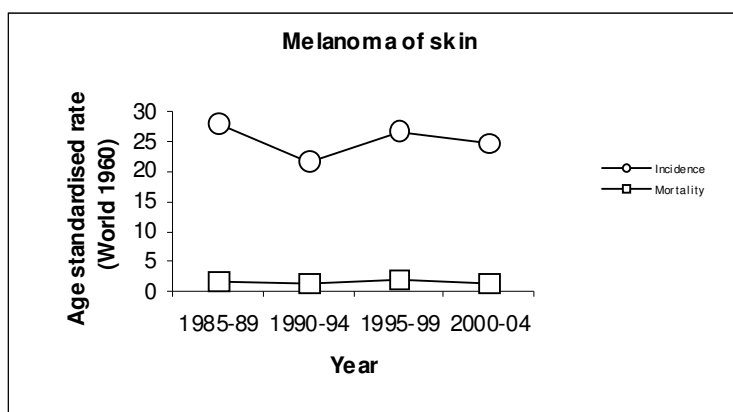
There was no clear trend in age standardised incidence over time (Figure 33). Women showed a slight downward trend in age standardised mortality rates (1.7 per 100,000 in 1985-1989; 1.5 per 100,000 in 1990-1994; 1.9 per 100,000 in 1995-1999; 1.2 per 100,000 in 2000-2004).

Variation with age

Melanoma of skin is a rarely reported disease under the age of 20 years. The majority of the new cases (85 percent) were diagnosed in persons 40 years and over (Figure 33).

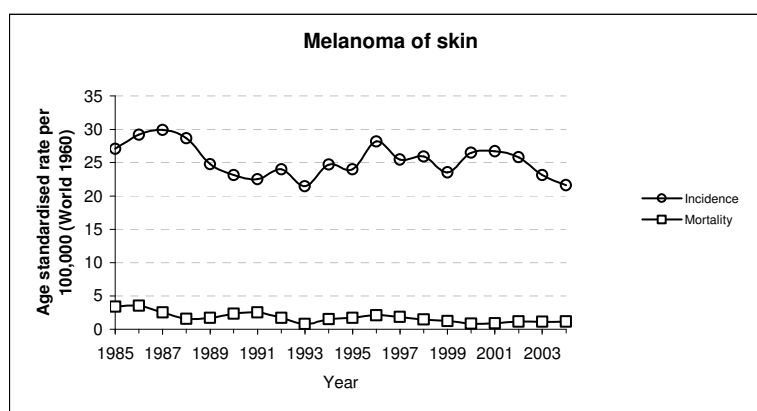
The overall mortality from melanoma of skin was much lower than the incidence (i.e. most people who get melanoma of skin, survive).

Figure 31: Melanoma of skin, age standardised incidence and mortality rates in women, ACT, 1985-2004



Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 32: Melanoma of skin, age standardised incidence and mortality rates in women, ACT, 1985-2004 (3-year moving average)



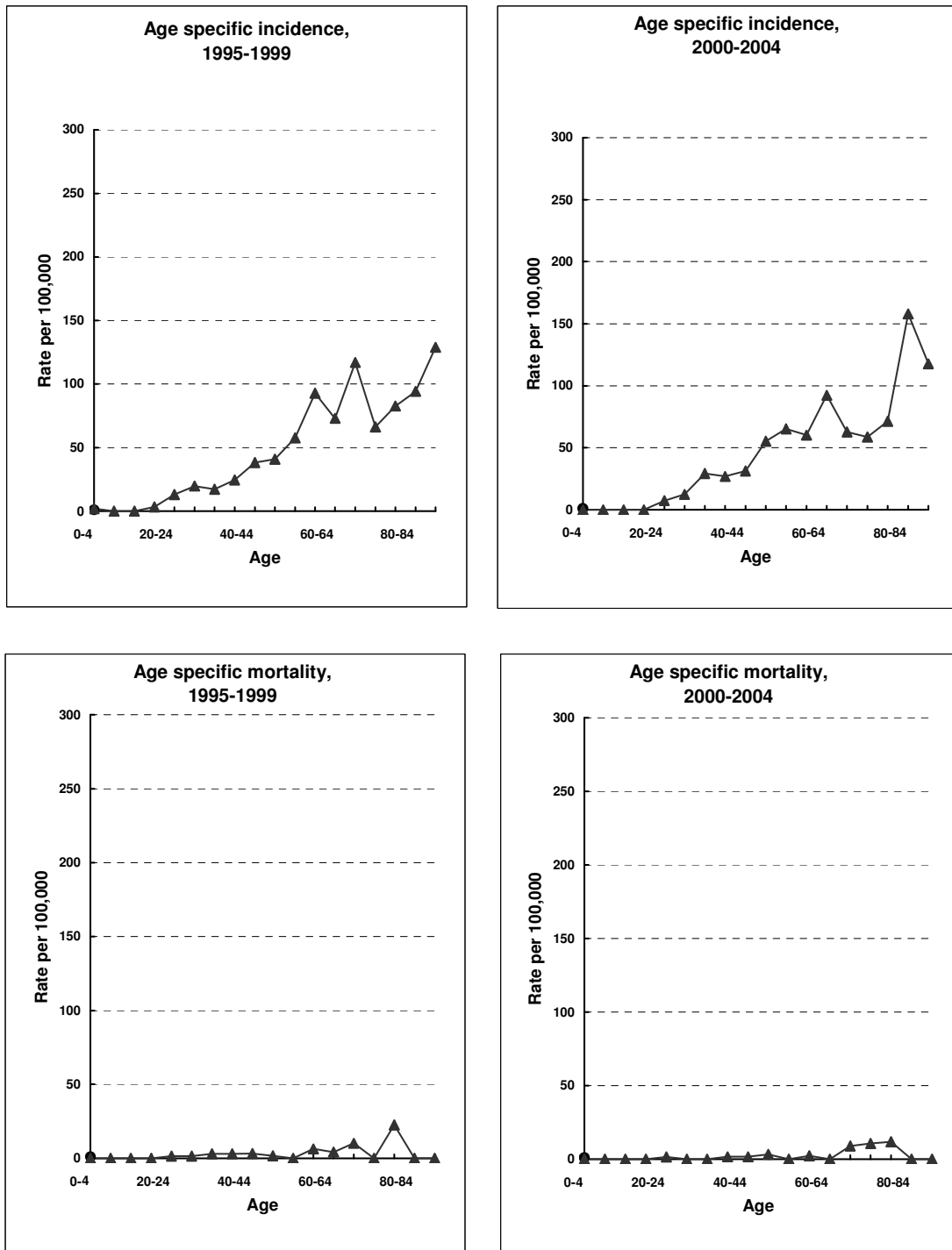
Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Table 32: Melanoma of skin, incidence and mortality in women, ACT, 1985-2004

Melanoma of skin	1985-1989	1990-1994	1995-1999	2000-2004
Incidence				
Number of cases	189	175	236	260
Percent of all cancers	12.8	9.7	10.2	9.3
Crude incidence rate	28.5	23.8	30.3	32.0
ASR (World 1960)	28.0	21.8	26.7	24.7
Sex ratio (F:M= 1:x)	1.1	1.1	1.3	1.1
Cumulative Risk*	1 in 37	1 in 46	1 in 36	1 in 40
Mortality				
Number of deaths	11	12	17	12
Percent of all deaths	2.1	1.9	1.9	1.3
Crude mortality rate	1.7	1.6	2.2	1.5
ASR (World 1960)	1.7	1.5	1.9	1.2
Sex ratio (F:M= 1:x)	2.1	2.9	1.7	3.4
Cumulative Risk*	1 in 450	1 in 724	1 in 574	1 in 670

Note: *Cumulative risk refers to a directly standardised rate with equal weights in each age group of interest and zero weight otherwise. It is calculated from the age-specific rates.
Crude incidence/mortality rate and age standardised rate (ASR) per 100,000 women.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 33: Melanoma of skin, age specific incidence and mortality in women, ACT, 1995-2004



Source: ACT Cancer Registry, Confidentialised unit record file

5.15 Lung cancer

Lung cancer was the fourth most common cancer in women in the ACT. Lung cancer was the third most common cause of death from cancer in women. According to the most recent cancer statistics during 2000-2004, one in 64 women developed lung cancer before the age of 75 years. Mortality and incidence rates were similar, giving an indication of poor survival from this cancer.

The most prominent risk factor for lung cancer is tobacco smoking.⁷⁰ Family history, marijuana smoking, air pollution, vitamin A deficiency or excess are other known risk factors.⁷⁰ Another known risk factor is exposure to industrial carcinogens including asbestos, radon, arsenic polycyclic hydrocarbons, nickel and chromium.⁷⁰

Lung cancer is more common in North America, Europe, Israel, most of the Asian countries including China, Japan, Korea and the Philippines. It is less common in African countries.⁶⁰ In general, men have a much higher incidence than women. The overseas trend probably reflects the access to tobacco and prevalence of smoking in their populations.

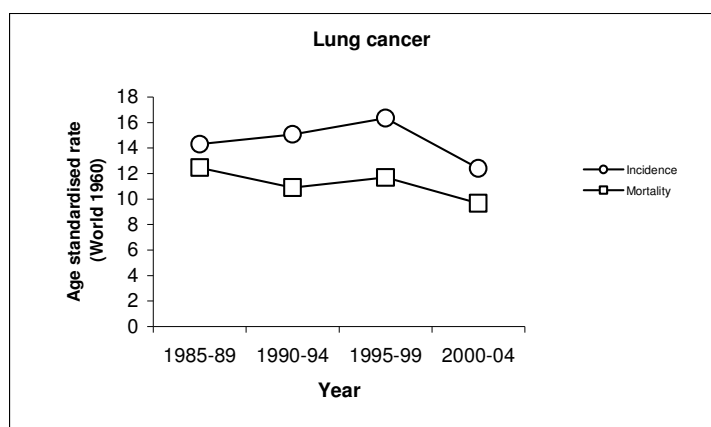
Time trends

There was no clear trend of incidence or mortality over time. Compared to 1985-1989, the latest age standardised incidence rates (2000-2004) fell slightly (14.3 per 100,000 women in 1985-1989; 12.4 per 100,000 women in 2000-2004); and likewise for the age standardised mortality (12.5 per 100,000 women in 1985-1989; 9.7 per 100,000 women in 2000-2004).

Variation with age

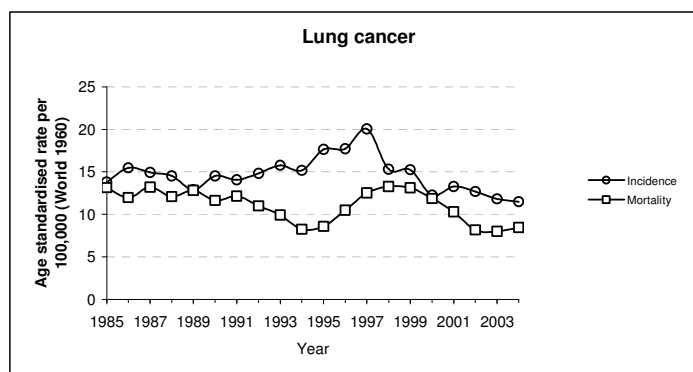
As for most cancers, incidence and mortality increased with age. Age specific rates of incidence and mortality fell at or after the age of 80 (Figure 36).

Figure 34: Lung cancer, age standardised incidence and mortality rates in women, ACT, 1985-2004



Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 35: Lung cancer, age standardised incidence and mortality rates in women, ACT, 1985-2004 (3-year moving average)



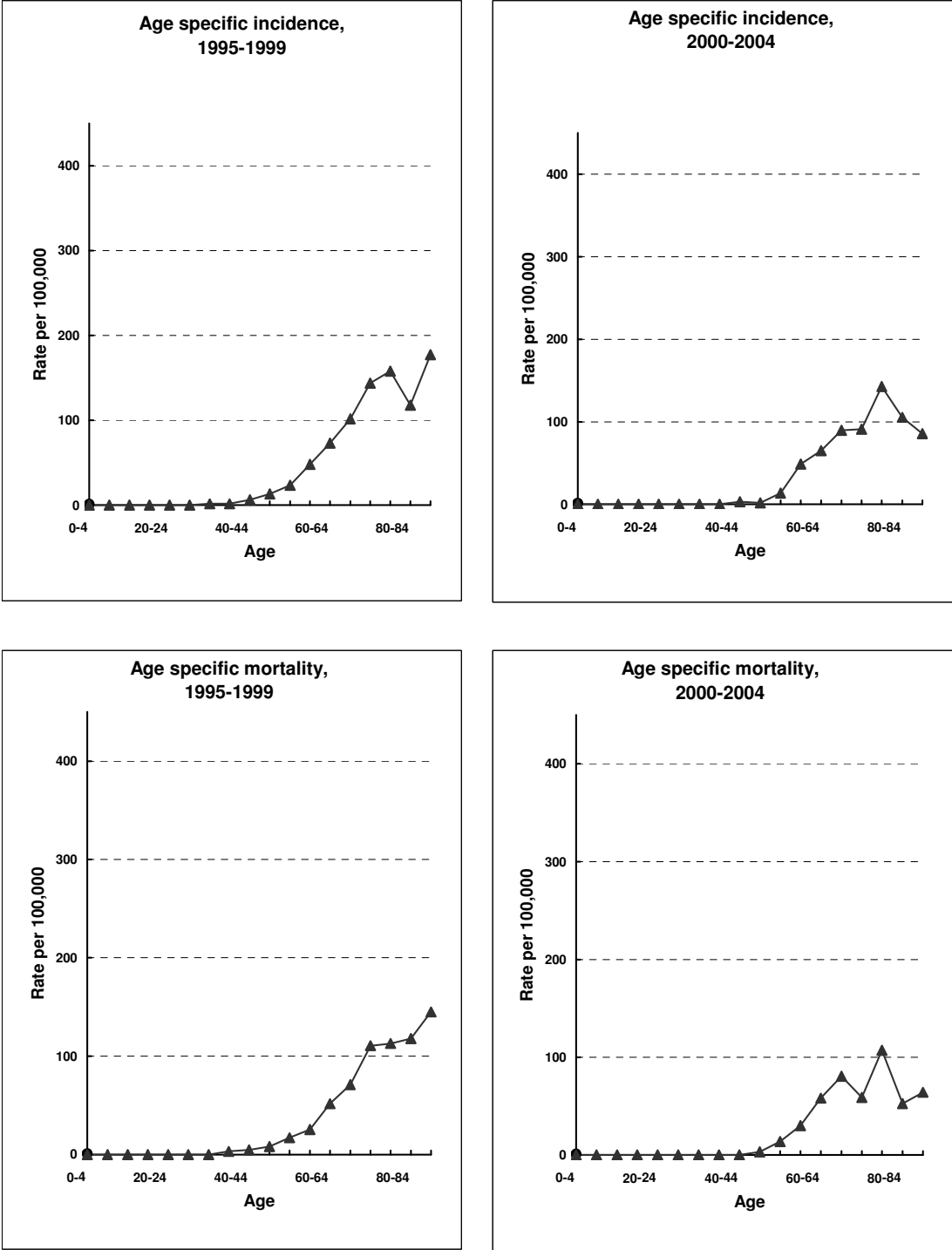
Note: Age standardised incidence/mortality rate per 100,000 population.
Source: ACT Cancer Registry, Confidentialised unit record file

Table 33: Lung cancer, incidence and mortality in women, ACT, 1985-2004

Lung	1985-1989	1990-1994	1995-1999	2000-2004
Incidence				
Number of cases	83	112	145	132
Percent of all cancers	5.6	6.2	6.3	4.7
Crude incidence rate	12.5	15.2	18.6	16.3
ASR (World 1960)	14.3	15.1	16.4	12.4
Sex ratio (F:M= 1:x)	2.6	1.9	1.4	1.8
Cumulative Risk*	1 in 58	1 in 55	1 in 49	1 in 64
Mortality				
Number of deaths	72	82	106	99
Percent of all deaths	13.9	12.8	12.1	11.0
Crude mortality rate	10.9	11.2	13.6	12.2
ASR (World 1960)	12.5	10.9	11.7	9.7
Sex ratio (F:M= 1:x)	2.2	2.3	1.6	2.0
Cumulative Risk*	1 in 66	1 in 77	1 in 69	1 in 82

Note: *Cumulative risk refers to a directly standardised rate with equal weights in each age group of interest and zero weight otherwise. It is calculated from the age-specific rates.
Crude incidence/mortality rate and age standardised rate (ASR) per 100,000 women.
Source: ACT Cancer Registry, Confidentialised unit record file

Figure 36: Lung cancer, age specific incidence and mortality in women, ACT, 1995-2004



Source: ACT Cancer Registry, Confidentialised unit record file

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