4 Health risk factors and preventive measures

Health risk is the likelihood that an individual exposed to certain factors will develop disease. Risk factors are attributes or exposures associated with an increased probability of disease. These include factors in the physical environment, such as toxins and infectious agents, as well as factors in the social environment, such as family disruption, which are associated with increased rates of disease. Behavioural factors such as smoking or physical inactivity are also associated with increased rates of disease. For example, cigarette smokers have an increased risk of developing lung cancer and cardiovascular disease.

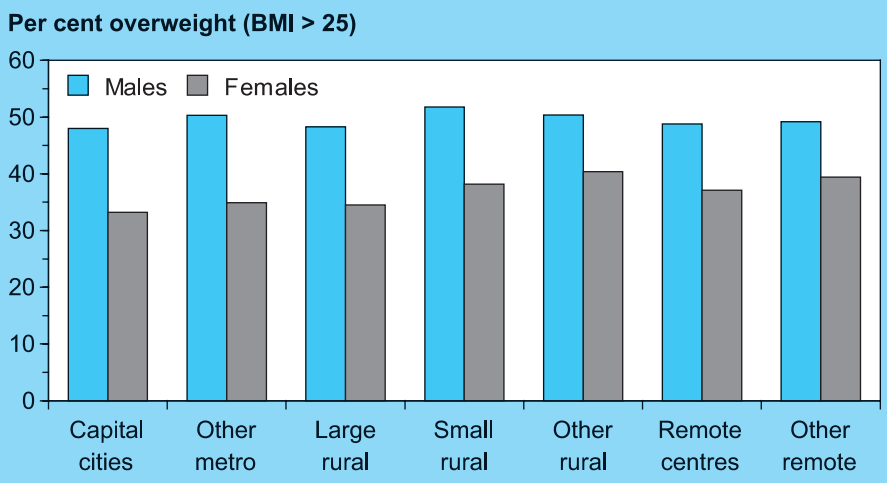
Risk factors are often used as predictors of disease in individuals if the causal link between the factor and the disease is established. More often, especially when the disease is uncommon, risk factors are useful as predictors of disease in populations. For example, there are elderly people with a long history of cigarette smoking but no lung cancer, and their survival is often touted as evidence that cigarette smoking is not related to lung cancer. However, when a population of long-term cigarette smokers is compared with a population of people who have never smoked, it becomes immediately apparent that smokers have an increased risk of lung cancer.

In some cases, a risk factor may not cause the disease directly but instead may be associated with the causal factor. In this case, the risk factor becomes a marker for the disease because it 'marks' an increased probability of developing the disease. For example, a low level of maternal education may be a marker for infant malnutrition if mothers are not fully aware of food constituents. Educating women in a community may make them more aware of the types of nutritious foods that they need to feed their infants.

Risk factors for chronic conditions such as cardiovascular disease may be difficult to determine. Often there is a long time lag between exposure to a risk factor and development of the disease. There may also be more than one cause of a disease and therefore, several different risk factors may need to be examined. Cardiovascular disease is a good example of a disease that is associated with many different risk factors including being overweight, smoking, physical inactivity, high blood pressure and high serum cholesterol. Any one or a combination of these factors can put an individual at higher risk of developing the disease.

The 1995 National Health Survey asked Australians about their specific disease-related risk factors. This chapter uses the survey information to determine if there are risk factor differences between metropolitan, rural and remote population groups. Understanding the differences in risk factors between rural, remote and metropolitan populations of Australia is the first step to introducing preventive measures in these communities.

Overweight and obesity, 1995



	Metropolitan		Rural			Remote		
Sex	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	Total
Males	48.0	50.3	48.3	51.8	50.4	48.8	49.2	48.8
Females	33.2	34.9	34.5	*38.2	*40.4	37.1	39.4	*34.8

* Significantly different from 'capital cities' at the 5% level.

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. Ages 15 and over reporting BMI > 25.

Source: 1995 ABS National Health Survey.

Body weight

- Being overweight is a risk factor for several disabling and/or life-threatening diseases and conditions including diabetes, stroke and ischaemic heart disease. When energy intake is greater than energy expenditure over a long period, body weight increases and can result in an individual becoming overweight or obese (Lester 1994).
- Body Mass Index (BMI) is the ratio of self-reported weight to self-reported height squared (weight/(height)^2). The range of BMI associated with the lowest mortality and morbidity is greater than 20 and less than 25. A BMI of greater than 25 is used as a measure of overweight.
- Self-reported height and weight may differ significantly from measured height and weight and the deviations will result in biased BMI estimates. Waters (1993) has found that average self-reported height is greater than average measured height for males of most ages but only for females over the age of 45. Both males and females tend to underestimate their weight. Smaller proportions of females than males misreport their weight. However, those females that do misreport weight do so to a greater extent than do males.
- During the 1995 survey a lower percentage of females from all areas of Australia reported being overweight compared with males. However, because weight and height are self-reported measures of BMI and males and females may over- or underestimate weight and height to different degrees, comparisons between the sexes are difficult to interpret.
- Approximately 50% of males from all RRMA categories reported being overweight in the 1995 survey, with no signifcant differences between the proportions of any one RRMA category.

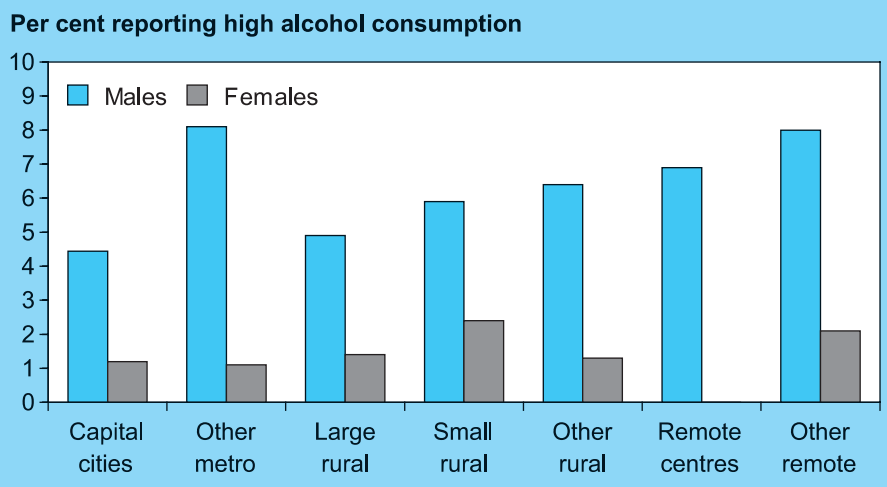
- Around 40% of females from 'small rural centres', 'other remote areas' and 'other rural areas' report being overweight in contrast to one-third of females from 'capital cities', 'other metropolitan centres' and 'large rural centres'.

For more information, see:

Lester I 1994. Australia's food and nutrition. Canberra: AGPS.

Waters AM 1993. Assessment of self-reported height and weight and their use in the determination of body mass index. Canberra: AIHW.

Self-reported high alcohol consumption, 1995



	Metropolitan		Rural			Remote		
Sex	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	Total
Males	4.4	*8.1	4.9	5.9	*6.4	6.9	*8.0	*5.2
Females	1.2	1.1	1.4	*2.4	1.3	*0.0	2.1	1.4

* Significantly different from 'capital cities' at the 5% level.

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. Ages 25–64 reporting high alcohol consumption.

Source: 1995 ABS National Health Survey.

High alcohol consumption

- Heavy alcohol consumption is a risk factor for coronary heart disease (Lester 1994). Consumption of alcoholic beverages is also associated with increased risk of several types of cancer including cancers of the breast, stomach, colon, pancreas, rectum and liver (Abraham et al. 1995). Long-term heavy alcohol consumption leads to cirrhosis of the liver and may lead to alcohol-related brain damage.
- High alcohol consumption can also be a risk factor for non-disease-related mortality and morbidity. For example, it is the leading cause of road traffic accidents. It is also associated with mental problems, in particular depression.
- The National Health and Medical Research Council (1987) recommends that high alcohol consumption be defined as greater than 50 ml for females or greater than 75 ml of alcohol per day for males. By this definition, four standard glasses of wine or three-and-a-half (300 ml) glasses of beer per day places a female above the limit. A male drinking six standard glasses of wine or five (300 ml) glasses of beer per day would be considered a high alcohol consumer.
- Information on high alcohol consumption in the National Health Survey is self-reported. This may lead to an underestimate of high alcohol consumption especially if high alcohol consumers do not report the amount of alcohol they consume.
- For all regions, the greatest proportion consuming high levels of alcohol are men. The highest proportions of these males are from 'other metropolitan centres' and 'other remote areas'. The lowest proportions reporting high alcohol consumption are from 'capital cities' and 'large rural centres'.

- Males from 'other metropolitan centres', 'other rural areas' and 'other remote areas' report significantly greater proportions of heavy alcohol consumption compared with males from 'capital cities'. The highest high alcohol consumption for females is reported by females from 'small rural centres'. 'Remote centres' have significantly lower rates of females consuming high levels of alcohol than do 'capital cities'.

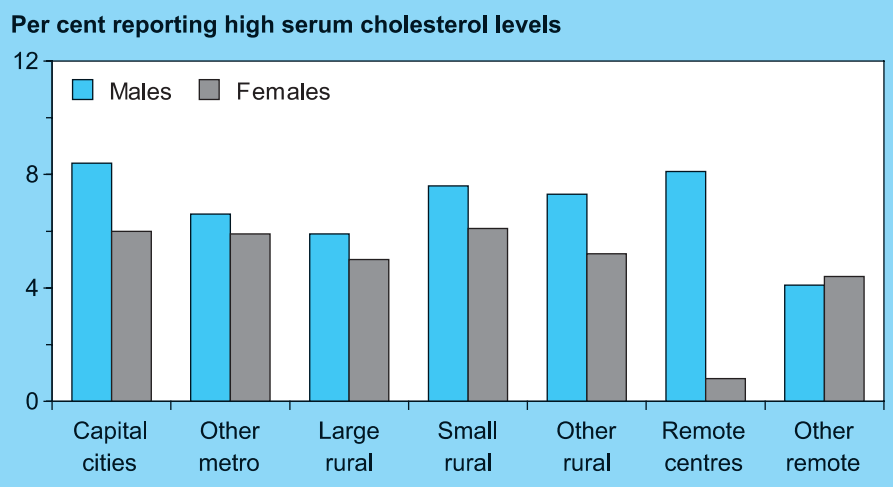
For more information, see:

Abraham B, d'Espaignet ET & Stevenson C 1995. Australian health trends 1995. Canberra: AIHW.

Lester I 1994. Australia's food and nutrition. Canberra: AGPS.

Mathers CD 1994. Health differentials among adult Australians aged 25–64 years. Australian Institute of Health and Welfare: Health Monitoring Series No. 1. Canberra: AGPS.

Self-reported high serum cholesterol levels, 1995



	Metropolitan		Rural			Remote		
Sex	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	Total
Males	8.4	*6.6	*5.9	7.6	7.3	8.1	*4.1	7.9
Females	6.0	5.9	5.0	6.1	5.2	*0.8	4.4	5.7

* Significantly different from 'capital cities' at the 5% level.

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. Ages 25–64 years reporting high serum cholesterol.

Source: 1995 ABS National Health Survey.

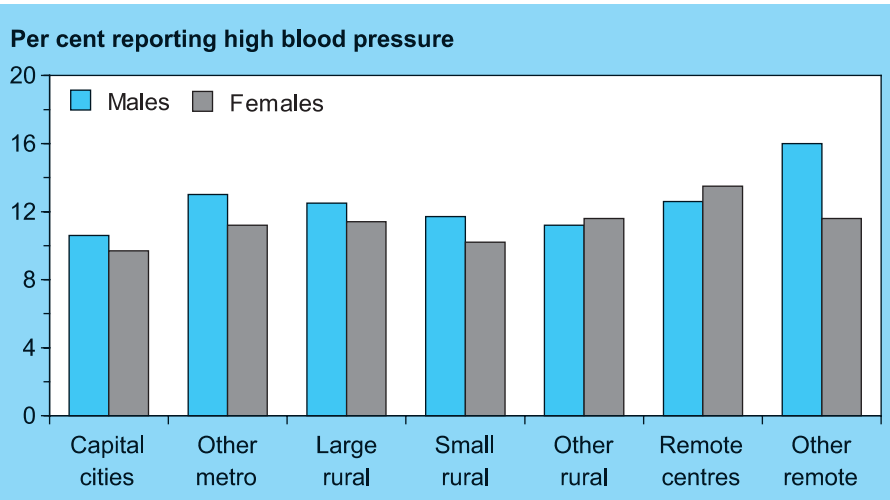
High serum cholesterol

- High serum cholesterol is a risk factor for developing atherosclerosis, which leads to coronary heart disease. Data from the Multiple Risk Factor Intervention Trial (MRFIT) shows that a 1% increase in serum cholesterol can lead to a 2% increase in risk of coronary heart disease (Lester 1994).
- Up to 12% of respondents report having high cholesterol. Self-reported serum cholesterol levels may not reflect the true level of high serum cholesterol in the population because only people who have visited their doctor recently for a test are able to report high serum cholesterol levels. People living in the remote zone may not have been tested for high serum cholesterol, thus leading to underestimation or overestimation of the risk in these areas.
- More males from most RRMA categories report having high cholesterol than do females. Males from 'capital cities', 'small rural centres', 'other rural areas' and 'remote centres' have the highest percentage of self-reported high serum cholesterol, at between 7-8.5%. In contrast, about 4.0–6.6% of males from 'other remote areas', 'other metropolitan centres' and 'large rural centres' report having high cholesterol.
- Over 5% of females from 'capital cities', 'other metropolitan centres', 'small rural centres' and 'other rural areas' report having high serum cholesterol levels and this is contrasted with rates of between 0.8% from 'remote centres' to 4.4% from 'other remote areas'. Females from 'remote centres' report high serum cholesterol significantly less often than their counterparts in 'capital cities'.

For more information, see:

Lester I 1994. Australia's food and nutrition. Canberra: AGPS.

Self-reported high blood pressure, 1995



	Metropolitan		Rural			Remote		
Sex	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	Total
Males	10.6	*13.0	12.5	11.7	11.2	12.6	*16.0	11.1
Females	9.7	11.2	11.4	10.2	*11.6	13.5	11.6	10.3

* Significantly different from 'capital cities' at the 5% level.

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. Ages 25–64 years reporting high blood pressure.

Source: 1995 ABS National Health Survey.

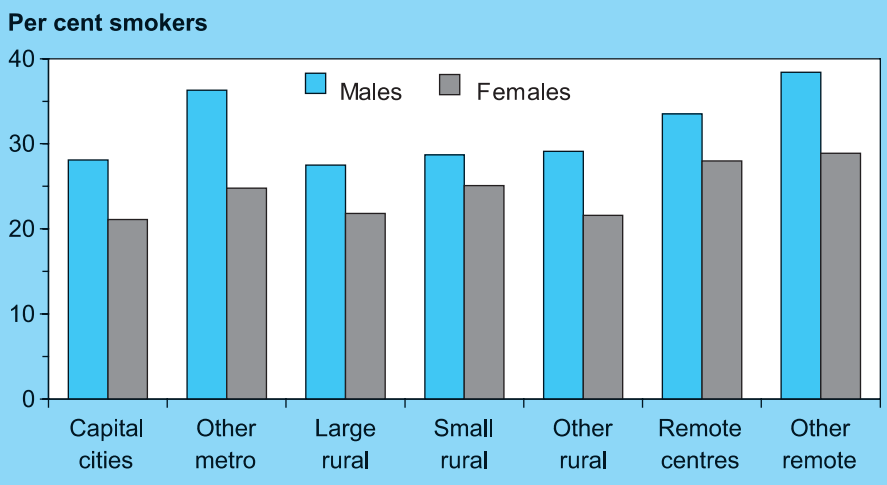
High blood pressure

- High blood pressure is an independent risk factor for total mortality, death from coronary heart disease and death from stroke in both males and females (Lester 1994). High blood pressure is also associated with high serum cholesterol and non-insulin-dependent diabetes mellitus. People who have diets high in salt, or who are heavy alcohol users or overweight are at increased risk of developing high blood pressure.
- Females show lower rates of self-reported high blood pressure than males for all areas except for 'other rural areas' and 'remote centres'. Females from the remote zone, particularly 'remote centres', report the highest prevalence of high blood pressure.
- 'Other rural areas' had significantly higher rates of females self-reporting high blood pressure than females in 'capital cities'. 'Large rural centres', 'other metropolitan centres' and 'other remote areas' had the highest proportion of males reporting high blood pressure. 'Other remote areas' had significantly higher rates of males reporting high blood pressure than males in 'capital cities'.
- The 1995 National Health Survey measures self-reported high blood pressure, so accurate measures may only be available for people who have seen a medical practitioner recently. Many other factors affect the reporting of high blood pressure, including use of medication to relieve high blood pressure and time between measurements by a doctor.

For more information, see:

Lester I 1994. Australia's food and nutrition. Canberra: AGPS.

People who smoke, 1995



	Metropolitan		Rural			Remote		
Sex	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	Total
Males	28.1	*36.3	27.5	28.7	29.1	*33.5	*38.4	29.0
Females	21.1	*24.8	21.8	*25.1	21.6	28.0	*28.9	21.9

* Significantly different from 'capital cities' at the 5% level.

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. Ages 25–64 years reporting tobacco smoking.

Source: 1995 ABS National Health Survey.

Smoking

- Cigarette smoking is a leading cause of mortality and morbidity in Australia (AIHW 1998a). It is a risk factor that has been causally linked to several serious diseases including lung cancer, heart attack and stroke. Smokers are more likely to report fair/poor health and unhappiness, and to have significantly more days of reduced activity relative to non-smokers (Mathers 1994).
- Rates of smoking have declined in Australia since the 1980s (DHFS & AIHW 1998b). However, recent estimates indicate that there are still 3.2 million adult smokers in Australia (DHFS 1995).
- Lung cancer is a particularly serious outcome of long-term cigarette smoking. In 1996, lung cancer resulted in 4,773 male and 2,054 female deaths. The 5-year survival rates for lung cancer are only 10% for both males and females (DHFS & AIHW 1998b).
- The highest proportion of smokers in Australia are in the age group 25–29 years. After age 30, smoking decreases in both males and females (AIHW 1998a). Tobacco smoking is more common in Indigenous population groups who are twice as likely to be regular smokers than are non-Indigenous people (AIHW 1998a).
- The remote zone reports the highest proportions of male and female smokers. Approximately one in three living in remote areas report smoking compared with just over one in four males and one in five females from 'capital cities'. These rates are significantly higher than those for people living in 'capital cities'. The rural zone reports proportions of smokers that are similar to those in 'capital cities'. However, 'other metropolitan centres' have a significantly higher proportion of smokers than 'capital cities'.

- Females from all RRMA categories report less smoking when compared with males. However, nationally, a higher percentage of young females between the ages of 16 and 29 years report being current smokers (AIHW 1998a). The rate of smoking in young females is increasing. Subsequent increases in lung cancer and cardiovascular disease for females may be the result in years to come.

For more information, see:

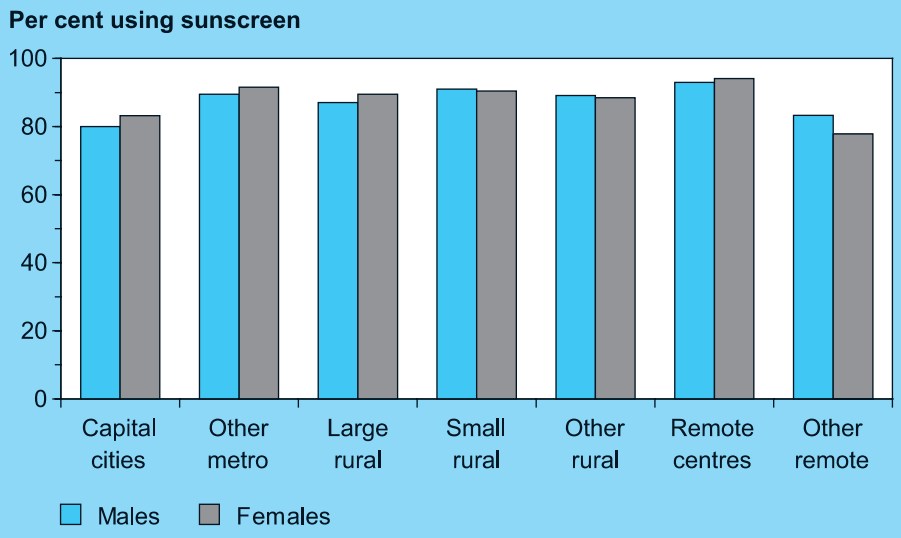
Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.

Commonwealth Department of Health and Family Services 1995. National drug strategy household survey. Canberra: AGPS.

Commonwealth Department of Health and Family Services & Australian Institute of Health and Welfare 1998. National Health Priority Areas report. Cancer control 1997. AIHW Cat. No. PHE 4. Canberra: DHFS & AIHW.

Mathers CD 1994. Health differentials among adult Australians aged 25–64 years. Australian Institute of Health and Welfare: Health Monitoring Series No. 1. Canberra: AGPS.

Use of sun protection, 1995



Sex	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Males	80.0	*89.5	*87.1	*91.0	*89.1	*93.0	83.3	*83.4
Females	83.2	*91.6	*89.5	*90.4	*88.5	94.1	77.8	*85.5

* Significantly different from 'capital cities' at the 5% level.

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. Ages 5 and over reporting use of sun protection.

Source: 1995 ABS National Health Survey.

Sun protection

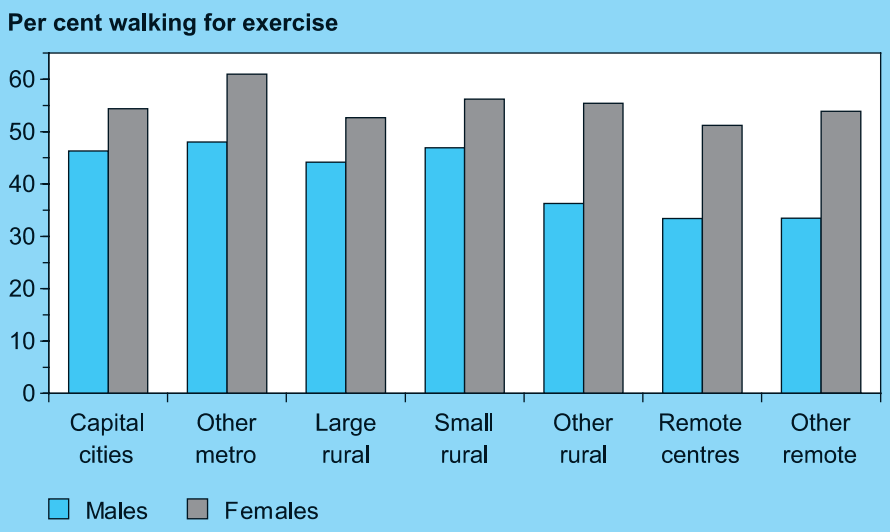
- Excessive sun exposure leads to melanoma and other skin cancers as well as premature ageing of the skin (AIHW 1998a). Use of sun protection measures such as hats, sunscreen with sun protective factor 15 or higher and sunglasses reduce the risk of melanoma by preventing sunburn. Other risk factors for melanoma include having fair skin, not using sun protection and exposure to the sun under the age of 10.
- For people with fair skin and children under the age of 10, use of sun protection is particularly important to prevent the occurrence of skin cancers. Overexposure to the sun during the first two decades of life appears to be an important predictor of melanoma (DHFS & AIHW 1998b).
- Males and females from all areas report similar levels of use of sun protection, although significantly higher sun protection use was reported for males in 'other metropolitan centres', the rural zone and 'remote centres' when compared with males from 'capital cities'. Females in 'other metropolitan centres' and the rural zone also report significantly higher rates of sun protection use compared with women in 'capital cities'.
- Over 90% of males and females from 'remote centres' report that they use sun protection measures. All areas report high use of sun protection. However, care must be taken when interpreting these results because many people regard wearing a hat to be adequate sun protection. Such protection may not reduce overall sun exposure or prevent sunburn, which are the aims of prevention (DHFS & AIHW 1998b).
- Males from 'capital cities' and 'other remote areas' report the least (approximately 78–83%) usage of sun protection measures. In fact, males and females from 'capital cities' report

significantly less use of sun protection than do all Australians combined. Females from 'other remote areas' report the lowest use of sun protection measures, although their rates do not differ significantly from the rates of females living in 'capital cities'.

For more information, see:

Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.

Walking for exercise, 1995



	Metropolitan		Rural			Remote		
Sex	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	Total
Males	46.3	48.0	44.2	46.9	*36.3	*33.4	*33.5	*44.6
Females	54.4	*61.0	52.7	56.2	55.4	51.2	53.9	55.1

* Significantly different from 'capital cities' at the 5% level.

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. Ages 25–64 years reporting walking for exercise.

Source: ABS 1995 National Health Survey.

Walking for exercise

- Walking is the type of low-intensity exercise that lowers the risk of cardiovascular disease. Walking for exercise is an indicator of a healthy lifestyle. Exercise that allows an individual to expend more than 800 kilocalories per week is 'adequate' exercise (AIHW 1998a). Twenty minutes of light exercise three times a week increases cardiovascular fitness and decreases weight gain for both males and females.
- Walking for exercise has increased in popularity in Australia with greater numbers of males and females reporting walking for exercise in the 1995 National Health Survey compared with the 1989–90 National Health Survey. However, the proportions of males and females undertaking 'adequate' exercise still decline with increasing age (AIHW 1998a). However, walking for exercise may not be an accurate indicator of physical activity, particularly for people engaging in more vigorous exercise.
- Over half the females surveyed report walking for exercise compared with only a third of males from the remote zone and less than half of males from other zones. Females from all areas report walking for exercise in similar proportions, with the highest proportion of females walking for exercise from 'other metropolitan centres'. The rates for these females are significantly higher than the rates for females from 'capital cities'. However, the rates for females walking for exercise in rural and remote communities are not significantly different from the rates for females in 'capital cities'. Females in rural and

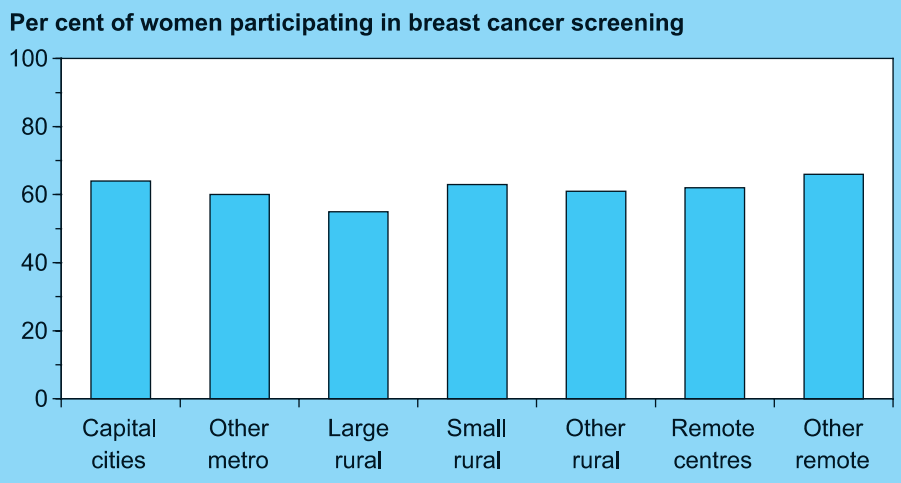
remote zones may take on employment that is physically demanding and may not feel the need to report walking for exercise as a means of keeping physically fit.

- Significantly fewer males from the remote zone and 'other rural areas' report walking for exercise compared with males from 'capital cities'. Males from the remote zone and 'other rural areas' may be employed in jobs that require a high level of physical activity and, as a result, may not feel the need to walk to get 'adequate' exercise.
- For rural and remote communities, 'walking for exercise' may not be an appropriate indicator of physical fitness for either males or females.

For more information, see:

Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.

Breast cancer screening, 1995



Sex/ Age group	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Women aged 40 years and over	64	60*	*55	63	61	62	66	63

* Significantly different from 'capital cities' at the 5% level.

Note:

1. Age-standardised to the Australian population at 30 June 1991.

Source: ABS 1995 National Health Survey.

Breast cancer screening

- Apart from non-melanocytic skin cancers, breast cancer is the most common cancer detected in Australian women (AIHW 1998a). Mammographic screening is regarded as the most cost-effective method for identifying early breast cancer and reducing mortality (Kricker & Jelfs 1996).
- Breast cancer screening as reported during the ABS 1995 National Health Survey involves both mammography and breast examination by a doctor. Participation in breast cancer screening is measured by counting those who have had either a mammograph in the last 5 years and/or those who have had a breast examination by a doctor in the last 2 years.
- Death rates for breast cancer have remained stable from the early 1980s to 1994 (AIHW 1998a). The death rate was 26.6 per 100,000 women in 1994 and is projected to fall to 25 per 100,000 women by 1999 (AIHW 1998a).
- Over 50% of women from all areas have participated in some form of breast cancer screening program. There is little difference in participation rates between those living in metropolitan, rural and remote zones. However, women from 'other metropolitan centres' and 'large rural centres' report significantly less participation in breast cancer screening than those living in 'capital cities'. Overall, most women seem to be familiar with the importance of breast cancer screening for the prevention of death from breast cancer.

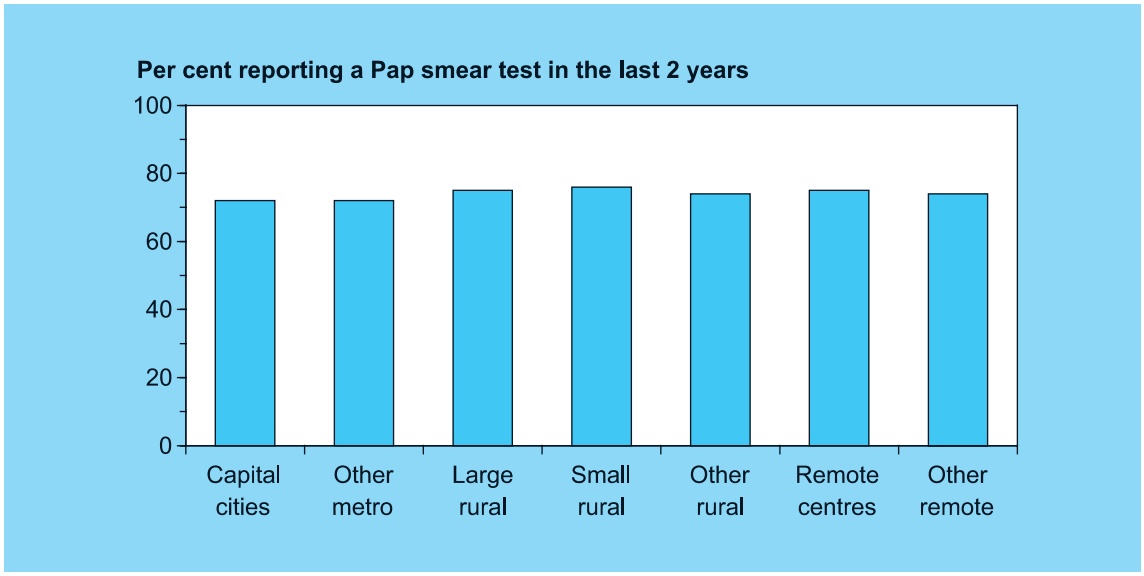
For more information, see:

Australian Institute of health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.

Commonwealth Department of Health and Family Services & Australian Institute of Health and Welfare 1998. National Health Priority Areas report. Cancer control 1997. AIHW Cat. No. PHE 4. Canberra: DHFS & AIHW.

Kricker A & Jelfs P 1996. Breast cancer in Australian women 1921–1994. AIHW Cancer Series No. 6. Canberra: AIHW.

Pap smear tests, 1995



Sex/ Age group	Metropolitan		Rural			Remote		Total
	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	
Women aged 18–69 years	72	72	75	76	74	75	74	73

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. None of the rates is significantly different from 'capital cities' at the 5% level.

Source: ABS 1995 National Health Survey.

Pap smear tests for women

- Cervical cancer is the ninth most common cancer in Australian women (AIHW 1998a). Rates of cervical cancer have declined in recent years because of improved detection and management of precursor lesions and early disease.
- The most common form of cervical cancer, squamous cell carcinoma, is preceded by a number of non-malignant abnormalities that can be detected by Pap smear tests before they develop into a malignant condition. Pap smear tests are recommended at an interval of every 2 years for women who are sexually active.
- Cervical cancer is related to infection by the human papilloma virus (HPV). Risk factors for cervical cancer include not having regular Pap smear tests, early age at first sexual intercourse and multiple sex partners.
- The risk of cervical cancer increases with age and 50% of new cases are diagnosed in women over the age of 50 (AIHW 1998a). However, the lifetime risk of a woman developing cervical cancer before the age of 75 years is 1 in 101.
- Incidence data from the Northern Territory indicate that the rate of cervical cancer for Indigenous women is higher than for non-Indigenous women (d'Espaignet et al. 1996). Women from many cultures, including Indigenous women, may be reluctant to have a Pap smear test performed by a male GP, especially on their first visit to that GP (Healthsharing Women 1994). A recent survey of women's satisfaction with GP consultations found that young women in particular prefer being examined by a female GP (Young et al. 1998).
- The participation rates in screening programs are not high among women of non-English-speaking backgrounds or among Indigenous women (AIHW & DHFS 1997). Culturally sensitive screening practices may enable more women to feel comfortable with the Pap smear test and make it a part of their routine check-up.

- All areas report a similar percentage of women undertaking Pap smear tests in the last 2 years. The percentage of women reporting a recent Pap smear test is relatively high. This indicates that the importance of screening for cervical cancer is well known across all areas of Australia.

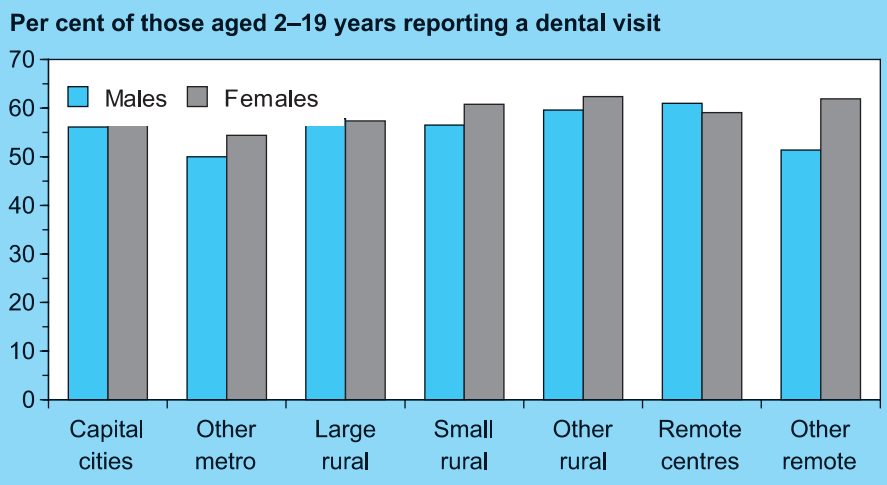
For more information, see:

Australian Institute of health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AGPS.

d'Espaignet E, Measey M, Condon J et al. 1996. Cancer in the Northern Territory 1987–1993. Darwin: Northern Territory Health Services.

Healthsharing Women 1994. Women, health and the rural decline in Victoria. In Franklin MA, Short LM & Teather EK (eds). Country women at the crossroads. Armidale: University of New England Press, 92–98.

Dental visits for those aged 2–19 years, 1995



	Metropolitan		Rural			Remote		
Sex	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	Total
Males	56.1	50.0	57.8	56.5	59.6	61.0	51.4	56.3
Females	58.1	54.4	57.4	60.8	62.4	59.1	61.9	58.8

Notes

1. Age-standardised to the Australian population at 30 June 1991.
2. None of the rates is significantly different from 'capital cities' at the 5% level.
3. Ages 2–19 years reporting visits to a dentist in the last 12 months.

Source: ABS 1995 National Health Survey.

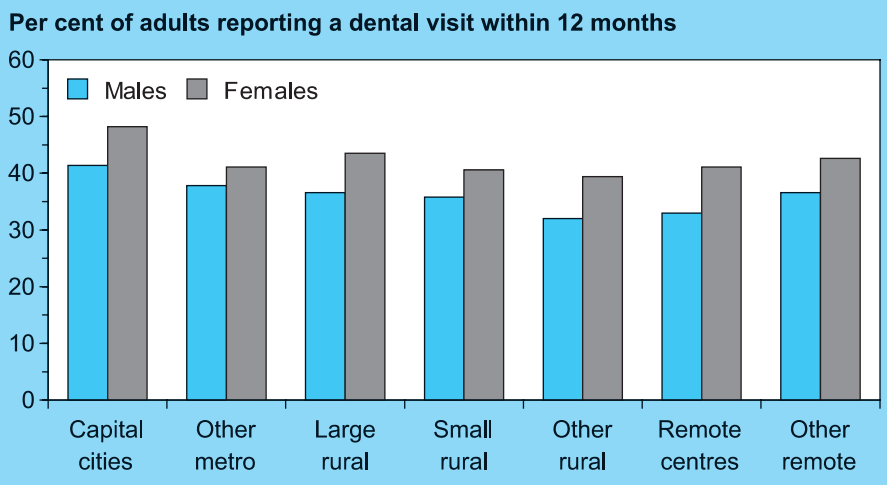
Visits to the dentist

- Children and young adults aged 2–19 years were more likely to consult a dentist in 1996 than were adults (AIHW 1998a). There has been a large increase in young adult visits to the dentist in recent years due to the increase in orthodontal services (AIHW 1998a).
- Youths from rural and remote zones report seeing a dentist in the last 12 months at a similar rate to those from the metropolitan zone. Less than 60% of males and females report going to a dentist over a 12-month period. Frequent visits to the dentist may prevent loss of natural teeth to decay or periodontal (gum) disease later in life. The relatively low levels of dental visits reported here indicate that this age group may be missing the benefits of regular dental check-ups.
- Higher proportions of females from all areas except 'remote centres' and 'large rural centres' report visiting the dentist compared with males. Males from 'other metropolitan centres' had a substantially lower percentage of reported dental consultations for the 12-month period than males from 'capital cities'. The highest percentages of dental consultations occurred in the rural and remote zones.

For more information, see:

Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.

Dental consultations among adults, 1995



	Metropolitan		Rural			Remote		
Sex	Capital cities	Other	Large centres	Small centres	Other	Centres	Other	Total
Males	41.4	37.8	36.6	*35.8	*32.0	33.0	36.6	*39.0
Females	48.2	*41.1	43.5	*40.6	*39.4	41.1	42.6	45.5

* Significantly different from 'capital cities' at the 5% level.
Note: Ages 20 years and over reporting visits to a dentist in the last 12 months.
Source: 1995 ABS National Health Survey.

Visits to the dentist

- Frequent dental visits ensure better overall oral health and reduced loss of natural teeth. However, less than a quarter of adult males reported visiting a dentist in the last 12 months compared with less than a third of females.
- Financial burden is often cited as a reason for avoiding or delaying visits to the dentist. Nearly 25% of people surveyed stated that they delayed dental visits due to the cost of the service and a further 19% reported being prevented from having necessary dental work done because of the cost (AIHW 1998a).
- Females from 'capital cities' recorded the highest percentage of visits to a dentist within the 12-month period. Males from the metropolitan zone had the highest percentage reporting a visit to the dentist within 12 months, whereas males from the rural and remote zones had much lower proportions than their counterparts in 'capital cities'. Males from 'small rural centres' and 'other rural areas' had significantly lower proportions compared with males from 'capital cities'.

For more information, see:
Australian Institute of Health and Welfare 1998. Australia's health 1998: the sixth biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW.