Australian Government
Australian Institute of Health and Welfare

The health of Australia's males

Web report | Last updated: **27 Jun 2023** | Topic: Men & women

About

Australian males experience different health outcomes to females. They experience more of their total disease burden from dying prematurely than from living with disease and injury. Leading causes of disease burden include heart disease, dementia and mental health and substance use disorders. Males are also more likely to engage in risky health behaviours such as tobacco, alcohol and substance abuse. They are also less likely to seek health care services.

To learn more about the health outcomes of females, see *The health of Australia's females*.

Cat. no: PHE 239

- Fact sheet
- Data

Findings from this report:

- 40% of disease burden among males could have been prevented by avoiding or reducing exposure to certain risk factors
- 49% of Australian males have 1 or more of 10 selected chronic conditions, in 2020–21
- 43% of Australian males experienced a mental health problem at some point in their lifetime
- 79% of Australian males aged 15+ visited a GP in the last 12 months in 2021–22

Summary

This report uses the latest available data to summarise the health of males in Australia including health behaviours and risk factors, the impact of COVID-19 on health, chronic conditions, sexual and reproductive health, leading causes of disease burden and how males access health care.

Males experience more of their total disease burden due to dying early from disease and injury rather than from living with disease and injury.

Australian males experience different health outcomes to females. Leading causes of ill health and death for males include suicide and self-inflicted injuries, coronary heart disease and dementia.

Males are more likely to engage in risky health behaviours such as tobacco, alcohol and other substance use, physical inactivity and poor dietary choices. More males than females live with overweight and obesity. Males are also less likely to seek health care such as general practitioners (GP) and health professionals for their mental health.

Male health varies for some population groups including by socioeconomic area and for those living in rural and remote areas.

This report focuses on males aged 18 and over, and the term 'males' refers to males aged 18 and over, unless otherwise specified. To learn more about the health outcomes of females, see The health of Australia's females. To learn more about the health of children see Australia's children, and for the health of youths, see Australia's Youth.

For more information on reporting of sex and gender at the AIHW, see AIHW data by sex and gender.

Data by sex and gender

This web report focuses on male health. A separate web report focuses on female health.

The use of the word 'male' in this report may relate to either sex or gender due to the nature of the data sources that we use. Most current data sources do not record sex and gender as separate concepts so it can be unclear which is the focus. For example, a survey may ask participants for their 'sex' or 'gender', but in each case, a participant can respond to the question according to how they identify, or how they interpret the question. In other instances, an interviewer conducting a survey may assume a person's sex or gender rather than ask. Similarly, for administrative data, a health service provider may not ask a person to specify their sex or gender.

The AIHW is working towards including other categories when reporting by sex or gender. However, it is not always possible to do so as data on other categories may not be available. The AIHW is only able to report on the sex or gender categories that are available in the health service or program administrative records or survey that provide us with the underlying data.

For more information on reporting of sex and gender at the AIHW, see AIHW data by sex and gender.

Who are Australia's males?

Page highlights

The male population is ageing

- The median age of males has increased from 35.3 years in 2003 to 37.7 years in 2022.
- The proportion of the male population aged 65 and over has increased from 13% of the total male population in 2012 to 16% in 2022.

Some males are more disadvantaged

- One in 8 (13%) males in all age groups are living under the poverty line.
- Around 69,000 males are considered homeless.

Aboriginal and Torres Strait Islander males

- There are nearly 500,000 Aboriginal and Torres Strait Islander males, representing 3.9% of the male population.
- Indigenous males tend to be younger than non-Indigenous males – 34% are aged under 15, compared with 20% of non-Indigenous males.

Australian males have diverse backgrounds

Nearly 3 in 10 (29%) of all Australian males are born overseas.

Males outnumber females in remote areas

There is a higher share of males in *Remote and very remote* areas – 108 males per 100 females.

There are 12.5 million males of all ages in Australia, just under half (49%) of the country's population, in 2021. Overall, there are 97.4 males for every 100 females (ABS 2021a).

The typical Australian male is 37 years old, has a life expectancy of 81.3 years, lives in a major city, is employed, has a non-school qualification, but is less likely to have a university degree compared with Australia's females (ABS 2022q).

The male population is ageing

Over the last nearly 20 years the median age of males, where half the male population is older and half is younger, has increased from 35.3 years in 2003 to 37.7 years in 2022 (ABS 2023c).

Over the last 10 years, the proportion of the male population aged 65 and over has also increased – from 13% of the total male population in 2012 to 16% in 2022. Percentage growth over the same 10-year period shows that males aged 65 and over grew by 39%, compared with those aged under 18, which grew by 11%, and those aged 18–64, which grew by 10% (ABS 2012, ABS 2023b).

Some males are more disadvantaged

One in 8 (13%) males in all age groups are living under the poverty line, defined as those living on after-tax household incomes below 50% of the median household income (Davidson, et al. 2020).

Around 69,000 males are considered homeless, with the greatest proportion being in the 25–34 age range (ABS 2018a). In 2021-22, around 100,300 males presented to Specialist Homelessness Services as homeless, or at risk of homelessness (AIHW 2022n).

There are around 37,600 male prisoners in adult corrective services custody (around 13 times as many as females) with the greatest proportion in the 30-34 age group (ABS 2021e). The most common offence relates to acts intended to cause injury (26%) (ABS 2021e).

Aboriginal and Torres Strait Islander males

There are nearly 500,000 Aboriginal and Torres Strait Islander males as at 30 June 2021, representing 3.9% of the male population (ABS 2021b, ABS 2022b).

The typical Indigenous male is younger than non-Indigenous males. Around 3 in 10 (34%) are aged under 15, compared with around 20% of non-Indigenous males (ABS 2021a). They are outnumbered by females in older age groups, with 85.5 Indigenous males for every 100 Indigenous females aged 65 and over (ABS 2022b).

Around 3 in 5 (61%) Indigenous males aged 15 and over identify with a clan, tribal or language group and 17% speak an Indigenous language, in 2014–15 (ABS 2016).

The disease groups causing the most ill health and death in Indigenous males are mental and substance use disorders, injuries and cardiovascular diseases (AIHW 2022e).

For more information on burden of disease in Indigenous Australians, please see Disease burden among Aboriginal and Torres Strait Islander people.

To learn more, see Indigenous Australians.

Australian males have diverse backgrounds – almost 3 in 10 are born overseas.

Almost one third (29%) of Australian males are born overseas, in 2021. Of these, the most common countries of birth are England (13%), India (10.5%), New Zealand (7.8%) and China (7.2%) (ABS 2022a).

Males outnumber females in remote areas

The density of the male population varies across the country. For example, in 2021, in *Remote and very remote* areas, there are 108 males for every 100 females compared with 97 males for every 100 females in *Major cities* (ABS 2021f).

According to the latest available data from the 2021 ABS Census (ABS 2021f):

7 in 10 (72%) Australian males live in *Major cities*

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

fewer than 1 in 10 (8.2%) live in *Outer regional* areas

1 in 50 (2.0%) live in *Remote and very remote* areas.

References

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How healthy are Australia's males?

Page highlights

Self-assessed health status
3 in 5 (58%) of Australian males rate their health as excellent or very good.

Burden of disease
Australian males lost more healthy years of life from dying prematurely (54%) than from living with disease and injury (46%).

Chronic conditions
49% of Australian males have 1 or more of the 10 selected chronic conditions.

Cancer
An estimated 89,000 new cancer cases will be diagnosed in males, in 2022.

Mental Health
43% of Australian males have experienced a mental health problem at some point in their lifetime.

Dementia
About 149,600 Australian males aged 30 and over are estimated to be living with dementia, the equivalent of 12 per 1,000 males.

Sexual health
About 73,100 new cases of selected nationally notifiable sexually transmissible infections were reported for Australian males in 2021.

Life expectancy and mortality
Australian males born in 2019–2021 can expect to live 30 years longer than males born in 1891–1900.

A person's health status is a general measure combining physical, social, emotional and mental health and wellbeing. A person's overall level of health can be measured through:

- self-assessment
- burden of disease analysis
- the health impact of disease
- injury in a population
- presence of chronic conditions and comorbidities
- mental health
- sexual health
- life expectancy.

Self-assessed health status

Self-assessed health status reflects a person's perception of their own health at a particular point in time; it can give a broad picture of the population's overall health (ABS 2018d).

In 2020–21, 58% of males rated their health as excellent of very good. The proportion of males who rated their health as excellent or very good varies by age group. Eight in 10 (80%) of males aged 15–24 rated their health as excellent or very good compared with 36% of males aged 75 and over in 2020–21 (ABS 2022d).

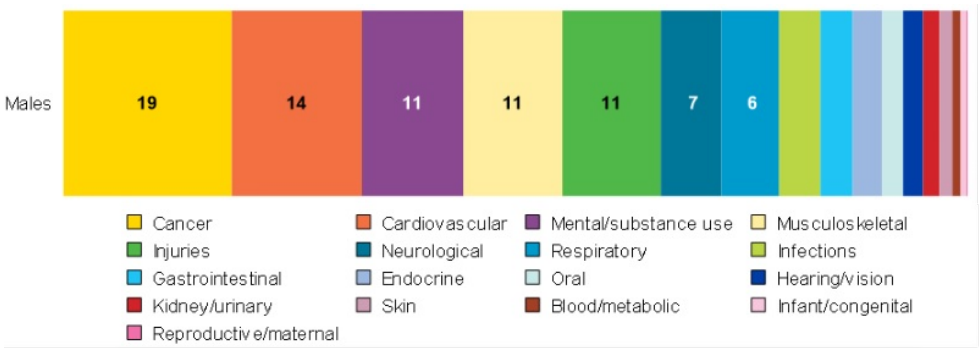
Burden of disease

Burden of disease quantifies the health impact of disease on a population in a given year – both from dying early and from living with disease or injury. The summary measure disability-adjusted life years (DALY) measures the years of healthy life lost from both premature death (fatal burden) and ill health (non-fatal burden).

In 2022 (AIHW 2022d):

- Australian males experienced a greater share of ill health and death (53%) than females (47%)
- after adjusting for age, males experience 1.2 times the rate of total burden and 1.6 times the rate of fatal burden of females, while rates of non-fatal burden are similar
- Australian males lost more healthy years of life from dying prematurely (54%) than from living with disease and injury (46%)
- the highest proportion of ill health and death for males was due to these top 5 disease groups: cancer (19%), cardiovascular diseases (14%), mental health conditions/substance use disorders (11%), injuries (11%), and musculoskeletal conditions (11%) (Figure 1)
- males experienced a greater share than females of ill health and death from some disease groups including injuries (70%), kidney & urinary diseases (62%), cardiovascular diseases (60%), endocrine disorders (mostly diabetes) (58%), infant & congenital conditions (58%) and cancer (56%).

Figure 1: Leading causes of ill health and death (% DALY) by disease group, males, 2022



Notes:

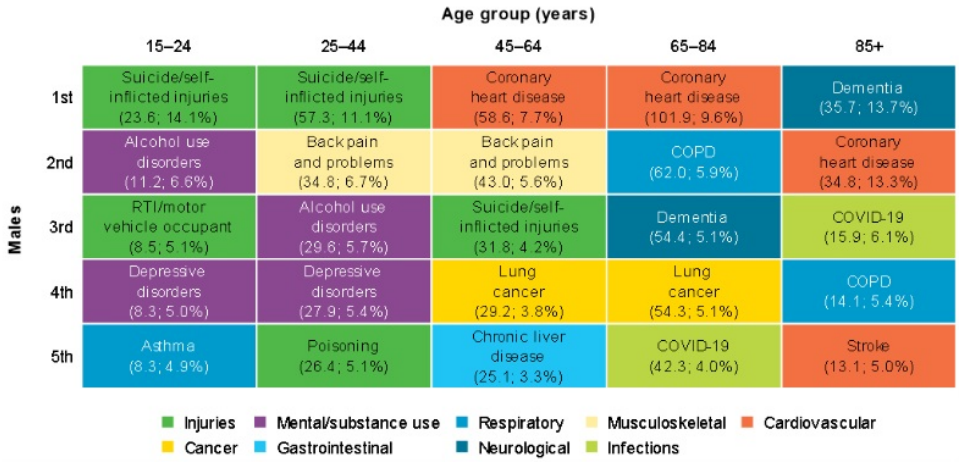
DALY = Disability Adjusted Life-Year. This is a measure of healthy life lost, either through premature death or living with disability due to ill health. It is the basic unit used to measure the burden of a disease.

Source: AIHW analysis of AIHW 2022d

Ill health and death vary across age groups for males. Suicide and self-inflicted injuries were the leading cause of total burden for males aged 15–44. Alcohol use disorders was ranked second for total burden among males aged 15–24, with back pain second among those aged 25–44. Coronary heart disease was the leading cause of burden among males aged 45–84, and second for those aged 65 and over. COVID-19 features for the first time in the top 5 leading causes for males aged over 65 (Figure 2) (AIHW 2022d).

For more information see Australian Burden of Disease Study 2022.

Figure 2: Leading causes of ill health and death (DALY'000; proportion %) among males aged 15 and over, 2022



DALY = Disability Adjusted Life-Year.

Notes:

1. RTI = road traffic injury, COPD = chronic obstructive pulmonary disease.
2. Disease rankings exclude ‘other’ residual conditions from each disease group; for example, ‘other musculoskeletal conditions’.

Source: AIHW analysis of AIHW 2022d

Chronic conditions

Chronic conditions pose significant health problems and have a range of potential impacts on individual circumstances. Data in this section focus on 10 common chronic conditions including:

- arthritis
- asthma
- back problems
- cancer
- chronic obstructive pulmonary disease
- diabetes
- heart, stroke and vascular disease
- chronic kidney disease
- osteoporosis
- mental health conditions.

For more information see Chronic conditions.

Among Australian males aged 15 and over, 49% are estimated to have one or more of the 10 selected common chronic conditions. About 1 in 3 (29%) males aged 15 and over have one, 13% have 2, and 6.8% have 3 or more (ABS 2022c). Prevalence of the 10 selected conditions is shown in Table 1 (ABS 2022d, AIHW 2022g).

The self-reported prevalence of chronic conditions increases with age (ABS 2022d):

- Almost 3 in 10 (37%) of males aged 15–44 have at least one chronic condition.
- 53% of males aged 45–64 have at least one chronic condition.
- 74% of males aged 65 and over have at least one chronic condition.

Table 1: Number and percentage of selected chronic conditions, males aged 15 and over, 2020–21[(1)]

Condition	Number	Percentage[2]
Back problems[3]	1,884,500	19
Mental and behavioural conditions[4]	1,792,200	18
Arthritis[5]	1,275,700	13
Asthma	936,700	9.4
Diabetes mellitus[6]	705,400	7.1
Heart, stroke and vascular disease[7]	605,500	6.1
Cancer	268,500	2.7
Osteoporosis[8]	139,900	1.4
Kidney disease	124,900	1.3
Chronic obstructive pulmonary disease (COPD)[9]	108,700	1.1

Notes

1. This data is self-reported and likely under-reports the true prevalence of chronic conditions.
2. Percentages is calculated out of the total male population aged 15 and over.
3. Includes sciatica, disc disorders, back pain/problems not elsewhere classified and curvature of the spine.
4. Includes harmful use or dependence on alcohol and/or drugs, mood (affective) disorders, anxiety related disorders, organic mental disorders and other mental and behavioural conditions.
5. Includes rheumatoid arthritis, osteoarthritis, other and type unknown.
6. Includes Type 1 and Type 2 diabetes mellitus and type unknown. These estimates include persons who reported they had diabetes mellitus but that it was not current at the time of interview.
7. Includes angina, heart attack, other ischaemic heart diseases, stroke and other cerebrovascular diseases, oedema or heart failure, and diseases of the arteries, arterioles and capillaries. Estimates include persons who reported they had angina, heart attack, other ischaemic heart diseases, stroke and other cerebrovascular diseases or heart failure but that these conditions were not current at the time of interview.
8. Includes osteopenia.
9. Includes chronic bronchitis, emphysema and chronic airflow limitation. Asthma is reported separately.

Source: ABS 2022d, AIHW 2022g

For more detailed information about chronic conditions, see Chronic conditions.

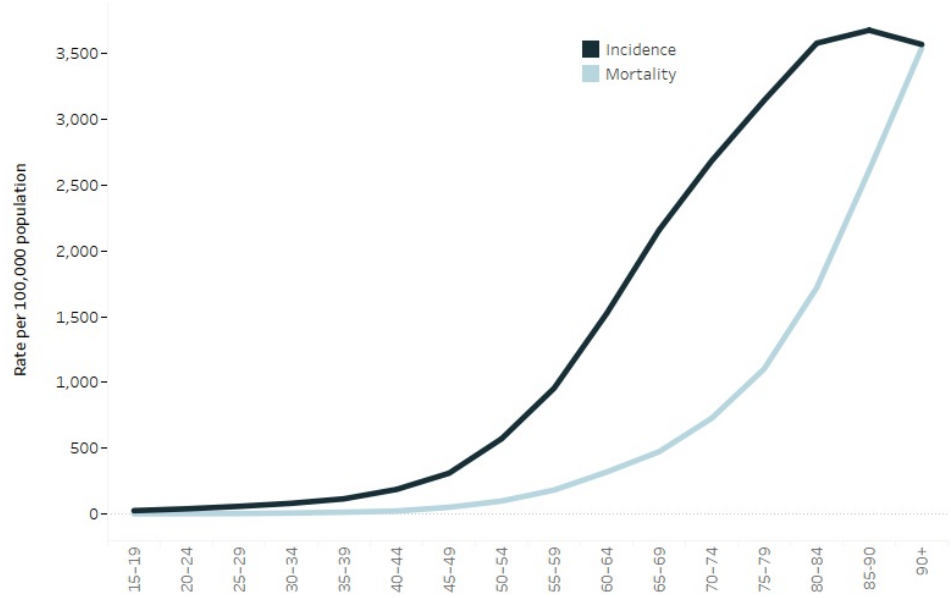
Cancer

In 2022, the estimated number of new cancer cases in males of all ages is around 89,000, which accounts for 55% of all cases. The most common cancer diagnosis in males is prostate cancer, followed by melanoma of the skin, colorectal cancer, and lung cancer (AIHW 2022f). The risk for Australian males of being diagnosed with cancer is 1 in 3 by the age 75, and 1 in 2 by age 85 (AIHW 2019).

The most common cancer diagnosis among males varies by age. In 2022, leukaemia and brain cancer were the most common for males aged under 20. Testicular cancer and melanoma were the most common in males aged under 40, with prostate cancer and melanoma the most common in males aged over 40. The estimated age-specific incidence of all cancers increases sharply from age 45, and the associated mortality rate is delayed and increases sharply from age 65 (Figure 3) (AIHW 2022f).

Figure 3: Estimated age-specific incidence and mortality rate for all cancers, males, 2022

The figure shows that the incidence of all cancers increases with age, as does the associated mortality. However, mortality is delayed due to the period of living with cancer.



Source: AIHW 2022f. See Table S11 for data and footnotes.
http://www.aihw.gov.au

Mental health

A lifetime mental health disorder refers to people who met the diagnostic criteria for having a disorder at some time in their life. This does not imply that a person has had a disorder throughout their entire life. Based on the 2020–21 National Study of Mental Health and Wellbeing (NSMHW) (ABS 2022h):

- 43% of males aged 16–85 report having a mental disorder at some point in their lifetime
- 22% of males report having an anxiety related and substance use (27%) disorders.

A 12-month mental health disorder refers to the people who met the diagnostic criteria for having a disorder at some time in their life and had sufficient symptoms of that disorder in the 12 months prior to the survey.

Based on the 2020–21 NSMHW, for males aged 16–85 (ABS 2022h):

- around 18% had any 12-month mental disorder
- just over 1 in 10 (12%) reported having a 12-month anxiety-related disorder
- 12-month mental health disorders varied by age, with 31% of males aged 16–24 having a 12-month mental health disorder, compared with 22% of those aged 25–44, and 10% of those aged 65–74.

For more information of the mental health of Australians, see Mental health services.

Dementia

Dementia is a significant and growing health and aged care issue in Australia. It has substantial impact on the health and quality of life of males with this condition, as well as on their family and friends. Dementia is the 5th leading causes of ill health and premature death in males of all ages and becomes the number one leading cause in males aged 85–99 (AIHW 2023c). Dementia is the second leading cause of death in males overall, accounting for 6.8% of all male deaths in 2020.

Estimates indicate that about 149,600 Australian males aged 30 and over are living with dementia in 2022, which is equivalent to 12 males with dementia per 1,000 males. This estimate is projected to increase to 315,000 in 2058 (AIHW 2023d).

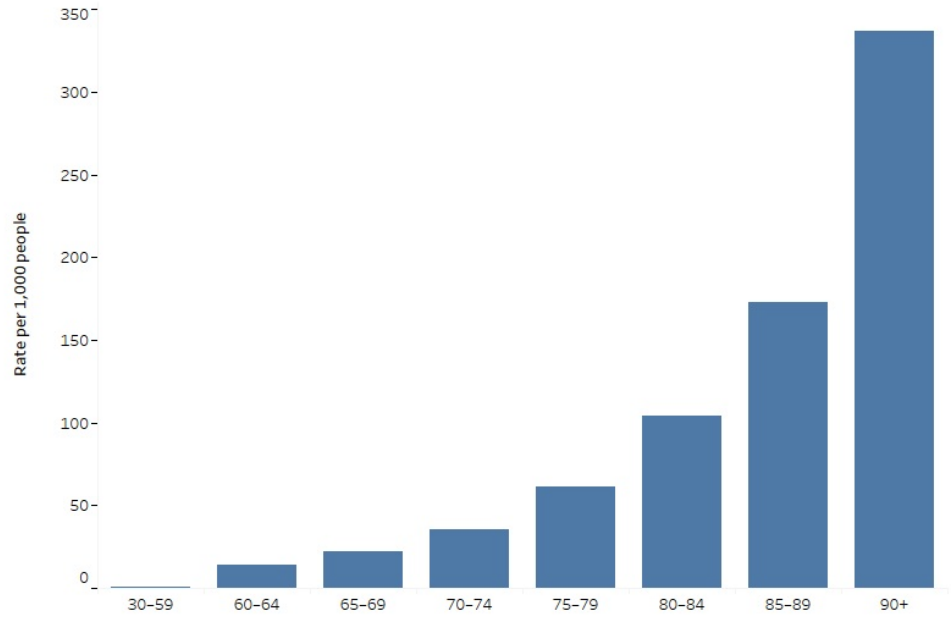
Age is a main risk factor for dementia with the estimated prevalence of men living with dementia increasing as aged increase (Figure 4) (AIHW 2023c). Other modifiable risk factors recognised as having strong evidence for increased risk of developing dementia include low level of education in early life and hearing loss in midlife (AIHW 2023c).

The 2 leading health risk factors measured by the Australian Burden of Disease Study for dementia are overweight (including obesity) and physical inactivity, contributing 20% and 11%, respectively to the total burden due to dementia (AIHW 2023d).

For more information on Dementia and its associated risk factors, see Dementia in Australia.

Figure 4 Prevalence of dementia by age group (per 1,000 population), males, 2022

This bar chart shows the rate of dementia across age groups, with the prevalence increasing with age and highest in those aged 90 and over.



Source: AIHW 2023c. See Table S7 for data and footnotes.
http://www.aihw.gov.au

Sexual health

Sexual health is a state of physical, mental and social well-being in relation to sexuality. Measures of sexual health include the prevalence of sexual difficulties and sexually transmissible infection rates (WHO 2022a).

Sexual difficulties

A study published in 2016 indicated that more than half (54%) of males aged 18–55 had experienced some sexual difficulty lasting at least 3 months in the last 12 months, in 2013–2014 (Schlichthorst, et al. 2016).

Of these males (Table 2):

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

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

Other types of sexual difficulty differed by age (Schlichthorst, et al. 2016):

- 'did not reach climax or took a long time' was the next most common issue in males aged 18–24
- 'lacking interest in having sex' was most common among males in aged 45–55.

Table 2: Type of sexual difficulty experienced by males aged 18–55 who experienced at least 1 sexual difficulty(1) in the past 12 months, 2013–2014

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

Notes:

1. Sexual difficulty experienced for at least three months in the 12 months before the study.
2. 95% CI = 95% confidence interval. We can be 95% confident that the true value is within this range of values.

Source: Schlichthorst, et al. 2016.

Sexually transmissible infections

Sexually transmissible infections (STIs) are a subset of communicable diseases known to be transmitted through sexual contact. More than 30 different viruses, bacteria and parasites are known to be transmitted sexually (WHO 2022b). Although some STIs can be cured, a person can have an STI without symptoms of disease. If left untreated, these infections can have serious consequences for long-term health.

Nationally notifiable diseases which are sexually transmissible include chlamydia, gonococcal infection, syphilis, human immunodeficiency virus (HIV), donovanosis, hepatitis B and hepatitis C. It should be noted that HIV, hepatitis B and C are also transmissible via other routes such as exposure to unsafe injecting drug use.

In 2021, there were about 73,137 notifications of chlamydia, gonococcal infection, syphilis, hepatitis B and hepatitis C for males, which accounted for 56% of all notifications in both males and females for these selected STI's (Table 3) (DoHAC 2022).

In 2021, there were 486 new cases of HIV among males. After adjusting for age, the rate of HIV notifications decreased by 55% since 2012. The declines seen between 2019 and 2021 are likely attributable in part to the impact of COVID-19 restrictions on social activity, healthcare access and testing, and travel (UNSW 2022).

Table 3: Number, proportion and rate of selected sexually transmitted infection notifications, males, 2020 and 2021

This table shows the number of notifications, per cent of total cases, and age-standardised rates of notifications for chlamydia, gonococcal infection, syphilis, hepatitis b and c for the years 2020 to 2022. For HIV, only 2020 and 2021 data are available.

Year
○ 2020
◉ 2021

Year	STI	Number of notifications	Per cent of notifications in males	Age-standardised rate per 100,000
2021	Chlamydia	42,311	49	339
	Gonococcal infection	18,400	69	146
	Infectious Syphilis	4,698	54	37
	Hepatitis B	2,541	54	19
	Hepatitis C	2,541	51	19
	HIV	486	88	4

Source: Kirby Institute, 2022 (HIV), National Notifiable Disease Surveillance System, ABS National, state and territory population (for obtaining population rates). See Table S12 for data and footnotes.
http://www.aihw.gov.au

Notes:

1. Total excludes cases where sex was missing.
2. Hepatitis B and C notifications include newly acquired and unspecified cases and could have been transmitted through other routes.
3. Syphilis notifications include syphilis of less than 2 years duration (infectious) and excludes syphilis of more than 2 years or unknown duration (unspecified).
4. There are no new cases of donovanosis reported in males in 2020 and 2021.

After adjusting for age, notification rates in males for viral hepatitis B and hepatitis C have decreased by 39% and 29%, respectively, from 2012 to 2022. In 2021, rates for hepatitis B are the highest among males aged 30–39 (36 per 100,000 population). For hepatitis C, rates are the highest in males aged 25–29 (74 per 100,000 population) (DoHAC 2022).

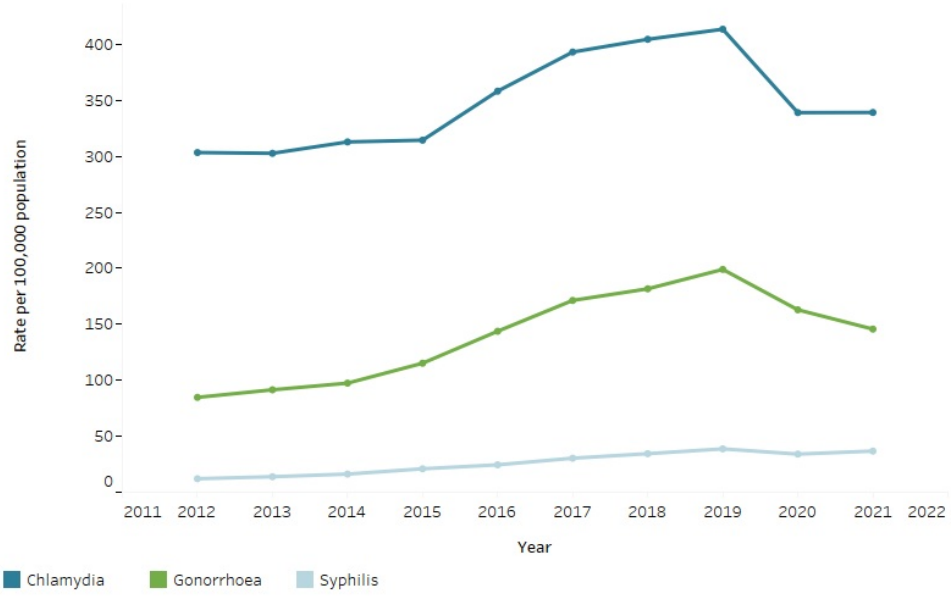
After adjusting for age, there has been an increase in rates of chlamydia, gonococcal infections and syphilis notifications since 2012, peaking in 2019 and then decreasing in 2020 and 2021 which is likely related to the COVID-19 pandemic, and may not be reflective of the trend in new infections (Figure 5). Rates of notifications have increased from 2021 to 2021 for all three infections (Figure 5). Chlamydia is the most frequently notified STI in Australia in both males and females.

After adjusting for age, compared with 2012, rates of these infections in 2021 for males were (DoHAC 2022):

- 3.0 times higher for syphilis, with the highest rate seen in males aged 30–39
- 1.7 times higher for gonococcal infections, with the highest rate seen in males aged 25–29
- 1.1 times as high for chlamydia, with the highest rate seen in males aged 20–24.

Figure 5: Age-standardised rate per 100,000 of gonococcal, syphilis and chlamydia notifications, males, 2012–2021

The line graph shows the notification rates for chlamydia, gonorrhoea and syphilis across the years, from 2012 to 2022. It shows an increase in rates for all three infections.



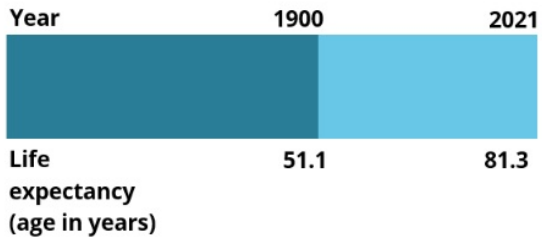
Source:AIHW analysis of DoHAC 2022. See Table S13 for data and footnotes.
http://www.aihw.gov.au

For more information, see HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2022, and the Department of Health and Aged Care National Notifiable Disease Surveillance System.

For more information on male sexual health, see the Healthy Male organisation website Healthy Male Australia: Generations of healthy Australian men.

Life expectancy and mortality

Life expectancy is expressed as either the number of years a newborn baby is expected to live, or the expected years of life remaining for a person at a given age.



Source: AIHW 2022h

Life expectancy at birth in Australia has improved dramatically in the last century, and males born in 2019–2021 can expect to live 30 years longer than males born in 1891–1900 (ABS 2022h):

- Males born in Australia in 2019–2021 can expect to live to the age of 81.3 years on average (an increase of 1.6 years in the past 10 years) (ABS 2022f).
- International comparisons of life expectancy at birth for males in 2021 indicate that Australian males have the sixth highest life expectancy in the world (81.2 years). Switzerland is ranked first with 81.9 years (OECD 2021).

For more information see: Deaths in Australia: Life expectancy.

Health Adjusted Life Expectancy

Health Adjusted Life Expectancy (HALE) reflects the length of time an individual at a specific age could, on average, expect to live in full health. It can be measured at any age but is typically reported:

- from birth
- at age 65, describing health in an ageing population.

Life expectancy for males born in 2022 is 81.2 years, while the average number of healthy years for these babies is 71.6 years (AIHW 2022d). The difference between life expectancy and HALE (that is, the time expected in less than full health) is 9.6 years. This means that males can expect to spend 88% of their lives in full health (AIHW 2022d).

Males born in 2022 are expected, on average, to live 4.1 years less than females, and are expected to have 2.5 less years of healthy life than females (AIHW 2022d).

Life expectancy in 2022 for males aged 65 was 20.3 years; that is, they could expect to live to the age of 85. At age 65, males could expect on average 15.3 healthy years of life and 5.0 years in less than full health (AIHW 2022d).

Between 2003 and 2022, life expectancy and HALE at birth increased for males. Males gained 3.1 years in life expectancy (from 78.1 years in 2003 to 81.2 in 2022) and 2.2 years in HALE (from 69.4 to 71.6 years) (AIHW 2022d).

For more information see: Australian Burden of Disease Study 2022.

Mortality

Looking at how many people die and what caused their deaths can provide vital information about the health of a population. Patterns and trends in deaths can help explain differences and changes in the health of a population (AIHW 2022h).

Causes of death can be used to:

- assess the success of interventions to improve disease outcomes
- signal changes in community health status and disease processes
- highlight inequalities in health status between population groups.

In 2021, around 89,400 Australian males died. The median age at death was 79.6 years and the leading cause of death was coronary heart disease (12%), followed by dementia including Alzheimer's disease (6.3%), and lung cancer (5.6%) (Figure 6). The leading causes of death varied by age group (Figure 7) (AIHW 2021a).

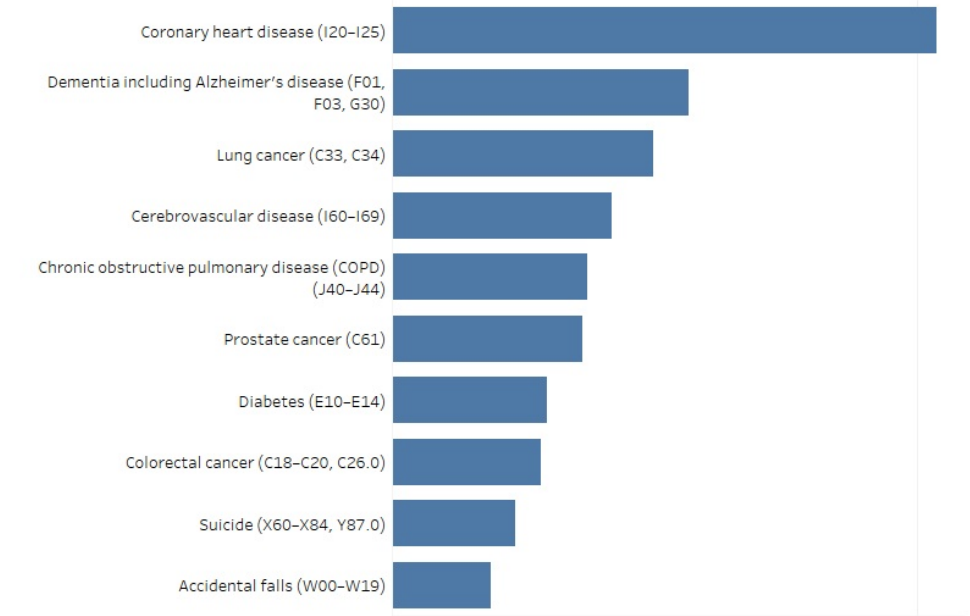
The median age at death for males also varies by population group:

- It decreases from 80 years old in *Major cities* to 66 in *Very remote* areas (AIHW 2022k).
- It decreases from 81 years in the highest socioeconomic areas, to 77 in the lowest socioeconomic areas (AIHW 2022l).

For more information see Deaths in Australia: Life expectancy.

Figure 6: Leading causes of death, males of all ages, 2021

This horizontal bar chart shows the leading causes of death in males. Leading causes of death include coronary heart disease, dementia including Alzheimer's disease and lung cancer.



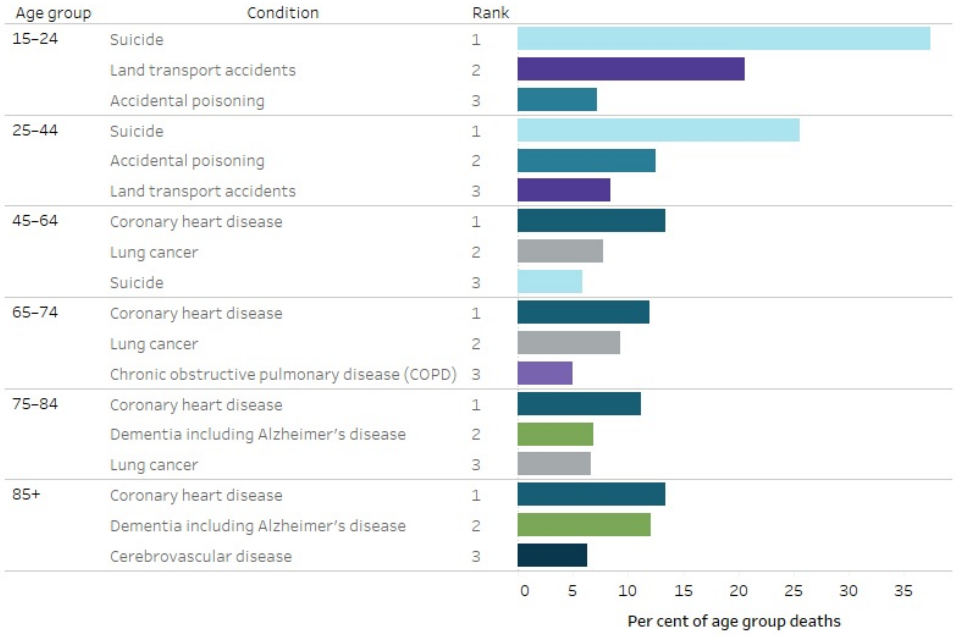
Source: AIHW 2021a. See Table S14 for data and footnotes
http://www.aihw.gov.au

Notes

1. Year refers to year of registration of death. Deaths registered in 2021 are based on the preliminary version of cause of death data and are subject to further revision by the Australian Bureau of Statistics (ABS).
2. Rates are calculated using the sum of estimated resident populations at 30 June for each year. Estimated resident populations for 2020 and 2021 have been impacted by COVID-19.
3. Leading causes of death are based on underlying causes of death and classified using an AIHW-modified version of Becker et al. 2006. A method for deriving leading causes of death. Bulletin of the World Health Organization 84: 297–304. International Statistical Classification of Diseases and Related Health Problems, 10th revision.
4. International Statistical Classification of Diseases (ICD-10) codes are presented in parentheses.

Figure 7: Leading 3 underlying causes of death (number, %), by age group (years), males, 2019-2021

This horizontal bar chart shows the top three causes of death in rank order, and the changes with increasing age groups. Suicide affects younger age groups while coronary heart disease is ranked as the leading cause of death for those aged 45 and over.



Source: AIHW 2021a. See Table S15 for data and footnotes.
http://www.aihw.gov.au

Notes

1. Year refers to year of registration of death. Deaths registered in 2019 are based on the revised version, deaths registered in 2020 and 2021 are based on the preliminary version. Revised and preliminary versions are subject to further revision by the Australian Bureau of Statistics.
2. Leading causes of death are based on underlying causes of death and classified using an AIHW-modified version of Becker et al. 2006.
3. Data by causes of death have been adjusted for Victorian additional death registrations in 2019. A time series adjustment has been applied to causes of death to enable a more accurate comparison of mortality over time. When the time series adjustment is applied, deaths are presented in the year in which they were registered (that is, removed from 2019 and added to 2017 or 2018). For more details, please refer to Technical note: Victorian additional registrations and time series adjustments in Causes of death, Australia, 2019 (ABS Cat. no. 3303.0).
4. Per cents have been calculated using the adjusted number of deaths due to all causes (see note 2) as the denominator, however the number of deaths due to all causes presented in the table have not been adjusted.

Premature and potentially avoidable deaths

Premature deaths are deaths occurring before the age of 75. Four in 10 (40%) of all deaths are premature in males, and males account for 62% of all premature deaths. The proportion of premature deaths and the premature mortality rate varies by population groups. After adjusting for age, which removes the effects of age when comparing rates between population groups with different age structures (AIHW 2022j):

- About 7 in 10 (70%) deaths in *Very remote* areas are premature, compared to around 4 in 10 (39%) in *Major cities*.
- The premature mortality rate increases as remoteness increase, with rates in *Very remote* areas 1.8 times higher (400 deaths per 100,000 people) than the rate in *Major cities* (220 per 100,000).
- Over 4 in 10 (44%) deaths in the lowest socioeconomic area are premature, compared with 34% in the highest socioeconomic area.
- The premature mortality rate in the lowest socioeconomic area was also twice as high (343 deaths per 100,000 people) as the highest socioeconomic area (159 per 100,000).

Potentially avoidable deaths refer to deaths before the age of 75 from conditions that are potentially preventable through individualised care and/or treatable through existing primary or hospital care. Potentially avoidable deaths account for 20% of total deaths in males, and 51% of all premature deaths in males. The proportion of premature deaths that are potentially avoidable and the rate of potentially avoidable deaths generally differed between population groups. After adjusting for age:

- Males in *Very remote* areas had a higher proportion of premature deaths that are potentially avoidable (58%), compared to males in *Major cities* (50%). The rate of potentially avoidable deaths in *Very remote* areas (235 deaths per 100,000 people) is over twice the rate in Major cities (111 per 100,000 people).
- The proportion of premature deaths that are potentially avoidable did not differ between the lowest and the highest socioeconomic area. However, males in the lowest socioeconomic areas had twice the rate of potentially avoidable deaths per 100,000 population compared with males in the highest socioeconomic areas (182 and 82 per 100,000 respectively).

For more information see: Mortality Over Regions and Time.

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Impact of COVID-19 on the health of Australia's males

Page highlights

How has COVID-19 affected Australia's males directly?

- From December 2021 to December 2022, the rate of COVID-19 cases in males was 34,836 per 100,000 population.
- About 7,400 Australian males died from COVID-19 in Australia by March 2023.

What are some of the indirect impacts of the COVID-19 pandemic on males?

- 6.8% of Males delayed seeing a GP, and 6.0% delayed seeing medical specialist when needed in the previous 12 months due to COVID-19.
- Mental health and wellbeing for males were less adversely impacted than females, with lower levels of psychological distress.

COVID-19 is a disease caused by the virus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). It is a major health threat resulting in both direct and indirect effects on health of Australia's males.

For more information on AIHW COVID-19 reporting see COVID-19 and Changes in the health of Australians during the COVID-19 period.

How has COVID-19 affected Australia's males directly?

From 15 December 2021 to 18 December 2022, the rate of COVID-19 cases in males was 34,836 per 100,000 population. The highest rate was seen in the 18–29-year age group (CDI 2023).

About 7, 400 males have died from COVID-19 in Australia by March 2023, which accounted for 55% of all COVID-19 deaths. The highest rates of deaths were seen in males aged 90 and over (ABS 2023a). The most common associated causes of death were pneumonia and respiratory failure.

In 2022, COVID-19 is the seventh leading cause of disease burden in males, responsible for 3.0% of total ill health and premature death in Australia. In comparison, COVID-19 ranked twelfth among specific diseases in females and was responsible for 2.5% of total disease burden. In males, the burden from COVID-19 was predominantly due to premature death, accounting for 78% of total COVID-19 disease burden. The total disease burden due to COVID-19 was the highest in males aged 75–79 (14.4%) and 80–84 and over (13.3%) (AIHW 2022d).

What are some of the indirect impacts of the COVID-19 pandemic on males?

COVID-19 and mental health from 2020 to 2021

For some Australians, the COVID-19 pandemic and associated implications appear to have had a negative effect on mental health (AIHW 2021f).

Negative effects can result from concerns about the virus itself, and the impact of the measures used to contain the spread of the virus (NMHC 2020).

Data from the Ten to Men study in Australia showed rates of mental health service use during the pandemic between March 2020 and February 2021 among males were similar to pre-COVID levels (January 2018 to February 2020 for the study). However, the way in which services were delivered changed, with 18% of services during COVID-19 provided through expanded telehealth measures, suggesting substantial uptake of these services (Wong, et al. 2022). While the levels of mental health service use did not change for men during the COVID period between January 2020 to January 2021, MBS data showed that there was an uptake in mental health care during this first year of COVID-19 by men who had never or had not been in contact with such services for a long time (Wong, et al. 2022).

A survey of mental health and wellbeing during the first 2 years of COVID–19 in Australia found that males were less adversely impacted than females, with lower levels of psychological distress (Biddle, et al. 2022).

For detailed information see Changes in the health of Australians during the COVID–19 period and Mental health impact of COVID-19.

Delayed and foregone health care during 2020–21

Due to lockdowns and isolation requirements during 2020 and 2021, there was concern people may not receive the care they required if they were unable to access a General Practitioner (GP) which provide primary care in Australia.

Males aged 15 and over delayed health care when needed it in the previous 12 months due to COVID-19 (ABS 2022n):

- 9.4% delayed seeing a dental professional
- 6.8% delayed seeing a GP
- 5.4% delayed after-hours GPs
- 6.0% delayed seeing medical specialists.

There was a large increase in male visits to GPs in 2021, well above the expected rate based on projections from data for the period to 2019. This increase was likely driven by the large role GP's played in the vaccine rollout (AIHW 2022c).

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Health behaviours and risk factors of Australia's males

Page highlights

Risk factors causing the most health burden

- 40% of ill health and premature death among males could have been potentially prevented by avoiding or reducing exposure to certain risk factors.
- The leading risk factors contributing to the most ill health and premature death among males are tobacco, overweight (including obesity), all dietary risks, and alcohol and drug use.

Tobacco, alcohol and other drugs

- Tobacco is the leading preventable cause of ill health and premature death in males, responsible for 9.2% of total disease burden.
- Around 1 in 10 (12%) Australian males smoke daily.
- Around 11% of males used an e-cigarette or vaping device at least once in their lifetime
- 27% of Australian males drink more than 10 standard drinks per week.
- Nearly 1 in 2 (49%) of males have tried at least one illicit drugs in their lifetime.

Overweight and obesity

- Overweight (including obesity) is the 2nd leading preventable cause of ill health and premature deaths in males, responsible for 9.0% of total disease burden.
- 3 in 4 (75%) of Australian males are living with overweight or obesity.

Diet

- Dietary risk factors are the 3rd leading preventable cause of ill health and premature death in males, responsible for 6.6% of total disease burden.
- 4% of males meet the vegetable intake guideline, and only 3% met the guideline for both fruit and vegetables.

Physical inactivity

- 65% of Australian males are sufficiently physically active.
- Only 28% of males do enough strength or toning activities on 2 or more days per week.

Occupational exposures and hazards

- 96% of people killed at work in Australia are males.
- Occupational exposures and hazards was estimated to contribute to 2.6% of ill health and premature death in males aged 15 and over.

Violence against males

- Over 4 in 10 (43%) Australian males have experienced physical and/or sexual violence since the age of 15.
- Males experience more physical violence from a stranger (22%) than from a known person (15%).

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

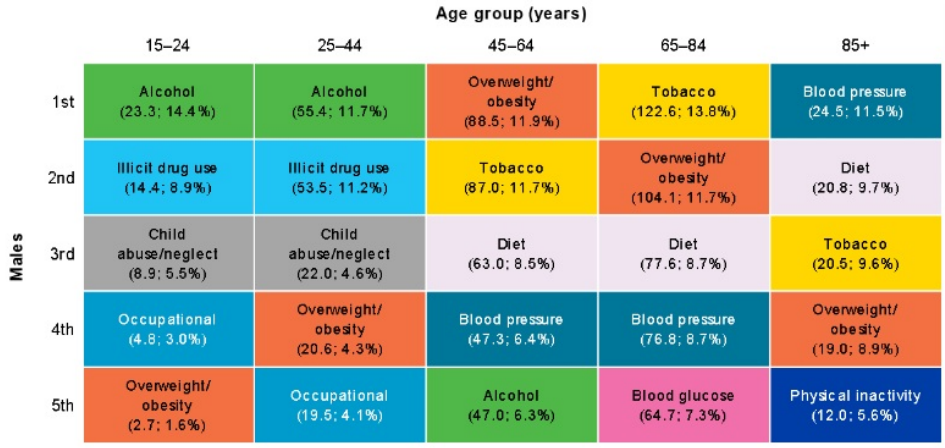
Which risk factors cause the most health burden in males?

Around 40% of ill health and premature death in Australian males was potentially preventable in 2018 – that is, it could have been potentially prevented had exposure to certain risk factors been reduced or avoided (AIHW 2023a).

The leading risk factors contributing to ill health and premature death in Australia among males were tobacco use, overweight (including obesity), all dietary risks, alcohol and illicit drug use in 2018 (AIHW 2021b). Risk factors that have the most impact on the burden of disease for males vary across age groups (Figure 8).

For more information see Burden of disease.

Figure 8: Leading risk factor contribution to ill health and premature death (attributable DALY per 1,000 population; proportion of DALY), males aged 15 and over, 2018



Notes:

1. For age groups under 25, many risk factors were not measured due to data limitations of linked diseases among these age groups.
2. DALY = Disability Adjusted Life-Year.
3. Partner violence = Intimate partner violence; Blood glucose = High blood glucose; Blood pressure = High blood pressure; Occupational = occupational exposures and hazards

Source: AIHW analysis of AIHW 2021b

http://www.aihw.gov.au

Tobacco, alcohol and other drugs

Tobacco smoking

Tobacco is a leading preventable cause of ill health and premature death for males, responsible for 9.2% of total burden of disease in Australia in 2018. Tobacco is linked to a number of common and serious health conditions including cancer, cardiovascular diseases, and respiratory diseases such as chronic obstructive pulmonary disease and asthma (AIHW 2021b).

Tobacco use contributed to about 12,000 deaths among males (14% of all male deaths) in 2018 (AIHW 2021b). The burden of tobacco use was 3 times higher in the lowest socioeconomic areas when compared with the highest areas (AIHW 2021b).

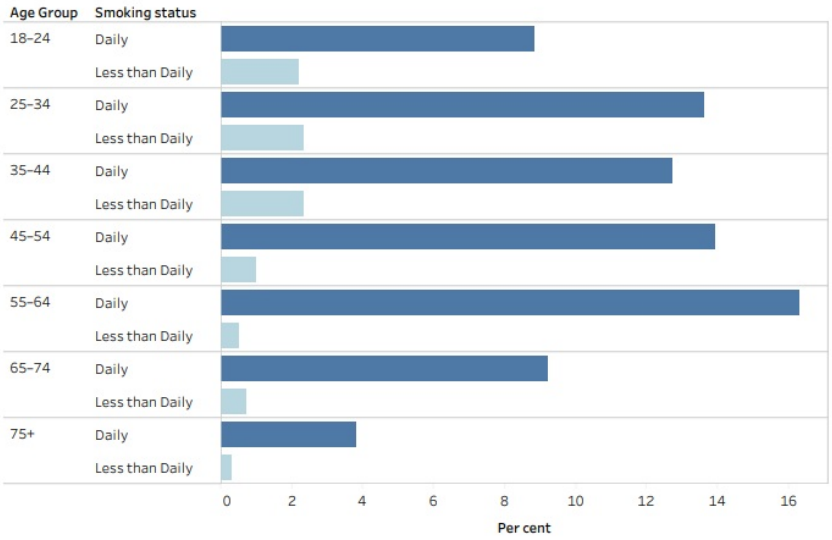
The latest data pooled from multiple ABS surveys report that 12% of males are current daily smokers, while 1.4% are current smokers who smoke less than daily (ABS 2022e).

Smoking rates for current daily smokers varies by age group among males, peaking in the age group of 55–64 at 16%, with rates being lowest in males aged 15–17 years (2.4%) (Figure 9).

The proportion of males who smoked daily varies by population groups. After adjusting for differences in age structure:

- males living in the lowest socioeconomic area were 3 times as likely to smoke daily as males in the highest area (26% and 8.7%, respectively) in 2017–18 (Figure 10) (ABS 2019)
- males living in *Outer regional and remote* areas were 1.5 times as likely to smoke daily as males in *Major cities* (24% and 16%, respectively), in 2017–18 (Figure 10) (ABS 2019)
- Aboriginal and Torres Strait Islander males aged 15 and over were 2.5 times as likely to smoke daily as non-Indigenous males, with 40% of Indigenous males aged 15 and over smoking daily, according to 2018–19 data (AIHW 2020a)
- the proportion of Indigenous males who are current smokers was the highest in *Remote and very remote* areas (62%) compared with non-remote areas, such as *Major cities* (29%), *Inner regional* areas (40.2%) and *Outer regional* areas (55%) (AIHW 2020a).

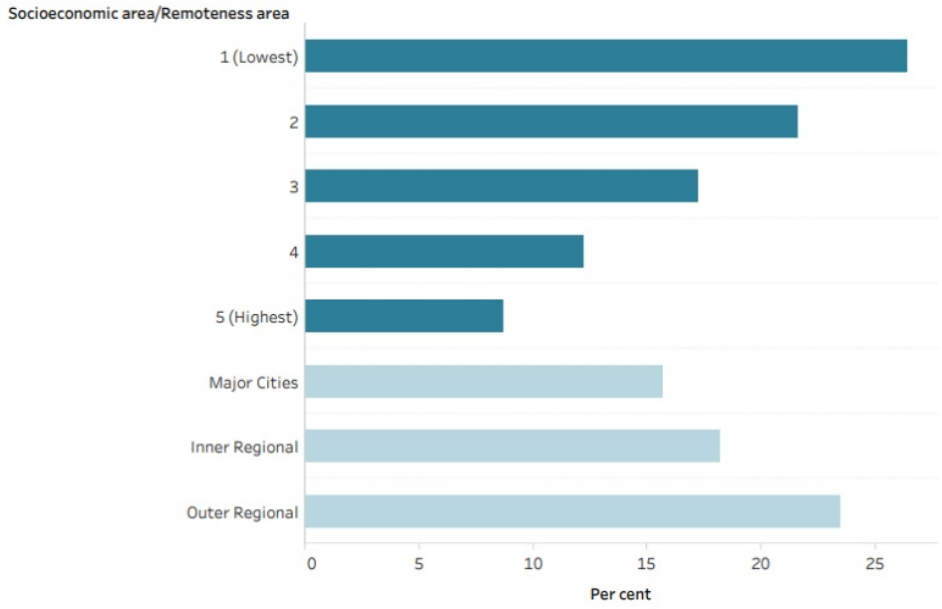
Figure 9: Daily smoking status of current smokers by age group (percentage), males aged 15 and over, 2020–21



Source: ABS 2022e. See Table S8 for data and footnotes.

http://www.aihw.gov.au

Figure 10: Daily smoking by socioeconomic and remoteness areas (percentage), males aged 18 and over, 2017–18



Source: ABS 2019. See Table S8 for data and footnotes.

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Electronic cigarettes/e-cigarettes or vapes

Electronic cigarettes/e-cigarettes or vapes are the most common alternative inhaled nicotine delivery system (DoHAC 2012). These devices contain nicotine, flavourings and other chemicals which is turned into a vapour, rather than smoke, and inhaled by the user.

In 2020–21, around 11% of males used an e-cigarette or vaping device at least once in their lifetime (ABS 2022l). Just over 1 in 5 of males aged 18–24 (20%) and 25–34 (22%) had tried an e-cigarette or vaping device, the highest among male age groups.

Around 2.9% of males currently use and e-cigarette or vaping device in 2020–21. Males aged 18–35 have the highest proportions of those currently using an e-cigarette or vaping device at 5.1% (ABS 2022l).

Alcohol

Alcohol was the 4th leading preventable cause of ill health and premature death in males, responsible for 6.1% of total disease burden in 2018. Alcohol use is linked to chronic liver disease, accident and injury, such as motor vehicle accidents, self-inflicted injuries, physical violence and homicide.

Alcohol use contributed to around 4,100 deaths in males (4.9% of all male deaths). The burden of alcohol use was 1.9 times higher in males from the lowest socioeconomic areas when compared with males from the highest areas (AIHW 2021b).

To reduce the risk of harm from alcohol-related disease or injury, it is recommended that healthy males should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day. The less you drink, the lower your risk of harm from alcohol (NHMRC 2020).

Reporting against these guideline recommendations, in 2020–21 (ABS 2022i):

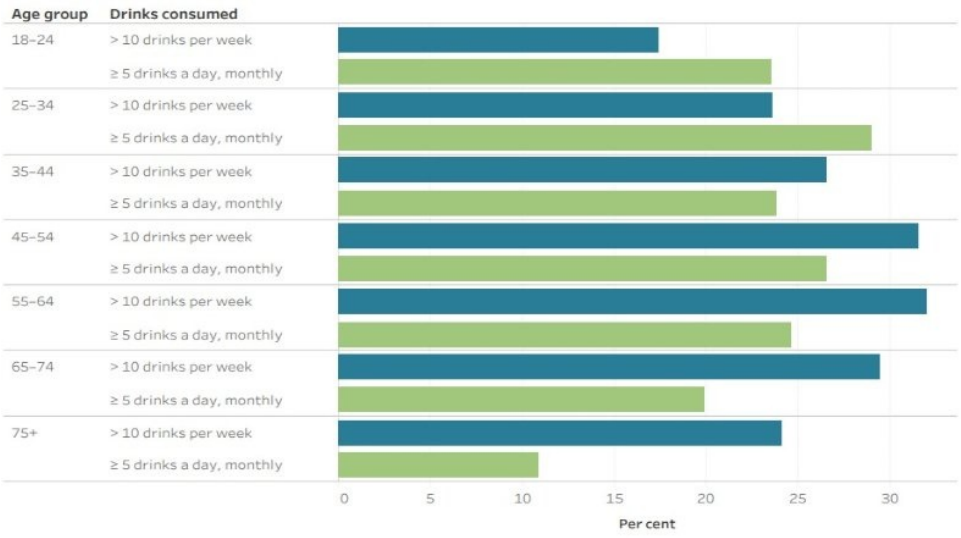
- 27% of males exceed the guideline by consuming more than 10 standard drinks per week, and of these 81% consumed 14 drinks or more.
- 24% of males exceeded the guideline by consuming 5 or more standard drinks on a single day, at least monthly in the last 12 months.
- The percentage of males who exceed 10 standard drinks per week is highest in those aged 45–54 (32%) and 55–64 (32%), while the percentage who exceed 5 drinks on a single day at least monthly is highest in those aged 25–34 (29%) (Figure 11).

After adjusting for differences in age structures, the proportion of males exceeding the lifetime alcohol risk guidelines (drinking more than 2 standard drinks per day) is (Figure 12) (AIHW 2022a):

- similar between the lowest and highest socioeconomic areas, based on the 2017–18 NHS
- is 1.7 times higher in males living in *Outer regional and remote* areas (37%) compared with males living in *Major cities* (22%).

For more information see Alcohol.

Figure 11: Alcohol drink consumption by age group and number of drinks (percentage) against the recommended guidelines, males, 2020–21

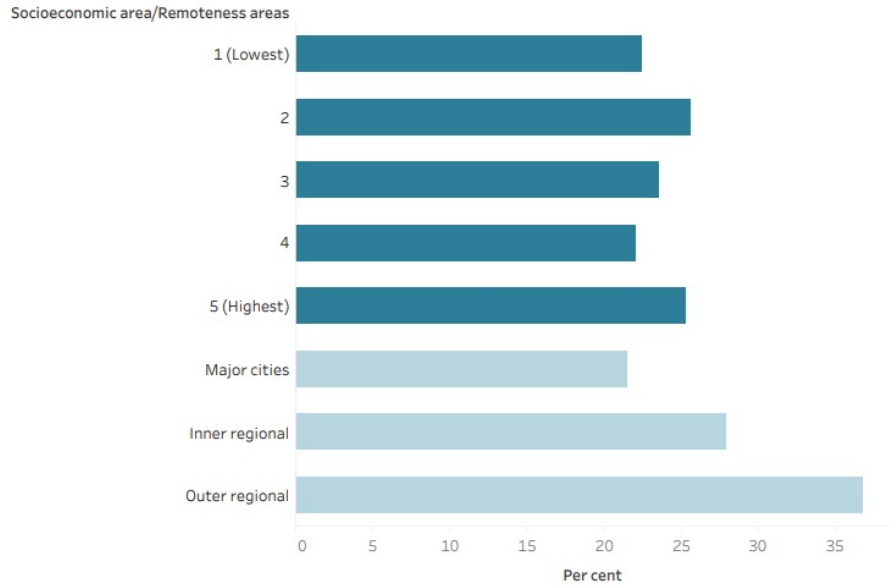


Source: ABS 2022i. See Table S9 for data and footnotes.
http://www.aihw.gov.au

Source: ABS 2022i. See Table S9 for data and footnotes.

http://www.aihw.gov.au

Figure 12: Lifetime alcohol use risk by socioeconomic and remoteness areas (percentage), males, 2017–18



Source: AIHW 2022a. See Table S9 for data and footnotes.

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Illicit use of drugs

Illicit use of drugs includes use of illegal drugs, non-medical use of pharmaceuticals and inappropriate use of other substances, such as naturally occurring hallucinogens.

Illicit drug use is the 7th leading preventable cause of ill health and premature death, responsible for 4.1% of ill health and premature mortality in males aged 15 and over; in males aged 15–44, illicit drug use is ranked as the 2nd leading preventable cause of ill health and death (Figure 8). Illicit drug use includes opioid use (1.3%), amphetamine use (1.0%), cocaine (0.5%), cannabis (0.4%) and other illicit drug use (0.2%) (AIHW 2021b). Illicit drug use is linked to death, disability, and is a risk factor for many diseases. It contributes to social and family disruptions, violence, crime and community safety issues.

Illicit drug use contributes to over 2,000 deaths among males (2.4% of all male deaths). The burden of illicit drug use is almost 2 times higher for males living in the lowest socioeconomic areas when compared with the highest socioeconomic areas.

Among males, 49% have used at least one illicit drug at some point in their lifetime. The age groups who were most likely to have ever used an illicit drug were those aged 30–39, 40–49 and 50–59 (all 56%) (AIHW 2020c).

In the previous 12 months, around 20% of Australian males used an illicit drug, with the greatest use in the 20–29 age group (36%) compared with 8.1% of males aged 60 or over (AIHW 2020b).

For more information, see Alcohol, tobacco and other drugs in Australia, and the AIHW National Drug Strategy Household Survey report 2019 on illicit drug use in Australia.

For more information on the disease burden due to illicit drug use, see Burden of disease.

Overweight and obesity

Overweight (including obesity) was the second leading preventable cause of ill health and premature death for males, responsible for 9.0% of ill health and premature death in Australia in 2018. Overweight (including obesity) is linked to 27 diseases in males, including 14 types of cancer, 3 cardiovascular diseases, stroke, type 2 diabetes, dementia, asthma and chronic kidney disease.

Overweight (including obesity) contributed to around 8,600 deaths among males (10% of all male deaths) and this has the greatest impact on those aged over 65.

The burden of overweight (including obesity) for males is 2.2 times greater in the lowest socioeconomic areas compared with the highest socioeconomic areas (AIHW 2021b).

For more information on the disease burden due to overweight (including obesity), see Burden of disease.

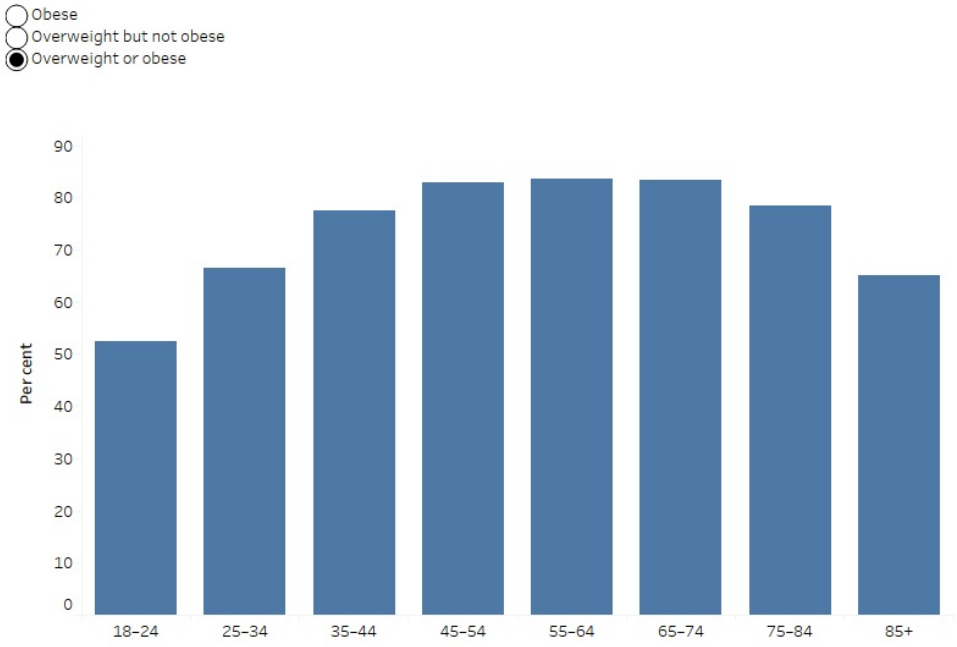
According to 2017–18 NHS data (ABS 2018c):

- 3 in 4 (75%) Australian males are living with overweight or obesity
- 2 in 5 (42%) are living with overweight (but not obesity)
- 3 in 10 (33%) are living with obesity.

Overweight and obesity is more common in older age groups, around 4 in 5 males aged 55–64 are living with overweight or obesity (84%), compared with 1 in 2 males aged 18–24 (52%) (Figure 13) (AIHW 2023e).

Figure 13: Prevalence of various weight classifications by age group (percentage), males, 2017–18.

By selecting the various weight classifications in this bar chart, the prevalence of the individual classification will be shown across age groups.



Source: AIHW 2023e. See Table S4 for data and footnotes.
http://www.aihw.gov.au

Note: # Proportion has a high margin of error and should be used with caution.

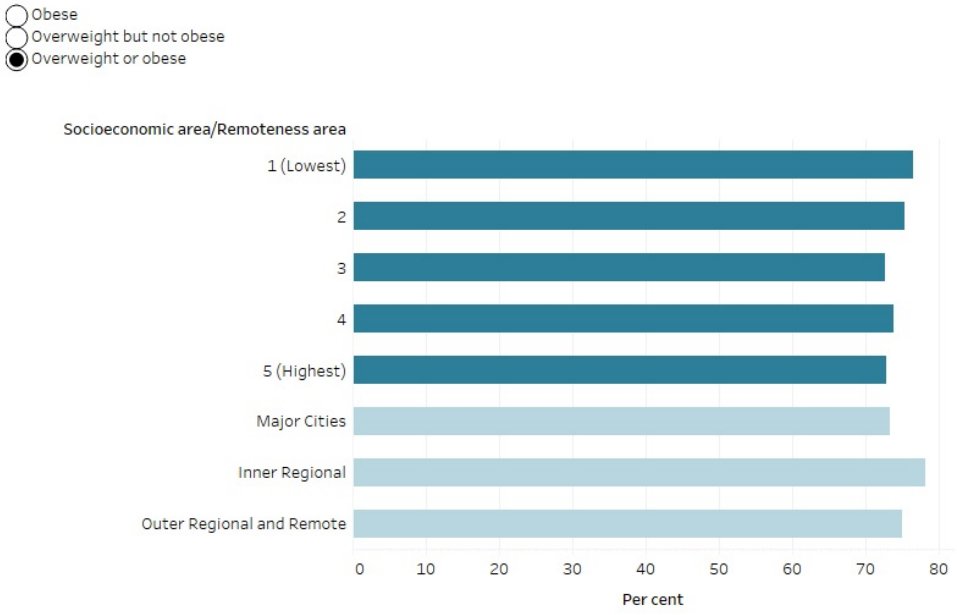
The proportion of males who were living with overweight or obesity varied for some population groups. After adjusting for age (ABS 20123g):

- males living in *Inner regional* areas are more likely to be living with overweight or obesity than those living in *Major cities* (78% compared with 73%), with little difference found for those living in *Outer regional and Remote* areas (75%)
- males living in the lowest socioeconomic areas were more likely to be living with overweight or obesity compared to males living in the highest socioeconomic areas (77% and 73%, respectively) (Figure 14).

For more information see Overweight and obesity.

Figure 14: Prevalence of various weight classifications by socioeconomic group and regional area (percentage), males, 2017-18

By selecting the various weight classifications in this bar chart, the prevalence of the individual classification will be shown across different socioeconomic and remoteness areas.



Source: AIHW 2023g. See Table S5 for data and footnotes.
http://www.aihw.gov.au

Waist circumference

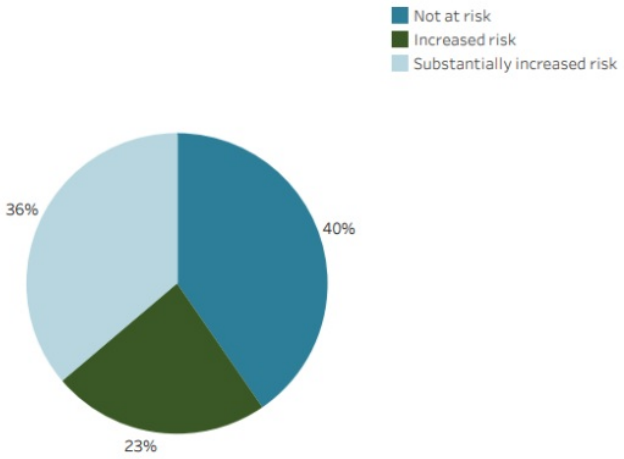
Waist circumference is another common measure of overweight and obesity. For males, a waist circumference above 94cm is associated with an increased risk of metabolic complications, and above 102cm a substantially increased metabolic risk (AIHW 2023f).

Among Australian males, about 3 in 5 (60%) have a high-risk waist circumference; that is, one associated with an increased or substantially increased risk of metabolic complications (Figure 15). The average waist circumference for males in 2017–18 is 98cm (ABS 2018c).

High-risk waist circumference was more common in older males and increased with age:

- 57% of males aged 65–74 had a waist circumference greater than 102cm, placing them at substantially increased metabolic risk.
- 14% of men aged 18–24 and 43% of men aged 45–54 had substantially increased risk.

Figure 15: Waist circumference by health risk category (percentage), males, 2017–18



Source: ABS 2018c. See Table S6 for data and footnotes.

http://www.aihw.gov.au

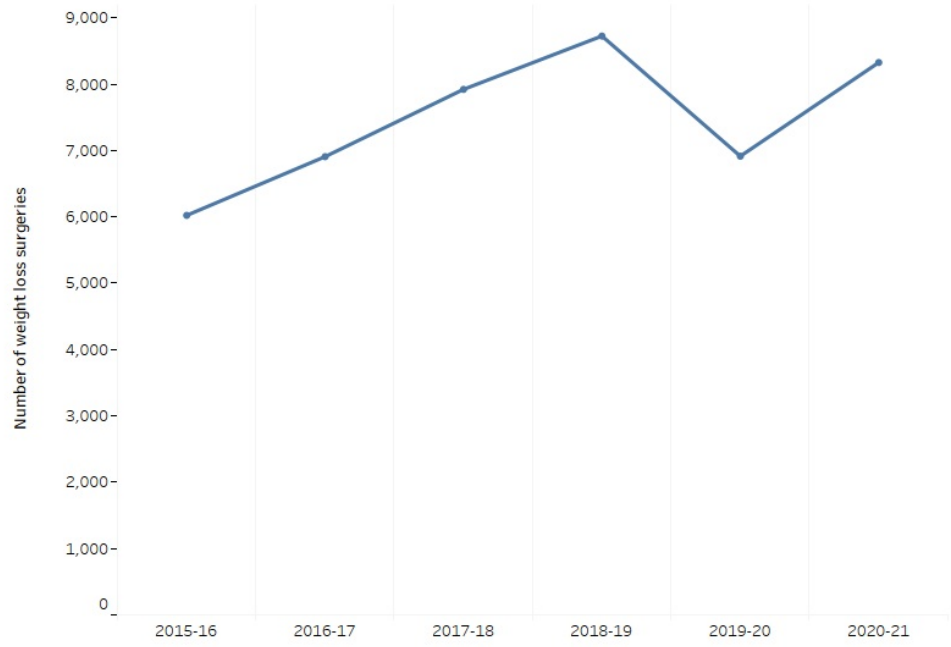
Management of overweight obesity

While excess weight is commonly managed using dietary intervention and exercise, for those who are living with morbid obesity, or conditions related to their excess weight, weight loss surgery may be appropriate. Weight loss surgery (bariatric surgery) aims to help patients lose weight and lower the risk of medical problems by restricting the amount of food, or altering the process of digestion so that fewer calories are absorbed.

Males accounted for 20% of procedures for obesity (8,300 procedures) in 2020–21. Except for a drop in 2019–20, the number of weight loss surgery procedures in males has generally increased since 2015–16 (6,000 procedures), peaking in 2018–19, at 8,700 procedures (Figure 16) (AIHW 2022m).

Figure 16: Weight loss surgeries, males, 2015-16 to 2020-21

This line graph shows that weight loss surgeries had been increasing over time until 2019-20 when there was a decrease, possibly due to pandemic restrictions, however this recovered quickly as restrictions eased.



Source: AIHW 2022m. See Table S18 for data and footnotes.
http://www.aihw.gov.au

Diet

Dietary risk factors were the 3rd leading preventable cause of ill health and premature death for males, responsible for 6.6% of ill health and premature death in Australia in 2018. 'All dietary risks' include components where adequate amounts in the diet are required to prevent disease, and diets where excessive consumption contributes to disease development. The 12 individual dietary risks are:

- a diet low in: fruit and vegetables, milk, nuts and seeds, whole grains and high fibre cereals, legumes, polyunsaturated fat, and fish and seafood
- a diet high in: sodium, sugar-sweetened beverages, and red and processed meats.

All dietary risks contribute to 52% of coronary heart disease, 28% of stroke, 26% of type 2 diabetes, 26% of bowel cancer and 23% of oesophageal cancer.

All dietary risks contribute to about 8,900 deaths (11% of all male deaths). The ill health and death attributable to all dietary risks for males was 2.2 times higher in the lowest socioeconomic areas compared with the highest socioeconomic areas (AIHW 2021b).

For more information on the disease burden due to dietary risks, see Burden of disease.

Fruit and vegetables

The 2013 Australian Dietary Guidelines recommend males consume a minimum of 2 serves of fruit and 5 to 6 serves of vegetables each day, depending on age, to ensure good nutrition and health.

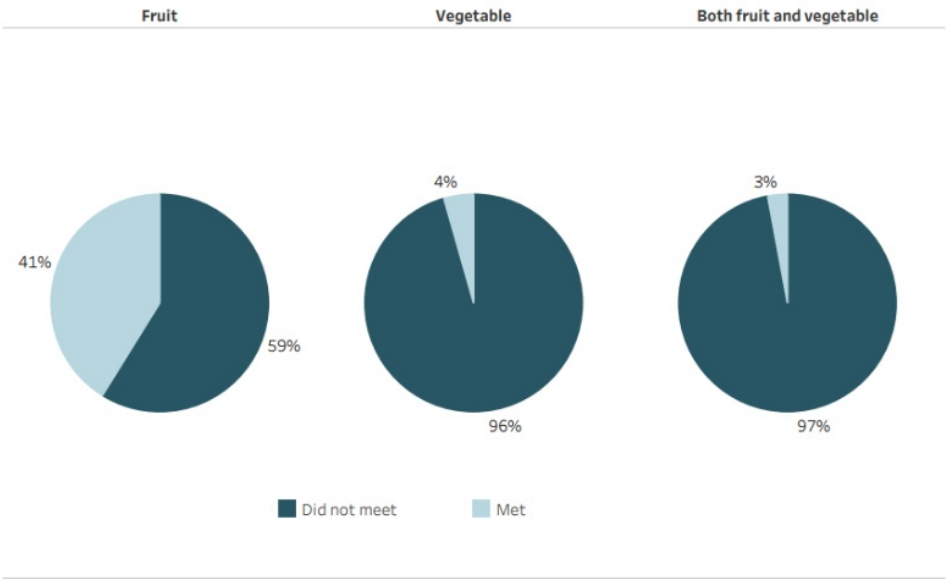
Among males (Figure 17) (ABS 2022k):

- 41% of males meet the fruit intake guideline
- 4% meet the vegetable intake guideline
- only 3% meet the guideline for both fruit and vegetables.

The proportion of males meeting the guideline varied by age (Figure 18) (ABS 2022k):

- 37% of males aged 18–44 met the guideline for fruit intake compared to 55% of those aged 75 and over.
- 8.3% of males aged 75 and over met the vegetable guideline compared to 3.7% of those aged 18–44.

Figure 17: Fruit and vegetable consumption against the Australian Dietary Guidelines (percentages), males, 2020–21

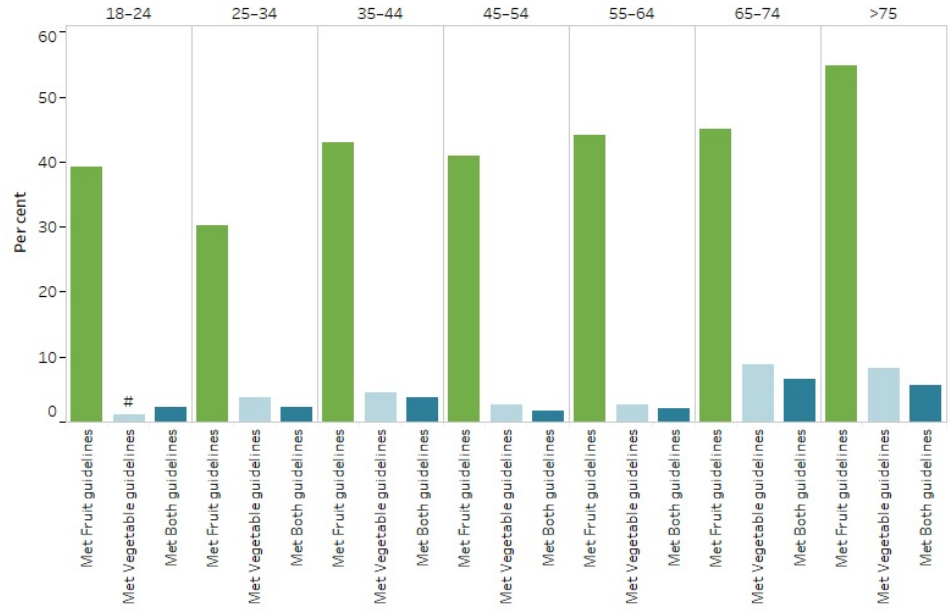


Source: ABS 2022k. See Table S2 for data and footnotes.

http://www.aihw.gov.au

Figure 18: Fruit and vegetable consumption against the Australian Dietary Guidelines (percentage), by age group, males, 2020-21

The bar chart shows the percentage of males who meet the 2013 fruit and vegetable intake guidelines across age groups. Males eat more fruit than vegetables in all age groups and this is highest in those aged 75 and over where 55% met the fruit intake guideline.



Source: ABS 2022k. See Table S2 for data and footnotes.
http://www.aihw.gov.au

Note: # Proportion has a high margin of error and should be used with caution.

Whether males ate enough fruit and vegetables varies for some population groups. In 2017–18, after adjusting for age (ABS 2018b):

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

Sugar sweetened and diet drinks

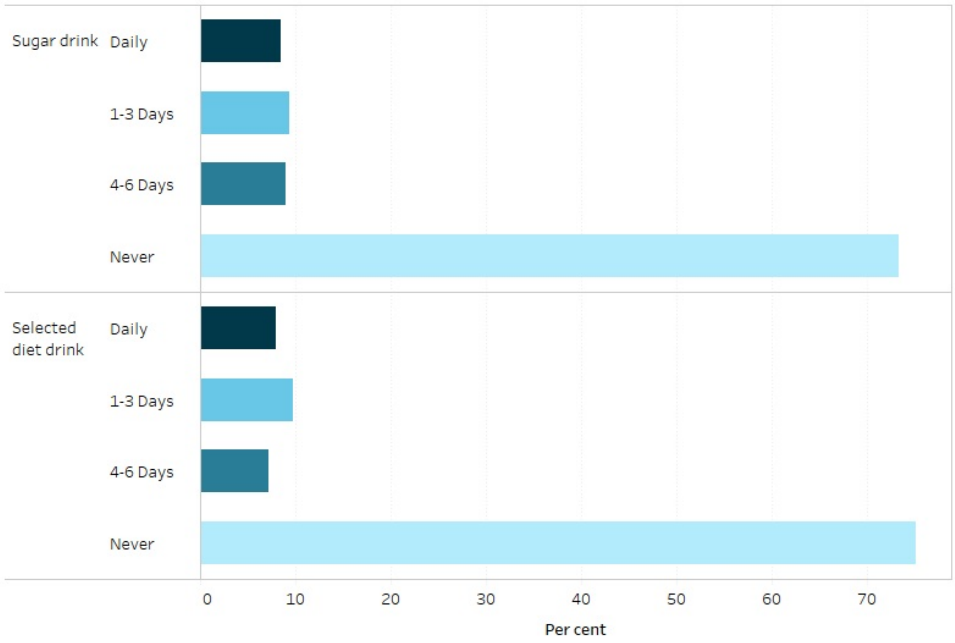
Discretionary foods like sugar sweetened and diet drinks are not an essential part of a healthy diet and a limited intake of these is recommended in the Australian Dietary Guidelines. A diet high in sugar sweetened drinks is linked to type 2 diabetes and coronary heart disease, and contributes to around 140 deaths among males (0.2% of all male deaths (AIHW 2021b).

According to 2020–21 NHS data (Figure 19) (ABS 2022k):

- 8.5% of males drink sugar sweetened drinks daily and 18% drink it less than daily (usually consume 1-6 days per week)
- 8.0% of males drink diet drinks daily and 17% drink is less than daily (usually consume 1-6 days per week.

Figure 19: Consumption of sugar sweetened or selected diet drinks, by usual consumption per week, males 2020-21

This horizontal bar chart shows the percentage males who consume sugar sweetened or selected diet drinks by usual consumption per week. It shows that 8.0% of males drink diet drinks daily and 8.5% drink sugar sweetened drinks daily.



Source: ABS 2022j. See Table S3 for data and footnotes.
http://www.aihw.gov.au

Notes:

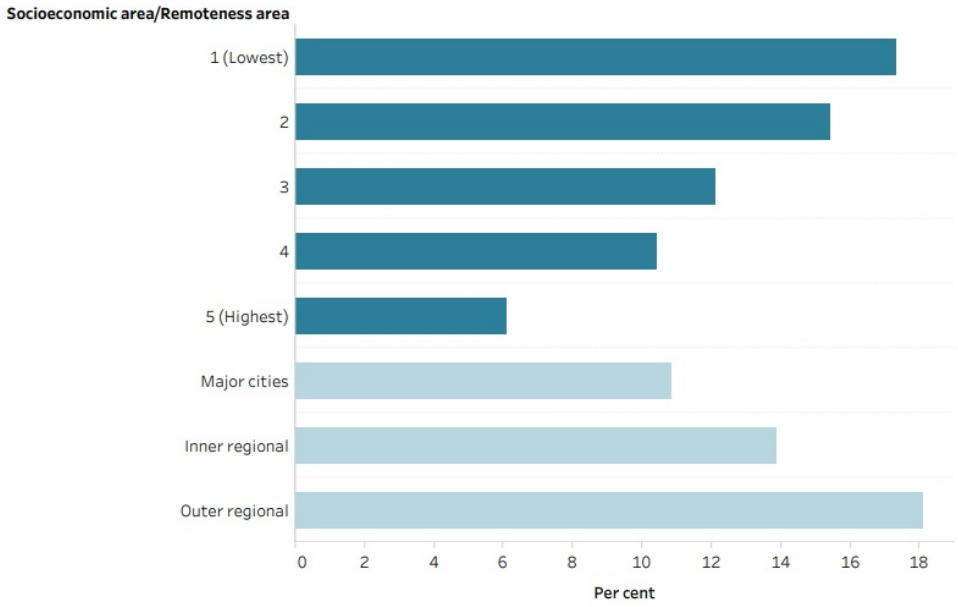
1. Sugar sweetened drinks includes soft drink, cordials, sports drinks or caffeinated energy drinks and may include soft drinks in ready to drink alcoholic beverages. Fruit juice, flavoured milk, 'sugar free' drinks or coffee/hot tea are excluded.
2. Diet drinks includes drinks that have artificial sweeteners added to them rather than sugar. Includes diet soft drink, cordials, sports drinks or caffeinated energy drinks. May include diet soft drinks in ready to drink alcoholic beverages. Excludes non-diet drinks, fruit juice, flavoured milk, water or flavoured water or coffee/tea flavoured with sugar replacements.

The percentage of males who consume sugar sweetened daily varies by age group. More males aged 18–24 (11%) than males aged 65 and over (4.6%) drink sugar sweetened drinks daily.

Consumption also varied for some population groups. After adjusting for age, in 2017–18 (Figure 20) (ABS 2018b):

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

Figure 20: Daily consumption of sugar sweetened drinks by socioeconomic and remoteness areas (percentage), males, 2017–18



Note: Sugar sweetened drinks includes soft drink, cordials, sports drinks or caffeinated energy drinks and may include soft drinks in ready to drink alcoholic beverages. Fruit juice, flavoured milk, 'sugar free' drinks or coffee/hot tea are excluded.

Source: AIHW analysis of ABS 2018b. See Table S3 for data and footnotes.

http://www.aihw.gov.au

For more information on diet as risk factor for poor health, see Diet.

Physical inactivity

Low levels of physical activity are a major risk factor for many chronic conditions. Being physically active improves mental and musculoskeletal health and reduces other risk factors such as overweight and obesity, high blood pressure and high blood cholesterol.

Physical inactivity was the 10th leading preventable cause of ill health and premature death in males, responsible for 2.4% of ill health and premature death in Australia in 2018 (AIHW 2021b). Physical inactivity is linked to type 2 diabetes, coronary heart disease, dementia and bowel cancer.

Physical inactivity contributed to 3,800 deaths among males (4.5% of all male deaths) (AIHW 2022e). The ill health and death attributable to physical inactivity among males was almost double in the lowest socioeconomic areas compared with the highest socioeconomic areas (AIHW 2021b).

For more information on the disease burden due to physical inactivity, see Burden of disease.

Australia's Physical Activity and Sedentary Behaviour Guidelines

Australia's Physical Activity and Sedentary Behaviour Guidelines outline the minimum amount of physical activity required for health benefits (DoHAC 2021). These recommend that adults aged 18–64:

- accumulate 150 to 300 minutes (2.5 to 5 hours) of moderate intensity physical activity or 75 to 150 minutes (1.25 to 2.5 hours) of vigorous intensity physical activity or an equivalent combination of both moderate and vigorous activities, each week
- do muscle-strengthening activities on at least 2 days each week.

For adults aged 65 and over, the Guidelines recommend at least 30 minutes of moderate intensity physical activity on most, preferably all, days. The data presented in this section are for adults only. For information on physical activity for children and young people see Physical activity across the life stages report.

'Sufficiently physically active' refers to meeting the physical activity component of the Guidelines and is defined in this report as:

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

Among males, 65% of males do sufficient moderate and vigorous physical activity per week, and only 28% do strength or toning activities on 2 more days per week, in 2020–21 (ABS 2022g).

Overall, only 24% of males meet the guidelines for physical activity and strength (Figure 21) (ABS 2022g).

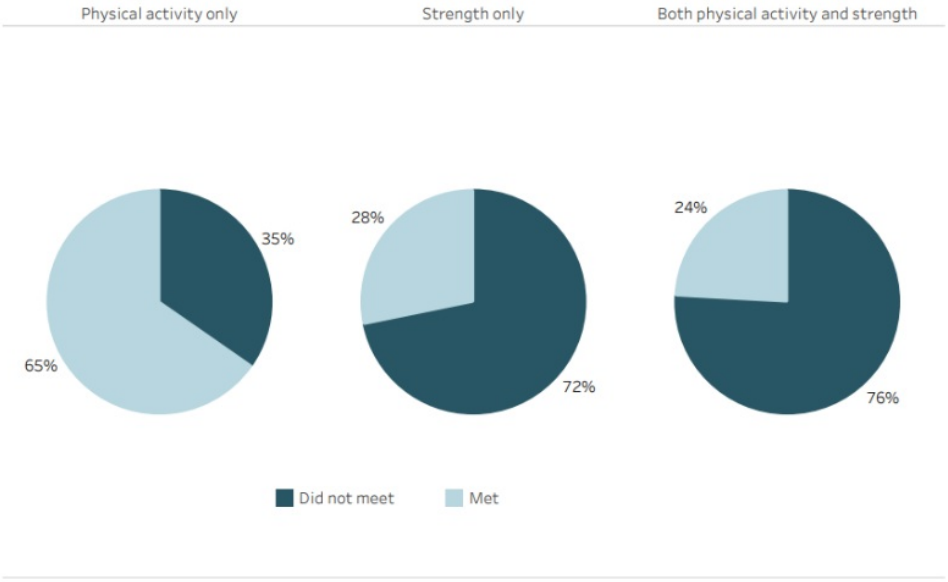
The proportion of males who were sufficiently physically active varies by age and for some population groups:

- 71% of males aged 18–24 are sufficiently physically active compared with 53% aged 65 and over (Figure 22).

- After adjusting for age, 56% living in the highest socioeconomic areas were sufficiently physically active, compared with around 42% living in the lowest socioeconomic areas (ABS 2018b).

For more information, see Physical activity.

Figure 21: Physical activity guidelines compliance (percentage), males, 2020–21

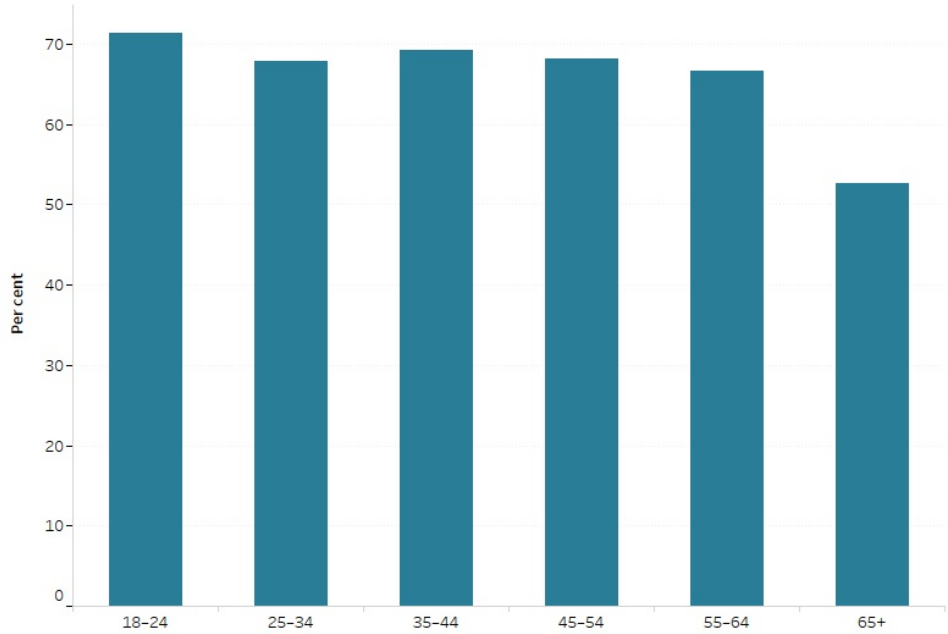


Source: AIHW analysis of ABS 2022g. See Table S1 for data and footnotes.

http://www.aihw.gov.au

Figure 22: Sufficient physical activity by age group, males, 2020–21

The bar chart shows the percentage of males who are sufficiently active across various age groups. Physical activity generally decreases with age, with the most sufficiently physically active in 18–24 years (71.3%).



Source: AIHW analysis of 2022p. See Table S1 for data and footnotes.
http://www.aihw.gov.au

Occupational exposures and hazards

Occupational exposures and hazards were the 9th leading risk factor for ill health and premature deaths for males (AIHW 2021b). The proportion of ill health and premature death attributed to occupational exposures and hazards among males aged 15 and over is estimated to be 2.6% in 2018, almost 2.5 times that for females. Occupational exposures and hazards are linked to a number of serious health conditions, including 9 types of cancers, mesothelioma, asbestosis, silicosis, COPD.

Occupational exposures and hazards contribute to around 1,600 deaths (1.9% of all male deaths). The burden of Occupational exposures and hazards is almost 2 times higher for males in the lowest socioeconomic area compared with the highest socioeconomic area (AIHW 2021b).

Deaths from traumatic injuries in the workplace are reported to SafeWork Australia. Males account for 96% of the people killed at work in 2021 (163 of 169 traumatic injury fatalities). However, the rate of males killed at work in 2021 (2.5 per 100,000 workers) is half of the rate recorded in 2007 (5.0 deaths per 100,000 workers) (SWA 2021b).

A serious claim is one accepted by workers' compensation for an incapacity resulting in a total absence from work of 1 working week or more. According to preliminary 2020–21 data, males accounted for 61% of serious claims. Of these, 89% arose from injury and musculoskeletal disorders, and the remaining 11% from diseases (SWA 2021a).

For males, the rate of serious claims in 2020–21 was highest in the industries of:

- agriculture, forestry and fishing (22 claims per 1,000 employees)
- manufacturing (21 claims per 1,000 employees)
- construction (19 claims per 1,000 employees)

The most common types of workplace injuries among males in 2022 are (SWA 2023):

- traumatic joint, ligament and muscle and/or tendon injury (40% of serious claims)
- wounds, lacerations, amputations and internal organ damage (18%)
- musculoskeletal and connective tissue diseases (15%).

The incidence of serious claims varied across age groups. Males younger than 20 years (9.9 claims per 1,000 employees) and males aged 65 and over (9.6 claims per 1,000 employees) had the lowest rate of claims. The rates of claims increased in males aged 45–64, with 13.4 claims per 1,000 employees in those aged 45–49 peaking to 16.2 claims per 1,000 employees in those aged 60–64.

For more information see Safe Work Australia.

Violence against males

Violence is a broad term, often used to encompass a wide range of behaviours and definitions that vary according to different legislation and practices. Harm from violence can be wide-ranging, including physical, sexual and psychological, with serious and long-term impacts on individuals, families and communities (AIHW 2022i).

Family, domestic and sexual violence (FDSV) is a term used to capture forms of violence that occur within family relationships, and sexual violence that occurs in both family and non-family relationships. Broadly speaking, family relationships are between family members, such as partners (or previous partners), parents, siblings, and other family members or kinship relationships.

Experiences of violence since the age of 15

Over 4 in 10 (43%) males have experienced physical and/or sexual violence since the age of 15, compared to 39% of females. This is because more males experience physical violence (42%) compared with females (31%) (ABS 2023d).

Males experience more physical assault from a stranger (22%) than from a known person (15%) (ABS 2023f).

Around 1 in 16 (6.1%) males have experienced sexual violence (ABS 2023d).

While males are more likely to experience physical and/or sexual violence, they are also more likely to be perpetrators of both physical and sexual violence. It is estimated that 38% (or 7.5 million) of Australians aged 18 and over have experienced physical and/or sexual violence by a male at least once since the age of 15 compared with 11% (or 2.2 million) who have experienced violence by a female (ABS 2023d).

Experiences of violence in the last 12 months

In the last 12 months, 6.0% of males have experienced physical and/or sexual violence (ABS 2023e).

Based on 2016 data, the highest rates of physical and/or sexual violence was reported among males aged 18–24 (11%), and the lowest among males aged 65 and over (1.4%) (ABS 2017).

Intimate partner violence

Violence between partners is sometimes referred to as partner violence, or intimate partner violence, and can cover cohabiting partners and boyfriend/girlfriend/dates (AIHW 2022i). Experiences of intimate partner violence since the age of 15, either sexual or physical, was reported by 7.3% of males (ABS 2023d).

For information on family, domestic and sexual violence see Family, domestic and sexual violence in Australia: continuing the national story 2019.

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How do Australia's males access health care?

Page highlights

Medicare services

Australian males claimed more than 218 million services through Medicare, which equates to an average of 17 Medicare services per person, in 2020–21.

Cancer screening

Males had a lower participation rate for bowel cancer screening than females (39% compared with 43%) across the 50–74 target age range, in 2020–21.

Primary Health Care

- Almost 8 in 10 (79%) Australian males aged 15 and over visited a GP in the previous 12 months.
- 21% of males aged 15 and over who needed to and saw a GP, waited longer than they felt acceptable to get an appointment with a GP, in 2020–21.

Private health insurance

58% of Australian males had some form of private health insurance, in 2020–21.

Hospital care

There were 4.3 million emergency department presentations among males, with rates of presentations highest in those aged 85 and over, in 2020–21.

The Australian health system provides a wide range of preventive, treatment and palliative health care services. Monitoring people's health needs, their help-seeking behaviours, and their patterns of health service use helps governments and health service providers to identify inequalities in access and predict future health care needs.

Medicare services

The Medicare Benefits Schedule (MBS) is a listing of the Medicare services subsidised by the Australian Government. Claims data comprise information on services that qualify for a Medicare Benefit, for which a claim has been processed (including bulk billed services). In 2021–22, Australian males (of all ages) claimed more than 218 million services through Medicare, an increase from 178 million services in 2018–19. This equates to an average of 17 Medicare services per person in that year (SA 2022).

Australian males (of all ages) claimed more than 41 million GP services in 2021–22 (SA 2022). This equates to an average of 3.3 GP services per person in that year. In comparison, females (of all ages) claimed an average of 4.1 GP services per person.

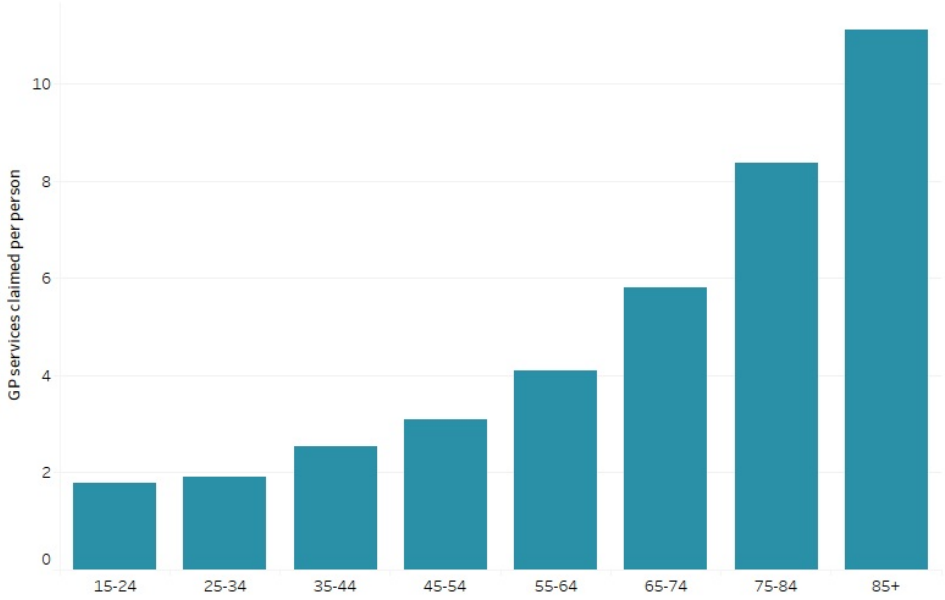
The average number of GP services claimed by males varies by age group (Figure 23). In 2021–22 (SA 2022):

- males aged under 45 claimed 2.2 services per person on average
- males aged 75 and over claimed 9.0 services per person on average.

Figure 23: Average number of GP services per person, claimed through Medicare, by age group, males, 2021–22

Figure 23: Average number of GP services per person claimed through Medicare, by age group, males, 2021

This bar chart shows the number of GP services claimed across age groups, with the number of services claimed increasing with age, peaking in the oldest age group of 85+.



Source: Services Australia (SA 2022). See Table S16 for data and footnotes.
http://www.aihw.gov.au

Cancer screening

Population-based cancer screening involves testing for signs of cancer or conditions that cause cancer before a person has symptoms. Early detection of cancer allows for early intervention, which can improve outcomes.

Preliminary data show that in 2020–21 males had a lower participation rate for bowel cancer screening than females (39% compared with 43%) across the 50–74 target age range. Participation increased across male age groups from 30% in the 50–54 years group to 52% in the 70–74 group (AIHW 2023b).

Australia does not have a population-based program for prostate cancer. This is because, unlike for cancers of the bowel, breast or cervix, there is insufficient evidence to support the benefits of population-based screening for prostate cancer with the prostate specific antigen (PSA) test, and that potential harm may outweigh the benefit (DoHAC 2014). However, men have the option to be tested if they are at higher risk due to family history of prostate cancer, symptoms, or being aged 50–69.

For more information see Cancer screening and Prostate cancer screening.

Primary health care

In Australia, primary health care is usually a person's first encounter with the health system when they have a health concern. Primary health care broadly encompasses health care that is not related to a hospital visit.

Around 79% of males aged 15 and over visited their general practitioner (GP) in the last 12 months in 2021–22. The proportion increased as age increased with 62% of males aged 15–24 compared to 95% of males aged 65 and over having seen a GP in the last 12 months (ABS 2021c).

Barriers to accessing health services may impede the best possible health outcomes for males. In 2020–21, among males aged 15 and over (ABS 2021d):

- 21% waited longer than they felt acceptable to get an appointment with a GP
- 2.7% delayed seeing or did not see a GP when needed because of cost
- 4.9% delayed getting, or did not get, prescribed medication because of cost.

Among males aged 15 and over:

- 12% needed to and saw a mental health professional, in 2021–22 (ABS 2022o)
- 1.5% reported that they saw another mental health professional other than their GP, psychologist or psychiatrist (such as mental health nurse, social worker, counsellor or occupational therapist), in 2021–22 (ABS 2022o)
- 12% of males discussed the issue of reaching a healthy weight with their GP, and this was most discussed in the 45–54 age group (19%) (ABS 2022c)
- 43% reported visiting a dentist at least once in the past 12 months, while 27% reported their last visit was more than 2 years ago (ABS 2022c).

For more information see: Primary health care.

Private health insurance

In Australia, private health insurance is available for those wanting to fully or partly cover the costs of being admitted to hospital as a private patient and/or the costs of other ancillary health services.

Based on the 2021–22 ABS Patient Experience Survey, 58% Australian males had some form of private health insurance (ABS 2022m):

- 48% had both hospital and extras cover
- 6% had hospital cover only
- 4% had extras cover only
- 42% had no private health insurance.

Hospital care

Emergency department care

Hospital emergency departments provide care for patients who present for urgent medical attention.

In 2021–22, there were 4.3 million emergency department presentations among all Australian males, accounting for 49% of all presentations with rates of emergency department presentations highest in those aged 85 and over (AIHW 2021e).

For males aged 15 and over, one of the most common reasons for emergency care is 'Injury and poisoning'. For those aged 45–64 and 65+, 'Musculoskeletal system diseases' and 'Circulatory system diseases' were among the top reasons, respectively (AIHW 2022b).

For more information see Emergency department care

Admitted patient care

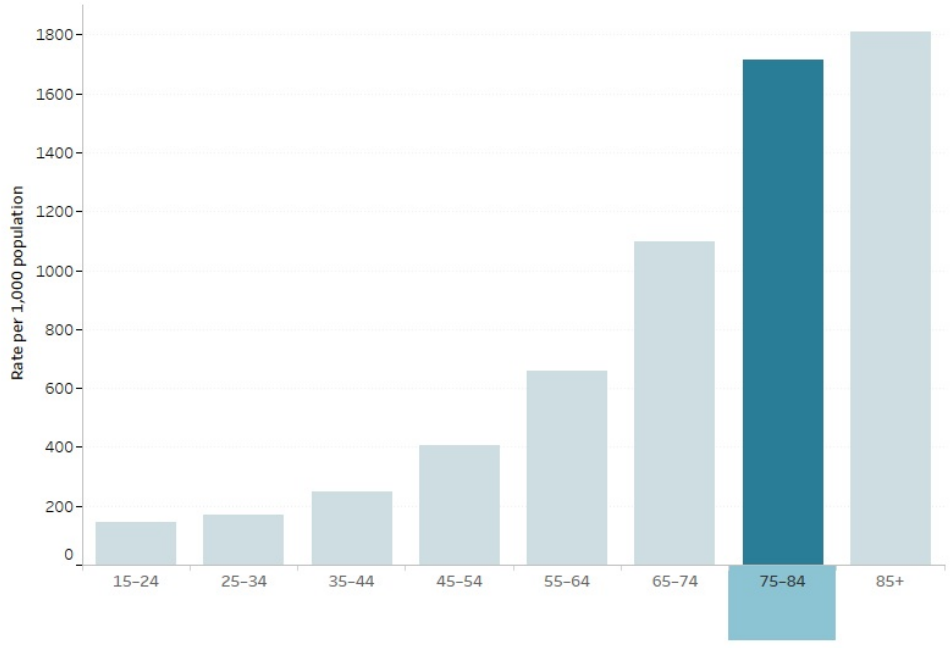
Admitted patient care refers to care provided by public and private hospitals to admitted patients. A hospitalisation is an episode of hospital care that starts with the formal admission process and ends with the formal separation process.

In 2020–21, there were 5.6 million hospitalisations among Australian males, accounting for 48% of all hospitalisations. Hospitalisation rates generally increase with age, and are highest in males aged 85 and over (Figure 24) (AIHW 2021d).

The reasons for hospitalisation vary by age as males experience different health issues over life stages. For males aged under 5, the top reasons were 'Perinatal period conditions' and 'Respiratory system diseases'. For those aged 5–14 and 15–24, the top two reasons were 'Injury and poisoning' and 'Digestive system diseases', while the third most common reason differed between these two age groups – 'Respiratory system diseases' for those aged 5–14 and 'Mental and behavioural disorders' for those aged 15–24. For males aged 25–64, 'Digestive system diseases' and 'Injury and poisoning' continued to be one of the top 3 reasons, while in those aged over 65 'Neoplasms' and 'Circulatory system diseases' become the most common reasons for hospitalisation (AIHW 2022b).

Figure 24: Hospitalisations per 1,000 population by age group, males, 2020-21

This bar chart shows the rate of hospital admissions across age groups, with the rate of hospitalisations increasing with age.



Source: AIHW 2021d. See Table S17.1 for data and footnotes.
http://www.aihw.gov.au

For more information see Admitted patient care.

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How does the health of females and males compare?

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

Technical notes

Data gaps and opportunities

Comprehensive, accurate and timely data are needed for effective population health monitoring. Although national health information collections and research continue to develop and improve, data and information gaps remain.

Current gaps and emerging male health issues include:

- Data on sexual and reproductive health issues including prevalence, health service use and the impacts of:
  - infertility
  - contraception, including vasectomy
- Data for priority population groups relating to reproductive and sexual health, such as males who:
  - are Aboriginal and Torres Strait Islander
  - live in rural and remote areas
  - identify as LGBTIQA+
  - live with a disability
  - are from culturally and linguistically diverse (CALD) communities
  - are in the justice system
  - are carers or receiving care.

Commonwealth investment in male health research

Between 2000 and 2022, the National Health and Medical Research Council (NHMRC) has expended $386 million towards research relevant to male health.

For its inception in 2015 to 31 March 2023, the Medical Research Future Fund has invested $31.05 million in 12 grants with a focus on male health research. This includes research grants focussing on suicide prevention, prostate cancer, and male fertility, such as:

- $6.02 million to The Movember Foundation to carry out research projects with a potential for near-term, transformative impact on the clinical management of prostate cancer.
- $5.62 million to The University of Melbourne to trial interventions designed to prevent suicide in men and boys.
- $4.60 million to the University of New South Wales to apply advanced epidemiological and analytical techniques to answer key questions in male reproductive health.

Data sources and quality

The data presented in this report come from multiple data sources, including surveys and administrative data sources. These sources include:

- Australian Government Department of Health and Aged Care
- Australian Institute of Health and Welfare's (AIHW) Australian Burden of Disease Study 2018: Interactive data on risk factor burden
- AIHW Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2018.
- AIHW Australian Burden of Disease Study 2022
- AIHW National Drug Strategy Household Survey 2019
- The Australian Bureau of Statistics (ABS) 2020–21 National Health Survey (NHS)
- ABS 2018–19 Australian Aboriginal and Torres Strait Islander Health Survey
- ABS 2017–18 NHS
- ABS National Study of Mental Health and Wellbeing
- ABS 2016 Personal Safety Survey
- COVID-19 Epidemiology and Surveillance Team
- National Mental Health Commission
- National Study of Mental Health and Wellbeing
- NHMRC
- Organisation for Economic Co-operation and Development (OECD)
- Safe Work Australia
- Services Australia – Medicare
- Ten to Men Study
- University of NSW – The Kirby Institute
- World Health Organisation

Data considerations

Previous versions of the NHS have primarily been administered by trained ABS interviewers and were conducted face to face. The 2020–21 NHS was conducted during the COVID-19 pandemic. To maintain the safety of survey respondents and ABS Interviewers, the survey was collected via online, self-completed forms.

Non-response is usually reduced through interviewer follow-up of households who have not responded. As this was not possible during lockdown periods, there were lower response rates than previous NHS cycles, which impacted sample representativeness for some sub-populations. Therefore, the 2020–21 NHS was not used to produce estimates at sub-national levels. For this reason, 2017–18 NHS data are used when there are sub-national levels estimates.

As the 2020–21 NHS was considered a break in cycle, therefore direct comparisons to previous NHS surveys cannot be made.

For further information, refer to the ABS National Health Survey: First results methodology.

Data

Report editions

This release

The health of Australia’s males | 27 Jun 2023

Previous releases

- The health of Australia's males |
  Publication | 14 Jun 2011

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