DESIRED OUTCOMES

Everybody has the opportunity to enjoy a long and healthy life. Avoidable deaths, disease and injuries are prevented. Everybody has the ability to function, participate and live independently or appropriately supported in society.

Health

INTRODUCTION

Good health is critical to wellbeing. Without good health, people are less able to enjoy their lives to the fullest extent, their options are limited and their general levels of contentment and happiness are likely to be reduced.

Good health has two core dimensions: how long people live and the quality of their lives. The desired outcomes recognise both aspects. As well as enjoying long lives, people want to be free from the pain, suffering and incapacity that result from injury or illness.

The desired outcomes also acknowledge that not everybody can live a fully independent life. For some people, illness or disability means they need support from families, government agencies or other networks to overcome barriers to their participation in society. Getting this support is an important part of social wellbeing.

People with injuries or illness (both mental and physical) may experience barriers to participating in education, training and employment, thus reducing their economic standard of living. These barriers can also reduce people's ability to participate in other areas of life, such as family life, socialising with friends, joining community activities and taking part in recreation and leisure pursuits, which can lead to feelings of frustration and isolation.

A range of factors affect and are affected by health outcomes, including genetic predisposition, behaviour, the physical and social environment and the availability of health services. Increasing attention is being paid to the interaction between socio-economic and health outcomes. People with low incomes, poor housing and few qualifications are likely to have disproportionately poorer health.[16]

INDICATORS

Six indicators are used in this chapter. Together they provide a picture of the current state of the nation's health and the likely trends in the future. They cover the length and quality of life and include both physical and mental health. The indicators are: health expectancy, life expectancy, suicide, cigarette smoking, obesity and potentially hazardous drinking.

The first three indicators are relevant to the current state of the nation's health. Together, they directly measure the desired outcomes relating to long and healthy lives, and people's ability to participate in society. The last three indicators are strong predictors of future health outcomes.

Health expectancy refers to the number of years a person can expect to live independently, ie free of any disability requiring the assistance of another person or complex assistive device. This is a summary measure of a population's health integrating both fatal (life expectancy) and non-fatal (disability requiring assistance) health outcomes.

Life expectancy measures the survival experience of the population: how long people live. It is an indicator of fatal health outcomes.

The suicide death rate serves as a proxy for the mental health status and social wellbeing of the population. The indicator covers the suicide death rate for society as a whole and includes details for subsets of the population. New Zealand's suicide death rates are trending down, but our youth suicide death rates remain high compared with other OECD countries.

The links between cigarette smoking and poor health are widely recognised. For example, cigarette smoking (active and passive) is a risk factor for many cancers and respiratory and cardiovascular diseases, and has been linked with low birth weight, Sudden Infant Death Syndrome, and other adverse child health outcomes. Obesity is linked with poor health outcomes, such as an increased risk of heart attacks, strokes, type 2 diabetes and some cancers.[17]

Alcohol is the most commonly used recreational drug in New Zealand, with the majority of New Zealanders consuming alcohol at least occasionally.[18] Potentially hazardous drinking is an established pattern of alcohol consumption that carries a high risk of future damage to physical or mental health, but may not yet have resulted in significant adverse effects.[19] Alcohol also contributes to death and injury due to traffic accidents, drowning, suicide, assaults and domestic violence.[20]

Health expectancy

DEFINITION

The number of years a person could expect to live in good health if current mortality and morbidity rates persist.

The particular measure of health expectancy used here is the number of years a person could expect to live independently, ie live without any functional limitation requiring the assistance of another person or complex assistive device. Hence it is also described as independent life expectancy. The measure uses information from the 1996, 2001 and 2006 Disability Surveys to calculate disability-adjusted life expectancy estimates.

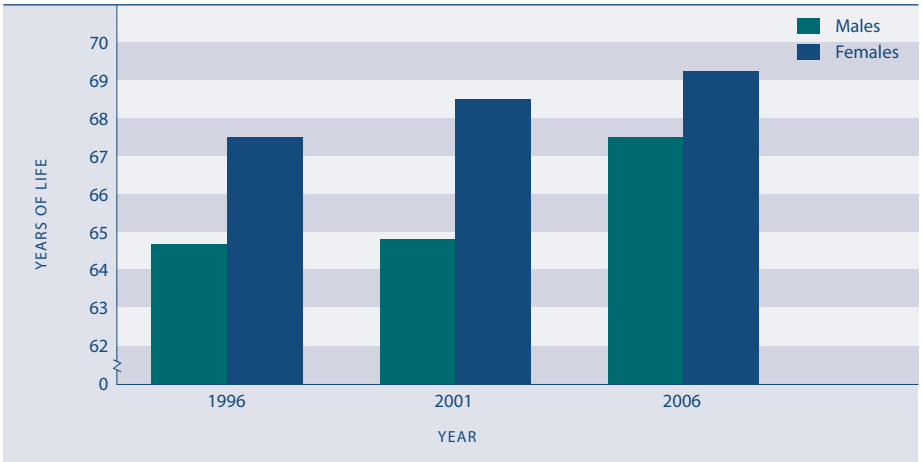
RELEVANCE

Health expectancy is a summary measure of a population's health that captures both the "quantity" and "quality" of life dimensions of health. Independent life expectancy at birth is a positive measure, capturing expectations of a life free from functional limitation that requires assistance. Improvements in health expectancy reflect changes in social and economic conditions, lifestyle changes, medical advances and better access to health services.

CURRENT LEVEL AND TRENDS

In 2006, males and females had an independent life expectancy at birth of 67.5 years and 69.2 years respectively. The overall sex gap in independent life expectancy at birth is 1.7 years, down two years since 2001. For the total population, independent life expectancy at birth has improved since 1996 (an increase of 2.8 years for males, 1.7 years for females). Note that the estimates for 2006 are provisional, as the official life tables for 2005–2007 are not yet available. In addition, the 2006 Disability Survey reported a significant decline in the levels of disability reported in the previous survey, due to a range of methodological and other factors. Statistics New Zealand has advised that caution should be exercised when comparing the results with those from previous surveys.

Figure H1.1 **Independent life expectancy at birth, by sex, 1996, 2001 and 2006**



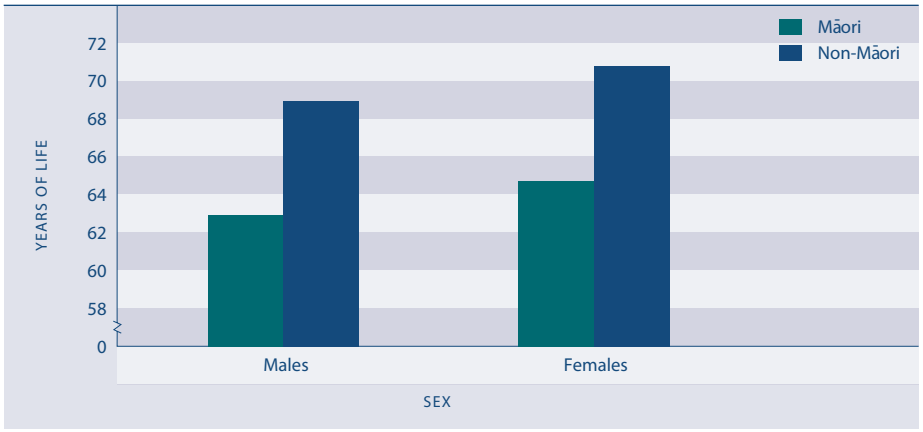
Source: Ministry of Health, provisional data

ETHNIC DIFFERENCES

Independent life expectancy for Māori was produced in the same way as for the total New Zealand population. These ethnic-specific statistics are comparable with those for the total population.

Māori males had an independent life expectancy at birth of 62.9 years in 2006. The figure for Māori females was 64.7 years, a gender gap of 1.8 years. There are large ethnic inequalities in health expectancy, despite a very rapid improvement in survivorship for Māori in recent years. In 2006, the gap in independent life expectancy at birth between Māori and non-Māori was 6.0 years for males and 6.1 years for females (the independent life expectancy at birth for non-Māori was 68.9 years and 70.8 years for males and females respectively).

Figure H1.2 **Independent life expectancy at birth, Māori and non-Māori population, by sex, 2006**



Source: Ministry of Health, provisional data

Life expectancy

DEFINITION

Life expectancy at birth indicates the total number of years a person could expect to live, based on the mortality rates of the population at each age in a given year or period.

RELEVANCE

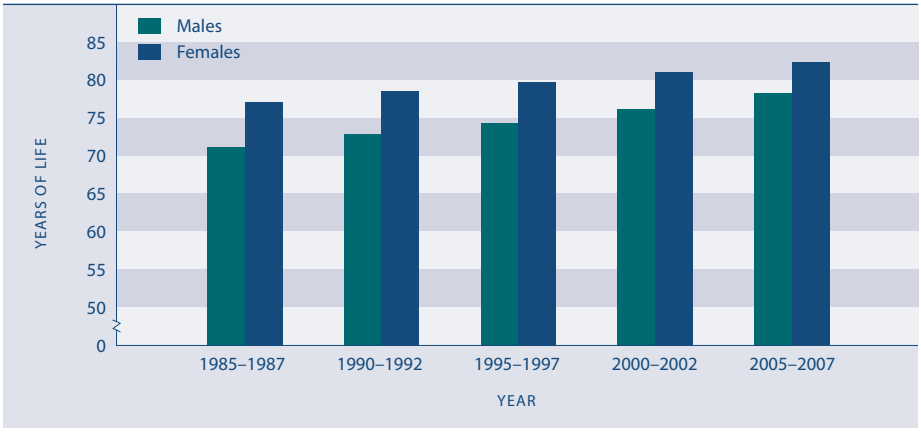
Life expectancy at birth is a key summary indicator of fatal health outcomes, ie the survival experience of the population.

CURRENT LEVEL AND TRENDS

Based on the mortality experiences of New Zealanders in the period 2005–2007, life expectancy at birth was 78.1 years for males and 82.2 years for females. Since the mid-1980s, gains in longevity have been greater for males than for females. Between 1985–1987 and 2005–2007, life expectancy at birth increased by 7.0 years for males and 5.1 years for females. As a result, the sex gap in life expectancy narrowed from 6.0 years to 4.1 years over this period.

With the decline in the infant mortality rate (from 11.2 deaths per 1,000 live births in 1986 to 4.9 per 1,000 in 2007), the impact of infant death on life expectancy has lessened. The gains in life expectancy since the mid-1980s can be attributed mainly to reduced mortality in the middle-aged and older age groups (45–84 years).

Figure H2.1 **Life expectancy at birth, by sex, selected years, 1985–1987 to 2005–2007**



Source: Statistics New Zealand
Note: Abridged life table data has been used 2005–2007

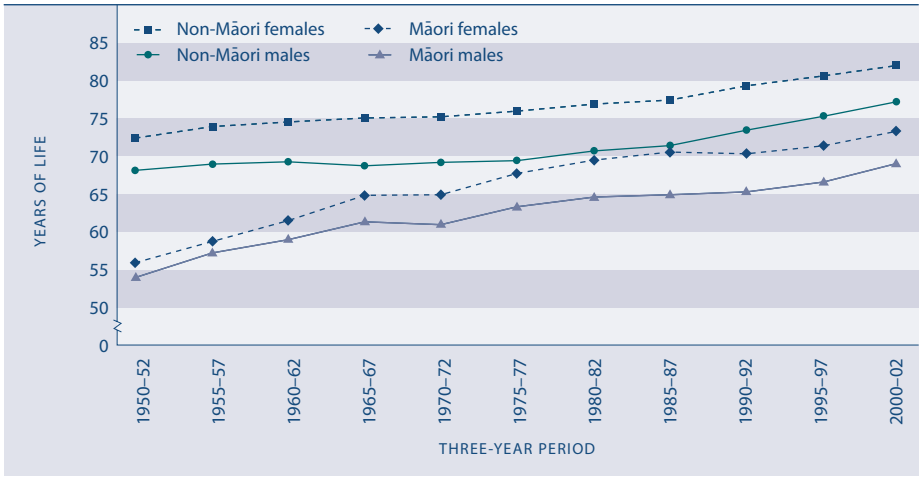
ETHNIC DIFFERENCES

There are marked ethnic differences in life expectancy. In 2000–2002, male life expectancy at birth was 77.2 years for non-Māori and 69.0 years for Māori, a difference of 8.2 years. Female life expectancy at birth was 81.9 years for non-Māori and 73.2 years for Māori, a difference of 8.8 years.

The pace of improvement in life expectancy has varied by ethnic group. For non-Māori, there was a fairly steady increase in life expectancy at birth over the period from 1985–1987 to 2000–2002, with males gaining 5.8 years and females 4.5 years. For Māori, there was little change during the 1980s, but a dramatic improvement in the five years to 2000–2002. While the gain in Māori life expectancy over the whole period 1985–1987 to 2000–2002 (4.1 years for males, 2.7 years for

females) was less than that for non-Māori, Māori gained more than non-Māori in the latter five-year period. As a result, the gap in life expectancy at birth between non-Māori and Māori, which widened by 2.4 years between 1985–1987 and 1995–1997, reduced by 0.6 years in the five years to 2000–2002.

Figure H2.2 **Life expectancy at birth, by ethnic group and sex, 1950–1952 to 2000–2002**



Source: Statistics New Zealand; Ministry of Health
Note: Ministry of Health data has been used for 1980–1982 to 1995–1997. It includes an adjustment for the undercount of Māori deaths relative to the Māori population by linking mortality to census records

SOCIO-ECONOMIC DIFFERENCES

There is an association between life expectancy and the level of deprivation in the area where people live. In 2000–2002, males in the least deprived 10th of small areas in New Zealand could expect to live 8.9 years longer than males in the most deprived 10th of small areas (79.9 versus 71.0 years). For females, the difference was smaller, but still substantial, at 6.6 years (83.8 versus 77.2 years). These figures illustrate the links between socio-economic status and health.[21]

INTERNATIONAL COMPARISON

In 2005–2006, New Zealanders' life expectancy at birth was 81.9 years for females and 77.9 years for males. This was slightly below the OECD median of 82.3 years for females and slightly above the OECD median of 77.1 years for males. Out of 30 OECD countries, New Zealand was ranked 19th equal, with the Netherlands and Luxembourg, for females, and eighth for males. In 1960–1961, New Zealand's ranking was ninth for females and seventh equal for males. Over the 1970s and 1980s, longevity improved faster in many other OECD countries than in New Zealand. Since the early-1990s, faster-than-average gains in life expectancy in New Zealand, particularly for males, have improved its relative position.
In 2006, life expectancy at birth was highest for females in Japan (85.8 years) and highest for males in Iceland (79.4 years). Compared to New Zealand, female life expectancy was higher in Australia (83.5 years) and Canada (82.7 years in 2005), but lower in the United Kingdom (81.1 years in 2005) and the United States (80.4 years in 2005). Male life expectancy was higher in Australia (78.7 years), similar in Canada (78.0 years in 2005), and lower in the United Kingdom (77.1 years in 2005) and the United States (75.2 years in 2005).[22]

Suicide

DEFINITION

The number of suicide deaths per 100,000 population, expressed as a three-year moving average age-standardised rate, for the population aged 5 years and over.

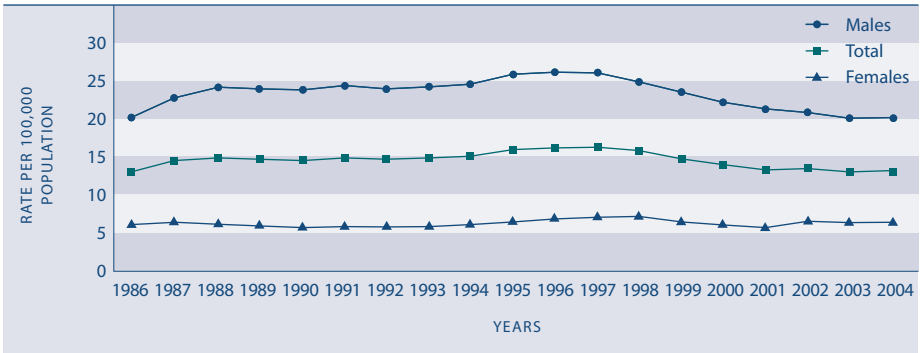
RELEVANCE

Suicide is an indicator of the mental health and social wellbeing of society and a major cause of injury-related death in the population.

CURRENT LEVEL AND TRENDS

In 2005, 502 people died by suicide, an increase from the 488 people who died in 2004.[23] The three-year moving average age-standardised[24] suicide death rate was 13.2 per 100,000 population in 2003–2005, compared with 13.1 per 100,000 in 2002–2004. Over the 1980s and 1990s there was an upward trend in the suicide death rate, which reached a peak of 16.3 per 100,000 in 1995–1997 and 1996–1998. The rate for 2003–2005 (13.2 deaths per 100,000 people) was similar to the rate for 1985–1987 (13.1 per 100,000).

Figure H3.1 **Age-standardised suicide death rate, three-year moving average, by sex, 1985–2005**

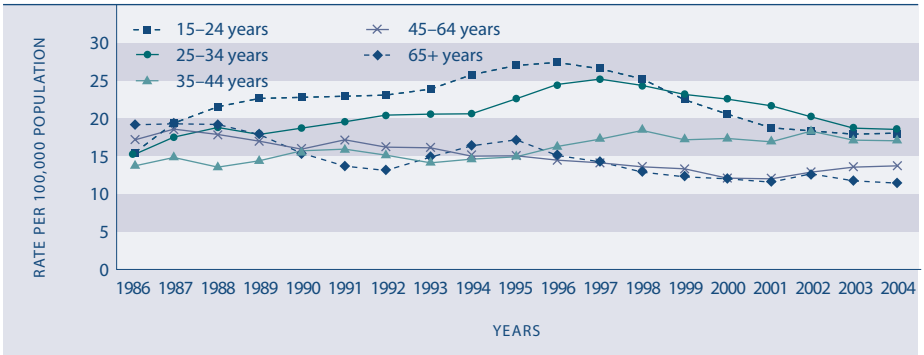


Source: Ministry of Health, Public Health Intelligence
Notes: (1) The three-year moving average rates are plotted on the mid-point year (eg 2004 is the mid-point year of 2003–2005)
(2) 2005 figures are provisional (3) Age-standardised to WHO standard population

AGE DIFFERENCES

People aged 25–34 years had the highest three-year moving average suicide death rate in 2003–2005 (18.6 per 100,000 population, with 108 deaths in 2005), followed by people aged 15–24 years (18.1 per 100,000, also with 108 deaths in 2005).

Figure H3.2 **Suicide death rate, three-year moving average, by age, 1985–2005**



Source: Ministry of Health, Public Health Intelligence
Notes: (1) The three-year moving average rates are plotted on the mid-point year (eg 2004 is the mid-point year of 2003–2005)
(2) 2005 figures are provisional

The youth (15–24 year olds) suicide death rate increased steeply in the late-1980s, peaking at 27.2 per 100,000 people aged 15–24 years in 1995–1997. It has fallen by 33 percent since then, but is still higher than the 1985–1987 rate of 15.8 per 100,000. The pattern is similar for 25–34 year olds. Suicide death rates have been falling among people aged 45 years and over. These age patterns may reflect, in part, cohort effects.

SEX DIFFERENCES

Males have a much higher rate of death by suicide than females, with 20.3 deaths per 100,000 males in 2003–2005, compared with 6.5 deaths per 100,000 females.[25] The male suicide rate increased sharply in the late-1980s, declined after 1996–1998, and in 2003–2005 was the same as the 1985–1987 rate of 20.3 deaths per 100,000 males. In comparison, the female rate has been relatively stable over the last 20 years. Because of the small numbers involved, it is more reliable to consider the trend over several years.

While the suicide death rate is higher for males, more females than males are hospitalised for intentional self-harm. In 2006, the female–male rate ratio for intentional self-harm in New Zealand was 2.0 female hospitalisations to every male hospitalisation per 100,000 population. Females more commonly choose methods that are less likely to be fatal.[26]

ETHNIC DIFFERENCES

In 2005, there were 100 Māori deaths from suicide, accounting for 20 percent of all suicide deaths in that year. The three-year moving average age-standardised rate of suicide deaths in 2003–2005 was 17.9 per 100,000 population for Māori, compared to 12.0 per 100,000 for non-Māori. The suicide death rate for Māori youth (15–24 year olds) in 2003–2005 was 33.2 per 100,000, compared with the non-Māori rate of 14.6 per 100,000. Suicide death rates for both Māori and non-Māori, for all ages and youth, were lower in 2003–2005 than in 1996–1998. Because of the small numbers, trends in Māori suicide rates should be treated with caution.

INTERNATIONAL COMPARISON

A comparison of the latest age-standardised suicide death rates in 13 OECD countries between 2002 and 2005 shows New Zealand's (2005) rate was the fourth highest for males (18.2 per 100,000 males) and the fifth highest for females (5.9 per 100,000 females).[27] Finland had the highest male suicide death rate (28.1 per 100,000 in 2004), while Japan had the highest female rate (9.5 per 100,000 in 2004). Australia (16.0 in 2003) had a lower rate of male suicide deaths than New Zealand, as did Canada and the United States (each 16.5 in 2002). The United Kingdom had the lowest male suicide death rate (9.8). Canada and Australia (4.7), the United States (3.8) and the United Kingdom (2.9) all reported lower female suicide death rates than New Zealand.

New Zealand had the second highest male youth (15–24 years) suicide death rate (after Finland), and the third highest female youth suicide death rate (after Finland and Japan). New Zealand is one of a small number of countries which have higher suicide death rates at younger ages than at older ages.[28]

Cigarette smoking

DEFINITION

The proportion of the population who currently smoke cigarettes. Up to 2005, the survey population was people aged 15 years and over (ACNielsen survey). From 2006, the survey population is people aged 15–64 years (New Zealand Tobacco Use Survey, New Zealand Health Survey).

RELEVANCE

Tobacco smoking is a well-recognised risk factor for many cancers and for respiratory and cardiovascular diseases. In addition, exposure to environmental tobacco smoke (particularly maternal smoking) is a major risk factor for Sudden Infant Death Syndrome and respiratory problems in children. Smoking has been identified as the major cause of preventable death in OECD countries.[29]

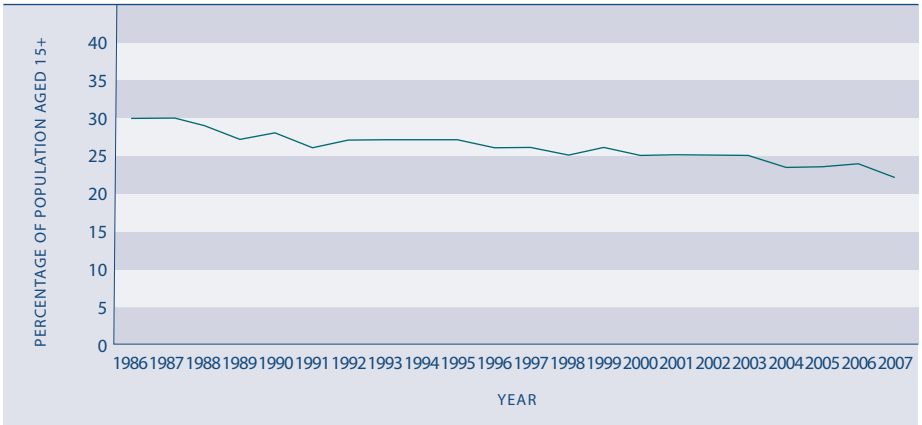
CURRENT LEVEL AND TRENDS

In 2006/2007, 22 percent of people aged 15–64 years were cigarette smokers, according to the New Zealand Health Survey. This is below the 24 percent derived from the New Zealand Tobacco Use Survey conducted in the first quarter of 2006.

Long-term trends are available only for the population aged 15 years and over. For this population, smoking prevalence fell to 19.9 percent in 2006/2007. This was below the 24 percent derived from the ACNielsen survey for 2005 and the lowest level in over three decades. Among the population aged 15 years and over, smoking has declined from 30 percent in 1986, with most of the decline occurring between 1987 and 1991.

It is important to note that there are methodological differences between these three surveys and some caution should be used when comparing figures. Ongoing monitoring in the social report will be based on the New Zealand Tobacco Use Survey. As this survey is carried out in two out of every three years, it allows the most frequent updates.

Figure H4.1 **Prevalence of cigarette smoking, 1986–2007**



Source: Ministry of Health
Notes: (1) Data not standardised for age (2) 1986–2005: population aged 15+ years; 2006, 2007: population aged 15–64 years

AGE AND SEX DIFFERENCES

Smoking rates for females and males have been similar since the mid-1980s. In 2006/2007, 23 percent of males and 21 percent of females smoked. However, this sex difference was not statistically significant.

In 2006/2007, smoking was most prevalent among people aged 25–34 years, followed by those aged 15–24 years. People aged 55–64 years had a significantly lower smoking prevalence than younger age groups. Since the mid-1980s, people aged 55 and over have experienced the greatest decline in smoking prevalence.[30]

Daily smoking rates for 14–15 year olds have declined considerably since 1999. Between 1999 and 2006, the prevalence of daily smoking declined by 56 percent for males in this age group (from 14 percent to 6 percent) and by 42 percent for females (from 17 percent to 10 percent).

ETHNIC DIFFERENCES

Smoking prevalence is significantly higher among Māori and Pacific peoples, at around 44 percent and 28 percent respectively, than among the total population aged 15–64 years in 2006/2007. It is significantly lower among Asian ethnic groups (12 percent) in that year. Among Māori, the prevalence of smoking is significantly higher for women than for men. The opposite is the case among Pacific peoples and Asians. European women and men have similar smoking rates.

Since 1990, smoking prevalence has declined by seven percentage points for Māori and by three percentage points for the European/Other ethnic groups.[31]

Table H4.1 **Age-standardised prevalence (%) of cigarette smoking, by sex and ethnicity, 2006/2007**

	Percentage in each ethnic group who smoke cigarettes				
	European/Other	Māori	Pacific peoples	Asian	Total
Male	22.3	40.3	34.5	19.4	23.4
Female	21.1	47.3	21.8	5.3	20.9
Total	**21.7**	**44.1**	**27.9**	**11.9**	**22.1**

Source: Ministry of Health (2008d)
Notes: (1) Rates are age-standardised using the WHO world population (2) People who reported more than one ethnic group are counted once in each group reported

SOCIO-ECONOMIC DIFFERENCES

In 2006/2007, the smoking prevalence rate in the most deprived areas (NZDep2006 deciles 9–10) was 2.8 times the rate in the least deprived areas (deciles 1–2).[32]

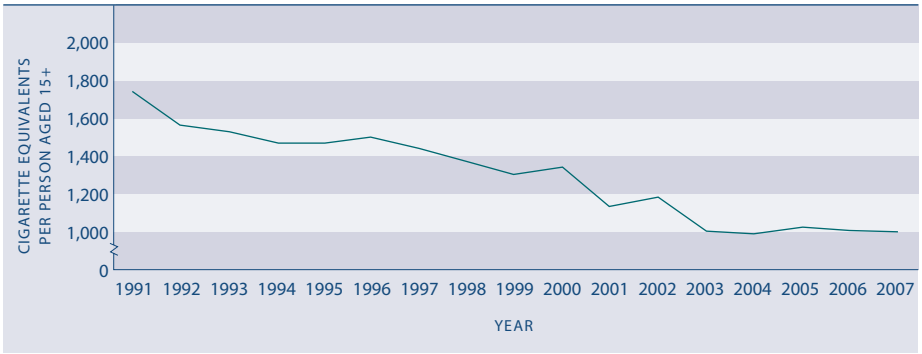
INTERNATIONAL COMPARISON

In an OECD comparison of daily smoking rates for adults aged 15 years and over, New Zealand had a rate of 21 percent in 2006, compared with an OECD median of 24 percent.[33] New Zealand ranked seventh lowest out of 30 OECD countries. Smoking prevalence was highest in Greece (39 percent in 2004) and lowest in Sweden (16 percent in 2005). New Zealand's rate was lower than that of the United Kingdom (22 percent in 2006), but higher than those of Australia (18 percent in 2004), the United States and Canada (both 17 percent in 2006 and 2005 respectively). Compared to other OECD countries, New Zealand's smoking levels are relatively low for males and relatively high for females.[34]

TOBACCO CONSUMPTION

In 2007, tobacco consumption was 1,002 cigarette equivalents per person aged 15 years and over, down slightly from 1,006 in 2006. Since 1991, tobacco consumption has decreased by 42 percent. Over this period, the drop in tobacco consumption has been more rapid than the drop in smoking prevalence.

Figure H4.2 **Tobacco consumption, cigarette equivalents per person aged 15 years and over, 1991–2007**



Sources: Ministry of Health (2006c) Table D1; Statistics New Zealand (2008a)

Obesity

DEFINITION

The proportion of the population aged 15 years and over who are obese, and the proportion of children aged 5–14 years who are obese.

For adults aged 18 years and over, obesity is defined as having a body mass index (BMI) greater than or equal to 30 kg/m^2 (for all ethnic groups).[35] For those under 18 years, internationally defined sex and age specific BMI cut-off points have been used.[36]

RELEVANCE

Obesity is associated with a long list of adult health conditions, including heart disease, high blood pressure and strokes, type 2 diabetes, various types of cancer, and psychological and social problems. Obese children are likely to be obese into adulthood.[37]

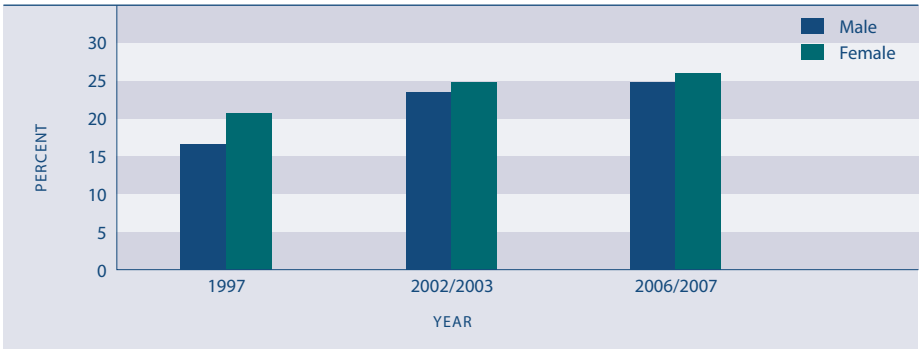
CURRENT LEVEL AND TRENDS

In 2006/2007, the age-standardised obesity prevalence rate for the population aged 15 years and over was 25 percent. This was similar to the 2002/2003 rate of 24 percent but a significant increase from the 1997 rate of 19 percent.[38]

In 2006/2007, 8 percent of children aged 5–14 years were obese, a prevalence rate similar to that of 2002 (9 percent).[39]

The major drivers of the increase in obesity rates have been changing dietary and physical activity patterns, reflecting an environment that promotes the over-consumption of energy-dense foods and drinks and limits the opportunities for physical activity.[40]

Figure H5.1 **Age-standardised prevalence of obesity, total population aged 15 years and over, by sex, 1997, 2002/2003, 2006/2007**



Source: Ministry of Health, Public Health Intelligence

AGE AND SEX DIFFERENCES

Age-standardised prevalence rates for 2006/2007 showed no significant sex difference in the proportion of the population aged 15 years and over who were obese (males, 25 percent; females, 26 percent). This was also the case in 2002/2003. In 1997, the age-standardised rate for females was significantly higher than the rate for males.

Among children aged 5–14 years, there was no significant difference by sex or age in the prevalence of obesity, either in 2002 or in 2006/2007.

Among those aged 15 years and over in 2006/2007, the prevalence of obesity was highest in the 55–64 years age group (36 percent), followed by the 65–74 years age group.

Table H5.1 **Prevalence (%) of obesity, by age group and sex, 2006/2007**

	5–14	15–24	25–34	35–44	45–54	55–64	65–74	75+
Males	8.1	12.7	22.2	29.9	30.8	35.9	29.9	21.7
Females	8.6	15.7	26.6	26.9	30.2	35.9	35.7	20.1
Total	**8.3**	**14.2**	**24.4**	**28.4**	**30.5**	**35.9**	**32.8**	**20.8**

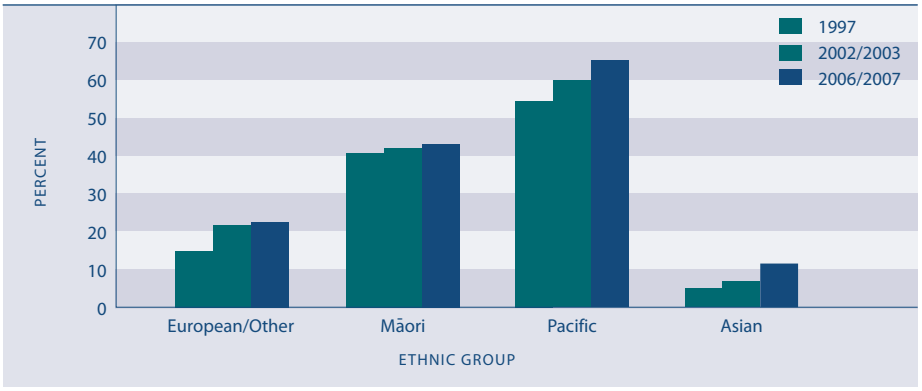
Source: Ministry of Health, Public Health Intelligence

ETHNIC DIFFERENCES

There are large differences in the prevalence of obesity by ethnicity. Among the population aged 15 years and over in 2006/2007, Pacific peoples (65 percent) and Māori (43 percent) had significantly higher age-standardised obesity rates than the total population in this age group, while Asians (12 percent) had a significantly lower rate. The obesity rate of European/Other was (23 percent). For Māori, there was no significant change from 1997 to 2006/2007 in the prevalence of obesity, adjusted for age, either for men or for women. Between 2002/2003 and 2006/2007, only Asians had a statistically significant increase in obesity.

Among children aged 5–14 years in 2006/2007, the pattern of ethnic differences in the prevalence of obesity was similar to that of the population aged 15 years and over. Pacific children had the highest rate (26 percent), followed by Māori children (13 percent), Asian children (6 percent) and children of European/Other ethnic groups (5 percent).

Figure H5.2 **Age-standardised prevalence of obesity, population aged 15 years and over, by ethnic group, 1997, 2002/2003, 2006/2007**



Source: Ministry of Health, Public Health Intelligence
Note: People who reported more than one ethnic group are counted once in each group reported

SOCIO-ECONOMIC DIFFERENCES

The prevalence of obesity is higher in relatively deprived neighbourhoods. In 2006/2007, 38 percent of the population aged 15 years and over living in NZDep2006 quintile 5 (the most disadvantaged fifth of neighbourhoods) were obese, compared with 26 percent of those living in quintile 4, 23 percent of those living in quintile 3 and 21 percent of those living in quintiles 1 and 2.

INTERNATIONAL COMPARISON

New Zealand has a relatively high prevalence of obesity compared with other OECD countries. In 2006/2007, New Zealand's rate was 25 percent, compared to an OECD median of 13 percent. New Zealand was ranked 28th out of 30 OECD countries reporting obesity prevalence from 1999–2006. However, most countries use the self-reporting method to measure obesity whereas New Zealand and five other countries use actual measurements recorded by an interviewer.[41] Out of the six countries that use actual measurements, New Zealand was ranked second highest with a lower obesity rate than the United States (34 percent in 2006), and a similar rate to the United Kingdom (24 percent in 2006) and Australia (22 percent in 1999). Of all OECD countries, Japan and Korea had the lowest prevalence of obesity (both 4 percent in 2005).[42]

Potentially hazardous drinking

DEFINITION

The proportion of the population aged 15 years and over who drink alcohol, who scored eight or more on the Alcohol Use Disorders Identification Test (AUDIT), as measured in the New Zealand Health Surveys conducted by the Ministry of Health in 1996/1997, 2002/2003 and 2006/2007.

The AUDIT is a 10-item questionnaire covering alcohol consumption, alcohol-related problems and abnormal drinking behaviour.

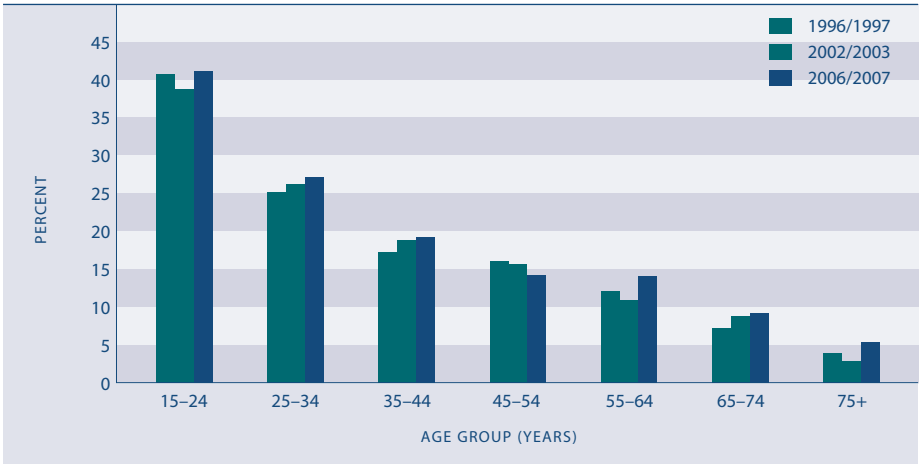
RELEVANCE

Potentially hazardous drinking, defined by an AUDIT score of eight or more, is an established pattern of alcohol consumption that carries a high risk of future damage to physical or mental health, but may not yet have resulted in significant adverse effects.[43] Alcohol also contributes to death and injury due to traffic accidents, drowning, suicide, assaults and domestic violence.[44]

CURRENT LEVEL AND TRENDS

In 2006/2007, 22.9 percent of drinkers aged 15 years and over had a potentially hazardous drinking pattern, as indicated by an AUDIT score of eight or more. This was similar to the proportions recorded in the 1996/1997 and 2002/2003 surveys (22.3 percent and 22.5 percent, respectively).[45]

Figure H6.1 **Potentially hazardous drinking among drinkers, by age, 1996/1997, 2002/2003, 2006/2007**



Source: Ministry of Health, Public Health Intelligence

AGE AND SEX DIFFERENCES

For both males and females, the proportion of drinkers with a potentially hazardous drinking pattern is highest among those aged 15–24 years and declines at older ages.

In 2006/2007, male drinkers (29.2 percent) were significantly more likely than female drinkers (13.0 percent) to have a potentially hazardous drinking pattern. This was the case for all age groups and in each survey year.

Table H6.1 **Proportion (%) of drinkers with a potentially hazardous drinking pattern, by age group and sex, 1996/1997, 2002/2003, 2006/2007**

	15–24	25–34	35–44	45–54	55–64	65–74	75+
1996/1997							
Male	49.8	35.7	25.5	25.2	21.1	12.6	7.3
Female	31.6	13.9	8.1	6.0	1.8	1.0	0.8
Total	**40.8**	**24.9**	**17.1**	**16.0**	**12.0**	**7.3**	**3.9**
2002/2003							
Male	45.8	36.1	28.0	23.5	18.1	16.4	4.4
Female	31.0	16.0	9.3	7.1	3.0	1.1	1.0
Total	**38.7**	**26.1**	**18.7**	**15.7**	**10.8**	**8.7**	**2.7**
2006/2007							
Male	49.2	36.2	29.0	21.1	23.1	14.7	7.9
Female	32.6	18.2	9.5	7.3	4.3	3.0	2.5
Total	**41.1**	**27.1**	**19.2**	**14.2**	**14.0**	**9.1**	**5.2**

Source: Ministry of Health, Public Health Intelligence

ETHNIC DIFFERENCES

Māori and Pacific drinkers are significantly more likely than drinkers in the total population to have a potentially hazardous drinking pattern. Asian drinkers are significantly less likely to have such a pattern. These ethnic differences are evident for both sexes.

Table H6.2 **Age-standardised potentially hazardous drinking prevalence rate (%), for drinkers aged 15 years and over by ethnic group and sex, 1996/1997, 2002/2003, 2006/2007**

	European/ Other	Māori	Pacific peoples	Asian	Total 15+
1996/1997					
Male	31.0	46.1	48.2	11.6	30.9
Female	12.0	30.6	20.8	5.1	13.3
Total	**21.6**	**38.3**	**38.1**	**9.4**	**22.3**
2002/2003					
Male	29.9	42.4	44.1	11.5	30.6
Female	13.3	24.1	24.3	4.8	14.2
Total	**21.7**	**32.9**	**36.1**	**8.6**	**22.5**
2006/2007					
Male	32.1	46.8	46.6	12.9	31.2
Female	14.5	28.5	25.8	3.8	14.7
Total	**23.1**	**37.5**	**37.7**	**8.9**	**22.9**

Source: Ministry of Health, Public Health Intelligence

Notes: (1) Rates are age-standardised using the WHO world population (2) People who reported more than one ethnic group are counted once in each group reported

SOCIO-ECONOMIC DIFFERENCES

The proportion of drinkers aged 15 years and over with a potentially hazardous drinking pattern in 2006/2007 was significantly higher (at 30.8 percent) in the most deprived small areas (NZDep2006 quintile 5) than in all other areas (quintiles 1–4), where proportions ranged from 19–24 percent.

INTERNATIONAL COMPARISON

Because of the paucity of international data using the AUDIT method of identifying potentially hazardous drinking, this section uses information on annual per person alcohol consumption compiled by the OECD. New Zealand had the 14th lowest level of alcohol consumption out of 30 OECD countries in 2003–2006, with a per person consumption of 9.4 litres in 2006. New Zealand's alcohol consumption was higher than that of the United States (8.4 litres in 2005) and Canada (8.0 litres in 2005), similar to that of Australia (9.8 litres in 2005), but lower than that of the United Kingdom (10.9 litres in 2006). The OECD median in 2003–2006 was 9.8 litres of alcohol per person.