

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.²¹

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.

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.²²

Alcohol is the most commonly used recreational drug in New Zealand, with the majority of New Zealanders consuming alcohol at least occasionally.²³ 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.²⁴ Alcohol also contributes to death and injury due to traffic accidents, drowning, suicide, assaults and domestic violence.²⁵

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

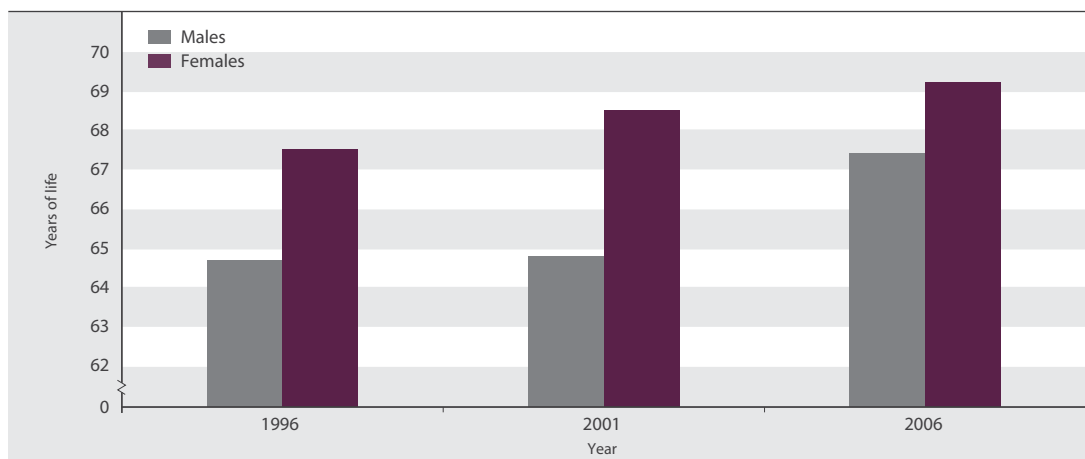
Health expectancy is a summary measure of a population's health that captures both the "quantity" and "quality" of life dimensions of health. Independent life expectancy at birth is a positive measure, capturing expectations of a life free from functional limitation that requires assistance. Improvements 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 67.4 years and 69.2 years respectively. The gap between males and females in independent life expectancy at birth was 1.8 years in 2006, a decrease of two years since 2001. For the total population, independent life expectancy at birth has improved since 1996 (an increase of 2.7 years for males, 1.7 years for females).

It should be noted that the 2006 Disability Survey reported a significant decline in the levels of disability to those reported in the previous survey, due to a range of methodological and other factors. Statistics New Zealand has advised caution when comparing the results of the 2006 Disability Survey with those from previous surveys.

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



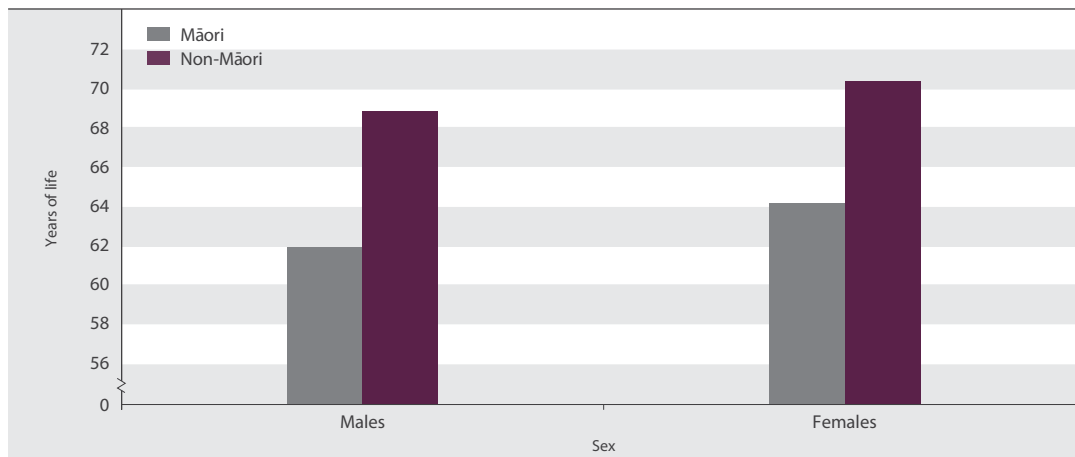
Source: Ministry of Health

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 62.0 years in 2006. The figure for Māori females was 64.2 years, a gender gap of 2.2 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 6.8 years for males and 6.2 years for females (the independent life expectancy at birth for non-Māori was 68.8 years and 70.4 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

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

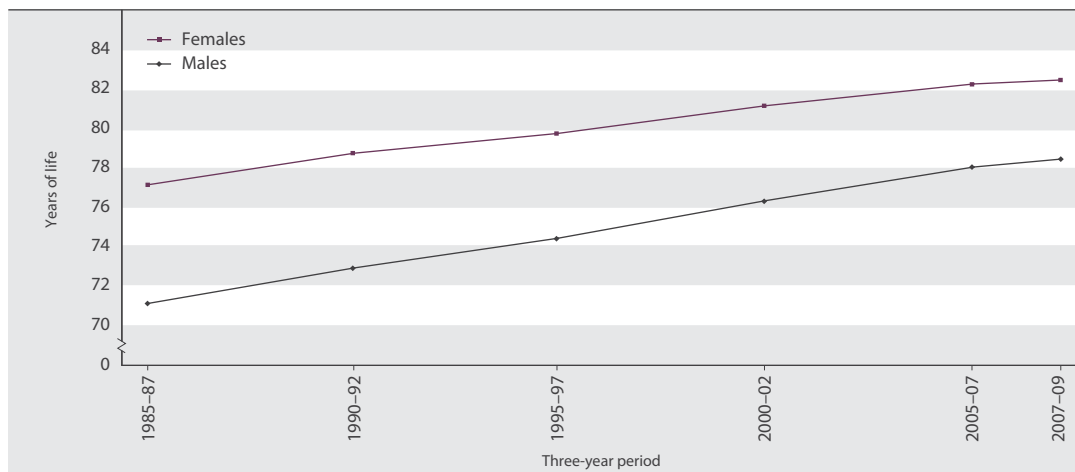
Life expectancy at birth is a key summary indicator of fatal health outcomes, ie the survival experience of the population.

Current level and trends

Based on the mortality experiences of New Zealanders in the period 2007–2009, life expectancy at birth was 78.4 years for males and 82.4 years for females. Since the mid-1980s, gains in longevity have been greater for males than for females. Between 1985–1987 and 2007–2009, life expectancy at birth increased by 7.3 years for males and 5.3 years for females. As a result, the gap between males and females in life expectancy narrowed from 6.0 years to 4.0 years over this period.

The gains in life expectancy at birth since the mid-1980s can be attributed mainly to reduced death rates for people in the late-working and retirement age groups (55–84 years). However, reduced death rates for infants (from 11.2 deaths per 1,000 live births in 1986 to 4.9 per 1,000 in 2009), for people aged 45–54 years, and for women aged 85 years and over were also significant.

Figure H2.1 Life expectancy at birth, by sex, 1985–1987 to 2007–2009



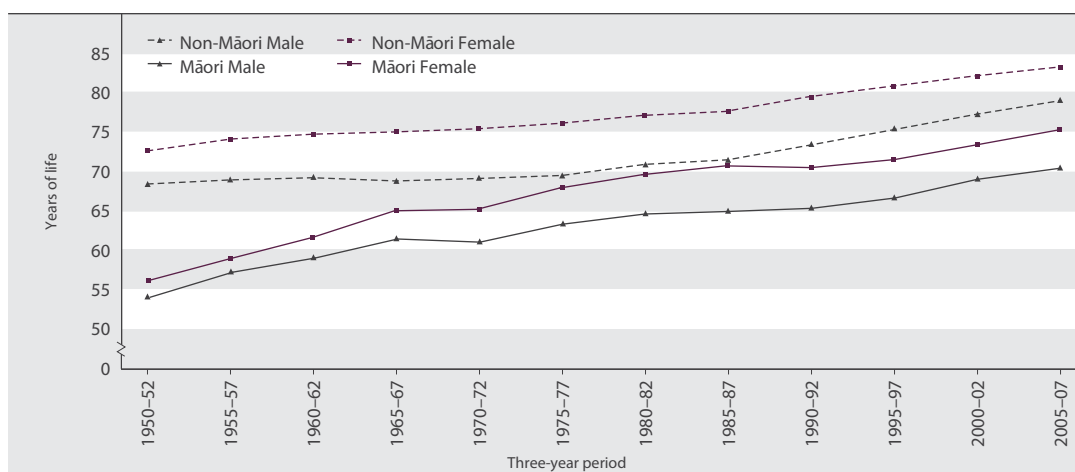
Source: Statistics New Zealand
Note: The period life table data in this graph is from complete life tables for all periods up to 2005–2007 and an abridged life table for 2007–2009.

Ethnic differences

There are marked ethnic differences in life expectancy. In 2005–2007, male life expectancy at birth was 79.0 years for non-Māori and 70.4 years for Māori, a difference of 8.6 years. Female life expectancy at birth was 83.0 years for non-Māori and 75.1 years for Māori, a difference of 7.9 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 2005–2007, with males gaining 7.6 years and females 5.6 years. For Māori, there was little change during the 1980s, but a substantial improvement in the 10 years to 2005–2007 (a gain of 3.8 years for both sexes). This exceeded the improvement for non-Māori over the same period (3.6 years for males and 2.4 years for females). However, the overall gain in Māori life expectancy from 1985–1987 to 2005–2007 (5.5 years for males, 4.6 years for females) was less than that for non-Māori.

Figure H2.2 **Life expectancy at birth, by ethnic group and sex, 1950–1952 to 2005–2007**



Source: Statistics New Zealand

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 2005–2007, males in the least deprived 10th of small areas in New Zealand could expect to live 8.8 years longer than males in the most deprived 10th of small areas (82.1 versus 73.3 years). For females, the difference was smaller, but still substantial, at 5.9 years (84.6 versus 78.7 years). These differences illustrate the links between socio-economic status and health.

International comparison

In 2005–2007, New Zealanders' life expectancy at birth was 82.2 years for females and 78.0 years for males. This was slightly below the OECD median of 82.7 years for females and slightly above the OECD median of 77.6 years for males for the latest year up to 2008. Out of 30 OECD countries, New Zealand was ranked 21st for females and 10th equal for males. In 1960–1961, New Zealand's ranking was ninth for females and seventh equal for males. Through the 1960s, 1970s and 1980s, longevity improved faster in many other OECD countries than it did in New Zealand. Since the 1980s, faster-than-average gains in life expectancy in New Zealand, particularly for males, have improved New Zealand's relative position.

In 2007–2008, life expectancy at birth was highest for females in Japan (86.1 years) and highest for males in Switzerland (79.8 years). Compared to New Zealand, female life expectancy was higher in Australia (83.7 years) and Canada (83.0 years in 2007), similar in Ireland (82.3 years), but lower in the United Kingdom (81.8 years) and the United States (80.4 years). Male life expectancy was higher in Australia (79.2 years), similar in Canada (78.3 years), and lower in the United Kingdom (77.6 years in 2007), Ireland (77.5 years) and the United States (75.3 years in 2007).²⁶

Suicide

Definition

The number of suicide deaths per 100,000 population.

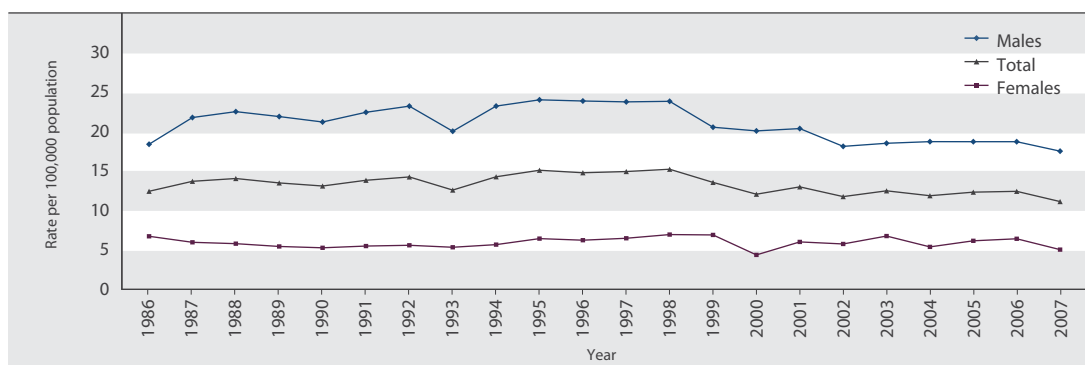
Relevance

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

Current level and trends

In 2007, 483 people died by suicide, a decrease from the 526 people who died in 2006.²⁷ The age-standardised²⁸ suicide death rate was 11.0 per 100,000 population in 2007, a decrease from 12.3 per 100,000 in 2006. Over the 1980s and 1990s there was an upward trend in the suicide death rate, which peaked at 15.1 per 100,000 in 1998. The rate has generally declined since then and in 2007 it was lower than the rate in 1986 (12.3 per 100,000).

Figure H3.1 Age-standardised suicide death rate, by sex, 1986–2007

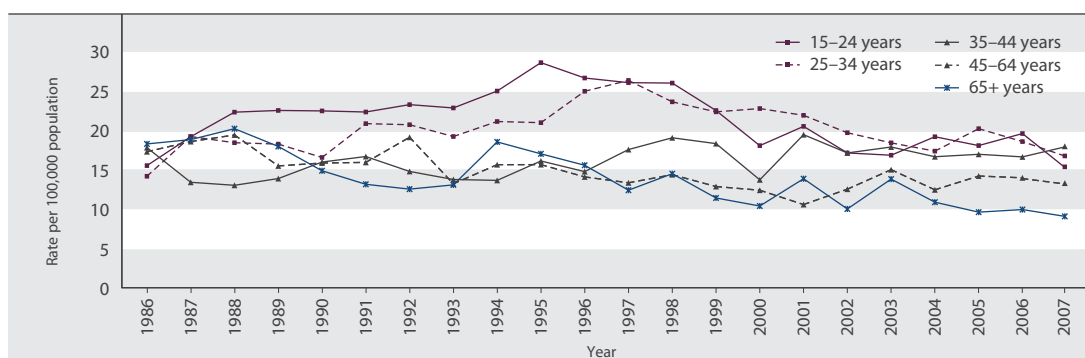


Source: Ministry of Health
Notes: (1) The 2007 figures are provisional. (2) Age-standardised to WHO standard population.

Age differences

People aged 35–44 years had the highest suicide death rate in 2007 (17.8 per 100,000 population, with 113 deaths), followed by people aged 25–34 years (16.7 per 100,000, with 91 deaths), people aged 15–24 years (15.3 per 100,000, with 94 deaths), and people aged 45–64 years (13.2 per 100,000 with 135 deaths). Older people aged 65 years and over had the lowest rate (9.1 per 100,000 with 48 deaths).

Figure H3.2 Suicide death rate, by age group, 1986–2007



Source: Ministry of Health
Note: The 2007 figures are provisional.

The youth (15–24 year olds) suicide death rate increased steeply in the late-1980s, peaking at 28.7 per 100,000 people aged 15–24 years in 1995. By 2007, it had fallen by 47 percent to 15.3 per 100,000, similar to the 1986 rate of 15.6 per 100,000. The pattern was similar for 25–34 year olds. Suicide death rates have fallen over the past two decades among people aged 45 years and over. These age patterns may reflect, in part, cohort effects.

Sex differences Males have a significantly higher rate of death by suicide than females, with an age-standardised rate of 17.4 deaths per 100,000 males in 2007, compared with 4.9 deaths per 100,000 females. The male suicide death rate increased sharply in the late-1980s, peaked at 23.9 deaths per 100,000 males in 1995, then declined after 1998. In comparison, the female rate has been relatively stable over the last 20 years. For both sexes, suicide death rates were lower in 2007 than they had been in 1986. 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 2007, the female to male rate ratio for intentional self-harm in New Zealand was 1.8 female hospitalisations to every male hospitalisation per 100,000 population. Females more commonly choose methods that are less likely to be fatal.²⁹

Ethnic differences In 2007, there were 97 Māori deaths from suicide, accounting for 20 percent of all suicide deaths in that year. The age-standardised rate of suicide deaths in 2007 was 16.1 per 100,000 population for Māori, compared to 9.9 per 100,000 for non-Māori. The suicide death rate for Māori youth (15–24 year olds) in 2007 was 28.1 per 100,000, compared with the non-Māori rate of 12.3 per 100,000. Since 1996, suicide death rates have declined for non-Māori but there is no obvious trend for Māori, although the small numbers of Māori suicide deaths make it hard to ascertain trends.

Socio-economic differences Suicide is more common in deprived neighbourhoods. In 2007, the age-standardised suicide death rate in the most deprived areas (NZDep2001 quintiles 3–5) was 13.3 per 100,000 population. This was significantly higher than the rate of 7.7 per 100,000 population in the least deprived areas (quintile 1). Rates of hospitalisation for intentional self-harm show a similar pattern.

International comparison A comparison of the latest age-standardised suicide death rates in 13 OECD countries³⁰ between 2002 and 2007 shows New Zealand's (2007) rate was the fourth highest for males (17.4 per 100,000 males) and the sixth highest for females (4.9 per 100,000 females).³¹ Finland had the highest male suicide death rate (27.4 per 100,000 in 2006), while Japan had the highest female rate (10.0 per 100,000 in 2006). Canada (15.5 in 2005) had a lower rate of male suicide deaths than New Zealand, as did the United States (16.2 in 2005) and Australia (16.0 in 2003). The United Kingdom had the lowest male suicide death rate (9.4 in 2005). Canada (4.8), Australia (4.4), the United States (4.0) 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 second highest female youth suicide death rate (after Japan).

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.³²

Current level and trends

In 2009, 22 percent of people aged 15–64 years were current cigarette smokers, according to the New Zealand Tobacco Use Survey. This was below the smoking prevalence rate derived from the New Zealand Tobacco Use Survey conducted in 2008 (24 percent).

Note: Updated information on trends for the population aged 15 years and over, and on age, sex, ethnic and socio-economic differences, will be included following the release of the full report on the 2009 Tobacco Use Survey, planned for late 2010.

Long-term trends are available only for the population aged 15 years and over. The Ministry of Health's estimate of smoking prevalence for this population in 2008 is 21.0 percent. This is similar to the 2006/2007 New Zealand Health Survey estimate of 19.9 percent and the 2006 Census figure of 20.7 percent, but below the 24 percent derived from the ACNielsen survey for 2005. 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 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 allows the most frequent updates.

Age and sex differences

Smoking rates for females and males have generally been similar since the mid-1980s. However, after adjusting for age, the male rate was higher than the female rate in 2008 (26 percent and 22 percent respectively).

In 2008, smoking was most prevalent among people aged 25–34 years (28 percent), followed by those aged 15–24 years (26 percent). People aged 55–64 years had a significantly lower smoking prevalence rate (17 percent) than younger age groups. Since the mid-1980s, people aged 55 years and over have experienced the greatest decline in smoking prevalence.³³

Daily smoking rates for 14–15 year olds have declined considerably since 1999. Between 1999 and 2009, the prevalence of daily smoking declined by 65 percent for boys in this age group (from 14 percent to 5 percent) and by 63 percent for girls (from 17 percent to 6 percent).

Ethnic differences

After adjusting for age, smoking prevalence is significantly higher among Māori and Pacific peoples (at around 46 percent and 31 percent respectively in 2008), than among the total population aged 15–64 years. It is significantly lower among Asian ethnic groups (13 percent in 2008). Among Māori adults, smoking prevalence is significantly higher for women than for men. The opposite is the case for other ethnic groups, particularly Asians: Asian men have a significantly higher smoking prevalence rate than Asian women.

Among 14–15 year olds, Māori girls had the highest daily smoking rate in 2009 (18 percent), but it had halved from 36 percent in 1999. The rate for Māori boys was 11 percent in 2009, down from 24 percent in 1999. For Pacific students, the daily smoking rate fell by around two-thirds over the decade (from 23 percent to 7 percent for girls and from 17 percent to 6 percent for boys).

Table H4.1 **Age-standardised prevalence (%) of cigarette smoking, by sex and ethnic group, 2008**

	Percentage in each ethnic group who smoke cigarettes				Total
	European/Other	Māori	Pacific peoples	Asian	
Male	23.8	41.5	35.0	21.5	25.7
Female	20.9	49.3	28.1	5.2	22.3
Total	22.3	45.7	31.4	13.1	23.9

Source: Ministry of Health (2009b)

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

Socio-economic differences

In 2008, the age-standardised smoking prevalence rate for 15–64 year olds in the most deprived areas (NZDep2006 deciles 9 and 10) was 2.7 times the rate in the least deprived areas (deciles 1 and 2).³⁴

Among 14–15 year olds in 2009, daily smoking rates were four times higher for girls and more than twice as high for boys at schools drawn from low socio-economic communities (school deciles 1–3) than for boys and girls at schools in more advantaged communities (school deciles 8–10).

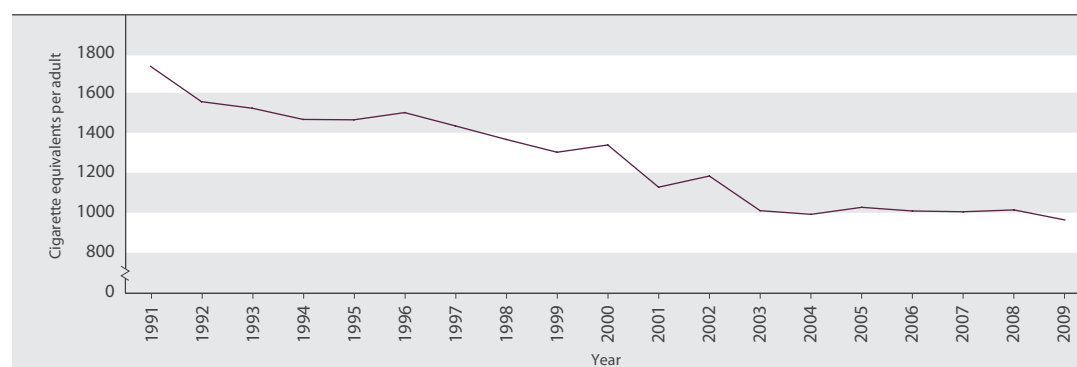
International comparison

In an OECD comparison of daily smoking rates for adults aged 15 years and over, New Zealand had a rate of 18.1 percent in 2007, compared with an OECD median of 23.2 percent.³⁵ New Zealand ranked seventh lowest out of 30 OECD countries. Smoking prevalence was highest in Greece (39.7 percent in 2008) and lowest in Sweden (14.5 percent in 2006). New Zealand’s daily smoking rate was lower than the rates in Ireland (29.0 percent in 2007) and the United Kingdom (22.0 percent in 2008) and a little higher than the rates in Canada (17.5 percent in 2008), Australia (16.6 percent in 2007) and the United States (16.5 percent in 2008). The rate for New Zealand males was around two-thirds of the OECD median for males, while the rate for New Zealand females was similar to the OECD median for females.³⁶

Tobacco consumption

In 2009, tobacco consumption was 961 cigarette equivalents per person aged 15 years and over, down slightly from 1,011 in 2008. Between 1991 and 2003, tobacco consumption fell by 43 percent, but there has been little change in recent years. Since 1991, the drop in tobacco consumption has been more rapid than the drop in smoking prevalence.

Figure H4.1 **Tobacco consumption, cigarette equivalents per person aged 15 years and over, 1991–2009**



Source: Statistics New Zealand

Note: The data includes cigarettes and tobacco available for consumption.

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/m² (for all ethnic groups).³⁷ For those aged under 18 years, internationally defined sex and age specific BMI cut-off points have been used.³⁸

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.³⁹

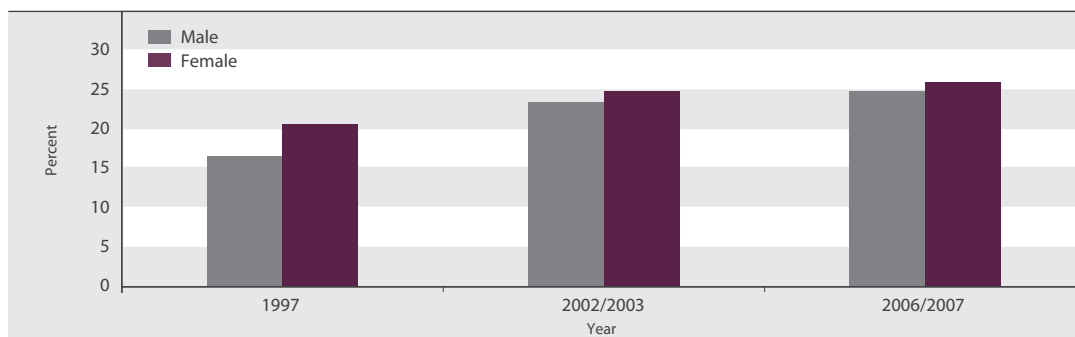
Current level and trends

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.⁴⁰

In 2006/2007, 8 percent of children aged 5–14 years were obese, a prevalence rate similar to that of 2002 (9 percent).⁴¹

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.⁴²

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



Source: Ministry of Health

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**

	Age group (years)							
	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

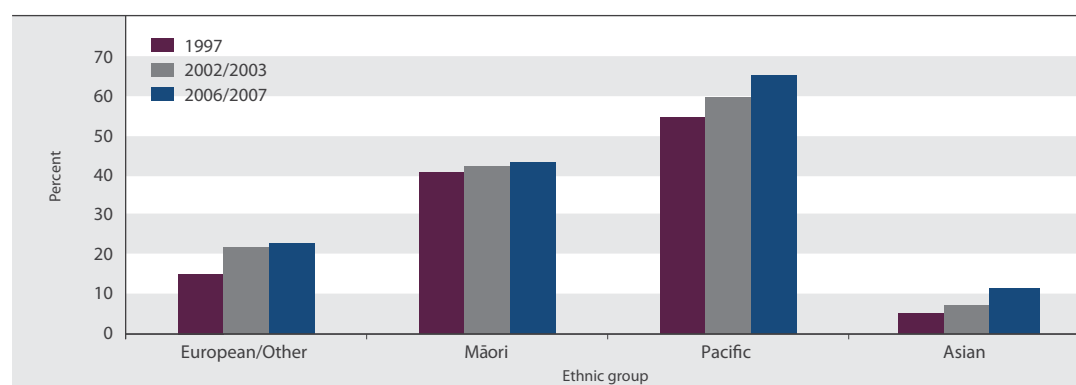
Source: Ministry of Health

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 and 2006/2007**



Source: Ministry of Health

Note: People who reported more than one ethnic group are counted once in each group reported.

Socio-economic differences

The prevalence of obesity is highest 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

International comparisons of the prevalence of obesity are difficult to make because different methods of measurement are used. For the 18 OECD countries that use the self-reporting method only, the median was 13.2 percent in 2003–2009. For the 12 countries that, like New Zealand, use actual measurements of height and weight recorded by an interviewer, the median was 23.6 percent in 2005–2008. New Zealand's unadjusted obesity rate of 26.5 percent in 2006/2007 was the third highest measured obesity rate after the United States (33.8 percent in 2008) and Mexico (30.0 percent in 2006). Other countries with measured obesity rates similar to New Zealand's include Australia (24.8 percent in 2007–2008), the United Kingdom (24.5 percent in 2008) and Canada (24.2 percent in 2008). The rate for Ireland was slightly lower (23.0 percent in 2007). Japan (3.4 percent in 2008) and Korea (3.8 percent in 2008) had the lowest measured prevalence of obesity.⁴³

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.

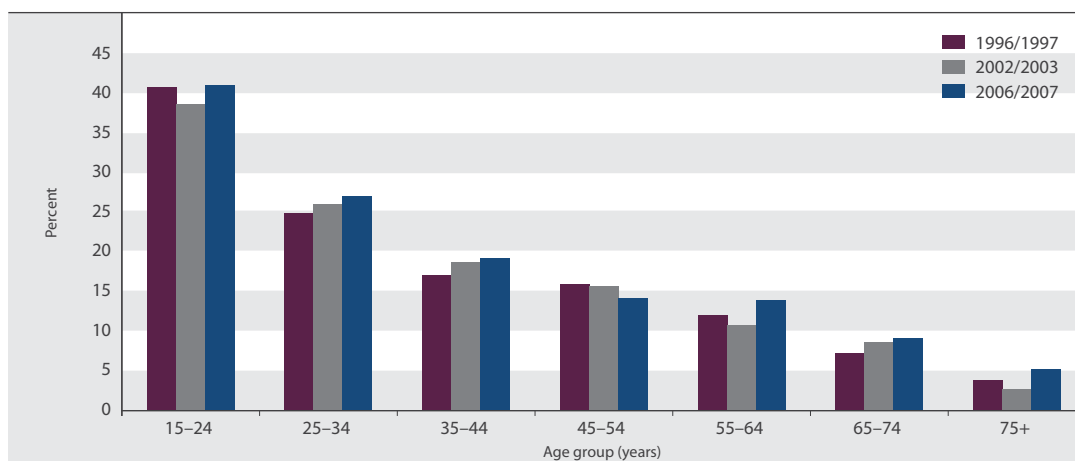
Relevance

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.⁴⁴ Alcohol also contributes to death and injury due to traffic accidents, drowning, suicide, assaults and domestic violence.⁴⁵

Current level and trends

In 2006/2007, 22.9 percent of adult drinkers 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).⁴⁶

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



Source: Ministry of Health

Age and sex differences

For both males and females, the proportion of adult 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 adult drinkers with a potentially hazardous drinking pattern, by age group and sex, 1996/1997, 2002/2003, 2006/2007**

	Age group (years)						
	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

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 adult drinkers, 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

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 adult drinkers 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 percent to 24 percent.

International comparison

Because of the paucity of international data using the AUDIT method of identifying potentially hazardous drinking, this section uses OECD information on annual consumption of alcohol per person aged 15 years and over. New Zealand had the 12th lowest level of alcohol consumption out of 30 OECD countries in 2003–2009, at 9.3 litres per person in 2009. New Zealand's alcohol consumption per person was higher than that of the United States (8.7 litres in 2007) and Canada (8.2 litres in 2009), but lower than that of Australia (10.0 litres in 2007), the United Kingdom (10.8 litres in 2008) and Ireland (12.4 litres in 2008). The OECD median in 2003–2009 was 10.0 litres of alcohol per person.⁴⁷