Wellbeing in Queensland

Report of

The Social Wellbeing Project

The University of Queensland
Institute for Social Science Research
ABN: 63942 912 684

September 2011

Institute for Social Science Research

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This project is funded by the Australian Research Council under LP0775040 "The development and application of a conceptual and statistical framework for the measurement of non-market factors affecting social inequality and social wellbeing" and by Together (the Union formed from the amalgamation of the Queensland Public Sector Union and the Australian Municipal, Administrative, Clerical Services Union, Central and Southern Queensland Branch).

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Acknowledgements: The Project Team would like to acknowledge the support of the 4,000 Queenslanders who responded to our questionnaires and provided the information on which this report is based.

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What is social wellbeing and why is it important?

During the past decade Queensland has experienced a wave of social, economic and environmental change that has had wide-ranging consequences for the wellbeing of individuals and families. These factors have also had a differential impact on quality of life in regions, localities and communities.

In this context, existing economic measures used to assess the impact of social change and to inform policy have proved to be unsuitable for the purpose of assessing individual and societal wellbeing and the strength of community resilience. This is because many of the determinants of social wellbeing are not monetary resources but aspects of people's life circumstances.

Indeed, our approach to social wellbeing rejects the idea that economic growth and material consumption are, of themselves, suitable measures of quality of life. Our measures of wellbeing are derived from survey-based evidence that records what people in Queensland care about and how satisfied they and their families are with the things that they consider important for the quality of their lives.

The Social Wellbeing Project makes a fundamental contribution to a range of increasingly important research and policy questions through the development of alternative measures of the progress of Queensland regions, communities and households. The outcome allows us to monitor and explain socioeconomic trends in cities and regions and provide a nationally recognized evidence base on which to develop policies of importance to the quality of life in Queensland's urban and regional communities.

These key indicators of social and economic progress can help us to better understand which programs, policies, functions, and activities are working and which are not. Key indicators can assist policymakers make necessary policy choices, including facilitating better targeting of government actions, while ensuring the long-term fiscal, social and environmental sustainability of existing and proposed government policies and programs.

3,959 respondents living in Queensland have assisted us to collect information for this study by completing questionnaires distributed in 2008, 2009 and 2010. The survey results, discussed in this report, provide us with reliable measures of Queenslanders' life satisfaction across a number of key domains such as: health, housing, work and leisure, financial security, family and community ties and personal security. More importantly, we are able to show how these measures are affected by a range of factors such as where you live or by your employment circumstances.

What's good and bad about living in Queensland?

In recent times, Queensland communities have witnessed or been subject to major events that have impacted on wellbeing and standards of living:

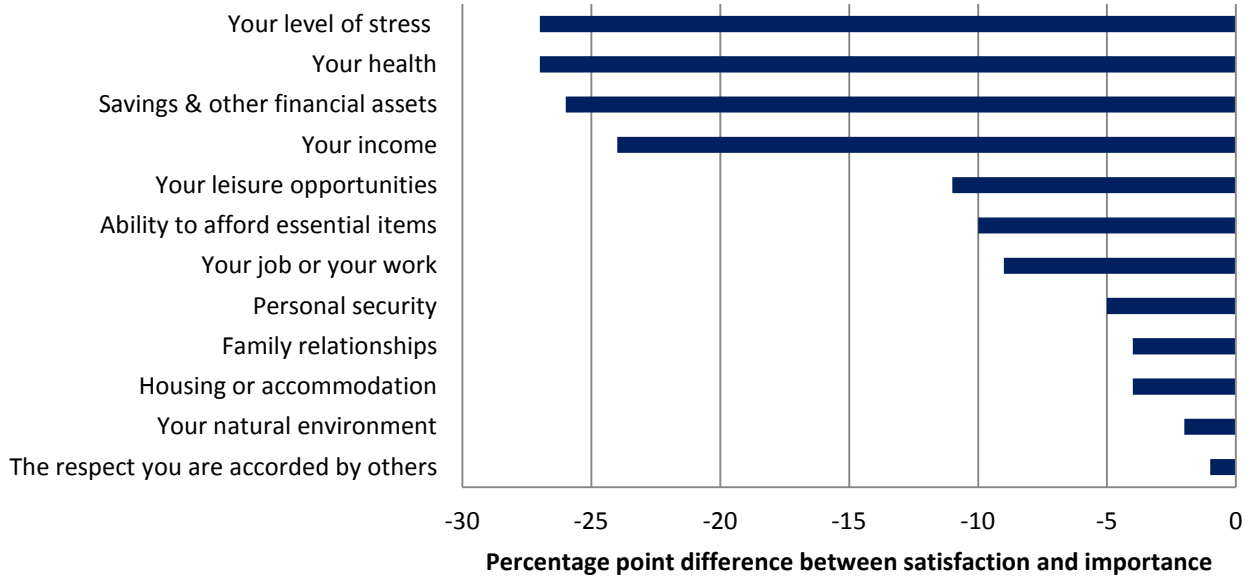
- Population growth (1.8 million 1970 – 4.6 million 2010) has placed considerable pressure on social and economic infrastructure, on public services and on public finances.
- Queensland has recorded the largest population growth rate of any state or territory except Western Australia for each of the past eight years, with average increases in excess of 102,000 people each year from 2004–05 to the present.
- Economic and industrial restructuring and the decline of some industry sectors have had significant consequences for regional economic development and employment security.
- The global financial crisis has had a continuing impact on public and private budgets and on post-retirement incomes.
- Queensland's recent natural disasters have been responsible for significant social impacts and are likely to alter the profile of economic activity in the state in the short to medium term.

Despite these circumstances, most Queenslanders are satisfied with their quality of life. As Figure 1 shows, over 70 percent of Queenslanders were satisfied with seven of the twelve elements that they considered to be most important to their overall social wellbeing. More than 50 percent Queenslanders were satisfied with the remaining five elements. The social wellbeing index, discussed in subsequent sections, is the average score for these twelve elements.

Figure 1: Proportion of respondents who are satisfied with key elements of social wellbeing, 2010

The results portrayed in Figure 1 should not lead to complacency about overall levels of wellbeing in Queensland. This is evident when we analyse the difference between the ratings for importance of each item and the ratings for satisfaction which are depicted in Figure 2. For each item, satisfaction levels were lower than the importance attributed to them. Most noticeable were levels of stress, health, savings, and income, where the satisfaction levels were at least 20 percentage points lower than the importance attributed to that element. In general, these data provide evidence showing where there is a deficit between the aspirations and the realities of peoples' lives.

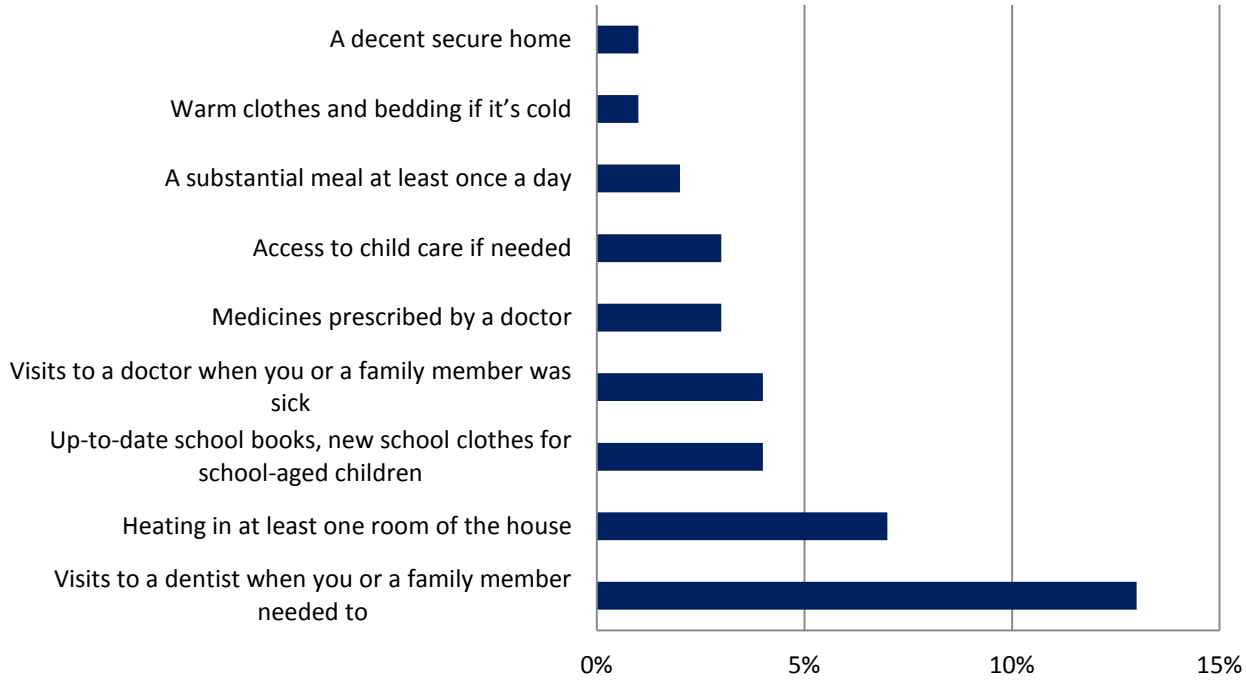
Figure 2: Social wellbeing satisfaction/importance gap, 2010



In addition to social wellbeing, the project focused specifically on a measure of social disadvantage. This enabled us to obtain a clearer focus on the factors associated with the incidence of disadvantage in Queensland. The social disadvantage index[1] comprised responses about whether families were *sometimes* or *most of the time* forced to do without things because they could not afford them, these responses were scored 1 and all other responses (i.e., never or rarely) were scored 0. The nine items included: warm clothes and bedding; a substantial meal once a day; medicines prescribed by a doctor; a decent and secure home; heating in at least one room in the house; school books and new school clothes; visits to a doctor; visits to a dentist; and access to child care. The social disadvantage index, discussed in subsequent sections, is the average score for these nine items. The conclusion supported by this data, and illustrated in Figure 3, is that while most Queenslanders are clearly not disadvantaged, a significant minority of families are struggling to afford social necessities such as medical and dental care.

[1] The social disadvantage measure is adapted from an instrument developed by Professor Peter Saunders from the Social Policy Research Centre at the University of NSW (Saunders, 2011).

Figure 3: Proportion of respondents experiencing disadvantage on key elements of social disadvantage, 2010



What characteristics are associated with wellbeing and disadvantage?

The social wellbeing project collected data on a wide range of demographic and social factors. In this section we report on three of those factors that are associated with the social disadvantage and wellbeing measures outlined above: gender, age, and household structure. Significant differences were found between age and wellbeing and between gender and social disadvantage. However, it should be noted that females had higher wellbeing scores than males until age 55, when males have higher wellbeing than females. Respondents aged 35 to 54 years old have the lowest wellbeing and reported higher social disadvantage than the other age groups (Table 1). One explanation for the lower scores would be that a high number of these respondents have children under the age of 18 years of age living in the home. Of the 626 respondents who indicated that they had children under the age of 18 years of age living in their home (See Table 2), 77% fell in the 35 to 54 years age band. Previous research has found that parents with children living in the home have lower wellbeing than non-parents (Ross, Mirowsky, & Goldsteen, 1990). A possible explanation could be that having children in the home increases economic hardship and decreases emotional support spouses would otherwise have provided to each other. The possible economic strain on the family due to the presence of children is particularly prevalent in single-parent families (McLanahan & Adams, 1987; Ross & Huber, 1985). When we examine the results in terms of household structure (Tables 3 and 4) we find that single parents with children under 18 years of age living at home, have the lowest wellbeing scores and this decreases substantially if they are single fathers. Single parent households with children under 18 years of age comprise 16 percent of the households with children under 18 years of age; this is aligned to findings by the (Australian Bureau of Statistics, 2011c). Gender differences were found only for respondents living alone and couples with no children.

Table 1: Social wellbeing and disadvantage (mean index scores) by age and gender, 2010

18-34 year olds	Male	Female	Total
Social Wellbeing [2]	5.08	5.16	5.13
Social Disadvantage [3]	0.04	0.05	0.04
35-54 year olds	**Male**	**Female**	**Total**
Social Wellbeing	4.98	5.08	5.05
Social Disadvantage	0.05	0.07	0.06
55+	**Male**	**Female**	**Total**
Social Wellbeing	5.43	5.40	5.41
Social Disadvantage	0.02	0.06	0.04
Total all age groups	**Male**	**Female**	**Total**
Social Wellbeing	5.24	5.23	5.24
Social Disadvantage	0.03	0.06	0.05

Table 2: Household structure by age categories, 2010

Household structure	18-34 (%)	35-54 (%)	55+ (%)	Total
Lone person	11	82	288	381
	(7.6)	(9.7)	(28.4)	(19.0)
Couple with no children	39	179	578	796
	(27.1)	(21.3)	(56.9)	(39.8)
Couple with children under 18 years of age	79	414	48	541
	(54.9)	(49.2)	(4.7)	(27.0)
Single parent children under 18 years of age	9	68	8	85
	(6.3)	(8.1)	(0.8)	(4.2)
Couple with children 18+ years of age	5	84	63	152
	(3.5)	(10.0)	(6.2)	(7.6)
Single parent children 18+ years of age	1	15	30	46
	(0.7)	(1. 8)	(3.0)	(2.3)
Total	**144**	**842**	**1,015**	**2001**
	(100)	**(100)**	**(100)**	**(100)**

[2] Social wellbeing mean scores range from 1 (low) -7 (high).

[3] Social disadvantage mean scores range from 0 (low) -1 (high).

Table 3: Social wellbeing (mean index scores[4]) by household structure and gender, 2010

Household structure	Male	Female
Lone person	5.20	5.19
Couple with no children	5.44	5.39
Couple with children under 18 years of age	5.06	5.15
Single parent children under 18 years of age	4.09	5.02
Couple with children 18+ years of age	5.34	5.23
Single parent children 18+ years of age	4.73	5.24

Table 4: Social wellbeing (mean index scores) by household structure and age, 2010

Lone person	18-34	35-54	55+
Lone person	4.96	4.85	5.30
Couple with no children	5.29	5.10	5.52
Couple with children under 18 years of age	5.11	5.13	4.95
Single parent children under 18 years of age	5.13	4.87	4.53
Couple with children 18+ years of age	4.93	5.20	5.42
Single parent children 18+ years of age	*[5]	4.86	5.33

As illustrated in Figure 4, single parents with children under 18 years of age, living in their household, have the lowest wellbeing, while couples with no children experience the highest wellbeing. In exploring social disadvantage by family type (Figure 5) shows that single parents with children living in their household are significantly more disadvantaged than other family types. Couples with no children seem to be the least disadvantaged of the family types. Reviewing these results, shows that couple households that do not have children of any age living in the household have higher wellbeing and lower disadvantage. While couples with children under 18 years of age living at home have low wellbeing, they indicated low levels of disadvantage. Single parents with children living at home, have low wellbeing and high disadvantage. However, it should be noted that, in general, the survey indicated that respondents reported low levels of disadvantage, with a score of zero indicating no disadvantage and one indicating disadvantage.

[4] Social wellbeing mean scores range from 1 (low) -7 (high).

[5] Number of respondents in this category is too low to allow statistically significant findings.

Figure 4: Social wellbeing (mean index score) by household structure, 2010

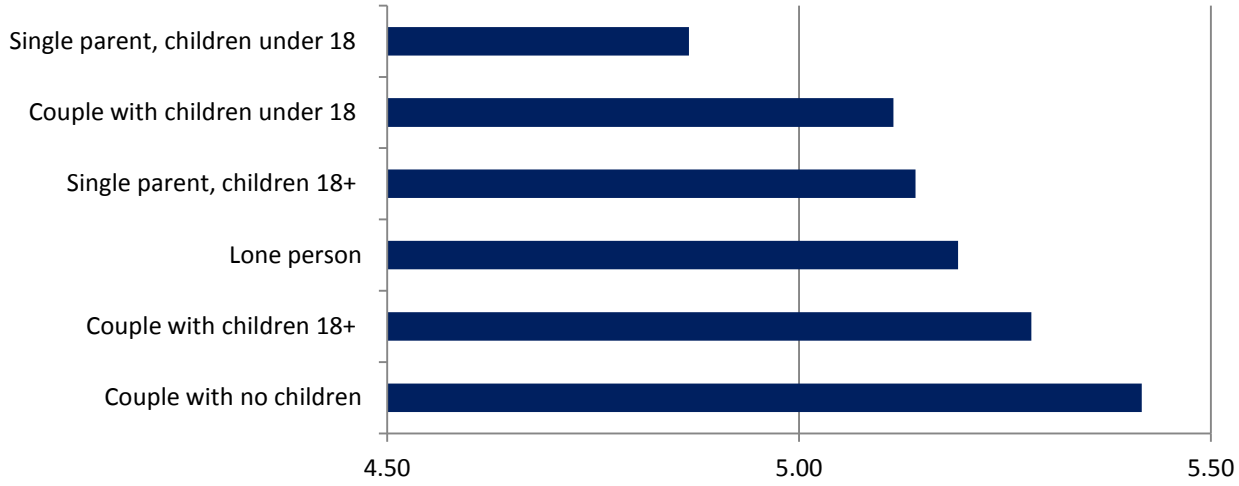
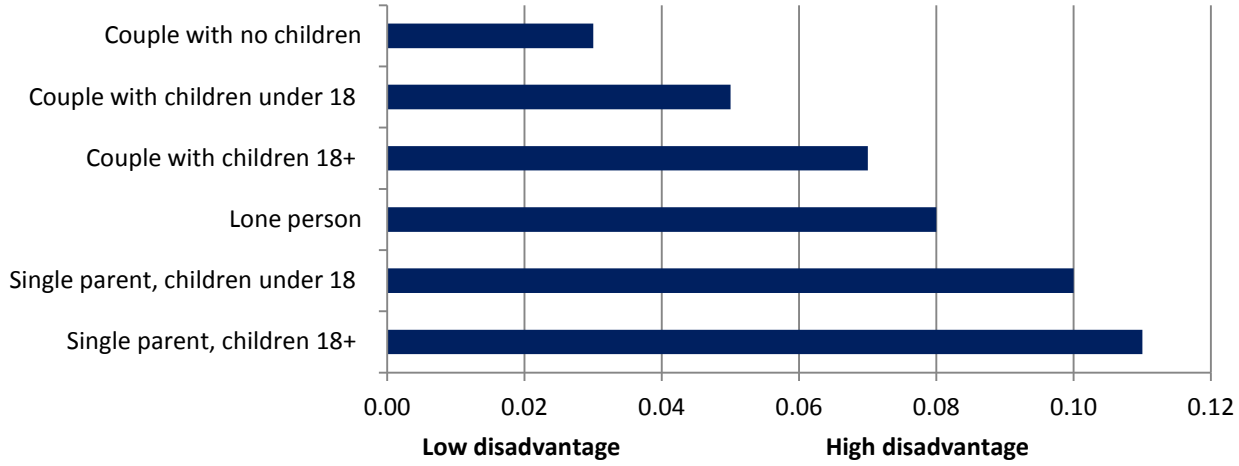


Figure 5: Social disadvantage (mean index score) by household structure, 2010



When we review the relationships between social wellbeing and household type (Table 5) we note that single parents with children under 18 years of age living in the household have the lowest satisfaction ratings for seven out of the twelve elements of wellbeing. These are specifically: stress; housing; income; ability to afford essential items; savings; personal security; and leisure opportunities. Single parents with children 18 years and older living in the household had the lowest satisfaction ratings for health. Respondents living on their own had the lowest satisfaction ratings for their job, family relationships, the respect accorded by others, and the natural environment.

Table 5: Proportion of respondents who are satisfied with key elements of social wellbeing by household structure, 2010

Social wellbeing elements	Lone %	Couple no children %	Couple child U18 %	Single child U18 %	Couple child 18+ %	Single child 18+ %
Your health	59.6	66.0	66.7	71.8	68.2	58.7
Your level of stress	55.5	57.3	49.6	40.5	45.7	50.0
Housing or accommodation	83.2	89.9	82.3	75.0	88.0	82.6
Your income	57.5	65.9	66.1	50.6	65.8	56.5
Ability to afford essential items	69.8	79.0	80.0	63.5	76.2	73.9
Savings & other financial assets	54.8	64.5	56.4	43.5	62.7	46.7
Your job or your work	57.1	57.2	68.7	63.9	71.4	59.0
Family relationships	80.3	89.2	88.8	83.3	88.6	86.7
Personal security	79.2	83.1	85.3	77.7	91.3	82.2
The respect you are accorded by others	74.9	81.3	76.5	75.3	75.5	82.6
Your natural environment	80.1	84.0	82.6	84.7	85.2	84.8
Your leisure opportunities	71.6	75.3	66.7	64.7	75.5	65.2

Table 6 shows that the most disadvantaged households are individuals living on their own and single parent households. Lone parent households had higher levels of disadvantage for the following elements: a substantial meal at least once a day; a decent secure home; and heating in at least one room of the house. Single parents with children under the age of 18 years, had higher levels of disadvantage for the following elements: warm clothes and bedding if it's cold; up-to-date school books; new school clothes for school-aged children; visits to a doctor when you or a family member was sick; and access to child care if needed. Overall, single parent households reported higher levels of disadvantage especially with respect to being able to afford medicines prescribed by a doctor and dental visits.

Table 6: Proportion of respondents experiencing disadvantage on key elements of social disadvantage by household structure, 2010

Forced to go without sometimes/most of the time in the last 12 months	Lone %	Couple no children %	Couple child U18 %	Single child U18 %	Couple child 18+ %	Single child 18+ %
Warm clothes and bedding if it's cold	3.3	0.5	0.6	3.8	0.8	2.4
A substantial meal at least once a day	3.8	0.9	1.2	2.4	2.3	0.0
Medicines prescribed by a doctor	5.5	1.0	2.4	8.4	5.3	9.1
A decent secure home	2.6	0.4	1.2	1.2	0.0	0.0
Heating in at least one room of the house	9.9	5.5	4.9	9.6	7.6	7.3
Up-to-date school books, new school clothes for school-aged children	3.2	0.8	3.7	11.8	5.4	9.5
Visits to a doctor when you or a family member was sick	5.8	2.0	3.8	8.3	5.3	4.9
Visits to a dentist when you or a family member needed to	14.3	8.5	13.0	25.6	10.4	28.6
Access to child care if needed	2.3	0.5	3.7	13.3	2.4	0.0

Does where you live affect your wellbeing?

Queensland has a diverse and dispersed population in which location has a significant impact on social wellbeing and social disadvantage. Regional differences in the cost of living clearly affect the standard of living of households in different locations (Curran, Wolman, Hill, & Furdell, 2008; Sorensen, 2000).

In this section we examine spatial factors that are associated with wellbeing and social disadvantage.

The regions have been grouped into six, namely Fitzroy-Darling Downs, Northern (including Mackay and Cairns), Remote, South East Queensland (SEQ), Ipswich SSD and West Moreton SD, and Wide Bay-Burnett.

As can be seen in Table 7, individuals who reside in the Ipswich SSD and West Moreton SD region had the lowest satisfaction levels for seven of the twelve wellbeing elements. Other regions that had low satisfaction levels for certain elements of wellbeing were the Wide Bay-Burnett region (savings and other financial assets and their family relationships), Northern region (personal security), and Fitzroy-Darling Downs (respect accorded by others and leisure opportunities).

Individuals residing in the South East Queensland region had the highest satisfaction levels for seven of the twelve elements of wellbeing. Other regions that had high satisfaction levels for certain elements of wellbeing were Remote (stress and personal security), Wide Bay-Burnett (income and natural environment), and Northern region (work).

Table 7: Proportion of respondents who are satisfied with key elements of social wellbeing by region, 2010

Social wellbeing elements	Fitzroy-Darling Downs %	Northern (incl Mackay & Cairns) %	Remote %	SEQ %	Ipswich SSD & West Moreton SD %	Wide Bay-Burnett %
Your health	62.0	61.9	65.8	67.8	56.6	60.8
Your level of stress	45.0	51.0	56.6	55.3	42.7	51.3
Housing or accommodation	83.3	86.1	85.5	86.5	79.0	82.5
Your income	63.2	62.2	62.5	63.2	55.9	63.3
Ability to afford essential items	76.0	75.1	76.4	77.4	65.5	72.2
Savings & other financial assets	57.3	59.3	58.1	60.0	53.9	53.1
Your job or your work	61.1	69.6	67.9	61.5	53.2	57.1
Family relationships	88.0	84.1	87.3	88.3	83.8	82.8
Personal security	83.3	75.9	87.6	84.1	77.5	83.5
The respect you are accorded by others	71.9	78.4	77.5	78.9	78.3	78.2
Your natural environment	80.3	82.2	84.4	83.2	76.9	86.0
Your leisure opportunities	64.6	71.3	70.0	73.8	69.2	68.9

Social disadvantage is spread across four of the six regions (Table 8). Individuals from the following regions had the highest scores for specific elements of social disadvantage: Wide Bay-Burnett (substantial meal; decent secure home; school books and clothes; doctor visits); Ipswich SSD and West Moreton SD region (medicines; dentist visits; and child care); Remote (warm clothes and bedding); and Fitzroy-Darling Downs (heating in the home). Individuals living in the Northern region followed by those living in South East Queensland appear to be the least disadvantaged.

Table 8: Proportion of respondents experiencing disadvantage on key elements of social disadvantage by region, 2010

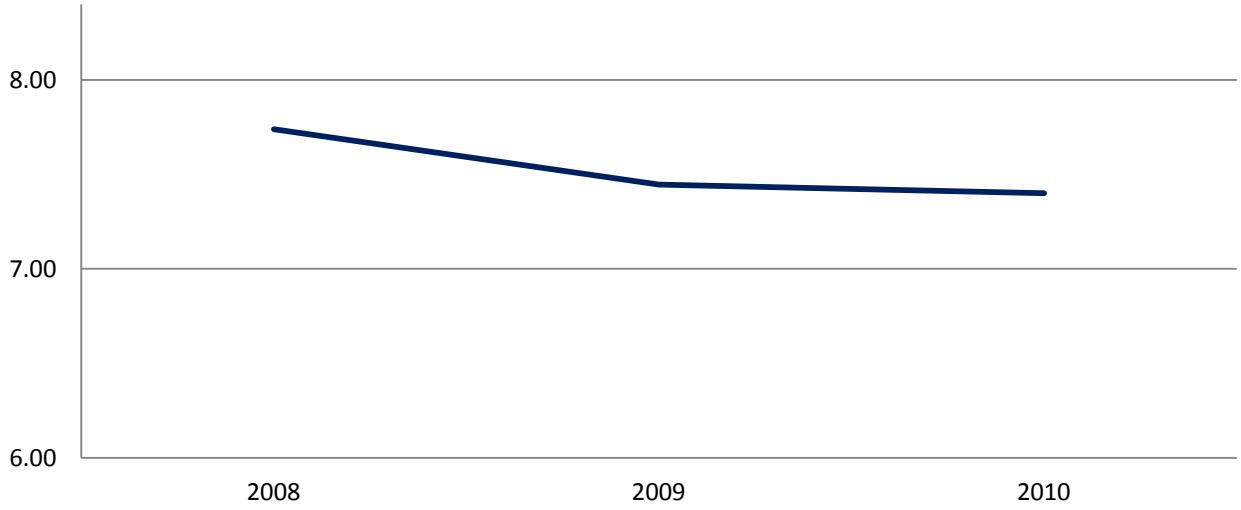
Forced to go without sometimes/most of the time in the last 12 months	Fitzroy-Darling Downs %	Northern (incl Mackay & Cairns) %	Remote %	SEQ %	Ipswich SSD & West Moreton SD %	Wide Bay-Burnett %
Warm clothes and bedding if it's cold	1.2	0.0	3.7	1.1	1.6	0.6
A substantial meal at least once a day	1.8	0.0	2.8	1.6	0.8	3.5
Medicines prescribed by a doctor	1.8	0.0	4.1	3.4	5.6	4.1
A decent secure home	0.0	0.5	2.1	0.8	1.6	2.4
Heating in at least one room of the house	9.2	0.7	5.8	6.9	8.3	6.4
Up-to-date school books, new school clothes for school-aged children	4.2	0.9	4.9	3.2	6.5	8.8
Visits to a doctor when you or a family member was sick	4.2	1.6	4.9	3.7	5.6	7.6
Visits to a dentist when you or a family member needed to	12.9	9.8	14.3	12.0	17.1	14.7
Access to child care if needed	3.0	5.6	3.8	2.0	6.7	1.4

Are things getting better or worse?

The first wave of the survey was implemented around the time of the global financial crisis. Due to the financial crisis, households borrowed less to cut their debt, which meant less money was available to spend on goods and services, and ultimately led to cuts in production and job losses. This in turn prompted individuals to save more in fear of being made redundant and having a significantly reduced income. The Australian Bureau of Statistics (ABS) noted an economic downturn in the Australian economy (although mild in strength and severity) in late 2008 to early 2009, which was triggered by the global financial crisis. The ABS defines an economic downturn as typically being characterised by falling employment, rising unemployment and a decrease in the labour force participation rate (Australian Bureau of Statistics, 2011a). To explore some of the effects of the global financial crisis on individuals in the sample, we reviewed people's satisfaction with their standard of living and their levels of disadvantage over the period 2008-2010.

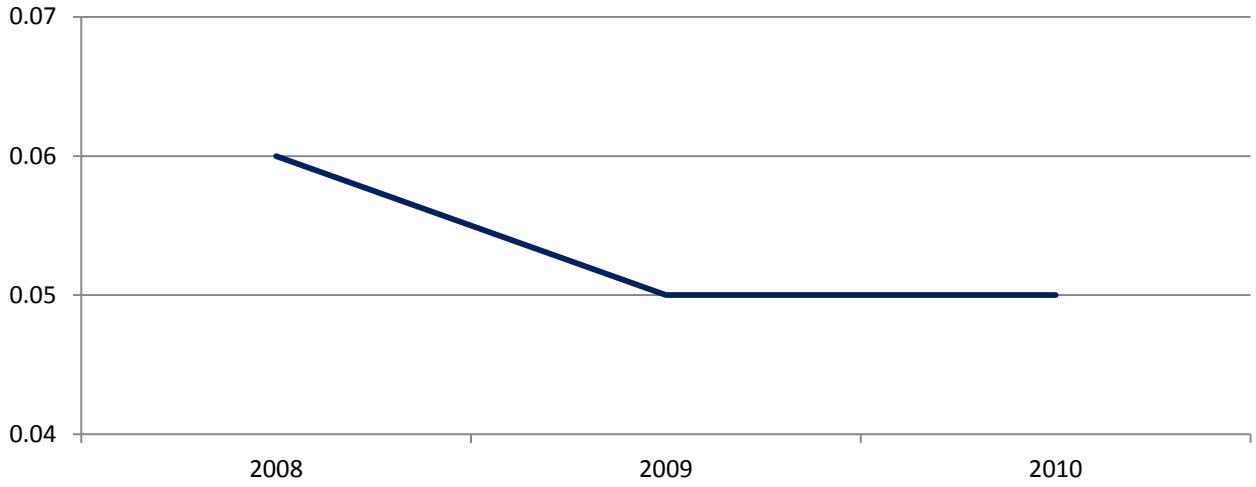
As illustrated in Figure 6, there has indeed been a decrease in satisfaction with standards of living between 2008 and 2010. The differences between Waves 1 and 2 and Waves 1 and 3 were small but statistically significant, as were the differences observed for individuals. Satisfaction with overall standard of living was a single item, with scores that ranged from 0 to 10, with 10 representing complete satisfaction.

Figure 6: Satisfaction with overall standard of living (mean score), 2008-2010



While the respondents indicated less satisfaction at the end of the three year period, they also reported lower levels of social disadvantage in 2010 compared with 2008 (Figure 7). There were no statistically significant differences found in this measure across the three years. Social disadvantage is an index which is comprised of 9 items, with the mean score for this index ranging from zero (no social disadvantage) to one (social disadvantage).

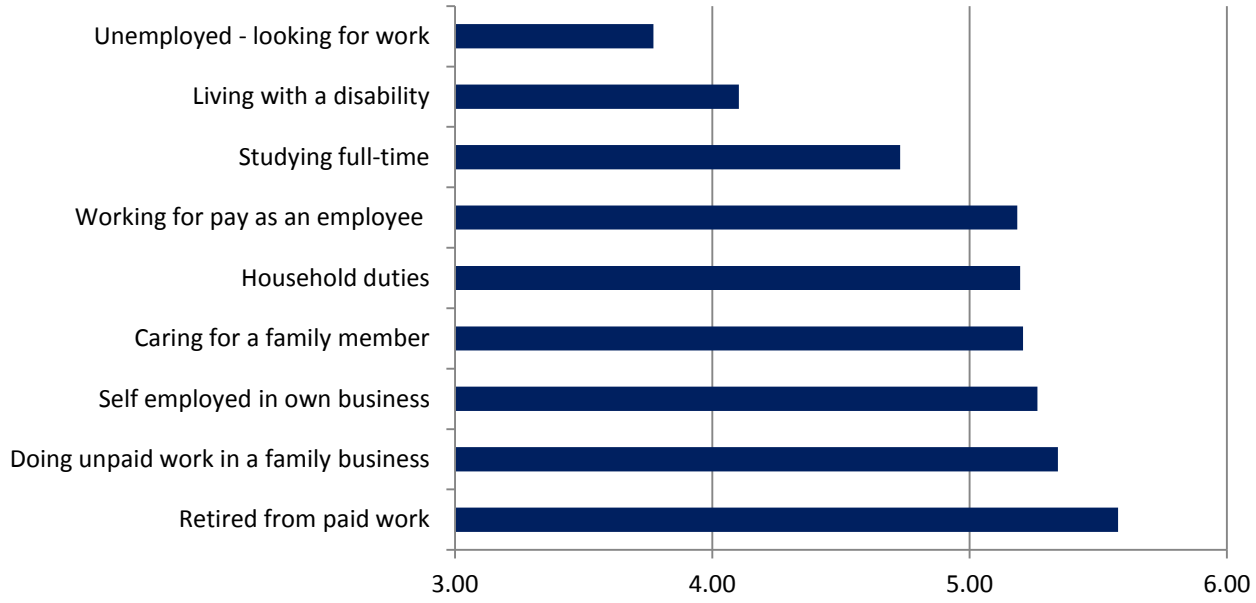
Figure 7: Social disadvantage (mean score), 2008-2010



How is wellbeing affected by employment?

A great deal of previous research has shown that unemployed individuals have poorer levels of wellbeing (Andersen, 2009; Creed, 1999; Creed & Machin, 2002; Winkelmann & Winkelmann, 1998). Employment status may have two important functions for the individual, it fulfils basic psychological needs, such as social contact, personal and social identity, and provides meaning (Nordenmark & Strandh, 1999); however, it is important to bear in mind that individuals who are voluntarily unemployed may achieve these needs through other means, such as parenting, volunteer work and so forth. Taking this into consideration, unemployment may affect individuals and the household unit on financial, personal and social levels (Slee, 2006). In this study, we found that respondents who were unemployed reported significantly lower wellbeing scores (Figure 8). Individuals living with a disability also reported significantly lower wellbeing scores. Being retired from paid work indicated significantly higher wellbeing scores. The social wellbeing index scores range between 1 (low wellbeing) and 7 (high wellbeing).

Figure 8: Social wellbeing (mean index score) by main activity 2010

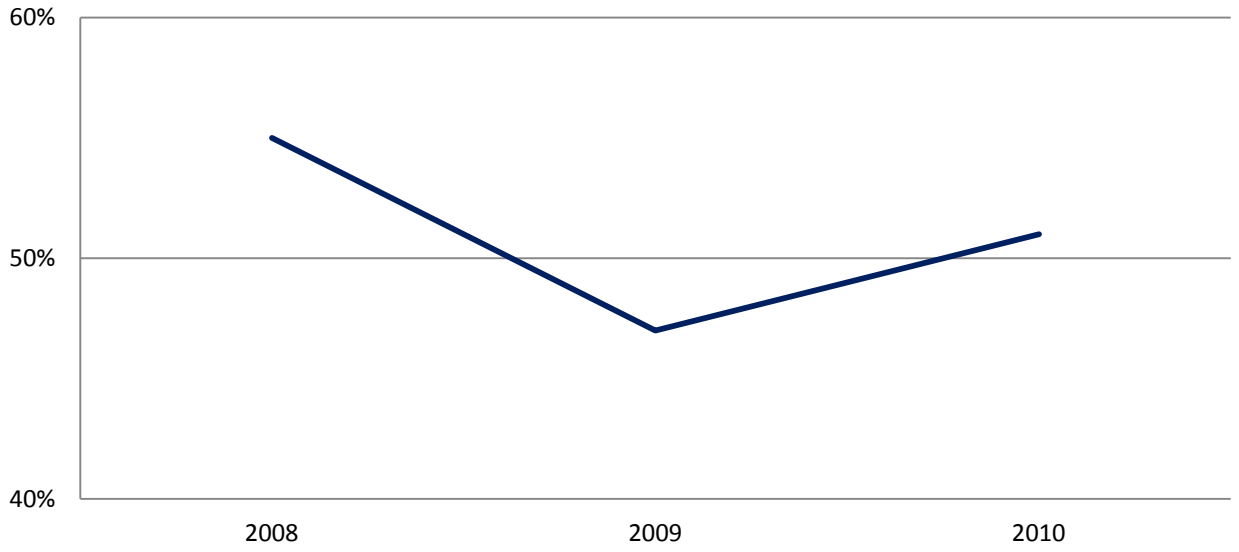


As reported in Table 9, respondents seemed more concerned about job security in 2008 and 2009. The proportion of respondents who indicated that the security of their job depended on working extra hours, halved between 2008 and 2010. These findings could be explained by a shift in thinking, in that job security, due to the financial crisis, could now have an external locus of control and job loss is more likely to occur if business declines. A fairly high percentage of respondents in 2008 and 2009 indicated that it was likely that a family member in the household would lose employment in the next twelve months. However, by 2010, fewer respondents were concerned about a job loss in the household. This trend is also seen in Figure 9, where 55 percent of the respondents in 2008 indicated that there was zero percent chance of them losing their job, while in 2009 this percentage dropped to 47 percent, indicating that respondents were feeling less confident about job security. In 2010, a slight rise in confidence is evident but not to the levels observed in 2008.

Table 9: Job insecurity, 2008-2010 (percentage)

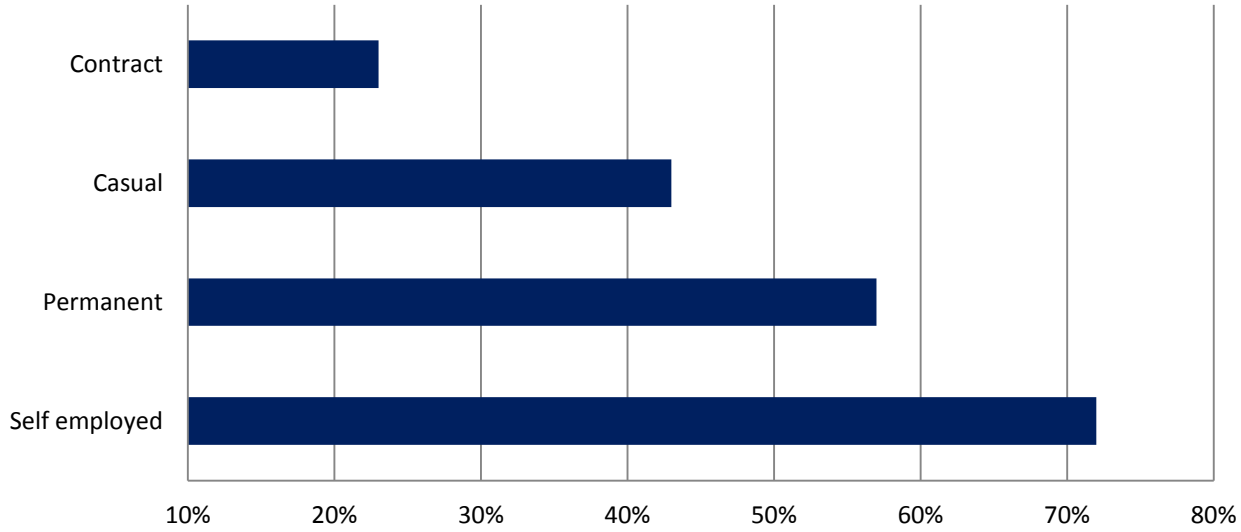
Job insecurity	2008 %	2009 %	2010 %
The security of the job depends on regularly working extra hours	15.6	13.3	8.2
My employer regularly puts off people if business declines	15.5	16.6	13.4
Some family members in my household are likely to lose their jobs in the next 12 months (i.e., get retrenched/ fired/ not have a contract renewed)	14.1	14.8	9.8

Figure 9: Proportion of respondents who indicated they had no chance of losing their job, 2008-2010



When we consider reported job security by employment category (Figure 10), we find that only 23 percent of respondents employed on a contract basis in 2010 indicated that there was a zero chance of their losing their job in the next 12 months. Self employed and permanent employees have a higher perceived job security.

Figure 10: Proportion of respondents who indicated they had no chance of losing their job by employment category, 2010



A number of indices were created to portray the quality of work - life experienced by Queenslanders. These were job insecurity, job satisfaction, job stress and job flexibility. These measures were all on a 5-point scale ranging from 1 (low) to 5 (high). Job insecurity recorded whether respondents had to work extra hours to secure their job, if their employer laid off staff when business declined, and whether family members in the household were likely to lose their jobs in the next 12 months. Job satisfaction was a single item. Job stress was comprised of three items: heavy workload; problems at work affecting health; and demands of the job causing stress. Job flexibility comprised four items: flexible work hours; ability to take a day off at full pay; ability to take a day off unpaid; and being able to start work late or leave early occasionally.

As shown in Table 10, individuals with lower job insecurity and job related stress and higher job satisfaction reported significantly higher levels of wellbeing. No significant differences in terms of job flexibility were observed for individuals with either low or high wellbeing.

Table 10: Quality of work life indices (mean index scores) by social wellbeing category, 2010

Quality of work life indices	High wellbeing [6]	Low wellbeing [7]
Job insecurity	2.06	2.47
Job Satisfaction	3.63	2.98
Job Stress	2.31	2.71
Job Flexibility	3.28	3.34

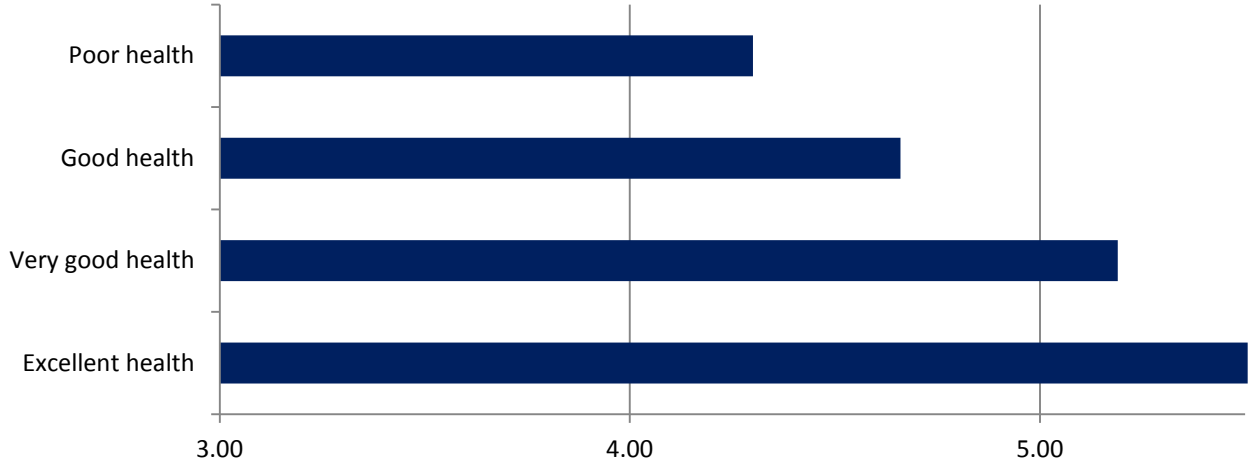
[6] High wellbeing – social wellbeing scores of 5 or higher on a 1-7 scale.

[7] Low wellbeing – social wellbeing scores of less than 5 on a 1-7 scale.

How does health affect wellbeing?

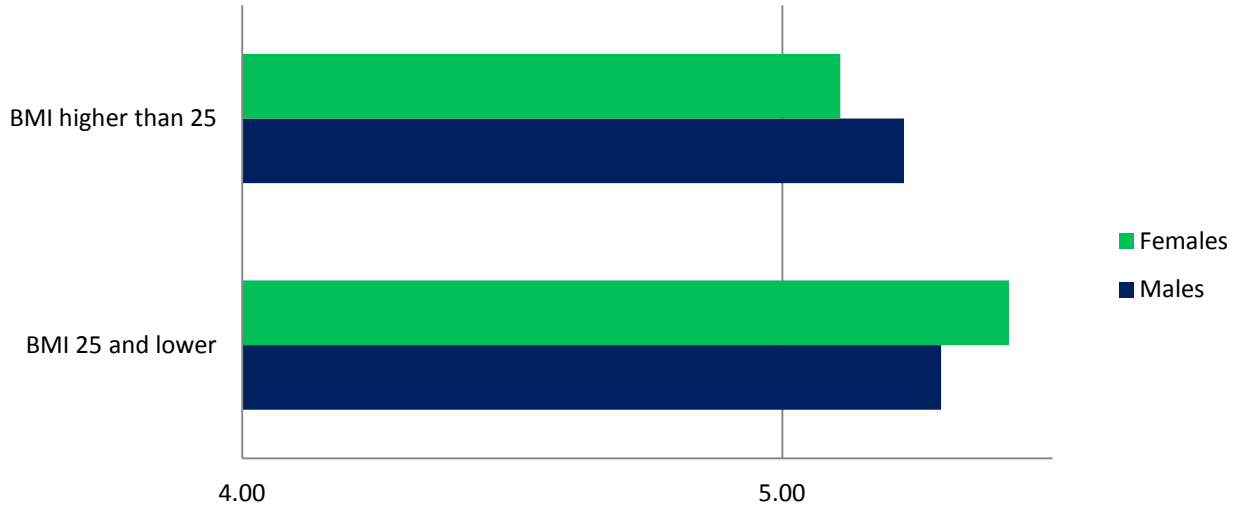
Health has been shown to be strongly associated with wellbeing. “Health is a key component of individual and social wellbeing [and]...the health of a population is a key driver of labour and capital investment and consequent economic growth” (Wilkie & Young, 2009, p. 57). Investment in health can also have a significant effect on economic development (Bloom & Canning, 2000; Bloom, Canning, & Sevilla, 2004; Fogel, 2004). Good health contributes to economic performance and is positively associated with individual wellbeing (Bloom & Canning, 2000; Bloom & Canning, 2005; Hsiao & Heller, 2007). The measure used for this variable, asked respondents to rate their health on a five point scale ranging from poor to excellent. The distribution of the responses we have used below defines health status as poor to fair health, good health, very good health, and excellent health. As illustrated in Figure 11, the poorer was reported health, the lower were wellbeing scores. This confirms that the important relationship between health and social wellbeing is prevalent in Queensland.

Figure 11: Social wellbeing (mean index score) by health, 2009



The relationship between weight and health is also widely acknowledged. According to the Australian Bureau of Statistics, one in four Australians aged 18 years and over were obese in 2007-08. Since 1995, the rate of obesity has risen from 19% to 24%, with men gaining weight faster than women (2011b). Excess weight has strong associations with health problems such as heart disease, Type II diabetes, high blood pressure and stroke. One measure commonly used to measure overweight status and obesity is the Body Mass Index (BMI). The BMI represents a relationship between weight and height that is associated with body fat, nutritional status and health risk. A BMI of 25 or less is considered to be healthy, while a BMI higher than 25 is considered overweight or obese. In this sample, 62 percent have a BMI higher than 25 and 27 percent fall in the obese range. In 2009, a higher proportion of males (68%) as compared to females (59%) have a BMI higher than 25. In Figure 12, we review the respondents’ wellbeing by the two BMI categories and observe that the wellbeing of females seems to be more affected by a BMI higher than 25.

Figure 12: Social wellbeing (mean index score) by Body Mass Index and gender, 2009



When asked to indicate if they were underweight, just right or overweight, 48 percent of the sample reported that they were overweight and 7 percent indicated that they were very overweight, which is lower than when we use BMI. Tables 11 and 12 report these findings across regions for self reported weight and BMI. These results seem to indicate that a lower proportion of the sample sees themselves as obese (7%) when compared to the proportion that would be classified as obese using BMI (27%). There were no noticeable differences found across regions.

Table 11: Proportion of respondents in each self reported weight category by region, 2009

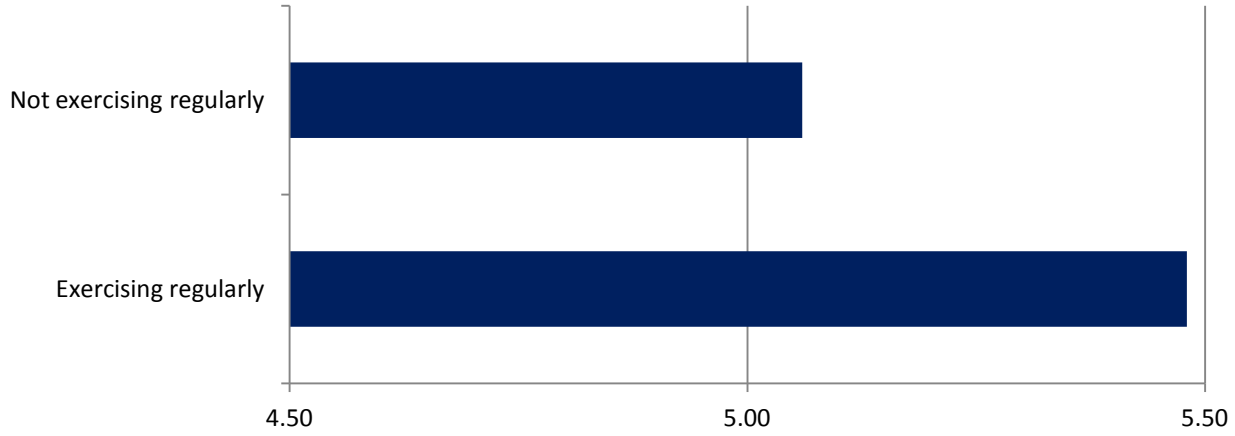
Self reported weight	Fitzroy-Darling Downs %	Northern (incl Mackay & Cairns) %	Remote %	SEQ %	Ipswich SSD & West Moreton SD %	Wide Bay-Burnett %
Very underweight	0.0	0.0	0.0	0.4	0.0	0.0
Underweight	1.6	1.5	1.2	2.4	2.1	2.5
Just about right weight for you	47.7	41.1	40.0	43.7	34.0	43.6
Overweight	41.5	50.2	49.7	47.3	54.9	46.7
Very overweight	9.2	7.2	9.1	6.2	9.0	7.2

Table 12: Proportion of respondents in each Body Mass Index category by region, 2009

Body Mass Index	Fitzroy-Darling Downs %	Northern (incl Mackay & Cairns) %	Remote %	SEQ %	Ipswich SSD & West Moreton SD %	Wide Bay-Burnett %
Under 18 - you are very underweight and possibly malnourished	0.5	1.0	0.0	1.1	0.7	0.5
Under 20 - you are underweight and could afford to gain a little weight	3.3	4.0	4.4	3.9	0.7	3.7
20 to 25 - you have a healthy weight range for young and middle-aged adults	29.1	27.2	34.4	34.4	26.8	37.0
26 to 30 - you are overweight	40.7	32.7	33.1	36.6	35.5	28.6
Over 30 - you are obese	26.4	35.1	28.1	24.0	36.3	30.2

Physical activity also contributes to good health as it helps to increase vitality, raise beneficial cholesterol levels and increase the metabolic rate, making it easier to burn stored fat for fuel. As illustrated in Figure 13, respondents who exercised regularly had significantly higher wellbeing.

Figure 13: Social wellbeing (mean index score) by physical exercise, 2009



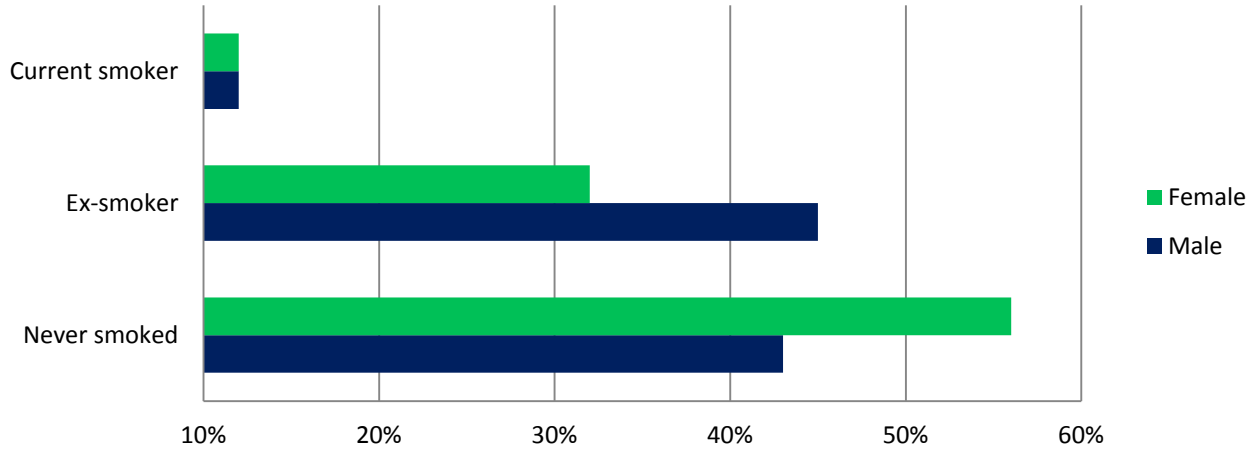
Smoking is viewed as the single most common cause of preventable deaths, estimated at around 15,000 per annum (Begg et al., 2007; Collins & Lapsley, 2007). Smoking is an important risk factor for the three diseases that cause most deaths in Australia: heart disease, stroke and lung cancer. About half (53%) the respondents in this survey have never smoked, 35 percent are ex-smokers and 12 percent currently smoke. Reviewing these results across regions, the highest proportion of current smokers can be seen in the Wide Bay-Burnett and Northern regions.

Table 13: Proportion of respondents in each smoker status category by region, 2009

Smoking Status	Fitzroy-Darling Downs %	Northern (incl Mackay & Cairns) %	Remote %	SEQ %	Ipswich SSD & West Moreton SD %	Wide Bay-Burnett %
Never smoked	53.3	50.5	50.3	53.5	58.3	47.2
Ex-smoker	36.5	34.0	35.8	35.0	29.9	35.9
Current smoker	10.2	15.5	13.9	11.5	11.8	16.9

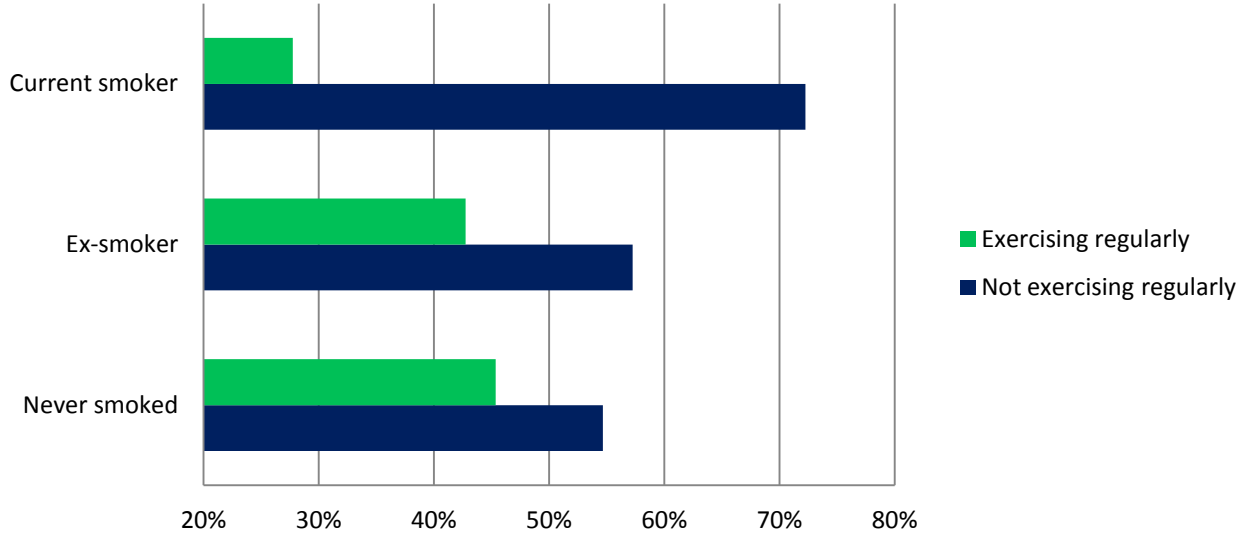
According to the ABS (2011b), smoking seems to increase the metabolism and reduce food intake, thus often people tend to gain weight after they quit smoking. As illustrated in Figure 14, only a small proportion of current smokers fall into the overweight or obese category, while a higher proportion of male ex-smokers are classified as obese as compared to those who currently smoke or never smoked. While these findings are similar to those reported by the ABS, we cannot determine from this analysis a causal effect. Although being overweight is prevalent in both non-smokers and ex-smokers, it may be useful for health initiatives to consider ways to reduce the effect quitting smoking may have on weight.

Figure 14: Proportion of overweight or obese respondents by smoker status and gender, 2009



According to the Australian Bureau of Statistics (2006), smokers tend to have higher alcohol consumption, lower daily fruit and vegetable intake and lower levels of exercise than ex-smokers and non-smokers. As illustrated in Figure 15, 72 percent of the current smokers are not exercising regularly.

Figure 15: Exercise by smoker status, 2009 (Percentage)



As reported in Tables 14 and 15, inaccessibility to health services and facilities is more acute for individuals who live in remote areas. For most regions there appears to be an improvement between 2009 and 2010 in that a lower percentage of respondents reported that these health services and facilities were inaccessible.

Table 14: Proportion of respondents in 2009 (taking into account their personal circumstances) that indicated that health services and facilities are inaccessible, by region

Health services and facilities	Fitzroy-Darling Downs %	Northern (incl Mackay & Cairns) %	Remote %	SEQ %	Ipswich SSD & West Moreton SD %	Wide Bay-Burnett %
Doctor	7.1	4.8	7.9	1.4	1.4	4.1
Community health centre	12.9	7.4	13.1	9.4	14.4	11.0
Doctor in a public hospital	16.1	18.3	13.3	10.6	14.6	9.9
Medical specialist (e.g. Gastroenterologist)	37.0	23.2	53.3	10.2	26.2	28.0
Counselling services	14.5	9.2	25.6	7.7	16.3	11.2
Other health professionals (e.g. Physiotherapist)	10.9	9.0	22.0	3.4	9.6	9.0
On-line services and health websites	8.1	9.2	15.7	5.9	4.9	6.2
Dentist	18.3	13.8	25.3	4.4	7.2	20.6
Optometrist	8.9	4.5	15.5	2.4	3.6	5.4

Table 15: Proportion of respondents in 2010 (taking into account their personal circumstances) that indicated that health services and facilities are inaccessible, by region

Health services and facilities	Fitzroy-Darling Downs %	Northern (incl Mackay & Cairns) %	Remote %	SEQ %	Ipswich SSD & West Moreton SD %	Wide Bay-Burnett %
Doctor	10.4	1.9	7.5	0.7	0.7	6.7
Community health centre	16.5	5.9	11.9	7.9	10.4	10.1
Doctor in a public hospital	13.6	10.3	16.6	10.2	8.3	14.5
Medical specialist (e.g. Gastroenterologist)	34.6	19.9	47.2	8.1	20.8	31.6
Counselling services	20.6	10.8	31.0	7.1	13.9	17.0
Other health professionals (e.g. Physiotherapist)	13.0	5.8	22.6	2.7	6.9	11.5
On-line services and health websites	9.6	3.9	12.3	5.9	7.4	6.9
Dentist	17.9	10.1	27.0	3.5	7.1	14.9
Optometrist	7.4	3.0	18.1	2.1	3.6	5.9

According to the results reported in Table 16, individuals who do not have access to health services and facilities have lower wellbeing than individuals who do have access.

Table 16: Social wellbeing (mean index score) by accessibility of services and facilities, 2010

Health services and facilities	Not accessible	Accessible
Doctor	4.86	5.25
Community health centre	4.69	5.28
Doctor in a public hospital	4.63	5.29
Medical specialist (e.g. Gastroenterologist)	4.80	5.33
Counselling services	4.70	5.25
Other health professionals (e.g. Physiotherapist)	4.62	5.28
On-line services and health websites	4.70	5.25
Dentist	4.74	5.30
Optometrist	4.67	5.27

How does housing affect wellbeing?

The World Health Organization (WHO) (Bonnefoy, 2007) defines housing as being based on four interlinked levels, with an array of possible health effects in each:

i) home - a protective, safe and intimate refuge where one develops a sense of identity and attachment;
ii) dwelling conditions - the physical structure, efficiency of heating or cooling systems, mould growth, crowding and noise exposure;
iii) community - the quality of the neighbourhood and its relation to social cohesion, social interactions, sense of trust and collective efficacy; and
iv) immediate environment - the quality of urban design (e.g., public services, playgrounds, green space, parks, places to socialise).

Adequate housing is dependent on the sufficient provision of services and conditions in all four domains. Housing is one of the basic needs for families and the costs involved are among the highest ongoing expenses that families will incur in their lifetime. Research has found that while income has doubled in the years 1985 to 2004, there has been a fourfold increase in house prices in that time (National Centre for Social and Economic Modelling, 2008). Thus, home ownership is becoming increasingly out of reach of lower-income groups. In the Social Wellbeing study, various aspects (e.g., type of dwelling, satisfaction with housing or accommodation, tenure) of housing were covered. Reviewing wellbeing by type of dwelling, Figure 16 illustrates that, except for those living in a caravan, respondents' wellbeing scores were similar across type of dwelling. Exploring wellbeing levels by tenure in Figure 17, significant differences in wellbeing were found between the tenure types and those individuals who owned their homes without a mortgage had the highest wellbeing. Figure 18 illustrates that the majority of these individuals are aged 55 years and older. Satisfaction with housing or accommodation was significantly lower for those respondents living in a caravan /mobile or relocatable home (Figure 19).

Figure 16: Social wellbeing (mean index score) by type of dwelling, 2010

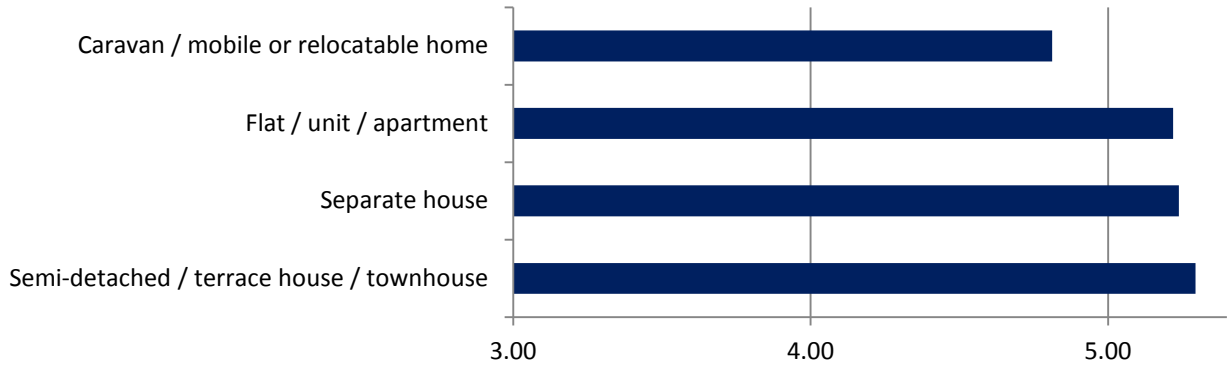


Figure 17: Social wellbeing (mean index score) by tenure, 2010

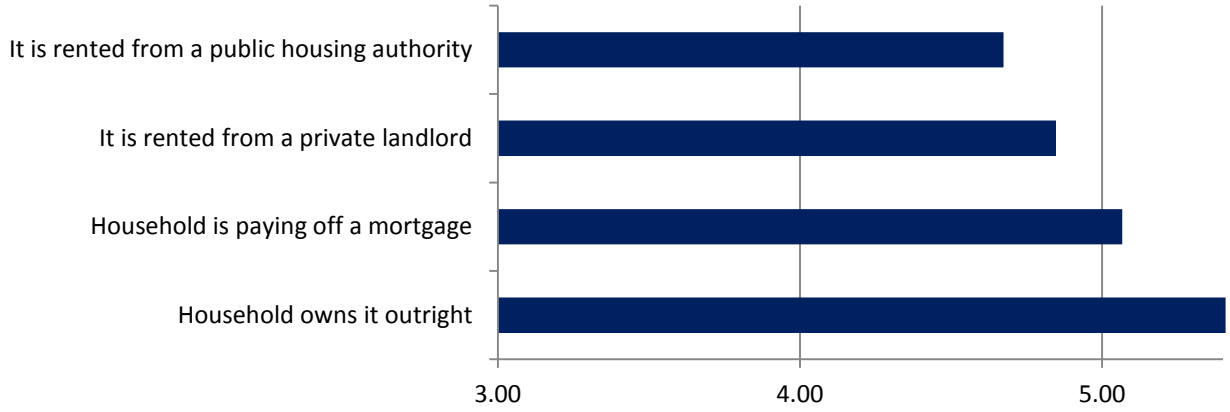


Figure 18: Proportion of the sample in each tenure category by age group, 2010

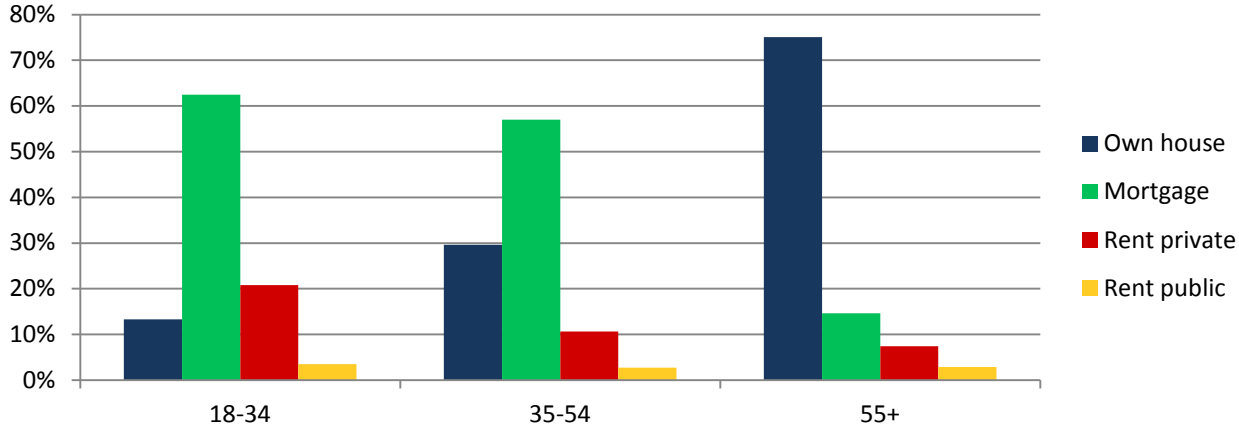
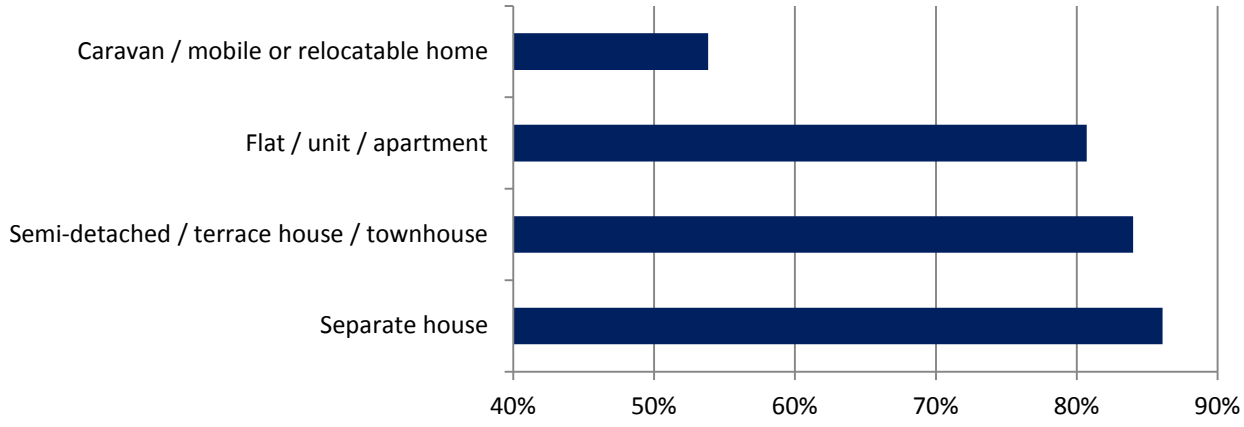


Figure 19: Satisfaction with housing or accommodation (mean score) by type of dwelling, 2010



What is the relationship between wellbeing and personal security?

Safety or personal security is an important component of wellbeing. Feeling safe can be just as important to wellbeing as actually experiencing harm. Therefore, feeling safe in a home or neighbourhood not only has a positive impact on wellbeing, it also facilitates cohesion within that community. Ziersch, Baum, MacDougall and Putland (2005) found that perceptions of safety increased with levels of trust and that women reported lower levels of perceived safety than men. Most Queenslanders seem to trust their neighbours (61%); to feel safe in the neighbourhoods (80%) in which they live (Figure 20); and have higher wellbeing than respondents who distrusted their neighbours or felt unsafe in their neighbourhoods (Figure 21). No gender or age differences were found.

Figure 20: Neighbourhood personal security, 2010 (Percentage)

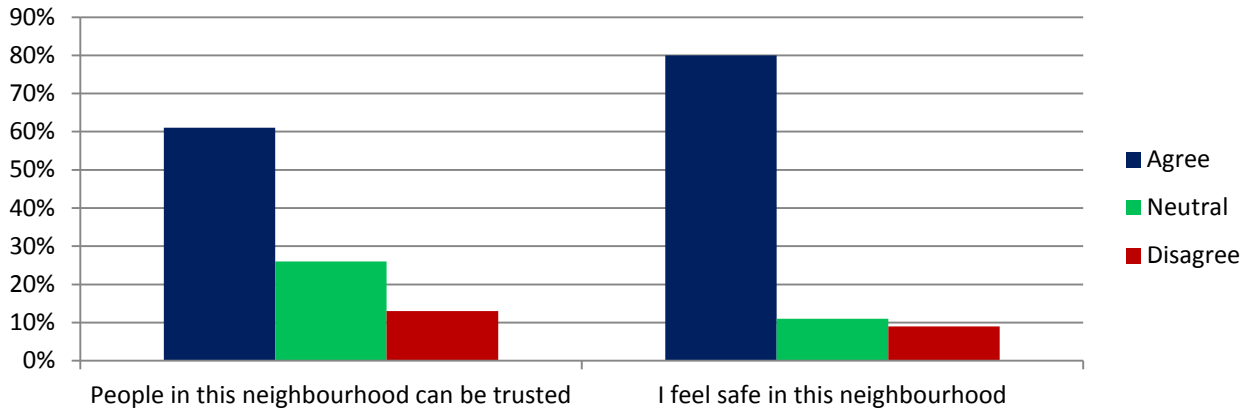
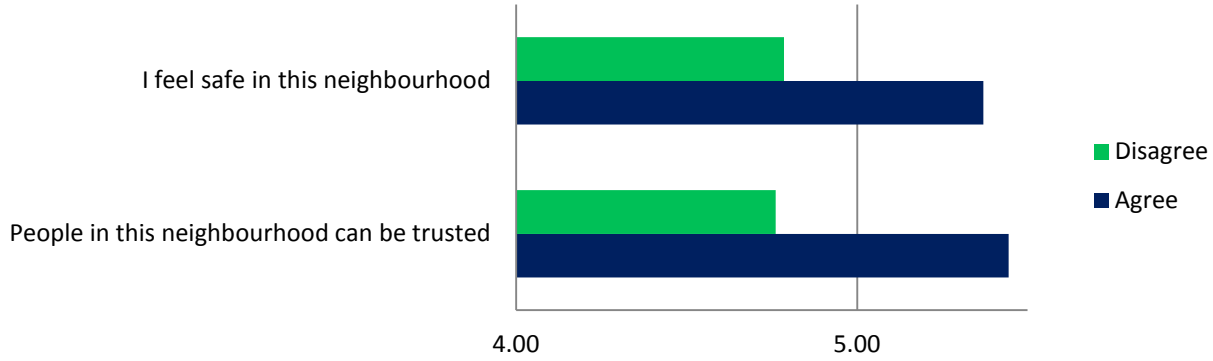
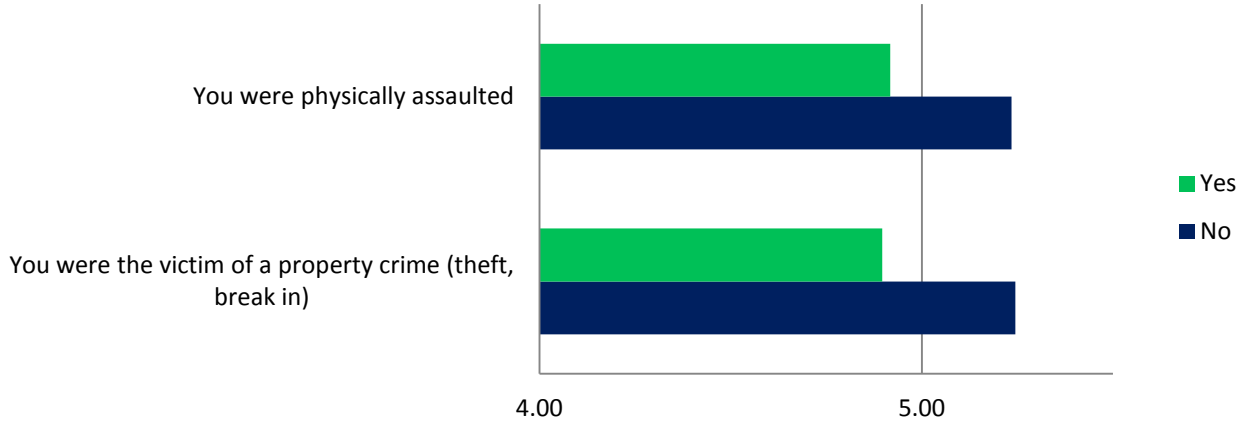


Figure 21: Social wellbeing (mean index score) by neighbourhood personal security, 2010



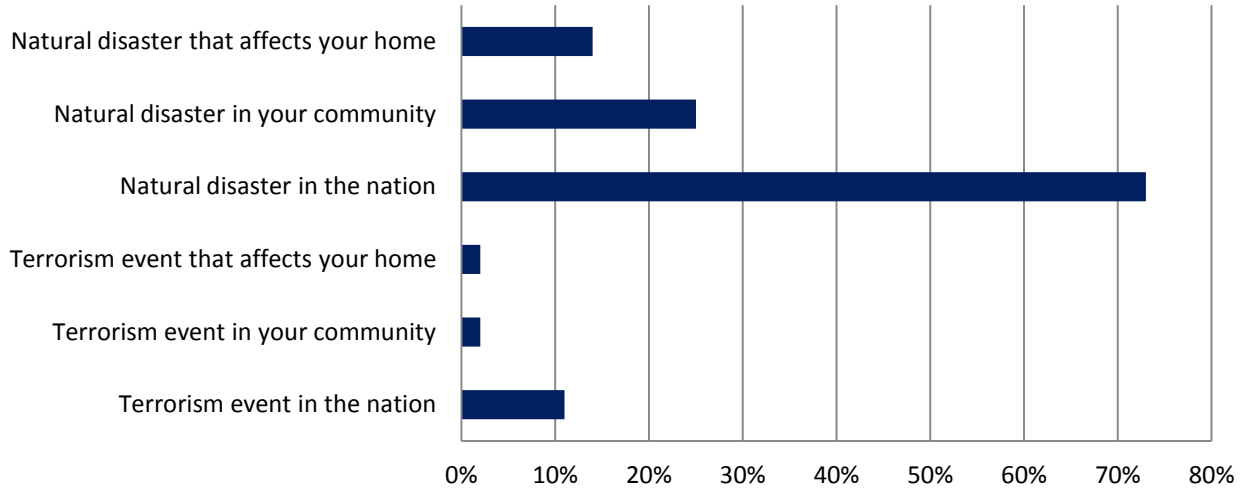
Only four percent of our respondents were victims of property crime and only one percent reported that they had been assaulted. As Figure 22 illustrates, wellbeing is significantly lower for respondents who have been subjected to either property crime or assault.

Figure 22: Social wellbeing (mean index score) by criminal victimization, 2010



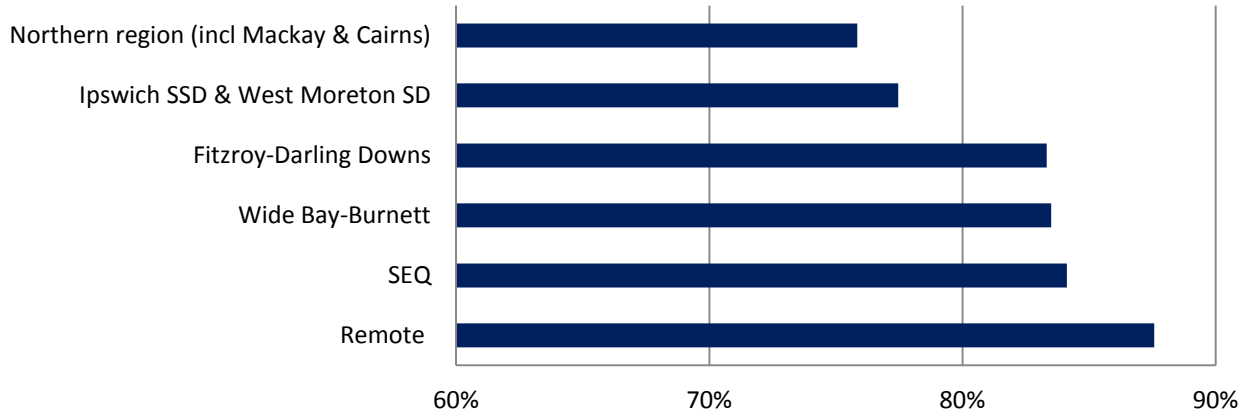
Respondents were also asked about the likelihood of a natural disaster or terrorism event occurring in the next six months in the nation or in their community, and if such an event would affect their home. Only 11 percent of the respondents indicated that it was likely that a terrorism event would occur in the nation over the next six months and only two percent thought this might affect them directly through their community or affect their home specifically (Figure 23). A much higher proportion (73%) indicated that it was likely that the nation would be affected by a natural disaster; while 25 percent indicated that it was likely to affect the community and 14 percent said it was likely the natural disaster would affect their home. These responses were collected only a few months prior to the Queensland floods and cyclone that devastated many families.

Figure 23: Proportion of the respondents who indicated that there was a likelihood of a natural disaster or terrorism event occurring in the next 6 months, 2010



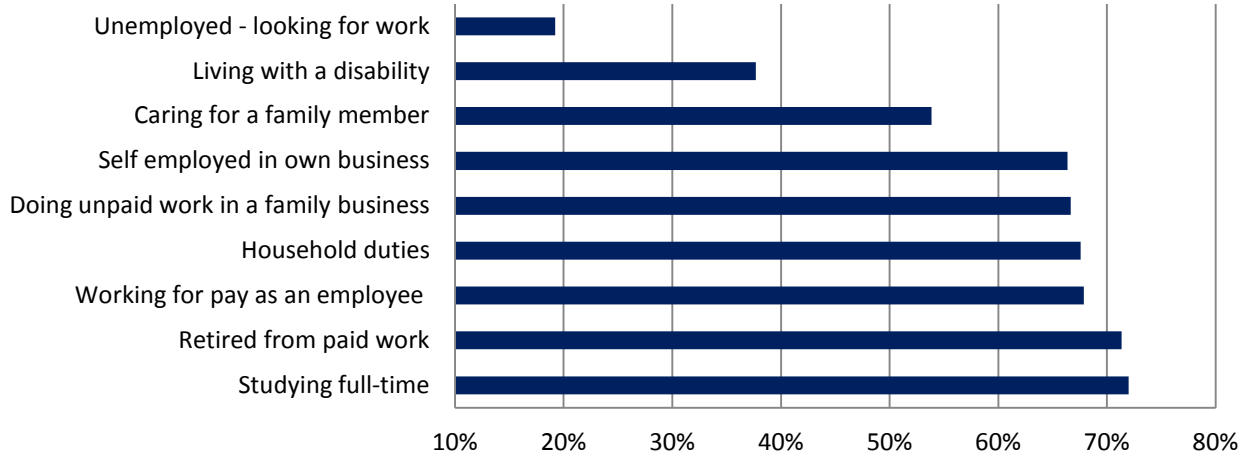
As shown in Figure 24, respondents living in remote regions seem more satisfied with their personal security than respondents living in the Northern, Ipswich and West Moreton regions.

Figure 24: Proportion of respondents satisfied with their personal security by region, 2010



As illustrated in Figure 25, only a small proportion of unemployed respondents indicated that they were satisfied with their future security. Similarly, a smaller proportion of respondents living with a disability were satisfied with their future security.

Figure 25: Proportion of respondents who are satisfied with their future security by main activity, 2010



How well are we served by the Queensland public sector?

Access to services and facilities is vital for the health and wellbeing of the community. As Figures 26 and 27 illustrate, with the exception of those residing in the South East Queensland region, at least 10 percent of respondents residing in other regions indicate that they are dissatisfied with their access to health services and public services. The wellbeing of respondents who are dissatisfied with access to services is significantly lower than those who are satisfied (Figure 28).

Figure 26: Proportion of respondents who are dissatisfied with their access to health services by region, 2010

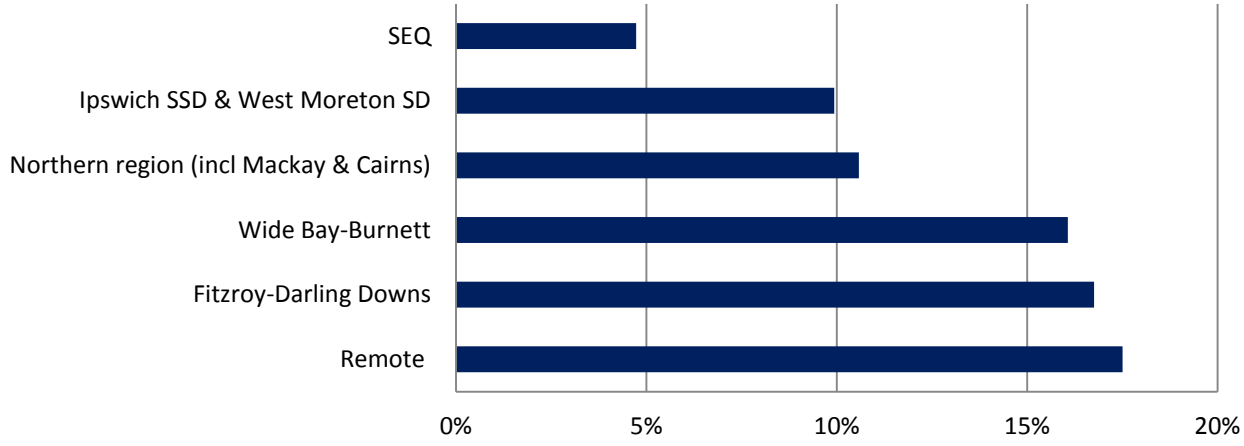


Figure 27: Proportion of who are dissatisfied with their access to public services by region, 2010

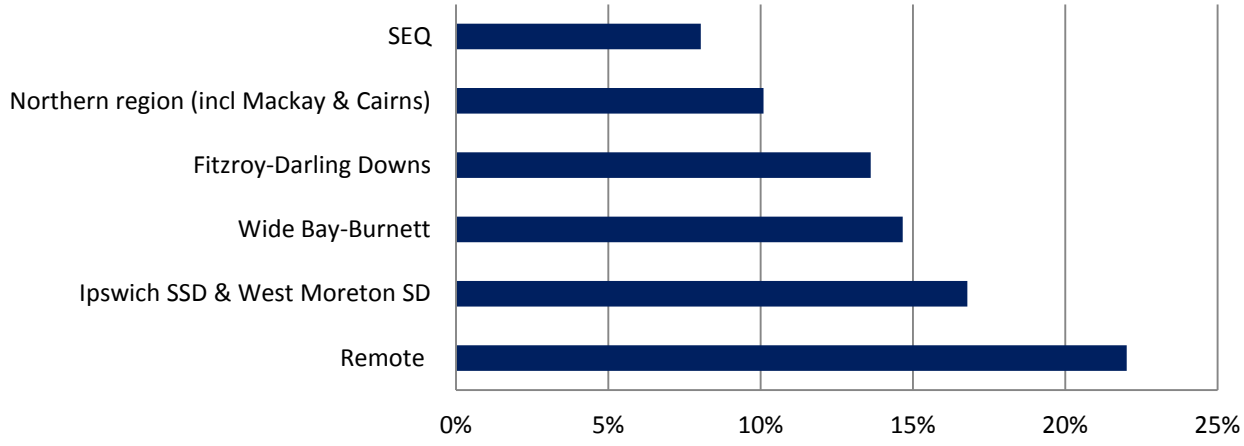
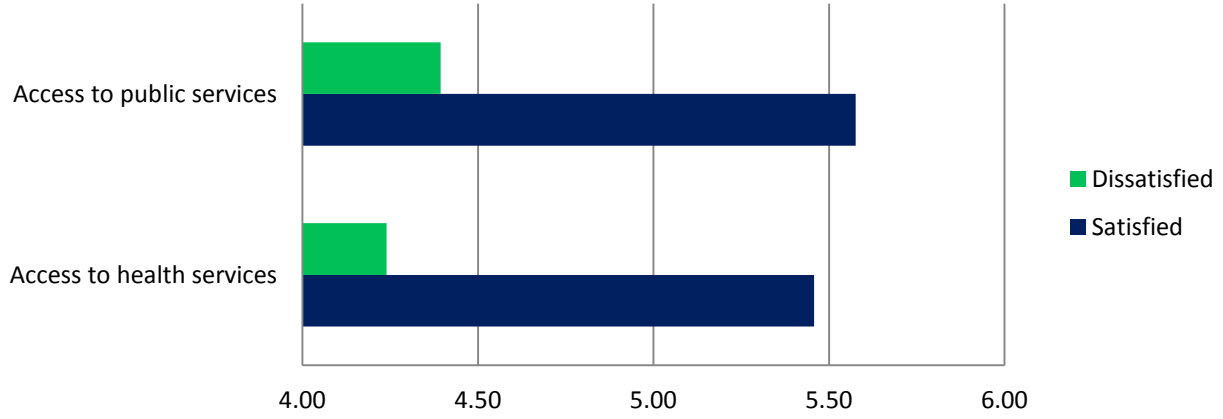
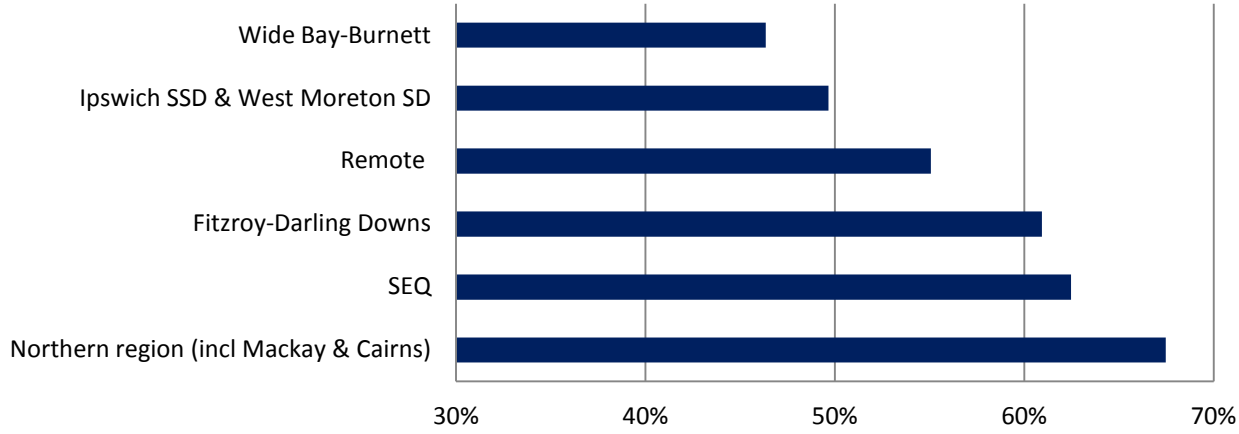


Figure 28: Social wellbeing (mean index score) by access to services, 2010



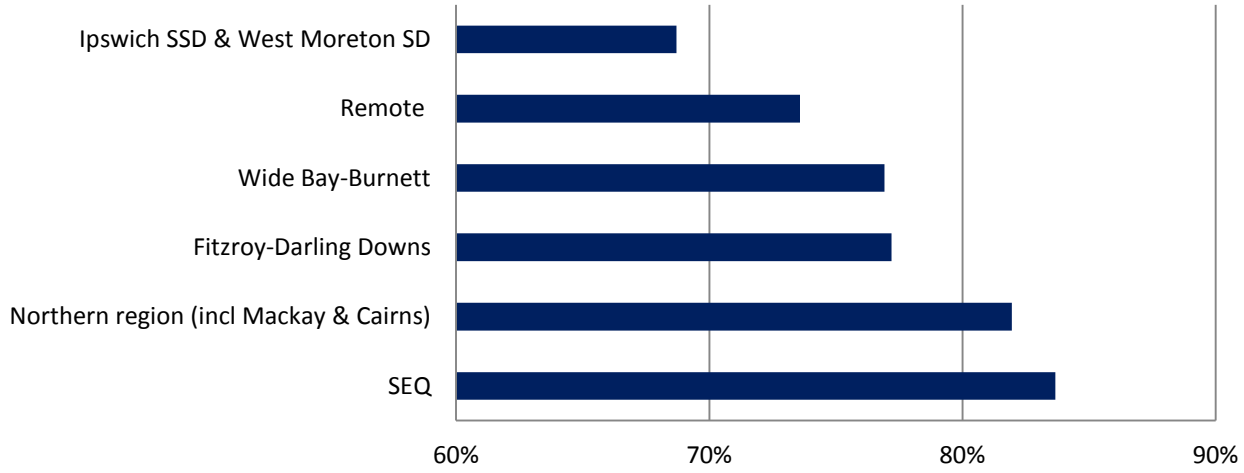
Sixty percent of the sample indicated that economic conditions were good. However, the numbers dropped substantially for individuals living in the Ipswich and West Moreton (50%) and Wide Bay-Burnett (46%) regions reflecting depressed or declining economic conditions in these areas (Figure 29).

Figure 29: Proportion of the respondents who indicated that the economic conditions are good by region, 2008



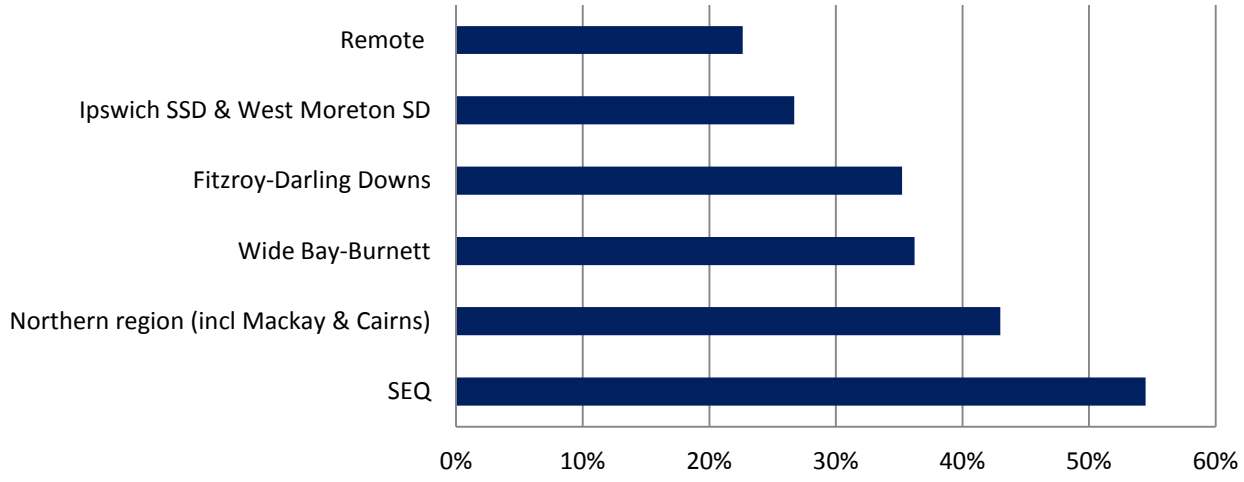
Eighty-one percent of the sample felt that the natural environment that they were familiar with was of good quality. Respondents from the Ipswich and West Moreton (69%) region were significantly less satisfied with their natural environment than respondents from the other regions (Figure 30).

Figure 30: Proportion of the respondents who indicated that the natural environment is good by region, 2008



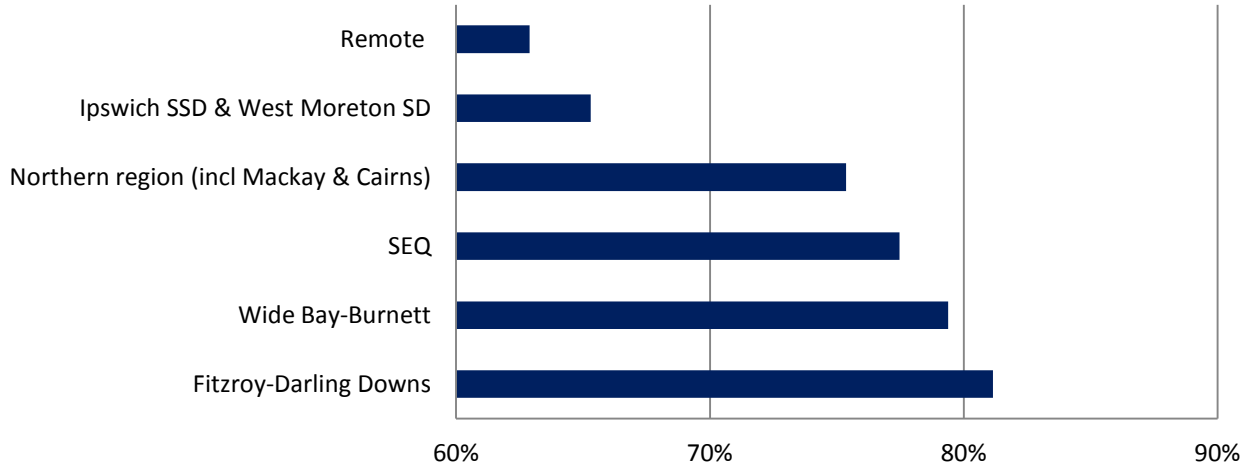
Only 46 percent of respondents indicated that transportation was good and transportation appears to be particularly problematic in the Remote (23%) and Ipswich and West Moreton (27%) regions (Figure 31).

Figure 31: Proportion of the respondents who indicated that transportation is good by region, 2008



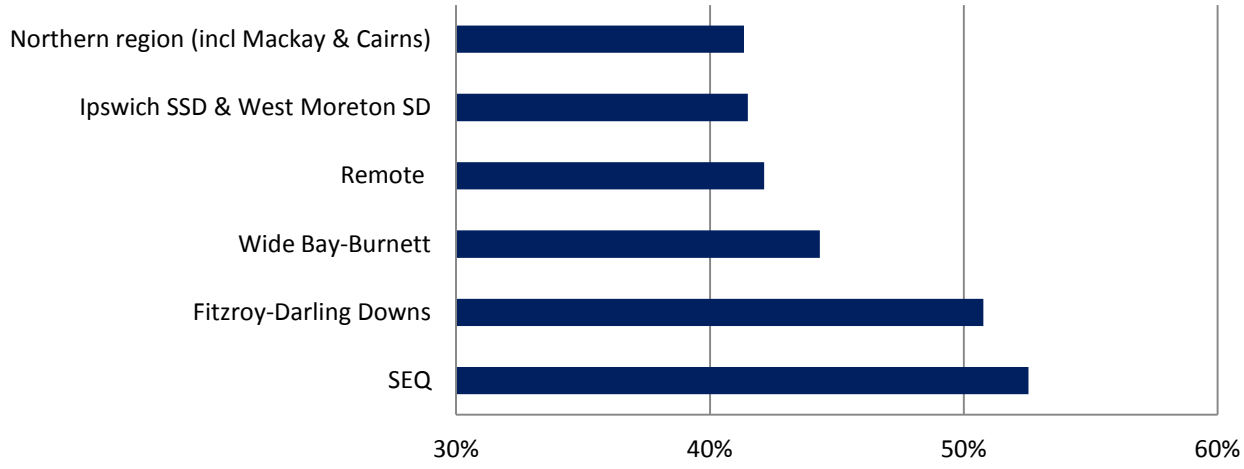
Overall, seventy-six percent of our respondents were happy with educational services, however, individuals living in Remote (23%) and Ipswich and West Moreton (27%) regions were much less satisfied with the educational services in their region (Figure 32).

Figure 32: Proportion of the respondents who indicated that the educational services are good by region, 2008



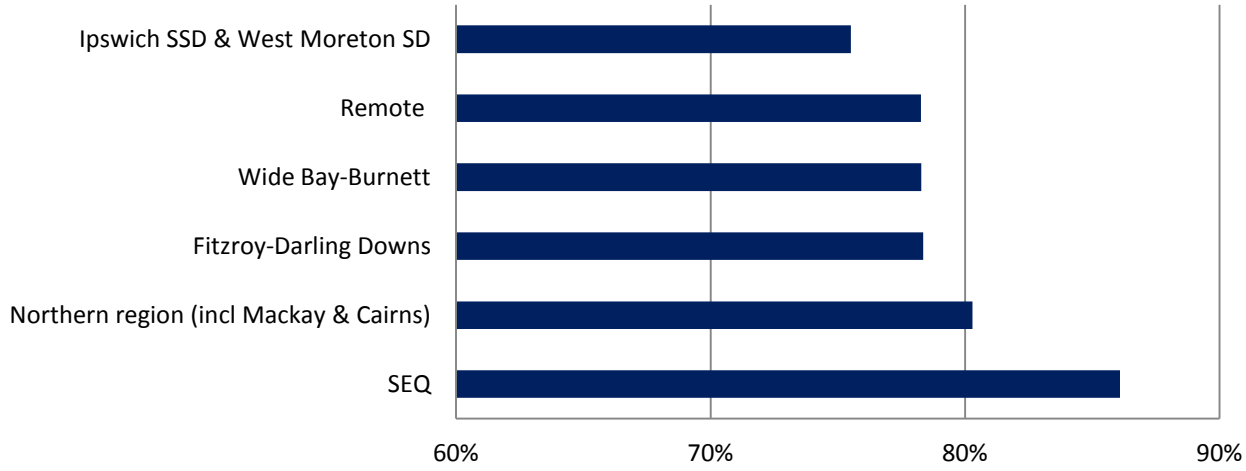
Fewer than half (49%) of the respondents indicated that health services were good in their area. The provision of health services was significantly better for those in the South East Queensland and Fitzroy-Darling Downs regions (Figure 33).

Figure 33: Proportion of the respondents who indicated that the health services are good by region, 2008



The majority (83%) of respondents indicated that their overall quality of life is good. Respondents living in the South East Queensland region seem the most satisfied with their quality of life (Figure 34).

Figure 34: Proportion of the respondents who indicated that their overall quality of life is good by region, 2008



Respondents were asked to rate how accessible services and facilities were in their local area. While a low proportion of the sample indicated they did not have access to these services or facilities, 30 percent indicated that public transport is not accessible to them and 12 percent indicated that hospital/healthcare services are not accessible (Figure 35). Inaccessibility of these services is higher for individuals living in remote regions (Figures 36 and 37). These are important findings as inaccessibility to public transport reduces equality of opportunity and the ability to participate in civic life (Dibben, 2001; Torrance, 1992).

Figure 35: Proportion of the respondents who indicated that services were inaccessible, 2008

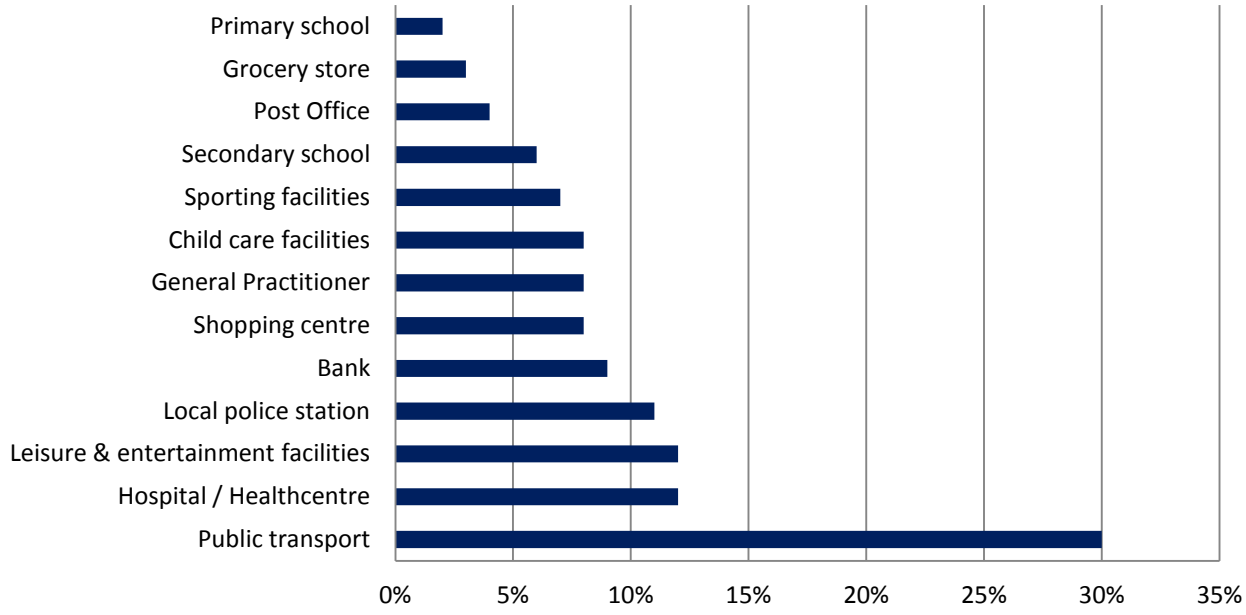


Figure 36: Proportion of the respondents who indicated that hospitals/healthcare services or facilities were inaccessible by region, 2008

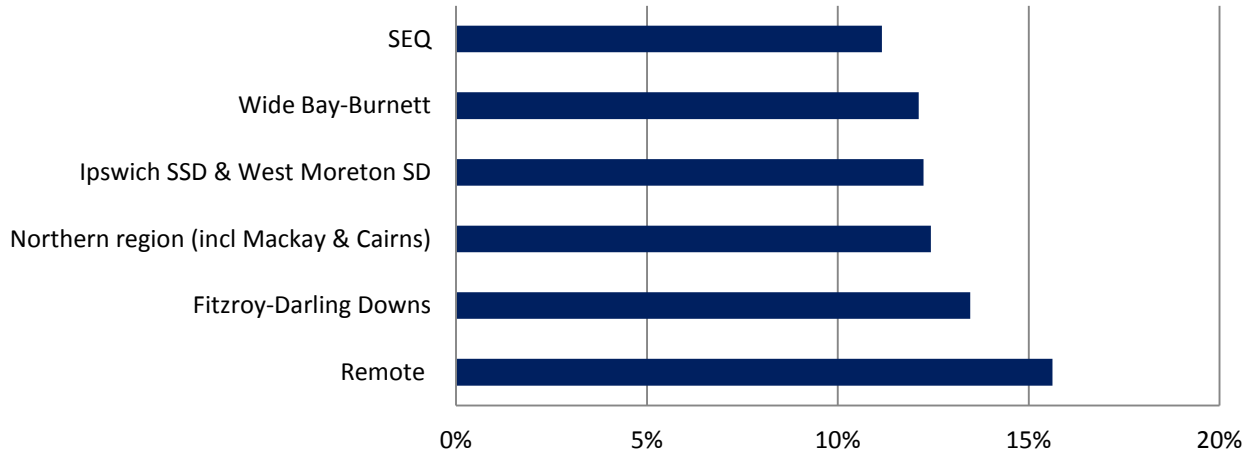
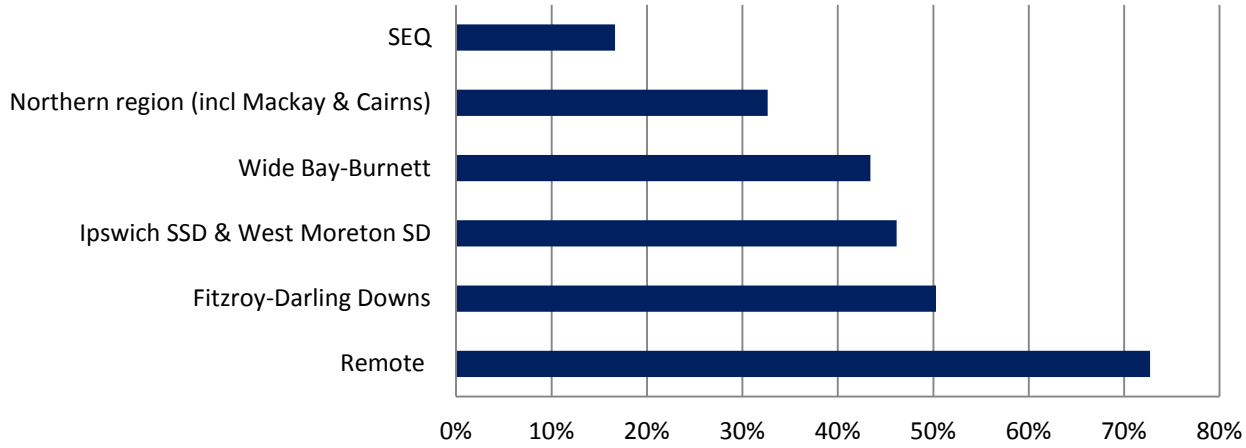


Figure 37: Proportion of the respondents who indicated that public transport services or facilities were inaccessible by region, 2008



Conclusion

The results presented in this report have allowed us to provide a comprehensive picture of quality of life in Queensland cities and regions during the past three years. It is important to recognize that it was not our intention simply to present a report card on social wellbeing in Queensland but rather to provide an analysis of the most important factors that influence the quality of life of individuals, families and communities across the State. These findings make a significant contribution to a range of important policy questions by providing a recognized evidence base on which to develop policies to address the needs for social and economic infrastructure to support social wellbeing in Queensland's urban and regional communities.

The results portrayed in this report show that most Queenslanders are satisfied with their quality of life. However, when we analyse the difference between what people aspire to and their satisfaction levels, there are some notable deficits between the aspirations and the realities of peoples' lives. In addition to social wellbeing, the project focused on a measure of social disadvantage. This enabled us to obtain a clearer focus on the factors associated with the incidence of disadvantage in Queensland. The conclusion supported by this data is that while most Queenslanders are clearly not disadvantaged, a significant minority of families are struggling to afford social necessities such as medical and dental care.

A number of circumstances emerge that are clearly associated with lower wellbeing and poorer quality of life. These factors include single parent households; unemployed people; people with disabilities; families with sub-standard accommodation; people who reside in unsafe neighbourhoods; and individuals who live in regions that lack access to services and facilities. For many families and individuals these conditions tend to accumulate which makes breaking out of disadvantaged circumstances all the more difficult.

Many of the issues which are positively associated with wellbeing such as health, housing, employment, personal security and access to public services such as hospitals, public transport and policing are amenable to policy intervention - albeit in the context of government finances and the willingness of the community to support higher expenditure on public services through taxation. In this report we have endeavoured to pinpoint the demographic and geographic factors associated with wellbeing that may allow these policy interventions to be better targeted. Future iterations of this survey will be able to provide us with indicators of the success or otherwise of such government policies and programs.

Studies of social wellbeing have assumed an increased prominence in the lexicon of statisticians and policymakers. In order to answer broader questions about the quality of life of families and communities we need to consider a range of measures of wellbeing that move beyond the economic domain and that take into account key aspects of individuals' satisfaction with their life circumstances. In this study we have developed such a model. The analysis provided in this report supports our view that wellbeing depends on a range of social conditions that have value for individuals, families and communities such as health, housing, family relations, personal security, employment and leisure. The results of this analysis also show that, while household and individual income may be an important element in the alleviation of

disadvantage, these material concerns are only a very small component of how people regard their quality of life or wellbeing. This is an important finding for policymakers and it suggests that more attention needs to be paid to the social circumstances of individuals and families and not just their financial means if the quality of their lives is to be addressed.

References

Andersen, S. H. (2009). Unemployment and subjective well-being. A question of class? *Work and Occupations, 36*(1), 3-25.

Australian Bureau of Statistics. (2006). *Tobacco smoking in Australia: A snapshot, 2004-05, cat. no. 4831.0.55.001* Canberra. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4831.0.55.001

Australian Bureau of Statistics. (2011a). Labour force characteristics during recent economic downturns *Australian Labour Market Statistics, AusStats electronic collection cat. no. 6105.0* Retrieved from http://census.abs.gov.au/ausstats/abs@.nsf/Lookup/4D36BD64C8E2D1EBCA257810001134D5

Australian Bureau of Statistics. (2011b). *Overweight and obesity in adults in Australia: A snapshot, 2007-08, cat. no. 4842.0.55.001* Canberra. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4842.0.55.001Media%20Release12007–08?opendocument&tabname=Summary&prodno=4842.0.55.001&issue=2007–08&num=&view=

Australian Bureau of Statistics. (2011c). *State and Territory Statistical Indicators, 2011, cat. no. 1367.0* Canberra. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by+Subject/1367.0~2011~Main+Features~Children+in+Lone+Parent+Families~4.18

Begg, S., Vos, T., Barker, B., Stevenson, C., Stanley, L., & Lopez, A. D. (2007). *The burden of disease and injury in Australia, 2003. cat. no. PHE 82*. Canberra: AIHW. Retrieved from www.aihw.gov.au/publications/index.cfm/title/10317

Bloom, D., & Canning, D. (2000). The health and wealth of nations. *Science 287*, 1207-1209.

Bloom, D., & Canning, D. (2005). *Health and economic growth: Reconciling the micro and macro evidence*. Stanford Stanford Institute on International Studies. Retrieved from http://iis-db.stanford.edu/pubs/20924/BloomCanning_42.pdf

Bloom, D. E., Canning, D., & Sevilla, J. (2004). The Effect of Health on Economic Growth: A Production Function Approach. *World Development 32*(1), 1–13.

Collins, D. J., & Lapsley, H. M. (2007). *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*. Canberra: Department of Health and Ageing. Retrieved from http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/mono64/$File/mono64.pdf

Creed, P. A. (1999). Predisposing factors and consequences of occupational status for long-term unemployed youth: A longitudinal study. *Journal of Adolescence, 22*, 81-93.

Creed, P. A., & Machin, M. A. (2002). The relationship between mental health and access to the latent benefits of employment for unemployed and underemployed individuals. *Psychological Reports, 90*, 1208-1210.

Curran, L. B., Wolman, H., Hill, E. W., & Furdell, K. (2008). *Poverty, programs and prices: How adjusting for cost of living would affect federal benefit eligibility*: Metropolitan Policy Program, The Brookings Institution. Retrieved from ftp://urban.csuohio.edu/utility/hill/ust%20624%20Distressed%20People_places/3%20Measuring%20Poverty/Curran%20et%20al_Brookings03_08.pdf

Dibben, P. (2001). *Transport and social exclusion in rural areas*. St Anne's College, Oxford

Fogel, R. (2004). *The Escape from Hunger and Premature Death, 1700-2100: Europe, America, and the Third World*. Cambridge: Cambridge University Press.

Hsiao, W., & Heller, P. (2007). *What should macroeconomists know about health care policy?, IMF Working Paper, no WP/07/13*. Washington DC: International Monetary Fund. Retrieved from http://www.imf.org/external/pubs/ft/wp/2007/wp0713.pdf

McLanahan, S., & Adams, J. (1987). Parenthood and psychological well-being. In W. R. Scott & J. F. Short (Eds.), *Annual review of sociology* (Vol. 13, pp. 237-257). Palo Alto, CA: Annual Review.

Nordenmark, M., & Strandh, M. (1999). Towards a sociological understanding of mental well-being among the unemployed: the role of economic and psychosocial factors. *Sociology, 33*(3), 577-597.

Ross, C., & Huber, J. (1985). Hardship and depression. *Journal of Health and Social Behavior, 26*, 312-327.

Ross, C., Mirowsky, J., & Goldsteen, K. (1990). The impact of the family on health: The decade in review. *Journal of Marriage and the Family, 52*(4), 1059-1078.

Saunders, P. (2011). *Down and out: Poverty and exclusion in Australia*. Bristol: Policy Press.

Slee, P. (2006). *Families at risk: the effects of chronic and multiple disadvantage*. Adelaide: Shannon Research Press.

Sorensen, T. (2000). *Regional development: some issues for policymakers, Parliamentary Library research paper no. 26 1999–2000*. Canberra: Parliament of Australia Retrieved from http://www.aph.gov.au/library/pubs/rp/1999-2000/2000rp26.pdf

Torrance, H. (1992). Transport for all: equal opportunities in transport policy. In J. Cleary, K. Hamilton, J. Hanna, & J. Roberts (Eds.), *Travel Sickness: The Need for Sustainable Transport Policy for Britain*. London: Lawrence Wishart.

Wilkie, J., & Young, A. (2009). Why health matters for economic performance. *Economic Round-up, 1*, 57-72. Retrieved from http://www.apo.org.au/node/1239

Winkelmann, L., & Winkelmann, R. (1998). Why are the unemployed so unhappy? Evidence from panel data. *Economica, 65*, 1-15.

Ziersch, A. M., Baum, F. E., MacDougall, C., & Putland, C. (2005). Neighbourhood life and social capital: the implications for health. *Social Science & Medicine, 60*(1), 71-86.