

A SOCIAL HEALTH ATLAS OF AUSTRALIA

Second Edition

Volume 8: Northern Territory

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 **Public Health Information Development Unit**

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Foreword

The publication of this second edition of ***A Social Health Atlas of Australia*** brings together a wide range of information about the health status of Australians by region, and the health service use by the Australian population.

By presenting the data as maps, the atlas provides a graphical image of the distribution of health status, and differences in the patterns and levels of access to and use of health services at the local level throughout the cities, towns, and rural and remote areas of Australia. The format of the atlas makes the information easy to understand and readily accessible to a broad group of users, including public health planners, providers, researchers, students and the general public.

The graphs of the newly developed Accessibility/Remoteness Index for Australia (ARIA) provide useful information for communities, as well as practitioners and managers in the health sector, to better understand the differences in the statistics that describe health status and health service use.

This data is essential for policy development and local area planning, and for monitoring and evaluating health services. It is also of major importance for resource allocation at the broadest level, and between areas, services and population groups. The maps and tabulations presented in this atlas represent a major compilation of information for these purposes.

I congratulate all those who have contributed to this important project.



Dr Michael Wooldridge
The Minister for Health and Aged Care

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Executive summary

The information in the atlas series adds to a convincing body of evidence built up over a number of years in Australia on the striking disparities in health that exist between groups in the population. People of low socioeconomic status (those who are relatively socially or economically deprived) experience worse health than those of higher socioeconomic status for almost every major cause of mortality and morbidity. The challenge for policy makers, health practitioners and governments is to find ways to address these health inequities.

The primary aims of the first edition of *A Social Health Atlas of Australia* were to illustrate the spatial distribution of the socioeconomically disadvantaged population, and to compare this with patterns of distribution of major causes of illness and death and use of health services. The maps and correlation analysis highlighted associations between social and economic factors in relation to health and illness.

A number of new variables have been included in this second edition, together with new data on many of the variables from the first edition. One of the additions is the presentation of data by the new Accessibility/Remoteness Index of Australia (ARIA). Also included is a cluster analysis, providing profiles at the Statistical Local Area (SLA) level of the socioeconomic status, health status and health service utilisation of the population.

The extent of change (between the editions) in the patterns of distribution in death rates by socioeconomic status is also highlighted.

Findings

Correlation analysis

There were few correlations of significance at the SLA level in **Darwin** between the measures of socioeconomic disadvantage and the health status variables. This is in part due to the small numbers of cases at the SLA level. The strongest of the associations were correlations of meaningful significance between high rates of people with a handicap and unskilled and semi-skilled workers (0.56) and the Indigenous population (0.51) (**Table 8.1**).

There were more correlations of significance at the SLA level in the non-metropolitan areas of Northern Territory than was the case in **Darwin**. The strongest of these were with a number of the measures of health status and, to a lesser extent, with many of the variables for use of health services. The strongest correlations with the measures of socioeconomic disadvantage were with the variables for people reporting their health as fair or poor, the PCS, the handicap status of the population, deaths of males and females aged 15 to 64 years and years of potential life lost (the summary measure of premature death). There were positive, although weaker, correlations with many of the variables for admissions to hospital.

For the Indigenous population, there were correlations of substantial significance at the SLA level with these same variables: for people reporting their health as fair or poor, the PCS, the handicap status of the population, deaths of males and females aged 15 to 64 years and years of potential life lost (the

summary measure of premature death). There were positive, although generally weaker, correlations with many of the variables for admissions to hospital: an exception was the correlation of substantial significance with high rates of admission for infectious and parasitic diseases (0.76).

Changes in socioeconomic status

Marked variations were recorded between 1986 and 1996 for a majority of the socioeconomic status variables mapped for the Northern Territory (**Table 9.1**). For **Darwin**, the largest increases were for the population aged 65 years and over (an increase of 77.3 per cent over this ten year period); low income families (49.1 per cent); dwellings without a motor vehicle (37.4 per cent); the occupational grouping of managers and administrators, and professionals (34.0 per cent); Aboriginal and Torres Strait Islander people (33.1 per cent); and single parent families (32.3 per cent). The largest decreases recorded over this ten year period were for the variables for people born overseas in predominantly non-English speaking countries and resident in Australia for less than five years (down by 35.4 per cent) and unemployment among 15 to 19 year olds (down by 22.7 per cent).

Variations of this order were also recorded in the non-metropolitan areas of the Northern Territory. The major differences from the changes noted for **Darwin** were the larger increases for the occupations of managers and administrators and professionals and the number of single parent families; smaller increases in the population of people aged 65 years; and larger decreases for people who reported poor proficiency in English.

Substantial variations were recorded in income support payments to residents of **Darwin** for all of the payment types analysed. The number of recipients for each of the payment types increased substantially, with the number of disability support pensioners increasing by 67.9 per cent (**Table 9.1**). Similar, although smaller, increases were recorded in the non-metropolitan areas of the Northern Territory for recipients of the Age and Disability Support Pensions, while larger increases were recorded for people receiving unemployment benefits and dependent children in families receiving income support.

Changes in death rates

Death rates in the Northern Territory have declined over the years 1985 to 1989 and 1992 to 1995 for the majority of causes studied.

In **Darwin**, the largest decreases were recorded for deaths of people aged from 15 to 64 years from diseases of the circulatory system (down by 32.8 per cent), accidents, poisonings and violence (down by 13.9 per cent) and respiratory system diseases (down by 13.7 per cent). All causes mortality was 19.1 per cent lower over this period, marginally more so for females (20.6 per cent) than for males (16.9 per cent).

There were also reductions in rates of premature death in the non-metropolitan areas of the Northern Territory for all but lung cancer, for which there was a marked increase (54.5 per cent). The reductions were all greater than those recorded for **Darwin**.

Summary of findings by socioeconomic status of area of residence

Comparisons are made of differences in the health status and health service use of the population by socioeconomic status. In the absence of any direct measure of socioeconomic status in the health status data, the socioeconomic status of the SLA of usual residence in the health status records is used. In this analysis socioeconomic status is measured by the Index of Relative Socio-Economic Disadvantage (IRSD, see page 18). The SLAs in **Darwin** have been grouped into five groups (quintiles) based on the IRSD score, with Quintile 1 comprising the twenty per cent of SLAs with the highest IRSD scores, and Quintile 5 comprising the twenty per cent of SLAs with the lowest IRSD scores. The SLAs in the non-metropolitan areas of the Northern Territory have been grouped in the same way.

Health status

Although there is some variability across the quintiles, the pattern is generally for the highest socioeconomic status SLAs (those in Quintile 1) to have the most advantageous (ie. in the majority of cases the lowest) rates and, generally, for the most disadvantaged SLAs (those in Quintile 5) to have the highest rates (**Figure 9.2**). The most notable exceptions are the variables for people with a handicap, people with a disability and the Total Fertility Rate in **Darwin** and the Physical Component Summary and people with a disability in the non-metropolitan areas.

Years of potential life lost (YPLL) from deaths between the ages of 15 to 64 years varied from a standardised ratio (SR) in the most advantaged areas of 41 (59 per cent fewer YPLL than were expected from the Northern Territory rates) to an SR of 149 in the most disadvantaged areas (indicating that there were 49 per cent more YPLL than were expected from the Northern Territory rates). Large differentials were also evident for deaths of 15 to 64 year old males (from an SDR of 39 in Quintile 1 to 99 in Quintile 4 and 88 in Quintile 5) and deaths of 15 to 64 years olds from circulatory system diseases (26 to 96) and respiratory system diseases (from an SDR of 32 in Quintile 1 to 111 in Quintile 4 and 77 in Quintile 5) (**Figure 9.2**).

Figure 9.3 shows the rate ratios for each of the health status variables for SLAs in the non-metropolitan areas of the Northern Territory. The most notable differences from the gradients evident for **Darwin** are for the variables for people with a handicap, infant deaths and the Total Fertility Rate. Again, the pattern is for the highest socioeconomic status SLAs (those in Quintile 1) to have the most advantageous (ie. in the majority of cases the lowest) rates and, generally, for the most disadvantaged SLAs (those in Quintile 5) to have the highest rates. The most notable exceptions are the variables for the Physical Component Summary (PCS) score (for which low scores indicate poorer health) and people with a disability.

Health service utilisation

It has not been possible to produce this analysis for the health service utilisation data mapped in Chapter 6, as this data was only available for the four postcode groupings, too few areas to be allocated to the five quintiles.

There is considerable variability across the quintiles in the rate ratios for the health service utilisation variables for SLAs in the non-metropolitan areas of the Northern Territory (**Figure 9.4**). Even where the most advantaged SLAs (those in Quintile 1) have the lowest admission rates and the most disadvantaged SLAs (those in Quintiles 3 and 5) have the highest rates, the pattern is often broken in Quintile 3 and 4. Quintile 3 includes the remote areas of Groote Eylandt and Elsey-Balance as well as the town of Tennant Creek and Cox-Finniss, which is located near **Darwin**. On other occasions the most disadvantaged (and also the most remote) areas have the lowest admission rates. The rates in these areas, in particular, are likely to be affected by a lack of access to hospital facilities.

The variables which consistently have higher rates of admission in the high socioeconomic status areas are those for admissions to a private hospital, same day admissions and admissions for psychosis; for neurotic, personality and other mental disorders; and for bronchitis, emphysema and asthma. The standardised ratios for admissions involving a surgical procedure (other than for Caesarean sections) also generally decrease with increasing disadvantage. A gradient is also evident for the use of GP services for both males and females, and immunisation rates of children at age 12 months, which is likely to reflect a lack of access to these services.

Change in health status by socioeconomic status of area of residence

As noted above, there has been an overall decrease in death rates in the Northern Territory; there are also differentials in death rates by socioeconomic status of area. It is possible to examine the extent of the change in death rates by socioeconomic status of area. As data was not available for non-metropolitan SLAs in the first edition of the atlas, the following comparisons have been limited to **Darwin**.

Caution should be exercised in interpreting these data. Although there is a clear gradient in socioeconomic status at the suburb level in **Darwin** (**Figure 9.1**), the suburbs have relatively small, and often diverse, populations which can affect the results of this analysis. Despite these limitations, the analysis has been undertaken and the data included below.

It is clear that despite the overall decline in death rates, the gradient between the quintiles remains, although it is generally smaller than in the other capital cities. The differential in death rates for male residents of **Darwin** aged from 15 to 64 years between Quintile 1 (the most advantaged areas) and Quintile 5 (the most disadvantaged areas) decreased from 1.21 times higher in the most disadvantaged areas to 1.15 times higher. The percentage decline in death rates between the two periods is largest in Quintiles 3 and smallest in Quintile 1.

Death rates for female residents of **Darwin** aged from 15 to 64 years are lower than for males. As shown in **Figure 9.5**, the rates in the later period are lower than in the earlier period for each quintile, other than for Quintile 5 where the rate is slightly higher.

The largest percentage decreases were recorded in Quintiles 3 (40.8 per cent) and 4 (29.8 per cent), while there was an increase of 2.1 per cent in Quintile 5. For females, the differential in death rates between Quintile 1 (the most advantaged areas) and Quintile 5 (the most disadvantaged areas) increased, from 0.80 in 1985-89 (more deaths of residents of the high status than in the disadvantaged areas) to 1.01 in 1992-95.

The graph for deaths of all people aged from 15 to 64 years, the combination of the male and female rates, shows similar gradients to those discussed above. The differential in death rates between Quintile 1 (the most advantaged areas) and Quintile 5 (the most disadvantaged areas) decreased from 1.14 times higher in the most disadvantaged areas in 1985-89 to 1.10 times higher in 1992-95.

The differential in the infant death rate (infant deaths per 1,000 live births) in **Darwin** between Quintile 1 (the most advantaged areas) and Quintile 5 (the most disadvantaged areas) also increased, from 0.78 in 1985-89 to 0.81 in 1992-95.

There has been a small increase in the differential evident for premature deaths from cancer between Quintile 1 and Quintile 5, from 0.71 in 1985-89 to 0.78 in 1992-95. Similarly, the differential in death rates for lung cancer in **Darwin** is lower in 1992-95 than in 1985-89 (1.22, compared with 1.30).

There is no clear gradient evident in the rates of premature death from circulatory system diseases in either period. However, the differential in death rates between Quintile 1 (the most advantaged areas) and Quintile 5 (the most disadvantaged areas) has almost doubled, increasing from 1.02 times higher in the most disadvantaged areas in 1985-89 to 1.99 times higher in 1992-95.

Similarly, there is no clear gradient evident in the death rates from respiratory system diseases in either of the periods shown, although the differential between Quintiles 1 and 5 has increased (by 116.2 per cent) from 0.84 in 1985-89 to 1.81 in 1992-95. This was the largest increase in the differential in **Darwin** for the causes studied.

Death rates of 15 to 64 year old people from the external causes of accidents, poisonings and violence are highest in the most disadvantaged areas of **Darwin**. However the differential in 1992-95 is smaller than in 1985-89 (down from 1.60 to 1.07).

The last graph in **Figure 9.5** shows details for all other causes of death between the ages of 15 and 64 years. After higher rates in Quintile 1, there is a gradient in the death rates in both periods from Quintile 2 to Quintile 5. However, as a result of the increase in death rates in Quintile 1 and a reduction in Quintile 5, the differential between these quintiles has decreased, from 1.39 in 1985-89 to 0.98 in 1992-95.

In summary, the overall impression is that death rates for these causes vary between the quintiles; and that the rates have fallen in more of the quintiles than have seen an increase (35 quintiles have a lower death rate and 15 have a higher death rate).

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Using the *Social Health Atlas*

The social health atlas package

This second edition of *A Social Health Atlas of Australia* comprises:

- this volume for the Northern Territory and a companion volume (Volume 8.1) containing the data mapped (the numbers and rate/ratio/percentages on which the maps are based); and
- similar volumes for each of the other States and Territories and a separate atlas for Australia as a whole (each of these atlases also has a companion volume containing the data mapped).

Some of the data from the atlas are also available on the **HealthWIZ** statistics database product, which comprises comprehensive health statistics from Australia's hospital systems, cause of death registries, population censuses, cancer registries, Medicare and income support system, as well as details of aged care and child care.

This volume contains general background information to the atlas, as well as maps of selected variables showing patterns of socioeconomic status, health status and health and welfare service use at a small area level. Each of these maps is accompanied by a commentary.

The text and maps can also be downloaded for reading and printing from the Public Health Information Development Unit World Wide Web site at www.publichealth.gov.au. The text (including the maps and graphs) and datasets on which the maps are based are available on CD-ROM (for Windows). Further details are in Appendix 1.1, *Project Resources and Output*.

Content

The atlas has nine chapters, an appendix, a bibliography and an index. The chapters are:

- 1 Introduction
- 2 Methods
- 3 Demography and socioeconomic status
- 4 Income support payments
- 5 Health status
- 6 Utilisation of health services
- 7 Availability of selected health services
- 8 Statistical analysis
- 9 Summary

Chapters 1 and 2 provide an overview of the atlas and the approach taken in analysing and mapping data. These sections contain important information on the limitations of the mapped data. The Appendix provides additional background information, and the *Glossary*, at the end of this section, defines some of the terms used.

Chapters 3 to 7 each provide an introduction to the topic(s) being mapped, as well as the maps and associated commentary.

Chapter 8 shows the results of the correlation and cluster analyses. Chapter 9 presents details of the major changes noted in the data between this second and the first edition, as well as some summary measures of the health differentials calculated from the health status and health service utilisation data mapped in Chapters 5 and 6.

Using the atlas

Some people will use the atlas as a reference source, either going to particular maps (eg. of hospital surgical procedures), or using the index to find a particular topic (eg. deaths from circulatory system diseases) or variable (eg. tonsillectomy).

Others may choose to examine the correlation matrices and to then view the maps for variables for which the data are highly correlated. Or they may access the data in a spreadsheet and re-group the SLAs to suit their own purpose, recalculating the percentages or standardised ratios to represent the new spatial groupings.

To assist users in reading the maps, the layout of the two map types used most frequently is described below. The more detailed discussion in Chapter 2 on the way in which the data have been analysed and presented is, however, important in terms of gaining an understanding of how best to use the data and maps in this atlas. Users of the atlas are particularly encouraged to read this chapter to ensure they are aware of the deficiencies in the datasets presented, as well as in the mapping approach used.

Map of Darwin

Area mapped

The area mapped is the Statistical Division of **Darwin** (generally known as the capital city area). The spatial unit mapped is the Statistical Local Area (SLA). However, SLAs in **Darwin** are based on suburbs and are relatively small (and much smaller on average than SLAs in most other large cities). Small SLAs are likely to have smaller numbers of cases (whether of population, hospital admissions or of deaths) and these are likely to produce results (percentages, ratios) which are less reliable than those for larger areas. Throughout the atlas, estimates with small numbers of cases have not been mapped. To ensure that the majority of areas in these major urban centres are of sufficient size to produce useful results, many of the SLAs have been grouped to form larger areas. The groupings approximate (and are frequently the same as) individual postcode areas.

Additional details, including key maps to assist in the location and identification of particular SLAs and postcode areas, are in *Appendix 1.2*: a set of clear film overlays to assist in this process is included in a pocket inside the back cover of this atlas.

Data measures mapped

The map sub-title indicates the format in which the data are presented. In a majority of cases, data are mapped as either a percentage or age (or age-sex) standardised ratio (the process of

standardisation is described in Appendix 1.3, *Analysis and presentation of data*). The exceptions are the maps, in Chapter 7, of the location of selected health services; the Index of Relative Socio-Economic Disadvantage mapped in Chapter 3; the infant death rate; and the Total Fertility Rate.

The legend shows the data ranges used to indicate the spatial distribution of the characteristic being mapped.

Footnotes on the map page draw attention to particular aspects of the mapped data and the source of data.

Description

The text associated with the maps provides background information on the variable being mapped and describes the pattern of distribution of the variable at the SLA level.

The commentary in the top section provides information about the topic being mapped, as well as a comparison between the capital cities and, where the data is available, refers to the situation reported in the first edition of the atlas. For variables where the data are age (or age-sex) standardised, these comparisons are made across Australia (with Australia as the standard for comparison).

In the lower two thirds of the page, attention is drawn to other sources of information about the variable, or characteristics of the population under discussion. The pattern of distribution shown in the map is then described, and associations evident in the correlation analysis with other variables are noted. Users should note that in these descriptions, where data has been standardised, it has been re-calculated to a new standard – in this atlas, to the Northern Territory rates (rather than the Australian rates). This allows comparisons to be made between the rates for the SLAs or postcode groups within **Darwin**, and the Northern Territory rates – ie. in effect the Territory average. This differs from the commentary on the top of the page, for which comparisons are made with the Australian rates.

Where the numbers of cases are relatively small (and, in particular, where these small numbers are associated with elevated rates), the absolute numbers are included in the commentary. The numbers (as well as the percentages, rates and ratios) are available in printed and electronic forms and should be used in conjunction with the information in this atlas.

Map of the Northern Territory: referred to as the 'non-metropolitan areas' of the Northern Territory Area mapped

The spatial units mapped are again SLAs: however **Darwin** is mapped as one area (ie. not by SLA) to enhance comparisons between the capital city and non-metropolitan areas.

Towns with a population of 7,500 or more (but less than the urban centre cut-off of 100,000) are represented on the maps as circles. Unfortunately, data for many towns is not available for the datasets in the atlas (other than the Census data).

As noted above in relation to the map of **Darwin**, additional details are in *Appendix 1.2*: a set of clear film overlays to assist in the location and identification of particular SLAs is included in a pocket inside the back cover of this atlas.

Data measures mapped

See comments above concerning **Darwin**.

Description

Again, commentary in the top section provides information about the topic being mapped, as well as national comparisons, this time comparing the 'other' major urban centres (those population centres of 100,000 or larger which are not capital cities) and the areas of Australia outside of the capital cities and other major urban centres. These regional/rural/remote areas are referred to in the text as 'non-metropolitan areas'. Where the data are age (or age-sex) standardised, the standard is, again, Australia.

The lower two thirds of the page again draws attention to other sources of information about the variable, or characteristics of the population under discussion. The pattern of distribution shown in the map is then described, and associations evident in the correlation analysis with other variables are noted. Users should note that in these descriptions, where data has been standardised, it has been re-calculated to a new standard – in this atlas, to the Northern Territory rates (rather than the Australian rates). This allows comparisons to be made between the rates for the SLAs within the non-metropolitan areas of the Northern Territory and the Territory rates – ie. in effect the Territory average.

The cautions in the main introduction and in the introductory notes to each chapter are particularly relevant to the non-metropolitan areas, with their geographically large SLAs and relatively small, scattered populations.

Additional information: ARIA Index

In addition to the map, the map page includes a graph showing the average measure for the variable in each of five levels of accessibility/remoteness, as determined by the Accessibility/Remoteness Index for Australia (ARIA). This Index is described in more detail in Chapter 2, under the heading *Accessibility and Remoteness*. In brief, each SLA in Northern Territory has been allocated to one of five categories, which range from Highly Accessible, through Accessible, Moderately Accessible and Remote, to Very Remote. The average percentage, rate or ratio for each of the five categories is then calculated for each variable and presented as a graph. The graph is accompanied by a brief comment on the distribution across the categories.

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Colin Mathers of the AIHW and Theo Voss of the Victorian Department of Human Services readily agreed to the use in the atlas of the results of their recent (unpublished) studies into links between socioeconomic status and health status.

All of the data in Chapter 3, as well as a range of other data used throughout the atlas, were purchased from the Australian Bureau of Statistics (ABS). The staff of the Adelaide office of the ABS handled these requests and were thorough and helpful in assisting us to define the data so that it was comparable with that published in the first edition of the atlas. The staff of the ABS office in Darwin were also helpful in providing details of population counts for areas affected by boundary changes that had implications for the datasets being used.

The cluster analysis was a major exercise and was undertaken in a highly professional manner by Graeme Tucker. The ARIA graphs and the graphs in Chapter 9 were exported from a module produced by Andrew McAlindon. This module streamlined the calculation of the many rates, percentages etc. used in these sections of the atlas, as well as the production of the final graphs.

Diana Hetzel and Jeanette Pope provided invaluable support in strengthening the discussion of the socioeconomic determinants of health in Chapter 1. Diana contributed in a number of other ways, in particular by providing much of the referenced background material in the topic introductions throughout the atlas; she also read the final drafts. Tony Woollacott and Fearnley Szuster read a number of earlier drafts and Fearnley also provided many useful comments on later drafts. Thanks are also due to Julie Johinke who produced the cover design, and to Paul Doherty for the photographic image used on the cover.

The final responsibility for the content and comment remains with me.

John Glover
Project Manager
December 1999

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Glossary and Explanatory notes

Cause of death

Causes of death are classified by the Australian Bureau of Statistics to the Ninth (1975) Revision of the World Health Organisation's International Classification of Diseases (ICD-9) which was adopted for world-wide use from 1979.

The cause of death particulars in this publication relate to the underlying cause of death, which the World Health Organisation has defined as the disease or injury which initiated the train of morbid events leading directly to death. Accidental and violent deaths are classified to the circumstances of the accident or violence which produced the fatal injury. Deaths of infants aged less than one month are classified according to the main condition in the infant which contributed to the death.

Details of the ICD-9 codes applicable to the variables mapped in Chapter 5 are shown in *Appendix 1.4*.

Coding of hospital admissions

Diagnoses and procedures are classified according to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM October 1988 Revision). External causes are classified according to ICD-9-CM Supplementary Classification of External Causes of Injury and Poisoning ('E' codes) classification codes.

Details of the codes applicable to the variables mapped in Chapter 6 are shown in *Appendix 1.4*.

Admissions

The technical term describing a completed hospital episode (ie. the discharge, death or transfer of a patient) is a 'separation'.

At the time of admission, the age, sex, address of usual residence and other personal details of the patient are recorded. At the end of the episode, at the time of separation from hospital, details of the episode itself are recorded, including the principal diagnosis (and other diagnoses), principal procedure (and other procedures), and the date, time and method (discharge, transfer or death) of separation. Consequently, hospital inpatient data collections are based on separations. In this atlas the more commonly used term of 'admission' has been used. In an analysis such as this, which excludes long stay patients (other than the few long stay acute patients), there is little difference between the number of admissions and the number of separations in a year. Also, 'admission' is a much more familiar term to many people who will use this atlas.

Standardised ratios

Data on which many of the variables have been mapped has been adjusted to remove differences in the data between areas mapped where those differences result from differences in the age and/or sex profiles of the populations being examined. This standardisation process is described in Appendix 1.3, *Analysis and presentation of data*.

Statistical Local Area

The Statistical Local Area (SLA) is a standard geographic area established by the Australian Bureau of Statistics (ABS) to cover the whole of Australia, for the purposes of geographically coding data. It is, in a majority of cases, equivalent to a legal local government area (LGA). SLAs comprise whole LGAs; part LGAs (where the LGA has been split for planning, administrative or statistical purposes); or are unincorporated areas. In Northern Territory there were 8 LGAs and 63 SLAs at 1 July 1996 (ABS 1996).

Symbols used

n.a. not available

.. not applicable

- nil, or less than half the final digit shown

CGC Community Government Council

S Shire

T Town

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