A SOCIAL HEALTH ATLAS OF AUSTRALIA

Second Edition

Volume 7: Tasmania

John Glover, Vija Watts and Sarah Tennant

December 1999

Φ PHIDU Public Health Information Development Unit

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National Library of Australia Cataloguing in Publication entry

Glover, John, 1945-
A social health atlas of Australia

2nd ed.
Bibliography.
Includes index.
ISBN 0 7308 9021 X (set).

ISBN 0 7308 9028 7 (v. 7).

1. Medical geography –Australia - Maps. 2. Medical - geography –Australia - Statistics. 3. Public health –Australia - Maps. 4. Public health –Australia - Statistics. 5. Health facilities –Australia – Utilization - Maps. 6. Health facilities –Australia –Utilization –Statistics. 7. Health surveys – Australia. I. Watts, Vija. II. Tennant, Sarah. III. University of Adelaide. Public Health Information Development Unit. IV. Commonwealth Department of Health and Aged Care (Australia). V. Title.

362.10994

A Social Health Atlas of Australia was produced by the Public Health Information Development Unit, University of Adelaide, South Australia. The project was funded by the Commonwealth Department of Health and Aged Care and supported by the South Australian Department of Human Services.

The majority of data mapped in the atlas, and the maps, was produced by Prometheus Information Pty Ltd, using the HealthWIZ software package. Further details of these and other contributors to the project are noted in the *Acknowledgements*.

Cover design by Julie Johinke using a photograph by Paul Doherty (photograph entitled *Merti Merti Sandhills, Strzelecki Track*).

Printed in Australia by Openbook Publishers.

Related publications and software products

A Social Health Atlas of Australia, 1992, Vols 1 & 2

HealthWIZ: details available at www.prometheus.com.au

Social health atlas World Wide Web site: www.publichealth.gov.au

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

Introduction

The information in this atlas adds to a convincing body of evidence built up over a number of years in Australia as to 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.

Background

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 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 correlations of significance at the SLA level between the indicators of socioeconomic disadvantage and a number of the health status variables in **Hobart**. The strongest of these were generally with the variables for people reporting their health as fair or poor (as opposed to those reporting their health as being excellent, very good, or good); the Physical Component Summary (PCS, a measure of physical health); and the handicap status of the population (**Table 8.1**). Similarly, strong associations were also evident in the correlation analysis with the health service use variables of admissions to hospital (total admissions and admissions to public acute hospitals), as well as admissions for lung cancer, circulatory system diseases, ischaemic heart disease, surgical procedures, hysterectomy.

There were fewer correlations of significance at the SLA level in the non-metropolitan areas of Tasmania than was the case in **Hobart**. This is, in part, a result of the number of areas with relatively small numbers of cases (population, deaths, hospital admissions, etc.) which reduces the strength of the analysis. However a number of variables are highly correlated with each other: these are the variables for single parent families, low income families, unemployed people, dwellings rented from the State housing authority and dwellings without a vehicle. Various sub-sets of these are correlated with measures of health status and 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, and the PCS. Although generally weaker, there was a consistent association between socioeconomic disadvantage and the variables for deaths of males; admissions of males; and admissions for circulatory system diseases; the external causes of accidents, poisonings and violence; and surgical procedures.

Changes in socioeconomic status

Marked variations were recorded between 1986 and 1996 for a majority of the socioeconomic status variables mapped for Tasmania (**Table 9.1**). For **Hobart**, the largest increases were for the population of Aboriginal and Torres Strait Islander people (an increase of 120.3 per cent over this ten year period); low income families (38.2 per cent); single parent families (37.8 per cent); the occupational grouping of managers and administrators, and professionals (35.6 per cent); people aged 65 years and over (24.8 per cent); unemployed people (17.3 per cent); and female labour force participation (10.1 per cent). The largest decreases recorded over this ten year period were for the variables for unskilled and semi-skilled workers (down by 18.5 per cent) and unemployment among 15 to 19 year olds (down by 15.3 per cent).

Variations of this order were also recorded in the non-metropolitan areas of Tasmania. The major differences from the changes noted for **Hobart** were the smaller increases in the population of Aboriginal and Torres Strait Islander people and the occupational grouping of managers and administrators; and larger decrease for unemployment among 15 to 19 year olds.

Substantial variations were recorded in income support payments to residents of **Hobart** for all of the payment types analysed, other than the Age Pension, for which there was a small decrease (a decrease of 5.7 per cent). The number of recipients for each of the other payment types increased substantially, with large increases occurring for disability support pensioners (an increase of 62.6 per cent) and unemployment beneficiaries (61.1 per cent) (**Table 9.1**). Similar, although larger increases were recorded in the non-metropolitan areas of Tasmania for all of these income support payments other than the Age Pension, for which there was a larger decrease (5.9 per cent).

Changes in death rates

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

In **Hobart**, the largest decreases were recorded in the infant death rate (down by 23.2 per cent); and for deaths of people aged from 15 to 64 years from circulatory system diseases (down by 35.0 per cent), lung cancer (down by 29.4 per cent) and respiratory system diseases (down by 15.9 per cent). All causes mortality was 18.4 per cent lower over this period, marginally more so for males than for females.

There were also reductions in rates of premature death in the non-metropolitan areas of Tasmania for all but respiratory system diseases (for which there was a slight increase). However the reductions were all lower, excluding infant deaths and premature deaths from accidents, poisonings and violence, than those recorded for **Hobart**.

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 17). The SLAs in **Hobart** 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 Tasmania have been treated 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 for the most disadvantaged SLAs (those in Quintiles 4 and 5) to have the highest rates. The most notable exception is the Physical Component Summary (PCS) score, for which low scores indicate poorer health. There is also a less consistent pattern evident for a number of the variables for premature deaths, with relatively low rates in Quintile 5 (**Figure 9.2**).

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 73 (27 per cent fewer YPLL than were expected from the Australian rates) to an SR of 115 in Quintile 4 (with 15 per cent more YPLL than were expected from the Australian rates): there was a lower SR of 101 in Quintile 5, the most disadvantaged areas. Similar differentials were also evident for deaths of 15 to 64 year olds from circulatory system diseases (from an SDR of 74 in Quintile 1 to 115 in Quintile 4 and 110 in Quintile 5) and females (77 in Quintile 1 to 126 in Quintile 4); and deaths of 15 to 64 years olds from respiratory system diseases (48 to 231).

The main differences from the charts for **Hobart** are the stronger gradients evident for many of the variables.

Health service utilisation

Although there is some variability across the quintiles, the pattern is generally for the most advantaged SLAs (those in Quintile 1) to have the lowest admission rates, and for the most disadvantaged SLAs (those in Quintile 5) to have the highest rates. The major exceptions include the variables for admissions to a private hospital, admissions for infectious and parasitic diseases and psychosis. There is a less consistent pattern evident for a number of the other variables, particularly those involving a same day admission or admissions for cancer or a lens insertion. There are only minor variations between the quintiles in the percentages for immunisation rates of children at age 12 months (**Figure 9.3**).

The main differences from the charts for **Hobart** are the stronger gradients evident for many of the variables.

Change in health status by socioeconomic status of area of residence

As noted above, there has been an overall decrease in death rates in Tasmania; 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 **Hobart**.

Death rates in **Hobart** declined between 1985-89 and 1992-95 for all of the causes of death, both overall and in the majority of quintiles of socioeconomic status of area.

It is clear, however, that despite the overall decline, the strong gradient in death rates between the quintiles remains. In fact, the differential in death rates for male residents aged from 15 to 64 years between Quintile 1 and Quintile 5 was 2.11 in both 1985-89 and 1992-95: ie. the rates in the most disadvantaged areas were more than twice those in the most advantaged areas.

For females, overall death rates decreased to a similar extent to those for males, and the differential in death rates for female residents aged from 15 to 64 years between Quintile 1 and Quintile 5 also decreased, from 1.85 times higher in the most disadvantaged areas in 1985-89 to 1.78 times higher in 1992-95.

The differential in infant deaths rate between Quintile 1 (the most advantaged areas) and Quintile 5 (the most disadvantaged areas) has increased notably, from five per cent higher in the most disadvantaged areas in 1985-89 (a rate ratio of 1.05) to more than twice as high in 1992-95 (a rate ratio of 2.42).

Death rates in the 15 to 64 year age group declined for all cancers and for lung cancer (a larger decline), and the differential in rates between Quintile 1 and Quintile 5 also declined, from 1.64 times higher in the most disadvantaged areas in 1985-89 to 1.33 times higher in 1992-95 for cancer, and, more substantially so, for lung cancer, from 3.31 to 1.84.

The overall decline in death rates for deaths of 15 to 64 year olds from circulatory system diseases was the highest among the causes of death studied, at over one third (35.0 per cent) in **Hobart**. The differential in rates between Quintile 1 and Quintile 5 increased, from 2.07 times higher in the most disadvantaged areas in 1985-89 to 2.29 times higher in 1992-95.

The differential in death rates from respiratory system diseases across the quintiles of socioeconomic status of area of residence in **Hobart** increased substantially. In 1985-89 it was 2.61; by 1992-95 it had increased (by 40.6 per cent) to 3.67. This was the largest differential in death rates for any of the causes studied.

Death rates of 15 to 64 year old people from the external causes of accidents, poisonings and violence are also highest in the most disadvantaged areas of **Hobart**. Again, the differential in 1992-95 is higher than in 1985-89 (up from 2.68 to 2.85).

Conclusion

There is clear evidence in the data of an association at the SLA level between high premature death rates (both for deaths from all causes and from most specific causes) and socioeconomic disadvantage, as measured by the IRSD. These associations are generally evident not only between the most advantaged (Quintile 1) and disadvantaged areas (Quintile 5), but also at each of the intervening levels of socioeconomic status (Quintiles 2 to 4) (**Figures 9.2 and 9.4**).

Similarly, there are associations between socioeconomic disadvantage and high rates of hospital admission in both **Hobart** and the non-metropolitan areas of Tasmania (**Figures 9.3 and 9.5**).

It is also clear that, despite an overall improvement in death rates from all causes and for all of the specific causes studied for **Hobart** (**Table 9.2**, **Figure 9.6**), these improvements have not resulted in significant overall reductions in the disparities evident in death rates between residents of the most well off areas and those in the poorest areas.

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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 Tasmania and a companion volume (Volume 7.1) 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 Hobart

Area mapped

The area mapped is the Statistical Division of **Hobart** (generally known as the capital city area). The spatial unit mapped is the Statistical Local Area (SLA).

Additional details, including key maps to assist in the location and identification of particular SLAs, 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 Tasmanian State rates (rather than the Australian rates). This allows comparisons to be made between the rates for the SLAs within **Hobart**, and the Tasmanian rates – ie. in effect the State 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 Tasmania: referred to as the 'non-metropolitan areas' of Tasmania

Area mapped

The spatial units mapped are again SLAs: however **Hobart** is mapped as one area (ie. not by SLA) to enhance comparisons between this major urban centre and the 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 **Hobart**, 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 **Hobart**.

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 Tasmanian State rates (rather than the Australian rates). This allows comparisons to be made between the rates for the SLAs within the non-metropolitan areas of Tasmania and the State rates – ie. in effect the State 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 Tasmania 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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Acknowledgements

The atlas series was produced with the assistance of a number of people and organisations. This atlas for Tasmania was produced by John Glover, Vija Watts and Sarah Tennant, with the assistance of Kevin Harris. Sarah was also responsible for day to day management of the data (for checking and storing it), for producing many of the tables and graphs, and for generally keeping in touch with the whole project. Some of the early drafting of Chapter 3 in this atlas was undertaken by David Forster and Cameron Joyce, and Caroline Bruce was responsible for the majority of the work in checking and validating the Census data that was supplied for all of the atlases. These three people moved on to other jobs in the early stages of this project. Lucy Glover checked the data in the drafts against the source material and edited it as necessary. Nicholas Glover inserted many of the map files (as did Kieran Moors) and set up the graphs in Chapter 9.

Outside the Public Health Information Development Unit (PHIDU), Prometheus Information Pty Ltd was the major contributor to the project. Prometheus is contracted by the Commonwealth Department of Health and Aged Care to develop HealthWIZ, the software which was used to produce the maps in this atlas and the data tables (on which the maps are based) in Volume 1.1. Some of the information was already held by Prometheus, and other information needed to be obtained from various Commonwealth, State and Territory agencies and added to the HealthWIZ database in a way that ensured comparability. This was no small task. Although the HealthWIZ software included a mapping facility, the particular approach to publishing the atlas required that special arrangements be made to output the maps in a suitable format. For example, the maps were exported from HealthWIZ and pasted into frames in a MS Word document. Each of these documents was then inserted into the appropriate page in the atlas. Much of the work was highly complex and technical, and required attention to detail and knowledge of the datasets (in particular in identifying potential problems in the data and following these up to confirm or correct them) and statistical geography over a number of years. The quality of the final result, evident in the published product, is testimony to their efforts. George Preston, a Director of the company, was always willing to assist. His knowledge of health statistics and his statistical expertise were frequently of value in making decisions about alternative approaches to the analysis and interpretation of data. Daryel Akerlind and Alain Remont designed the software enhancements to provide the pullouts and town overlays for the maps. Other major contributors at Prometheus were Jane Gorrie and Jennifer Chorley, Zlatan Dzumhur, Jane Lindsay, Jennie Widdowson, Ayse Idehen and (in the earlier stages of the project) Swandi Candra.

In addition to funding the project, the Commonwealth Department of Health and Aged Care took a keen interest in the ongoing work. A number of people had a key role in this, including Ruth Parslow, Karl Higgins and Frances Byers (in aspects of project establishment and contract management) and Jan Bennett and Brendan Gibson (overall direction of the project). In more recent months, Joy Eshpeter and Renata Rustowski have had a major role in seeing the project signed off and in negotiating release arrangements. The support and encouragement of this group of people (and others in the Department) has been greatly appreciated, as were their comments on the final drafts.

The South Australian Department of Human Services had contract responsibility for the atlas for much of the time over which it was produced. They provided a supportive environment in which the atlas could be produced, and made possible the transition of responsibility for the project to PHIDU in April 1999. The support of many people in the Department, including the Chief Executive, Christine Charles, is gratefully acknowledged.

The Australian Institute of Health and Welfare (AIHW) provided the majority of the hospital inpatient data. The AIHW provided other background descriptive material for this chapter, in addition to the data mapped. The main individuals who assisted were Jenny Hargreaves, Janis Shaw and Paul Halliday. The State and Territory health agencies all provided additional details of hospital admissions not available from the AIHW (of admissions of residents of one State or Territory occurring in another).

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 Hobart 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 the 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 Tasmania there were 29 LGAs and 44 SLAs at 1 July 1996 (ABS 1996).

Symbols used

n.a.	not available
..	not applicable
-	nil, or less than half the final digit shown
C	City
M	Municipality

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