

# ***A SOCIAL HEALTH ATLAS OF AUSTRALIA***

***Second Edition***

## **Volume 2: New South Wales**

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**December 1999**

 **Public Health Information Development Unit**

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## Related publications and software products

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

HealthWIZ: details available at [www.prometheus.com.au](http://www.prometheus.com.au)

Social health atlas World Wide Web site: [www.publichealth.gov.au](http://www.publichealth.gov.au)

## Foreword

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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

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The information in this atlas 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.

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 use of general medical practitioner services in the major urban centres, and for most of the variables for hospital admission in both the major urban centres and the non-metropolitan areas of New South Wales (**Figures 9.4 and 9.5**). The gradients for admissions by socioeconomic status of area are particularly strong in the non-metropolitan SLAs.

It is also clear that, despite an overall improvement in death rates from all causes and for all of the specific causes studied (with the exception of the 'other causes' group) for **Sydney, Newcastle** and **Wollongong** (**Table 9.2, Figure 9.6**), these improvements have not resulted in any significant reduction in the disparities evident in death rates between residents of the most well off areas and those in the poorest areas. In fact, for all but infant deaths and deaths from the external causes of accidents, poisonings and violence, the gap in death rates has increased (**Figure 9.6**).

## Correlation analysis

There were correlations of significance at the SLA level between the indicators of socioeconomic disadvantage drawn from the 1996 Population Census (Chapter 3) and a number of the health status variables. In **Sydney**, 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); the handicap status of the population; and premature deaths from circulatory and respiratory system diseases (**Table 8.1**). Similarly strong associations were evident in the correlation analysis with the variables for the use of GP services by males and females; and of admissions to hospital for circulatory and respiratory system diseases, and admissions to a public hospital.

There were fewer correlations of significance at the SLA level in the non-metropolitan areas of New South Wales than was the case in **Sydney**. 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 low income families, unemployed people, Indigenous Australians, people born in non-English speaking countries, people with poor proficiency in English and dwellings without a vehicle.

Various sub-sets of these indicators of socioeconomic disadvantage are correlated with indicators 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. There was a consistent although weaker association between socioeconomic disadvantage and the variables for deaths of males; hospital admissions of males and females; and hospital admissions from circulatory and respiratory system diseases.

There was a correlation of substantial significance at the SLA level between high proportions of the Indigenous population and the variable for years of potential life lost (the summary measure of premature death). There were also correlations of substantial significance with high rates of admission to hospital (the total of public and private hospitals); admissions to a public hospital; admissions from the combined causes of accidents, poisonings and violence; and admissions for neuroses.

## Changes over time in socioeconomic status

Marked variations were recorded between 1986 and 1996 for a majority of the socioeconomic status variables mapped for New South Wales (**Table 9.1**). For **Sydney**, the largest increases were for the population of Aboriginal and Torres Strait Islander people (an increase of 85.3 per cent over this ten year period); the occupational grouping of managers and administrators, and professionals (41.3 per cent); people born overseas in

predominantly non-English speaking countries: an increase of 41.2 per cent for those resident for five years or more, of 33.2 per cent for those resident for less than five years, and of 36.0 per cent for those with poor proficiency in English; single parent families (30.3 per cent); low income families (29.8 per cent); and housing authority rented dwellings (23.0 per cent). The largest decreases recorded over this ten year period were for the variables for unemployment among 15 to 19 year olds (down by 26.5 per cent) and early school leavers (down by 17.8 per cent).

Variations of this order were also recorded in the non-metropolitan areas of New South Wales. The major differences from the changes noted for **Sydney** were larger increases in the population aged 65 years and over, single parent families and dwellings without a motor vehicle; and smaller increases for the occupations of managers and administrators and professionals, Indigenous people, each of the three variables for people born overseas in predominantly non-English speaking countries, and housing authority rented dwellings.

Changes over this period for the major urban centres of **Newcastle** and **Wollongong** were relatively consistent, with the exception of the population aged from 0 to 4 years, unemployment (all ages), the three variables for people born overseas in predominantly non-English speaking countries, housing authority rented dwellings and dwellings without a motor vehicle: the change recorded for these variables varied between the two cities. The changes in **Newcastle** and **Wollongong** were generally consistent with those recorded for **Sydney** (and frequently showed larger increases), other than for the variable for the population aged 65 years and over and the three variables for people born overseas in predominantly non-English speaking countries (which all recorded lower increases).

Substantial variations were recorded in income support payments to residents of **Sydney** for all of the payment types analysed (Disability Support pension, Sole Parent Pension and unemployment benefits), other than the Age Pension, for which there was a small decrease (a decrease of 4.1 per cent). The number of recipients for each of the other payment types increased substantially, with the number of disability support pensioners doubling (an increase of 100 per cent) and similar increases occurring for dependent children (68.6 per cent) and disability support pensioners (65.7 per cent) (**Table 9.1**). Similar, although smaller increases were recorded in the non-metropolitan areas of New South Wales for all of these income support payments other than the Age Pension, for which there was a much smaller increase (5.8 per cent). The increases in **Newcastle** and **Wollongong** were more in line with those recorded for the non-metropolitan areas of the State than with those in **Sydney**.

### Changes over time in death rates

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

In **Sydney**, the largest decreases were recorded in the infant death rate (down by 34.4 per cent); and for deaths of people aged from 15 to 64 years from circulatory system diseases (-42.2 per cent), respiratory system diseases (-30.7 per cent) and accidents, poisonings and violence (-28.9 per cent). All causes

mortality was 25.4 per cent lower over this period, marginally more so for males than for females.

There were reductions in death rates for each of the causes studied for **Newcastle** and **Wollongong**, with the decreases being generally more pronounced in **Wollongong**.

There were also reductions in rates of premature death in the non-metropolitan areas of New South Wales for all but cancer (for which there was a slight increase). However the reductions were all lower than those recorded for **Sydney**, at around half (52.4 per cent) for all cause mortality.

### Differences in health 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 the major urban centres of **Sydney**, **Newcastle** and **Wollongong** 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.

### Health status by socioeconomic status of area of residence

Although there is some variability across the quintiles, the pattern is always 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 exception is the Physical Component Summary, for which low scores indicate poorer health (**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 72 (28 per cent fewer YPLL than were expected from the New South Wales State rates) to an SR of 122 in the most disadvantaged areas (indicating that there were 22 per cent more YPLL than were expected from the State rates). Large differentials were also evident for deaths of 15 to 64 year old males (from an SDR of 74 in Quintile 1 to 127 in Quintile 5) and deaths of 15 to 64 years olds from lung cancer (70 to 124), circulatory system diseases (66 to 117) and respiratory system diseases (61 to 124).

The most notable differences from the gradients evident for **Sydney** and the other major urban centres are deaths from the external causes of accidents, poisonings and violence (for the 15 to 64 year age group, the ratios are less consistent, and for the 15 to 24 year group are substantially different) and for the Total Fertility Rate (which shows little association in the non-metropolitan areas with socioeconomic status) (**Figure 9.4**).

## Health service utilisation by socioeconomic status of area of residence

Although there is some variability across the quintiles for the health service utilisation variables for SLAs in **Sydney, Newcastle** and **Wollongong**, the pattern is generally for the most advantaged SLAs (those in Quintile 1) to have the lowest rates of admission, and for the most disadvantaged SLAs (those in Quintile 5) to have the highest rates. The exceptions include the variables for admissions to a private hospital, for all cancers and for breast cancer of females aged 40 years and over, and for the surgical procedures of myringotomy, hip replacement and endoscopy. Others, including the variables for admissions for psychosis and same day admissions for a surgical procedure, reveal a less consistent pattern (**Figure 9.3**).

The main differences from the gradients evident for **Sydney** and the other major urban centres are for the variables for GP services to males and females and for admissions to a private hospital and admissions for cancer; breast cancer; psychosis; neurotic, personality and other mental disorders; and for a myringotomy (**Figure 9.5**).

## Changes over time in health status by socioeconomic status of area of residence

As noted above, there has been an overall decrease in death rates in New South Wales; 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 **Sydney, Newcastle** and **Wollongong**.

With the exception of the 'other' causes group (for which there was an increase in death rates in each quintile, other than Quintile 4), death rates in **Sydney, Newcastle** and **Wollongong** declined between 1985-89 and 1992-95 for all of the causes of death studied, both overall and in each quintile 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 (the most advantaged areas) and Quintile 5 (the most disadvantaged areas) increased, from 1.71 times higher in the most disadvantaged areas in 1985-89 to 1.87 times higher in 1992-95. Similar differentials occur for other deaths variables studied.

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 increased, from 1.38 times higher in the most disadvantaged areas in 1985-89 to 1.45 times higher in 1992-95.

Infant death rates declined by around one third (34.4 per cent and 34.1 per cent) in **Sydney** and **Wollongong** respectively between 1985-89 and 1992-95 (and by 12.8 per cent in **Newcastle**), and the differential in rates between Quintile 1 and Quintile 5 also declined, from 1.31 times higher in the most disadvantaged areas in 1985-89 to 1.18 times higher in 1992-95.

Despite a decline in death rates of the 15 to 64 year old population for all cancers and lung cancer (with a larger decline), the differential in rates between Quintile 1 and Quintile 5 increased, from 1.38 times higher in the most disadvantaged areas in 1985-89 to 1.45 times higher in 1992-95 for cancer, and from 1.78 to 2.14 for lung cancer.

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 40 per cent in **Sydney** and one third in **Newcastle** and **Wollongong**. The differential in rates between Quintile 1 and Quintile 5 increased from 1.80 times higher in the most disadvantaged areas in 1985-89 to 2.03 times higher in 1992-95.

The gradients in deaths rates from respiratory system diseases across the quintiles of socioeconomic status of area of residence in **Sydney, Newcastle** and **Wollongong** are particularly strong over both periods. In 1985-89, the differential between Quintiles 1 and 5 was 2.20; by 1992-95 this had increased (by 17.4 per cent) to 2.58. This was the largest differential 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 **Sydney, Newcastle** and **Wollongong**. Unlike most of the other variables described above, the differential in 1992-95 is marginally smaller than in 1985-89 (down from 1.42 to 1.40). This is a result of the larger declines in death rates in Quintiles 2 (the largest, down by 31.7 per cent), 4 (-27.5 per cent) and 5 (-27.0 per cent).

Death rates for 15 to 24 year olds from these external causes show a different pattern. Although rates are down strongly in all quintiles, there is little difference in the rates between Quintiles 1, 2 and 5, although the rate in Quintile 5 is marginally the highest.

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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 New South Wales and a companion volume (Volume 2.1) 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](http://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 Sydney, Newcastle and Wollongong

### Area mapped

The area mapped is the Statistical Division of **Sydney** (generally known as the capital city area) and the Statistical Subdivisions of **Newcastle** and **Wollongong**. These latter two areas are referred to as 'other major urban centre': together with **Sydney**, they comprise the three major urban centres (urban centres with a population of 100,000 or more) in New South Wales. 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 New South Wales State rates (rather than the Australian rates). This allows comparisons to be made between the rates for the SLAs within **Sydney**, **Newcastle** and **Wollongong**, and the New South Wales 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 New South Wales: referred to as the ‘non-metropolitan areas’ of New South Wales

### Area mapped

The spatial units mapped are again SLAs: however **Sydney**, **Newcastle** and **Wollongong** are each mapped as one area (ie. not by SLA) to enhance comparisons between these major urban centres 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 **Sydney**, 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 **Sydney**.

## 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 New South Wales 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 New South Wales 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 New South Wales 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.

# Contents

<b>Chapter</b>	<b>Page</b>
<b>Foreword</b>	iii
<b>Executive summary</b>	v
<b>Using the <i>Social Health Atlas</i></b>	ix
<b>List of maps</b>	xiv
<b>List of tables</b>	xviii
<b>List of figures</b>	xxii
<b>Acknowledgements</b>	xxiii
<b>Glossary and explanatory notes</b>	xxv
<b>1 Introduction</b>	1
<b>2 Methods</b>	7
<b>3 Demography and socioeconomic status</b>	15
<b>Introduction, data sources and explanatory notes</b>	
<b>Age distribution</b>	
children aged 0 to 4 years	20
people aged 65 years and over	24
<b>Families</b>	
single parent families	28
low income families	32
<b>Labour force</b>	
unskilled and semi-skilled workers	36
unemployed people	38
female labour force participation	42
<b>Educational participation and achievement</b>	
people who left school at age 15 years or less, or did not go to school	46
<b>Aboriginal and Torres Strait Islander people</b>	50
<b>People born in predominantly non-English speaking countries</b>	
number resident in Australia for five years or more	54
number resident in Australia for less than five years	58
proficiency in English	62
<b>Housing</b>	
dwellings rented from State/Territory housing authority	66
dwellings with no motor vehicle	70
<b>SEIFA Index of Relative Socio-Economic Disadvantage</b>	74
<b>4 Income support payments</b>	79
<b>Introduction, data sources and explanatory notes</b>	
Age pensioners	82
Disability support pensioners	86
Female sole parent pensioners	90
People receiving an unemployment benefit	94
Dependent children of selected pensioners and beneficiaries	98

<b>Chapter</b>	<b>Page</b>
<b>5 Health status</b>	103
<b>Introduction, data sources and explanatory notes</b>	
<b>Synthetic Predictions of selected health status measures</b>	109
<b>Introduction, data sources and explanatory notes</b>	
<b>People reporting their health as fair or poor</b>	112
<b>Physical Component Summary, SF36</b>	116
<b>Handicap status</b>	120
<b>Deaths</b>	125
<b>Introduction, data sources and explanatory notes</b>	
under one year of age : infant deaths	132
15 to 64 year olds	
all causes: males	136
all causes: females	140
all cancers	144
lung cancer	148
circulatory system diseases	152
respiratory system diseases	156
accidents, poisonings and violence	161
15 to 24 year olds	
accidents, poisonings and violence	168
<b>Years of potential life lost</b>	172
<b>Total Fertility Rate</b>	177
<b>6 Utilisation of health services</b>	183
<b>Introduction, data sources and explanatory notes</b>	
<b>Hospital admissions (including for surgical procedures)</b>	185
<b>Introduction and explanatory notes</b>	
public acute hospitals and private hospitals	196
public acute hospitals	200
private hospitals	204
public acute and private hospitals	
males	208
females	212
same day patients	216
infectious and parasitic diseases	220
all cancers	224
lung cancer	228
cancer of the female breast	232
psychosis	236
neurotic, personality or other mental disorders	240
all circulatory system diseases	244
ischaemic heart disease	248
all respiratory system diseases	252
0 to 4 years olds with respiratory system disease	256
bronchitis, emphysema and asthma	260
accidents, poisonings and violence	264

<b>Chapter</b>	<b>Page</b>
<b>Hospital admissions for surgical procedures</b>	269
<b>Introduction, data sources and explanatory notes</b>	
admissions for a surgical procedure	272
same day admissions for a surgical procedure	276
tonsillectomy and/or adenoidectomy	280
myringotomy	284
Caesarean section	288
hysterectomy	292
hip replacement	296
lens insertion	300
endoscopy	304
<b>General medical practitioner (GP) services</b>	309
<b>Introduction, data sources and explanatory notes</b>	
GP services	
males	312
females	316
<b>Immunisation status of one year old children</b>	320
<b>7 Availability of selected health services</b>	325
<b>Introduction, data sources and explanatory notes</b>	
Population per GP	328
Hospital beds	
public acute hospitals	332
private hospitals	336
Residential care places	
Nursing home places	340
Hostel places	344
<b>8 Statistical analysis</b>	349
<b>Introduction and explanatory notes</b>	
<b>Correlation analysis</b>	349
<b>Cluster analysis</b>	355
<b>9 Summary of findings</b>	375
<b>Introduction</b>	
<b>Changes in data rates between editions</b>	375
<b>Summary of findings by socioeconomic status of area of residence</b>	376
<b>Appendix 1: Supporting documentation</b>	387
1.1 Project resources and output	389
1.2 Geographic areas mapped	391
1.3 Analysis and presentation of data	397
1.4 Classification of deaths, admissions and procedures	399
1.5 Synthetic estimates for small area	401
1.6 Additional details of cluster analysis	405
<b>Bibliography</b>	409
<b>Index</b>	419

# List of maps

<b>Chapter &amp; Map</b>	<b>Page</b>
<b>2 Methods</b>	
2.1 Accessibility/Remoteness Index of Australia (ARIA), 1996	9
2.2 Accessibility/Remoteness Index of Australia (ARIA), for SLAs in New South Wales, 1996	10
<b>3 Demography and socioeconomic status</b>	
3.1 Children aged 0 to 4 years, Sydney, Newcastle and Wollongong, 1996	21
3.2 Children aged 0 to 4 years, New South Wales, 1996	23
3.3 People aged 65 years and over, Sydney, Newcastle and Wollongong, 1996	25
3.4 People aged 65 years and over, New South Wales, 1996	27
3.5 Single parent families, Sydney, Newcastle and Wollongong, 1996	29
3.6 Single parent families, New South Wales, 1996	31
3.7 Low income families, Sydney, Newcastle and Wollongong, 1996	33
3.8 Low income families, New South Wales, 1996	35
3.9 Unskilled and semi-skilled workers, Sydney, Newcastle and Wollongong, 1996	37
3.10 Unemployed people, Sydney, Newcastle and Wollongong, 1996	39
3.11 Unemployed people, New South Wales, 1996	41
3.12 Female labour force participation, Sydney, Newcastle and Wollongong, 1996	43
3.13 Female labour force participation, New South Wales, 1996	45
3.14 People who left school at age 15 years or less, or did not go to school, Sydney, Newcastle and Wollongong, 1996	47
3.15 People who left school at age 15 years or less, or did not go to school, New South Wales, 1996	49
3.16 Aboriginal and Torres Strait Islander people, Sydney, Newcastle and Wollongong, 1996	51
3.17 Aboriginal and Torres Strait Islander people, New South Wales, 1996	53
3.18 People born in predominately non-English speaking countries and resident in Australia for five years or more, Sydney, Newcastle and Wollongong, 1996	55
3.19 People born in predominately non-English speaking countries and resident in Australia for five years or more, New South Wales, 1996	57
3.20 People born in predominately non-English speaking countries and resident for less than five years, Sydney, Newcastle and Wollongong, 1996	59
3.21 People born in predominately non-English speaking countries and resident for less than five years, New South Wales, 1996	61
3.22 Poor proficiency in English of people aged five years and over and born in predominately non-English speaking countries, Sydney, Newcastle and Wollongong, 1996	63
3.23 Poor proficiency in English of people aged five years and over and born in predominately non-English speaking countries, New South Wales, 1996	65
3.24 Dwellings rented from the State housing authority, Sydney, Newcastle and Wollongong, 1996	67
3.25 Dwellings rented from the State housing authority, New South Wales, 1996	69
3.26 Dwellings with no motor vehicles, Sydney, Newcastle and Wollongong, 1996	71
3.27 Dwellings with no motor vehicles, New South Wales, 1996	73
3.28 SEIFA Index of Relative Socio-Economic Disadvantage, Sydney, Newcastle and Wollongong, 1996	75
3.29 SEIFA Index of Relative Socio-Economic Disadvantage, New South Wales, 1996	77
<b>4 Income support payments</b>	
4.1 Age pensioners, Sydney, Newcastle and Wollongong, 30 June 1996	83
4.2 Age pensioners, New South Wales, 30 June 1996	85
4.3 Disability support pensioners, Sydney, Newcastle and Wollongong, 30 June 1996	87
4.4 Disability support pensioners, New South Wales, 30 June 1996	89
4.5 Female sole parent pensioners, Sydney, Newcastle and Wollongong, 30 June 1996	91
4.6 Female sole parent pensioners, New South Wales, 30 June 1996	93
4.7 People receiving an unemployment benefit, Sydney, Newcastle and Wollongong, 30 June 1996	95
4.8 People receiving an unemployment benefit, New South Wales, 30 June 1996	97
4.9 Dependent children of selected pensioners and beneficiaries, Sydney, Newcastle and Wollongong, 30 June 1996	99
4.10 Dependent children of selected pensioners and beneficiaries, New South Wales, 30 June 1996	101

**5 Health status**

5.1	People reporting their health as fair or poor, Sydney, Newcastle and Wollongong, 1995	113
5.2	People reporting their health as fair or poor, New South Wales, 1995	115
5.3	Physical Component Summary, SF-36, Sydney, Newcastle and Wollongong, 1995	117
5.4	Physical Component Summary, SF-36, New South Wales, 1995	119
5.5	Estimated number of people with a handicap, Sydney, Newcastle and Wollongong, 1993	121
5.6	Estimated number of people with a handicap, New South Wales, 1993	123
5.7	Infant deaths, Sydney, Newcastle and Wollongong, 1992 to 1995	133
5.8	Infant deaths, New South Wales, 1992 to 1995	135
5.9	Deaths of males aged 15 to 64 years from all causes, Sydney, Newcastle and Wollongong, 1992 to 1995	137
5.10	Deaths of males aged 15 to 64 years from all causes, New South Wales, 1992 to 1995	139
5.11	Deaths of females aged 15 to 64 years from all causes, Sydney, Newcastle and Wollongong, 1992 to 1995	141
5.12	Deaths of females aged 15 to 64 years from all causes, New South Wales, 1992 to 1995	143
5.13	Deaths of people aged 15 to 64 years from cancer, Sydney, Newcastle and Wollongong, 1992 to 1995	145
5.14	Deaths of people aged 15 to 64 years from cancer, New South Wales, 1992 to 1995	147
5.15	Deaths of people aged 15 to 64 years from lung cancer, Sydney, Newcastle and Wollongong, 1992 to 1995	149
5.16	Deaths of people aged 15 to 64 years from lung cancer, New South Wales 1992 to 1995	151
5.17	Deaths of people aged 15 to 64 years from circulatory system diseases, Sydney, Newcastle and Wollongong, 1992 to 1995	153
5.18	Deaths of people aged 15 to 64 years from circulatory system diseases, New South Wales, 1992 to 1995	155
5.19	Deaths of people aged 15 to 64 years from respiratory system diseases, Sydney, Newcastle and Wollongong, 1992 to 1995.	157
5.20	Deaths of people aged 15 to 64 years from respiratory system diseases, New South Wales, 1992 to 1995	159
5.21	Deaths of people aged 15 to 64 years from accidents, poisonings and violence, Sydney, Newcastle and Wollongong, 1992 to 1995	165
5.22	Deaths of people aged 15 to 64 years from accidents, poisonings and violence, New South Wales, 1992 to 1995	167
5.23	Deaths of people aged 15 to 24 years from accidents, poisonings and violence, Sydney, Newcastle and Wollongong, 1992 to 1995	169
5.24	Deaths of people aged 15 to 24 years from accidents, poisonings and violence, New South Wales, 1992 to 1995	171
5.25	Deaths of people aged 15 to 64 years; years of potential life lost, Sydney, Newcastle and Wollongong, 1992 to 1995	173
5.26	Deaths of people aged 15 to 64 years; years of potential life lost, New South Wales, 1992 to 1995	175
5.27	Total Fertility Rate, Sydney, Newcastle and Wollongong, 1992 to 1995	179
5.28	Total Fertility Rate, New South Wales, 1992 to 1995	181

**6 Utilisation of health services**

6.1	Admissions to public acute hospitals and private hospitals, Sydney, Newcastle and Wollongong, 1995/96	197
6.2	Admissions to public acute hospitals and private hospitals, New South Wales, 1995/96	199
6.3	Admissions to public acute hospitals, Sydney, Newcastle and Wollongong, 1995/96	201
6.4	Admissions to public acute hospitals, New South Wales, 1995/96	203
6.5	Admissions to private hospitals, Sydney, Newcastle and Wollongong, 1995/96	205
6.6	Admissions to private hospitals, New South Wales, 1995/96	207
6.7	Admissions of males, Sydney, Newcastle and Wollongong, 1995/96	209
6.8	Admissions of males, New South Wales, 1995/96	211
6.9	Admissions of females, Sydney, Newcastle and Wollongong, 1995/96	213
6.10	Admissions of females, New South Wales, 1995/96	215
6.11	Same day admissions, Sydney, Newcastle and Wollongong, 1995/96	217
6.12	Same day admissions, New South Wales, 1995/96	219
6.13	Admissions for infectious and parasitic diseases, Sydney, Newcastle and Wollongong, 1995/96	221
6.14	Admissions for infectious and parasitic diseases, New South Wales, 1995/96	223
6.15	Admissions for cancer, Sydney, Newcastle and Wollongong, 1995/96	225
6.16	Admissions for cancer, New South Wales, 1995/96	227
6.17	Admissions for lung cancer, Sydney, Newcastle and Wollongong, 1995/96	229
6.18	Admissions for lung cancer, New South Wales, 1995/96	231
6.19	Admissions of females aged 40 years and over for breast cancer, Sydney, Newcastle and Wollongong, 1995/96	233
6.20	Admissions of females aged 40 years and over for breast cancer, New South Wales, 1995/96	235
6.21	Admissions for psychosis, Sydney, Newcastle and Wollongong, 1995/96	237
6.22	Admissions for psychosis, New South Wales, 1995/96	239
6.23	Admissions for neurotic, personality or other mental disorders, Sydney, Newcastle and Wollongong, 1995/96	241
6.24	Admissions for neurotic, personality or other mental disorders, New South Wales, 1995/96	243

<b>Chapter &amp; Map</b>	<b>Page</b>
6.25 Admissions for circulatory system diseases, Sydney, Newcastle and Wollongong, 1995/96	245
6.26 Admissions for circulatory system diseases, New South Wales, 1995/96	247
6.27 Admissions for ischaemic heart disease, Sydney, Newcastle and Wollongong, 1995/96	249
6.28 Admissions for ischaemic heart disease, New South Wales, 1995/96	251
6.29 Admissions for respiratory system disease, Sydney, Newcastle and Wollongong, 1995/96	253
6.30 Admissions for respiratory system diseases, New South Wales, 1995/96	255
6.31 Admissions of children aged 0 to 4 years for respiratory system diseases, Sydney, Newcastle and Wollongong, 1995/96	257
6.32 Admissions of children aged 0 to 4 years for respiratory system diseases, New South Wales, 1995/96	259
6.33 Admissions for bronchitis, emphysema or asthma, Sydney, Newcastle and Wollongong, 1995/96	261
6.34 Admissions for bronchitis, emphysema or asthma, New South Wales, 1995/96	263
6.35 Admissions from accidents, poisonings and violence, Sydney, Newcastle and Wollongong, 1995/96	265
6.36 Admissions from accidents, poisonings and violence, New South Wales, 1995/96	267
6.37 Admissions for a surgical procedure, Sydney, Newcastle and Wollongong, 1995/96	273
6.38 Admissions for a surgical procedure, New South Wales, 1995/96	275
6.39 Same day admissions for a surgical procedure, Sydney, Newcastle and Wollongong, 1995/96	277
6.40 Same day admissions for a surgical procedure, New South Wales, 1995/96	279
6.41 Admissions for a tonsillectomy and/or adenoidectomy, Sydney, Newcastle and Wollongong, 1995/96	281
6.42 Admissions for a tonsillectomy and/or adenoidectomy, New South Wales, 1995/96	283
6.43 Admissions of children aged 0 to 9 years for a myringotomy, Sydney, Newcastle and Wollongong, 1995/96	285
6.44 Admissions of children aged 0 to 9 years for a myringotomy, New South Wales, 1995/96	287
6.45 Admissions of females aged 15 to 44 years for a Caesarean section, Sydney, Newcastle and Wollongong, 1995/96	289
6.46 Admissions of females aged 15 to 44 years for a Caesarean section, New South Wales, 1995/96	291
6.47 Admissions of females aged 30 years and over for an hysterectomy, Sydney, Newcastle and Wollongong, 1995/96	293
6.48 Admissions of females aged 30 years and over for an hysterectomy, New South Wales, 1995/96	295
6.49 Admissions for a hip replacement, Sydney, Newcastle and Wollongong, 1995/96	297
6.50 Admissions for a hip replacement, New South Wales, 1995/96	299
6.51 Admissions for a lens insertion, Sydney, Newcastle and Wollongong, 1995/96	301
6.52 Admissions for a lens insertion, New South Wales, 1995/96	303
6.53 Admissions for an endoscopy, Sydney, Newcastle and Wollongong, 1995/96	305
6.54 Admissions for an endoscopy, New South Wales, 1995/96	307
6.55 General medical practitioner services to males, Sydney, Newcastle and Wollongong, 1996	313
6.56 General medical practitioner services to males, New South Wales, 1996	315
6.57 General medical practitioner services to females, Sydney, Newcastle and Wollongong, 1996	317
6.58 General medical practitioner services to females, New South Wales, 1996	319
6.59 Immunisation status of children at 12 months of age, Sydney, Newcastle and Wollongong, 1998	321
6.60 Immunisation status of children at 12 months of age, New South Wales, 1998	323
<b>7 Availability of selected health services</b>	
7.1 Population per general medical practitioner, Sydney, Newcastle and Wollongong, 1996/97	329
7.2 Population per general medical practitioner, New South Wales, 1996/97	331
7.3 Public acute hospital beds per 1,000 population, Sydney, Newcastle and Wollongong, 1995/96	333
7.4 Public acute hospital beds per 1,000 population, New South Wales, 1995/96	335
7.5 Private hospital beds per 1,000 population, Sydney, Newcastle and Wollongong, 30 June 1997	337
7.6 Private hospital beds per 1,000 population, New South Wales, 30 June 1997	339
7.7 Nursing home places per 1,000 population aged 70 years and over, Sydney, Newcastle and Wollongong, 30 June 1997	341
7.8 Nursing home places per 1,000 population aged 70 years and over, New South Wales, 30 June 1997	343
7.9 Hostel places per 1,000 population aged 70 years and over, Sydney, Newcastle and Wollongong, 30 June 1997	345
7.10 Hostel places per 1,000 population aged 70 years and over, New South Wales, 30 June 1997	347

<b>Chapter &amp; Map</b>	<b>Page</b>
<b>8 Statistical analysis</b>	
8.1 Socioeconomic clusters based on Statistical Local Areas in Sydney, Newcastle and Wollongong	360
8.2 Health status clusters based on Statistical Local Areas in Sydney, Newcastle and Wollongong	361
8.3 Health service utilisation clusters based on Statistical Local Areas in Sydney, Newcastle and Wollongong	362
8.4 Social health clusters based on Statistical Local Areas in Sydney, Newcastle and Wollongong	363
8.5 Socioeconomic clusters based on Statistical Local Areas in New South Wales	368
8.6 Health status clusters based on Statistical Local Areas in non-metropolitan areas of New South Wales	369
8.7 Health service utilisation clusters based on Statistical Local Areas in non-metropolitan areas of New South Wales	370
8.8 Social health clusters based on Statistical Local Areas in non-metropolitan areas of New South Wales	371
<b>Appendix 1</b>	
A1 Key map for Statistical Local Areas in Sydney, Newcastle and Wollongong, 1996	392
A2 Key map for Statistical Local Areas in the non-metropolitan areas of New South Wales, 1996	394

# List of tables

<b>Chapter &amp; Table</b>	<b>Page</b>
<b>1 Introduction</b>	
1.1 Correlation coefficients for small areas in Sydney	2
1.2 Small area data of relevance to the National Health Priority Areas	4
<b>2 Methods</b>	
2.1 Conversion of 1996 deaths data to SLA using the ABS Census-based postcode converter: deaths by age group for selected SLAs, South Australia, 1996	12
<b>3 Demography and socioeconomic status</b>	
3.1 Population and area, New South Wales, 1996	15
3.2 Population of Indigenous Australians, 1986 to 1996	16
3.3 Details of demographic and socioeconomic variables mapped	18
3.4 Proportion of population aged 0 to 4 years, capital cities	20
3.5 Proportion of population aged 0 to 4 years, State/Territory	22
3.6 Proportion of population aged 65 years and over, capital cities	24
3.7 Proportion of population aged 65 years and over, State/Territory	26
3.8 Structure of population aged 65 years and over, New South Wales, 1986 and 1996	26
3.9 Single parent families, capital cities	28
3.10 Single parent families, State/Territory	30
3.11 Low income families, capital cities	32
3.12 Low income families, State/Territory	34
3.13 Unskilled and semi-skilled workers, capital cities	36
3.14 Unemployed people, capital cities	38
3.15 Unemployed people, State/Territory	40
3.16 Unemployment rates by age, sex and area, New South Wales, 1996	40
3.17 Female labour force participation, capital cities	42
3.18 Female labour force participation, State/Territory	44
3.19 People who left school at age 15 years or less, or did not go to school, capital cities	46
3.20 People who left school at age 15 years or less, or did not go to school, State/Territory	48
3.21 Aboriginal and Torres Strait Islander people, capital cities	50
3.22 Aboriginal and Torres Strait Islander people, State/Territory	52
3.23 People born in predominantly non-English speaking countries and resident in Australia for 5 years or more, capital cities	54
3.24 People born in predominantly non-English speaking countries and resident in Australia for 5 years or more, State/Territory	56
3.25 People born in predominantly non-English speaking countries and resident in Australia for less than 5 years, capital cities	58
3.26 People born in predominantly non-English speaking countries and resident in Australia for less than 5 years, State/Territory	60
3.27 Poor proficiency in English of people aged 5 years and over and born in predominantly non-English speaking countries, capital cities	62
3.28 Poor proficiency in English of people aged 5 years and over and born in predominantly non-English speaking countries, State/Territory	64
3.29 Dwellings rented from the State housing authority, capital cities	66
3.30 Dwellings rented from the State housing authority, State/Territory	68
3.31 Dwellings with no motor vehicle, capital cities	70
3.32 Dwellings with no motor vehicle, State/Territory	72
3.33 SEIFA Index of Relative Socio-Economic Disadvantage, capital cities	74
3.34 SEIFA Index of Relative Socio-Economic Disadvantage, State/Territory	76

<b>4</b>	<b>Income support payments</b>	
4.1	Income support payments mapped, 30 June 1996	79
4.2	Age pensioners, capital cities	82
4.3	Age pensioners, State/Territory	84
4.4	Disability support pensioners, capital cities	86
4.5	Disability support pensioners, State/Territory	88
4.6	Female sole parent pensioners, capital cities	90
4.7	Female sole parent pensioners, State/Territory	92
4.8	People receiving an unemployment benefit, capital cities	94
4.9	People receiving an unemployment benefit, State/Territory	96
4.10	Dependent children of selected pensioners and beneficiaries, capital cities	98
4.11	Dependent children of selected pensioners and beneficiaries, State/Territory	100
<b>5</b>	<b>Health Status</b>	
5.1	Health status indicators by socioeconomic disadvantage of area and sex, Australia, late 1980s	103
5.2	Rate ratio of mortality inequality by socioeconomic disadvantage of area, 1985-87 and 1995-97	104
5.3	People reporting their health as fair or poor, capital cities	112
5.4	People reporting their health as fair or poor, State/Territory	114
5.5	Physical Component Summary, capital cities, 1995	116
5.6	Physical Component Summary, State/Territory, 1995	118
5.7	Estimated number of people with a handicap, capital cities	120
5.8	Estimated number of people with a handicap, State/Territory	122
5.9	Deaths by cause and age, New South Wales, 1992 to 1995	127
5.10	Deaths by selected cause and area, New South Wales, 1992 to 1995	128
5.11	Infant deaths, capital cities	132
5.12	Infant deaths, State/Territory	134
5.13	Deaths of males aged 15 to 64 years from all causes, capital cities	136
5.14	Deaths of males aged 15 to 64 years from all causes, State/Territory	138
5.15	Deaths of females aged 15 to 64 years from all causes, capital cities	140
5.16	Deaths of females aged 15 to 64 years from all causes, State/Territory	142
5.17	Deaths of people aged 15 to 64 years from cancer, capital cities	144
5.18	Deaths of people aged 15 to 64 years from cancer, State/Territory	146
5.19	Deaths of people aged 15 to 64 years from lung cancer, capital cities	148
5.20	Deaths of people aged 15 to 64 years from lung cancer, State/Territory	150
5.21	Deaths of people aged 15 to 64 years from circulatory system diseases, capital cities	152
5.22	Deaths of people aged 15 to 64 years from circulatory system diseases, State/Territory	154
5.23	Deaths of people aged 15 to 64 years from respiratory system diseases, capital cities	156
5.24	Deaths of people aged 15 to 64 years from respiratory system diseases, State/Territory	158
5.25	Deaths from accidents, poisonings & violence, by cause, New South Wales, 1992 to 1995	161
5.26	Deaths from accidents, poisonings and violence, by area of residence, New South Wales, 1992 to 1995	161
5.27	Deaths of people aged 15 to 64 years from accidents, poisonings and violence, capital cities	164
5.28	Deaths of people aged 15 to 64 years from accidents, poisonings and violence, State/Territory	166
5.29	Deaths of people aged 15 to 24 years from accidents, poisonings and violence, capital cities	168
5.30	Deaths of people aged 15 to 24 years from accidents, poisonings and violence, State/Territory	170
5.31	Deaths of people aged 15 to 64 years: years of potential life lost, capital cities, 1992 to 1995	172
5.32	Deaths of people aged 15 to 64 years: years of potential life lost, State/Territory, 1992 to 1995	174
5.33	Total Fertility Rate, capital cities, 1992 to 1995	178
5.34	Total Fertility Rate, State/Territory, 1992 to 1995	180

**6 Utilisation of health services**

6.1	Health service use by socioeconomic disadvantage of area and sex, Australia, late 1980s	183
6.2	Admissions of Indigenous Australians to public acute and private hospitals, by cause, Australia, 1996/97	186
6.3	Public acute and private hospital admissions included in the analysis, New South Wales, 1995/96	192
6.4	Public acute and private hospital admissions, by type of admission: Comparison between editions	194
6.5	Admissions of residents of New South Wales by State/Territory of location of hospital, 1995/96	194
6.6	Admissions to public acute hospitals and private hospitals, capital cities	196
6.7	Admissions to public acute hospitals and private hospitals, State/Territory	198
6.8	Admissions to public acute hospitals, capital cities, 1995/96	200
6.9	Admissions to public acute hospitals, State/Territory, 1995/96	202
6.10	Admissions to private hospitals, capital cities, 1995/96	204
6.11	Admissions to private hospitals, State/Territory, 1995/96	206
6.12	Admissions of males, capital cities	208
6.13	Admissions of males, State/Territory	210
6.14	Admissions of females, capital cities	212
6.15	Admissions of females, State/Territory	214
6.16	Same day admissions, capital cities, 1995/96	216
6.17	Same day admissions, State/Territory, 1995/96	218
6.18	Admissions with a principal diagnosis of infectious and parasitic diseases, capital cities	220
6.19	Admissions with a principal diagnosis of infectious and parasitic diseases, State/Territory	222
6.20	Admissions with a principal diagnosis of cancer, capital cities	224
6.21	Admissions with a principal diagnosis of cancer, State/Territory	226
6.22	Admissions with a principal diagnosis of lung cancer, capital cities	228
6.23	Admissions with a principal diagnosis of lung cancer, State/Territory	230
6.24	Admissions of females aged 40 years and over with a principal diagnosis of breast cancer, capital cities	232
6.25	Admissions of females aged 40 years and over with a principal diagnosis of breast cancer, State/Territory	234
6.26	Admissions with a principal diagnosis of psychosis, capital cities, 1995/96	236
6.27	Admissions with a principal diagnosis of psychosis, State/Territory, 1995/96	238
6.28	Admissions with a principal diagnosis of neurotic, personality or other mental disorders, capital cities, 1995/96	240
6.29	Admissions with a principal diagnosis of neurotic, personality or other mental disorders, State/Territory, 1995/96	242
6.30	Admissions with a principal diagnosis of circulatory system diseases, capital cities	244
6.31	Admissions with a principal diagnosis of circulatory system diseases, State/Territory	246
6.32	Admissions with a principal diagnosis of ischaemic heart disease, capital cities	248
6.33	Admissions with a principal diagnosis of ischaemic heart disease, State/Territory	250
6.34	Admissions with a principal diagnosis of respiratory system diseases, capital cities	252
6.35	Admissions with a principal diagnosis of respiratory system diseases, State/Territory	254
6.36	Admissions of 0 to 4 year olds with a principal diagnosis of respiratory system diseases, capital cities	256
6.37	Admissions of 0 to 4 year olds with a principal diagnosis of respiratory system diseases, State/Territory	258
6.38	Admissions with a principal diagnosis of bronchitis, emphysema or asthma, capital cities	260
6.39	Admissions with a principal diagnosis of bronchitis, emphysema or asthma, State/Territory	262
6.40	Admissions with an external cause of accidents, poisonings and violence, capital cities	264
6.41	Admissions with an external cause of accidents, poisonings and violence, State/Territory	266
6.42	Admission rates for selected sentinel procedures, public and private hospitals, 1996/1997	269
6.43	Standardised admission ratios for selected surgical procedures, New South Wales	269
6.44	Admissions for a surgical procedure, capital cities, 1995/96	272
6.45	Admissions for a surgical procedure, State/Territory, 1995/96	274
6.46	Same day admissions for a surgical procedure, capital cities, 1995/96	276
6.47	Same day admissions for a surgical procedure, State/Territory, 1995/96	278
6.48	Admissions with a principal procedure of tonsillectomy and/or adenoidectomy, capital cities, 1995/96	280
6.49	Admissions with a principal procedure of tonsillectomy and/or adenoidectomy, State/Territory, 1995/96	282
6.50	Admissions of children aged 0 to 9 years with a principal procedure of myringotomy, capital cities, 1995/96	284
6.51	Admissions of children aged 0 to 9 years with a principal procedure of myringotomy, State/Territory, 1995/96	286
6.52	Admissions of females aged 15 to 44 years with a principal procedure of Caesarean section, capital cities, 1995/96	288
6.53	Admissions of females aged 15 to 44 years with a principal procedure of Caesarean section, State/Territory, 1995/96	290
6.54	Admissions of females aged 30 years and over with a principal procedure of hysterectomy, capital cities, 1995/96	292
6.55	Admissions of females aged 30 years and over with a principal procedure of hysterectomy, State/Territory, 1995/96	294

<b>Chapter &amp; Table</b>	<b>Page</b>
6.56 Admissions with a principal procedure of hip replacement, capital cities, 1995/96	296
6.57 Admissions with a principal procedure of hip replacement, State/Territory, 1995/96	298
6.58 Admissions for a lens insertion, capital cities, 1995/96	300
6.59 Admissions for a lens insertion, State/Territory, 1995/96	302
6.60 Admissions with a principal procedure of endoscopy, capital cities, 1995/96	304
6.61 Admissions with a principal procedure of endoscopy, State/Territory, 1995/96	306
6.62 Location of Royal Flying Doctor Service bases and number of services, 1997	310
6.63 General medical practitioner services to males, capital cities	312
6.64 General medical practitioner services to males, State/Territory	314
6.65 General medical practitioner services to females, capital cities	316
6.66 General medical practitioner services to females, State/Territory	318
6.67 Proportion of children who were fully immunised at 12 months of age, capital cities, 1998	320
6.68 Proportion of children who were fully immunised at 12 months of age, capital cities, 1998	322
<b>7 Availability of selected health services</b>	
7.1 Patient days for nursing home type patients in public acute hospitals, by area, States and Territories, 1997/98	326
7.2 Nursing home and hostel places per 1,000 population aged 70 years and over, 1997	326
7.3 Population per general medical practitioner, capital cities	328
7.4 Population per general medical practitioner, State/Territory	330
7.5 Public acute hospital beds per 1,000 population, capital cities	332
7.6 Public acute hospital beds per 1,000 population, State/Territory	334
7.7 Private hospitals beds per 1,000 population, capital cities	336
7.8 Private hospital beds per 1,000 population, State/Territory	338
7.9 Nursing home places per 1,000 population aged 70 years and over, capital cities	340
7.10 Nursing home places per 1,000 population aged 70 years and over, State/Territory	342
7.11 Hostel places per 1,000 population aged 70 years and over, capital cities	344
7.12 Hostel places per 1,000 population aged 70 years and over, State/Territory	346
<b>8 Statistical analysis</b>	
8.1 Correlation matrix for SLAs in Sydney	351
8.2 Correlation matrix for SLAs in the non-metropolitan areas of New South Wales	353
8.3 Variables used in cluster analysis	355
8.4 Composition of SLA clusters in Sydney	356
8.5 Composition of SLA clusters in Newcastle and Wollongong	359
8.6 Composition of SLA clusters in the non-metropolitan areas of New South Wales	365
8.7 Composition of town clusters in Australia	373
<b>9 Summary of findings</b>	
9.1 Changes in demographic and socioeconomic status variables, by Section of State, New South Wales	375
9.2 Changes in health status variables, by Section of State, New South Wales	376
<b>Appendix</b>	
A1 Urban centres in New South Wales	391
A2 Key to Statistical Local Areas in Sydney, Newcastle and Wollongong, 1996	393
A3 Key to Statistical Local Areas in non-metropolitan areas of New South Wales, 1996	395
A4 Data sources	398
A5 ICD-9 Codes for causes of death mapped in Chapter 5	399
A6 ICD-9 Codes for diagnoses/external causes mapped in Chapter 6	399
A7 ICPM Codes for surgical procedures mapped in Chapter 6	399

# List of figures

<b>Chapter &amp; Figure</b>	<b>Page</b>
<b>3 Demography and socioeconomic status</b>	
3.1 SEIFA Index of Relative Socio-Economic Disadvantage, capital cities	74
3.2 SEIFA Index of Relative Socio-Economic Disadvantage, Rest of State/Territory	76
<b>4 Income support payments</b>	
4.1 Age pensioners, New South Wales, 1996	80
4.2 Disability support pensioners, New South Wales, 1996	80
4.3 Female sole parent pensioners, New South Wales, 1996	81
4.4 Unemployment beneficiaries, New South Wales, 1996	81
<b>5 Health Status</b>	
5.1 Death rates of people aged from 15 to 64 years, by cause, Australia	126
5.2 Death rates of people aged from 15 to 64 years, by cause, New South Wales	126
5.3 Deaths from all causes, by age and sex, New South Wales, 1992 to 1995	128
5.4 Deaths from cancer, by age and sex, New South Wales, 1992 to 1995	129
5.5 Deaths from circulatory system diseases, by age and sex, New South Wales, 1992 to 1995	129
5.6 Deaths from respiratory system diseases, by age and sex, New South Wales, 1992 to 1995	129
5.7 Deaths from accidents, poisonings and violence, by age and sex, New South Wales, 1992 to 1995	130
5.8 Suicide rates of people aged from 25 to 64 years., Sydney and Rest of State	131
5.9 Suicide rates of people aged from 15 to 24 years, Sydney and Rest of State	131
5.10 Total Fertility Rate, Sydney and Rest of State, 1992 to 1995	177
<b>6 Utilisation of health services</b>	
6.1 Admissions to public acute and private hospitals, by age, New South Wales and Australia, 1995/96	186
6.2 Admissions to public acute and private hospitals, by age and sex, New South Wales, 1995/96	187
6.3 Admissions to public acute hospitals, by age and sex, New South Wales, 1995/96	187
6.4 Admissions to private hospitals, by age and sex, New South Wales, 1995/96	188
6.5 Same day admissions, by age and sex, New South Wales, 1995/96	188
6.6 Admissions for circulatory system diseases, by age and sex, New South Wales, 1995/96	189
6.7 Admissions for respiratory system diseases, by age and sex, New South Wales, 1995/96	189
6.8 Admissions from accidents, poisonings and violence, by age and sex, New South Wales, 1995/96	190
6.9 Admissions for a surgical procedure, by age and sex, New South Wales, 1995/96	190
6.10 Same day admissions for a surgical procedure, by age and sex, New South Wales, 1995/96	190
6.11 General medical practitioner services, by age and sex, New South Wales, 1996-97	310
<b>9 Summary of findings</b>	
9.1 Differentials in IRSD scores for SLAs in Sydney	377
9.2 Health status differentials by quintile of socioeconomic disadvantage of area, Sydney, Newcastle and Wollongong	378
9.3 Health service utilisation differentials by quintile of socioeconomic disadvantage of area, Sydney, Newcastle and Wollongong	379
9.4 Health status differentials by quintile of socioeconomic disadvantage of area, Rest of State	381
9.5 Health service utilisation differentials by quintile of socioeconomic disadvantage of area, Rest of State	382
9.6 Change in health status by quintile of socioeconomic disadvantage of area, Sydney, Newcastle and Wollongong	385

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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

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## 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 New South Wales there were 177 LGAs and 189 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
- A NSW Local Government Area

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