SOCIAL HEALTH ATLAS AND 1989/90 NATIONAL HEALTH SURVEY

Information Circular No. 16

QUEENSLAND HEALTH

EPIDEMIOLOGY AND HEALTH INFORMATION BRANCH

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The Social Health Atlas of Australia, Volume 2, maps and tabulates health status, disability, risk factor and health related action prevalence. This report (Figure 1) summarises how various important health indicators in Queensland, Brisbane or the State balance (rural and provincial areas) compare to the Australian average. (see Glossary and Appendix for definitions and cautions re: interpretation).

GLOBAL HEALTH STATUS

Queenslanders reported somewhat higher levels of recent illness (4.5% above) and long-term conditions (7.1% above) than the Australian average.

In contrast, the Queensland prevalence of reported disability (4.9% below) and handicap (5.2% below) was lower than the national average. These lower prevalences were recorded in both Brisbane and the rural/provincial areas and were consistently present when specific handicaps were examined.

RECENT INJURY

Recent injury prevalence is 32.7% above the Australian average in Queensland with Brisbane having the highest capital city ratio (43.4% above). Rural and provincial Queensland prevalence is 23.9% above average.

Queensland Health's injury policy is currently under review. Prevention programs will target children, Aboriginal and Torres Strait Islanders (ATSI), low socioeconomic groups, young men and the elderly in their relevant settings e.g. the home, rural etc. The strategy in 1993 is to promote regional injury awareness.

National Goals and Targets for the year 2000 include:

1. To reduce the all-cause mortality from injury and poisoning for the whole population by 20% from a baseline 46 per 100,000 (1990).

2. To reduce hospital admissions for injury and poisoning among the Aboriginal (ATSI) males and females by 50% towards levels in the non-Aboriginal population from a baseline: rate ratio - males 2.4, females 3.5. (An example of one of the target groups).

PAP SMEARS AND MAMMOGRAMS IN WOMEN 18-64 YEARS

Queensland is above the national average for women ever having had mammography (8.3% above) and ever having had a Pap smear (7% above, the highest State ratio). Brisbane had the highest capital city ratio for Pap smears (6.5% above) and the second highest for mammography (15.8% above) after Sydney. Pap smears were also reported at a high rate in rural and provincial Queensland (7.4% above average).

The Queensland Breast Cancer Screening Program has a **State Plan** to establish a dedicated breast screening and assessment service in each of the health regions within a 5 year implementation strategy.

National Goals and Targets for the year 2000 for women's cancer prevention include:

1. To reduce the mortality from breast cancer in women aged 50-69 years by 10% from a baseline 72.8 per 100,000 (1990).

2. To reduce the mortality and morbidity from cervical cancer in sexually active women aged 18-70 years by 30% from a baseline 3.5 per 100,000 (1987).

LONG-TERM ASTHMA AND CHRONIC RESPIRATORY DISEASE

Queenslanders reported high levels of long term respiratory disease. Asthma prevalence is 18.4% above the Australian average and the prevalence of bronchitis or emphysema is 21.5% above. Brisbane (34% above) and Queensland had the highest capital and State ratios for asthma. Bronchitis and emphysema prevalence (31.6% above) in rural and provincial Queensland was high in comparison with similar areas in the rest of the country.

A **strategy on Passive Smoking** in the Hospitality Industry is to be launched mid 1993. It will target the risks to asthmatics from passive smoking. It is proposed to pilot outcome studies linked to hospitalisation for asthma in the Mackay Region. These have been endorsed as consistent with the National Asthma Strategy. There is a trial underway supported by NSW Health at the Bathurst Hospital.

National Goals and Targets for the Year 2000 include:

1. To reduce asthma mortality in people aged 10-29 years by 50% from a baseline 1.9 deaths per 100,000 (1990).

2. To reduce the asthma mortality in people aged under 75 by 25% from a baseline 5.1 deaths per 100,000 (1990).

SMOKING

Smoking prevalence was near the Australian average for males and females in Brisbane and Queensland as a whole.

The **Queensland Drug Strategy** incorporates goals to reduce the effects of passive smoking, to reduce premature death and illness associated with smoking and to favourably alter the population proportions of smokers and non-smokers with an emphasis on the young, Aboriginal and Torres Strait Islanders and the socioeconomically disadvantaged.

National Goals and Targets for the year 2000 include:

1. To reduce the smoking prevalence in males and females aged 16 years and over to 22% from baselines of 30% in males and 27% in females (1989).

2. To reduce the prevalence of current smoking in secondary school students 12-16 years from 27% to 22% in males and 30% to 24% in females (1987).

HIGH RISK ALCOHOL INTAKE

For high risk alcohol intake, rural and provincial Queensland was 24.8% above the national average. Despite respondents in Brisbane reporting near the average for this risk factor, the overall State prevalence was high (13.8% above average), second only to the Northern Territory.

The Alcohol and Drug Branch, Queensland Health is developing a comprehensive **Queensland Drug Strategy** at an intersectoral level. Broad policy objectives include the reduction of premature mortality and injury in high risk groups (e.g. youth), alcohol related traffic accident rates and the incidence of high risk and binge drinking.

National Goals and Targets for the year 2000 include:

1. To reduce the incidence of alcohol-related road accident fatalities (drivers, motorcyclists, pedestrians) in males 17-59 years by 30% from a baseline 4.6 per 100,000 (1988).

2. To reduce the percentage of drinkers 12-17 years who drink more than 5 drinks in a row at least once in the previous fortnight to 10% (females) and 20% (males) from baselines of 15% (age standardised females) and 26% (aged standardised males).

OBESITY AND OVERWEIGHT PREVALENCE

The prevalence of these risk factors was also near the national average for males and females across the State.

Concern has been expressed that the national average in regard to obesity has increased between the 1983 and 1989 National Heart Foundation survey periods. The proportion of males aged 25 to 64 years who were obese rose from 7.9% to 9.6% and for females 25 to 64 years it rose from 9.9% to 11.4%.

Goals and targets have been developed for various stages of life. Examples of National Goals and Targets for the year 2000 include:

1. To reduce the proportion of males and females aged 20-39 years who are obese to 4% in males from a baseline of 7.9% and to 5% in females from a baseline 8% (1989).

2. To reduce the proportion of males and females aged 60-69 years who are obese to 7% in males from a baseline of 11.9% and to 11% in females from a baseline 18% (1989).

LONG-TERM MENTAL DISORDERS AND RECENT USE OF TRANQUILLISERS/SEDATIVES

Queenslanders had the highest reported prevalence of mental disorders, 20% above the Australian average. Brisbane respondents reported rates 55.2% above average, and this was also the highest capital city prevalence.

Queensland and Brisbane also recorded the highest levels of use of tranquillisers and sedatives. Queensland was 12.5% above and Brisbane was 26.9% above average.

The policy directions and objectives for mental health services in Queensland are consistent with those identified in the National Mental Health Policy. Key policy directions identified to date are mainstreaming, integration, continuity of care, regional self-sufficiency, intersectoral linkages, consumer rights, accountability.

Mental Health Goals and Targets for the year 2000 and Beyond address five broad diagnostic groups:

a) Schizophrenia and Severe Mental Disorders
b) Organic Mental Disorders
c) Post-traumatic Stress disorder
d) Depression, Anxiety Disorders and Somatization Disorders
e) Conduct Disorders

Details on individual goals and targets are available from the Mental Health Branch, Queensland Health. (Contact the Director's office on (07) 234 0674)

LONG-TERM EYESIGHT AND HEARING DISORDERS

Queenslanders reported experiencing above average levels of correctable eyesight/refractive problems (9.3% above) and high levels of partial and complete deafness (23.2% above average). Queensland had the highest State prevalence for deafness. Eyesight and hearing disorders were above average in both Brisbane and rural/provincial areas.

HOSPITAL ADMISSIONS (PREVIOUS 12 MONTHS) AND PRIVATE HEALTH INSURANCE (HOSPITAL COVER)

Hospital admission ratios were above the national average in rural and provincial Queensland. They were 8.2% above average for all persons, 9.6% above average for females and 6.2% above for males (non-significant). This contrasted with below average ratios in the Brisbane area.

Queensland was the only State which had a below average level of private health insurance providing hospital cover. The ratio was 25.5% below the national average. The low coverage levels were seen in both Brisbane and the balance of the State.

COMMENTS

1. Queensland has achieved relatively high coverage rates for Pap smear uptake and mammography.

2. The high reported prevalence of injury, asthma, hearing and eyesight disorders, high risk alcohol intake and mental disorder in Queensland suggest the need for Queensland Health to develop goals and targets and programs to address these issues.

3. Hospital admission rates are comparatively high in rural and provincial Queensland and the low coverage for private health insurance further accentuates the demand on public hospital resources.

GLOSSARY OF DEFINITIONS

The following are abridged definitions from the Social Health Atlas (ABS catalogue No. 4385.0) and NHS Users Guide (ABS catalogue No. 4363.0).

1. Asthma refers to a long-term condition, International Classification Diseases (ICD) code 493.

2. Bronchitis or emphysema - refers to long-term conditions, ICD codes 466, 490-492, 494-496.

3. Disabled person - is a person who had one or more of the following disabilities or impairments which had lasted or were likely to last for 6 months or more:
   a) loss of sight (even when wearing glasses or contact lenses),
   b) loss of hearing,
   c) speech difficulties in native language,
   d) blackouts, fits, or loss of consciousness,
   e) slowness at learning or understanding,
   f) incomplete use of arms or fingers,
   g) incomplete use of feet or legs,
   h) long term treatment for nerves or an emotional condition,
   i) restriction in physical activities or in doing physical work,
   j) disfigurement or deformity,
   k) need for help or supervision because of a mental disability, and
   l) long term treatment or medication (but was still restricted in some way by the condition being treated).

4.1. Disabling Condition - is any condition which caused one or more of the disabilities or impairments listed under disabled person.

4.2. Disabling Conditions have been grouped into 9 broad categories:
   a) Mental disorders other than retardation, degeneration or slow at learning,
   b) Mental retardation, mental degeneration due to brain damage, slow at learning and specific delays in development,
   c) Sight loss,
   d) Hearing loss,
   e) Nervous system diseases,
   f) Circulatory diseases,
   g) Respiratory diseases,

h) Diseases of the musculo-skeletal system and connective tissue

i) All other diseases and conditions.

5. Deafness - refers to partial or complete hearing loss.

6. Eyesight disorders - refers to disorders of refraction and accommodation but excludes partial or complete blindness not corrected by glasses.

7. Handicapped Person - is a disabled person aged 5 years or over who was further identified as being limited to some degree in his/her ability to perform certain tasks in relation to one or more or the following five areas:

   a) Self care,
   b) Mobility,
   c) Verbal communication,
   d) Schooling, and/or
   e) Employment

8. High Risk Alcohol Intake - refers to alcoholic drinks consumed in 7 days prior to interview. Risk was assessed in terms of average daily intake in 3 categories. High relative risk is defined as >75ml per day (males) and >50ml per day (females) in terms of absolute alcohol (1ml = 0.70gms alcohol).

9. Hospital Admissions - refers to inpatients and day patients who have a formal admission/ discharge within the preceding 12 months.

10. Injuries refers to recent condition, ICD codes 800 - 995.

11. Long-Term Conditions - refers to illness, injury or disability which has lasted or will last at least 6 months or other chronic conditions whether recurrent (e.g. asthma) or under control (e.g. refractive eye conditions)

12. Mental Disorder - refers to nerves, tension, nervousness and emotional problems (no ICD code), depression, psychoses and other mental disorders but excludes mental retardation and other specific development delays.

13. Obesity and Overweight - refers to self reported data on height and weight of persons aged 18 years and over. The NHMRC definition using Quetelet's BM Index is:

   Overweight: BMI between 25-30 kg/m^2

   Obese: BMI over 30 kg/m^2

14. Pap smear and mammography - refers to women 18 to 64 years who at some time had the test to exclude cancer.

15. Private Health Insurance Cover - refers to private health insurance arrangements of people aged 15 years and over (who are not still attending school). Cover refers to those who have cover for hospital inpatient treatment (in private hospitals or as private patients in public hospitals).

16. Recent Illness - refers to illness, injury or disability experienced in the 2 weeks prior to interview. Respondents reports were prompted by an "actions" based approach.

17. Sedatives or Tranquillisers - refers to use in the previous 2 weeks. Reflects the reason medication was used rather than type of drug. Sleeping medication not included.

18. Smokers - defined as one or more cigarettes (or pipes or cigars) per day on average.

Appendix: Explanatory and Cautionary Notes

1. This report is a follow-up to Information Circular No. 4 "Australian Health Survey 1989-90. Summary of Results".

2. The Social Health Atlas of Australia, Volume 2, presents further descriptive analyses of the National Health Survey data. The Atlas also maps data from other sources including the 1988 ABS Survey of Disabled and Aged Persons.

3. All data comparisons are with the Australian average. The data are presented as standardised prevalence ratios e.g. the ratio for people who reported recent illness in Brisbane in the 2 weeks prior to interview was 107.7 i.e. there were 7.7% more people reporting recent illness than the Australian average, after making allowances for age and sex differences between the population of this Statistical Division and Australia as a whole.

4. Descriptions in this circular have been confined to Queensland, Brisbane and the balance of Queensland (rural and provincial areas). All results are statistically significant unless stated otherwise.

5. The Atlas (Volume 2) maps data to the level of Statistical Region but caution is warranted in interpreting this level data. A briefing note on the Social Health Atlas (Volume 1) has previously been distributed. The briefing note and the technical notes in the Atlas detail caveats relevant to interpreting small area data.

6. The Atlas uses a 5% significance level to test the significance of ratios. A rough estimate of the number of tests used for regional Queensland is 135 variables by 11 Statistical Regions. At this level of significance, we can expect 74 (5%) of results to occur by chance. The possibility of a result being due to sampling variation is much greater with multiple comparisons being made at the regional level.

Figure 1. SOCIAL HEALTH ATLAS AND 1989/90 NATIONAL HEALTH SURVEY

Brisbane, Balance of Queensland and Queensland Percentage difference from the Australian Average