EVEN BIGGER AND BETTER: *REPORT OF THE CHIEF HEALTH OFFICER 2002*

Greg Stewart
Chief Health Officer

I am proud to announce the release of the fourth edition of the *Health of the people of New South Wales—Report of the Chief Health Officer* on 28 October. The Report is the biggest yet, weighing in at 368 pages and containing information on 223 health indicators.

I believe that it is also the best yet, reflecting the continuing development of the infrastructure for monitoring population health in NSW. Many components of this infrastructure are recognised as being at the 'leading edge' of such work, nationally. These include our population health datamart (the Health Outcomes Information and Statistical Toolkit, or HOIST), the NSW Health Survey Program, our training programs to build workforce capacity—including the NSW Public Health Officer Training Program and the NSW Biostatistical Officer Training Program—and of course, the *NSW Public Health Bulletin*.

Future editions of the Report will benefit from current developments through the NSW Program for Enhanced Population Health Infostructure (PEPHI), which has been funded through the National Health Development Fund. Products of PEPHI that are in or nearing production include: a web-based emergency department reporting system; a web-based distributed Geographic Information System (GIS); a web-based application for analysing mortality data (using open-source software); and a metadata database for survey management.

The 2002 edition of the *Report of the Chief Health Officer* also reflects current areas of focus for public health in NSW. It presents new information on trends in socioeconomic inequalities in health over time, and on the range of health inequalities associated with living in rural or remote areas. Also, it includes expanded information on chronic diseases and their determinants, environmental health, and the health of NSW children.

CONTENTS

Don't forget to take a look at the interactive web version of the Report. Already, this contains more, and newer, information than the hard copy version, and it will be continually updated.

Finally, I congratulate everyone who contributed to the 2002 edition of the Report. I confidently predict that it will prove not only the biggest and best but also the most influential ever, through its support for evidence-based public health planning and practice. ▓

TRENDS IN POTENTIALLY AVOIDABLE MORTALITY IN NSW

Andrew Hayen, Doug Lincoln, and Helen Moore
Centre for Epidemiology and Research
NSW Department of Health

Margaret Thomas
Centre for Health Promotion
NSW Department of Health

In Australia, mortality rates, prevalence of health risk behaviours (such as smoking and inadequate physical activity), and prevalence of risk factors (such as obesity), have been shown to be significantly higher in lower socioeconomic (SES) groups than in higher SES groups.[1] Similar inequalities in health have also been shown to exist in NSW.[2]

Avoidable mortality refers to deaths that *potentially* could be avoided either through prevention or through early medical intervention.[3] To assess the potential effect of health interventions, it is useful to classify each condition that causes avoidable death according to the level of intervention (primary, secondary, and tertiary) to which that condition is responsive. Primary avoidable mortality (PAM) consists of conditions that are preventable by change in individual behaviour or through population-level interventions including healthy public policy that, for example, may result in introducing laws to reduce exposure to hazards, such as tobacco smoke.[3]

The study of inequalities in PAM allows an analysis of the effectiveness of primary level health interventions in different socioeconomic status groups and highlights conditions for which primary prevention approaches can potentially reduce inequalities. This article describes trends and differences in PAM by sex and socioeconomic status for some of the diseases and injuries that are amenable to primary prevention.

METHODS

Our analysis is based on death data for NSW for the period 1980–2000. All 'premature' deaths—that is, those that occur before 75 years of age—were classified into avoidable and unavoidable deaths, using the 9th revision of the International Classification of Diseases for deaths registered before 1999, and the 10th revision of the International Classification of Diseases for deaths registered from 1999 onwards.[4] Avoidable deaths were subcategorised using the algorithm of Tobias and Jackson,[3] which divides all cases of each potentially avoidable condition into three groups. Cases are allocated to each group based on the evidence for the proportion that could potentially be prevented using primary, secondary, or tertiary interventions. The proportions for lung cancer are 0.95, 0 and 0.05 (for primary, secondary, and tertiary, respectively); for road traffic injury, they are 0.6, 0 and 0.4 respectively; and for ischaemic heart disease, they are 0.5, 0.25 and 0.25 respectively.

For example, for every 100 potentially avoidable deaths from ischaemic heart disease—where the proportions are 0.5, 0.25 and 0.25 respectively—it is estimated that 50 deaths could be avoided through primary interventions (for example, smoking cessation, improved diet, and increased physical activity); 25 deaths could be avoided through secondary interventions (lowering of cholesterol and blood pressure for those with early stage disease); and 25 deaths could be avoided through tertiary interventions (for example, angioplasties for those who have had heart attacks).

Socioeconomic (SES) groups were constructed using the Index of Relative Socioeconomic Disadvantage (IRSD), which is produced by the Australian Bureau of Statistics from census data.[5] Each local government area in NSW was assigned an IRSD according to the socioeconomic characteristics of the area's residents such as income, occupation, education, non-English speaking background, and indigenous status.

Using the IRSD scores for the local government areas, the NSW population was split into three groups: the 'lowest' SES group, or the most disadvantaged 20 per cent of the population; the 'highest' SES group, or the least