

27 Socioeconomic status

Differences in the health status of people from different socioeconomic groups have been demonstrated in many studies (for example, Mathers 1994, Fox & Benzeval 1995; Marmot et al. 1997; Townson 1999). Information on these gradients for young Australians (aged 15–24 years) was published in 1996 (Mathers 1996), based on data relating to the late 1980s. The report indicated marked differences in the health of young people using a number of measures of health and socioeconomic status.

There are a number of ways of measuring socioeconomic status including income, occupation and education. However, none of these is perfect, and each poses particular difficulties for the age group in this report. The ages 12–24 years represent a period of transition, from dependence on parents/caregivers through to some level of independence. The age of this transition varies greatly, depending on factors such as when studies are completed and age at entering the workforce. For some individuals it would be appropriate to assign socioeconomic status based on measures relating to parents (for example, income), whereas measures more appropriate to others would be based on the individual's circumstances.

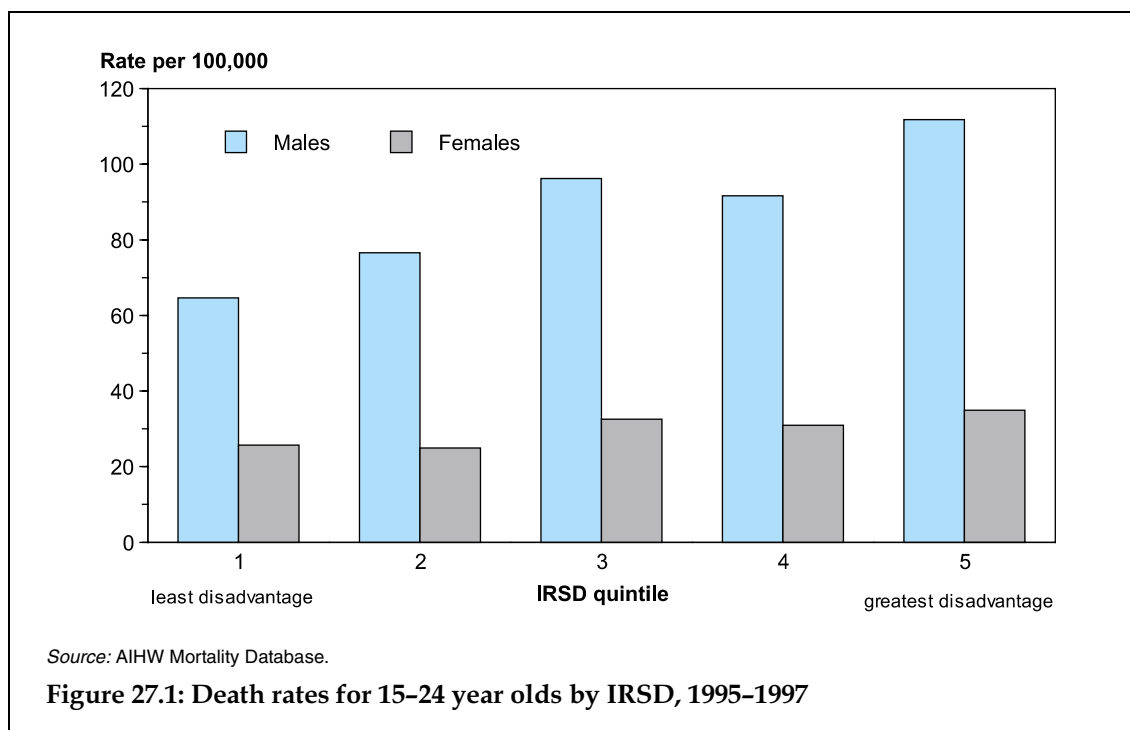
A way to measure the socioeconomic status by proxy is based on the individual's area of residence. Many sources of health information (including mortality and hospital morbidity information) collect information on the area of usual residence (for example, using statistical local area [SLA] or postcode) for each individual. These areas can then be grouped into areas with similar levels of socioeconomic disadvantage.

The Australian Bureau of Statistics has developed socioeconomic indexes for areas (SEIFA) based on information collected in censuses. A version of the SEIFA based on the 1996 Census has been released (ABS 1998). One of five SEIFA indexes, the Index of Relative Socioeconomic Disadvantage (IRSD), is based on factors such as average household income, education levels and unemployment rates. The IRSD groups areas into quintiles of socioeconomic disadvantage: areas with scores in the highest 20% are classed as having the 'least disadvantage'; while those with scores in the lowest 20% are classed as having the 'most disadvantage'.

The method used in this chapter to measure socioeconomic status is based on the IRSD indexes of socioeconomic disadvantage. This measure avoids some of the difficulties described above in measuring socioeconomic status in this age group, and allows a consistent measure of socioeconomic status to be used when analysing information from a range of health data sources, including mortality, hospitalisations and a number of population surveys.

Mortality

This section presents information on death rates for 15–24 year olds by socioeconomic disadvantage, both using recent data and making comparisons over a 10-year period.



- A gradient across socioeconomic disadvantage groups is apparent in the death rates for 15–24 year olds as shown in Figure 27.1. That is, death rates increase across these groups, from the lowest rates in quintile 1 (least disadvantage) and, in general, progressively higher death rates in each subsequent group, ending with the highest rates in quintile 5 (greatest disadvantage).
- For males, the death rate in quintile 1 was 65 per 100,000 over the 3 years 1995–1997. The corresponding rate for quintile 5 was 1.7 times higher at 112 per 100,000.
- The overall death rate for young females is around one-third the rate for young males (discussed further in Chapter 5). However, death rates for young females also differ by socioeconomic status, with females in quintile 5 having death rates 1.4 times higher than those in quintile 1 (35 per 100,000 compared with 26 per 100,000).

Table 27.1: Death rates for selected causes of death by IRSD, 15–24 year olds, 1995–1997

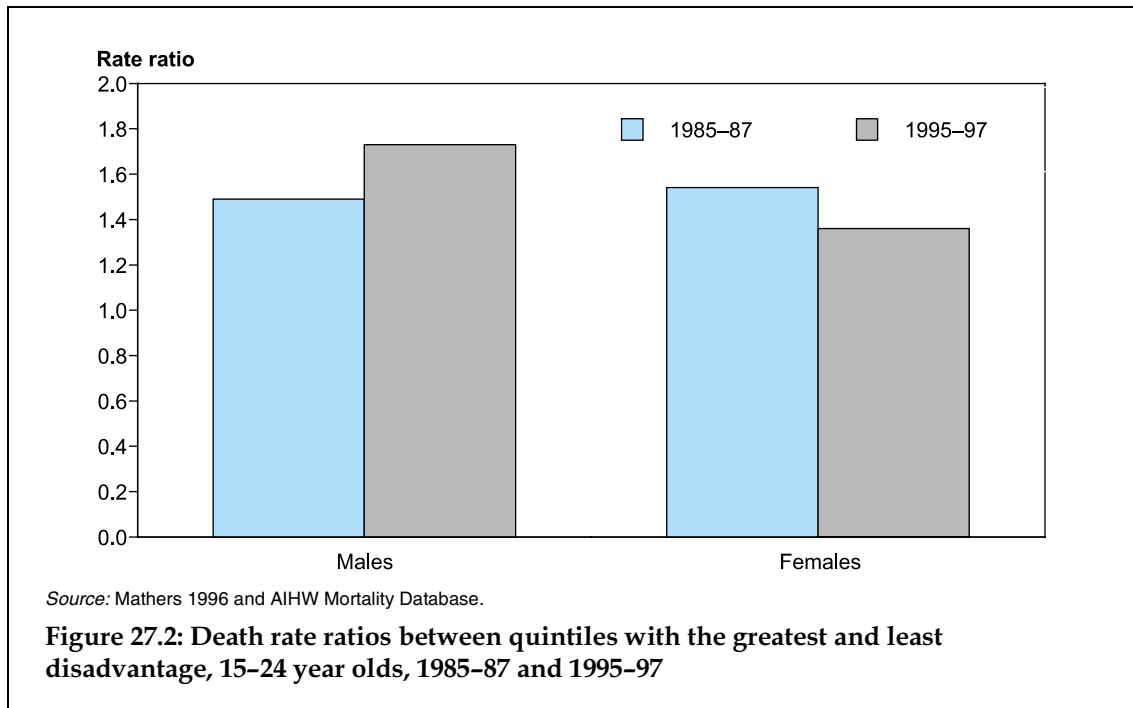
Cause of death ^(a)	IRSD quintile					Q5:Q1 Ratio
	(least disadvantage)				(greatest disadvantage)	
	1	2	3	4	5	
	Rate per 100,000					
Motor vehicle accidents	6.8	9.6	15.4	14.6	16.2	2.4
<i>All transport</i>	<i>11.0</i>	<i>14.8</i>	<i>23.6</i>	<i>21.5</i>	<i>23.7</i>	<i>2.2</i>
Suicide	11.7	12.9	15.9	13.3	17.6	1.5
Violence	0.6	1.2	1.9	1.7	3.4	5.4
<i>All injury</i>	<i>29.3</i>	<i>36.0</i>	<i>47.7</i>	<i>42.8</i>	<i>53.1</i>	<i>1.8</i>
Infectious diseases	0.9	0.6	0.5	0.5	0.8	0.9
Endocrine	1.1	0.9	1.1	1.0	1.4	1.3
Mental disorders	4.4	3.2	3.5	4.4	4.3	1.0
Circulatory	1.3	1.5	1.4	2.1	3.1	2.3
Respiratory	0.7	0.3	1.2	1.7	1.4	1.9
Other	7.7	8.6	9.7	9.6	10.1	1.3
Total	45.5	51.2	65.0	62.0	74.2	1.6

(a) Based on ICD-9 codes.

Source: AIHW Mortality Database.

- The gradients shown in Figure 27.1 are apparent for the majority of the specific causes of death shown in Table 27.1.
- Injury, the most common cause of death in this age group, shows a marked gradient across socioeconomic disadvantage groups (except quintile 3). Further, young people in quintile 5 had injury death rates 1.8 times higher than those in quintile 1 (53 per 100,000 compared with 29 per 100,000) in 1995–1997.
- Transport accidents are the largest component of these injury deaths, for which the ratio between quintiles 5 and 1 was 2.2. For suicide, the ratio was 1.5.
- Deaths related to mental disorders are almost exclusively drug-related in this age group (see Chapter 9). For these deaths, there was only a marginal difference in the rates between quintiles 1 and 5 (Table 27.1). However, lower rates were recorded in quintiles 2 and 3.

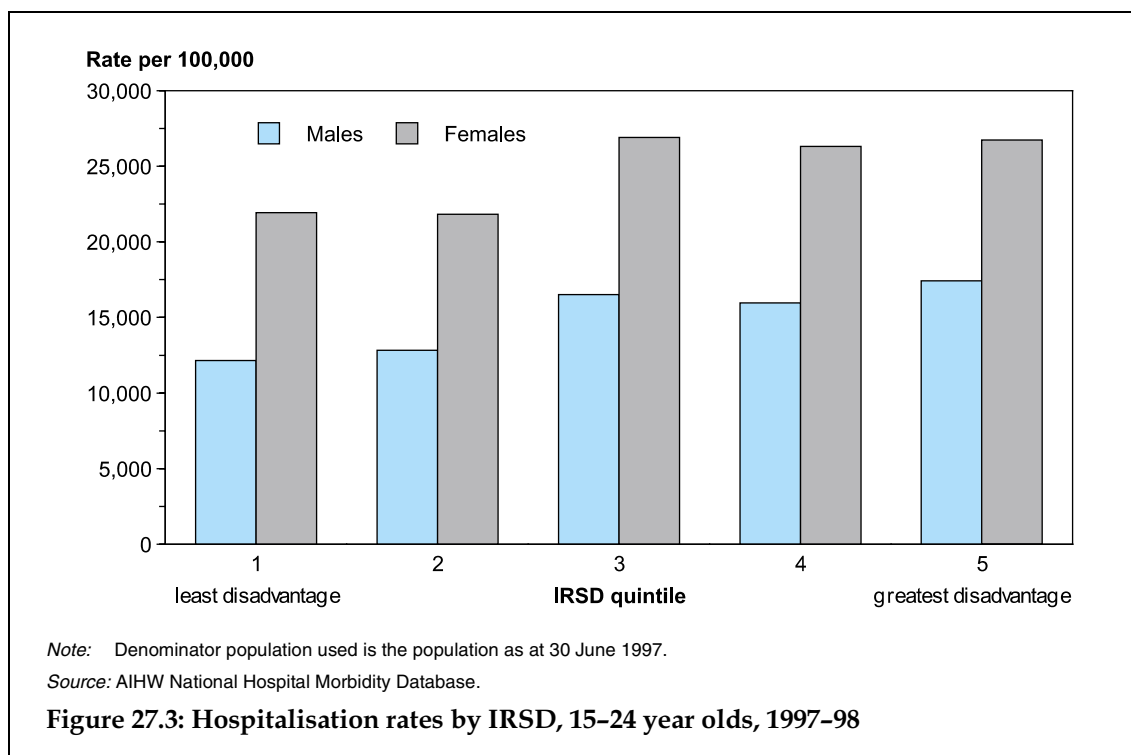
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- The rate ratios shown in Figure 27.2 are calculated by dividing the death rates for quintile 5 by the death rates for quintile 1 (also shown in the last column of Table 27.1). They thus provide a measure of the difference in death rates between these two groups. A rate ratio greater than 1 indicates that the death rate is higher in quintile 5 than in quintile 1. The larger the rate ratio, the greater the difference between the two groups.
- For males, the rate ratio has increased over the 10 years from 1985-87 to 1995-97, from 1.5 to 1.7. Over this period, overall death rates have declined (see Chapter 5). Therefore, the above results suggest that the gains made over the last 10 years have benefited quintile 1 to a greater extent than quintile 5.
- For females, the rate ratio decreased over the 10-year period, from 1.5 to 1.4. This indicates that there has been a greater reduction in death rates in the quintile 5 than in quintile 1.

Morbidity

Data used for this section are hospitalisation rates across socioeconomic disadvantage groups. Such information provides an indication of the level of illness in a population group. However, it is important to note that these rates may also be affected by access to services and differing admission practices. These issues are discussed further in Appendix 3. The data are based on the location of the patient's residence, not the location of the hospital.



- For this age group, hospitalisation rates for females are higher than for males, largely due to obstetric hospitalisations (see Chapter 6). For females, quintiles 3, 4 and 5 had higher hospitalisation rates in 1997–98 than quintiles 1 and 2. The ratio between the quintiles 5 and 1 was 1.2. Much of this is also accounted for by obstetric hospitalisations for which the rate for quintile 5 is three times the rate of quintile 1.
- A similar pattern is also observed for male hospitalisations. In this case the ratio between quintiles 5 and 1 was 1.4.

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Table 27.2: Selected reasons for hospitalisation, 15–24 year olds, 1997–98

Principal diagnosis/ external cause ^(a)	IRSD quintile					Q5:Q1 ratio
	(least disadvantage)				(greatest disadvantage)	
	1	2	3	4	5	
	Rate per 100,000					
Motor vehicle accidents	124	153	167	156	166	1.3
<i>All transport</i>	295	332	379	365	351	1.2
Self-inflicted injury	135	124	153	156	134	1.0
Violence	94	110	142	175	196	2.1
<i>All injuries</i>	1,444	1,475	1,551	1,676	1,642	1.1
Infectious	188	173	204	208	188	1.0
Endocrine	121	120	153	136	137	1.1
Mental disorders	1,201	750	823	709	782	0.7
Circulatory	104	96	113	113	106	1.0
Respiratory	631	593	727	692	680	1.1
Digestive	2,035	1,673	1,783	1,591	1,452	0.7
Obstetric ^(b)	2,823	4,638	6,970	7,309	8,483	3.0
Other	9,852	10,085	12,831	12,324	12,841	1.3
Total	16,964	17,241	21,590	21,010	21,977	1.3

(a) Based on ICD-9-CM codes.

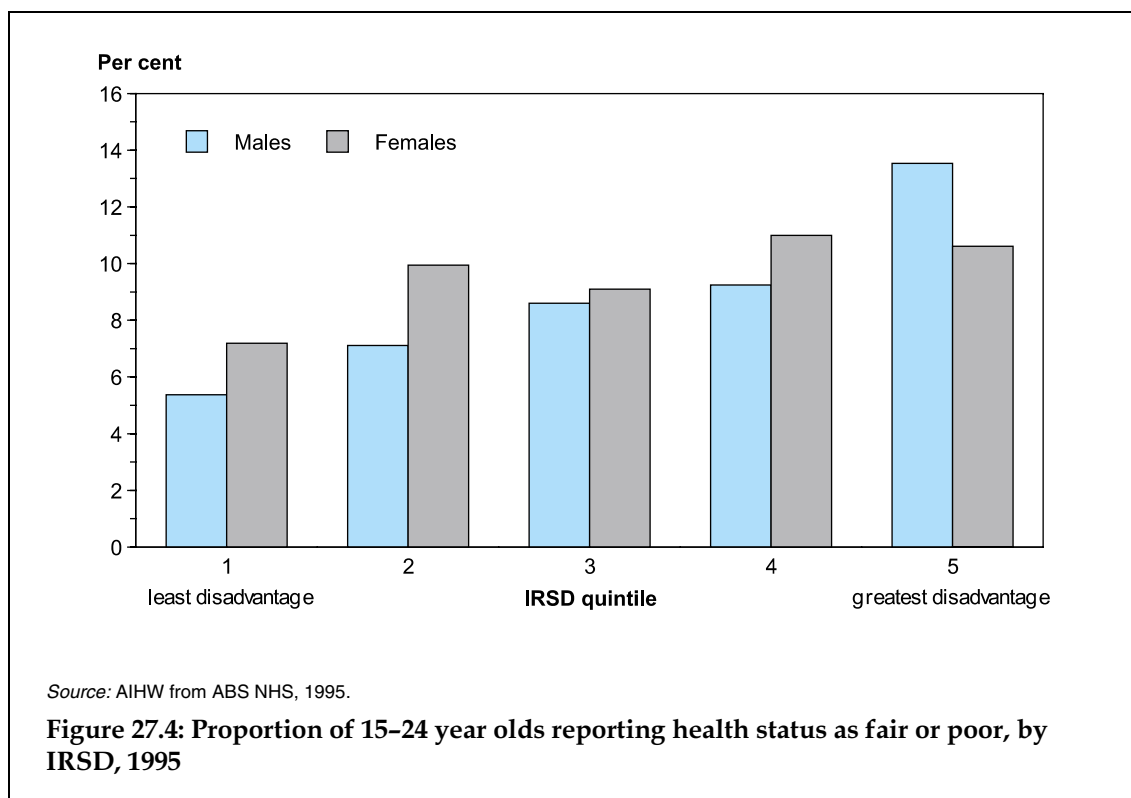
(b) Rate per 100,000 females.

Source: AIHW National Hospital Morbidity Database.

- For hospitalisations related to injury there is, to some extent, a gradient in the rates across the socioeconomic disadvantage groups. However, the ratio between the groups with the greatest and least disadvantage (quintiles 5 and 1) was only 1.1. This however, translates to nearly 200 extra hospitalisations per 100,000 population. For the specific injuries listed above, the largest differential between quintiles 5 and 1 was for violence-related injuries, with a rate ratio of 2.1.
- Mental disorders and digestive disorders have larger rates in quintile 1 than in quintile 5.
- For obstetric hospitalisations, there is a clear gradient in the rates across socioeconomic disadvantage groups. The rate in quintile 5 was three times that for quintile 1.

Health status

Information is presented here on self-assessed health status, using data from the ABS National Health Surveys. In the 1995 survey, participants were asked to rate their overall health as either excellent, very good, good, fair or poor. In the 1989–90 survey, the possible responses to the survey were excellent, good, fair or poor. Results below show the proportion of young people rating their health at the lower end of this scale; as fair or poor.



- Overall, slightly more young females than young males reported their health as only fair or poor in 1995 (see Chapter 3). Quintile 5 was the only group with higher proportions of young males than females reporting their health as fair or poor (14% compared with 11%).
- For females, there was a general increase with increasing socioeconomic disadvantage in the proportion reporting their health as fair or poor (Figure 27.4). The ratio between quintile 5 and quintile 1 was 1.5.
- The gradient across IRSD groups is more marked for young males – with a rate ratio of 2.5, compared to 1.5 for females.

References

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