Health Inequalities Monitoring Series
Number 1

Health inequalities in Australia: mortality

September 2004

Queensland University of Technology
and the Australian Institute of Health and Welfare
Canberra

AIHW Cat. No. PHE 55

This is the first joint publication by Queensland University of Technology and the Australian Institute of Health and Welfare in the Health Inequalities Monitoring Series.

ISSN 1832-0031

ISBN 1 74024 401 X

This report was produced as part of the project *'Strengthening and extending Australia's research capacity and infrastructure as these relate to socioeconomic health inequalities and area disadvantage'* funded by the Australian Government through the Public Health Education and Research Program, Department of Health and Ageing. The views expressed in this report are those of the authors.

The principal authors are Glenn Draper, Gavin Turrell, and Brian Oldenburg. Mr Draper was responsible for the analysis of the data, the compilation and presentation of the tables and figures, and drafting earlier versions of the report. Dr Turrell was responsible for the original conception and design of the mortality study, the structure, organisation and focus of the report, and the interpretation of data. Professor Oldenburg contributed to the conception and design of the study and to the report's Introduction and Discussion sections.

Michael de Looper, Dr Paul Jelfs, Ilona Brockway and Mohan Singh from the Australian Institute of Health and Welfare read and commented on the publication, and provided statistical and publishing support. Dave Hallinan, Brian Harrison, Colin Sindall, Jean Douglass, John Mathews, and Brendan Gibson from the Australian Government Department of Health and Ageing also read and commented on the publication.

Suggested citation

Draper G, Turrell G & Oldenburg B 2004. Health Inequalities in Australia: Mortality. Health Inequalities Monitoring Series No. 1. AIHW Cat. No. PHE 55. Canberra: Queensland University of Technology and the Australian Institute of Health and Welfare.

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Cover design by Levitate Graphic Design

Text edited by Raylee Singh

Printed by Pirion Pty Ltd

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Acknowledgments

The preparation of this report was assisted by many people, and their encouragement and support is greatly appreciated.

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Funding

Funding for this project was provided by the Australian Government Department of Health and Ageing under the Public Health Education and Research Program (PHERP) Innovations Scheme.

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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ARIA	Accessibility/Remoteness Index of Australia
ARPHI	Australian Research Program on Health Inequalities
ASCO	Australian Standard Classification of Occupations
CCLO	Classification and Classified List of Occupations
CURF	Confidentialised Unit Record File
DHAC	Department of Health and Aged Care
DoHA	Department of Health and Ageing
FWEs	Fulltime Workload Equivalents
ICD-9	International Classification of Diseases: 9th revision
ICD-10	International Classification of Diseases: 10th revision
IRSD	Index of Relative Socioeconomic Disadvantage
NCCH	National Centre for Classification in Health
NHMRC	National Health and Medical Research Council
NHPA	National Health Priority Areas
PHERP	Public Health Education Research Program
PYLL	Potential Years of Life Lost
QUT	Queensland University of Technology
RRMA	Rural, Remote & Metropolitan Areas
SACC	Standard Australian Classification of Countries
SEIFA	Socio-Economic Indexes for Areas
SEP	Socioeconomic Position
SIDS	Sudden Infant Death Syndrome
SLA	Statistical Local Area
–	Nil, or rounded to zero
*	$p<0.05$
**	$p<0.01$
***	$p<0.001$

Summary of findings

The health of the Australian population improved markedly during the twentieth century. For example: the toll of infectious disease was reduced sharply, life expectancy at birth continued to increase, death rates from coronary heart disease and stroke have declined since the late 1960s and in more recent years, we have witnessed a downward trend in deaths from lung, colorectal and breast cancer. Despite this, health gains have not been equally shared across all sections of the population. At the end of the twentieth century, there were considerable mortality inequalities between population subgroups in Australia.

This report examines mortality inequalities by sex, geographic region, socioeconomic disadvantage, occupation, and country of birth among infants and children (0–14 years), young adults (15–24 years), working-aged adults (25–64 years), and older persons (65 years or more) for the period 1998–2000, and between 1985–1987 and 1998–2000. Mortality inequalities were examined on the basis of life expectancy, potential years of life lost, potentially avoidable deaths, age-standardised death rates, rate ratios, and a measure of excess mortality.

During 1998–2000, rates of death were substantially higher for males, those living in remote and very remote regions, those living in socioeconomically disadvantaged areas, blue-collar employees, and the Australian-born. While this publication does not focus in detail on Indigenous health, it is also well established that Indigenous peoples have a much poorer mortality profile than non-Indigenous Australians.

The mortality burden in the Australian population attributable to inequality based on sex, geographic region, socioeconomic disadvantage, occupation, and country of birth is large: much of this burden is potentially avoidable. Deaths attributable to inequality constitute a loss of economically productive members of society, and raise health care costs.

Throughout this report we make extensive use of the rate ratio, an internationally accepted measure of inequality that is widely used in health and epidemiological research. However, the reader needs to be aware that the rate ratio must be interpreted carefully when making comparisons between groups and over time: this issue is discussed more fully in Chapter 2 (Section 2.6).

Mortality differences by sex

In 1998–2000, life expectancy at birth for Australian males and females was 76.6 and 82.0 years respectively. Between 1990 and 2000, life expectancy increased by about 2.7 years for males at birth, and by 1.9 years for females. During the same period, the sex difference in life expectancy narrowed: in 1990 a new-born girl could expect to live 6.2 years longer than a new-born boy, and by 2000 this difference had reduced to 5.4 years.

Between 1985–1987 and 1998–2000, all-cause death rates declined for both males and females in each age group; at each period, however, death rates were significantly higher for males.

Across all ages, males experienced significantly higher all-cause death rates than females in 1998–2000 (Table S1). The relative difference was smallest among infants (25%) and largest among adolescents and young adults (163%). However, the sex difference in the absolute number of deaths per 100,000 was twice that among infants (118 more male deaths) compared with adolescents and young adults (59 more male deaths).

Table S1: Age-standardised mortality rates for all causes, by sex, 1998–2000

	Males	Females	% difference
Deaths per 100,000 persons			
Less than 1 year	587	469	25
0–14 years	58	46	27
15–24 years	96	37	163
25–64 years	308	170	81
Deaths per 1,000 persons			
65 years and over	49	32	54
65–74 years	25	13	85
75 years and over	86	60	44

Significant differences in death rates between males and females were evident for all major causes of death. Specific causes of death for which males had higher death rates included:

Less than 1 year	Accidents and injury (56% higher, 8 more male deaths per 100,000), Sudden Infant Death Syndrome (51% higher, 23 more male deaths per 100,000)
0–14 years	Accidents and injury (59% higher, 4 more male deaths per 100,000), potentially avoidable deaths (32% higher, 7 more male deaths per 100,000)
15–24 years	Suicide (293% higher, 17 more male deaths per 100,000), accidents and injury (227% higher, 49 more male deaths per 100,000)
25–64 years	Diseases of the circulatory system (160% higher, 47 more male deaths per 100,000), lung cancer (100% higher, 12 more male deaths per 100,000), potentially avoidable deaths (88% higher, 93 more male deaths per 100,000)
65 years and older	Diseases of the respiratory system (93% higher, 2 more male deaths per 1,000) diseases of the circulatory system (40% higher, 6 more male deaths per 1,000), lung cancer (190% higher, 2 more male deaths per 1,000)
65–74 years	Accidents and injury (112% higher, 0.35 more male deaths per 1,000), diabetes mellitus (60% higher, 0.25 more male deaths per 1,000), all cancers (82% higher, 5 more male deaths per 1,000)
75 years and older	All cancers (96% higher, 10 more male deaths per 1,000), diabetes mellitus (42% higher, 0.59 more male deaths per 1,000), diseases of the circulatory system (26% higher, 8 more male deaths per 1,000)

In 1998–2000, if males had experienced the same death rate as females, a large number of deaths could have been avoided, ranging from 553 among those aged less than 1 year to 20,693 among working-aged adults (Table S2).

Table S2: Number and percentage of deaths from all causes that would have been avoided in 1998–2000 if males had the same mortality rate as females

	Number[(a)]	Per cent[(b)]
Less than 1 year	553	11.4
0–14 years	725	12.1
15–24 years	2,456	45.4
25–64 years	20,693	28.3

(a) Total number of deaths that would have been avoided if males had the same mortality rate as females.

(b) Percentage of all deaths that would have been avoided if males had the same mortality rate as females.

Mortality differences by geographic region

In this report, geographic remoteness was ascertained using the Accessibility/Remoteness Index of Australia (ARIA). All Statistical Local Areas (SLAs) comprising each state and territory were grouped into four categories—Highly Accessible, Accessible, Moderately Accessible, Remote/Very Remote—with SLAs in each category having similar degrees of access to population centres containing basic services (e.g. health, education, and retail). This summary reports on mortality differences between areas classified as Highly Accessible and Remote/Very Remote; the mortality profile of all four ARIA categories is presented in the main text.

In 1998–2000, life expectancy at birth for males born in areas classified as Highly Accessible was 77.3 years, and 73.1 years for males born in areas classified as Remote/Very Remote. The corresponding figures for females were 82.7 and 79.7 years.

For both males and females in each age group, all-cause death rates were significantly higher for residents in Remote/Very Remote areas than for those in Highly Accessible areas (Table S3). For males, relative differences in death rates between the two ARIA categories were largest among adolescents and young adults (150%), which equates to 128 more deaths per 100,000 for males living in Remote/Very Remote areas; and smallest for those aged 65 years and over (2%), which equates to 1 more male death per 1,000 for those living in Remote/Very Remote areas. For females, the relative difference in death rates between the geographic regions was also largest among 15–24 year olds (162%), which equates to 53 more deaths per 100,000 for females living in Remote/Very Remote areas; and smallest among those 65 years or more (5%), which equates to 2 more deaths per 1,000 for females living in Remote/Very Remote areas.

It is now well established that Indigenous persons have considerably poorer health than the non-Indigenous population. Also, in Remote/Very Remote areas of Australia, Indigenous persons constitute a substantial proportion of the population. Given this, the report examined whether the higher mortality rate in Remote/Very Remote regions was partly due to the poorer health status of their Indigenous populations. This was done by comparing all-cause mortality rates for geographic regions that first included and then excluded Indigenous deaths. Differences in death rates across geographic regions were reduced substantially when based on only the non-Indigenous population (compared with all Australians) and the most marked reductions were observed in Remote/Very Remote areas. This evidence suggests that many of the mortality inequalities between geographic regions reported above were due in part to the disproportionate concentration of Indigenous peoples in non-metropolitan regions.

Table S3: Age-standardised mortality rates for all causes, for regions of Australia classified by their accessibility to, or remoteness from, basic services, 1998–2000

	Males			Females		
	Highly Accessible	Remote/ Very Remote	% difference	Highly Accessible	Remote/ Very Remote	% difference
Deaths per 100,000 persons						
Less than 1 year	539	968	80	430	1,091	154
0–14 years	54	101	89	42	97	129
15–24 years	85	213	150	33	86	162
25–64 years	288	521	81	162	323	99
Deaths per 1,000 persons						
65 years and over	49	50	2	31	33	5
65–74 years	24	32	34	13	19	43
75 years and over	86	76	11	60	55	8

It is worth noting that the use of the age group '65 years and over' obscures some important mortality inequalities between geographic regions for older age groups. Further, whilst mortality inequalities between geographic regions were observed among older persons, the magnitude of the inequalities was smaller than that found for those aged less than 65 years. A similar pattern is evident for a number of other sociodemographic indicators.

Differences in death rates between Highly Accessible and Remote/Very Remote regions were found for many specific causes of death. Mortality rates were significantly higher in Remote/Very Remote regions for:

Less than 1 year	Males	Certain conditions originating in the perinatal period (61% higher, 156 more male deaths per 100,000)
	Females	Congenital malformations, deformations, and chromosomal abnormalities (140% higher, 64 more female deaths per 100,000) and certain conditions originating in the perinatal period (120% higher, 243 more female deaths per 100,000)
0–14 years	Males	Accidents and injury (170% higher, 15 more male deaths per 100,000)
	Females	Accidents and injury (190% higher, 11 more female deaths per 100,000), potentially avoidable deaths (150% higher, 31 more female deaths per 100,000)
15–24 years	Males	Suicide (280% higher, 56 more male deaths per 100,000), accidents and injury (190% higher, 115 more male deaths per 100,000)
	Females	Potentially avoidable deaths (146% higher, 27 more female deaths per 100,000)
25–64 years	Males	Diseases of the circulatory system (111% higher, 77 more male deaths per 100,000), diseases of the respiratory system (231% higher, 22 more male deaths per 100,000), lung cancer (63% higher, 14 more male deaths per 100,000)
	Females	Diseases of the circulatory system (193% higher, 50 more female deaths per 100,000), diseases of the respiratory system (245% higher, 19 more female deaths per 100,000), potentially avoidable deaths (103% higher, 104 more female deaths per 100,000)

65 years and over	Males	None
	Females	Diabetes mellitus (112% higher, 0.85 more female deaths per 1,000), endocrine, nutritional and metabolic diseases (89% higher, 0.93 more female deaths per 1,000), heart failure (32% higher, 0.28 more female deaths per 1,000)
65–74 years	Males	All cancers (17% higher, 2 more male deaths per 1,000), diabetes mellitus (54% higher, 0.36 more male deaths per 1,000), accidents and injury (117% higher, 0.70 more male deaths per 1,000)
	Females	Diabetes mellitus (194% higher, 0.79 more female deaths per 1,000), diseases of the circulatory system (49% higher, 2 more female deaths per 1,000)
75 years and over	Males	None
	Females	Diabetes mellitus (73% higher, 0.96 more female deaths per 1,000)

In 1998–2000, if all geographic regions of Australia experienced the same death rate as Highly Accessible regions, substantial numbers of deaths could have been avoided (Table S4).

Table S4: Number and percentage of deaths from all causes that would have been avoided in 1998–2000 if all geographic regions of Australia had the same mortality rate as regions with the highest level of access to basic services

	Males		Females	
	Number[(a)]	Per cent[(b)]	Number	Per cent
Less than 1 year	174	6.3	130	6.3
0–14 years	227	6.7	172	6.7
15–24 years	373	9.6	104	7.4
25–64 years	2,411	5.2	1048	4.1

(a) Total number of deaths that would have been avoided if all ARIA categories experienced the same mortality rate as Highly Accessible areas.

(b) Percentage of deaths that would have been avoided if all ARIA categories experienced the same mortality rate as Highly Accessible areas.

Mortality differences by socioeconomic disadvantage

This report used an area-based measure of socioeconomic status known as the Index of Relative Socioeconomic Disadvantage (IRSD). The IRSD was developed by the Australian Bureau of Statistics using population census data, and it reflects the overall level of socioeconomic disadvantage of an area measured on the basis of attributes such as low income, low educational attainment, high levels of public sector housing, high unemployment, and jobs in relatively unskilled occupations. SLAs comprising each state and territory were categorised on the basis of their IRSD score into five groups (quintiles) so that each contained approximately 20% of the total Australian population. This summary reports on mortality differences between Quintiles 1 and 5. Quintile 1 contained the 20% least disadvantaged (i.e. the most advantaged) areas, and Quintile 5 the 20% most disadvantaged. The mortality profile of all IRSD quintiles is presented in the main text.

In 1998–2000, life expectancy at birth for males born in the least and most disadvantaged areas was 79.2 and 75.3 years respectively. The corresponding figures for females were 83.6 and 81.6 years.

For all age groups, males and females in the most disadvantaged areas had significantly higher all-cause death rates (Table S5). For males, relative differences between the least and most disadvantaged areas was largest among adolescents and young adults (89%), which equates to 57 more deaths per 100,000 for males living in the most disadvantaged areas; and smallest for those aged 75 years and over (10%), which equates to 8 more deaths per 1,000 for males living in the most disadvantaged areas. For females, the relative difference between the least and most disadvantaged areas was largest among children aged 0–14 years (62%), which equates to 22 more deaths per 100,000 for females living in the most disadvantaged areas; and smallest for those aged 75 years and over (4%), which equates to 3 more deaths per 1,000 for females living in the most disadvantaged areas.

Table S5: Age-standardised mortality rates for all causes, for the least and most socioeconomically disadvantaged areas of Australia, 1998–2000

	Males			Females		
	Least disadvantaged	Most disadvantaged	% difference	Least disadvantaged	Most disadvantaged	% difference
Deaths per 100,000 persons						
Less than 1 year	420	757	80	372	586	57
0–14 years	41	74	78	36	58	62
15–24 years	64	121	89	28	44	56
25–64 years	215	377	75	135	204	52
Deaths per 1,000 persons						
65 years and over	44	51	17	30	33	10
65–74 years	20	27	36	11	15	30
75 years and over	81	89	10	58	61	4

Differences in death rates between the least and most socioeconomically disadvantaged areas were found for many specific causes of death. Mortality rates were significantly higher in the most disadvantaged areas for:

Less than 1 year	Males	Sudden Infant Death Syndrome (204% higher, 66 more male deaths per 100,000), certain conditions originating in the perinatal period (59% higher, 131 more male deaths per 100,000), congenital malformations, deformations, and chromosomal abnormalities (61% higher, 71 more male deaths per 100,000)
	Females	Sudden Infant Death Syndrome (147% higher, 43 more female deaths per 100,000), congenital malformations, deformations, and chromosomal abnormalities (49% higher, 51 more female deaths per 100,000), certain conditions originating in the perinatal period (28% higher, 52 more female deaths per 100,000)
0–14 years	Males	Accidents and injury (235% higher, 11 more male deaths per 100,000), potentially avoidable deaths (82% higher, 17 more male deaths per 100,000)
	Females	Accidents and injury (156% higher, 6 more female deaths per 100,000), potentially avoidable deaths (76% higher, 12 more female deaths per 100,000)

15–24 years	Males	Suicide (103% higher, 15 more male deaths per 100,000), transport accidents (94% higher, 18 more male deaths per 100,000), potentially avoidable deaths (85% higher, 33 more male deaths per 100,000)
	Females	Accident and injuries (68% higher, 10 more female deaths per 100,000), potentially avoidable deaths (66% higher, 10 more female deaths per 100,000), suicide (59% higher, 3 more female deaths per 100,000)
25–64 years	Males	All cancers (45% higher, 35 more male deaths per 100,000), diseases of the circulatory system (112% higher, 53 more male deaths per 100,000), diseases of the respiratory system (181% higher, 10 more male deaths per 100,000), diseases of the digestive system (130% higher, 10 more male deaths per 100,000)
	Females	Lung cancer (73% higher, 6 more female deaths per 100,000), diseases of the circulatory system (127% higher, 23 more female deaths per 100,000), diseases of the digestive system (118% higher, 4 more female deaths per 100,000)
65 years and over	Males	All cancers (13% higher, 2 more male deaths per 1,000), diabetes mellitus (44% higher, 0.41 more male deaths per 1,000), diseases of the respiratory system (39% higher, 2 more male deaths per 1,000), diseases of the digestive system (30% higher, 0.35 more male deaths per 1,000)
	Females	Endocrine, nutritional, and metabolic diseases (64% higher, 0.51 more female deaths per 1,000), diabetes mellitus (84% higher, 0.45 more female deaths per 1,000), diseases of the digestive system (27% higher, 0.25 more female deaths per 1,000)
65–74 years	Males	All cancers (25% higher, 2 more male deaths per 1,000), diabetes mellitus (68% higher, 0.51 more male deaths per 1,000), diseases of the circulatory system (39% higher, 4 more male deaths per 1,000), accidents and injury (26% higher, 0.15 more male deaths per 1,000)
	Females	All cancers (9% higher, 0.45 more female deaths per 1,000), diabetes mellitus (116% higher, 0.29 more female deaths per 1,000), diseases of the circulatory system (46% higher, 2 more female deaths per 1,000)
75 years and over	Males	All cancers (6% higher, 1 more male deaths per 1,000), diabetes mellitus (32% higher, 0.51 more male deaths per 1,000), diseases of the circulatory system (8% higher, 3 more male deaths per 1,000)
	Females	Diabetes mellitus (72% higher, 0.71 more female deaths per 1,000), diseases of the circulatory system (5% higher, 1 more female death per 1,000)

If all SLAs in Australia experienced the same death rate as the least socioeconomically disadvantaged areas, more than 23,000 deaths could have been avoided in 1998–2000. This was especially so among persons aged 25–64, where socioeconomic inequality accounted for an estimated 13,749 male deaths, and 5,250 female deaths (Table S6).

Table S6: Number and percentage of deaths from all causes that would have been avoided in 1998–2000 if all areas of Australia had the same mortality rate as the least socioeconomically disadvantaged areas

	Males		Females	
	Number[(a)]	Per cent[(b)]	Number	Per cent
Less than 1 year	794	29.0	403	19.4
0–14 years	958	28.3	533	21.1
15–24 years	1,251	32.3	299	21.4
25–64 years	13,749	29.6	5,250	20.3

(a) Total number of deaths that would have been avoided if all IRSD quintiles had the same mortality rate as the least disadvantaged area.

(b) Percentage of deaths that would have been avoided if all IRSD quintiles had the same mortality rate as the least disadvantaged area.

Between 1985–1987 and 1998–2000, death rates fell across all IRSD quintiles for both males and females aged 25–64 (Table S7). For males, relative mortality inequalities over the two periods increased for all causes (from 68% to 75%), cancers (from 28% to 45%) and cardiovascular disease (from 65% to 110%). In terms of absolute death rates for all causes for males, differences between the most and least disadvantaged areas fell from 230 deaths per 100,000 in 1985–1987 (i.e. 568 minus 338) to 163 deaths in 1998–2000 (i.e. 382 minus 219), and from 82 to 54 deaths per 100,000 for cardiovascular disease; however, for cancers, absolute death rates widened slightly over the period from 33 to 36 deaths per 100,000. For females, relative and absolute mortality inequalities showed an identical patterning to that observed for males.

Table S7: Age-standardised mortality rates for the least and most socioeconomically disadvantaged areas of Australia, 1985–1987 and 1998–2000: males and females aged 25–64 years

	Males			Females		
	Least disadvantaged	Most disadvantaged	% difference	Least disadvantaged	Most disadvantaged	% difference
All causes[(a)(b)]						
1985–1987	338	568	68	190	285	50
1998–2000	219	382	75	137	207	51
Cancers						
1985–1987	118	151	28	103	113	10
1998–2000	79	115	45	79	92	31
Cardiovascular disease						
1985–1987	126	208	65	41	81	97
1998–2000	49	103	110	18	41	115

(a) Deaths per 100,000 persons.

(b) Age standardised to the total Australian population as at June 1988.

Mortality differences by occupation

Occupation is a widely used measure of an individual's socioeconomic status. This report compares the mortality profiles of different occupational categories using the Australian Standard Classification of Occupations (ASCO). ASCO is a skill-based measure that groups occupations requiring similar levels of education, knowledge, responsibility, on-the-job training

and experience. These occupational groupings are ranked by their skill levels, with those occupations having the most extensive skill requirements ranked at the top. For this analysis, occupations were grouped into three categories: managers, administrators and professionals; white-collar employees (comprising clerks, salespersons, and personal service workers); and blue-collar employees (comprising tradespersons, plant and machine operators and drivers, and labourers and related workers). Persons not active in the labour force at the time of death were excluded (e.g. the unemployed or retired). To minimise the effects of possible misclassification bias of retired decedents, the analysis of mortality inequality by occupation was restricted to people aged 25 to 54 years. This summary reports on mortality differences between managers, administrators and professionals and blue-collar workers; the mortality profile of all three occupational categories is presented in the main text.

In 1998–2000, males and females in blue-collar occupations had significantly higher death rates for all causes combined, and for many specific causes (Table S8).

Table S8: Age-standardised mortality rates for managers, administrators and professionals, and blue-collar employees, 1998–2000: persons aged 25–54 years

	Males			Females		
	Managers, administrators & professionals	Blue-collar employees	% difference	Managers, administrators & professionals	Blue-collar employees	% difference
All causes[(a)]	115	234	104	81	90	12
Potentially avoidable deaths	72	154	113	51	56	9
Cardiovascular disease	21	45	116	8	14	74
Lung cancer	4	10	155	4	5	52
Diseases of the respiratory system	2	4	129	2	4	139
Diseases of the digestive system	3	9	212	2	4	102

(a) Deaths per 100,000 persons.

If male blue-collar employees aged 25–54 experienced the same death rate in 1998–2000 as their counterparts in managerial, administrative and professional occupations, an estimated 5,642 deaths could have been avoided. The corresponding figure for females was markedly lower at 100 deaths.

Mortality differences by country of birth

Using data from death information forms, the Australian Bureau of Statistics (ABS) codes country of birth to the Standard Australian Classification of Countries (SACC). This report is based on the following country-of-birth groupings, which enabled comparisons with earlier studies of mortality inequality, and ensured a sufficiently large number of deaths in each grouping to produce reliable estimates:

- Australia
- UK & Ireland — United Kingdom and Ireland
- Other Europe — Continental Europe, including Eastern Europe, the former USSR and Baltic states
- Asia — Includes the Northeast, Southeast, and Southern Asia, the Middle East, and Northern Africa

- Other — Includes New Zealand, Oceania, North and South America, and Southern Africa

As an illustration, this summary focuses on mortality differences between Australian residents born in Asia and the Australian-born; the mortality profile of all country-of-birth groupings is presented in the main text.

Table S9 compares all-cause death rates for Australian residents born in Asia and those born in Australia: for each age group, death rates were significantly lower among the Asian-born.

Table S9: Age-standardised mortality rates for all causes, Australian-born and Asian-born Australians, 1998–2000

	Males			Females		
	Australian-born	Asian-born	% difference	Australian-born	Asian-born	% difference
Deaths per 100,000 persons						
15–24 years	101	53	47	38	24	35
25–64 years	331	192	42	182	117	36
Deaths per 1,000 persons						
65 years and over	51	36	17	32	26	20
65–74 years	26	18	30	14	11	23
75 years and over	88	63	29	61	49	19

Significant differences in death rates between the Asian-born and Australian-born were also found for many specific causes of death. Mortality rates were significantly lower among Asian-born Australian residents for:

15–24 years	Males	Potentially avoidable deaths (47% lower, 47 fewer male deaths per 100,000), accidents and injury (43% lower, 32 fewer male deaths per 100,000)
	Females	Potentially avoidable deaths (36% lower, 8 fewer female deaths per 100,000), accidents and injuries (35% lower, 8 fewer female deaths per 100,000)
25–64 years	Males	All cancers (36% lower, 38 fewer male deaths per 100,000), diseases of the circulatory system (32% lower, 26 fewer male deaths per 100,000), diseases of the respiratory system (64% lower, 9 fewer male deaths per 100,000), suicide (69% lower, 22 fewer male deaths per 100,000)
	Females	All cancers (28% lower, 24 fewer female deaths per 100,000), diseases of the circulatory system (31% lower, 10 fewer female deaths per 100,000), diseases of the respiratory system (71% lower, 7 fewer female deaths per 100,000), accidents and injury (56% lower, 9 fewer female deaths per 100,000)
65 years and over	Males	All cancers (36% lower, 5 fewer male deaths per 1,000), diseases of the circulatory system (27% lower, 3 fewer male deaths per 1,000), diseases of the respiratory system (39% lower, 2 fewer male deaths per 1,000), diseases of the digestive system (29% lower, 0.42 fewer male deaths per 1,000)
	Females	All cancers (18% lower, 1 fewer female deaths per 1,000), diseases of the circulatory system (25% lower, 4 fewer female deaths per

		1,000), diseases of the respiratory system (39% higher, 1 fewer female death per 1,000)
65–74 years	Males	All cancers (39% lower, 4 fewer male deaths per 1,000), diseases of the circulatory system (21% lower, 2 fewer male deaths per 1,000), accidents and injury (35% lower, 0.23 fewer male deaths per 1,000)
	Females	All cancers (28% lower, 2 fewer female deaths per 1,000), diseases of the circulatory system (23% lower, 1 fewer female death per 1,000)
75 years and over	Males	All cancers (33% lower, 7 fewer male deaths per 1,000), diseases of the circulatory system (29% lower, 12 fewer male deaths per 1,000), accidents and injury (23% lower, 0.43 fewer male deaths per 1,000)
	Females	All cancers (10% lower, 1 fewer female death per 1,000), diseases of the circulatory system (26% lower, 8 fewer female deaths per 1,000)

It is worth noting that for both males and females aged 65 years or more, 65–74 years, and 75 years or more, death rates for diabetes mellitus were significantly higher among the Asian-born than among the Australian-born, which contrasts markedly with most other specific causes of death. For males in the three older age groups, death rates for diabetes mellitus were between 35% and 52% higher among Asian-born Australians. The corresponding figures for females were 62% and 88%.