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Methods and data sources

Prevalence

Prevalence refers to the number or proportion (of cases, instances, etc.) present in a population at a given time. Prevalence data in this report have been obtained from national sample surveys.

Much of the prevalence data in this report has been reported by the respondent (self-report) and was not medically verified or necessarily based on a diagnosis by a medical practitioner. Conditions which have considerable effect on well-being or lifestyle are expected to be better reported than those with small effects. There may also be a degree of under- or overreporting of certain conditions/behaviours. For example, there appears to be a tendency for respondents in the general population to underreport alcohol and tobacco consumption levels, underestimate their weight and overestimate their height. These issues are particularly relevant when interpreting results from the National Health Survey, the Disability, Ageing and Carers Survey and the National Drug Strategy Household Survey.

Incidence

Incidence refers to the number of **new** cases (of a disease, condition or event) occurring during a given period. Incidence is calculated by counting the number of **new** cases of an event obtained from registers and extrapolating these estimates to the Australian population. National registers of new cases are not always available and in these cases data from local regional registers have been used (for instance, for stroke: Perth and Melbourne; for rheumatic fever and rheumatic heart disease: Top End region of the Northern Territory and Central Australia).

For coronary heart disease there are no national data sources for measuring incidence. However, counting the number of deaths from coronary heart disease and the number of non-fatal hospitalisations for AMI has been shown to provide a reasonable approximation of the incidence of all coronary heart disease events in the population.

Age-specific rates

Age-specific rates were calculated by dividing the number of events (such as prevalence, incidence, hospitalisations or deaths) occurring in each specified age group by the mid-year estimated resident population for the corresponding age group.

Age standardised rates

Age standardised rates for prevalence, incidence, hospitalisations and deaths were used to remove the influence of age when comparing populations with different age structures. This was done by applying age-specific rates to a standard population. The 2001 Australian population was used as the standard population in all Australian comparisons, unless otherwise stated.

Direct age standardisation

Direct age standardisation is the most common method of age standardisation, and is used in this report for prevalence, incidence, hospitalisations and deaths data. This method is generally used when the populations under study are large and the age-specific rates are reliable. The calculation of direct age-standardised rates comprises three steps:

- Step 1: Calculate the age-specific rate for each age group.
- Step 2: Calculate the expected number of cases in each age group by multiplying the age-specific rate by the corresponding standard population for each age group.
- Step 3: Sum the expected number of cases in each age group and divide this sum by the total of the standard population to give the age-standardised rate.

Indirect age standardisation

In situations where populations are small or where there is some uncertainty about the stability of age-specific rates, indirect standardisation has been used. This effectively removes the influence of the age structure, but does not provide a measure of prevalence in terms of a rate. Rather, the summary



measure is a comparison of the number of observed cases compared to the number expected if the age-specific prevalence rates of the standard population are applied to the study population. The method used for this calculation entails three steps:

- Step 1: Calculate the age-specific rates for each age group in the standard population.
- Step 2: Apply these age-specific rates to the number in each age group of the study population and sum to derive the total expected number of cases for the study population.
- Step 3: Sum the observed cases in the study population and divide this number by the expected number derived in Step 2 to calculate the Standardised Prevalence/Morbidity/Mortality Ratio (SPR/SMR).

An SPR/SMR of 1 indicates the same number of observed cases as were expected (suggesting rates in the study and standard populations are similar). A result greater than one indicates more cases than expected. A result less than one indicates fewer cases than expected. The indirect method is more appropriate when calculating standardised rates for the Indigenous population. In this report, the indirect method has been used for comparing death rates between Indigenous and other Australians. Other Australians has been used as the standard population in these analyses.

For example, if there are twice as many deaths as expected (SMR of 2.0) then the rate of death in the Indigenous population can be assumed to be twice that of other Australians.

Significance testing

Many significance tests have been performed throughout this report, particularly when comparing populations with different age structures, such as comparisons between Indigenous and other Australians, or between regional and remote areas of Australia. The method varies slightly depending on the type of data source—population data (hospitalisations or deaths) or survey data (risk factors).

In both cases significance tests for a difference between two quantities (age-standardised rates for population data; sample proportion estimates for survey data) were performed by comparing confidence intervals. The difference between the two quantities was calculated and 95% confidence intervals were constructed around this value. Adjustments were made for multiple comparisons. If the confidence interval did not contain zero, the two quantities were considered to be significantly different. For population data the confidence intervals were constructed using a standard pooled variance formula, however for survey data an estimate of the pooled variance was used (see Armitage & Berry 1994 in the further reading list).

International rates

Death rates

Data on death rates were extracted from the 2003 OECD Health Database. The 1980 OECD standard population is used in calculating the age-standardised death rates. It is important to note that the age-standardised death rates which appear in this report are not directly comparable to the rates published in the 1999 and 2001 editions of this report as a different standard population was used (WHO standard population).

Risk factor prevalence

International comparisons for blood cholesterol, blood pressure and obesity were extracted from the WHO SuRF Report 1 (2003).

Data on blood pressure were reported as the prevalence of high blood pressure. In this report, only countries reporting at the national level using the WHO definition of high blood pressure were included.

Data on blood cholesterol were reported as the prevalence of high blood cholesterol and/or mean blood cholesterol levels. In this report, mean blood cholesterol was included for countries reporting this data at the national level from 1998 onwards.

Data on excess body weight was reported as the prevalence of obesity (BMI of 30 or more). In this report, only countries reporting at the national level from 1998 onwards for adults using body mass index of 30 or more were included.

Care should be taken when making comparisons based upon data from the SuRF report, as they may apply to different years, age ranges and have not been age-standardised.

International comparisons for alcohol consumption and tobacco smoking were extracted from the 2003 OECD Health Database.

Classifications

Cause of death and hospital diagnosis

Australia uses the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) classification system for coding of causes of

death. In this report deaths data before 1997 have been coded to ICD-9 (International Classification of Diseases, Ninth Revision) and thereafter to ICD-10. The tables below list the ICD-9 and ICD-10 disease and procedure codes used in this report. The introduction of ICD-10 and the move from manual coding to automated cause of death coding has resulted in a break in the deaths time series. To overcome this difficulty the ABS coded the 1997 deaths data using both ICD-9 (manual coding) and ICD-10 (automatic coding), which allowed comparability factors between ICD-9 and ICD-10 to be derived. These comparability factors for each disease can be found in ABS 2002.

For hospital diagnosis and procedures these international classifications (ICD-9 and ICD-10) have been modified for Australia. Hospital data before 1998–99 were coded using ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) and thereafter using ICD-10-AM (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification).

Codes for deaths and hospital data used in this report

Disease codes	ICD-9 & ICD-9-CM code	ICD-10 & ICD-10-AM code
Acute rheumatic fever and chronic rheumatic heart disease	390–398	I00–I09
Coronary heart disease	410–414	I20–I25
Acute myocardial infarction	410	I21
Heart failure	428	I50
Stroke ^(b)	430–438	I60–I69
Peripheral vascular disease ^(a)	440–444	I70–I74
Abdominal aortic aneurysm	441.3, 441.4	I71.3, I71.4
Heart, stroke and vascular diseases (diseases of the circulatory system)	390–459	I00–I99
Congenital heart diseases	745–747	Q20–Q28
Diabetes	250	E10–E14
Kidney failure	584–586	N17–N19
Transient ischaemic attack	435	G45

(continued)



Codes for deaths and hospital data used in this report (continued)

Procedure codes	ICD-9-CM code	ICD-10-AM code
Abdominal aortic aneurysm ^(c)	38.44	33112-00, 33115-00, 33118-00, 33121-00, 33151-00, 33154-00, 33157-00, 33160-00, 90213-02 (blocks: 715, 710)
Cardiac defibrillator implants	37.94–37.98	38524-00, 38521-01, 38521-02, 38521-03 (block: 653)
Carotid or jugular endarterectomy	38.12	33500-00 (block: 700)
Coronary angiography	88.55–88.57	38215-00, 38218-00, 38218-02 (block: 668)
Coronary angioplasty (without coronary stent)	36.01, 36.02, or 36.05	35304-00, 35305-00 (block: 670)
Coronary artery bypass grafting	36.1	38497, 38500, 38503, 90201 (blocks: 672–679)
Coronary stenting	36.06 or 36.07	35310 (block: 671)
CT scan of the head ^(d)	87.03	56001-00, 56007-00, 56010-02, 56010-03 (blocks: 1952, 1953)
Embolectomy or thrombectomy of renal artery	n.p.	33806-06 (block: 702)
Haemodialysis or peritoneal dialysis		13100-00, 13100-06, 13100-07, 13100-08 (blocks: 1059–1060)
Heart transplant	37.59, 33.6, 33.5	90172-00, 90172-01, 90205-00, 90205-01 (blocks: 660, 555)
Heart valve defect	n.c.	38456-10, 38483-00, 38480-00, 38481-00, 38488-00, 38488-01, 38489-00, 38489-01, 38487-00, 38485-01, 38480-01, 38481-01, 38475-00, 38477-00, 38488-02, 38488-03, 38489-02, 38456-11, 38480-02, 38481-02, 38475-01, 38477-01, 38488-04, 38488-05, 38489-03, 38456-01, 38488-06, 38488-07, 38489-04, 38489-05 (blocks: 621–638)
Kidney transplantation	n.p.	36503-00 (block: 1057)
Lower limb amputation ^(e)	84.15–84.17	44367 (blocks: 1484, 1505)
MRI of the brain ^(d)	n.c.	90901-00 (block: 2015)
Renal artery endarterectomy	n.p.	33524-00, 33527-00 (block: 700)
Renal bypass	n.p.	32721-00, 32724-00, 32721-01, 32724-01 (blocks: 711–712)

n.c. = Not comparable.

n.p. = Not presented.

(a) In this report atherosclerosis of the aorta and renal artery (ICD-9 code 440 and ICD-10 code I70) are included in the peripheral vascular disease category. In previous editions of this report this was not the case.

(b) In ICD-10 transient ischaemic attack is not included in the heart, stroke and vascular diseases (circulatory system) chapter but is included in the chapter relating to diseases of the nervous system. In ICD-9 it was part of the heart, stroke and vascular diseases (circulatory system) chapter.

(c) Principal diagnosis of abdominal aortic aneurysm, ICD-9-CM codes 441.3, 441.4 and ICD-10-AM codes I71.3, I71.4.

(d) Principal diagnosis of stroke, ICD-9-CM codes 430–438 and ICD-10-AM codes I60–I69.

(e) Principal diagnosis of atherosclerosis of aorta and atherosclerosis of arteries of extremities, ICD-9-CM codes 440.0, 440.2 and ICD-10-AM codes I70.0, I70.2.

International Classification of Primary Care (ICPC)

In the BEACH data, patient reasons for encounter, problems managed, procedures, other non-pharmacological treatments, referrals, pathology and imaging are classified according to the International Classification of Primary Care—Version 2, a product of the World Organization of Family Doctors (WONCA).

ICPC codes (BEACH survey data)

Disease/problem name	ICPC-2 code
Atherosclerosis/peripheral vascular disease	K92
Atrial fibrillation or flutter	K78
Cardiac check-up	K30, K31
Cerebrovascular disease (stroke and TIA)	K89, K90
Coronary heart disease	K74–K76
Diabetes	T89, T90
Heart failure	K77
High blood cholesterol/lipid disorders	T93
Hypertensive disease	K86, K87
Overweight/obesity	T82, T83
Tobacco abuse	P17
Urological problems	U70–U72, U75–U80, U85, U88, U90, U95, U98, U99

Aboriginal and Torres Strait Islander peoples

Indigenous Australians refers to people who identify themselves as being of Aboriginal and/or Torres Strait Islander origin. Data quality issues exist in the identification of Indigenous Australians across population surveys and administrative data collections. In the 1996 census, the number of people who identified themselves as Indigenous Australians was about a third higher than the number who did so in 1991. Between the 1996 and 2001 Census, the total Indigenous population increased by around 16%.

These differences are much larger than can be explained by natural increase alone. While factors such as propensity to identify as Indigenous in the census can be identified, it is not possible to estimate how these factors are likely to change over time. In addition, accurate births and deaths data, required to estimate the natural growth in the Indigenous population between censuses, are not nationally available. These uncertainties affect the quality of the population estimates and make the assessment of trends difficult and potentially misleading.

Deficiencies in health data for Indigenous Australians occur in the AIHW National Mortality Database and the AIHW National Hospital Morbidity Database. Indigenous Australians are not completely identified in these administrative data collections due to different methods of data collection and failure to record the person's Indigenous status. At present, there is considerable variation across the states and territories in the quality of mortality data for Indigenous Australians. For the years 1998–02, deaths data for only Queensland, Western Australia, South Australia and the Northern Territory are considered to have sufficient coverage of Indigenous Australian deaths. The variation in Indigenous hospitalisations across the states and territories suggests that there was variation in the proportion of Indigenous Australians who were identified as such in the AIHW National Hospital Morbidity Database. The quality of the data provided on Indigenous Australians in 2001–02 continues to improve; however, there is still need for further improvement. In this report, hospitalisations for Indigenous Australians should be interpreted with caution.

Data quality issues also exist when interpreting Indigenous data from the National Health Survey relating to the collection of individual and household survey data about Aboriginal and Torres Strait Islander Australians living in remote areas and the relevance of the questions and concepts used. Furthermore, differences between the Indigenous and non-Indigenous populations should be interpreted



with caution as the Indigenous population was sampled over a six-month period and other Australians over a 10-month period; seasonal effects may be exaggerated in the Indigenous sample.

Socioeconomic status

The ABS has constructed a number of socioeconomic indexes to classify areas on the basis of social and economic information collected in the Census of Population and Housing.

In this report, the index of relative socioeconomic disadvantage (IRSD) is used. This is derived from social and economic characteristics of the local area such as low income, low educational attainment, high levels of public sector housing, high unemployment and jobs in relatively unskilled occupations.

Individual records were classified into quintiles of socioeconomic disadvantage according to the value of this index for the statistical local area of usual residence. Quintile 1 includes the most disadvantaged households and quintile 5 the least disadvantaged households. Statistical local areas were grouped into quintiles so that each quintile contained approximately 20% of the total Australian population.

It is important to note that the index of socioeconomic disadvantage relates to the average disadvantage of all people living in the statistical local area. These measures of socioeconomic inequality will thus generally understate the true inequality in health at the individual level in Australia. In this report 0.8% of deaths could not be mapped to a quintile of socioeconomic disadvantage. These deaths were excluded from the analysis.

Highest level of education was used to form socioeconomic groups where the index of socioeconomic disadvantage was not available (insufficient physical activity, high blood pressure, high blood cholesterol, overweight and diabetes).

The three categories used were: did not complete secondary school; completed secondary school; and TAFE/tertiary.

Region

Most comparisons of region in this report have been defined using the Australian Standard Geographical Classification (ASGC) Remoteness structure (see ABS 2001).

The categories include Major Cities, Inner Regional, Outer Regional, Remote, Very Remote and Migratory. For the purposes of this report, Inner and Outer Regional were collapsed to form Regional, and Remote and Very Remote were collapsed to form Remote. The population spread in 2001 across these categories was as follows: Major Cities (66%), Regional (31%) and Remote (3%). In this report all deaths were assigned to these three categories, with 0.4% of deaths being classified as migratory.

Other comparisons of region use the rural, remote and metropolitan areas (RRMA) classification, developed in 1994 by the then Commonwealth Department of Primary Industries and Energy and the then Commonwealth Department of Human Services and Health.

The RRMA classification assigns each statistical local area in Australia into one of seven categories—2 metropolitan, 3 rural and 2 remote zones. These can be regrouped into three larger zones: urban (metropolitan), rural and remote. The classification is based primarily on population numbers and an index of remoteness.

Main data sources

AIHW National Hospital Morbidity Database contains demographic, diagnostic, procedural and duration of stay information on episodes of care for patients admitted to hospital. The data collection is maintained by the AIHW using data supplied by state and territory health authorities. The database is episode-based and it is not possible to count patients individually. In this report, disease data relate to the principal diagnosis reported for hospitalisations unless otherwise specified. Data presented in this report were extracted over the period February—March 2004.

AIHW National Mortality Database contains information on the cause of death supplied by the medical practitioner certifying the death or by a coroner. Registration of deaths is the responsibility of the state and territory registrars of Births, Deaths and Marriages. Registrars provide the information to the ABS for coding of cause of death and then provided to AIHW. In this report, unless otherwise specified, death data relate only to the underlying cause of death. Data presented in this report were extracted over the period February—March 2004.

Australia and New Zealand Dialysis and Transplant Registry (ANZDATA) collects information to monitor dialysis and transplant treatments from all renal units in Australia and New Zealand on all patients receiving kidney replacement therapy where the intention to treat is long-term. Cases of acute kidney failure are excluded. The Registry is coordinated within the Queen Elizabeth Hospital and is funded by the Australian Government Department of Health and Ageing.

Australian Diabetes, Obesity and Lifestyle Study (AusDiab) (1999–00) conducted by the International Diabetes Institute, was designed to provide estimates of the prevalence of diagnosed and undiagnosed diabetes and self-reported chronic conditions such as heart disease and high blood pressure. It also provided national measurements of blood pressure, blood lipids, blood glucose, body fat,

height and weight, and waist and hip circumference, as well as self-reported information on diet, smoking, alcohol consumption, physical activity, and general health and wellbeing. The study collected information in urban and non-urban areas in all states and the Northern Territory and sampled over 20,000 people aged 25 years and above, of whom more than 11,000 underwent a physical examination.

In this report, measured prevalence data on high blood pressure, high blood cholesterol and overweight was obtained from this source.

BEACH (Bettering the Evaluation and Care of Health) Survey of General Practice, an ongoing national survey looking at aspects of general practice in Australia, is conducted by the General Practice Statistics and Classification Unit (an AIHW collaborating unit within the Family Medicine Research Centre, University of Sydney). BEACH began in April 1998 and involves a random sample of approximately 1,000 general practitioners per year, each of whom records details regarding 100 consecutive patient encounters.

Burden of Disease and Injury in Australia Study (1996) was a study that assessed the total 'burden' of disease/injury by using a common metric developed by the Global Burden of Disease Study. The burden of disease refers to the impact on a 'healthy' life of premature mortality, disability, impairment, illness and injury. The burden is described by a summary measure of population health, the disability-adjusted life year or DALY, that combines information on the effect of premature death and of disability and other non-fatal health outcomes due to heart, stroke and vascular diseases, and their risk factors.

Central Australian Rheumatic Heart Disease Register includes data related to rheumatic heart disease diagnosis, hospitalisations, compliance with prophylactic antibiotic treatment, clinical progress, surgery and mortality. The register is run by Territory Health. Confidentialised data from the register were provided to AIHW.



Disability, Ageing and Carers Survey (1998)

conducted by the ABS, collected national information on the disability levels of Australians, their care needs, and the role of carers. It can be used with previous national disability surveys to monitor trends over time. The survey collected information from a sample of about 42,100 people over a three-month period from March to May 1998.

Drug Utilization Sub-Committee Database, held at the Australian Government Department of Health and Ageing, monitors the community (i.e. non-public hospital) use of prescription medicines in Australia. This database combines information on prescriptions subsidised by the PBS, the Repatriation Pharmaceutical Benefits Scheme and an estimate from the Pharmacy Guild Survey of those prescriptions that are not subsidised (i.e. private prescriptions and PBS prescriptions priced under the general patient copayment). The Pharmacy Guild Survey collects dispensing information each month from a random sample of about 250 pharmacies throughout Australia. Information on drugs prescribed in public hospitals and on highly specialised drugs available to outpatients through public hospital pharmacies under section 100 of the National Health Act are not included in this database.

National Diabetes Register is a database that collects information about people who use insulin as part of their treatment of diabetes. It includes data on persons who began to use insulin from 1 January 1999. Data for the register are obtained from two main sources: the National Diabetes Services Scheme, administered by Diabetes Australia, and the Australasian Paediatric Endocrine Group (APEG) state-based registers. APEG registers collect information about children with diabetes aged less than 15 years. Data presented in this report were extracted in January 2004.

National Dietary Survey of Adults (1983) was conducted as a component of the second Risk Factor Prevalence Survey. The survey was designed to obtain national information on dietary intake to

determine the food composition and nutrient intake of Australians aged 25–64 years. The survey collected information from a sample of 5,950 people living in the six capital cities of Australia.

National Drug Strategy Household Survey (2001) includes data on 26,744 Australians aged 14 years and older. This was the seventh survey in a series that began in 1985. Respondents were asked about their knowledge of drugs, their attitudes towards drugs, their drug consumption histories and related behaviours. This follows on from the 1998 National Drug Strategy Household Survey. It was conducted between June and September 1998, with 10,030 Australians aged 14 years and older participating.

In this report, self-reported prevalence of tobacco smoking and alcohol consumption was obtained from this source.

National Health surveys (1989–90, 1995 and 2001), a series of surveys conducted by the ABS, were designed to obtain national information on the health status of Australians, their use of health services and facilities, and health-related aspects of their lifestyle. The 2001 survey collected information from a sample of 26,900 people from February to November 2001. The 1995 survey was considerably larger and collected information from a sample of 57,600 people over a 12-month period from January 1995 to January 1996.

In this report, data on heart, stroke and vascular conditions, fruit and vegetable consumption, multiple risk factors, overweight (socioeconomic comparisons), and diabetes (regional and socioeconomic comparisons) were obtained from this source. Risk factor prevalence data among Indigenous Australians were also obtained from this source.

National Nutrition Survey (1995), conducted by the ABS, was the largest and most comprehensive Australian survey of food and nutrient intake, dietary habits and body measurements. The survey collected information from a subsample of respondents from

the 1995 National Health Survey, approximately 13,800 people from urban and rural areas of Australia. The National Nutrition Survey was conducted over a 13-month period from February 1995 to March 1996.

In this report, self-reported prevalence of high blood pressure and overweight (for regional comparisons) was obtained from this source.

National Physical Activity Surveys (1997, 1999 and 2000). The 2000 survey was conducted to give an assessment of physical activity patterns and knowledge of the benefits of physical activity among adult Australians after the Olympics in Sydney (September 2000). The survey collected information from a national sample of 3,590 people aged 18–75 years during November and December 2000. This survey follows on from the 1997 (the Active Australia Baseline survey) and 1999 National Physical Activity surveys. The 1997 survey collected information from a national sample of 4,821 people in November and December 1997. The 1999 survey collected information from a national sample of 3,841 people in November and December 1999.

Risk Factor Prevalence studies (1980, 1983 and 1989), a series of surveys conducted by the NHFA, were designed to obtain national information on biomedical and behavioural risk factors in Australia and to monitor trends over time. The studies collected information from a sample of around 22,000 adults living in capital cities of Australia (Canberra and Darwin were not included in the 1980 and 1983 surveys), between May/June and December of the survey year.

In this report, trend comparisons for measured prevalence of high blood pressure, high cholesterol and overweight were obtained from this source.

The Surveillance of Risk Factors report (SuRF 1), compiled by the WHO, presents available prevalence data on non-communicable risk factors at the country level for a number of member states of WHO. Risk factors included are tobacco and alcohol use,

patterns of physical inactivity, low fruit/vegetable intake, obesity, blood pressure, cholesterol and diabetes (measured by blood glucose).

Top End Rheumatic Heart Disease Register includes data related to rheumatic heart disease diagnosis, hospitalisations, compliance with antibiotic treatment, clinical progress, surgery and mortality. The register is run by Territory Health. Confidentialised data from the register was provided to AIHW.

Further reading

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Abbreviations

ABS	Australian Bureau of Statistics	IRSD	Index of relative socioeconomic disadvantage
ACE inhibitors	Angiotensin-converting enzyme inhibitors	LDL	Low-density lipoprotein
ACS	Acute coronary syndrome	MONICA Study	MONitor the trends and determinants of Cardiovascular disease Study (WHO)
AIHW	Australian Institute of Health and Welfare	MRI	Magnetic resonance imaging
AMI	Acute myocardial infarction	NHDD	National Health Data Dictionary
ANZDATA	Australia and New Zealand Dialysis and Transplant Registry	NHMRC	National Health and Medical Research Council
APEG	Australasian Paediatric Endocrine Group	NHFA	National Heart Foundation of Australia
ASGC	Australian Standard Geographical Classification	OECD	Organisation for Economic Co-operation and Development
ASR	Age-standardised rate	PBS	Pharmaceutical Benefits Scheme
AusDiab	Australian Diabetes, Obesity and Lifestyle Study	PCI	Percutaneous coronary intervention
BEACH	Bettering the Evaluation and Care of Health	PVD	Peripheral vascular disease
BMI	Body mass index	RRMA	Rural, remote and metropolitan areas classification
CABG	Coronary artery bypass grafting	SBP	Systolic blood pressure
CHD	Coronary heart disease	SIGNAL	Strategic Inter-Governmental Nutrition Alliance
CT scan	Computerised tomographic scan	SMR	Standardised mortality ratio
DALY	Disability-adjusted life year	SuRF	Surveillance of Risk Factors
DBP	Diastolic blood pressure	TAFE	Tertiary and further education
DDD	Defined daily dose	TIA	Transient ischaemic attack
DHAC	(Australian Government) Department of Health and Aged Care	WHO	World Health Organization
DoHA	(Australian Government) Department of Health and Ageing	WONCA	World Organization of Family Doctors
ESRD	End-stage renal disease		
GP	General practitioner		
HDL	High-density lipoprotein		
ICD-9	International Classification of Diseases, 9th Revision		
ICD-9-CM	International Classification of Diseases, 9th Revision Clinical Modification		
ICD-10	International Classification of Diseases, 10th Revision		
ICD-10-AM	International Classification of Diseases, 10th Revision Australian Modification		
ICPC	International Classification of Primary Care		
IDF	International Diabetes Federation		

Abbreviations of places

ACT	Australian Capital Territory
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Symbols

Symbol	Meaning
g	gram
kJ	kilojoule
mmHg	millimetre of mercury
mmol/L	millimoles per litre
n.a.	not available
n.c.	not comparable
n.p.	not presented
—	rounded to zero
..	not applicable
*	statistically significant difference at the 95% level
#	statistically significant difference from 1.0
\$m	\$ million