Australian Government

Australian Institute of Health and Welfare

Australian Institute of Health and Welfare

Annual report

2016–17

AIHW

About the AIHW

In 2017, the Australian Institute of Health and Welfare (AIHW) celebrates 30 years of providing high-quality, independent evidence on health and welfare in Australia. Over this time, especially over the last 5 years, our operating environment has changed markedly. It will continue to do so. The proliferation of data is now unprecedented. So, too, are the rapid changes in how data are captured, shared, analysed and communicated. The community, policy makers, service providers and researchers have high expectations that data are, and should be, available to inform them.

The AIHW is a national asset. As an independent information management agency, we enable other organisations to improve polices and services to achieve their goals by making better use of evidence—a fundamental requirement of good decision making.

Our vision

Stronger evidence, better decisions, improved health and welfare.

About this report

This is the AIHW's report to the Minister for Health for the financial year ended 30 June 2017. This report has been prepared in accordance with the Australian Government Department of Finance's *Resource management guide no. 136: annual reports for corporate Commonwealth entities*.

As required under the *Public Governance, Performance and Accountability Act 2013*, this report contains the AIHW's Annual Performance Statements for 2016–17. The Annual Performance Statement details the results the AIHW has achieved against our performance criteria as set out in the 2016–17 Health Portfolio Budget Statements and the AIHW's Corporate Plan 2016–17 to 2020–21.

This report also contains other mandatory requirements and information about the AIHW, our work and our people.

The compliance index on page 177 will direct you to where required information can be found.

Australian Institute of Health and Welfare

Annual report 2016–17

Australian Institute of Health and Welfare, Canberra staff, August 2017.

The Australian Institute of Health and Welfare is a major national agency whose purpose is to create authoritative and accessible information and statistics that inform decisions and improve the health and wellbeing of all Australians.

This publication is part of the Australian Institute of Health and Welfare's corporate series. A complete list of the Institute's publications is available from the Institute's website www.aihw.gov.au

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Availability and accessibility

This publication is available electronically in portable document format (PDF) and hypertext markup language (HTML) formats on the AIHW's website at www.aihw.gov.au. The full web address is www.aihw.gov.au/aihw-annual-report-2016-17/.

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Please note that there is the potential for minor revisions of data in this report.
Please check the online version at www.aihw.gov.au

Letter of transmittal

Australian Government
Australian Institute of Health and Welfare

AIHW

The Hon. Greg Hunt, MP
Minister for Health
Minister for Sport
Parliament House
CANBERRA ACT 2600

Dear Minister

I am pleased to present you with the annual report of the Australian Institute of Health and Welfare (AIHW) for the year ending 30 June 2017.

The AIHW is established as a body corporate under section 4 of the *Australian Institute of Health and Welfare Act 1987* and, for the year ending 30 June 2017, was subject to the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

The report meets the requirements of section 46 of the PGPA Act and related legislation as follows:

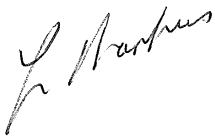
- Public Governance, Performance and Accountability Rule 2014
- Public Governance, Performance and Accountability (Financial Reporting) Rule 2015.

The report also provides information required by other applicable legislation.

The members of the AIHW Board resolved to approve the report at their meeting on 28 September 2017.

I am satisfied that the AIHW has prepared fraud risk assessments and fraud control plans and has in place appropriate fraud prevention, detection, investigation, reporting and data collection procedures that meet the specific needs of the entity.

Yours sincerely



Louise Markus
Board Chair
28 September 2017

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AIHW Board Chair's report

On 14 December 2016, I was appointed as the Chair of the AIHW Board. I was delighted to join a succession of talented and skilled chairs who have led the Institute since its establishment. I was privileged to meet a number of them as part of the AIHW's 30th birthday celebrations. On behalf of the board, I would like to thank my predecessor Dr Mukesh C Haikerwal AO for his contribution to the AIHW during his time as chair.

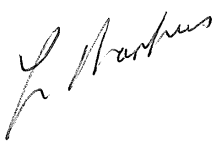
The commemoration of the AIHW's 3 decades of service to the Australian community provides an opportunity to acknowledge the many contributors—staff, partners and other stakeholders—who have together built an organisation that has developed the capacity to accurately measure and present a clear and informative picture of the state of the nation's health and welfare.

The 2016–17 year was another of significant change at the AIHW. We responded to a rapidly changing information and policy environment while continuing to fulfil our core charter of providing high-quality information and statistics across many key subject areas. Our work continues to promote an understanding of the key characteristics of and influences on the wellbeing of the Australian community, with the ultimate aim of making a real difference to people's lives.

The AIHW continues to pay close attention to the needs of our stakeholders. During the year under review, the AIHW Board adopted a new set of Strategic Directions, which reflected the outcome of extensive review and consultative processes. The AIHW's *Strategic directions 2017–2021* sets out ambitious strategic goals for the Institute and articulates how we will apply and strengthen our capabilities to achieve them.

The renewed AIHW vision, 'Stronger evidence, better decisions, improved health and welfare', will guide our efforts in the coming years and maintain our focus on growing the important evidence base required for quality decision making in the health and welfare sector, whether by government or the private sector. Real solutions can be found to complex and difficult issues when debate and discussion are informed by accurate, timely and comprehensive data.

This annual report documents another successful year for the AIHW. I am pleased to acknowledge the professional input of the skilled members of the AIHW Board, who are providing the Institute with the strategic leadership necessary to meet today's challenges. Of course, the AIHW's success depends on the work of our expert and highly committed staff and the skilled leadership of the AIHW Director Barry Sandison. As we reflect on AIHW's achievements since its creation in 1987, we have reason to be very proud of our hard earned reputation as champions of open and accessible data and information.



Louise Markus
AIHW Board Chair

AIHW Director's report

During 2016–17, the AIHW continued to deliver on its purpose to provide authoritative information and statistics to promote better health and wellbeing for all Australians.

The activities recorded in this annual report evidence another busy and productive year for the Institute. We have continued to strengthen our reputation as national leaders in producing high-quality health and welfare information and statistics.

I was proud to participate in the AIHW's 30th anniversary celebrations, which enabled us to reflect on how far we have come since our establishment in 1987. We have continued to expand our range of products and reporting. If our success can be measured by our growing list of stakeholders and customers, we have much of which to be proud.

During the year, we released 188 products in a variety of formats. We reached a wide audience, with many of our products receiving significant media coverage.

Some of the highlights of 2016–17 for the AIHW were:

- a fundamental review of our strategic objectives and processes, culminating in the adoption by the AIHW Board of a new set of strategic directions, to ensure we remain relevant and responsive to the needs of the many users of our information and products. We reviewed every aspect of our business model with an eye to innovation and enhanced flexibility
- identification of 10 priority areas associated with core aspects of our work. In each of these we have identified a set of investments to drive improvements
- the formation of a dedicated business improvement team and an improvement advisory committee to assist in driving innovation and capacity building. Progress will be actively monitored by the AIHW Board
- continued work on the National Data Linkage Demonstration Project, under the auspices of the Australian Health Ministers' Advisory Council, to establish an enduring linked data set incorporating hospitals, Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and National Death Index data
- improved access to statistical products that provide data in manipulatable formats
- successful completion of data linkage services for 55 projects as agreed under the National Collaborative Research Infrastructure Strategy.

Some notable publications released during 2016–17 were:

- The first national *Indigenous eye health measures 2016* report brought together for the first time a comprehensive collection of data from a range of sources.
- The in-brief summary report *Incidence of suicide among serving and ex serving Australian Defence Force personnel 2001–2015* is part of an authoritative study that will continue to be updated as new data become available.

- We extended our work on the Australian Burden of Disease Study 2011 by releasing *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011*. This report provided the estimates of the non-fatal and fatal burden of disease for the Aboriginal and Torres Strait Islander population.
- The report on *Vulnerable young people: interactions across homelessness, youth justice and child protection—1 July 2011 to 30 June 2015* provides analysis of a linked data set from the Specialist Homelessness Services Collection with child protection and youth justice data held by the AIHW.

Our future

From 1 July 2017, we introduced a new management structure to ensure we are best positioned for the challenges ahead. This included completing the integration into the organisation of AIHW's reporting responsibilities under the Performance and Accountability Framework (PAF) following the closure of the National Health Performance Authority in July 2016.

We have allocated specific staff resources for the coordination of a whole-of-population approach to monitoring and reporting on the current status and future needs of veterans and their families. This is part of a 3-year strategic work program funded by the Department of Veterans' Affairs.

Under our new structure, dedicated teams will work to deepen and expand our work in primary health care, community services and family and domestic violence.

The AIHW will continue to support the Australian Government's open data initiatives through our involvement in the Data Integration Partnership for Australia program, and work with other agencies in assisting government consideration and response to the recommendations of the Productivity Commission report on *Data availability and use*.

During 2017–18, the AIHW will continue to engage with the Department of Health to support and implement changes to funding structures and the way the AIHW works with the department to ensure we are adequately resourced to meet future needs.

I would like to take this opportunity to thank the AIHW Board for its support and to recognise the contributions from the former chair Dr Mukesh C Haikerwal AO and the new Chair Mrs Louise Markus.

None of the AIHW's achievements would have occurred without the support of the Institute's talented staff and I thank them for their dedication, enthusiasm and willingness to innovate in order to maintain our place at the information cutting edge.

I am proud and honoured to help lead an organisation whose work has, over 3 decades now, contributed to demonstrable differences to the lives of all Australians. We look forward confidently to meeting the many challenges ahead.

Barry Sandison
AIHW Director

In Brief

Our purpose

To create authoritative and accessible information and statistics that inform decisions and improve the health and welfare of all Australians.

Our values

In pursuing our vision, we draw on our independence and our expertise in health and welfare, to strive for excellence in all we do. We also uphold the Australian Public Service values:

- **Impartial**—we are apolitical and provide the Australian Government with advice that is frank, honest, timely and based on the best available evidence.
- **Committed to service**—we are professional, objective, innovative and efficient, and work collaboratively to achieve the best results for the Australian community and the government.
- **Accountable**—we are open and accountable to the Australian community under the law and within the framework of Ministerial responsibility.
- **Respectful**—we respect all people, including their rights and their heritage.
- **Ethical**—we demonstrate leadership, are trustworthy, and act with integrity, in all that we do.

Our strategic goals

Over the next 5 years, we will apply and strengthen our capabilities to be:

Leaders in health and welfare data
We will engage nationally and internationally with authorities in our domain to develop, promote and deliver quality standards, systems and processes for collecting, curating and linking health and welfare data.

Champions for open and accessible data and information
We will leverage emerging technology and enhance our products and services in order to provide data and information tailored to diverse access, timeliness and quality requirements. We will support our partners in making their data accessible, while protecting privacy.

Trusted strategic partners
We will foster strategic partnerships and engage collaboratively with stakeholders to deliver program-specific expertise and enable others to achieve their strategic goals.

Expert sources of value-added analysis
We will harness and enhance our capabilities in the health and welfare domains to turn data and information into knowledge and intelligence. We will translate this evidence to provide insight into patterns, trends and outcomes, including how these compare across organisations, regions and internationally.

Drivers of data improvements
We will build on our trusted status to identify and respond to gaps and opportunities in multisource health and welfare data holdings. We will support our partners to develop and capture the data required to inform national priorities.

Our organisation

The AIHW Act is our enabling legislation and establishes the AIHW Board as the Institute's governing body. Further information about how we operate and the role and composition of the board are specified in **Chapter 4 Our organisation**.

The board is accountable to the Parliament of Australia through the Minister for Health, and is responsible for setting the overall policy and strategic direction of the Institute. As at 30 June 2017, the Minister for Health was the Hon. Greg Hunt, MP.

The Charter of Corporate Governance outlines AIHW's governance arrangements including the board's structure, processes and responsibilities. The AIHW Director manages the day-to-day affairs of the Institute with the assistance of an executive committee. Our staff operate within 8 organisational groups.

The Institute operates in accordance with the PGPA Act. For planning purposes, it prepares a corporate plan and budget estimates as required by the PGPA Act. For reporting purposes, it prepares this annual report, which must include a set of annual financial statements and an annual performance statement, also as required by the PGPA Act. Much of the work we undertake is subject to ethical clearance by the AIHW Ethics Committee, which is established by the AIHW Act.

Our stakeholders

We aspire to clearly communicate our data, information and analytical products to all our stakeholders as widely as possible in accessible formats, while protecting the privacy of this information. Collaborating with other entities is integral to the way the AIHW operates. These relationships are built on the solid foundations of mutual interest, complementary expertise and robust governance arrangements.

We engage closely with data providers and other stakeholders to understand their information needs and ensure data quality and integrity. We foster strong relationships with Australian Government and state and territory government agencies which are critical to our activities. Much of the data collected and reported by the AIHW is provided to us by these agencies and relates to services they provide or fund. The AIHW works with relevant agencies to improve the timeliness and comparability of their information.

We have built effective partnerships with universities, research centres, non-government organisations and individual experts throughout the country. We also work with international partners, including the World Health Organization, the Organisation for Economic Co-operation and Development, the Canadian Institute for Health Information and the International Group for Indigenous Health Measurement.

30 years of the AIHW—key achievements

1987–89 Australian Institute of Health established.
First *Australia's health* biennial report published.
Published report on Australian Health Expenditure.

1990–92 Appointed as WHO Collaborating Centre for the Classification of Diseases.
Welfare functions added to Act; name changed to Australian Institute of Health and Welfare.
Produced first Data Catalogue.

1993–94 First *Australia's welfare* biennial report published.
Australia's food and nutrition report published.

1996–98 Joint AIHW–ABS report, *The health and welfare of Australia's Aboriginal andTorres Strait Islander peoples*.
Minister for Health and Family Services, launched the AIHW home page.
Held a conference to launch *Australia's welfare 1997* and *Australia's health 1998*.
The first *National community services data dictionary* published.

2001–03 Hosted a meeting of Heads of World Health Organization Collaborating Centres for the Family of International Classifications.

2004–05 Launched Metadata Online Registry (METeOR).

2007–09 Released first publication on children and young people that used linked data.
Published online interactive atlases of population health of Aboriginal and Torres Strait Islander people.
Reconciliation Action Plan launched.

2010–12 Launched MyHospitals website and new online Indigenous Observatory.
Developed Validata®—a new data validation tool.
AIHW is accredited as an Integrating Authority.
Reported results from the first quarter's data from the new Specialist Homelessness Services Collection.

2015–16 Assumed Performance and Accountability Framework reporting following NHPA closure.
Department of Health authorised supply of MBS and PBS data to the AIHW.
Completed 33 data linkage projects.

2016–17 30th birthday.

Chapter 1 Our performance

Data linkage services

We completed data linkage services for 55 projects during 2016–17, including linkage of data sets to Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data, the National Death Index and the Australian Cancer Database.

Access to data for analysis

During 2016–17, we completed 135 requests for customised data analysis, which provides access to statistics that are not available in published reports, tables, dynamic data displays or data cubes. In addition, we are continuing to develop ways to release more statistical products that allow users to manipulate information into formats suitable for their analysis.

Our financial performance

Our total revenue for 2016–17 was $57.8 million, which represents an increase of $9.4 million from 2015–16. This increase was due to an appropriation adjustment related to the AIHW's assumption of responsibility for the PAF functions of the former National Health Performance Authority. Our financial result for the year was a surplus of $76,000.

Chapter 2 Our products

Products released

We released 188 products during 2016–17, covering a broad range of topics, such as life expectancy and disability in Australia, the impact of overweight and obesity, youth justice, Australian hospital statistics, mental health, Australia's health and Indigenous eye health measures.

Chapter 3 Our communications

Infographics

In 2016–17, we produced and expanded the number of infographics across all topic areas, providing our audience with easy-to-interpret graphics.

Media and Online Presence

Both media coverage and website traffic increased in 2016–17 compared with the previous year.

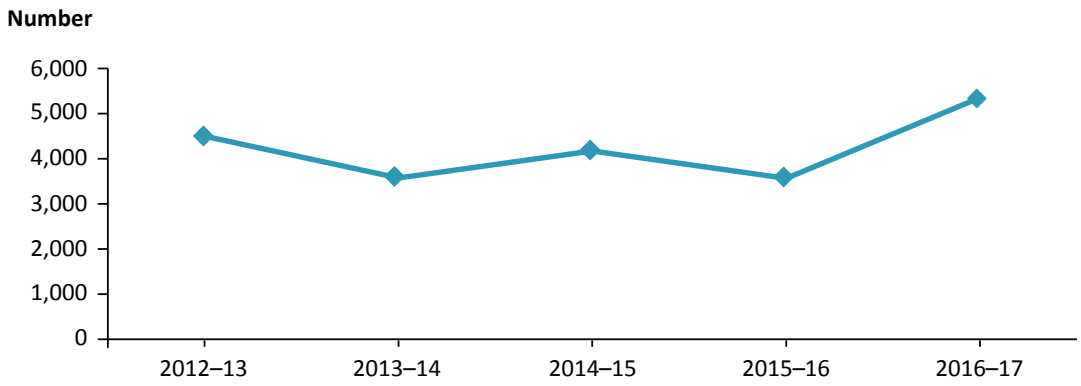


Figure 1: Number of mentions in the media attributed to the AIHW

Website sessions	*million*
2016–17	**3.0**
2015–16	**2.8**

Media coverage	*items*
2016–17	**5,354**
2015–16	**3,566**

Chapter 4 Our organisation

AIHW Board

The AIHW is managed by the AIHW Board. The board is an 'accountable authority' under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act). The board's composition is prescribed by section 8(1) of the *Australian Institute of Health and Welfare Act 1987* (AIHW Act).

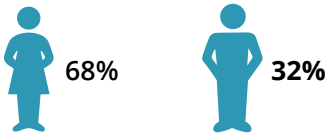
Board members are appointed by the Governor-General and hold office for a specified term not exceeding 3 years. In addition, there are 3 ex-officio board members: the AIHW's Director, the Australian Statistician or nominee, and the Secretary of the Department of Health or nominee. In 2016–17, the AIHW Board met 6 times and considered a range of issues relating to the management of the AIHW, including the new *Strategic directions 2017–2021*.

AIHW Ethics Committee

The AIHW Ethics Committee is established under section 16(1) of the AIHW Act. Its main responsibility is to advise on the ethical acceptability or otherwise of current or proposed health- and welfare-related activities of the AIHW, or of bodies with which the AIHW is associated. In 2016–17, the AIHW Ethics Committee met 4 times and considered 62 new project applications.

Chapter 5 Our people

369 staff were **employed** at the AIHW in 2016–17.

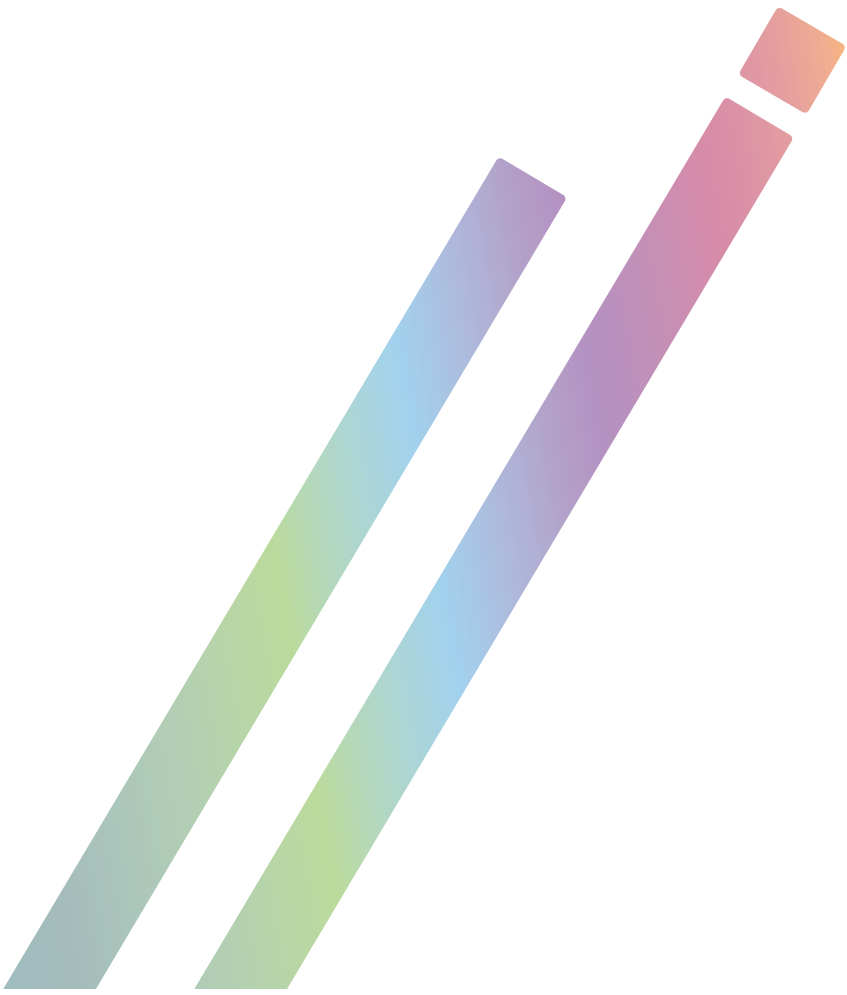


27% of our employees worked within **part-time** arrangements.

14 staff were employed as a part of our **graduate intake** in 2016–17.

14 staff during the year were presented with **long-service awards**, having reached their 10- or 30-year anniversaries.

Contents



Chapter 1

Our performance

This chapter encompasses our 2016–17 performance statement, which is the required means for reporting on all performance criteria included in our corporate plan. It focuses on our performance in achieving our key performance indicators and expected major deliverables for the year.

The chapter also summarises our financial performance, which is detailed in our 2016–17 financial statements in Appendix 7, and our compliance with legislation on reporting.

Statement by accountable authority

Australian Government
Australian Institute of Health and Welfare

AIHW

On behalf of the board of the Australian Institute of Health and Welfare (AIHW), which is the accountable authority of the AIHW, I present, in this chapter of the *Australian Institute of Health and Welfare annual report 2016–17*, the 2016–17 annual performance statement of the AIHW, as required under paragraph 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

In my opinion, this 2016–17 annual performance statement is based on properly maintained records, accurately reflects the performance of the Institute, and complies with subsection 39(2) of the PGPA Act.

The members of the AIHW Board resolved to approve this 2016–17 annual performance statement at their meeting on 28 September 2017, in the context of approval of the *Australian Institute of Health and Welfare annual report 2016–17*. This statement is made in accordance with that resolution.

The chapter also includes summary information about financial performance and compliance with legislation.

Louise Markus
Board Chair
28 September 2017

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Our purpose

To create authoritative and accessible information and statistics that inform decisions and improve the health and welfare of all Australians.

Our work provides governments, key stakeholders and the broader Australian community with valuable evidence and insights about key issues affecting the health and welfare of Australia's population.

The information and data we publish, and otherwise make available, inform open debate and discussion at the national and jurisdictional levels on significant issues aimed at securing a sustained increase in quality of life for Australians over time.

Outcome

A robust evidence base for the health, housing and community sectors, including through developing and disseminating comparable health and welfare information and statistics.

We are committed to providing high-quality national health- and welfare-related data and analysis across all relevant sectors, presented in meaningful and relevant ways and delivered in a timely manner. Accurate statistical information, comprehensive data development, high-quality analyses and related services support an increased understanding of health and welfare issues. This evidence base is critical to good policy making and effective service delivery, both of which have a direct impact on the lives of Australians.

External confidence in the AIHW is demonstrated by our exemplary reputation and acknowledgment of our achievements over 30 years. It is also reflected in the high level of engagement with us by other organisations, in terms of pursuit of joint endeavours and use of our services. Another way to assess the value placed on our contribution is the level of our external funding and the volume and variety of commissioned project work.

Our achievements and valued contribution rest on our demonstrated record in providing information that is:

- authoritative, accurate, accessible and timely
- useful for governments, service providers and the community
- in formats that are useful to individual users.

Public Governance, Performance and Accountability Act 2013 **(PGPA Act)**

As required under the PGPA Act, this report contains the AIHW's annual performance statement for 2016–17. The annual performance statement details results achieved against the planned performance set out in the 2016–17 Portfolio Budget Statements (PBS) and the *Australian Institute of Health and Welfare Corporate Plan 2016–17 to 2019–20*.

In 2017, the Minister for Health the Hon. Greg Hunt, MP, said that: 'The Government recognises the amazing work that the Australian Institute of Health and Welfare (AIHW) and its staff undertake in using data to build and maintain the evidence base for health and welfare in Australia. The AIHW's value is highlighted across so many areas of social policy, including the important areas of mental health, hospitals, homelessness, aged care and Indigenous health and welfare.

AIHW continues to be a national asset and a trusted partner for governments, researchers and the Australian public.
As the Institute celebrates its 30th birthday, I particularly want to acknowledge the staff and encourage the Institute to continue to identify opportunities to strengthen the evidence base it makes available to the Australian community. The work is valuable and important and ultimately benefits the lives of all Australians.'

Program

Develop, collect, analyse and report high-quality national health and welfare information and statistics for governments and the community.

Our program objectives and performance criteria

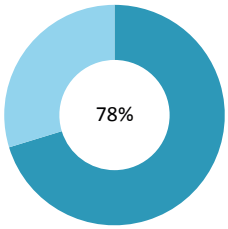
Our corporate plan includes 2 program objectives:

- improving the availability of health and welfare information
- improving the quality of health and welfare information.

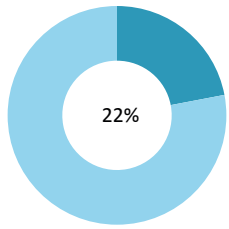
Targets relating to these objectives are grouped into 9 performance criteria, most of which have more than one measurable target. 7 of the criteria relate to the first program objective and 2 of the criteria relate to the second objective.

The sources for these criteria and targets are the 2016–17 PBS and the AIHW's 2016–17 to 2019–20 corporate plan available at http://www.health.gov.au/internet/budget/publishing.nsf/Content/2016-2017_Health_PBS> and http://www.aihw.gov.au/publication-detail/?id=60129556354>, respectively.

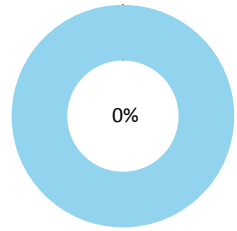
Summary of our performance results



7 of 9 performance criteria were met



2 of 9 performance criteria were partially met



0 of 9 performance criteria were not met

Of the 9 performance criteria:

- **7 performance criteria were met** according to all targets
- **2 performance criteria were partially met**, meaning at least 50% of the targets for those criteria were met, but at least 1 target was not met.

Details of performance against each of the targets for each criteria are provided in the tables later in this chapter.

Factors contributing to our performance

As described in greater detail in our corporate plan, the AIHW is operating in an environment that requires it to:

- compete for business in a changing policy and operational environment, including
  - institutional change and review
  - a reliance on external funding
- operate in a changing information environment, including the need to
  - maintain the trust of data providers
  - understand emerging data trends and issues
  - respond to changing demands for information
  - understand the policy and program environment
- protect information through strong privacy and data security arrangements.

Although the AIHW has undergone a number of recent changes relating to the development of the new strategic goals, there were no major changes to our activities or capabilities or to the environment in which we operate that had a significant impact on our performance during 2016–17.

Deliverables contributing to improving data availability

Table 1.1: Results for 2016–17 performance criteria: deliverables contributing to improving the availability of health and welfare information

Performance criteria: Release a range of information products relevant to key policy areas	
2016–17 target	**2016–17 result**
Products released by 30 June 2017, including:	
• a 2016 National Social Housing Survey report.	✓ A report providing information from the 2016 National Social Housing Survey report was released on 12 April 2017.
• key findings from the 2016 National Drug Strategy Household Survey.	✓ The key findings of the 2016 National Drug Strategy Household Survey were released on 1 June 2017.
• Indigenous estimates from the Australian Burden of Disease Study 2011.	✓ *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011* was released on 23 September 2016.
• a report on the AIHW's enhanced mortality database project for estimating Indigenous life expectancy.	× Not met: the report on the AIHW's enhanced mortality database project for estimating Indigenous life expectancy was not released by 30 June 2017—it will be released in late 2017. The report was delayed to allow for the extension of the analysis to include more recent data.
• a mapping report on the relative spatial distributions of the clinical health workforce and Indigenous Australians.	✓ *Spatial distribution of the supply of the clinical health workforce 2014: relationship to the distribution of the Indigenous population* was released on 28 November 2016. It provides analyses of the geographical supply of the clinical health workforce in 7 key professions with particular relevance to Indigenous Australians.
• a report on mothers and babies for 2014 and companion interactive perinatal data portal.	✓ *Australia's mothers and babies 2014—in brief* was released on 25 November 2016; the publication was also accompanied with a perinatal dynamic data display.
• a 2014–15 health expenditure report.	✓ *Health expenditure Australia 2014–15* was released on 6 October 2016. It provides an annual overview of key trends in health expenditure.
• regional aged care profiles.	✓ Regional aged care profiles were released with data as at 30 June 2015. They present graphical and tabular information on recipients of aged care services and operational government-funded aged care places for a selected aged care planning region. This information was released with a dynamic data display.
	Overall result: partially met

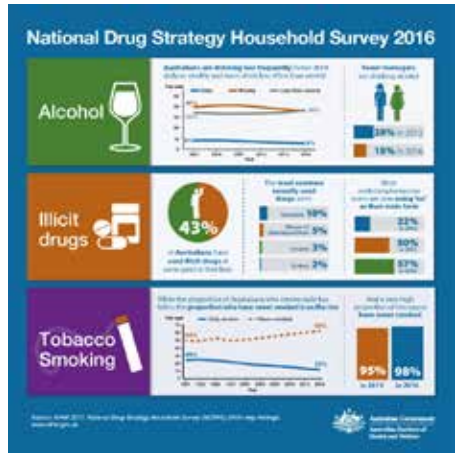
continued

National Drug Strategy Household Survey (NDSHS) 2016 key findings

The NDSHS is Australia's largest and most comprehensive survey on drug and alcohol use. The NDSHS collects data on alcohol and tobacco consumption and illicit drug use among the general population in Australia and information on attitudes and perceptions relating to these issues. Survey findings relate mainly to people aged 14 or older.

The 2016 NDSHS showed that younger people (aged under 30) were smoking less, drinking less and using fewer illicit drugs in 2016 than in 2001. However, for people in their 40s, 50s and 60s, there was little or no change in overall drug usage behaviours over this period but their use of some drugs had increased between 2013 and 2016. The report showed that the percentage of Australians who smoke daily nearly halved from 24% in 1991 to 13% in 2013, but showed little change from 2013 to 2016 (12%). The percentage of Australians who have never smoked continues to rise—from 60% in 2013 to 62% in 2016. In particular, fewer teenagers are taking up smoking—the percentage who have never smoked rose from 95% in 2013 to 98% in 2016.

Compared with 2013, fewer people in Australia drank alcohol in quantities that exceeded the lifetime risk guidelines in 2016 (17.1%, down from 18.2% in 2013), but there was no change in the proportion exceeding the single occasion risk guideline. Young adults were drinking less—a significantly lower percentage of those aged 18–24 consumed 5 or more standard drinks on a monthly basis (from 47% in 2013 to 42% in 2016). The proportion of people aged 12–17 abstaining from alcohol significantly increased from 2013 to 2016 (from 72% to 82%). However, more people in their 50s were consuming 11 or more standard drinks in 1 drinking occasion in 2016 than in 2013. Fewer people reported being a victim of an alcohol-related incident; the proportion declined from 26% in 2013 to 22% in 2016.

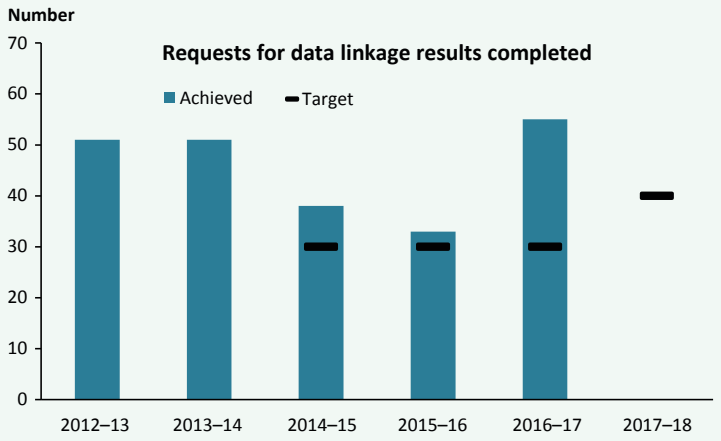


Those aged under 40 were less likely to have recently used illicit drugs than in the past, while those aged 40 and over were more likely. Between 2013 and 2016, the percentage of people in their 40s who had used illicit drugs in the last 12 months rose from 14% to 16%. Overall, the most common recently used drugs were cannabis (10%), misuse of pharmaceuticals (5%), cocaine (3%) and ecstasy (2%). Recent use of meth/amphetamines has fallen, but the report showed a continuing trend toward 'ice' (rather than other forms, such a powder). In 2016, 57% of meth/amphetamine users were mainly using ice, up from 22% in 2010.

Meth/amphetamine has overtaken excessive drinking of alcohol as the drug of most concern to Australians (40%).

The report is available at http://www.aihw.gov.au/alcohol-and-other-drugs/data-sources/ndshs-2016/key-findings/.

Table 1.1 (continued): Results for 2016–17 performance criteria: deliverables contributing to improving the availability of health and welfare information

Performance criteria: Continue to operate the Data Integration Services Centre to undertake complex data integration (linkage) projects as agreed under the National Collaborative Research Infrastructure Strategy 2013	
2016–17 target	**2016–17 result**
Satisfying requests for data linkage relating to more than 30 projects by 30 June 2017.	✓ We completed data linkage services for 55 projects, including linkage of other data sets to Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data, the National Death Index and the Australian Cancer Database, as agreed under the strategy. • Projects may be for academic researchers, government departments and research agencies. ✓ We continue to work to enhance our data linkage and analytical capabilities and methodologies. As well as requests for customised data analysis from external clients, some researchers ask us for the results of data linkages between their data collections and ours. In these cases, external researchers must submit project proposal applications for ethical clearance (see 'AIHW Ethics Committee' on page 58) before being granted access to linkage results. The AIHW Ethics Committee secretariat and relevant data custodians provide advice on how to progress applications. Once approval is obtained, the AIHW undertakes the linkages in a secure environment on a cost recovery basis. In 2016–17, we far exceeded our target; we have raised our target for 2017–18 to recognise the increased interest in data linkage across the health and welfare sectors.  **Figure 1.1 shows the trends from 2012–13 onwards and the target for 2017–18**
	Overall result: met

continued

Table 1.1 (continued): Results for 2016–17 performance criteria: deliverables contributing to improving the availability of health and welfare information

Performance criteria: Collect, produce and release data and information that assists community understanding, policy purposes or research purposes, within privacy and confidentiality constraints	
2016–17 target	**2016–17 result**
AIHW data collections—a number of which are 'Essential Statistical Assets for Australia'—are: • maintained securely over time and enhanced, where relevant • made accessible for the purposes of external research • used to disseminate information in diverse and accessible formats.	✓ We maintained our collections securely; there were no known data breaches. All data releases fully complied with all privacy and confidentiality requirements. ✓ The AIHW Ethics Committee approved 62 new research applications during 2016–17. ✓ Our collections were enhanced, notably through our participation in the National Data Linkage Demonstration Project, linking Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data, hospitals data from New South Wales and Victoria, and the National Death Index data. ✓ All our publications, including those about collections, are available free of charge as portable document format (PDF) documents on the AIHW's website. Increasingly, key publications are being made available in hypertext markup language (HTML) format and data are being made available in manipulatable formats, such as spreadsheets, data cubes and similar components.
Overall result: met	

Performance criteria: Maintain active engagement with key stakeholders to ensure current and emerging information needs that contribute to the evidence base for policy and service	
2016–17 target	**2016–17 result**
To demonstrate this, information for the year will be collated from operating units and from administrative information systems on: • our participation in national committees • the external organisations with which we have relationships and/or agreements • specific instances where we have met current and emerging information needs that contribute to the evidence base for policy and service delivery.	✓ The AIHW participates in more than 80 national committees dealing with a range of issues, such as: data linkage, Indigenous health and welfare, World Health Organization, ageing and aged care and child health. ✓ The AIHW continued to maintain relationships with our key stakeholders and external organisations; we currently manage more than 33 current agreements. Of these, 2 were extended and 5 were entered into during 2016–17. ✓ There have been many instances where the work of the AIHW has contributed to emerging information needs and evidence-based policy, such as the *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report*.
Overall result: met	

continued

Incidence of suicide among serving and ex-serving Australian Defence Force

The *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report* quantifies the level of suicide among serving and ex-serving Australian Defence Force (ADF) personnel and identifies characteristics that may be associated with risk of suicide.

Key findings from the in-brief report include:

- Between 2001 and 2015, there were 325 certified suicide deaths among people who had served in the ADF for any length of time since 2001.
- At the time of their death, more than half of those who died were no longer serving in the ADF.
- While men who were currently serving full-time or in the reserve were considerably less likely to die by suicide than Australian men generally, this was not the case for men no longer serving in the ADF who were marginally (14%) more likely to die by suicide than Australian men of the same age.
- Young discharged men were at particular risk—those aged 18 to 24 were twice as likely to die by suicide as men of the same age in the general population.

Certain service-related characteristics were associated with higher suicide rates among ex-serving men:

- those who were discharged involuntarily, particularly if the discharge was for medical reasons
- those who left the ADF after less than 1 year of service
- all ranks other than commissioned officers.

Further detailed results from the study are expected to be published in a comprehensive technical report in late 2017.

The report is available at http://www.aihw.gov.au/publication-detail/?id=60129559898.

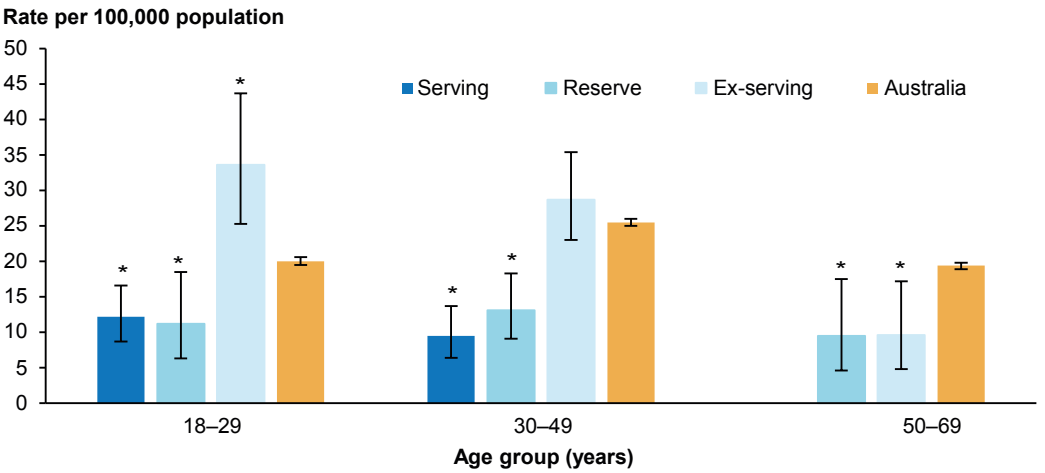


Figure 1.2: Age-specific rate of suicide death by broad age group, ADF populations and all Australian men, 2002–2014

*A statistically significant difference between the ADF population group and Australian men the same age.
Note: the vertical lines superimposed over the top end of each bar are 95% confidence intervals.

Table 1.1 (continued): Results for 2016–17 performance criteria: deliverables contributing to improving the availability of health and welfare information

Performance criteria: Provide leadership in satisfying information-related development requested by the Australian Government and state and territory governments	
2016–17 target	**2016–17 result**
Development, coordination and supply of data for governments, including a range of performance indicators in Council of Australian Governments (COAG) national agreements on health, housing and homelessness, disability, and Indigenous reform, including those for the Performance and Accountability Framework (PAF) agreed by the COAG	✓ Through the release of 14 products on the MyHealthyCommunities and MyHospitals websites, we have reported on 18 indicators listed under the PAF. ✓ We have continued to contribute to the development, coordination and supply of data for governments, through our participation in 9 working groups and provision of data and analysis for 12 chapters for the *Report on government services*. ✓ We actively participate in high-level committees in the health, child and family services and housing areas.
Overall Result: Met	

continued

Healthy Communities: Overweight and obesity rates across Australia, 2014–15

Healthy Communities: Overweight and obesity rates across Australia, 2014–15 presents, for the first time, overweight and obesity rates in adults by Primary Health Network (PHN) areas nationwide. Overweight and obesity are important public health issues in Australia, as health problems related to excess body weight impact on our health-care system, as well as individuals, families and the community. Presenting local area information helps identify those areas with the greatest need and assists in health planning and service delivery.

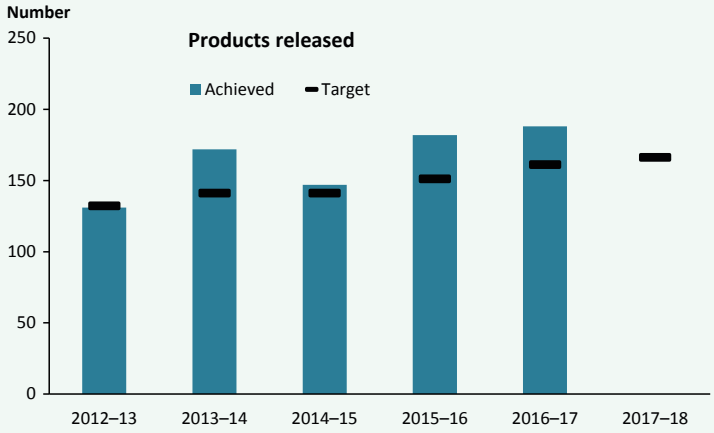
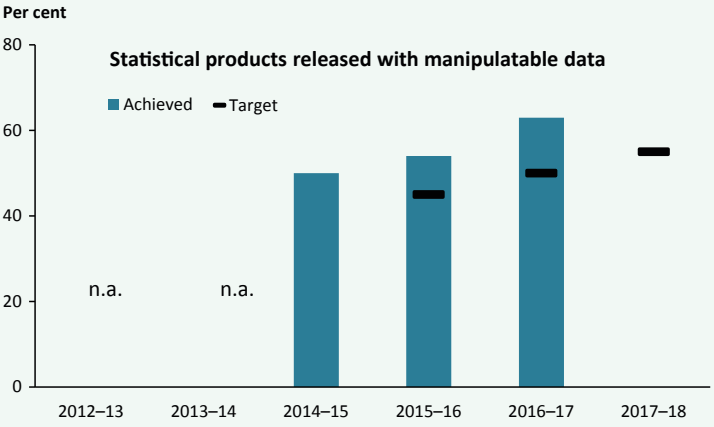
The key findings from the report were that in 2014–15:

- The percentage of overweight or obese adults ranged from 73% in Country SA (South Australia) to 53% in Northern Sydney.
- Overweight and obesity rates were generally higher in regional PHN areas than in metropolitan PHN areas.
- The 5 PHNs with the highest rates of overweight and obesity were all in regional locations, whereas the 5 with the lowest rates were all in metropolitan areas.
- Across PHN areas, adult obesity rates ranged from 38% in Country SA to 16% in Central and Eastern Sydney.

The report (combined with *Healthy Communities: Tobacco smoking rates across Australia, 2014–15*), had a good media response—a total of 257 items.

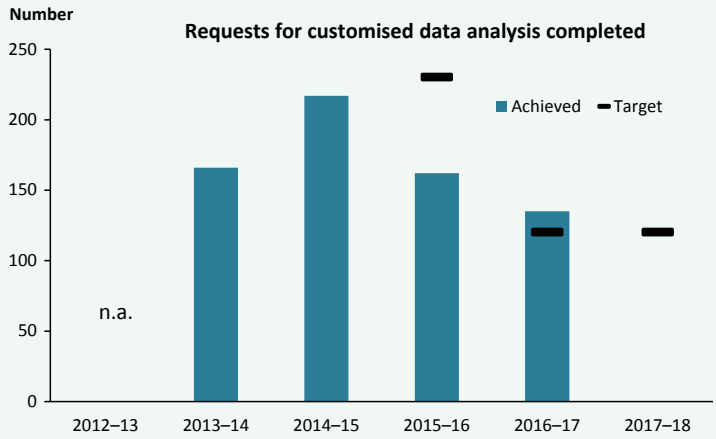
The report is available at http://www.myhealthycommunities.gov.au/our-reports/overweight-and-obesity-rates/december-2016.

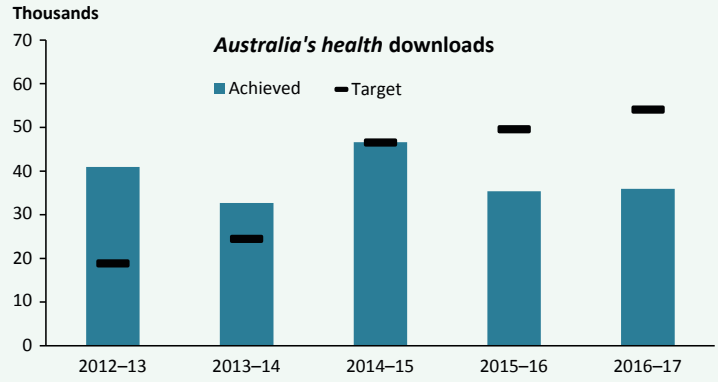
Table 1.1 (continued): Results for 2016–17 performance criteria: deliverables contributing to improving the availability of health and welfare information

Performance criteria: Improve availability of information	
2016–17 target	**2016–17 result**
Improved availability of information measured by release or completion of at least: • 161 products (the target set did not include products related to the transfer of the National Health Performance Authority (NHPA) functions to the AIHW)	✓ We completed 188 products during 2016–17. We have continued to increase the target number of products we release with some variability from year to year.  **Figure 1.3 shows the trends from 2012–13 onwards and the target for 2017–18**
• 50% of statistical products that include data in a manipulatable format	✓ We released 63% of statistical products that include data available in formats that permit manipulation by users to produce the specific information for which they are seeking. The results from 2016–17 show a marked increase in the number of products released with manipulatable data.  **Figure 1.4 shows the trends from 2014–15 onwards and the target for 2017–18**

continued

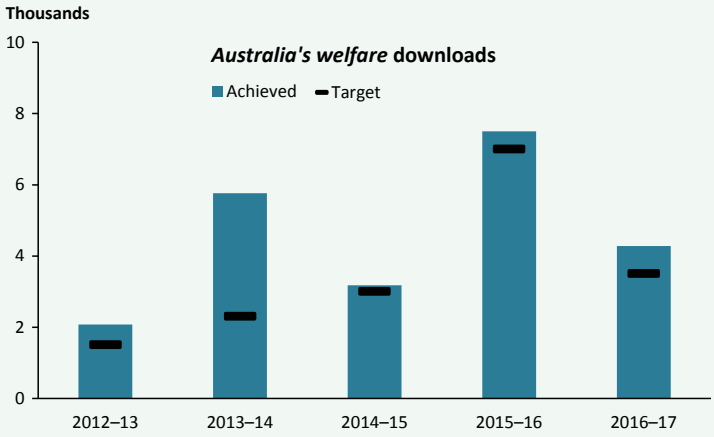
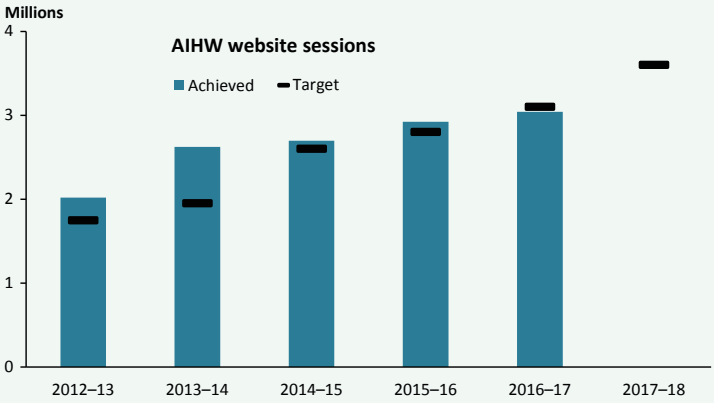
Table 1.1 (continued): Results for 2016–17 performance criteria: deliverables contributing to improving the availability of health and welfare information

• 120 requests for customised data analysis.	✓ We completed 135 requests for customised data analysis.  **Figure 1.5 shows the number of completed requests from 2014–15 onwards and the target for 2017–18**
	Overall result: met

Performance criteria: Provide free, high-quality information (all AIHW products are available free of charge at <www.aihw.gov.au>)	
2016–17 target	**2016–17 result**
• 54,000 website downloads of *Australia's health*	× Not met: 35,942 website downloads of editions of *Australia's health*. *Australia's health 2016* was tabled in September 2016. This publication is Australia's premier report card on the health of Australians and the performance of their health system. It is released every 2 years as a compilation of information from our data collections and those of other organisations.  **Figure 1.6 shows the trends in downloads of PDF versions over a 5-year period. This measure will not be reported against from 2017–18 onwards. It is no longer a comprehensive measure of information as *Australia's health* is now being provided in HTML and PDF versions**

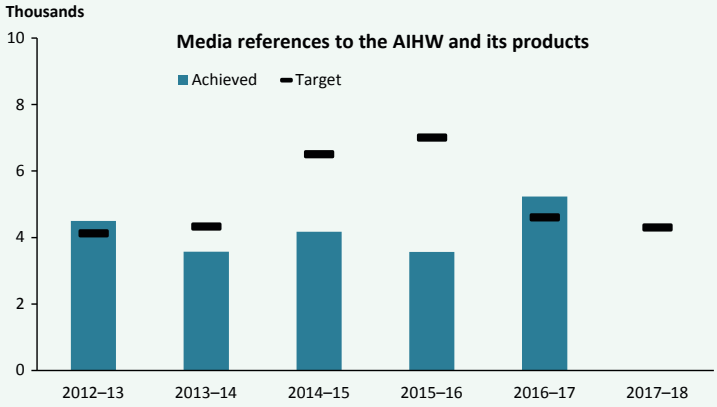
continued

Table 1.1 (continued): Results for 2016–17 performance criteria: deliverables contributing to improving the availability of health and welfare information

• 3,500 website downloads of *Australia's welfare*	✓ 4,284 website downloads of editions of *Australia's welfare*. *Australia's welfare* is a biennial welfare report. This comprehensive report provides an authoritative overview of the wellbeing of Australians, examining a wide range of relevant topics.  **Figure 1.7 shows the trends in downloads of PDF versions over a 5-year period. This measure will not be reported against from 2017–18 onwards. It is no longer a comprehensive measure of information as *Australia's welfare* is now being provided in HTML and PDF versions**
• 3.1 million sessions on the AIHW website	× Not met: 3,042,955 AIHW website sessions. We provide free, high-quality information through our website. The number of downloads reflects our success in making our data collections, and information we report about them, available to Australians in interesting and diverse formats. The increase in our target is indicative of the audience we continue to reach on our website. We will launch our new website in mid-2017, and expect our website sessions will continue to rise as a result.  **Figure 1.8 shows the trends from 2012–13 onwards and the target for 2017–18**

continued

Table 1.1 (continued): Results for 2016–17 performance criteria: deliverables contributing to improving the availability of health and welfare information

• 4,000 references to the AIHW and its products in the media	✓ 5,235 media references (media references to the AIHW and its products). We issue media releases highlighting many of our products at the time of their release. The media references generated can also inform and drive community debate about the information we produce.  Figure 1.9 shows the trends from 2012–13 onwards and the target for 2017–18
	Overall result: partially met

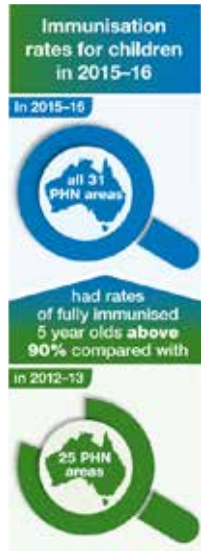
Deliverables contributing to improving data quality

Table 1.2: Results for 2016–17 performance criteria: deliverables contributing to improving the quality of health and welfare information

Performance criteria: Release information on performance indicators in the PAF agreed by COAG	
2016–17 target	**2016–17 result**
Performance information readily available via the MyHospitals and MyHealthyCommunities websites.	✓ Information about all products released during the year is available from our publications information systems. ✓ Performance information is readily available via the MyHospitals and MyHealthyCommunities websites. Reporting against the performance indicators in the PAF agreed by COAG is publicly available on the www.myhospitals.gov.au and the http://myhealthycommunities.gov.au/our-reports websites.
	Overall result: met

Healthy Communities: Immunisation rates for children in 2015–16

Healthy communities: Immunisation rates for children in 2015–16 presents information on the percentages of children aged 1, 2 and 5 who are fully immunised. Results are provided for the 31 PHN areas across Australia and, where possible, for smaller geographical areas, including more than 300 smaller local areas and around 1,500 postcodes. Results are also presented for Aboriginal and Torres Strait Islander children aged 1, 2 and 5.



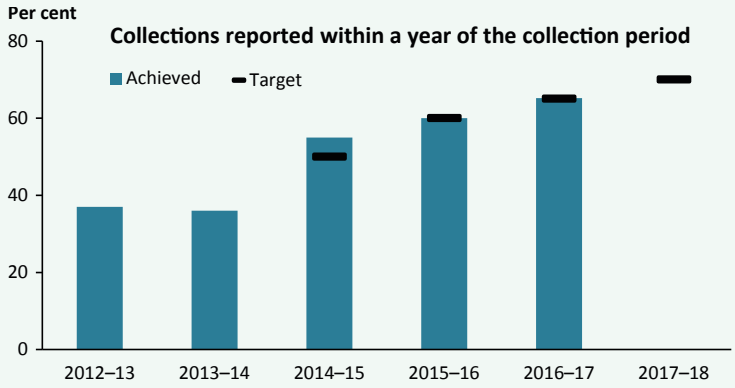
Immunisation is a safe and effective way to protect children from harmful infectious diseases and prevent the spread of these diseases in the community. Although Australia generally has high immunisation rates, there is still variation across local areas. By reporting local area rates, clinicians and health managers are better able to target their efforts to protect the health of children and the local community.

The report focuses on children aged 5, as this is the age when routine childhood immunisations are expected to be complete. Since 2011–12, national rates for 5 year olds increased from 90% to 93% but are still below the national target of 95%. For the first time, rates in all 31 PHN areas reached above 90% in 2015–16 and the gap in rates between the highest and lowest areas diminished over this time.

Across PHN areas, the percentage of fully immunised 5 year olds in 2015–16 was highest in Western NSW and Murrumbidgee (New South Wales) at 96%, and lowest in the North Coast (New South Wales), Perth North, Perth South and Gold Coast (Queensland), with rates at 90%–91%. For Aboriginal and Torres Strait Islander children aged 5, rates varied across PHN areas from 99% in the Gold Coast to 89% in Western Victoria.

The *Healthy communities: Immunisation rates for children in 2015–16* report was accompanied by a new interactive web tool on the MyHealthyCommunities website, which allows users to compare results for childhood immunisation rates in Australia over time by geography and age group. The report is available at http://www.myhealthycommunities.gov.au/our-reports/immunisation-rates-for-children/june-2017.

Table 1.2 (continued): Results for 2016–17 performance criteria: deliverables contributing to improving the quality of health and welfare information

Performance criteria: Improve timeliness of statistical information products	
2016–17 target	**2016–17 result**
Data for at least 65% of annual national collections are reported less than 1 year after the end of their data collection period.	Our indicator of the timeliness of our statistical information products relates to the length of time between the end of the data collection period and the release of annual publications that fully report or publicly release national data collections that we collate. Publications produced by AIHW collaborating centres are not included. ✓ Data for 65.2%[1] of annual collections was reported less than 1 year after the end of their data collection period. This represents 15 of 23 annual collections released in the period 1 July 2016 – 30 June 2017. We have been striving to improve the timeliness of our statistical information products. The elapsed time to release of these products includes: • time taken by data providers, after the end of the collection period, to prepare administrative data for supply to us • time taken by us to prepare data for release—ensuring that the statistics and analyses are of the quality and accuracy required for broader dissemination and publication. We work with data providers to introduce systems that assist them in providing data more quickly. For example, using the AIHW's Validata® application, data providers can validate the data they supply more easily and quickly. Together with our own efforts to reduce time taken to release data, this allows us to report earlier in the collection cycle than in previous years for those collections.  **Figure 1.10 shows the trends from 2012–13 onwards and the target for 2017–18. The appropriateness of this measure will be reviewed for future reporting periods as some external factors affecting timeliness are outside of the AIHW's control** 1. Some of our reports are unable to be released within 1 year due to data supply timeframes, such as screening program monitoring reports (breast, cervical & bowel). However, we do release (online) the participation data within 1 year from the end of the data collection period.
	Overall result: met

Looking ahead

We will pursue the new strategic goals approved by the AIHW Board in early 2017. We strive to be:

- leaders in health and welfare data
- champions for open and accessible data and information
- expert sources of value analysis
- trusted strategic partners
- drivers of data improvements.

The AIHW has developed the following 10 priority areas for action that are critical to achieving our goals:

1. Data governance
2. Data management infrastructure
3. Data analysis capability
4. Data gaps
5. Presentation of work
6. Timeliness
7. Data accessibility
8. Communication and stakeholder engagement
9. Our people and structures
10. Our processes

Each of these priority areas are sponsored by a senior executive and will feature various projects and activities. These projects and activities form the AIHW's business improvement plan for the coming period. Further information regarding the priority areas can be found in the *Australian Institute of Health and Welfare Corporate Plan 2017–18 to 2020–21* at http://www.aihw.gov.au/publication-detail/?id=60129560149.

Data Integration Partnerships Australia (DIPA) collaboration between the AIHW and the Australian Bureau of Statistics (ABS)

DIPA is a coordinated investment in the Australian Public Service (APS) to maximise the use and value of the Government's vast data assets, allowing timely and cost-effective insights into important policy questions.

There are several components to the DIPA and, as 1 component, the ABS and the AIHW have received funding to improve technical infrastructure and build on and improve interoperability in the ABS and the AIHW's current data integration capabilities and systems. The AIHW will provide technical support services to the DIPA analytics units to facilitate delivery of improved, evidence based programs and policy.

In providing these services, the AIHW is strengthening capability to deliver on our 2017–18 strategic goals. As the DIPA progresses, the AIHW will also begin to utilise an enhanced data integration capability based on the effective use of DIPA data integration processes, capability and infrastructure.

Our financial performance

Results

The AIHW's financial results since 2012–13 are summarised in Table 1.3.

Table 1.3: Financial results, 2012–13 to 2016–17 ($ million)

	2012–13	2013–14	2014–15	2015–16	Change 2015–16 to 2016–17	2016–17
Income	52.225	52.982	49.240	48.401	▲	57.844
Expenditure	51.822	52.926	48.671	48.135	▲	57.768
Surplus (or deficit)	**0.403**	**0.056**	**0.569**	**0.266**	▼	**0.076**
Total assets	33.752	37.200	42.119	42.612	▲	73.536
Total liabilities	29.079	32.471	36.821	36.926	▲	42.606
Total equity	**4.673**	**4.729**	**5.298**	**5.686**	▲	**30.930**

Income and expenditure

The AIHW has 2 main types of income—appropriation income from the Australian Parliament and income from externally funded projects.

Our appropriation income from the Australian Parliament was $26.9 million in 2016–17, compared with $15.6 million in 2015–16 (Table 1.4 and Figure 1.11). This increase was due to an appropriation adjustment related to the AIHW's assumption of responsibility for the PAF functions of the former NHPA. This increase is offset by efficiency dividends and wage cost index adjustments required by the Australian Government.

Due to the funding profile of a couple of large projects, income from externally funded projects fell to $29.6 million in 2016–17 from $31.3 million in 2015–16—a decrease of 5.4%. Most of this income came from Australian Government departments, with the largest source being the Department of Health.

Interest income rose to $1,021,000 in 2016–17, compared with $759,000 in 2015–16.

Employee-related expenditure increased to $36.5 million in 2016–17 from $33.8 million in 2015–16. This was because of the AIHW's acquisition of PAF functions as described above.

The overall result for the year was a surplus of $76,000.

Table 1.4: Income and expenditure, 2012–13 to 2016–17 ($ million)

	2012–13	2013–14	2014–15	2015–16	Change 2015–16 to 2016–17	2016–17
Appropriation revenue	15.912	15.898	15.800	15.625	▲	26.918
Revenue for project work for external agencies	35.410	36.176	32.365	31.334	▼	29.628
Interest	0.897	0.890	0.682	0.759	▲	1.021
Other revenue	0.006	0.018	0.394	0.683	▼	0.277
Total revenue	**52.225**	**52.982**	**49.240**	**48.401**	▲	**57.844**
Employee-related expenditure	36.910	36.173	35.054	33.817	▲	36.513
Other expenditure	14.912	16.753	13.617	14.318	▲	21.255
Total expenditure	**51.822**	**52.926**	**48.671**	**48.135**	▲	**57.768**
Surplus (or deficit)	**0.403**	**0.056**	**0.569**	**0.266**	▼	**0.076**

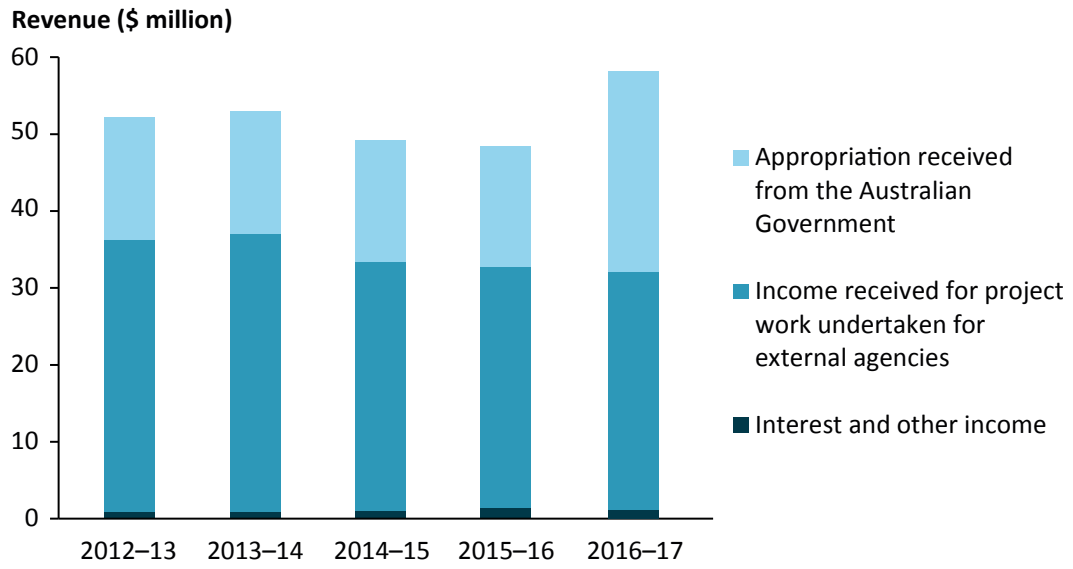


Figure 1.11: Revenue sources, 2012–13 to 2016–17

Balance sheet

Assets totalled $73.5 million in 2016–17—a rise of $30.9 million on the previous year (Table 1.5). The cash balance component of financial assets remains high at $59.7 million, most of which is invested in term deposits in accordance with our investment policy.

Liabilities rose by $5.7 million to $42.6 million in 2016–17, from $36.9 million in 2015–16. This increase relates mostly to an increase in income received in advance and employee provisions.

Overall, total equity increased to $30.9 million, from $5.7 million last year. The majority of this was due to assets received from the closure of the NHPA of $24.7 million.

Table 1.5: Balance sheet summary, 2012–13 to 2016–17 ($ million)

	2012–13	2013–14	2014–15	2015–16	Change 2015–16 to 2016–17	2016–17
Financial assets	31.590	26.821	32.420	33.655	▲	64.471
Non-financial assets	2.162	10.379	9.699	8.957	▲	9.065
Total assets	**33.752**	**37.200**	**42.119**	**42.612**	▲	**73.536**
Provisions	11.164	10.967	11.082	11.817	▲	12.108
Payables	17.915	21.504	25.739	25.109	▲	30.498
Total liabilities	**29.079**	**32.471**	**36.821**	**36.926**	▲	**42.606**
Equity	**4.673**	**4.729**	**5.298**	**5.686**	▲	**30.930**

Cash flow

Net cash received from operating activities in 2016–17 was $8.5 million. This related mainly to income received in advance at the end of year. We spent a net amount of $0.8 million on the purchase of property, plant and equipment, and leasehold improvements in 2016–17, compared with $0.4 million in 2015–16.

The net cash increase over the year was $32.5 million, increasing the cash balance to $59.7 million from $27.2 million. Cash received included $24.7 million from the closure of the NHPA (see the 'Cash flow statement for the period ended 30 June 2017' in Appendix 7 on page 145).

Financial outlook

Appropriation income from the Australian Parliament will increase by $1.2 million in 2017–18 consistent with the 2017–18 Budget measure *Public Service Modernisation Fund—transformation and innovation stream*. This will be slightly offset by whole-of-Australian Government efficiencies. We have budgeted for income from externally funded projects to be approximately $32.0 million.

We have budgeted to break even in 2017–18, before an accrual of $366,000 required by compliance with relevant accounting standards in relation to the AIHW's new office lease. We have obtained approval from the Department of Finance to run a loss to cover this accrual up until the end of 2017–18. This will have no effect on cash balances and will reverse over the lifetime of the lease.

The value of our land and buildings is expected to fall in 2017–18 due to depreciation of fit-out costs, which will continue over the term of the lease. We do not expect other significant changes in the balance sheet items.

Auditor-General's report

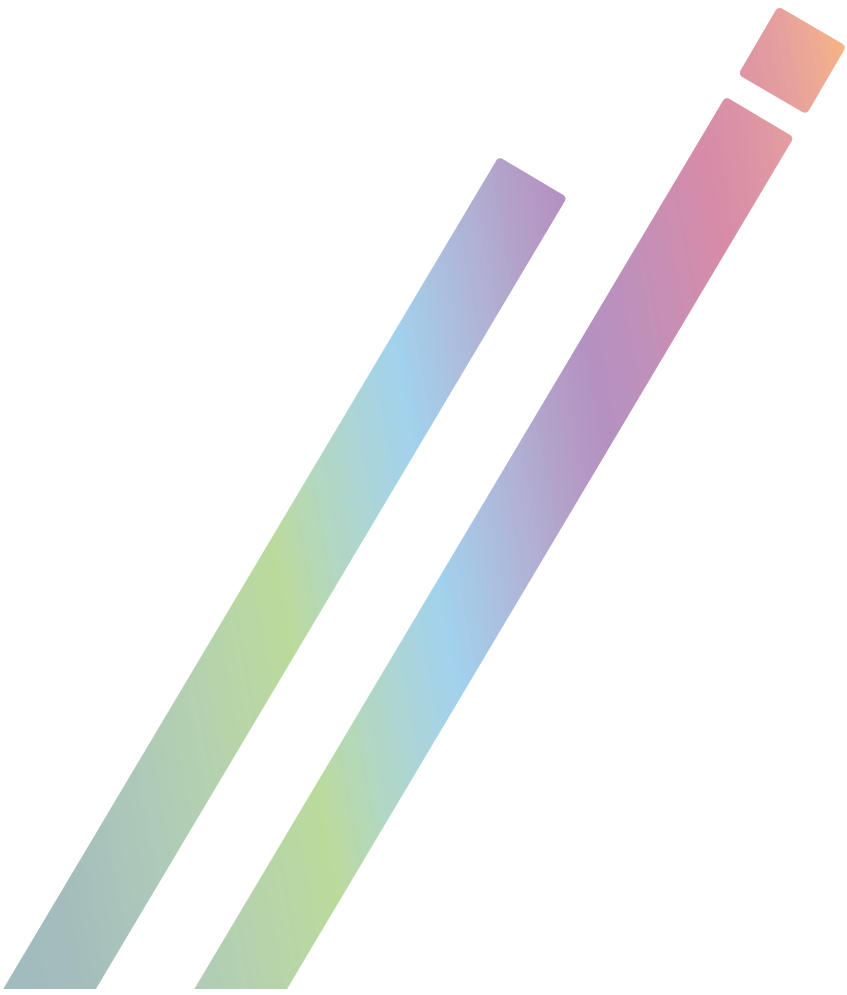
The Australian National Audit Office conducts an annual audit of our financial statements. The auditors issued an unqualified audit opinion that the financial statements for 2016–17 were appropriately prepared and give a 'true and fair view' of our financial position (see the auditor's report on page 139).

Our compliance with legislation on reporting

We complied with the key legislative and regulatory requirements that must be reported in this annual report. Information may be found on:

- the *Work Health and Safety Act 2011* and the *Environment Protection and Biodiversity Conservation Act 1999* in **Chapter 5 Our people**.
- other specific matters required to be reported by legislation in Appendix 6 on page 134.

The 'Compliance index' on page 177 provides more details about the sources of the various compliance requirements.



Chapter 2

Our products

This chapter highlights some of our products released in 2016–17.

The AIHW offers a broad variety of data and information-related products and services covering a wide range of health and welfare topics.

This chapter provides highlights from a sample of products released in 2016–17. A full list of products released during the year is provided in Appendix 2 on page 103.

For more information about each topic, please refer to the full report or web product.

Life expectancy and disability in Australia: expected years living with and without disability

While life expectancy is an important indicator of population health, people's health and wellbeing are also increasingly being considered in terms of their quality of life and functional status—with the key question being whether longer life is being exchanged for lower quality of life. The *Life expectancy and disability in Australia: expected years living with and without disability* fact sheet indicates that the disability-free life expectancy of Australians—that is, the estimated years they can expect to live without disability—has improved in recent years. This fact sheet updates previous work done by the AIHW on this subject.

The fact sheet is available at http://www.aihw.gov.au/publication-detail/?id=60129559120.

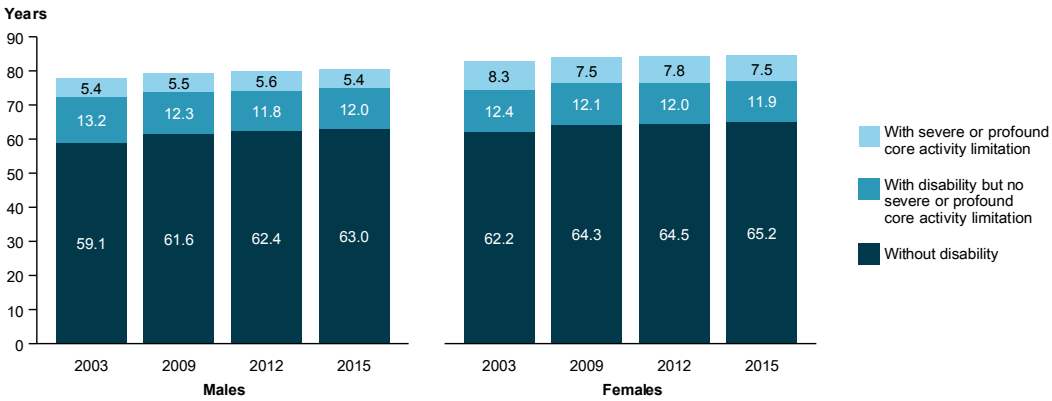
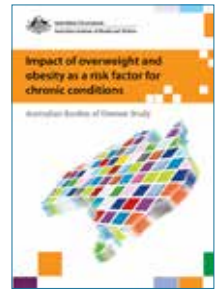


Figure 2.1: Selected health expectancies at birth, by sex 2003 to 2015

Impact of overweight and obesity as a risk factor for chronic conditions



The *Impact of overweight and obesity as a risk factor for chronic conditions* report updates and extends estimates of the burden due to overweight and obesity reported in the Australian Burden of Disease Study 2011 (ABDS 2011). The report now includes burden in people aged under 25, revised diseases linked to overweight and obesity based on the latest evidence, and estimates by socioeconomic group. This report also includes scenario modelling to assess the potential impact on the future health burden if current rates of overweight and obesity in the population continue to rise or are reduced.

In total, 22 diseases attributable to overweight and obesity were included in this analysis. These comprised 11 types of cancer (7 were included in the ABDS 2011), 3 cardiovascular conditions, chronic kidney disease, diabetes, dementia, gallbladder disease, gout, back pain and problems, osteoarthritis and asthma.

The study reports that 7% of the total health burden in Australia in 2011 was due to increased rates in overweight and obesity. Despite rising rates, the rate of burden was similar in 2003 and 2011 (after accounting for population increase and ageing). Scenario analysis provided in the report found that if people who were overweight or obese in 2011 reduced their weight by just 1 body mass index (BMI) point (equivalent to around 3 kilograms for people of average height), the overall health impact of excess weight would be reduced by 14% by 2020.

The clear message from the report, that relatively small weight loss or simply maintaining weight levels could have a significant effect in reducing the health impact of overweight or obesity in Australia, was well received by our stakeholders. Media coverage for this report included 80 items in 6 media types, reaching an audience of 5.3 million in the first week.

Over one-quarter (27%) of the entire disease burden, expressed as disability-adjusted life years (DALY), related to overweight and obesity, was due to coronary heart disease (83,324 DALY), 17% due to diabetes and 9.5% due to stroke. The amount of attributable burden due to these diseases was greater for males than for females. Osteoarthritis was responsible for a greater proportion of burden due to overweight and obesity in females than in males.

The report is available at http://www.aihw.gov.au/publication-detail/?id=60129559167.

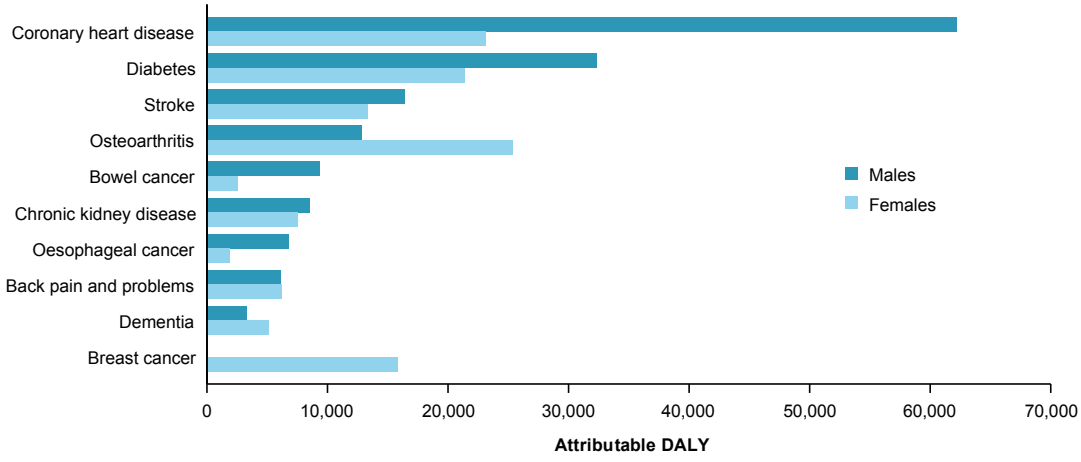
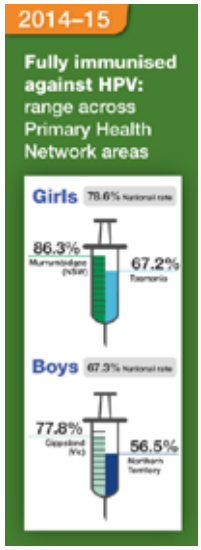


Figure 2.2: Burden due to overweight and obesity by sex and top 10 linked diseases, 2011

Healthy Communities: HPV immunisation rates in 2014–15



Healthy Communities: HPV immunisation rates in 2014–15 shows the percentage of girls and, for the first time, boys aged 15 who were fully immunised against the human papillomavirus (HPV) in 2014–15. Results are presented for the 31 PHN areas that cover Australia and for more than 80 smaller local areas of geography, called Statistical Areas Level 4.

Immunisation against the highly contagious HPV can prevent cervical and other cancers, and other HPV-related diseases. The National HPV Vaccination Program has been immunising adolescent girls since 2007 and was extended to boys in 2013.

The report shows that nationally in 2014–15, nearly 79% of girls aged 15 were immunised against HPV; an increase from 72% in 2012–13 and 74% in 2013–14. Though most PHN areas reported significant increases in HPV immunisation rates over time, there remains large variation in rates across PHNs. This ranged from 86% of girls fully immunised in Murrumbidgee in New South Wales to 67% in Tasmania. For boys aged 15 in 2014–15, 67% were fully immunised nationally, with percentages ranging across PHN areas from 78% in Gippsland (Victoria) to 57% in the Northern Territory.

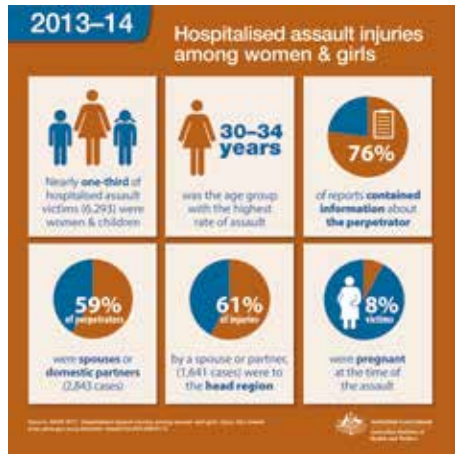
Providing local area level information on HPV immunisation rates for girls and boys helps school-based program managers and local health system managers determine where improvement in rates is needed. *Healthy Communities: HPV immunisation rates in 2014–15* sparked a strong media response, reaching a cumulative audience of 2,730,284 people through 106 media items.

The report is available at http://www.myhealthycommunities.gov.au/our-reports/HPV-rates/march-2017/report/overview.

Injury surveillance fact sheet: Hospitalised assault injuries among women and girls

This fact sheet, *Hospitalised assault injuries among women and girls*, examines the nearly 6,500 hospitalised assault cases against women and girls in 2013–14. Where relevant information was reported, 69% of these assaults took place in the home, and in 59% of cases the perpetrator was a spouse or domestic partner. Parents and other family members accounted for nearly half of the remaining cases where the type of perpetrator was specified.

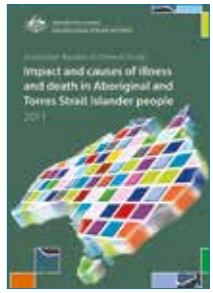
Among those who had been assaulted by a spouse or domestic partner, two-thirds were assaulted using bodily force, and the head and neck were the body regions most often injured as they were for all cases of assault against females. For female victims aged 15 and over, 8% were pregnant at the time of the assault.



More detailed investigation of hospitalised assault cases will occur in the future as part of the AIHW's expanding work on domestic, sexual and family violence, with the first statistical picture of the topic due for release in late 2017.

The fact sheet is available at http://www.aihw.gov.au/publication-detail/?id=60129559173.

Final results for Aboriginal and Torres Strait Islander people from the ABDS 2011



The ABDS 2011 was funded by the Department of Health and the former Australian National Preventive Health Agency in response to considerable stakeholder interest in availability of up-to-date burden of disease data specific to Australia and for the Aboriginal and Torres Strait Islander population. Burden of disease analysis combines information from multiple data sources to count and compare the total fatal and non-fatal impacts of diseases and injuries in a population, and their attribution to specific risk factors. The study incorporated methodological developments from recent global studies, adapted for the Australian health policy context. It generated estimates for over 200 diseases and injuries and 29 risk factors.

The *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011* is an important resource for Indigenous health policy formulation and service planning, and for monitoring the health of the Indigenous Australian population. The report shows that chronic diseases and injuries are the main causes of burden in Indigenous Australians, as well as being responsible for most of the gap in burden between Indigenous and non-Indigenous Australians. The disease group causing the most burden among Indigenous Australians was mental and substance use disorders (19% of the total), which includes conditions such as anxiety and depressive disorders, alcohol use disorders, and drug use disorders. Injuries (including self-harm and suicide) were the second greatest cause of burden, contributing 15% to the total, followed by cardiovascular diseases (12%) and cancer (9%). More than one-third (37%) of the burden, and half (51%) of the gap, was due to the modifiable risk factors included in the study.

During the study, we have been building infrastructure that enables efficient updates of burden of disease estimates as well as more detailed analysis for particular diseases and risk factors, and other extensions. For example, projects are underway looking in more detail at the burden of avoidable deaths in Indigenous Australians, and at the burden of vaccine-preventable diseases.

The report is available at http://www.aihw.gov.au/publication-detail/?id=60129557110.

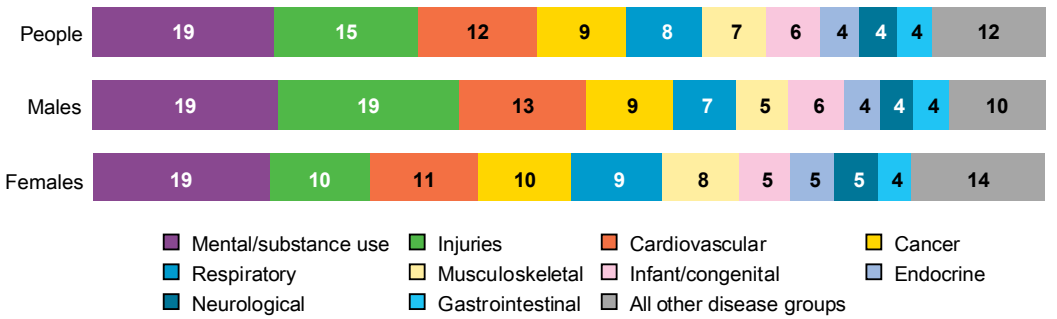


Figure 2.3: Percentage of total burden, by disease group and sex, Indigenous Australians, 2011

Admitted patient care 2015–16: Australian hospital statistics

Admitted patient care 2015–16: Australian hospital statistics focuses on care provided for admitted patients by public and private hospitals. It includes information on who used these services, why they received care, the types of services (or procedures) provided, the safety and quality of the care provided and how much it cost.

In 2015–16, there were 10.6 million hospitalisations in Australia's public and private hospitals. About 2.2 million hospitalisations involved surgery—with two-thirds of these occurring in private hospitals.

For the first time, the report included comparisons of waiting times for elective surgery in public hospitals—by the source of funds used by the patient. It found that, on the whole, patients who used private health insurance (to fund all or part of their admission) had much shorter waiting times than public patients. The median waiting time for public hospital elective surgery was 38 days overall—42 days for public patients and 20 days for patients who used private health insurance to fund all or part of their admission. There were also significant variations in waiting times depending on the type of procedure to be performed.

The new material on private health insurance patients in public hospitals attracted significant media interest and generated considerable commentary from industry and advocacy groups, and requests for more detailed information. The AIHW is currently preparing a short report that will examine this material in more detail, for publication in late 2017.

The report is available at http://www.aihw.gov.au/publication-detail/?id=60129559537.

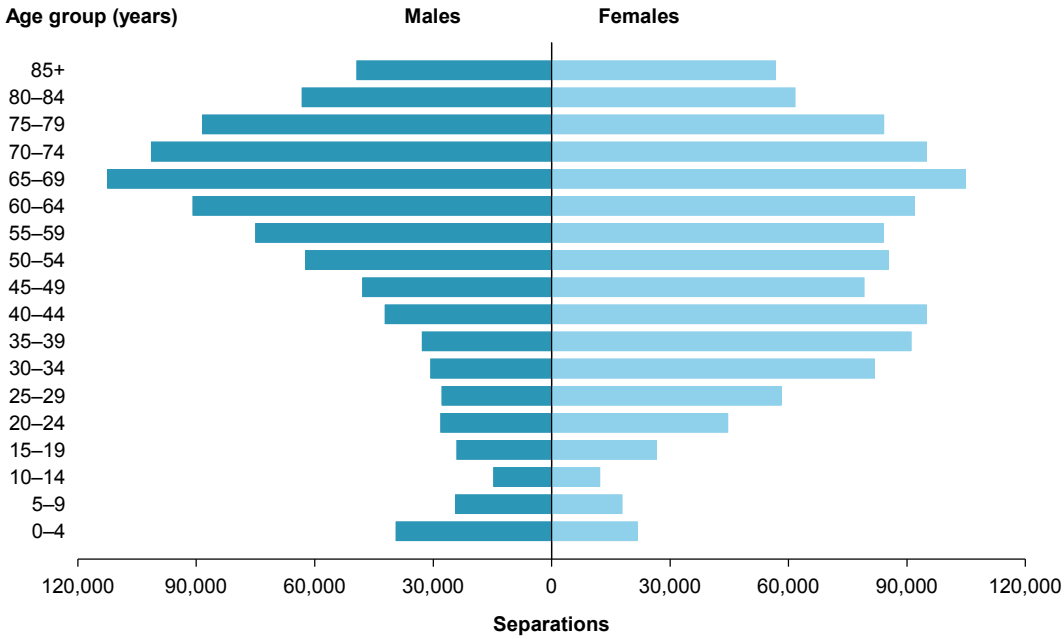


Figure 2.4 Elective admissions, involving surgery, by sex and age group, all hospitals, 2015–16

Note: There were more elective admissions involving surgery for females than males in the age groups from 15–64 and 85 and over. In particular, for age groups 30–39, females were 2.5 times as likely as their male counterparts to have had an elective admission involving surgery.

Vulnerable young people: interactions across homelessness, youth justice and child protection—1 July 2011 to 30 June 2015

The *Vulnerable young people: interactions across homelessness, youth justice and child protection—1 July 2011 to 30 June 2015* report linked data on homelessness with data on child protection and youth justice.

In an effort to better understand the characteristics of these vulnerable children and young people, data were linked from the Specialist Homelessness Services Collection for the period 2011–12 to 2014–15, the Child Protection National Minimum Data Set for 2013–14 and the Juvenile Justice National Minimum Data Set for 2011–12 to 2013–14.

From this linked data set, 3 matched cohorts were identified—the specialist homelessness service and child protection (SHS-CP) cohort, the specialist homelessness service and youth justice (SHS-YJ) cohort and the specialist homelessness service, child protection and youth justice (SHS-CP-YJ) cohort—as well as 3 corresponding SHS-only cohorts for comparison.

The report reveals that individuals who experience multiple, cross-sector services in the specialist homelessness, child protection or youth justice areas are a particularly vulnerable group. Clients experiencing 2 or more of these services were more likely than SHS-only clients to: report having substance use issues; report having mental health issues; have an over-representation of Aboriginal and Torres Strait Islander people; and receive more days of support and more support periods from specialist homelessness services agencies.

The report is available at http://www.aihw.gov.au/publication-detail/?id=60129557753.

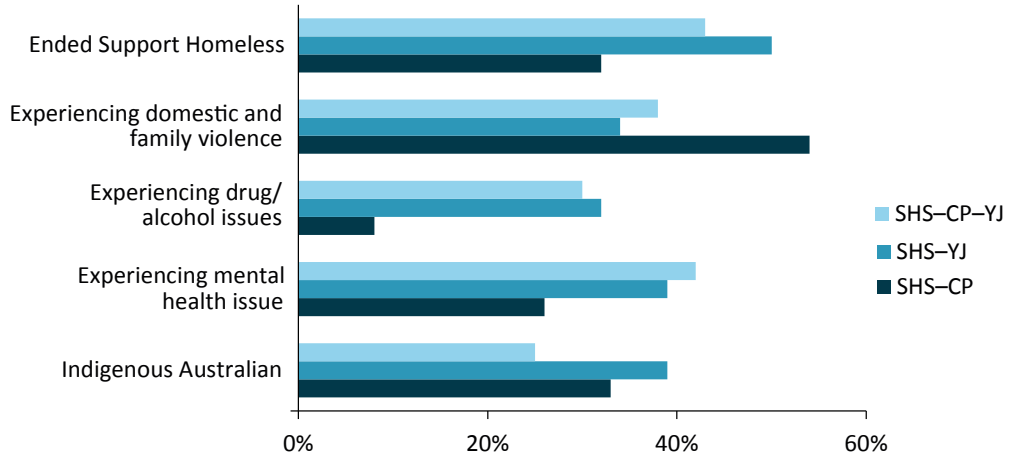


Figure 2.5: Selected characteristics of vulnerable youth

Inaugural release of national restraint events in public sector acute mental health hospital services 2015–16

AIHW released the first ever national restraint data (restraint is defined as the restriction of an individual's freedom of movement by physical or mechanical means) in conjunction with the Towards Elimination of Restrictive Practice forum in Perth in May 2017.

In 2005, Health Ministers endorsed the *National safety priorities in mental health: a national plan for reducing harm*, Australia's first national statement about safety improvement in mental health care. This plan identified 4 priority areas for national action, including 'reducing use of, and where possible eliminating, restraint and seclusion'. The plan recognised that seclusion and restraint are serious infringements of an individual's rights, and can cause psychological trauma and physical injury to consumers and to health-care staff.

Data for 2 forms of restraint were released: mechanical restraint (for example, using devices such as belts or straps); and physical restraint (for example, the application by health-care staff of hands-on immobilisation techniques). Unspecified restraint—that is, the type of restraint is unknown—was a very small component in 2015–16. Data improvement initiatives are expected to remove the need for an unspecified restraint category from 2016–17 onwards.

Nationally, there were 9.2 physical restraint events per 1,000 bed days; mechanical restraint was less common (1.7 events per 1,000 bed days). Data on mechanical restraint events were not reported by the Northern Territory, and data on physical restraint events were not reported by Queensland. Of states and territories with data, Victoria had the highest rate of mechanical and physical restraint events (5.8 and 23.2 events per 1,000 bed days, respectively). This is likely to be the result of higher acuity admission thresholds due to lower per capita bed numbers inflating the results on a per bed day basis.

The report is available at http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/.

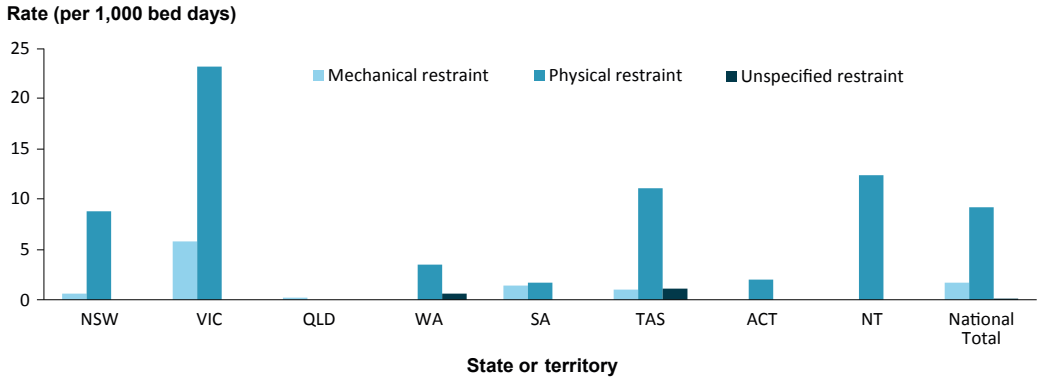


Figure 2.6: Rate of restraint events, public sector acute mental health hospital services, states and territories, 2015–16

Australia's mothers and babies 2014

Australia's mothers and babies 2014—in brief, and the complementary online perinatal dynamic data display, is an annual report that presents the key statistics from the AIHW National Perinatal Data Collection. Perinatal data are collected for each birth in each state and territory, most commonly by midwives. The report presents key statistics and trends in pregnancy and childbirth of mothers, and the characteristics and outcomes of their babies. The information can be used for monitoring and evaluating the safety and quality of maternity care in Australia.

In 2014, 307,844 women gave birth in Australia—an increase of 18% since 2004. Women in Australia are giving birth later in life. The percentage of mothers aged 35 and over increased from 20% in 2004 to 22% in 2014, while the percentage of mothers aged under 25, including teenagers, decreased from 19% to 16%. Teenage pregnancy is an area of policy interest, with the upcoming *Australia's mothers and babies 2015* due to be published in late 2017 featuring a greater focus on this area.

There were 312,548 babies born in 2014–an increase of 10% since 2004. A baby's birthweight is a key indicator of infant health and the vast majority of liveborn babies were in the normal birthweight range, with 6.4% of low birthweight. The report shows how rates of low birthweight babies vary depending on where mothers live, ranging from 5.1% in Northern Sydney PHN to 8.7% in the Northern Territory.

The report is available at http://www.aihw.gov.au/mothers-and-babies/.

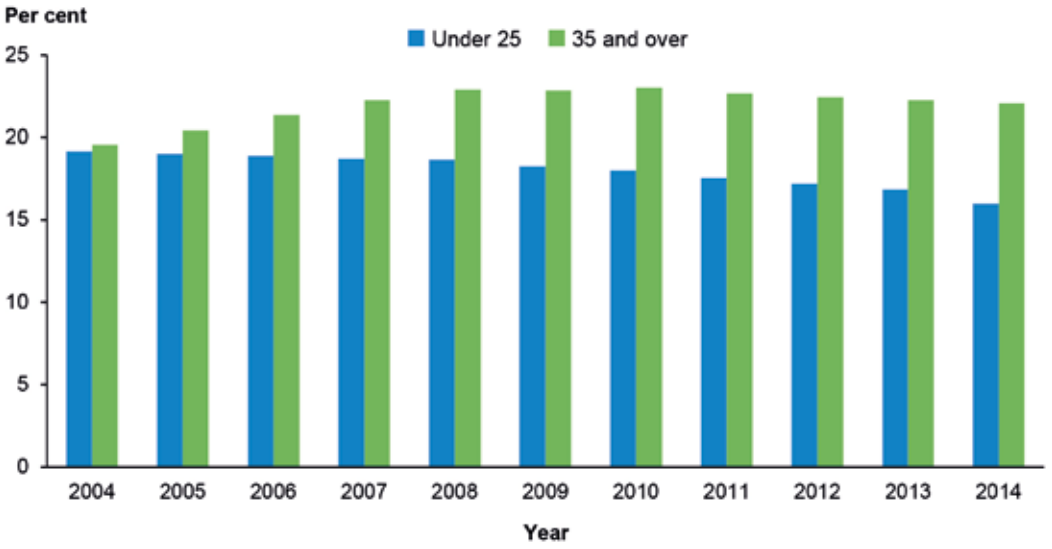
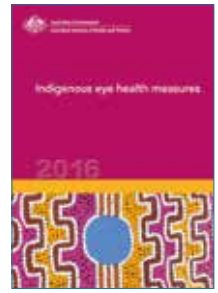


Figure 2.7: Trend in births to younger and older mothers in Australia, 2004 to 2014

The first national report on Indigenous eye health measures



The first national *Indigenous eye health measures 2016* report was launched by the Minister for Indigenous Health, the Hon. Ken Wyatt, MP, on 30 May 2017. This report brings together, for the first time, a comprehensive collection of data on Indigenous eye health from a range of sources. The eye health measures report on the full continuum of eye care and sought to answer the following key questions:

- What is the extent of eye health problems among Indigenous Australians?
- How are eye health problems treated?
- How are eye health problems identified?
- What is the size and distribution of the eye health workforce and outreach programs?

The report shows that Indigenous Australians suffer from vision impairment and blindness at 3 times the rate of non-Indigenous Australians. Of Indigenous Australians aged 40 and over, 1 in 9 (11%) suffer from vision impairment or blindness.

It found that more Indigenous Australians are accessing eye health services than previously (the percentage of Indigenous Australians who had an eye examination in the preceding 12 months increased from 13% in 2005–06 to 15% in 2014–15); a narrowing of the gap in access to cataract surgery (the Indigenous hospitalisation rate for cataract surgery rose by over 40% in the last 10 years); and a decrease in the rate of blindness for Indigenous Australians (from 1.9% in 2008 to 0.3% in 2016).

However, the report also found that, in 2014–15, a lower proportion of Indigenous Australians with diabetes had a diabetic eye examination in the preceding 12 months (15%) compared with non-Indigenous Australians (20%), based on age-standardised rates; and the median waiting time for elective cataract surgery was longer for Indigenous Australians (142 days) than for non-Indigenous Australians (84 days). Some Indigenous Australians are waiting more than 1 year for cataract surgery.

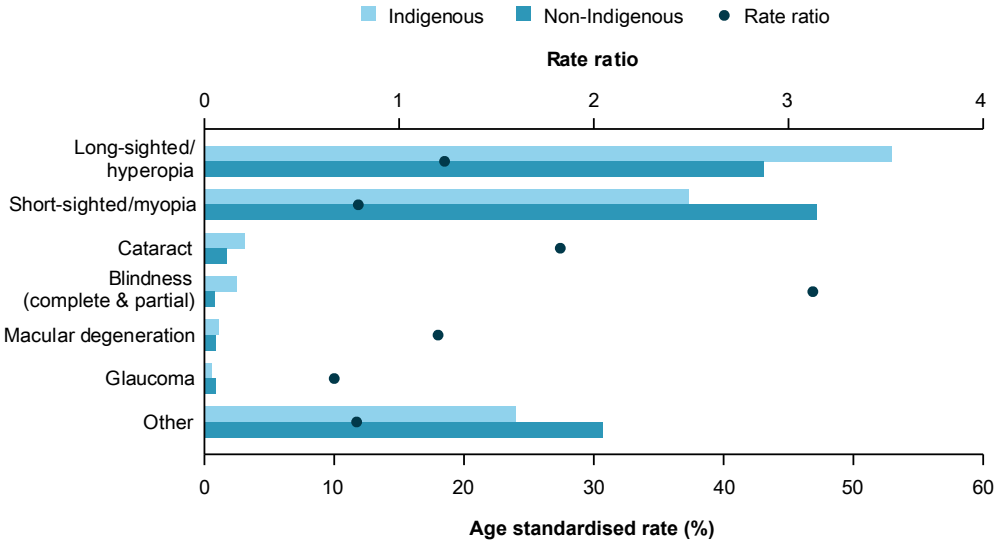


Figure 2.8: Prevalence of eye/sight problems, by main cause and Indigenous status, 2012–13

Chapter 3

Our communications

This chapter focuses on how we communicate with our audience and stakeholders.

New directions in communications

The commemoration of our 30th birthday in 2017 provides us with a timely opportunity to reflect on our past achievements and ensure we have appropriate strategies in place for the future.

The modern digital, information and communication environment is complex, with rapid developments in the capacity to capture and analyse large volumes of data, often in real time. Our *Strategic directions 2017–2021*, which we launched during the year, were developed to respond to growing expectations that this information will be made more accessible for research and community use and brought together in meaningful ways to meet multiple information needs. The AIHW remains at the forefront of important initiatives such as public sector open data, big data and digital health.

In 2016–17, we significantly increased our investment in communications, to enable us to better connect our audiences with our data and information. This builds on our already highly regarded expert management and analysis of people-centred data.

During the year, we undertook a wide-ranging program of review and development to strengthen our communications capabilities. This included internal and external consultation on:

- the efficiency of our communication effort, processes and systems
- the types of products we currently release and our release practices
- opportunities for greater coordination across the Institute and increased engagement with our stakeholders
- optimal staffing arrangements.

We developed a new corporate brand and a new website—our public interface and central repository for our work—which is due for launch in the second half of 2017.

Our new website will allow our audiences easier access to our data and products, including displays featuring at-a-glance facts and figures and new data visualisation capability.

There is growing demand for information that is easily accessible, very up to date or even available in real time, and integrated at national, state and territory and local levels. There is also growing interest in the presentation of data being in more flexible, user-friendly and interactive formats. In addition, there is an increasing interest in data presented at useful, finer geographical levels to support service planning and delivery information requirements.

We are releasing an increasing number of statistical products on our website in formats that allow users to manipulate and further review these data to suit their purposes. These formats include interactive and dynamic data visual displays. The AIHW makes data available through data cubes. A data cube is a multidimensional representation of the data set. It allows the user to quickly select, filter and arrange aggregated data for variables of interest using drag and drop functionality. This format also supports export to other software packages for data analysis and reporting. There are currently several data cubes available to support releases on a range of topics, such as disability services, SHS, hospitals and aged care. These data support more detailed, user-driven analysis. They can comprise demographic profiles; information on people centred outcomes and more generally about the services needed by area or by people.

We have been working throughout 2016–17 in collaboration with our stakeholders to bring together important aged care information, catering to many types of users. The culmination of this work will see the launch of a new website, GEN—Aged Care Data, a 1-stop shop for data and information about aged care services in Australia. The GEN website will be launched in the latter part of 2017.

Our new directions will ensure all of our work is prepared with key audiences in mind, with early discussions about the most suitable product range, followed by necessary design and authoring support.

Our investment in communications continues to connect our audiences with our information, resulting in better decisions, thereby improving the health and welfare of all Australians.

Reaching our audiences

The AIHW is committed to making its work widely accessible and easy to understand. Our information is downloadable free of charge on the AIHW's website in a variety of formats to suit individual users' needs. All publications are available in alternative formats upon request.

Notification services for clients and stakeholders

One of the key communication channels is our on-the-day email notification service alerting subscribers to new AIHW publication releases. As at 30 June 2017, more than 24,000 people subscribed to this service. Subscriptions to these notifications rose by 8% in 2016–17 compared with the previous year (Table 3.1).

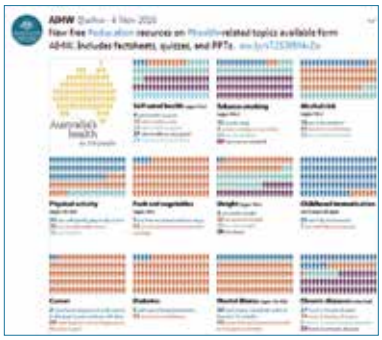
Table 3.1: Email notification service subscriptions, 2013 to 2017

Year at 30 June	2013	2014	2015	2016	Change 2016 to 2017	2017
For releases of our:						
• health-related products	6,090	5,729	5,984	6,308	▲	6,650
• welfare-related products	4,583	4,426	4,670	4,947	▲	5,250
• education resources and promotions	2,961	3,581	4,144	4,573	▲	5,010
• AIHW *Access* online newsletter profiling the AIHW's work and its people	3,620	4,632	5,609	6,499	▲	7,299
Total	**17,254**	**18,368**	**20,407**	**22,327**	▲	**24,209**

Twitter

In 2016–17, we expanded the use of Twitter (@aihw) as a means of communicating with our stakeholders. The AIHW had around 12,000 @aihw followers as at 30 June 2017; an increase of 26% compared with the previous year (9,500 in 2015–16). We will continue in 2017–18 to increase our communication with our Twitter followers through targeted Twitter campaigns.

During the year, we tweeted 264 times (compared with 109 tweets in 2015–16). The number of views of our tweets also rose with 786,000 'impressions', compared with 333,200 in 2015–16.



The tweet with the most impressions (18,262) retweets (60) and link clicks (113) was tweeted in November 2016 about AIHW education resources on health-related topics.

The most popular tweet associated with a report related to dementia—12,152 impressions and 37 retweets in December 2016.

Spotlight on publications

In 2016–17, we published 128 print-ready publications and 60 web products, including new and updated web snapshots, dynamic data displays and publications in HTML format (see Appendix 2).

The publications most frequently downloaded from the AIHW website in 2016–17 are detailed in Table 3.2. By this measure, *Australia's health 2016* was our most popular report during the year, with 23,692 downloads. *Australia's health* has been consistently our most downloaded publication for nearly 20 years.

Table 3.2: Top 10 publications downloaded from the AIHW website, 2016–17

Rank	Title	Release date	Downloads
1	*Australia's health 2016*	13 September 2016	23,692
2	*Australia's health 2016—in brief*	13 September 2016	10,605
3	*Health expenditure Australia 2014–15*	6 October 2016	6,578
4	*Young Australians: their health and wellbeing 2011*	10 June 2011	5,881
5	*Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011*	10 May 2016	5,773
6	*Australia's hospitals 2014–15: at a glance*	29 July 2016	4,887
7	*A picture of Australia's children 2012*	31 October 2012	4,124
8	*Mental health services—in brief 2016*	14 October 2016	3,671
9	*National Drug Strategy Household Survey detailed report 2013*	25 November 2014	3,651
10	*Australia's welfare 2015*	20 August 2015	3,337

Note: These rankings are based on downloads of each report during 2016–17 either for the full year or from the stated release date in 2016–17 to 30 June 2017.

Australia's health 2016 overview

Australia's health 2016 was released in September 2016. This was the Institute's 15th biennial health report; the first was released in 1988. It profiles current health issues in a collection of feature articles and statistical snapshots covering a range of subject areas in health.

It was officially launched by the then Minister for Health, the Hon. Sussan Ley, MP, at Parliament House in Canberra.

The Launch of *Australia's health 2016*

Left to right: Mr Barry Sandison, AIHW Director, the Hon. Dr David Gillespie, MP, Assistant Minister for Health, and Dr Mukesh C Haikerwal, the former chair of the AIHW Board

The former Minister for Health, the Hon, Sussan Ley, MP. Tweets about the launch of *Australia's Health 2016*.

As part of the *Australia's health 2016* release, we created a Twitter engagement campaign to extend our reach to more audiences and grow our audience of Twitter 'followers'. The campaign consisted of 'teaser', 'on-the-day' and 'post-release' tweets. During this campaign, we increased our @aihw Twitter followers by around 1,000, with 284 retweets of our *Australia's health* Twitter messages. Examples of the Twitter campaign are on the right:

Infographics

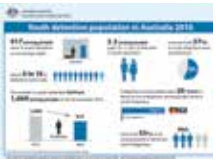
In 2016–17, we produced an increased number of infographics across all of our topic areas, providing our audience with easy-to-interpret graphics. Infographics are designed for users who need quick facts and are ideal for the education sector, the general public, media and policy makers. Examples include:

An infographic from the factsheet *DIY injuries in Australia* covering injuries that occurred as a result of falls (that is, from ladders and buildings) and while using tools and machinery (such as hand tools and lawnmowers) at home.

An infographic from the web report *National Drug Strategy Household Survey 2016 key findings* presenting information on alcohol and tobacco consumption, and illicit drug use among the general population in Australia.

An infographic from the *Adoptions Australia 2015–16* report presenting the latest data on adoptions of Australian children and children from overseas, and highlighting important trends in the number of adoptions over the last 25 years.

An infographic from the *Youth detention population in Australia 2016* report presenting information on the youth detention population in Australia, in 2016, with some comparisons with 2012.



AIHW website

The AIHW website at www.aihw.gov.au is the main conduit for all AIHW information; principally our PDF and HTML (web) reports and a range of other data-related outputs. All online products are free to view or download. In the second half 2017, we will launch our new website.

The AIHW uses 'sessions' as a measure of our web traffic—obtained through Google Analytics. A session is a discrete period of time in which a single visitor is actively engaged with the website.

There were 3.0 million sessions on our website in 2016–17—an increase from 2.8 million in 2015–16.

As at 1 July 2016, the AIHW assumed the management of 2 websites—MyHealthyCommunities and MyHospitals—from the former National Health Performance Authority.

MyHospitals

The MyHospitals website provides nationally consistent, locally relevant information that allows fair comparisons to be made between individual hospitals or health services. The intended audience for this website includes members of the public, clinicians including doctors and nurses, academics and researchers, hospital and health service managers and journalists.

There were nearly 770,000 sessions on this website in 2016–17—a slight decrease from 2015–16 (780,000).

MyHealthyCommunities is an interactive website that enables users to see how their local health area is performing and how it compares against other similar areas. It covers a range of topic areas, including hospitalisations, immunisation rates, patient experiences, participation in screening programs, incidence of cancers and risk factor rates.

There were just under 49,000 sessions on this website in 2016–17—a decrease from 2015–16 (59,000).

Media coverage

The AIHW issued 35 media releases in 2016–17, 22 fewer than in 2015–16, although overall media coverage rose significantly. This rise was due to a focused effort on issuing several high-profile media releases during the year (for example, domestic violence, immunisations and increased local-level reporting).

The largest increase in media coverage was for print items. This rise is partially explained by a change in counting methodology following the AIHW's engagement of a new media monitoring provider. Items previously counted as 'Australian Associated Press' are now included in the 'print' total. Table 3.3 provides the number of media mentions from 2012–13 to 2016–17.

Table 3.3: Media coverage (items) and media releases, 2012–13 to 2016–17

Media type	2012–13	2013–14	2014–15	2015–16	Change 2015–16 to 2016–17	2016–17
Print	458	507	426	798	▲	1,694
Radio	1,929	1,620	1,826	1,106	▼	1,617
Television	128	122	230	129	▼	221
Online	1,894	1,311	1,650	1,496	▼	1,822
Australian Associated Press	92	15	41	37	▼	. .
Total	**4,501**	**3,575**	**4,173**	**3,566**	▼	**5,354**
Media releases	**84**	**80**	**82**	**57**	▼	**35**

Media coverage of individual reports

The AIHW reports that attracted the most media coverage during the year are listed in Table 3.4. Heading the list was the combined release of 2 MyHealthyCommunities reports: *Healthy Communities: Overweight and obesity rates across Australia, 2014–15* and *Healthy Communities: Tobacco smoking rates across Australia, 2014–15*.

This was followed by *Healthy Communities: Immunisation rates for children in 2015–16*, which received 198 media mentions.

Table 3.4: Top 10 reports for media coverage, 2016–17

Rank	Title	Media mentions
1	*Healthy Communities: Overweight and obesity rates across Australia, 2014–15* and *Healthy Communities: Tobacco smoking rates across Australia, 2014–15*	257
2	*Healthy Communities: Immunisation rates for children in 2015–16*	198
3	*Hospitalised assault injuries among women and girls* (and 4 other injury publications)	147
4	*Cancer in Australia 2017*	146
5	*Australia's health 2016*	142
6	*Specialist Homelessness Services 2015–16*	136
7	*National Drug Strategy Household Survey (NDSHS) 2016: key findings*	132
8	*Child protection Australia 2015–16*	125
9	*Trends in alcohol availability, use and treatment 2003–04 to 2014–15*	106
9	*Healthy Communities: HPV immunisation rates in 2014–15*	106
10	*Impact of overweight and obesity as a risk factor for chronic conditions: Australian Burden of Disease Study*	100

Parliamentary relations

Budget estimates hearings

The AIHW Director appeared before the Senate Community Affairs Legislation Committee on 1 March 2017. During 2016–17, the AIHW provided responses to 4 questions on notice and input for 16 portfolio-wide responses to questions on notice, arising from this hearing and other annual Senate Estimates hearings occurring during 2016–17.

Inquiries

The AIHW provided 7 submissions to parliamentary and government committee inquiries in 2016–17 (Table 3.5). Staff appeared before 1 committee during the year.

Table 3.5: Submissions to parliamentary and government inquiries, 2016–17

Committee	Inquiry name
Federal	
Senate Select Committee on Community Affairs	Funding for Research into Cancers with Low Survival Rates
Office of the Australian Information Commissioner	Guide to the Big Data and the Australian Privacy Principles
Department of Education and Training—Chief Scientist	National Research Infrastructure Capability Issues Paper
Senate Standing Committee on Economics	2016 Census
Productivity Commission	The National Education Evidence Base
Productivity Commission	Data Availability and Use
State/territory	
Northern Territory—Royal Commission	Royal Commission into the Protection and Detention of Children in the Northern Territory

Chapter 4

Our organisation

This chapter describes our governance and management arrangements, including our accountabilities to the Minister for Health, and the roles and responsibilities of the AIHW Board and the AIHW Ethics Committee.

Legislation

The AIHW was established as a Commonwealth statutory authority in 1987 as the Australian Institute of Health. The composition of the Institute and its functions and powers in the analysis, reporting and dissemination of the nation's health-related information and statistics were set out in its enabling legislation, the *Australian Institute of Health Act 1987*.

In 1992, our role was expanded to include welfare-related information and statistics, and the organisation was renamed the Australian Institute of Health and Welfare. The amended Act became the *Australian Institute of Health and Welfare Act 1987* (AIHW Act).

- Information on the AIHW Act is in Appendix 1 on page 102.
- The AIHW Act establishes the AIHW Board as our governing body.
- We operate under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

The Institute's functions are prescribed in section 5 of the AIHW Act. In summary, these are:

- to collect and produce health and welfare-related information and statistics, and assist other bodies in these tasks
- to develop methods and undertake studies designed to assess the provision, use, cost and effectiveness of health services and health technologies
- to conduct and promote research into the health of the people of Australia
- to develop specialised statistical standards and classifications relevant to health and health and welfare services
- to enable researchers to have access to health and wefare related information and statistics held by the Institute or by bodies with which AIHW has contracts or arrangements
- to publish methodological and substantive reports on work carried out by the Institute
- to make recommendations to the Minister on the prevention and treatment of diseases and the improvement and promotion of the health and health awareness of the people.

The AIHW Act requires the AIHW to place information in the public domain; it also contains a strict confidentiality provision. Section 29 of the Act prohibits the release of documents and/or information 'concerning a person' held by the AIHW other than in compliance with any written terms and conditions imposed by the data provider.

As a Commonwealth entity, we are also subject to the *Privacy Act 1988* (Privacy Act), which imposes strict obligations in relation to the collection, use and disclosure of personal information. Hence, the data in our care are protected by 2 sets of obligations: those contained in the AIHW Act and those in the Privacy Act.

In certain circumstances, the AIHW Ethics Committee may authorise the release of personal information for medical research that would otherwise constitute a breach of an Australian Privacy Principle in the Privacy Act.

Accountability

We have a range of reporting mechanisms to ensure transparency and accountability in our operations. Key documents are:

- **AIHW strategic directions—**is the foundation for establishing, recording, refining and assigning priorities to our activities.
- **AIHW corporate plan—**is a requirement of section 35 of the PGPA Act.
- **Portfolio Budget Statements (PBS)—**Included with statements of other agencies in the Health portfolio. The AIHW develops an annual statement specific to our organisation, informing members of the Parliament of Australia of the proposed allocation of resources to government outcomes and programs. Annual direct funding from the Parliament of Australia is appropriated to us on the basis of outcomes. Our outcome and program structure under the PBS consists of 1 outcome and 1 program (see Chapter 1 on page 3).
- **Annual report—**is provided to the Minister for Health for presentation to the Australian Parliament, required by section 46 of the PGPA Act.

Ministerial accountability

The AIHW Board is accountable to the Parliament of Australia through the Minister for Health. It informs the minister of its activities as required. This includes occasions when we receive or expend significant funds; for example, when we undertake contract work valued over a certain amount (currently $3 million) for other agencies and organisations. This amount is specified in Regulations made under the AIHW Act (see Appendix 1 on page 102).

We ensure that the Minister for Health—and other relevant ministers in the Australian Government and state and territory governments—have early embargoed access to our products.

AIHW Board

The Institute is managed by the AIHW Board. The board is an 'accountable authority' under the PGPA Act.

The board's composition is prescribed by section 8(1) of the AIHW Act. Board members are appointed by the Governor-General and hold office for a specified term not exceeding 3 years. In addition, there are 3 ex-officio board members: the AIHW Director, the Australian Statistician or nominee, and the Secretary of the Department of Health or nominee. The AIHW Director is appointed by the Minister for Health on the recommendation of the Institute and may hold office for a term not exceeding 5 years.

Board members

Information follows about individual board members at 30 June 2017, including qualifications, current positions and affiliations. Appendix 3 on page 117 details the meetings attended by board members during 2016–17 and lists board members outgoing during 2016–17.

Louise Markus BSocWk
Chair
Non-executive Director
Term: 14 December 2016 – 13 December 2019

Mrs Markus was elected to the House of Representatives in 2004 and 2007 for the seat of Greenway and in 2010 for the seat of Macquarie.

During her time in the Parliament of Australia, Mrs Markus held the positions of shadow parliamentary secretary for immigration and citizenship and shadow minister for veterans' affairs. Mrs Markus left the House of Representatives on 2 July 2016.

Mrs Markus holds a Bachelor of Social Work from the University of New South Wales. During her career as a social worker, she worked at the Department of Social Security, Wesley Mission and as a TAFE teacher. Mrs Markus is passionate about developing and delivering programs that provide opportunities for our young people and being a strong voice for those in her community.

Barry Sandison BBusMgt, FANZSG
Director, Australian Institute of Health and Welfare
Executive Director
Term: 5 May 2016 – 4 May 2021

Mr Sandison has extensive public sector experience, with previous roles in both policy and service delivery. Most recently, he was the deputy secretary, health and information, in the Australian Government Department of Human Services where he was responsible for the administration and delivery of a range of programs in the health, government and business areas. Before this, Mr Sandison was a deputy chief executive at Centrelink and held senior executive roles in the Department of Families, Housing, Community Services and Indigenous Affairs and the Department of Employment and Workplace Relations. Mr Sandison is a board member of L'Arche Genesaret, an Australian Capital Territory community organisation for people with intellectual disabilities.

Zoran Bolevich DM, MBA, FRACMA
Nominee of the Australian Health Ministers' Advisory Council
Non-executive Director
Term: 11 February 2016 – 10 February 2019

Dr Bolevich is the Chief Executive and Chief Information Officer of eHealth NSW, a dedicated health information technology agency, responsible for planning, implementation and support of the digital transformation of New South Wales Health. During his 25-year career in health, he has worked in a range of senior health management and information and communications technology (ICT) leadership roles in Australia and New Zealand. Before joining eHealth NSW, Dr Bolevich worked at the New South Wales Ministry of Health as executive director for health system information and performance reporting and, most recently, as acting deputy secretary for system purchasing and performance. Earlier, he spent several years leading a regional shared services agency for district health boards, after which he moved to New Zealand's Ministry of Health where he was responsible for the national health information strategy and architecture.

Marilyn Chilvers BEc (Hons), Grad Dip Tert Ed, MAppStat, MAICD
Nominee of the Children and Families Secretaries Group (of state and territory departments)
Non-executive Director
Terms: 18 January 2016 – 17 January 2017; 19 January 2017 – 18 January 2018

Ms Chilvers is the Executive Director of Analysis and Research at the New South Wales Department of Family and Community Services (FACS). She is responsible for leading the development and dissemination of the agency's evidence base to inform policy, service design and local planning. Ms Chilvers is also co-investigator on a number of linkage research projects, and Chief Investigator for the FACS Pathways of Care Longitudinal Study, which examines the outcomes of children and young people entering out-of-home care in New South Wales for the first time.

Ms Chilvers' previous roles include several senior statistical and economic roles in FACS, the NSW Bureau of Crime Statistics and Research, and at Macquarie University.

Philip Fagan-Schmidt PSM MPublicPolicy
Representative of the State Housing Departments (nominated through the Senior Housing Officials—a network of Senior Officials from Commonwealth, state and territory governments)
Non-executive Director
Terms: 18 January 2016 – 17 January 2017; 19 January 2017 – 18 January 2018

Mr Fagan-Schmidt was appointed to the position of Executive Director, Housing SA in 2009. He was awarded a Public Service Medal for his work in social housing policy and practice in 2015. Mr Fagan-Schmidt has worked in both academic and government spheres and in a range of subject areas, including health, housing, natural resource management, infrastructure and major projects.

Luise McCulloch BA (Hons)
Nominated by Mr David Kalisch, Australian Statistician, Australian Bureau of Statistics
Non-executive Director
Term: Ex-officio appointment

Ms McCulloch is the Deputy Australian Statistician leading the Statistical Services Group. This Group has responsibility for producing the ABS' demographic, economic and social statistics. Ms McCulloch joined the ABS in November 2015 after 7 years at the Commonwealth Treasury department, during which time she held a number of positions including: division head, corporate and international tax division; acting executive director, policy coordination and governance; general manager, Budget Policy Division; general manager, Infrastructure, Industry, Environment and Defence Division; head of the Sustainable Population Strategy Taskforce and principal adviser (2010 Intergenerational Report).

Ms McCulloch previously held the positions of assistant secretary (tax, superannuation and workplace relations) and assistant secretary (fiscal policy) in the Department of the Prime Minister and Cabinet (PM&C). Ms McCulloch joined the public service in 1990 as a graduate with PM&C.

Mark Cormack BAppSc, MHlthMgmt
Nominated by Mr Martin Bowles, Secretary, Department of Health
Non-executive Director
Term: Ex-officio appointment

Mr Cormack joined the Department of Health in February 2015 as Deputy Secretary, Strategic Policy and Innovation Group. Mr Cormack is responsible for strategic national health policy, portfolio strategies and international engagement. His national program responsibilities include primary health, mental health, public hospital funding agreements and dental.

Before joining the department, Mr Cormack was deputy secretary of the Immigration Status Resolution Group in the Department of Immigration and Border Protection from August 2013–January 2015.

Mr Cormack has worked in and for the public health-care sector for over 30 years in various capacities as a health professional, senior manager, policy maker, planner, agency head and industry advocate.

Erin Lalor BSc (Hons) (Speech and Hearing), PhD, GCCM
Ministerial nominee with knowledge of the needs of consumers of health services
Non-executive Director
Terms: 21 November 2012 – 20 February 2013; 1 March 2013 – 29 February 2016; 23 March 2016 – 22 March 2017; 24 March 2017 – 23 March 2018

Dr Lalor has over 20 years of leadership experience in the health sector, working in clinical, academic and executive roles. She was most recently the CEO of the National Stroke Foundation and a Director of the World Stroke Organisation. She sits on a number of advisory committees in relation to public health, clinical improvements and evidence based approaches to healthcare delivery. She has a strong commitment to strengthening the consumer voice in planning health care and health policy. Dr Lalor was a Victorian finalist in the Telstra Businesswomen of the Year Awards 2013 and recognised as one of the Financial review/Westpac Top 100 Women of Influence in 2013.

David Conry
Ministerial nominee with knowledge of the needs of consumers of welfare services
Non-executive Director
Terms: 19 December 2014 – 30 June 2015; 1 July 2015 – 18 December 2015; 18 January 2016 – 17 January 2017; 19 January 2017 – 18 January 2018

Mr Conry is Managing Director of Damarcon, a privately owned advisory and investment business.

He contributes more broadly to the community as Chair of Brisbane Powerhouse and the Queensland Museum and holds non-executive directorships, or board roles with PHN Country to Coast and Inclusive Brisbane.

Mr Conry was named Queensland's Australian of the Year 2007 and Ernst & Young Global Limited Social Entrepreneur of the Year 2007 for his work in founding the national disability organisation Youngcare. He is an Australia Day Ambassador, provides support and advice to many Queensland not-for-profit organisations and remains a strong advocate for those with disabilities.

Michael Perusco BBus (Acc)
Ministerial nominee with knowledge of the needs of consumers of housing assistance services
Non-executive Director
Terms: 21 November 2012 – 20 February 2013; 1 March 2013 – 29 February 2016; 23 March 2016 – 22 March 2017; 24 March 2017 – 23 March 2018

Mr Perusco is the CEO of Unison in Melbourne, Victoria's largest provider of community housing which focuses particularly on housing people with a history of homelessness and disadvantage. Mr Perusco was previously CEO of St Vincent de Paul Society New South Wales. His experience also includes 9 years as CEO of Sacred Heart Mission, a Victorian organisation that works with people experiencing homelessness. Mr Perusco has also chaired the Council to Homeless Persons and Australians for Affordable Housing and been a member of the NSW Premier's Council on Homelessness and the board of the NSW Council of Social Service. He is currently on the board of the Community Housing Federation of Victoria. Mr Perusco also has experience in the commercial sector with KPMG and Arthur Andersen.

Lyn Roberts AO Dip App Sc, BA (Hons), PhD
Ministerial nominee with expertise in research into public health issues
Non-executive Director
Terms: 12 November 2009–11 November 2012; 21 November 2012 – 20 February 2013; 1 March 2013 – 29 February 2016; 3 April 2016 – 2 April 2017; 4 April 2017 – 3 April 2018

Dr Roberts has extensive experience in working within health non-government organisations, having spent over 25 years working at an executive level in state, national and international capacities. She has considerable expertise in strategic public health policy development and implementation, working with a wide range of stakeholders.

She has been a member of a number of expert advisory committees for the government and non-government sectors. Dr Roberts holds a number of board positions and her current roles include the Institute for Physical Activity and Nutrition at Deakin University (board member), Deakin University Council (council member) and the Victorian Government Justice Health Ministerial Advisory Committee (member). She is currently working part-time as a Principal Adviser with the Victorian Health Promotion Foundation.

Andrew Goodsall BA (Hons), Grad Dip Asian Studies, MBA
Ministerial nominee
Non-executive Director
Terms: 19 December 2014 – 30 June 2015; 1 July 2015 – 18 December 2015; 18 January 2016 – 17 January 2017; 19 January 2017 – 18 January 2018

Mr Goodsall has been Managing Director (Healthcare Analyst) with financial services firm UBS Australia since 2006. He serves on the boards of the North Shore Local Health District (Sydney), the New South Wales Bureau of Health Information and the Australian Institute of Policy and Science. Mr Goodsall's previous positions include chief of staff and senior adviser to a Victorian health minister, in addition to a management role within the Victorian Government, and an Australian Army Reserve officer.

Gillian Adamson
Ministerial nominee
Non-executive Director
Term: 1 September 2016 – 31 August 2017

Ms Adamson worked with Pfizer Australia for over a decade as Pfizer's senior manager for public affairs and policy, heading a team responsible for establishing and maintaining relationships with Australia's peak bodies for medical and nursing professions and health consumer organisations.

Her responsibilities also extended to the development and implementation of Pfizer's quality use of medicines strategy and the effective implementation of Pfizer Australia's community engagement strategy, including corporate volunteering and employee giving. She also represented Pfizer Australia on a number of industry committees.

During her time at Pfizer, Ms Adamson was awarded the W.E. Upjohn Award, a global award for outstanding dedication and exemplary performance in her role.

Since 2015, Ms Adamson has been a board member of Rare Cancers Australia and is currently working as a Management Consultant in the aged care sector.

Simone Ryan BMedSci, MBBS, FAFOEM (RACP), MOccEnvHlth, ACCAM, DAME
Ministerial nominee
Non-executive Director
Term: 1 September 2016 – 31 August 2017

Dr Ryan is a specialist occupational and environmental physician. She is the founder and current CEO of One Life. Live It, a multinational small–medium enterprise in the corporate health-care sector, leading teams across Australia, Asia and the United States of America. Dr Ryan has a keen interest in health-care data; her company is currently the only one in Australia that records return on investment for corporates regarding their health-care spend.

Dr Ryan is a past board member of the Royal Australasian College of Physicians (RACP) and past chair of the RACP College Trainees' Committee.

She is an active philanthropist, especially in the field of Australian Indigenous education and a current Member of the RACP Foundation reference group.

Marissa Veld BAppSc, MA (Bus)
Staff-elected representative
Non-executive Director
Term: 26 May 2017 – 25 May 2018

Ms Veld has worked at the AIHW since 2013 as a Senior Project Manager across a range of subject areas, including family, domestic and sexual violence and housing and homelessness reporting. Ms Veld has experience in policy and data reporting in welfare services and criminal justice sectors through her previous work for the Australian Federal Police, the Australian Capital Territory Government and the Australian Institute of Criminology.

Charter of Corporate Governance

The AIHW Board has adopted a Charter of Corporate Governance that outlines the governance framework of the Institute and is designed to assist board members meet their legislative and other obligations. The charter is available on our website at www.aihw.gov.au/aihw-board/.

Board performance review

Consistent with best practice, the AIHW Charter of Corporate Governance provides that the board reviews its performance every 2 years. Matters reviewed may include the board's success in pursuing the AIHW's objectives, clarity of roles, procedural matters and the individual performance of board members.

A review of the board was last conducted in 2012–13, with findings considered and adopted by the board in 2013.

In August 2015, the Australian Government asked the Department of Health to commission an independent review of the AIHW's role. The report of the review, by the Nous Group, recommended some changes to the AIHW's governance. These recommendations are under consideration by the Department of Health.

Education of board members

Board members are provided with information about the AIHW Board and the AIHW's governance framework at the start of their first term. They are also briefed by the AIHW Director on the board's role and key current issues for the Institute.

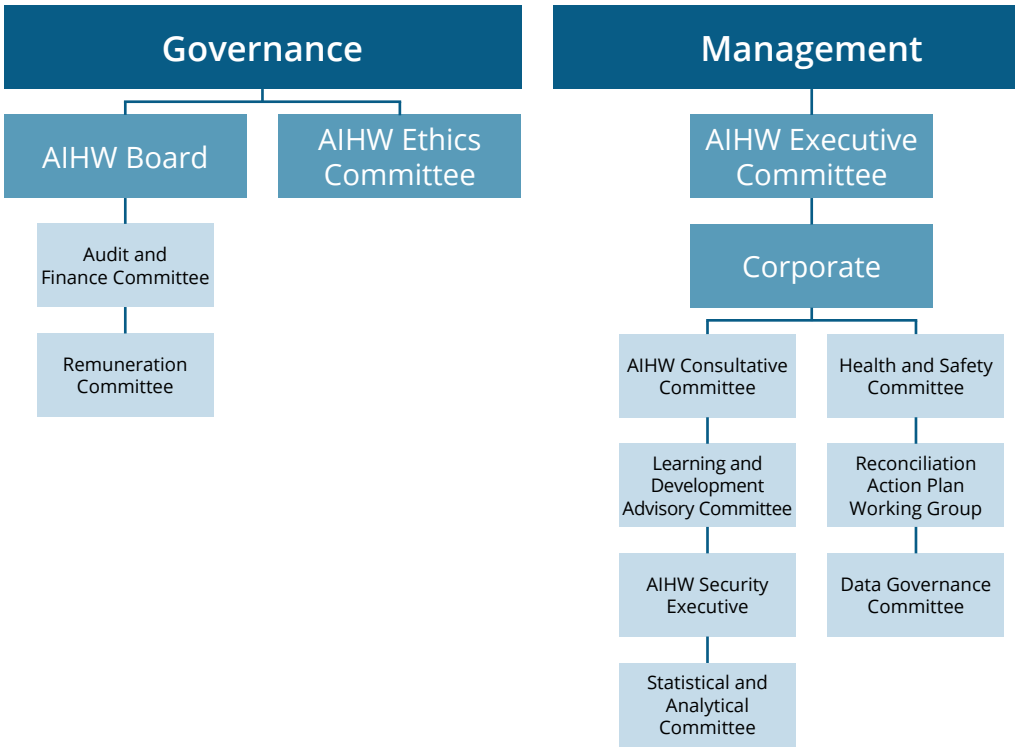
Remuneration and allowances for board members

Remuneration and allowances for board members are determined by the Remuneration Tribunal. As at 30 June 2017, the relevant determination is *Determination 2016/18: remuneration and allowances for holders of part-time public office* which can be found on the tribunal's website at www.remtribunal.gov.au.

Board members who were employed by an Australian Government, state or territory government department or entity did not receive remuneration for their work as a member of the AIHW Board.

Board committees

The AIHW Board has 2 committees: the Audit and Finance Committee and the Remuneration Committee (Figure 4.1). Details of their responsibilities and operation are provided in part 8 of the Charter of Corporate Governance, which is available at www.aihw.gov.au/aihw-board/. Details of attendance by members at meetings held during 2016–17, including members who departed during the year, are in Appendix 3 on page 117.



Notes

1. The AIHW Director is a member common to the AIHW Board, the AIHW Ethics Committee and the AIHW Executive Committee.
2. Operational Committees are convened as required.

Figure 4.1: Governance and management committees, 30 June 2017

Audit and Finance Committee

The Audit and Finance Committee authorises and oversees the AIHW's audit program and reports to the board on strategic, financial and data audit matters (see 'Financial management' on page 74 and 'Risk oversight and management' on page 75).

As at 30 June 2017, the committee comprised:

- 4 non-executive board members—Mr Michael Perusco (Chair), Dr Erin Lalor, Dr Lyn Roberts AO and Mr Andrew Goodsall whose details are available under 'Board members' earlier in this chapter
- 1 independent member—Mr Max Shanahan.

Maxwell Shanahan BA, FCPA, CGEIT, CISA, MACS (Senior), MIIAA
Independent member
Term: from 8 December 2011

Mr Shanahan is the Director of Max Shanahan & Associates. He is currently an independent member of the ABS Audit Committee, Chair of the Snowy Mountains Regional Council Audit Committee and a member of the Queanbeyan-Palerang Regional Council Audit, Risk and Improvement Committee. His prior experience includes 5 years with Walter Turnbull Chartered Accountants, 15 years with the Australian National Audit Office where he was a member of the senior executive with responsibility for information technology (IT) auditing. Mr Shanahan was the project editor for 2 governance-related standards: AS/NZ 8016: 2013 Governance of IT enabled projects and ISO/IEC TR 38502: 2014 Governance of IT, framework and model.

Auditors

Senior representatives from our internal auditors (Protiviti) and external auditors (the Australian National Audit Office) attend meetings of the committee.

Major matters reported to the board by the committee in 2016–17 included: the audit of the 2015–16 financial statements; our draft 2017–18 budget; our 2015–16 and 2016–17 internal audit programs; and reviews of our business risks. The committee also reviewed recommendations from internal audits completed in 2015–16 and 2016–17 on:

- data release management—to provide assurance of an adequate data governance framework and satisfactory controls for the management of the release of data to ensure compliance with key legislative requirements and contractual obligations
- IT applications management, including change control—to provide assurance about the effectiveness of governance and key controls in managing the IT application suite
- leave entitlement controls—to provide assurance about the design and operating effectiveness of key controls over leave entitlements and movements, including accuracy of balances and calculations of leave liabilities.

Appropriate action in response to the recommendations of these internal audits is underway.

During the year, Protiviti also assisted AIHW staff with the development of a data custodian self-assessment checklist and with updating the AIHW's Fraud Control Plan.

Protiviti commenced work in 2016–17 on a review of the AIHW's Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) data collections.

Remuneration Committee

The employing body for the AIHW Director is the AIHW Board. The position is within the Principal Executive Office structure administered by the Remuneration Tribunal, for which information can be found at www.remtribunal.gov.au/offices/principal-executive-offices. The board Remuneration Committee advises the board on the AIHW Director's performance and remuneration, within the constraints of the Remuneration Tribunal's *Determination 2015/19: Principal Executive Office—classification structure and terms and conditions*.

At 30 June 2017, the committee comprised:

- Chair of the AIHW Board—Mrs Louise Markus (Chair)
- Chair of the Audit and Finance Committee—Mr Michael Perusco
- 1 other board member—Dr Erin Lalor.

AIHW Ethics Committee

The AIHW Ethics Committee is established under section 16(1) of the AIHW Act. Its main responsibility is to advise on the ethical acceptability or otherwise of current or proposed health- and welfare-related activities of the AIHW, or of bodies with which the AIHW is associated. The Australian Institute of Health and Welfare Ethics Committee Regulations 1989 prescribe the committee's functions and composition (see Appendix 1 on page 102).

The committee is recognised by the National Health and Medical Research Council as a properly constituted human research ethics committee, and an annual report of its activities in each calendar year is provided to the council.

Subject to the requirements of the AIHW Act and the *Privacy Act 1988*, the AIHW may release personal health and welfare data for research purposes with the written approval of the committee, provided that release is consistent with the terms and conditions under which the data were supplied to us. The committee also approves the establishment of new health and welfare data collections.

Committee members

Information follows about individual AIHW Ethics Committee members at 30 June 2017. Appendix 3 on page 119 details the meetings attended by committee members during 2016–17 and lists committee members who departed during the year.

Wayne Jackson PSM BEc (Hons)
Chair
Terms: 1 July 2014 – 30 June 2016; 1 July 2016 – 30 June 2019

Mr Jackson is a retired Australian Government public servant, having served as deputy secretary in Prime Minister & Cabinet and in the former Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). He chaired a wide range of interdepartmental and corporate committees, including the FaHCSIA Risk Assessment and Audit Committee and the Research Committee, and was a member of the Australian Statistics Advisory Council. After leaving the public service, Mr Jackson undertook a number of projects as a consultant to FaHCSIA and the Department of Finance relating to disability income support, employment, and care and support (including the National Disability Insurance Scheme).

Mr Jackson was awarded a Public Service Medal in 2006 for outstanding public service in the development and implementation of social policy. He served as director of Aboriginal Hostels Limited from 2009 to 2016.

Barry Sandison BBusMgt, FANZSG
Director, Australian Institute of Health and Welfare
Term: 5 May 2017 – 4 May 2021

Information about Mr Sandison is provided in his entry under 'Board members' on page 50.

Purnima Bhat MBBS, FRACP, PhD
Person experienced in the professional care, counselling or treatment of people
Term: 25 September 2014 – 24 September 2017

Dr Bhat is a practising gastroenterologist and research scientist, having completed her PhD at the University of Melbourne on 'Hepatitis B virus in polarised epithelia'. She is currently a Senior Research Fellow at the Australian National University Medical School, where she lectures in gastrointestinal immunology and tumour immunology, and is also involved in student admissions.

Dr Bhat's recent research papers (2014) include: 'The kinematics of cytotoxic lymphocytes affect their ability to kill target cells' and 'mRNA structural constraints on EBNA1 synthesis impact on in vivo antigen presentation and early priming of CD8+ T cells'. Her current research interests include the development of immunotherapies for bowel cancer, and investigating the role of gut microbiota in disease and health.

Tim Driscoll FAVOEM, FAFPHM, PhD, MOHS, MBBS, BSc (Med)
Person experienced in areas of research regularly considered by the committee
Term: 1 July 2016 – 30 June 2019

Professor Driscoll is an occupational epidemiologist and a specialist physician in occupational and environmental medicine and public health medicine. He is a Professor in epidemiology and occupational medicine in the Sydney School of Public Health at the University of Sydney, where he runs the general epidemiology teaching and is Director of the Master of Public Health program. His main areas of research and professional interest are the burden of occupational disease and injury; occupational cancer and exposure to occupational carcinogens, particularly asbestos; occupational fatal injury; increasing the practical application and influence of epidemiological principles and findings; and improving the communication of epidemiological principles and findings to the general public. He leads the occupational risk factors expert working group in the Global Burden of Disease study.

Professor Driscoll has published more than 160 research papers in refereed journals and is on the editorial boards of the International Journal of Epidemiology and the International Journal of Occupational Safety and Health. He is Chair of the Scientific Committee on Occupational Medicine of the International Commission on Occupational Health (ICOH) and sits on the management committee of the ICOH scientific committee on occupational epidemiology. He served for 8 years as chair of the Education Committee of the Faculty of Occupational and Environmental Medicine of the RACP.

Amanda Ianna Grad Cert Change Mgt, AGSM
Nominee of Registrars of Births, Deaths and Marriages
Term: Ex-officio appointment

Ms Ianna has extensive experience in the field of civil registration, organisational change and leadership. She is currently the 17th Registrar (since 1856), at the New South Wales Registry of Births Deaths & Marriages which she commenced in 2014; 1 of only 2 women to hold this position. In her role, Ms Ianna has championed the registry's drive towards quality standards accreditation, building online solutions for the registry's customers and developing community outreach programs, especially with the homeless and Indigenous communities throughout New South Wales.

She is passionate about her staff, customers and keeping the records safe for the people of New South Wales. Ms Ianna has been in the public service sector for 31 years and has been in a number of leadership roles over this time.

James Barr BA (Hons), BTheol (Hons), MAppSci
Person who is a minister of religion
Terms: 12 December 2008 – 11 December 2011;
12 December 2011 – 11 December 2014; 12 December 2014 – 11 December 2017

The Reverend Barr has a background in leadership development, and pastoral and community work. His work has ranged from organising communities in Third World slums to consulting for companies and government agencies in the fields of corporate ethics and leadership development. An ordained Baptist minister, he has served as minister of the Collins Street Baptist Church, Melbourne, where he was founding director of the Urban Mission Unit (now Urban Seed), director of the Zadok Institute for Christianity and Society, pastoral associate of Melbourne City Mission and senior minister of the Canberra Baptist Church. The Reverend Barr is also a former member of the Human Research Ethics Committee of RMIT University and is currently co-Minister of the Melbourne Welsh Church.

Maryjane Crabtree BA/LLB, GAICD
Person who is a lawyer
Term: 14 April 2016 – 13 April 2019

Ms Crabtree was a partner of Allens Linklaters, until her retirement in 2016. Ms Crabtree has had previous experience on a human research ethics committee and is currently the Deputy President of the Epworth HealthCare Board of Management. Her expertise has been built on her experience in running a large national professional services organisation as well as practising in many fields, including occupational health and safety, environment and product liability and sport law. Ms Crabtree is also involved in not-for-profit organisations in the areas of health, education and sport. She is currently a member of Chief Executive Women, the Victorian Legal Admissions Committee, the Law Institute of Victoria Council, the Board of Ormond College Ltd, the Victorian Coronor's Council and the Board of Racing Analytical Services Ltd.

David Garratt BEd, GradDipRE
Male representing general community attitudes
Terms: 26 March 2010 – 25 March 2013; 26 March 2013 – 25 March 2016; 26 March 2016 – 25 March 2019

Mr Garratt is a retired school principal. His last appointment was as principal, Daramalan College, Canberra, from which he retired in 2008. He has extensive experience in education in the Australian Capital Territory and has served on committees administering government programs. Mr Garratt was on the founding boards of 2 schools, St Francis Xavier and the Orana School for Rudolf Steiner Education, and was chair of the latter. He was a community representative on the Dickson Neighbourhood Planning Group, is a board member of the Northside Community Service in Canberra and a member of the Company of the National Folk Festival.

Margaret Reynolds BA, Dip Special Ed
Female representing general community attitudes
Terms: 17 August 2011 – 16 August 2014; 17 August 2014 – 16 August 2017

Ms Reynolds has had a career in education, community advocacy and public policy development, and has served in various local government roles. She served as a Queensland local government councillor for 4 years and was elected to the Australian Senate from 1983 to 1999. During this time, she served 3 years as a minister—as minister for local government and regional development, minister assisting the Prime Minister for the status of women, and representative of the minister for immigration in the Senate. She has also served as the Australian Government representative on the Council for Aboriginal Reconciliation (1991–1996), chair of the Commonwealth Human Rights Initiative (1993–2004) and national president of the United Nations Association of Australia (1999–2005).

Ms Reynolds has been a visiting professor at the University of Queensland and University of Tasmania, and currently holds a similar position at the University of Technology in Sydney, where she works with the Australian Centre of Excellence in Local Government. In addition, she has spent the last 10 years working in the disability sector, advising state and federal governments on the introduction of the National Disability Insurance Scheme, and was the Tasmanian Expert with the Flinders University Team evaluating trial sites (2013–2016) for the scheme.

Ms Reynolds has also written 2 books—*The last bastion: Labor women working towards equality in the parliaments of Australia* and *Living politics*—and is currently working on a new publication, 'Trust the women'.

Work of the committee

The AIHW Ethics Committee met 4 times in 2016–17 and provided approvals regarding the ethical acceptability of 205 new or modified projects and data collections.

New project applications

In 2016–17, the committee considered 62 new project applications. Of these, 56 were approved and a decision was pending in relation to 6 applications at 30 June 2017 (Table 4.1).

Most (49) of the new applications were submitted by researchers from external organisations, such as departments and research centres affiliated with universities or large metropolitan teaching hospitals. For example, applications were received from the Princess Alexandra Hospital, Concord Hospital, the University of New South Wales, the University of Melbourne and other major Australian universities. The committee also received applications from research organisations such as the Murdoch Childrens Research Institute, QIMR Berghofer Medical Research Institute and various government agencies, including the Victorian Department of Health and Human Services and the Department of Finance.

The AIHW submitted 13 new applications. The majority of these submissions were to establish data collections, including the Australian Gulf War Veterans' health and, the National Hospital and Public Housing data collections.

Most applications for access to data sought approval for linkage to the National Death Index which is held at the AIHW. Other AIHW-held databases to which access was sought included the Australian Cancer Database, Medicare and Pharmaceutical Benefits data and hospitals data. There is an increasing number of researchers requesting linkage to Medicare Benefits Schedule and Pharmaceutical Benefits Scheme data. Researchers may request access to more than 1 database in each application; for example, some applications sought access to both the National Death Index and the Australian Cancer Database.

Table 4.1: Research project applications considered by the AIHW Ethics Committee, 2016–17

	Considered	Approved	Rejected	Decision pending
Applications for approval				
AIHW, including collaborating centres	13	13	—	—
External researchers	49	43	—	6
Subtotal	*62*	*56*	—	*6*
Applications for modification or extension				
AIHW, including collaborating centres	17	17	—	—
External researchers	120	119	—	1
Subtotal	*137*	*136*	—	*1*
Total	**199**	**192**	**—**	**7**

Monitoring projects

The committee monitors approved projects to their completion, and considers requests for modifications to previously approved projects. A total of 333 annual monitoring reports were received from researchers during 2016–17.

Requests for modification or extension

In all, 137 requests for amendment were considered during the year (Table 4.1). More than half (89) included a request for an extension of time and/or proposed research staff changes.

Finalised projects

To ensure that research outcomes are freely available, the AIHW Ethics Committee requires public dissemination of the results of approved projects. In 2016–17, the AIHW received 21 final project reports accompanied by associated research results, most of which were published in peer-reviewed journals or other publicly available reports. There are some limited exceptions where results are not released into the public domain: an example is when data are provided to a government department for the purpose of creating a model for internal use. In this situation, it is expected that any learnings are shared among other interested government agencies.

Organisational structure

The AIHW organisational structure comprises 8 groups. Information about the responsibilities of those groups during 2016–17 follows. Figure 4.2 shows the unit structure within each group as at 30 June 2017.

From 1 July 2017, the AIHW will introduce a new internal structure, of which an important objective will be to further integrate the AIHW's responsibilities under the Performance and Accountability Framework (PAF), which was transferred to the AIHW in July 2016. The new structure allows the AIHW to maintain the distinctive features of the PAF reporting and to extend them to other relevant areas of the AIHW's work.

Consistent with our new *Strategic directions 2017–2021*, to strengthen our capability as an expert source of value-added analysis and champion of open and accessible data and information, we will continue to build on our analytical and data visualisation expertise. To this end, a new Data Visualisation Unit will be established to improve the usefulness and accessibility of the data we release for public, policy, clinical and other stakeholders.

The AIHW has also dedicated resources to further develop and improve data in key health and welfare areas, such as primary health care, family and domestic violence, and community services.

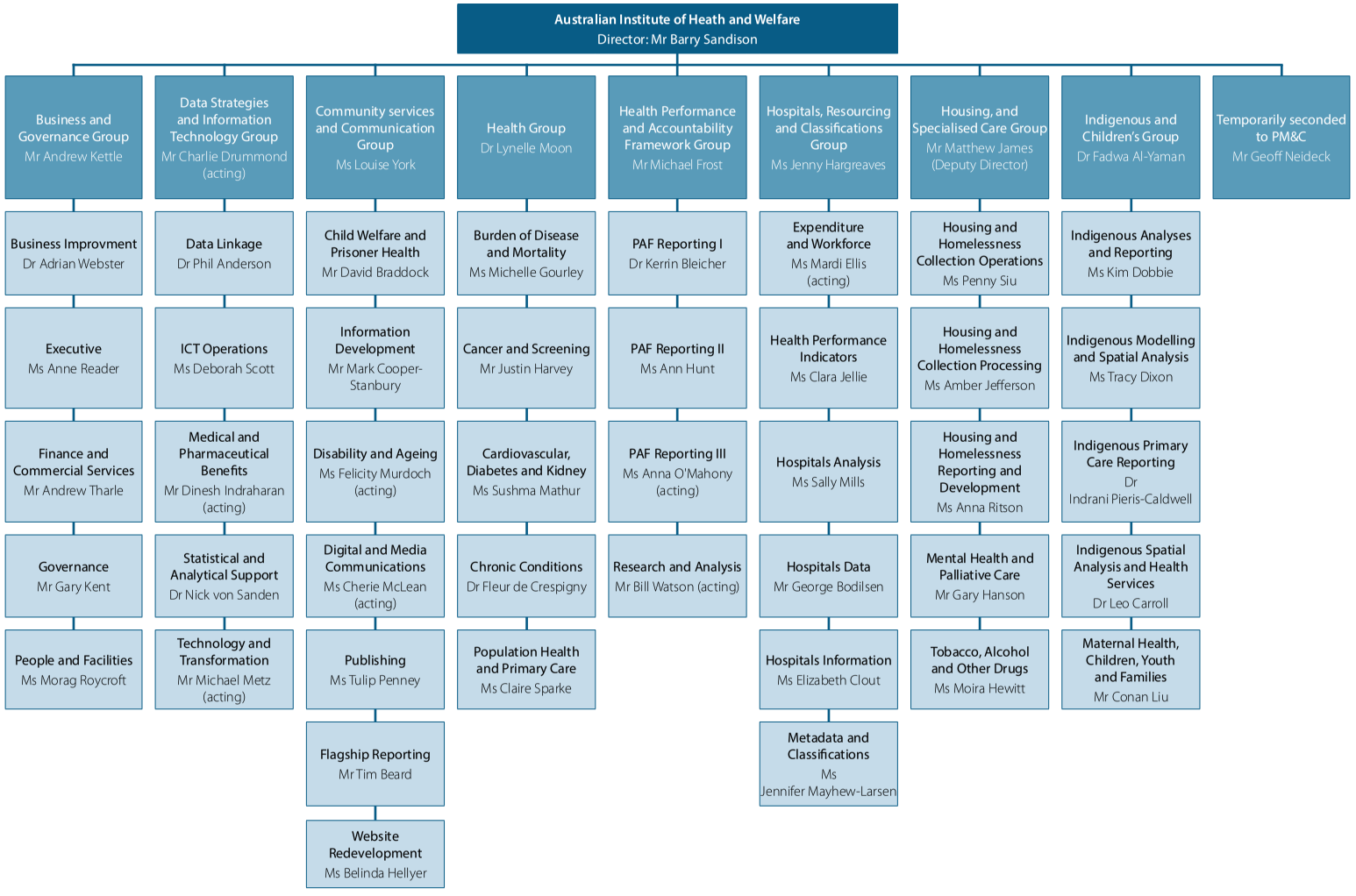


Figure 4.2: Organisational chart, 30 June 2017

Business and Governance Group

Providing leadership through corporate services

This group provides services and advice to enable optimal use of the Institute's financial and human resources to achieve business objectives. More specifically, the group is responsible for:

- executive support and secretariat services for the AIHW Director, AIHW Board, AIHW Executive Committee and a number of national information committees
- leadership and support in governance and legal matters, including data governance, management and release arrangements, ethics, privacy, development and negotiation of external agreements, the strategic management of internal and external relationships critical to our role, and the preparation of key corporate planning and reporting documents
- pricing and contract advice, business analysis and preparation of financial statements (see Appendix 7)
- recruitment services, coordination of learning and development activities, workforce planning, performance management support, management of people and building safety, facilities management and accommodation planning (see Chapter 5 Our people for more detailed descriptions of activities and achievements in 2016–17)
- business improvement and project management support, including advice on planning, risk management and delivery of projects.

Data Strategies and Information Technology Group

Enabling richer research

This group works with Australian Government agencies, state and territory governments and other key stakeholders to promote access to health and welfare data for policy, research and community information. The group aims to increase the information value of existing data collections through data integration (linkage) work—for the AIHW and external researchers—that supports innovative analyses. Examples of work supported in this way include longitudinal studies and movements of people between health and welfare services.

The group also:

Supporting data security

- identifies, develops and promotes business process innovations, computing and communications infrastructure and technological leadership in support of our strategic directions
- supports our ICT requirements.

'Data security' on page 77 describes activities and achievements in 2016–17 in relation to the group's corporate data security functions.

Community Services and Communication Group

Developing person-centred data about the welfare of key populations

This group develops, maintains and analyses national data to support monitoring and reporting of:

- the health and welfare of key subpopulations, including children and youth, older Australians and people with disability
- use of services within a range of health and welfare sectors, including community-based services focused on aged care, child protection, juvenile justice and disability services
- victims and perpetrators of family, domestic and sexual violence through the establishment of a new Family, Domestic and Sexual Violence Data Clearinghouse.

The group also:

Delivering corporate communications

- manages the AIHW's website, intranet and other related websites to deliver our online communication activities
- promotes the Institute and its work through media, marketing and client relations activities
- provides a range of print-ready publishing, production and distribution services for the organisation
- manages the production of biennial editions of both the *Australia's welfare* and *Australia's health* publications.

Chapter 3 Our communications provides detailed descriptions of activities and achievements in 2016–17 in relation to the group's corporate communication functions.

Health Group

Revealing the health of Australians

This group develops, maintains and enhances national data to support monitoring and reporting on the health of Australians, covering:

- chronic diseases, such as cardiovascular disease, diabetes, kidney disease, cancer (including cancer screening), musculoskeletal conditions and respiratory conditions
- health-related issues, such as population (preventive) health, health inequalities, risk factors, social determinants of health, international health comparisons, mortality, burden of disease and chronic disease management, particularly in primary health care
- specific population groups, such as veterans and people living in rural areas.

Health Performance and Accountability Framework Group

Reporting on health system performance

This group was created on 21 April 2016 to facilitate the transition of functions, staff and other resources from the NHPA, commencing 1 July 2016.

The group reported on hospitals and local health-care organisations under the PAF agreed by the COAG.

Hospitals, Resourcing and Classifications Group

Detailing the health-care system

This group develops data and information infrastructure, compiles data, undertakes analyses and disseminates policy-relevant statistical information about hospitals, resources in the health and welfare sectors, and health sector performance. The national hospitals databases and the *Australian hospital statistics* reports are major products, as are the national health expenditure database and *Health expenditure Australia* reports.

The group also provides metadata repository and publication services, and support for data developers in the health, housing and homelessness, early childhood education and care and selected community services sectors. This work includes management of METeOR, the AIHW's online national metadata repository.

The group also has responsibility for the coordination of Australia's international health classification work and manages the AIHW's relationship with the National Injury Surveillance Unit, one of the AIHW's collaborating centres.

Housing and Specialised Services Group

Providing statistics on a range of vulnerable groups

This group produces statistics, analysis and information on:

- homelessness
- community housing
- housing assistance
- mental health and palliative care services
- drug use and treatment services, including tobacco and alcohol.

Surveying alcohol and drug use

The group is responsible for the administration, data analysis and reporting of 2 national surveys, both of which will be released in 2017:

- the National Drug Strategy Household Survey—a large triennial household survey which collects information on alcohol and tobacco consumption, illicit drug use and attitudes and perceptions relating to tobacco, alcohol and other drug use
- the National Social Housing Survey—a biennial survey of tenants in selected housing programs, designed to collect information for national reporting about tenant satisfaction with housing amenities, facilities and services.

Indigenous and Children's Group

Monitoring the next generation's wellbeing

The group leads the development, monitoring and reporting of information and statistics on the health and welfare of Indigenous Australians, mothers, babies, children, youth and families.

Delivering better data on Indigenous people

In 2016–17, the group released a key report on burden of disease for the Aboriginal and Torres Strait Islander population. Other highlights in 2016–17 included the first national indicator report on Indigenous eye health, and a new online data product for the National Aboriginal and Torres Strait Islander Health Performance Framework.

Executive

The AIHW Director Mr Barry Sandison manages the day-to-day affairs of the Institute. He is supported by 8 senior executives, who together comprise the AIHW Executive Committee. During the year, the committee met regularly to consider policy, financial and other corporate matters.

During 2016–17, of the 8 senior executives, 4 managed organisational groups that oversaw specific statistical areas only; 1 managed a group that provided solely corporate support services to the whole organisation; and 3 managed groups that delivered both statistical and corporate services.

Senior executive team

Information on the AIHW's senior executive team, as at 30 June 2017, is given below. More detailed information on each person is available at www.aihw.gov.au/aihw-senior-staff/.

Senior Executive, Business and Governance Group
Andrew Kettle MA (Hons), CA

Mr Kettle has held a senior executive position since commencing at the AIHW in 2006. He is responsible for leading the management of the Institute's finances, human resources, governance, business improvement services and office accommodation. Mr Kettle qualified as a chartered accountant in the United Kingdom. He worked as a professional accountant for Coopers and Lybrand in Canada and Australia and was chief financial officer at the Australian Fisheries Management Authority. Mr Kettle acted as director of the AIHW for 6 months in 2015–16.

Senior Executive, Data Strategies and Information Technology Group
Geoff Neideck BBusStud, Grad Cert Management
(Temporarily seconded to PM&C)

Mr Neideck has been managing the AIHW's Data Strategies and Information Technology Group since December 2015. Prior to that, he headed the former Housing and Disability Group. Before joining the AIHW, he managed large national social and economic statistics programs at the ABS and Statistics Canada, where he gained experience in data design and statistical infrastructure projects.

Charlie Drummond BSc (Hons), Grad Dip Computer Sciences (acting)

Mr Drummond is currently responsible for the Institute's Data Strategies and Information Technology Group. He has worked at the AIHW since 2009 across various roles, chiefly in the former Business Information Technology Group. For the last 5 years, he has been managing significant aspects of the Institute's business transformation program. He has held senior IT and business roles in both the private and public sectors (Australia and United Kingdom).

Senior Executive, Community Services and Communication Group
Louise York BEc, BSc, Grad Dip Population Health

Ms York has led the Community Services and Communication Group since January 2017. The group's responsibilities span community services–related reporting and a range of communications and publishing functions. Ms York has over 20 years' experience at the AIHW, including leadership positions in both health and welfare areas, and 1 year at the Telethon Institute for Child Health Research.

Senior Executive, Health Group
Lynelle Moon BMath, Grad Dip Statistics, Grad Dip Population Health, PhD

Dr Moon is responsible for the Health Group which reports and collects data on the health of Australians, including population health, disease monitoring and primary health care. Dr Moon has held a number of health leadership positions in the AIHW since 1995, and spent 2 years working in the Health Division of the Organisation for Economic Co-operation and Development (OECD), Paris. She is also the lead analyst for the national component of the ABDS, which is a large project using international best-practice methods to calculate the fatal and non-fatal burden of 200 diseases and injuries, along with the attribution of this burden to various risk factors.

Senior Executive, Health Performance and Accountability Framework Group

Michael Frost BEc (Hons), Grad Dip Public Administration

Mr Frost transferred to the AIHW in April 2016 from his position as executive director, strategic initiatives, in the former NHPA. His experience in policy advice, performance reporting and administrative roles spans 17 years in federal and state governments, including as the deputy head, Secretariat for the COAG Reform Council.

Senior Executive, Hospitals, Resourcing and Classifications Group

Jenny Hargreaves BSc (Hons), Grad Dip Population Health

Ms Hargreaves has served on the AIHW senior executive team since 2006, when she was appointed to head the former Economics and Health Services Group. Her experience with Australian hospital statistics, for which she is responsible, is extensive. She is also responsible for the Institute's work related to health sector performance indicators, health classifications and management of national health and welfare data standards.

Senior Executive, Housing and Specialised Services Group

Matthew James PSM BEc (Hons)

Mr James is currently the Deputy Director and a Senior Executive at the AIHW. He was previously the assistant secretary, Information and Evaluation Branch, in the Indigenous Affairs Group in PM&C from 2013 to November 2016. It was during this role that he was honoured with a Public Service Medal in 2016. From 2008 to 2013, he was branch manager, Performance and Evaluation Branch in the former FaHCSIA. Before joining FaHCSIA, Matthew was a branch manager in the former Department of Education Employment and Training. In that department, Mr James worked on employment policy and implementation as well as workplace relations policy and analysis. From 2002 to 2004, he was counsellor, employment, education, science and training in the Australian Delegation to the OECD in Paris.

Senior Executive, Indigenous and Children's Group

Fadwa Al-Yaman PSM BSc, MA, PhD

Dr Al-Yaman has been on the AIHW Executive Committee since 2008. She has been instrumental in driving development of statistics on Indigenous health and welfare within the AIHW's data collections since she first came to the AIHW in 2001. In 2008, Dr Al-Yaman was awarded a Public Service Medal for outstanding public service in improving the accuracy and reliability of the data on Indigenous Australians contained in information collections for health, housing and community services.

Other staff

Further information about staff leading our units is in Appendix 4 on page 121 and about staff more generally is in Chapter 5 Our people.

Collaborating to achieve common objectives

In successfully performing our functions, we rely on forging and maintaining positive, productive relationships with many agencies and organisations across the Australian Government, state and territory governments, and non-government sectors. The multisectoral nature of our work is reflected in the statutory composition of the AIHW Board and the AIHW Ethics Committee and the diverse range of entities with which the AIHW has entered into agreements and memorandums of understanding (MoUs).

Australian Government

Department of Health

The AIHW is an independent corporate Commonwealth entity in the Health portfolio. The Institute has a strong relationship with the Department of Health. The AIHW provides the department with copies of all AIHW publications in advance of public release.

With the exception of work that must be put to competitive tender by the department, our work for the Department of Health is guided by an MoU between the 2 organisations. The department directly funds us to undertake significant additional projects beyond work funded through appropriation. During 2016–17, the parties extended the existing MoU arrangements for a further year and 1 month, to allow time for a new agreement to be finalised.

Department of Social Services

Our relationship with the Department of Social Services (DSS) is very important, particularly in areas such as housing and homelessness, disability services and child protection.

Under formal deed arrangements, the AIHW is data custodian of the department's Australian Government Housing Data Set and is a member of a panel of experts to support organisations funded under the DSS' Families and Children Activity. Additionally, an MoU guides work undertaken by the AIHW for the DSS that has not otherwise been subject to competitive tender. During 2016–17, the parties commenced discussions on arrangements to replace the MoU, which was due to expire on 30 June 2017.

We also provide the DSS with copies of all AIHW publications, relevant to DSS functions, in advance of public release.

Australian Bureau of Statistics

The AIHW interacts regularly with the ABS as a key partner on a range of activities. This relationship is enshrined in the AIHW Act, which provides that the collection of health- and welfare-related information and statistics by the AIHW requires the agreement of the ABS and, if necessary, its assistance. The Act also provides that the Australian Statistician (or their nominee) is a member of the AIHW Board.

The AIHW and the ABS are collaborators in a number of national information agreements with the Australian Government and state and territory governments, covering ongoing availability of health, community services, early childhood education and care, and housing and homelessness information.

Other Australian Government bodies

During 2016–17, we collaborated with many agencies in developing, collecting, compiling, analysing, managing and disseminating health and welfare data and information. These organisations included:

- **Australian Commission on Safety and Quality in Health Care:** the AIHW and the commission are parties to an MoU reflecting our joint commitment to working collaboratively towards a more informative and usable national system of information to enhance the safety and quality of health care. During 2016–17, the AIHW worked with the commission on data development activities and the Australian Atlas of Healthcare Variation.
- **Australian Institute of Family Studies:** The AIHW and the institute work collaboratively under an MoU acknowledging that the sharing of information and expertise is critical to effective and meaningful research by both bodies.
- **Cancer Australia:** The AIHW and Cancer Australia are parties to an MoU reflecting the commitment of both parties to work in a planned and coordinated manner (in consultation with partner organisations and stakeholders) to ensure that national cancer data needs are met effectively.
- **Department of Education and Training:** Our relationship with the Department focuses on areas such as the development of information on early childhood education and care.
- **Department of Human Services:** The AIHW and the department are parties to an agreement facilitating the sharing of advice and services in data and information areas where the agencies share common interests and responsibilities. This includes the provision of services to the department by the AIHW in our capacity as an accredited Commonwealth Data Integrating Authority.
- **Department of the Prime Minister and Cabinet:** The AIHW and PM&C are parties to an MoU that facilitates provision of data and information services by the AIHW to the department. During 2016–17, we provided services regarding Indigenous health expenditure and analysis of Indigenous health by region.
- **Department of Veterans' Affairs:** The AIHW and the department are parties to an MoU that reflects their commitment to the development of information sources for the delivery of world-class health-care policies and services to veterans. At an operational level, the MoU facilitates provision of services to the department, including research and analytical work, reporting, data linkage and integration and data custodianship. Over the next 3 years, the AIHW will expand this work through a whole-of-population approach to monitoring and reporting on the current status and future needs of veterans and their families.
- **Australian Taxation Office:** The AIHW and the Australian Taxation Office are parties to an agreement for the provision of re-identification risk management advice to facilitate researcher access to the Australian Longitudinal Individual File (aLife). This work aligns with AIHW strategic directions in making data accessible, while protecting privacy.
- **Independent Hospital Pricing Authority:** The AIHW's MoU with the authority supports cooperative work to improve national data on hospitals and exchange of hospitals-related data.

- **National Health Funding Body:** The AIHW and the funding body are parties to an MoU facilitating the exchange of information and assistance on matters of mutual interest, particularly with respect to data and information on public hospitals.
- **National Mental Health Commission:** The AIHW works with the commission under an MoU to source and analyse data for the commission's mental health and suicide prevention activities. We also provide technical assistance to the commission in formulating advice on national mental health performance reporting and monitoring issues.

State and territory governments

Much of the government services data reported by the AIHW at a national level are provided by state and territory government departments that fund those services. Close working relationships with state and territory governments are therefore critical to developing and reporting nationally consistent and comparable health and welfare data.

During 2016–17, we continued to engage with all jurisdictions through the various national and ministerial committees and forums charged with achieving this aim. We also maintained strong relationships with state and territory government departments, including those working under the auspices of the COAG.

The AIHW and numerous government entities from all jurisdictions are parties to national information agreements that underpin the activities of national information committees. Separate agreements cover health, community services, early childhood education and care, and housing and homelessness. The agreements ensure that effective infrastructure and governance arrangements are in place for the development, supply and use of nationally consistent data for each of these areas.

In engaging with other national committees in the areas of health, welfare and housing assistance, we focus on actively contributing evidence to policy debates and improving information arrangements. We contribute to these committees in various capacities; for example, as chair, member, observer and/or providing secretariat services.

Collaborating centres

During 2016–17, the AIHW had collaborating centre arrangements in place with 2 research organisations, based mainly at universities. These organisations were the:

- Australian Centre for Airways Disease Monitoring at the Woolcock Institute of Medical Research Ltd, which monitors asthma and linked chronic respiratory conditions and aims to help reduce the burden of asthma and other airways diseases by developing, collating and interpreting data relevant to airways disease prevention, management and health policy
- National Injury Surveillance Unit at Flinders University, which develops, analyses and reports national statistical information about injury and its control and contributes to the work of the World Health Organization (WHO) in developing the International Statistical Classification of Diseases and Related Health Problems, 11th Revision (ICD-11).

Other collaborations and partnerships

During 2016–17, we maintained and strengthened our engagement with allied organisations, including peak bodies and other national forums, to help satisfy their needs for information to assist policy development and program delivery.

Australian Research Council Centre of Excellence for Children and Families over the Life Course—under a multiparty agreement administered by the University of Queensland, the AIHW provides data and technical data expertise to assist activities undertaken by the collaborating parties.

University of Western Australia—under this arrangement, the AIHW participates in the Population Health Research Network—a network made possible through the National Collaborative Research Infrastructure Strategy. The strategy is administered by the Australian Government Department of Education and Training.

At an international level, the AIHW plays an important role in data standards and classifications work through the WHO's Family of International Classifications, and reports health statistics to the OECD.

During 2016–17, the AIHW and the Canadian Institute for Health Information (CIHI) continued to work together under an MoU to facilitate the temporary exchange of staff between the organisations.

Financial management

Financial management in the AIHW operates within the following legislative framework:

- *Australian Institute of Health and Welfare Act 1987*
- *Public Governance, Performance and Accountability Act 2013*
- *Auditor-General Act 1997*.

Our **internal** operations are funded by:

- parliamentary appropriations
- contributions from income received for project work undertaken for external agencies to provide corporate services for that work
- miscellaneous sources, such as bank interest, ad hoc information services and publication sales.

These funds are allocated in a detailed budget process conducted in May–June each year. Funds are spent on:

- project work undertaken by our statistical groups
- collaborations with universities that undertake specialist activities
- corporate services, such as financial, human resources, executive support, governance and legal, records management, business improvement services, communications and ICT services.

Our **externally funded** project work is undertaken by the AIHW's statistical groups for external agencies. The fees charged for each project are determined using a pricing template set to cover our costs, which include salaries and on-costs, other direct costs and a corporate cost-recovery charge which recovers infrastructure and corporate support costs. The template is updated on an annual basis. Expenditure incurred in each project is accounted for separately and monitored monthly.

Purchase contracts

For purchase contracts with suppliers, we use, wherever possible, template contracts prepared by legal advisers. These template contracts aim to manage risks and ensure value for money through provisions, such as: deliverables and performance standards linked to milestone payments; necessary insurances and indemnities; intellectual property ownership and requirements; and requirements for privacy and confidentiality.

Purchase contract payments are typically linked to delivery of services to a satisfactory standard.

Procurement requirements

The AIHW is required by section 30 of the Public Governance, Performance and Accountability Rule 2014 to comply with the Commonwealth Procurement Rules, which established requirements for Australian Government entities regarding their procurement activities. The procurement rules are available at www.finance.gov.au/procurement/procurement-policy-and-guidance/commonwealth-procurement-rules/.

The AIHW must comply with the mandatory procedures for all procurements above the $400,000 threshold.

We complied with our obligations under the procurement rules during 2016–17.

Revenue contracts

Most revenue contracts were for provision of services related to projects being managed by our statistical units.

Our revenue contracts and standard schedules for MoUs detail the scope, timing, deliverables and budget for most externally funded projects we undertake.

Contract approval

Purchase and revenue contracts, involving receipt or payment of amounts more than $3 million, must be approved by the Minister for Health.

Any contract over $200,000 ($100,000 in 2015–2016) must be approved by the Director (CEO).

Risk oversight and management

Effective risk management is integral to the AIHW's business operations. During the year, we twice updated our register of significant organisational risks and necessary mitigation actions in accordance with our Risk Management Framework. Both updates were reviewed by the Audit and Finance Committee and considered by the board. We also prepared a statement of risks of special relevance to board members. At the operational level, project managers are now required to identify, assess and monitor risks related to their project and record them in our project management system.

Areas of risk that we monitor closely include:

- the AIHW's position as a major national agency providing information and statistics on health and welfare matters, including
  - clarity of our purpose
  - our reputation for accurate, independent and timely reporting
  - relationships with funders, data providers and other stakeholders
  - security over confidentiality of data
- the AIHW's ability to attract and retain highly skilled staff
- the AIHW's commercial operations, including
  - financial matters, such as external funding, cash flow, cost management and appropriate internal controls
  - up-to-date and effective technology
  - the effectiveness of organisational operations and planning.

The AIHW Fraud Control Plan 2017–19 adopts a proactive approach to minimising the potential for instances of fraud within the AIHW. It contains appropriate fraud prevention, detection, investigation, reporting and data collection procedures and processes to meet the specific needs of the AIHW and comply with the Commonwealth Fraud Control Guidelines.

We engage external contractors to perform our internal audit function. In 2016–17, the internal auditors, Protiviti, completed 4 internal audits (see 'Audit and Finance Committee' on page 56).

The AIHW has a wide range of its own policies and practices to reduce and manage business risks, including those relating to:

- business continuity
- corporate governance
- data governance and management
- data custody
- data linkage
- embargoed release of reports and other information products
- ethical clearance
- financial delegations and guidelines
- fraud control
- indemnities for officers
- information privacy, confidentiality and reliability
- information security
- media engagement
- physical security
- publications review and refereeing
- record keeping
- social media
- tenders and procurements
- work health and safety

During 2016–17, we:

- engaged a consultant to review internal processes with a view to streamlining them
- began work to review our guidelines for the custody of data
- provided workforce reports to the AIHW Board every 6 months.

Protecting privacy

The AIHW protects the privacy of the information it holds under a comprehensive set of data governance arrangements involving designated data custodians, the AIHW Ethics Committee, audit activities and physical and IT security. These multiple layers of defence ensure that data are accessed only by authorised personnel for appropriate purposes in a secure environment.

Visit www.aihw.gov.au/privacy-of-data/ for a general overview of how the AIHW protects the privacy of individuals, and the Institute's data custody and governance arrangements.

Data governance

Our Data Governance Framework identifies and provides an overview of the AIHW's robust data governance arrangements, including:

- a description of key concepts in data and data governance
- the legal, regulatory and governance environment in which the AIHW operates
- core data governance structures and roles
- an overview of AIHW data-related policies, procedures and guidelines
- systems and tools supporting data governance
- compliance regimes.

These data governance arrangements apply to:

- data collected and/or enhanced by the AIHW
- data collected on behalf of others (for example, under collaborative or contractual agreements)
- data obtained from all external sources.

The framework and a short overview document are available at www.aihw.gov.au/data-governance-framework/.

Our Data Governance Committee establishes an annual work plan of data governance activities, makes appropriate operational decisions, and provides advice and recommendations to the AIHW Executive Committee.

In 2016–17, the Data Governance Committee met 5 times, convened 2 data custodian forums to discuss matters of interest and issues affecting AIHW data custodians, and reported regularly to the Executive Committee on the delivery and/or progress on a range of projects in its work plan. These included: the development of checklists for data custodians to provide greater guidance on key responsibilities and the documentary evidence required for audit purposes; a stocktake of data-related policies and guidelines and advice regarding their review; improvements to the AIHW's internal data catalogue; and the development of enhanced information on the AIHW's data holdings for publication on the AIHW's redeveloped website to be released in the latter part of 2017.

Data security

Data security at the AIHW is a high priority and is constantly adjusted to meet the changing needs of the organisation in response to any emerging security threats and vulnerabilities, security standards and measures required of government agencies and available technology solutions to deal with security issues.

Actions undertaken during the year to further improve our data security arrangements included:

- reviewed compliance with the Australian Signals Directorate mandatory top 4 security requirements
- trained and certified 1 security specialist on staff.

The AIHW's data holdings continue to grow and we have expanded our range of products and services. At all stages of data handling, from transfer, data management and storage to release of data, the AIHW has in place appropriate governance and security policies and practices. No data breaches have been experienced in the reporting period.

Freedom of information

In accordance with section 11C of the *Freedom of Information Act 1982* (FOI Act), the AIHW is required to publish information that has been released in response to an freedom of information access request. The AIHW is not required to publish:

- personal information about any person if publication of that information would be 'unreasonable'
- information about the business, commercial, financial or professional affairs of any person if publication of that information would be 'unreasonable'
- other information, covered by a determination made by the Australian Information Commissioner, if publication of that information would be 'unreasonable'
- any information if it is not reasonably practicable to publish the information because of the extent of modifications that would need to be made to delete the information listed in the above points.

In 2016–17, the AIHW published the details for 1 request made under the FOI Act. Details of freedom of information requests and records accessed under the FOI Act are published in the disclosure log on the AIHW website: www.aihw.gov.au/foi-disclosure-log/.

Information Publication Scheme

The FOI Act established the Information Publication Scheme for Australian Government agencies subject to the FOI Act. Under the scheme, agencies are required to publish a range of information, including an organisational chart, functions, annual reports and certain details of document holdings.

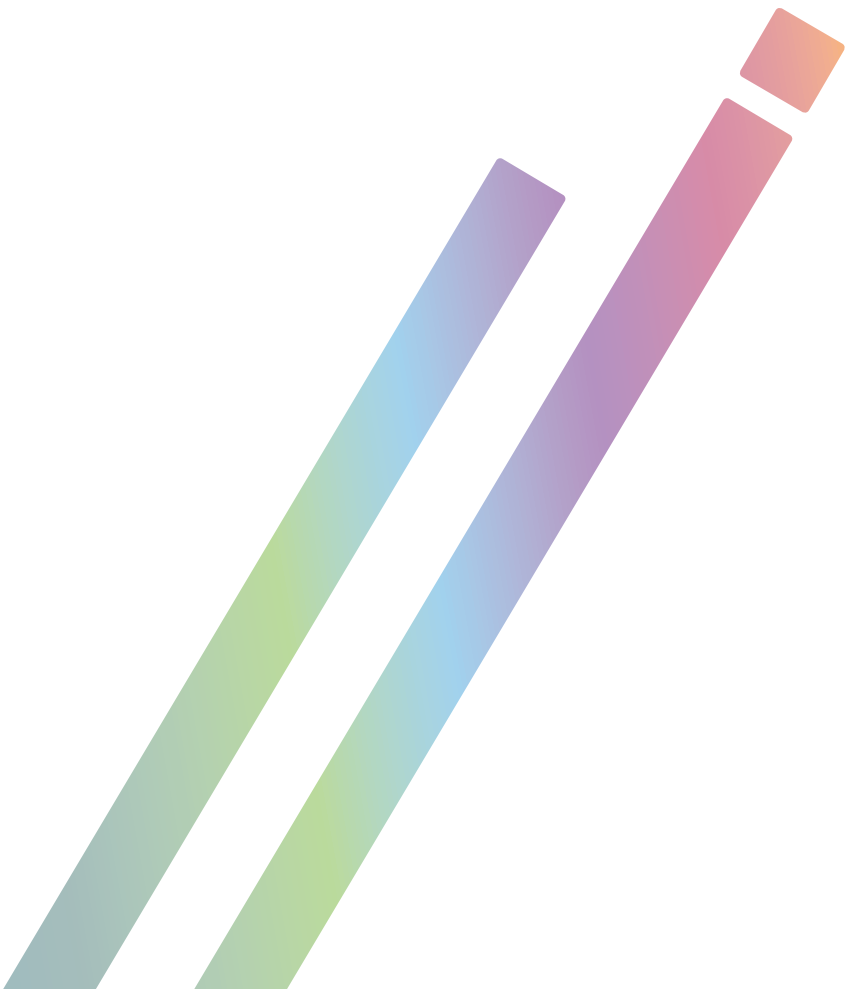
The required information is published at www.aihw.gov.au/ips/.

Enquiries

Enquiries about making a formal request under the FOI Act should be emailed to foi@aihw.gov.au.

Freedom of information requests should be sent to:

FOI Contact Officer
Governance Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601



Chapter 5

Our people

This chapter details our staffing profile and workforce strategies.

Our people

Our people are our greatest strength and we are committed to ensuring that AIHW's workplace continues to attract, develop and retain the right people with the right skills. These efforts are supported by the AIHW Enterprise Agreement (EA) 2016, which came into effect in October 2016.

Staff profile

Employment numbers and categories

We employed 344 active staff at 30 June 2017—compared with 310 active staff at 30 June 2016 (Table 5.1). The number of active full-time equivalent staff increased from 286.6 at 30 June 2016 to 318.0 at 30 June 2017. The numbers shown in Table 5.1 are for AIHW staff engaged under the *Public Service Act 1999* and do not include contract staff. As at 30 June 2017, the AIHW employed 17 contract staff which represents 4.7% of our active staff.

Table 5.1: Active staff and total staff, 2013–2017

	30 June 2013	30 June 2014	30 June 2015	30 June 2016	30 June 2017
			Number		
Active staff	343	322	308	310	344
Staff on long-term leave	20	25	31	37	25
Total staff	**363**	**347**	**339**	**347**	**369**
			Full-time equivalent		
Active staff	313.5	297.4	284.8	286.6	318.0
Total staff	**331.3**	**319.6**	**313.9**	**321.6**	**342.2**

Note: 'Staff on long-term leave' refers to staff on any form of continuous leave for more than 3 months—for example, long-service leave and maternity leave.

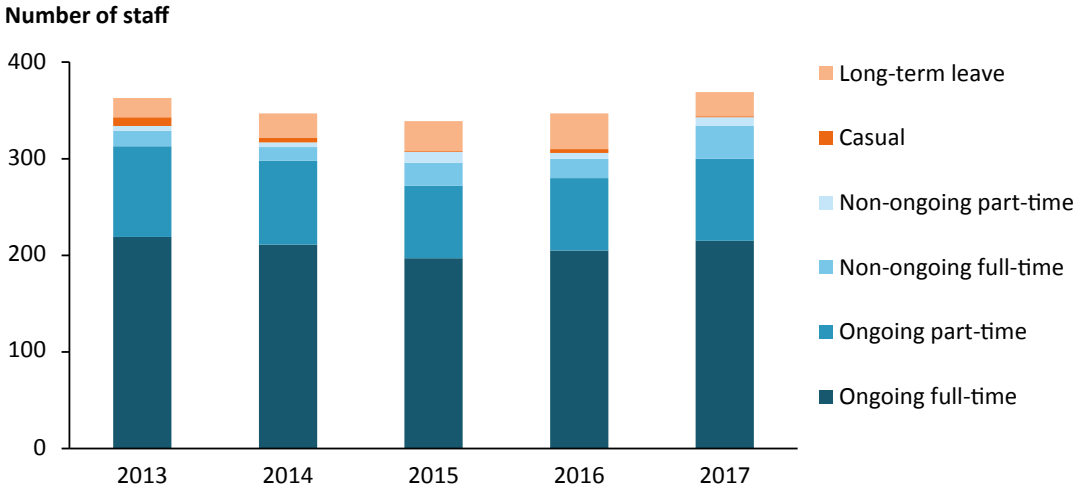
The number of staff on long-term leave of more than 3 months decreased to 25 at 30 June 2017, compared with 37 a year earlier.

Of our active staff at 30 June 2017:

- 300 (87%) were ongoing employees—an increase from the 280 (90%) level of a year earlier
- 94 (27.3%) worked part-time—a slight increase compared with 81 (26%) at 30 June 2016 (Figure 5.1).

Table 5.2 Staff numbers 2013–2017

	30 June 2013	30 June 2014	30 June 2015	30 June 2016	30 June 2017
			Number		
All Staff	363	347	339	347	344
Female Staff	251	241	237	241	234
Male Staff	112	106	102	105	110
Person who does not exclusively identify as male or female	. .	. .	. .	1	. .
All (Full-time equivalent)	331.3	319.6	313.9	321.6	318



Note: Staff in all categories except the long-term leave category are 'active'.

Figure 5.1: Category of staff employment, 2013–2017 (30 June)

Classification level

Of our active staff at 30 June 2017, 33% (112 staff) were classified and employed as Executive Level 1 (EL 1) officers and 27% (93 staff) were employed as APS 6 officers (Figure 5.2).

The percentage of active APS (2–6) level full-time equivalent (FTE) staff decreased for the first time in 3 years to 54%. EL FTE staff increased slightly to 43.0% compared with 42.5% at the same time last year. The most notable change between the previous and current year relates to APS 5 staff, where the percentage decreased slightly. All other classification levels remained relatively stable.

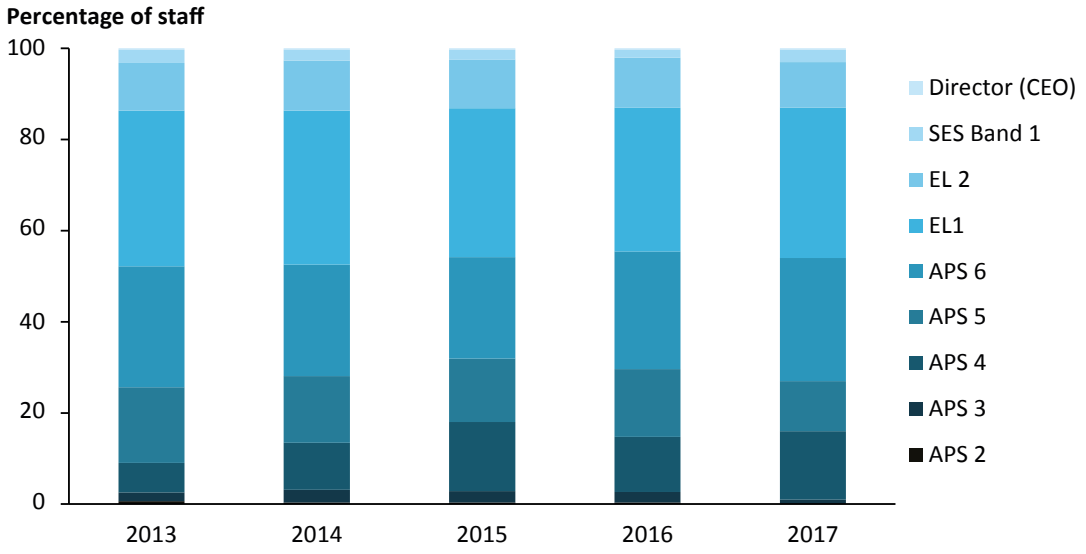


Figure 5.2: Active FTE staff by classification level, 2013–2017 (30 June)

By role

Of our active staff at 30 June 2017, 275 (80%) were employed in statistical work–related functions and 69 (20%) were employed in corporate support work–related functions, including IT, finance, governance, publications and media.

Workforce management

We aim to attract and retain talented staff by offering challenging and fulfilling work, competitive salaries, flexible working conditions, excellent learning and development opportunities, and a friendly and inclusive work environment.

Staff commencements and turnover

Forty-two new employees commenced ongoing employment with the Institute during 2016–17 (Table 5.2), of which 14 were in our 2016–17 graduate intake.

A total of 37 ongoing employees left the AIHW during 2016–17; 8 moved to another APS agency, including 1 who moved on promotion. Of the remaining 29 staff, 1 sadly passed away, 21 resigned and 7 retired. This equates to an 12.3% turnover rate for ongoing staff in 2016–17, a 3.0% decrease from the 2015–16 rate of 14.6% and a slight increase on the 9.9% rate in 2014–15.

Table 5.3: Commencements and separations of ongoing staff, 2016–17

Type	Number
Ongoing staff at 30 June 2016	**316**
• Staff engaged from outside the APS	+24
• Staff moving from another APS agency	+18
Total commencing staff	***+42***
• Staff separating through resignation	–21
• Staff separating through retirement	–7
• Deceased	–1
Sub-total separating staff	*–29*
• Staff who moved to another APS agency on transfer	–7
• Staff who moved to another APS agency on promotion	–1
Total exiting staff	***–37***
Ongoing staff at 30 June 2017	**321**

Notes

1. 'Ongoing staff' refers to staff employed on an ongoing basis, whether active or on long-term leave.
2. Staff aged 55 and over who resigned from the APS are counted as having retired.

AIHW graduate intake

Our annual graduate intake remains a key strategy for building the AIHW's workforce capability. We offer excellent employment opportunities for suitable graduates seeking to apply their qualifications in the fields of health and welfare information.

Of the 14 graduates employed in the 2016–17 intake, 9 relocated from interstate/overseas. Of the 7 graduates employed in the 2012–13 intake, 4 remain at the AIHW (Table 5.3).

Table 5.4: Graduate recruitment intake and outcomes, 2012–13 to 2016–17

	2012–13	2013–14	2014–15	2015–16	2016–17
Graduate intake (all at APS 4 level)	**7**	**8**	**8**	**21**	**14**
Graduates remaining at the AIHW at 30 June 2017	**4**	**6**	**5**	**17**	**14**
• as an APS 4	—	—	2	14	14
• promoted to APS 5	2	—	1	1	—
• promoted to APS 6	2	6	2	2	—

Managing performance and behaviour

Our Managing for Performance Policy recognises that regular constructive feedback encourages good performance, enhances continuing development and encourages employees and managers to communicate with each other informally and regularly about performance matters. The policy also affirms that performance management is a core activity at the AIHW that is embedded in all management functions.

Annual Individual Performance Agreements (IPAs) are designed to align individual performance to our strategic priorities, with the overall aim of improving individual and organisational performance. IPAs also focus on individual learning and development needs and broader APS career development. AIHW policy requires a current IPA to be in place for existing staff by July–August each financial year and, for new employees, within 3 months of their commencement at the Institute.

Recognising diversity

We continue to recognise and support the diversity of our staff. The EA provides flexible working and leave arrangements to support employees' caring responsibilities, religious commitments and attendance at events of cultural significance, including Institute-organised activities that commemorate Indigenous histories, cultures and achievements.

The Wiradjuri Echoes performing at the National Aborigines and Islanders Day Observance Committee celebrations held on 7 July 2016.

Figure 5.3 compares the proportions of AIHW staff with APS staff overall in terms of identifying as being of Aboriginal and/or Torres Strait Islander background, having a disability, and being from a non-English-speaking background. It also displays the proportion of staff who are women, and staff aged 50 and over. The AIHW continues to exceed the APS average for employment of women, but we are below average for employment of staff aged 50 and over, Indigenous staff and staff with a disability. As a result, the AIHW will continue to look at strategies to increase representation in each of these diversity areas.

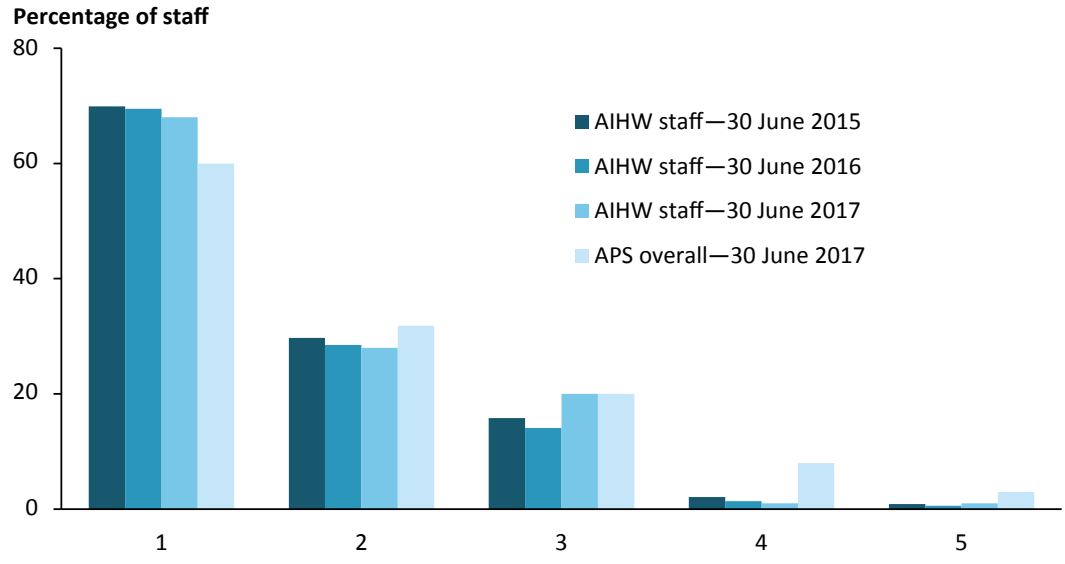


Figure 5.3: Staff diversity groups, 2015– 2017 (30 June)

Women comprised more than two-thirds of our total active staff (68%). Among our active staff, 4 of our 7 substantive Senior Executive Service (SES) Band 1 staff were women, and women represented 65% of our EL staff.

We maintain a Workplace Diversity Program aimed at ensuring that we:

- recognise, foster and make best use of the diversity of our employees within the workplace
- help employees to balance effectively their work, family and other caring responsibilities
- comply with all relevant anti-discrimination laws.

The Institute has a Reconciliation Action Plan and has appointed 2 members of the Senior Executive group to the roles of Disability Champion and Indigenous Champion.

Employment frameworks

As at 30 June 2017, all non-SES staff were employed under the AIHW's EA. Eight SES staff members were employed under common law contracts.

Enterprise Agreement

A new 3-year EA was approved and commenced on 19 October 2016. It has a nominal expiry date of 18 October 2019. The EA outlines the terms and employment conditions of non-SES employees of the AIHW.

Remuneration

Salary ranges based on classification level from our current EA are shown in Table 5.5. The AIHW's remuneration arrangements do not provide access to, or include, performance pay.

Table 5.5: AIHW EA salary range for APS and EL employees, 30 June 2017

	Salary points ($)	
	Lowest	Highest
APS 1	43,361	48,642
APS 2	50,423	55,232
APS 3	57,346	62,746
APS 4	64,277	69,617
APS 5	71,660	76,755
APS 6	80,374	88,851
EL 1	98,306	109,662
EL 2	120,308	135,205

Individual flexibility arrangements

Our EA contains provisions for flexible arrangements to enable tailoring of remuneration and conditions for individual employees in particular circumstances. As at 30 June 2017, 2 non-SES staff had individual flexibility arrangements in place.

SES terms and conditions

The terms and conditions of employment for SES staff , including remuneration, are contained in common law contracts. They provide for salary entitlements, as well as non-salary benefits relating to leave arrangements and entitlements, superannuation, salary sacrifice, travel and allowances. As at 30 June 2017, the ranges within which the AIHW Director could set salaries were $164,800 to $190,550 for SES Band 1 and $200,000 to $230,000 for SES Band 2.

Engaging with staff

We recognise the importance of engaging with staff in decisions that affect them. This leads to better service delivery, use of resources, overall performance and staff experiences. Our staff consultative arrangements include several formal committees.

Consultative Committee

The Consultative Committee is the principal forum through which formal consultation and discussions on workplace relations matters take place between management and employees.

Consultative Committee processes support the change management and consultation obligations outlined in the Institute's EA. The committee discusses workplace relations matters in a spirit of cooperation and trust.

The committee met 4 times during 2016–17. A key focus was discussion of proposed changes to a number of human resources policies following the introduction of the new EA, and the impacts and performance of technology to assist staff with their work.

Health and Safety Committee

The Institute maintained a Health and Safety Committee during 2016–17 as required by ss. 75–79 of the *Work Health and Safety Act 2011* (WHS Act). The committee facilitates cooperation between management and employees in initiating, developing and carrying out measures designed to ensure the health and safety of our people at work.

The committee met 4 times during the year and, among other matters, reviewed the work health and safety (WHS) policy statement and the Health and Safety Management Arrangements.

Learning and Development Advisory Committee

The Learning and Development Advisory Committee provides strategic direction for, and enables stakeholder input to, the planning and delivery of the AIHW learning and development program and initiatives across the Institute. The committee comprises representatives from each of the AIHW groups. The committee met 3 times during the year.

Social Club

The Institute has an active Social Club, which focuses on coordinating social activities and events to help foster a positive and collaborative workplace environment. The Social Club comprises members that include a Senior Executive sponsor and staff from the latest graduate intake each year. The members take the lead in organising the annual staff Christmas party and other events held throughout the year.

Recognising and building expertise

We recognise and make good use of the high levels of education and skills of our staff, both of which are critical to performing effectively the complex work of the Institute.

Staff qualifications

The AIHW values the professional capability of AIHW staff. Eighty per cent of our staff work directly on statistical and data-related work: preparing and linking data sets and undertaking data analysis. Of these at the end of April 2017, a high percentage (almost 88%) are tertiary qualified, we had 155 staff with postgraduate study (23 doctorates, 105 masters degrees and 27 graduate diplomas).These figures include staff on long-term leave.

External study

A study assistance scheme is available to reimburse employees for approved courses of study for a recognised qualification relevant to their work at the AIHW. Nineteen staff received assistance for formal study during Semester 2, 2016 and Semester 1, 2017. Areas of study included economics, statistics, public health, nutrition and dietetics, and clinical psychology.

Corporate learning and development program

We continue to invest in the learning and development of all our staff, including formal induction programs for all new employees.

Our program of in-house training sessions complements on-the-job training and helps ensure that staff develop and maintain specialised knowledge and skills. We provided 44 in-house courses on 78 occasions during 2016–17 under the Institute's Corporate learning and development program. These courses were attended by 871 staff in total (with some staff attending more than 1 course). The 2016–17 program continued to focus on key learning activities related to the work of the AIHW, including written communication, report writing, statistical and data analysis, project management and leadership.

Staff were also provided with regular opportunities throughout 2016–17 to attend other training courses and seminars relevant to their roles.

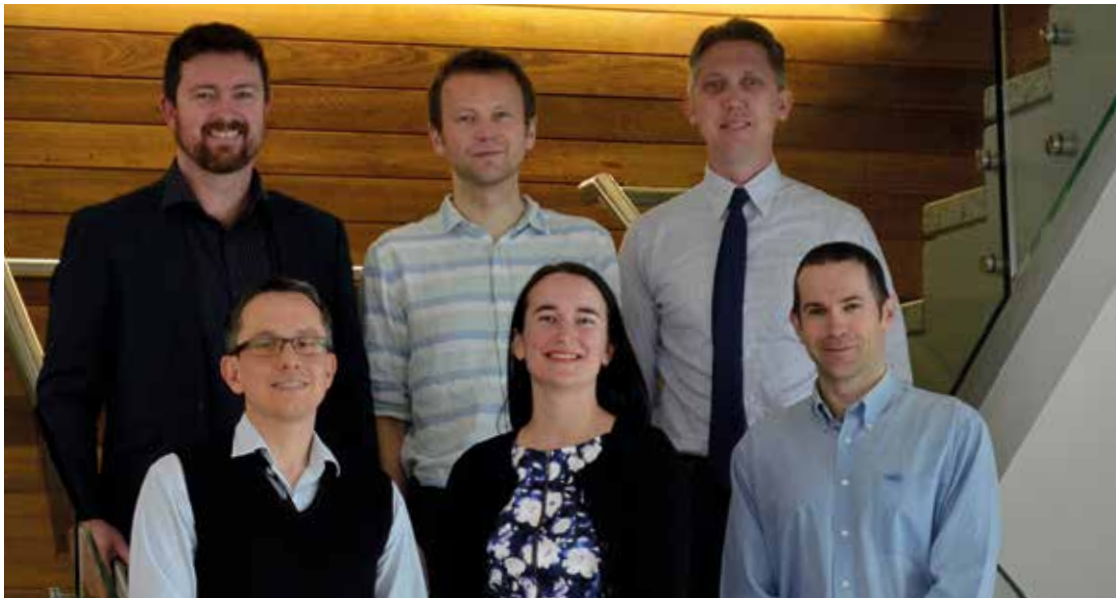
SAMAC conversations

The Statistical and Analytical Methods Advisory Committee (SAMAC) holds regular 'conversations' which aim to provide a forum for staff to:

- access relevant expertise
- discuss emerging practices and their implications
- share innovative and potentially reusable practices
- broaden their knowledge of the work of the Institute
- hone their skills in strategic conversation
- develop habits of constructively giving and receiving feedback on analytical issues.

Eight conversations were held in 2016–17. The topics discussed included:

- quality management frameworks—how to apply them in the AIHW context
- dark data—a conversation about the detective work required to open up old data
- influenza surveillance project—a discussion about the methodology used and whether it has further application for AIHW data.



AIHW staff who presented SAMAC conversations.
Front row (left to right): Leo Carroll, Alice Crisp and David Whitelaw.
Back row (left to right): Adrian Webster, Martin Edvardsson and Nick Von Sanden.
Absent: Geoff Neideck, Eden Brinkley and Sadie Law.

Institute Awards

The AIHW Institute Awards recognise exceptional individual and team contributions to the Institute. In 2017, new criteria for assessing nominations were introduced to recognise excellence in supporting 1 of the new strategic goals, and excellence in delivering and/or supporting AIHW services and products. All staff were invited to nominate an employee or team for the awards, with the final decision as to the successful candidates made by the AIHW Director.

Institute Awards were given out to 6 staff and 6 teams in 2016–17 (tables 5.6a and 5.6b).

Table 5.6a: Institute Awards, October 2016

Name	For enhancing the AIHW's reputation and innovation through:
Peita Bonato	outstanding work in the provision of expert metadata advice, training and assistance, and identification of new and innovative opportunities for improvement to METeOR.
Cathy Claydon	outstanding work in delivery of the 2016 National Drug Strategy Household Survey.
David Meere	enhancing the AIHW's reputation as a professional organisation by providing innovative research in data linkage in bowel cancer screening.
'Exploring drug treatment and homelessness in Australia' report team	an outstanding collaborative approach to delivering innovation and enhancing the AIHW's reputation.
'Online report card to measure Australia's progress against the National Framework for Protecting Australia's Children and the National Out-of-Home Care Standards' team	an outstanding collaborative approach to delivering innovation and enhancing the AIHW's reputation.
Team establishing the MBS/PBS data holding	an outstanding collaborative approach to delivering innovation and enhancing the AIHW's reputation in establishing the MBS/PBS data holding.

Institute Award recipients.
David Meere.
Absent: Peita Bonato and Cathy Claydon.

'Exploring drug treatment and homelessness in Australia' report team.
Left to right: Louise Tierney, Lauren McFarlane and Kristina Da Silva.
Absent: Mark Petricevic and Amelia Armstrong.

Table 5.6b: Institute Awards, April 2017

Name	For excellence in meeting 1 of the new strategic goals, and excellence in delivering and/or supporting AIHW services and products through:
Bill Watson	provision of expertise in mapping skills, particularly to the Australian Atlas of Healthcare Variation.
Joanne Paine	expertise in metadata, providing a valuable resource for all internal and external stakeholders seeking to improve data quality statements, collection specifications, and data standards in general.
Marissa Veld	single-handedly managing the operational aspects of establishing a Family, Domestic and Sexual Violence Unit at the AIHW, through extensive stakeholder engagement and demonstration of subject and data expertise.
Youth Justice team	being leaders in health and welfare data, drivers of data improvement and expert sources of value-added analysis.
Veterans suicide project team	tireless work to provide high-quality data linkage, analysis and presentation of very complex and sensitive information in producing the first ever estimates of suicide rates among the veteran population in Australia.
Hospitals Analysis Unit	being expert sources of value-added analysis for the *Second Australian Atlas of Healthcare Variation*, which is to be a joint publication of the Australian Commission on Safety and Quality in Health Care and the AIHW.

Institute Award recipients.
Left to right: Marissa Veld and Bill Watson.
Absent: Joanne Paine.

Hospitals Analysis Unit.
Front row (left to right): Caleb Leung and David Bulbeck.
Back row (left to right): Shubhada Shukla, Sally Mills and Barbara Gray.

Youth Justice team.
Front row (left to right): Kirsten Morgan and David Braddock.
Back row (left to right): Rachel Aalders, Josh Sweeney and Callin Ivanovici.

Veterans suicide project team.
Front row (left to right): Jeanette Tyas, Tylie Hodder, Mardi Ellis and Michelle Gourley.
Back row (left to right): Anna Reynolds, David Whitelaw, Ann Hunt and Phil Anderson.
Absent: Sadie Law.

Long-serving staff

During the year, 14 staff were presented with service awards. Thirteen staff were recognised for their 10 years of service, while 1 staff member, Ms Joanne Maples, was recognised for her 30 years of service at the Institute (Table 5.7).

Table 5.7: Staff long-service anniversary recognition, 2016–17

10 years	10 years	30 years
Rachel Aalders	Nicole Hunter	Joanne Maples
Denise Arnold	Andrew Kettle	
George Bodilsen	Jane McIntyre	
David Bulbeck	Tony Mole	
Lynda Carney	Andrew Tharle	
Alice Crisp	Richard Tuttle	
Melissa Goodwin		

Staff who were recognised in 2016–17 for reaching their 10-year service anniversaries.

Front row (left to right): Denise Arnold, David Bullbeck and Andrew Kettle.

Back row (left to right): Lynda Carney, Andrew Tharle and George Bodilsen.

Absent: Alice Crisp, Tony Mole, Jane McIntyre, Melissa Goodwin, Nicole Hunter, Rachel Aalders and Richard Tuttle.

Staff member recognised in 2016–17 for reaching her 30-year service anniversary.

Joanne Maples.

Staff exchanges

In January 2016, the AIHW extended to 30 June 2018 its MoU with the CIHI. CIHI was established as an independent, not-for-profit corporation to provide essential information on Canada's health system and the health of Canadians.

Through this non-binding MoU, the 2 organisations seek to provide for the reciprocal exchange of specialised knowledge about business practices and processes, the sharing of new initiatives and the transfer of expertise, primarily through the temporary exchange of employees.

In March 2017, the AIHW was very pleased to welcome 2 CIHI employees on secondment to the AIHW, each for an initial period of 12 months.

- Ms Candace Sheppard joined us from Montreal, and has a biomedical and health sciences background, with a master's degree in epidemiology where she looked at racial and socioeconomic disparities in cervical cancer survival (in the United States of America). She is working with the Indigenous Analyses and Reporting Unit on the hearing health and dental reports for the Northern Territory.

CIHI employees on secondment to the AIHW.
Left to right: Candace Sheppard and Eric Pelletier.

- Mr Eric Pelletier joined us from Ottawa and he has worked at CIHI for more than 11 years. He holds a Bachelor of Science in Physiotherapy and a certificate in Oracle database administration. He is also currently pursuing a Master of Science in Information Systems through distance education. He is working in our Statistical and Analytical Support Unit.

Also in March 2017, Mr Mark Petricevic started a 12-month secondment at CIHI in the position of Senior Analyst, Health Systems Research. Mr Petricevic, who has worked at the AIHW for more than 7 years, is based in CIHI's Toronto office.

Encouraging work health and safety

We are committed to maintaining a productive and safe work environment for all staff and to meeting our obligations under the WHS Act. Senior managers, supervisors, Health and Safety Representatives, the Health and Safety Committee, and all AIHW staff work cooperatively to ensure that WHS risks are effectively managed.

Initiatives and outcomes

During the year, we continued to focus on early prevention strategies. All staff have sit-stand workstations and professional training in initial workstation set-up.

The Institute also introduced several other initiatives during the year to ensure WHS, and to advance the overall wellbeing of staff. Table 5.8 provides a summary of these key WHS initiatives undertaken during 2016–17.

Table 5.8: Key WHS initiatives, 2016–17

Initiative	Outcomes
Resilience in the Workplace	1 course, 8 attendants
Mental Health Awareness Training	1 course, 18 attendants
Work Health and Safety, Roles and Responsibilities	1 course, 11 attendants
Health and Safety Committee Training	1 course, 5 attendants
A Supervisor's WHS Responsibilities	1 course, 7 attendants
Harassment Contact Officer Training	1 course, 5 attendants
Working with Change	1 course, 15 attendants
Employee Assistance Program	Staff utilisation rate: 10.6% (for 1 March 2016 to 28 February 2017)
Flu vaccinations	187 vaccinations were administered to staff (representing 50% of total active staff in April 2017)
Stroke assessment	66 staff participated in a free service, to-check their risk of experiencing a stroke (an initiative trialled in 2017)
Discounted gym membership	42 staff used this membership option (at 30 June 2017)

Rehabilitation Management System self-assessment

An external audit of the Institute's Rehabilitation Management System (RMS) was undertaken in late 2015, consistent with Comcare's Guidelines for Rehabilitation Authorities 2012. Having determined that the Institute is a 'low-risk' agency (based on parameters outlined in Comcare's guidelines), an annual audit was not required; however a 'self-assessment' using the RMS audit workbook was completed in early 2017. This was to ensure the Institute maintains a mechanism for identifying any weakness within the RMS.

The self-assessment found that the AIHW's RMS conformed to all applicable criteria outlined in the audit workbook.

Incidents and compensation

Despite the active promotion and implementation of various prevention measures, some workplace incidents/injuries occurred.

In 2016–17, 3 new compensation claims were lodged with Comcare (2 accepted, 1 denied), compared with 5 claims lodged in 2015–16 (3 accepted and 2 denied), 4 claims lodged and accepted in 2014–15, 3 claims lodged (2 accepted) in 2013–14 and 2 claims lodged and accepted in 2012–13.

Of the 2016–17 claims, 1 related to a psychological condition and 2 were for physical conditions.

Notifiable incidents and investigations

Under the WHS Act, the AIHW is required to notify Comcare (the regulator) when incidents occur that involve the death of a person, a serious injury or illness, or a dangerous incident as detailed in the WHS Act.

No incidents were notified to Comcare during the year.

Workplace inspections and Comcare investigations

During the year, our Health and Safety Representatives and staff responsible for facilities carried out 4 workplace inspections. These inspections occur about a fortnight before Health and Safety Committee meetings to enable findings and recommendations to be considered and actioned quickly. Changes made during 2016–17 were minor, such as the removal of trip hazards, improved health and safety signage and environmental measures, such as installation of new blinds and adjustments to the air conditioning.

No investigations by Comcare were conducted in 2016–17. No directions, notices, offences or penalties were served against the AIHW under the WHS Act.

Accommodation and energy efficiency

In Canberra, the AIHW operated from a single office building during 2016–17, located at 1 Thynne Street, Bruce. The AIHW is in the third year of a 15-year lease on a purpose-built 3-storey building. The building is designed to achieve a 4.5-star National Australian Built Environment Rating System (NABERS) rating.

Our Sydney-based staff operate from a small office at Level 9, 1 Oxford Street. The lease of these premises expires in May 2018.

Tables 5.9 and 5.10 provide more information on our efforts to reduce AIHW's impact on the environment.

Ecological sustainable development

We uphold the principles of ecologically sustainable development outlined in the *Environment Protection and Biodiversity Conservation Act 1999* and are committed to making a positive contribution to achieving the objectives of the legislation (see tables 5.8 and 5.9). Section 516A(6) of the Act requires the AIHW to report on environmental matters, including ecologically sustainable development.

Table 5.9: Ecologically sustainable development reporting, 30 June 2017

Reporting area	Activities undertaken by the AIHW
Legislation administered during 2016–17 accords with the principles of ecologically sustainable development	The AIHW does not administer legislation.
The effect of the AIHW's activities on the environment	The AIHW's key environmental impacts relate to the consumption of energy and goods, and waste generated by staff in the course of business activities. Table 5.9 includes available information on energy consumption and recycling of waste.
Measures taken to minimise the impact of AIHW activities on the environment in our main office in Canberra	Provision of amenities for staff who ride bicycles to work. Use of energy-efficient lighting, including the installation of light-emitting diode lighting in selected areas. Purchasing 10% GreenPower electricity. Purchasing only energy-efficient equipment that is Energy Star compliant. 'Shutting-down' multifunctional devices when they are left idle for long periods. Movement-activated lighting that turns off after 20 minutes of no movement being detected. Double-glazed windows to increase the efficiency of heating and cooling. Installation of a modern, efficient air-conditioning system. Installation of a rainwater tank system to supply the toilets, urinals and external taps. Recycling of toner cartridges and paper. Purchasing only paper with at least 50% recycled content for printing and copying. Re-use of stationery items such as ring binders. Recycling bins in AIHW kitchens for collection of organic waste. Printing of our publications using 'print-on-demand' processes is done using paper sourced from sustainably managed, certified forests in accordance with ISO14001 Environmental Management Systems and ISO9001 Quality Management Systems.
Mechanisms for reviewing and improving measures to minimise the impact of the AIHW on the environment	During 2016–17, the AIHW worked to comply with benchmark environmental impact indicators at 1 Thynne St, which is designed to achieve a 4.5-star NABERS rating.

The AIHW continues to manage its toner cartridge recycling and use of paper through central printing pools in the buildings, increased use of the Institute's online project management system and increased staff use of a redeveloped intranet site.

Table 5.10: Energy consumption and recycled waste, 2012–13 to 2016–17

	2012–13	2013–14	2014–15	2015–16	2016–17
Energy consumption					
Electricity Canberra (kilowatt hours, as office tenant light and power)[(a)]	858,439	753,153	630,093	689,494	701,147
Sydney office					69,238
Paper Canberra (reams)	3,380	2,570	1,620	1,605	1,927
Sydney office					55
Recycled waste					
Organics from kitchens (tonnes)	1.8	2.4	2.5	2.3	2.3
Toner cartridges Canberra (number)	331	329	74	81	70
Sydney office					8

(a) Office air-conditioning is metered to the base building while light and power are separately metered.
(b) The above figures are for both the Canberra and Sydney offices.

Government greenhouse and energy reporting

The Australian Government's Energy Efficiency in Government Operations policy helps government agencies to identify opportunities to save energy. The AIHW is required to comply with the policy because it derives more than half the funds for its operations from the Australian Government, either directly or indirectly.

The policy requires agencies to comply with certain minimum energy performance standards, including the requirement that eligible new leases contain a Green Lease Schedule with at least a 4.5-star NABERS energy requirement. As outlined earlier in this chapter, the lease agreement for our Canberra office meets this requirement. The Sydney office is exempt from this policy as the area leased is less than 2,000 square metres.

Appendixes

The appendixes contain information on governance and compliance matters, including the audited financial statements, and on activities and outputs, such as products and papers. Data that support figures used in this report are also included.

Appendix 1 Enabling legislation

The Commonwealth legislation and regulations that established and continue to govern the Australian Institute of Health and Welfare (AIHW) are listed here. The full text of these instruments, including a history of amendments, is on the Australian Government's Federal Register of Legislation website www.legislation.gov.au.

- *Australian Institute of Health and Welfare Act 1987* (AIHW Act) (Act No. 41 of 1987)

The AIHW Act established the AIHW and describes its composition, functions, powers and obligations.

The latest compilation current at 28 October 2016 started on 21 October 2016 and incorporates amendments to the AIHW Act up to Act No. 61, 2016. It may be found at www.legislation.gov.au/Details/C2016C01008.

- Australian Institute of Health and Welfare (Contracts) Regulation 2016

The regulation requires the AIHW to seek Ministerial approval to enter into contracts involving the expenditure or receipt of amounts exceeding $3 million. It may be found at www.legislation.gov.au/Details/F2016L01806.

- Australian Institute of Health and Welfare Ethics Committee Regulations 1989 (Statutory Rules 1989 No. 118 as amended, made under the AIHW Act)

The regulations prescribe the functions and composition of the AIHW Ethics Committee.

The compilation current at 30 June 2017 started on 5 April 2002 and includes amendments to the regulations up to the Australian Institute of Health Ethics Committee Amendment Regulations 2002 No. 62. It may be found at www.legislation.gov.au/Details/F2004C00363.

Appendix 2 Products, journal articles and presentations

Products

The Australian Institute of Health and Welfare (AIHW) and its collaborating centres published 188 products in 2016–17.

The AIHW released 128 print and/or print-ready publications and 60 web products, including new and updated web snapshots, dynamic data displays and reports in HTML format. Web versions of print products are not included in these figures to avoid duplication.

All print-ready publications are available free of charge on the AIHW's website as accessible PDF documents. Users are invited to contact the AIHW if they need information presented in an alternative format for accessibility reasons.

Printed copies of our 2 flagship products, *Australia's health* and *Australia's welfare*, are available for purchase. Other publications can be printed on demand, at a cost to the customer. Some printed publications, such as the AIHW annual report series, are available free of charge.

For further details about obtaining AIHW products, see www.aihw.gov.au/publications/.

Adoptions

Adoptions Australia 2015–16. Cat. no. CWS 59. Canberra: AIHW, 2016.

Adoptions (web page update and SAS VA dynamic data display) (accompanies Adoptions Australia 2015–16). Canberra: AIHW, 2016.

Ageing and aged care

Exploring the aged care use of older people from culturally and linguistically diverse backgrounds: a feasibility study—working paper 1 2016. Cat. no. AGE 77. Canberra: AIHW, 2016.

Improving access to data on length of stay in aged care in Australia: a feasibility study into options for a dynamic data display tool—working paper 2 2016. Cat. no. AGE 78. Canberra: AIHW, 2016.

Introduction to Pathways in Aged Care 2014. Cat. no. AGE 79. Canberra: AIHW, 2016.

National Aged Care Data Clearinghouse Data Dictionary: version 1.0 2016. Cat. no. AGE 80. Canberra: AIHW, 2016.

Older Australia at a glance (web report). Canberra: AIHW, 2016.

Older Australia at a glance 2017 (web report update). Canberra: AIHW, 2017.

Regional Aged Care Profiles (RACP) Tool: National Aged Care Data Clearinghouse (web page update and SAS VA dynamic data display). Canberra: AIHW, 2016.

Report on the Operation of the Aged Care Act (ROACA): National Aged Care Data Clearinghouse (web page update and data cubes dynamic display). Canberra: AIHW, 2016.

Residential aged care and Home Care 2014–15 (web report). Canberra: AIHW, 2016.

Alcohol and other drug treatment services

Alcohol and other drug treatment services in Australia 2015–16. Cat. no. HSE 187. Canberra: AIHW, 2017.

Alcohol and other drug treatment services in Australia, 2015–16: key findings (web report). Canberra: AIHW, 2017.

Alcohol and other drugs (web page update). Canberra: AIHW, 2016.

National Drug Strategy Household Survey (NDSHS) 2016—key findings (web report). Canberra: AIHW, 2017.

National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection 2016 (web report). Canberra: AIHW, 2017.

Tobacco indicators: measuring midpoint progress—reporting under the National Tobacco Strategy 2012–2018. Cat. no. PHE 210. Canberra: AIHW, 2016.

Trends in alcohol availability, use and treatment 2003–04 to 2014–15. Cat. no. HSE 179. Canberra: AIHW, 2016.

Arthritis and other musculoskeletal conditions

Impacts of chronic back problems. Cat. no. AUS 204. Canberra: AIHW, 2016.

Musculoskeletal conditions as underlying and associated causes of death 2013. Cat. no. AUS 203. Canberra: AIHW, 2016.

Asthma and other chronic respiratory conditions

Chronic airways disease risk factors and comorbidities (web report). Canberra: AIHW, 2016.

The use of lung function testing for the diagnosis and management of chronic airways disease: demonstration data linkage project using the 45 and Up Study 2001–2014. Cat. no. ACM 32. Canberra: AIHW, 2016.

Burden of disease

Australian Burden of Disease Study 2011: methods and supplementary material. Cat. no. BOD 6. Canberra: AIHW, 2016.

Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Cat. no. BOD 7. Canberra: AIHW, 2016.

Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011—summary report. Cat. no. BOD 8. Canberra: AIHW, 2016.

Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011—summary report. Cat. no. BOD 5. Canberra: AIHW, 2016.

Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011—supplementary tables (web data release). Canberra: AIHW, 2017.

Australian Burden of Disease Study: supplementary tables (web data release). Canberra: AIHW, 2016.

Burden of cancer in Australia: Australian Burden of Disease Study 2011. Cat. no. BOD 13. Canberra: AIHW, 2017.

Burden of lower limb amputations due to diabetes in Australia: Australian Burden of Disease Study 2011. Cat. no. BOD 11. Canberra: AIHW, 2017.

Contribution of vascular diseases and risk factors to the burden of dementia in Australia: Australian Burden of Disease Study 2011. Cat. no. BOD 10. Canberra: AIHW, 2016.

Diabetes and chronic kidney disease as risks for other diseases: Australian Burden of Disease Study 2011. Cat. no. BOD 9. Canberra: AIHW, 2016.

Impact of overweight and obesity as a risk factor for chronic conditions: Australian Burden of Disease Study. Cat. no. BOD 12. Canberra: AIHW, 2017.

Cancer

BreastScreen Australia and National Cervical Screening Program participation 2014–2015 (web page update). Canberra: AIHW, 2016.

BreastScreen Australia monitoring report 2013–2014. Cat. no. CAN 99. Canberra: AIHW, 2016.

Cancer 2017 (web pages update). Canberra: AIHW, 2017.

Cancer in Australia 2017. Cat. no. CAN 100. Canberra: AIHW, 2017.

Cancer in Australia: in brief 2017. Cat. no. CAN 101. Canberra: AIHW, 2017.

Cancer incidence in Australia by small geographic areas (web page update and SAS VA dynamic data display). Canberra: AIHW, 2016.

Cancer Incidence and Mortality Across Regions (CIMAR) books (web data release). Canberra: AIHW, 2016.

Cervical screening in Australia 2014–2015. Cat. no. CAN 104. Canberra: AIHW, 2017.

Cancer screening in Australia by small geographical areas (web page update and SAS VA dynamic data display). Canberra: AIHW, 2016.

National Bowel Cancer Screening Program: monitoring report 2016. Cat. no. CAN 97. Canberra: AIHW, 2016.

National Bowel Cancer Screening Program: monitoring report 2017. Cat. no. CAN 103. Canberra: AIHW, 2017.

National Cervical Screening Program Data Dictionary: version 1.0. Cat. no. CAN 102. Canberra: AIHW, 2017.

Participation in the National Bowel Cancer Screening Program by SA2 (web page update and SAS VA dynamic data display). Canberra: AIHW, 2017.

Radiotherapy in Australia: report on the second year of a pilot collection 2014–15. Cat. no. HSE 181. Canberra: AIHW, 2016.

Skin cancer in Australia. Cat. no. CAN 96. Canberra: AIHW, 2016.

Child protection

Additional tables for 'The views of children and young people in out-of-home care' (web data release). Canberra: AIHW, 2016.

Child protection Australia 2015–16. Cat. no. CWS 60. Canberra: AIHW, 2017.

Child protection Australia 2015–16 (web page update). Canberra: AIHW, 2017.

National framework for protecting Australia's children NFPAC indicators 2017 (web page update and SAS VA dynamic data display). Canberra: AIHW, 2017.

Permanency planning in child protection: a review of current concepts and available data 2016. Cat. no. CWS 58. Canberra: AIHW, 2016.

Children and youth

Children's Headline Indicators update (web page update and SAS VA dynamic data display). Canberra: AIHW, 2017.

Chronic diseases

Chronic conditions compendium updates 2016 (web pages update). Canberra: AIHW, 2016.

Corporate publications

AIHW Access no. 40. Cat. no. HWI 133. Canberra: AIHW, 2016.

Annual report 2015–16. Cat. no. AUS 209. Canberra: AIHW, 2016.

Australia's health 2016. Cat. no. AUS 199. Canberra: AIHW, 2016.

Australia's health 2016—in brief. Cat. no. AUS 201. Canberra: AIHW, 2016.

Australia's health 2016 fact sheet: how lifestyle choices affect our health. Cat. no. 206. Canberra: AIHW, 2016.

Australia's health 2016 fact sheet: the impact of chronic disease. Cat. no. 207. Canberra: AIHW, 2016.

Australia's health 2016 fact sheet: health care services. Cat. no. 208. Canberra: AIHW, 2016.

Australian Institute of Health and Welfare Corporate Plan 2016–17 to 2019–20. Cat. no. AUS 205. Canberra: AIHW, 2016.

Strategic directions 2017–2021. Cat. no. AUS 213. Canberra: AIHW, 2017.

Deaths

Deaths (mortality) update 2017 (web pages update). Canberra: AIHW, 2017.

Diabetes

Diabetes indicators—Australia (web report). Canberra: AIHW, 2016.

Diabetic ketoacidosis (DKA) among children and young people with type 1 diabetes. Cat. no. CVD 77. Canberra: AIHW, 2016.

Incidence of insulin-treated diabetes in Australia, 2015. Cat. no. CVD 78. Canberra: AIHW, 2017.

Incidence of insulin-treated diabetes in Australia (web pages update and SAS VA dynamic data display). Canberra: AIHW, 2017.

Use of medicines by older people with type 2 diabetes. Cat. no. CVD 76. Canberra: AIHW, 2016.

Disability

Autism in Australia (web report). Canberra: AIHW, 2017.

Disability in Australia: changes over time in inclusion and participation in community living. Cat. no. DIS 67. Canberra: AIHW, 2017.

Disability in Australia: changes over time in inclusion and participation in education. Cat. no. DIS 69. Canberra: AIHW, 2017.

Disability in Australia: changes over time in inclusion and participation in employment. Cat. no. DIS 68. Canberra: AIHW, 2017.

Disability support services: services provided under the National Disability Agreement 2015–16. Cat. no. AUS 212. Canberra: AIHW, 2017.

Life expectancy and disability in Australia: expected years living with and without disability. Cat. no. DIS 66. Canberra: AIHW, 2017.

Expenditure

Health expenditure Australia 2014–15. Cat. no. HWE 67. Canberra: AIHW, 2016.

Health indicators

OECD health-care quality indicators for Australia 2015. Cat. no. PHE 209. Canberra: AIHW, 2016.

Homelessness

A profile of Specialist Homelessness Services homeless clients 2011–12 to 2014–15 (web report). Canberra: AIHW, 2016.

Exploring drug treatment and homelessness in Australia: 1 July 2011 to 30 June 2014. Cat. no. CSI 23. Canberra: AIHW, 2016.

Specialist homelessness services 2015–16 (web report). Canberra: AIHW, 2016.

Specialist homelessness services 2015–16: additional content release (web report update). Canberra: AIHW, 2017.

Specialist homelessness services 2015–16: Australian Capital Territory fact sheet. Cat. no. HOU 280. Canberra: AIHW, 2017.

Specialist homelessness services 2015–16: New South Wales fact sheet. Cat. no. HOU 281. Canberra: AIHW, 2017.

Specialist homelessness services 2015–16: Northern Territory fact sheet. Cat. no. HOU 282. Canberra: AIHW, 2017.

Specialist homelessness services 2015–16: Queensland fact sheet. Cat. no. HOU 283. Canberra: AIHW, 2017.

Specialist homelessness services 2015–16: South Australia fact sheet. Cat. no. HOU 284. Canberra: AIHW, 2017.

Specialist homelessness services 2015–16: Tasmania fact sheet. Cat. no. HOU 285. Canberra: AIHW, 2017.

Specialist homelessness services 2015–16: Victoria fact sheet. Cat. no. HOU 286. Canberra: AIHW, 2017.

Specialist homelessness services 2015–16: Western Australia fact sheet. Cat. no. HOU 287. Canberra: AIHW, 2017.

Specialist Homelessness Services Collection Data Cubes 2011–16 (web data release). Canberra: AIHW, 2017.

Vulnerable young people: interactions across homelessness, youth justice and child protection—1 July 2011 to 30 June 2015. Cat. no. HOU 279. Canberra: AIHW, 2016.

Hospitals

Admitted patient care 2015–16: Australian hospital statistics. Cat. no. HSE 185. Canberra: AIHW, 2017.

Australia's hospitals 2014–15 at a glance. Cat. no. HSE 175. Canberra: AIHW, 2016.

Deaths in Australian hospitals 2014–15: hospital spotlight report (web report). Canberra: AIHW, 2017.

Elective surgery waiting times 2015–16: Australian hospital statistics. Cat. no. HSE 183. Canberra: AIHW, 2016.

Emergency department care 2015–16: Australian hospital statistics. Cat. no. HSE 182. Canberra: AIHW, 2016.

Hospital care for patients aged 85 and over, 2014–15: hospital spotlight report (web report). Canberra: AIHW, 2017.

Hospital resources 2014–15: Australian hospital statistics. Cat. no. HSE 176. Canberra: AIHW, 2016.

Non-admitted patient care 2014–15: Australian hospital statistics. Cat. no. HSE 174. Canberra: AIHW, 2016.

Non-admitted patient care 2015–16: Australian hospital statistics. Cat. no. HSE 188. Canberra: AIHW, 2017.

Staphylococcus aureus bacteraemia in Australian public hospitals 2015–16: Australian hospital statistics. Cat. no. HSE 184. Canberra: AIHW, 2017.

Weight loss surgery in Australia 2014–15: Australian hospital statistics. Cat. no. HSE 186. Canberra: AIHW, 2017.

Housing

National Social Housing Survey 2016 (web report). Canberra: AIHW, 2017.

National Social Housing Survey: a summary of national results 2016. Cat. no. HOU 288. Canberra: AIHW, 2017.

Indigenous health and welfare

Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2015–16. Cat. no. IHW 180. Canberra: AIHW, 2017.

Aboriginal and Torres Strait Islander health performance framework 2017 data tables and dynamic data display (web report). Canberra: AIHW, 2017.

Better Cardiac Care measures for Aboriginal and Torres Strait Islander people: second national report 2016. Cat. no. IHW 169. Canberra: AIHW, 2016.

Family violence prevention programs in Indigenous communities. Cat. no. IHW 173. Canberra: AIHW, 2016.

Healthy Futures—Aboriginal Community Controlled Health Services Report Card 2016. Cat. no. IHW 171. Canberra: AIHW, 2016.

Indigenous eye health measures 2016. Cat. no. IHW 178. Canberra: AIHW, 2017.

Indigenous eye health measures 2016: fact sheet. Cat. no. IHW 179. Canberra: AIHW, 2017.

Indigenous specific measures tool 5th release (web page update and SAS VA dynamic data display). Canberra: AIHW, 2016.

National frameworks about Aboriginal and Torres Strait Islander people. Cat. no. IHW 172. Canberra: AIHW, 2016.

National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: preliminary results from May 2015 (web report). Canberra: AIHW, 2017.

National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results from June 2016. Cat. no. IHW 177. Canberra: AIHW, 2017.

Northern Territory Remote Aboriginal Investment: Ear and Hearing Health Program—July 2012 to June 2016. Cat. no. IHW 176. Canberra: AIHW, 2017.

Northern Territory Remote Aboriginal Investment: Oral Health Program—July 2012 to December 2015. Cat. no. IHW 175. Canberra: AIHW, 2017.

Injury

DIY injuries. Cat. no. INJCAT 185. Canberra: AIHW, 2017.

Dog-related injuries. Cat. no. INJCAT 186. Canberra: AIHW, 2017.

Firearm injuries and deaths. Cat. no. INJCAT 187. Canberra: AIHW, 2017.

Hospitalised assault injuries among women and girls. Cat. no. INJCAT 184. Canberra: AIHW, 2017.

Hospitalised burn injuries Australia 2013–14. Cat. no. INJCAT 178. Canberra: AIHW, 2016.

Poisoning in children and young people 2012–13. Cat. no. INJCAT 173. Canberra: AIHW, 2016.

Serious unintentional injury involving a railway train or tram, Australia, 2009–10 to 2013–14. Cat. no. INJCAT 177. Canberra: AIHW, 2017.

Kidney diseases

Incidence of end-stage kidney disease in Australia 1997–2013. Cat. no. PHE 211. Canberra: AIHW, 2016.

Mental health

Mental health services in Australia/tranche 3 2016 (web pages update). Canberra: AIHW, 2016.

Mental health services in Australia/tranche 4 2016 (web pages update). Canberra: AIHW, 2016.

Mental health services in Australia/tranche 5 2016 (web pages update). Canberra: AIHW, 2016.

Mental health services in Australia/tranche 1 2017 (web pages update). Canberra: AIHW, 2017.

Mental health services in Australia: including the use of restraint in acute hospital mental health services/tranche 2 2017 (web pages update). Canberra: AIHW, 2017.

Mental health services in Australia/tranche 3 2017 (web pages update). Canberra: AIHW, 2017.

Mental health services—in brief 2016. Cat. no. HSE 180. Canberra: AIHW, 2016.

Mothers and babies

Australia's mothers and babies 2014—in brief. Cat. no. PER 87. Canberra: AIHW, 2016.

National Core Maternity Indicators stage 3 and 4 results from 2010–2013. Cat. no. PER 84. Canberra: AIHW, 2016.

National Core Maternity Indicators stage 3 and 4 (web page update and SAS VA dynamic data display). Canberra: AIHW, 2016.

Perinatal data module 4: birth outcomes (web page update and SAS VA dynamic data display). Canberra: AIHW, 2016.

Perinatal data portal update (web page update and SAS VA dynamic data display). Canberra: AIHW, 2016.

Perinatal deaths in Australia 1993–2012. Cat. no. PER 86. Canberra: AIHW, 2016.

Peripartum hysterectomy in Australia: a working paper using the National Hospital Morbidity Database 2003–04 to 2013–14. Cat. no. PER 85. Canberra: AIHW, 2016.

MyHealthy Communities

Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14. Cat. no. HSE 177. Canberra: AIHW, 2016.

Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14, technical supplement. Cat. no. HSE 178. Canberra: AIHW, 2016.

Healthy Communities: Hospitalisations for mental health conditions an international self-harm in 2014–15 (web update). Canberra: AIHW, 2017.

Healthy Communities: HPV immunisation rates in 2014–15. Cat. no. HPF 3. Canberra: AIHW, 2017.

Healthy Communities: Immunisation rates for children in 2015–16. Cat. no. HPF 4. Canberra: AIHW, 2017.

Healthy Communities: Incidence of selected cancers in 2006–2010 (web update). Canberra: AIHW, 2017.

Healthy Communities: Life expectancy and potentially avoidable deaths in 2011–2013 (web update). Canberra: AIHW, 2016.

Healthy Communities: Medicare Benefits Schedule GP and specialist attendances and expenditure in 2014–15 (web update). Canberra: AIHW, 2016.

Healthy Communities: Overweight and obesity rates across Australia, 2014–15. Cat. no. HPF 2. Canberra: AIHW, 2016.

Healthy Communities: Participation in national cancer screening programs in 2014–2015 (web update). Canberra: AIHW, 2017.

Healthy Communities: Patient experiences in Australia in 2015–16 (web update). Canberra: AIHW, 2017.

Healthy Communities: Tobacco smoking rates across Australia, 2014–15. Cat. no. HPF 1. Canberra: AIHW, 2016.

MyHealthyCommunities: Hospitalisations for mental health conditions and intentional self harm in 2014–15 (web update). Canberra: AIHW, 2017.

MyHealthyCommunities: Patient experiences in Australia in 2015–16 (web update). Canberra: AIHW, 2017.

My Hospitals

Healthcare-associated *Staphylococcus aureus* bloodstream infections in 2015–16 (web update). Canberra: AIHW, 2017.

Palliative care

Palliative care services in Australia 2016—tranche 2 (web pages update). Canberra: AIHW, 2016.

Palliative care services in Australia 2017—tranche 1 (web pages update). Canberra: AIHW, 2017.

Rural health

Rural health (web pages update). Canberra: AIHW, 2017.

Veterans' health

Fourth study of mortality and cancer incidence in aircraft maintenance personnel: a continuing study of F-111 Deseal/Reseal personnel 2016. Cat. no. CAN 98. Canberra: AIHW, 2016.

Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2014. Cat. no. PHE 212. Canberra: AIHW, 2016.

Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report. Cat. no. PHE 213. Canberra: AIHW, 2017.

Workforce

Medical practitioner workforce 2015 (web report). Canberra: AIHW, 2016.

Spatial distribution of the supply of the clinical health workforce 2014: relationship to the distribution of the Indigenous population. Cat. no. IHW 170. Canberra: AIHW, 2016.

Youth justice

Australian Capital Territory: youth justice supervision in 2015–16. Cat. no. JUV 96. Canberra: AIHW, 2017.

Comparisons between Australian and international youth justice systems: 2014–15. Cat. no. JUV 95. Canberra: AIHW, 2016.

Comparisons between the youth and adult justice systems: 2014–15. Cat. no. JUV 94. Canberra: AIHW, 2016.

First entry to youth justice supervision: 2014–15. Cat. no. JUV 92. Canberra: AIHW, 2016.

New South Wales: youth justice supervision in 2015–16. Cat. no. JUV 97. Canberra: AIHW, 2017.

Northern Territory: youth justice supervision in 2015–16. Cat. no. JUV 98. Canberra: AIHW, 2017.

Queensland: youth justice supervision in 2015–16. Cat. no. JUV 99. Canberra: AIHW, 2017.

Remoteness, socioeconomic position and youth justice supervision: 2014–15. Cat. no. JUV 91. Canberra: AIHW, 2016.

South Australia: overview of youth justice supervision in 2015–16. Cat. no. JUV 100. Canberra: AIHW, 2017.

Tasmania: youth justice supervision in 2015–16. Cat. no. JUV 101. Canberra: AIHW, 2017.

Trends in youth justice supervision to 2014–15. Cat. no. JUV 86. Canberra: AIHW, 2016.

Types of community-based youth justice supervision: 2014–15. Cat. no. JUV 87. Canberra: AIHW, 2016.

Victoria: youth justice supervision in 2015–16. Cat. no. JUV 102. Canberra: AIHW, 2017.

Western Australia: youth justice supervision in 2015–16. Cat. no. JUV 103. Canberra: AIHW, 2017.

Young people in child protection and under youth justice supervision 2014–15. Cat. no. CSI 24. Canberra: AIHW, 2016.

Young people in sentenced detention: 2014–15. Cat. no. JUV 89. Canberra: AIHW, 2016.

Young people in unsentenced detention: 2014–15. Cat. no. JUV 88. Canberra: AIHW, 2016.

Young people returning to sentenced youth justice supervision 2014–15. Cat. no. JUV 84. Canberra: AIHW, 2016.

Young people returning to sentenced youth justice supervision 2015–16. Cat. no. JUV 104. Canberra: AIHW, 2017.

Youth detention entries and exits: 2014–15. Cat. no. JUV 90. Canberra: AIHW, 2016.

Youth detention population in Australia 2016. Cat. no. AUS 210. Canberra: AIHW, 2016.

Youth justice in Australia (web). Canberra: AIHW, 2017.

Youth justice in Australia 2015–16. Cat. no. AUS 211. Canberra: AIHW, 2017.

Youth justice orders and supervision periods: 2014–15. Cat. no. JUV 85. Canberra: AIHW, 2016.

Youth justice supervision history: 2014–15. Cat. no. JUV 93. Canberra: AIHW, 2016.

Journal and other articles by AIHW staff

AIHW staff contributed to 11 journal articles in 2016–17:

Allan JA, Foster RM, Hanson GD, O'Mahony AJ, Schroder NL & Sara GE 2017. Six years of national mental health seclusion data: the Australian experience. Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists 25(3):277–81.

Andrew NE, Sundararajan V, Thrift AG, Kilkenny MF, Katzenellenbogen J, Flack F, et al. 2016. Addressing the challenges of cross-jurisdictional data linkage between a national clinical quality registry and government-held health data. Australian and New Zealand Journal of Public Health 40(5):436–42.

Budd A, Hammond I & Cancer Council Australia Cervical Cancer Screening Guidelines Working Party 2016. Cervical cancer in Australia. In: Cancer Council Australia Cervical Cancer Screening Guidelines Working Party (eds). National Cervical Screening Program: guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. Sydney: Cancer Council Australia, 40–54.

Goldsmid S, Johnston I, Kapira M, Claydon C, Petricevic M and Webber K 2017. Australian methamphetamine user outcomes. Statistical bulletin no. 03. Canberra: Australian Institute of Criminology.

Hsu B, Seibel MJ, Cumming RG, Blyth FM, Naganathan V, Bleicher K et al. 2016. Progressive temporal change in serum SHBG, but not in serum testosterone or estradiol, is associated with bone loss and incident fractures in older men: the Concord Health and Ageing in Men Project. Journal of Bone and Mineral Research 31(12):2115–22.

Humphrey MD 2016. Maternal mortality trends in Australia. Medical Journal of Australia 205(8):344–6.

Joenperä J 2017. Tales from the ACFI: dementia in residential aged care. Australasian Journal on Ageing 36(1):10–13.

Mohanty I, Edvardsson M, Abello A & Eldridge D 2016. Child social exclusion risk and child health outcomes in Australia. PLoS ONE 11(5):e0154536.

Morgan EL, Sanday K, Budd A, Hammond IG & Nicklin J 2017. Cervical cancer in women under 25 years of age in Queensland, Australia: to what extent is the diagnosis made by screening cytology? Australian and New Zealand Journal of Obstetrics and Gynaecology.

Ring I, Dixon T, Lovett RL & Al-Yaman F 2016. Are Indigenous mortality gaps closing: how to tell, and when? Medical Journal of Australia 205(1):11.

Presentations and posters by AIHW staff

AIHW staff gave 56 presentations and posters at conferences and workshops in 2016–17:

Al-Yaman F 2016. Close the Gap plenary session. Presentation at the Lowitja Institute International Indigenous Health and Wellbeing Conference 2016, Melbourne, 10 November.

Al-Yaman F 2016. Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Presentation to the National Aboriginal Community Controlled Health Organisation ICT IM Working Group meeting, 6 October.

Al-Yaman F 2016. Monitoring and Reporting Plan—National Aboriginal and Torres Strait Islander Cancer Framework. Presentation to the Cancer Australia Leadership Group on Indigenous Cancer Control, Sydney, 28 September.

Al-Yaman F 2016. Results from the Australian Burden of Disease Study. Presentation at the Community Care and Population Health Principal Committee meeting, 17 October.

Al-Yaman F 2017. Take Own Leave, Closing the Gap. Presentation at the National Take Own Leave Workshop, Alice Springs, 6 April.

Al-Yaman F 2017. The burden of chronic diseases: contribution to Closing the Gap. Presentation at the Innovations in Aboriginal Chronic Conditions Forum, Sydney, 20 June.

Al-Yaman F 2017. What explains spatial variation in Indigenous health outcomes? Presentation at the Wennberg International Collaborative Spring Policy Meeting 2017: Better Smarter Care—Reducing Unwarranted Variation, Melbourne, 4 May.

Al-Yaman F & Elston J 2017. Putting the spotlight on cancer for Aboriginal and Torres Strait Islander peoples: improving the outcomes. Presentation to the Australian Health Ministers' Advisory Council meeting, 17 February.

Allan J & Hanson G 2017. Establishment of the national restraint data collection. Presentation at the Towards Elimination of Restrictive Practices 11th National Forum, Perth, 4–5 May.

Anderson P 2017. Effective data linkage to improve policy. Presentation at the Strengthening Evidence-based Policy Conference, Canberra, 21–22 March.

Beard T, Petricevic M, Tierney L, Armstrong A & Hewitt M 2016. Exploring the overlap between Alcohol and Other Drug Treatment and Specialist Homelessness Services. Presentation at the Australasian Professional Society on Alcohol & other Drugs (APSAD) Conference, Sydney, 30 October–2 November.

Bracewell L & Hargreaves J 2016. Report from the WHO-FIC Network Advisory Council 2016. Poster presented at the WHO-FIC [World Health Organization Family of International Classifications] Network Annual Meeting 2016, Tokyo, 8–12 October.

Braddock D 2016. Youth justice health—there's no national data. Presentation at From Evidence to Practice: the 2nd Australasian Youth Justice Conference, Brisbane, 13–15 September.

Brown S, Claydon C, Webber K & Hewitt M 2016. Measuring progress against the National Tobacco Strategy 2012 to 2018. Poster presented at the Australasian Professional Society on Alcohol & other Drugs (APSAD) Conference, Sydney, 30 October–2 November.

Butler J 2016. Caring for Australians with dementia—planning for care needs. Presentation at the 49th Annual Australian Association of Gerontology conference, Canberra, 2–4 November.

Butler J 2017. Delivery of residential aged care in a culturally diverse Australia. Presentation at the 4th International Conference on Ageing in a Foreign Land, Adelaide, 21–22 June.

Clugston B & Young A 2017. Involuntary treatment: a comparison of Australian jurisdictions. Presentation at the Towards Elimination of Restrictive Practices 11th National Forum, Perth, 4–5 May.

Da Silva K & Petricevic M 2016. Geospatial analyses of access to Alcohol and Other Drug Treatment Services. Poster presented at the Australasian Professional Society on Alcohol & other Drugs (APSAD) Conference, Sydney, 30 October–2 November.

Dugbaza T, Al-Yaman F, Dixon T, Smith L & Choi C 2016. Life expectancy does not tell the whole story: differentials in mortality and life expectancy patterns between Indigenous and non-Indigenous Australians, 2001–2014. Presentation at the Australian Vital Statistics Interest Group (AVSIG) 2016 Workshop, Australian Bureau of Statistics, 21–22 November.

Fortune N, Whitelaw L & Hargreaves J 2016. Determinants of health in the WHO-FIC. Poster presented at the WHO-FIC Network Annual Meeting 2016, Tokyo, 8–12 October.

Gourley M 2017. Regional variation in disease burden in Australia. Presentation at the 14th National Rural Health Conference, Cairns, 26–29 April.

Gourley M & Moon L 2017. Cancer burden attributed to select risk factors. Paper presented at QIMR Berghofer Medical Research Institute, Brisbane, 23 May.

Guiver T 2017. AIHW update. Presentation at the National Stroke Data and Quality Improvement Workshop, Melbourne, 22 March.

Guo S, Trinh L, Reynolds A, Senes S, Moon L & Mathur S 2016. Glucose lowering medicine supply to an older concessional population with type 2 diabetes in 2012: a study using linked data. Poster presented at the Australian Epidemiological Society Annual Scientific Meeting, Canberra, 14–16 September.

Haddin J 2016. Premature deaths in Australia. Poster presented at the Australasian Epidemiological Association 23rd Annual Scientific Meeting, Canberra, 14–16 September.

Hanmer L, Hargreaves J & Macpherson B 2016. Family Development Committee annual report 2016. Poster presented at the WHO-FIC Network Annual Meeting 2016, Tokyo, 8–12 October.

Hanmer L, Hargreaves J & Macpherson B 2016. The 'Family' paper revision and WHO-FIC in the ICD-11 era. Poster presented at the WHO-FIC Network Annual Meeting 2016, Tokyo, 8–12 October.

Hargreaves J & Macpherson B 2016. Australian Collaborating Centre annual report 2016. Poster presented at the WHO-FIC Network Annual Meeting 2016, Tokyo, 8–12 October 2016.

Hargreaves J, Macpherson B & Lum On M 2016. ICD-11 pilot testing—the Australian experience. Poster presented at the WHO-FIC Network Annual Meeting 2016, Tokyo, 8–12 October.

Harvey J 2016. Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program. Presentation at the Gastroenterological Society of Australia Colorectal Cancer Screening Symposium, Adelaide, 10–11 October.

Ho W 2017. Direct and indirect burden of disease due to diabetes and chronic kidney disease. Presentation at the 15th World Congress on Public Health, Melbourne, 3–7 April.

Hunt A, Craig P, Pearce J & Brooks R. 2016. Monitoring the health impacts of mandatory folic acid and iodine fortification. Poster presented at the Australasian Epidemiological Association 23rd Annual Scientific Meeting, Canberra, 14–16 September.

Hunter N 2017. Academic performance of children and young people in care: how do they compare? Presentation at the Child Aware Approaches Conference, Brisbane, 15–16 May.

Hunter N 2017. Voices of children and young people in out-of-home care: what are they saying? Presentation at the Child Aware Approaches Conference, Brisbane, 15–16 May.

Joenperä J 2016. Complex caring: dementia in a residential aged care setting. Presentation at the Leading Age Services Australia National Congress, Gold Coast, 9–11 October.

Joenperä J 2016. Delivery of aged care in a culturally diverse Australia. Poster presented at the Australian Association of Gerontology National Conference, Canberra, 2–4 November.

Karmel R & Anderson P 2016. What happens next? Pathways in aged care. Poster presented at the Longitudinal Data Conference, Canberra, 26–27 November.

Lum On M 2016. Australian Burden of Disease Study 2011: a case-study in the use of coded data in population health. Presentation at the 18th World Congress of the International Federation of Health Information Management Associations, Tokyo, 12–14 October.

Macpherson B 2016. Pilot testing ICD-11: the Australian experience. Presentation at the 33rd Annual HIMAA NCCH National Conference, Melbourne, 8–10 November.

Macpherson B, Hargreaves J & Hanmer L 2016. Use of the Family of International Classifications in monitoring universal health coverage: an update. Poster presented at the WHO-FIC Network Annual Meeting 2016, Tokyo, 8–12 October.

Mills L, Faulks K, Xu D & Reinten T 2017. Regional variation in HPV vaccine coverage in Australian adolescent boys and girls. Presentation at the World Congress of Public Health, Melbourne, 3–7 April.

Moon L 2016. New, useful and exciting data from the Australian Institute of Health and Welfare. Presentation at the 5th Rural and Remit Health Scientific Symposium, Canberra, 7 September.

Moon L 2017. Estimation of burden of disease and recent actions in Australia. Presentation at the International Symposium on Burden of Disease Study and Policy Application, Seoul, 9 February.

Moon L 2017. Estimation of incidence of suicide of ex-serving Australian Defence Force personnel. Presentation at the Department of Veterans Affairs, Canberra, 19 September.

Ng P, Pearce J & Mathur S 2017. Increasing prevalence and impact of diabetes in Australia. Presentation at the World Congress on Public Health, Melbourne, 3–7 April.

Pagnini D 2017. Spatial distribution of the health workforce relative to the Indigenous population. Presentation at the 15th World Congress on Public Health. Melbourne, 3 April.

Pieris-Caldwell I 2016. National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care. Presentation at the Centre for Aboriginal Economic Policy Research (CAEPR) Seminar Series, Canberra, 28 September.

Pieris-Caldwell I & Seebus I 2016. nKPI data from Indigenous primary health services—key challenges. Presentation at the National Primary Health Network Conference, Sydney, 17–18 November.

Prescott V 2017. Contribution of cardiovascular disease, diabetes and vascular risk factors to the burden of dementia in Australia. Poster presented at the 15th World Congress on Public Health, Melbourne, 3–7 April.

Reynolds A, Trinh L, Guo S, Moon L & Mathur S 2016. The supply of selected cardiovascular medicines to an older concessional population with type 2 diabetes in 2012: a study using linked data. Poster presented at the Cardiac Society of Australia and New Zealand, Adelaide, 5–7 August.

Ritson A & Veld M 2016. Exploring drug treatment and homelessness in Australia, with a focus on those who presented to homelessness services for reasons of family and domestic violence. Presentation at the STOP Domestic Violence Conference, Brisbane, 5–7 December.

Schlumpp A 2016. Young people returning to sentenced youth justice supervision. Presentation at From Evidence to Practice: the 2nd Australasian Youth Justice Conference, Brisbane, 13–15 September.

Tong B 2017. How do data impact on health policy and health outcomes? AIHW experience with data management and analysis of NTER CHCI and its subsequent programs. Presentation at the National Indigenous Research Conference, Canberra, 21–23 March.

Vu T 2017. Estimating the total incidence of end-stage kidney disease in Australia. Poster presented at the World Congress on Public Health, Melbourne, 3–7 April.

Webber K & Claydon C 2016. What role do age and mental health play in substance use among lesbian, gay and bisexual people? Poster presented at the Australasian Professional Society on Alcohol & other Drugs (APSAD) Conference, Sydney, 30 October–2 November.

Webster A 2017. Data quality and governance. Presentation at the Asia–Pacific National Health Accounts Network/OECD (Organisation for Economic Co-operation and Development) Korea Policy Centre Annual Meeting 2016, Bangkok 29–31 March.

Appendix 3 Meeting attendance—AIHW Board and AIHW Ethics Committee, and outgoing members

This appendix provides details of meeting attendance in 2016–17 by members of the Australian Institute of Health and Welfare (AIHW) Board, the 2 board committees and the AIHW Ethics Committee. Information on members leaving the board during 2016–17 is also presented.

Biographical details of current members of the AIHW Board and AIHW Ethics Committee are in Chapter 4 Our organisation.

Meetings attended by AIHW Board members

Table A3.1: Meetings attended by AIHW Board members, 2016–17

Name	Position	Appointment change during the year	Meetings attended	Eligible meetings
AIHW Board meetings				
Dr Mukesh C Haikerwal AO	Chair	To 18 October 2016	2	2
Mrs Louise Markus	Chair	From 14 December 2016	3	3
Mr Barry Sandison	Director, AIHW		6	6
Dr Zoran Bolevich	Nominee of the Australian Health Ministers' Advisory Council		4	6
Ms Marilyn Chilvers	Nominee of the Children and Families Secretaries Group	To 17 January 2017; from 19 January 2017	6	6
Mr Phillip Fagan-Schmidt PSM	Representative of the State Housing Departments	To 17 January 2017; from 19 January 2017	3	6
Ms Luise McCulloch	Member nominated by the Australian Statistician		6	6
Mr Paul Madden	Member nominated by the Secretary, Department of Health	To 18 December 2016	2	3
Mr Mark Cormack	Member nominated by the Secretary, Department of Health		3	3
Dr Erin Lalor	Ministerial nominee with knowledge of the needs of consumers of health services	To 22 March 2017; from 24 March 2017	5	6

continued

Table A3.1 (continued): Meetings attended by AIHW Board members, 2016–17

Name	Position	Appointment change during the year	Meetings attended	Eligible meetings
AIHW Board meetings				
Mr Michael Perusco	Ministerial nominee with knowledge of the needs of consumers of housing assistance services	To 22 March 2017; from 24 March 2017	6	6
Dr Lyn Roberts AO	Ministerial nominee with expertise in research into public health issues	To 2 April 2017; from 4 April 2017 Acting Chair 1 December 2016 to 13 December 2016	6	6
Mr Andrew Goodsall	Ministerial nominee	To 17 January 2017; from 19 January 2017	6	6
Ms Gillian Adamson	Ministerial nominee	From 1 September 2016	5	5
Ms Simone Ryan	Ministerial nominee	From 1 September 2016	3	5
Ms Adriana Vanden Heuvel	Staff-elected representative	To 25 May 2017	3	4
Ms Marissa Veld	Staff-elected representative	From 26 May 2017	1	1
Audit and Finance Committee meetings				
Mr Michael Perusco	Chair	To 22 March 2017; from 24 March 2017	5	5
Dr Erin Lalor	Board member	To 22 March 2017; from 24 March 2017	5	5
Dr Lyn Roberts AO	Board member	To 2 April 2017; from 4 April 2017	2	2
Mr Max Shanahan	Independent member		4	5
Mr Andrew Goodsall	Board member	To 17 January 2017; from 19 January 2017	3	3
Remuneration Committee meetings				
Mrs Louise Markus	Chair	From 14 December 2016	1	1
Dr Lyn Roberts	Board member	To 2 April 2017; from 4 April 2017	1[(a)]	1
Dr Erin Lalor	Board member	To 22 March 2017; from 24 March 2017	2	2
Mr Michael Perusco	Board member	To 22 March 2017; from 24 March 2017	2	2

(a) Dr Lyn Roberts attended the AIHW Board Remuneration Committee held on 24 November 2016 as a point of contact for all Board related matters.

Outgoing members of the AIHW Board 2016–17

Dr Mukesh C Haikerwal AO

Board Chair, Australian Institute of Health and Welfare

Terms: 19 July 2014–18 July 2015; 19 July 2015–18 July 2016; 19 July 2016–18 October 2016

Mr Paul Madden

Nominee of the Secretary, Department of Health

Non-executive Director

Term: Ex-officio appointment from 23 January 2015–22 August 2016 and from 24 August–18 December 2016

Dr Adriana Vanden Heuvel

Staff-elected representative

Non-executive Director

Term: 26 May 2016–25 May 2017

Meetings attended by AIHW Ethics Committee members

Table A3.2: Meetings attended by AIHW Ethics Committee members, 2016–17

Name	Position	Appointment change during the year	Meetings attended	Eligible meetings
Mr Wayne Jackson PSM	Chair		4	4
Mr Barry Sandison	Director, AIHW		3	4
Dr Purnima Bhat	Person experienced in professional care, counselling and treatment of people		3	4
Professor Tim Driscoll	Person experienced in areas of research regularly considered by the committee		4	4
Ms Amanda Ianna	Nominee of Registrars of Births, Deaths and Marriages		3	4
The Reverend James Barr	Person who is a minister of religion		3	4
Ms Maryjane Crabtree	Person who is a lawyer		4	4
Mr David Garratt	Male representing general community attitudes		4	4
The Hon. Margaret Reynolds	Female representing general community attitudes		4	4

Outgoing members of the AIHW Ethics Committee 2016–17

Professor Malcolm Sim BMedSc, MBBS, MSc, GDipOccHyg, PhD, FAFOEM (RACP), FFOM (RCP)

Person with knowledge of, and current experience in, the areas of research that are regularly considered by the committee

Terms: 1 July 2007–30 June 2010; 1 July 2010–30 June 2013; 1 July 2013–30 June 2016

Appendix 4 Senior executives and unit heads

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Appendix 5 Data collections

This appendix details data collections managed by the Australian Institute of Health and Welfare (AIHW) at 30 June 2017. For further information about data collections held by the AIHW, see the 'Our data collections' page of the AIHW website http:www.aihw.gov.au.

Topic	Data collection	Description
Adoptions	Adoptions Australia data collection	Information on all finalised adoptions in Australia, including characteristics of adopted children, adoptive families and birth mothers. Includes data on the number of requests for information and the number of contact and information vetoes lodged by parties to adoption. Data are collected annually from state and territory departments and published in *Adoptions Australia* reports.
Ageing and aged care	National Aged Care Data Clearinghouse	An independent and central repository of national aged care data. The holdings are complex and include a relational database comprising more than 60 tables, most relating to aged care programs operating under the *Aged Care Act 1997*. Data are refreshed annually by the Department of Health (including full replacement of historical data) with data sourced from the Department of Human Services' payment systems, centralised client record systems and minimum data sets.
	Pathways in Aged Care 2014 linkage map	Data from aged care service programs, Aged Care Assessment Team assessments and the National Death Index were linked to create the Pathways in Aged Care linkage map. The database is suitable for person-based analysis of aged care pathways and patterns of program use over time. Covers aged care assessments and use of key aged care service programs, and deaths from 1 July 1997 to 30 June 2014.
Alcohol and other drugs	Alcohol and Other Drug Treatment Services National Minimum Data Set	Emanated from the national forum 'Treatment and research—where to from here?' held in 1995 by the Alcohol and Other Drugs Council of Australia. In December 1999, Australian Government and state and territory governments, through the then National Health Information Management Group, endorsed collection to begin on 1 July 2000. First data were collected for 2000–01 (considered a pilot year). The data from 2001–02 onwards contain information about alcohol and other drug treatment services, the clients who use these services, the types of drug problems for which treatment is sought and the types of treatment provided.
	National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection	Standardised jurisdictional data on the number of clients accessing pharmacotherapy for the treatment of opioid dependence, the number of prescribers participating in the delivery of pharmacotherapy treatment and quantitative information about the prescribing sector is aggregated. From this, national information on pharmacotherapy is reported.

continued

Topic	Data collection	Description
	1998 National Drug Strategy Household Survey master unit record file	National household survey of non-institutionalised persons aged 14 and over. Sixth in a series of surveys auspiced by the National Drug Strategy (and its predecessors) and the first conducted by the AIHW, with 10,030 completed responses collected. Fieldwork conducted by Roy Morgan Research. Topics include knowledge, attitudes and perceptions of drug-related issues, personal use of drugs (tobacco, alcohol and illicit drugs), support for drug-related policies, personal involvement in drug-related activities and victimisation, as well as typical demographics.
	2001 National Drug Strategy Household Survey master unit record file	National household survey of non-institutionalised persons aged 14 and over. Seventh in a series of surveys auspiced by the National Drug Strategy (and its predecessors), the second conducted by the AIHW, and the first to be conducted fully as an AIHW function, with 26,744 completed responses collected. Fieldwork conducted by Roy Morgan Research.
	2004 National Drug Strategy Household Survey master unit record file	National household survey of non-institutionalised persons aged 12 and over. Eighth in a series of surveys auspiced by the National Drug Strategy (and its predecessors) and the third conducted by the AIHW, with 29,445 completed responses collected. Fieldwork conducted by Roy Morgan Research.
	2007 National Drug Strategy Household Survey master unit record file	National household survey of non-institutionalised persons aged 12 and over. Ninth in a series of surveys auspiced by the National Drug Strategy (and its predecessors) and the fourth conducted by the AIHW, with 23,356 completed responses collected. Fieldwork conducted by Roy Morgan Research and the Social Research Centre.
	2010 National Drug Strategy Household Survey master unit record file	National household survey of non-institutionalised persons aged 12 and over. Tenth in a series of surveys auspiced by the National Drug Strategy (and its predecessors) and the fifth conducted by the AIHW, with 26,648 completed responses collected. Fieldwork conducted by Roy Morgan Research.
	2013 National Drug Strategy Household Survey master unit record file	National household survey of non-institutionalised persons aged 12 and over. Eleventh in a series of surveys auspiced by the National Drug Strategy (and its predecessors) and the sixth conducted by the AIHW, with 23,855 completed responses collected. Fieldwork conducted by Roy Morgan Research.

continued

Topic	Data collection	Description
Burden of disease	Australian burden of disease database	National and Indigenous burden of disease estimates for 2003 and 2011. Includes years of life lost years lost due to disability and disability-adjusted life years (DALY) for around 200 diseases included in the Australian Burden of Disease Study 2011.
Cancer	Australian Cancer Database	Data about all new cases of cancer diagnosed in Australia since 1 January 1982, excluding basal and squamous cell carcinomas of the skin. Cancer is a notifiable disease in all Australian states and territories. The relevant legislation requires certain individuals and organisations to notify all new cases of cancer to the jurisdiction's central cancer registry. These registries supply data annually to the AIHW, which cleans and standardises the data and notifies the registries of inter-state duplicates.
Child protection	Child Protection National Minimum Data Set	Annual collection of information on child protection in Australia. Contains data on children who come into contact with state and territory departments responsible for child protection, including: notifications, investigations and substantiations; care and protection orders; funded out-of-home care; and data for reporting on the National Standards for Out-of-Home Care. Data relating to carer households are also collected.
Deaths	National Death Index	Listing of all deaths that have occurred in Australia since 1980. An invaluable tool for epidemiologists and clinicians in following up research cohorts using record linkage.
	National Mortality Database	Contains records for deaths in Australia from 1964. Comprises information about causes of death and other characteristics of the person, such as sex, age at death, area of usual residence and Indigenous status.
Dental	Public dental waiting times national minimum data set	Enables reporting on the length of time that patients wait for public dental care in Australia, and the characteristics of patients who receive care, or who were listed for care in a reference period.
Diabetes	National (insulin-treated) Diabetes Register	The register aims to record all new cases of people who began to use insulin to treat their diabetes since 1 January 1999. Includes people with type 1, type 2, gestational and other forms of diabetes. Data are sourced from the National Diabetes Services Scheme and Australasian Paediatric Endocrine Group's state and territory registers.

continued

Topic	Data collection	Description
Disability	Disability Services National Minimum Data Set	Since 1991, disability support services in Australia have been provided under 4 national disability agreements. The Commonwealth/State Disability Agreement (CSDA) Minimum Data Set collection was set up in 1994 as a 'snapshot' after signing of the first CSDA in 1991. The 1998 CSDA reflected significant changes, requiring the CSDA Minimum Data Set collection to be redesigned, including changing the collection to a full year data collection. In 2002–03, it became the Commonwealth state/territory Disability Agreement (CSTDA) National Minimum Data Set. The first full financial year of data collection was 2003–04. The National Disability Agreement replaced the CSTDA on 1 January 2009. As a result, from 2009–10, the CSTDA National Minimum Data Set was renamed the Disability Services National Minimum Data Set.
Expenditure	Health and welfare expenditure database	Provides a picture of health expenditure in Australia, by area of expenditure and funding, and examines changes over time.
Homelessness	Specialist Homelessness Services Collection	Compiled data about Specialist homelessness services (SHS) clients and the support they receive from SHS. These services collect the data on an ongoing basis and submit the data to the AIHW on a monthly basis.
	Supported Accommodation Assistance Program (SAAP) National Data Collection	The SAAP aims to provide accommodation and support services to help people who are homeless and/or in crisis to achieve the maximum possible degree of self-reliance and independence. The collection holds details of SAAP-supported clients. Data are collected by service providers during, and immediately following, contact with clients and are then forwarded to the SAAP National Data Collection Agency after clients' support periods have ended, and at the end of the reporting period (30 June) for ongoing clients.
Hospitals	National hospitals data collection	Includes the major national hospitals databases held by the AIHW: the National hospital morbidity database; National public hospital establishments database; National non-admitted patient emergency department care database; National elective surgery waiting times data collection; National non-admitted patient care (aggregate) database; and National non-admitted patient (episode-level) database.

continued

Topic	Data collection	Description
	Radiotherapy Waiting Times Database	The database was primarily designed to enable reporting of waiting times for radiotherapy services, which are calculated as the time between the patient's ready-for-care date and the date of the first megavoltage external beam radiotherapy treatment. It is a collation of records related to courses of radiotherapy that began in a reference period. Data collected include administrative details, patient demographic characteristics and some clinical information.
	State/territory infection surveillance data	Data relating to episodes of *Staphylococcus aureus* (including methicillin-resistant *S. aureus*) bacteraemia (SAB) in acute care hospitals (healthcare-associated infections).
Housing	Australian Government Housing Data Set	Commonwealth Rent Assistance data are derived from the Australian Government Housing Data Set, drawn from administrative data used to monitor the Rent Assistance Program. Provides point-in-time data about income units in receipt of Centrelink payments; specifically, social security payments or Family Tax Benefit, Part A. The data set is provided to the AIHW by the Department of Social Services (DSS) and is used to derive national public housing performance indicators.
	Community Housing Data Collection	Annual data collection that captures information about community housing organisations, the dwellings and tenancy rental units they manage, households on the waiting list, and the tenants and households assisted.
	Home Purchase Assistance Data Collection	Home purchase assistance relates to the provision of financial assistance to households to improve their access to home ownership. Data have been collected since 1997.
	Indigenous Community Housing Data Collection	The annual collection captures information about Indigenous community housing organisations, the dwellings they manage and the households they assist.
	National Social Housing Survey	A biennial survey of social housing tenants which complements administrative data collected by social housing providers and includes information on tenants and their social housing experiences.
	Private rent assistance data collection	Private rent assistance relates to financial assistance provided by state and territory governments to eligible low-income households renting in the private market. Data have been collected since 1997.
	Public housing and state owned and managed Indigenous housing data collections	State and territory governments provide a range of public housing and state owned and managed Indigenous housing programs and provide administrative data about these programs to the AIHW.

continued

Topic	Data collection	Description
Injury	Australian Spinal Cord Injury Register	The register enables measurement of spinal cord injury incidence, study of circumstances and mechanisms. Data on first and subsequent admissions, from 1 July 1995, to any of the 7 specialised spinal units in Australia are being registered prospectively.
Mental health	National Community Mental Health Care Database	Contains service contact data at the patient level for specialised community mental health establishments in the public sector.
	National Mental Health Establishments Database	National collection of establishment-level data for specialised mental health services.
	National Residential Mental Health Care Database	Episodes of residential care for residents in all government-funded mental health services. Episodes of residential mental health care at patient level.
MBS and PBS	Medicare Benefits Schedule (MBS) data collection	Contains information on services that qualify for a benefit under the *Health Insurance Act 1973* and for which a claim has been processed. The database comprises information about MBS claims (including benefits paid), patients and service providers. The AIHW currently holds MBS claims data processed between 1 April 2010 and 30 June 2015.
	Pharmaceutical Benefits Scheme (PBS) data collection	Contains information on prescription medicines that qualify for a benefit under the *National Health Act 1953* and for which a claim has been processed. The database comprises information about PBS scripts and payments, patients, prescribers and dispensing pharmacies. The AIHW currently holds PBS claims data processed between 1 April 2010 and 30 June 2015, excluding PBS under co-payment claims data.
Mothers and babies	National Maternal Mortality Data Collection	Data are collected for all maternal deaths (up to and including 42 days postpartum) occurring in each state or territory. Data collection commenced 1 January 2013. Retrospective data for 2006–12 were also provided by most jurisdictions. Late maternal deaths (occurring from 43 days postpartum up to and including 365 days postpartum) are optional and can be supplied if the state/territory wishes to do so.
	National Perinatal Data Collection	National population-based cross-sectional collection of data on pregnancy and childbirth. Data are based on births reported to the perinatal data collection in each state and territory in Australia. Midwives and other birth attendants complete notification forms for each birth using information obtained from mothers and from hospital or other records. A standard de-identified extract is provided annually to the AIHW.

continued

Topic	Data collection	Description
	National perinatal mortality data collection	A national collection of all stillbirths and neonatal deaths occurring in each state and territory of at least 20 weeks' gestation or 400 grams birthweight. Stillbirths include fetus papyraceous and fetus compressus if they meet the definition.
	2010 Australian national infant feeding survey	The survey gathered information about infant feeding practices and attitudes from a sample of mothers and carers in Australia, including information about: the prevalence and duration of breastfeeding; other foods consumed by infants; barriers to initiating and continuing breastfeeding; and perinatal depression.
Physical activity	National physical activity surveys	The 1997, 1999 and 2000 surveys collected information about physical activity patterns in Australian adults. Activity levels were measured against National Physical Activity Guidelines. Also measured was awareness of physical activity campaigns and media messages current at the time of each survey.
Prisoner health	National Prisoner Health Data Collection	Held by the AIHW for 2009, 2010, 2012 and 2015. Scope includes data items about prison entrants and prison dischargees over a 2-week period, clinic attendances, medications administered and some general information about prisons and their operations.
Vaccination	Adult vaccination survey data collection	The survey gathered information about vaccination of adults for influenza, pneumonia, tetanus and shingles. The 2009 survey also gathered information about vaccination for pertussis ('whooping cough') and the pandemic (H1N1) virus, also known as 'swine flu'. The survey was run 7 times between 2000 and 2010. The AIHW holds data for 2002, 2004, 2006 and 2009/10.
Workforce	Labour force: medical	Data on the demographics and structure of the medical labour force.
	Labour force: nursing	Data on the demographics and structure of the nursing labour force.
	Labour force: occupational therapy	Data on the demographics and structure of the occupational therapy labour force in Vic, Qld, WA, ACT and NT. Occupational therapy data for 1998 survey, comprising Vic, Qld, WA, ACT and NT only.
	Labour force: optometry	Data on the demographics and structure of the optometrist labour force derived from Medicare data.
	Labour force: pharmacy	Data on the demographics and structure of the pharmacy labour force.
	Labour force: physiotherapy	Data on the demographics and structure of the physiotherapy labour force in 1993, 1998 and 2002. Not distributed in 2002 in Tas, WA or NT.

continued

Topic	Data collection	Description
	Labour force: podiatry	Data on the demographics and structure of the podiatry labour force. Exclusions: 1992 data exclude ACT and NT (no podiatry registration board); 1994 data excludes ACT and NT; 1999 data exclude NT; and 2003 data exclude WA, ACT and NT.
	National Health Workforce Data Set	A combination of registration and survey data collected through the registration renewal process for registered health practitioners.
Youth justice	Juvenile Justice National Minimum Data Set	An annual collection of information on young people under youth justice supervision in Australia. Contains data on all supervised orders (both community-based and detention) relating to young people under youth justice supervision.

Appendix 6 Compliance matters

This appendix describes the Australian Institute of Health and Welfare's (AIHW's) compliance in 2016–17 with:

- *Commonwealth Electoral Act 1918*
  - advertising and market research
- *Equal Employment Opportunity (Commonwealth Authorities) Act 1987* (EEO Act)
  - equal employment opportunity programs and reporting
- Legal Services Directions 2017
  - legal services expenditure
- Public Governance, Performance and Accountability Rule 2014 (PGPA Rule)
  - ministerial directions
  - government policy orders
  - significant issues relating to finance law non-compliance
  - related entity transactions
  - significant activities and changes affecting the entity
  - judicial or tribunal decisions affecting the entity
  - reports by third parties
  - unobtainable information from subsidiaries
  - indemnity applying to the entity and its officers.

See also 'Compliance index' on page 177.

Advertising and market research

Section 311A of the *Commonwealth Electoral Act 1918* requires that Commonwealth agencies report payments of $10,000 and above for advertising and market research, including those covered by the *Public Service Act 1999*.

In 2016–17, the AIHW did not undertake any advertising campaigns or make any individual payments for advertising that exceeded this threshold.

Equal employment opportunities

Section 5 of the EEO Act requires that the AIHW develop and implement an equal employment opportunity program. The program should ensure that, in relation to employment matters, appropriate action is taken to eliminate discrimination by the AIHW against women and persons in designated groups and promote equal opportunities for people in these groups.

Under section 9 of the EEO Act, the AIHW must report annually on the development and implementation of its program. The report may be submitted to the AIHW's responsible minister through its annual report. A report should include:

- a detailed analysis of action taken to develop and implement its program
- an assessment of how well program implementation is monitored and evaluated
- an assessment of the effectiveness of the program
- details of each direction given by the minister about the AIHW's performance obligations under the EEO Act.

The AIHW adopts equal employment opportunity practices common across the Australian Public Service (APS), including access to paid parental leave and maternity leave, and recruitment opportunities specifically for Indigenous people. The AIHW accommodates reasonable requests for flexible working arrangements so that staff can meet family commitments, and seeks to remove obstacles that might discourage people with disability or whose first language is not English from seeking employment at the AIHW.

The AIHW monitors and evaluates its equal employment opportunity policies by comparing itself against other agencies that similarly contribute information on diversity to the APS Commission's annual *State of the service report* to the Parliament of Australia. The AIHW is comparable with other APS agencies. However, notably in relation to equal employment opportunity, it has a higher than average proportion of female employees. Further details are in Chapter 5 Our people.

The AIHW has not received any ministerial directions about its performance obligations under the EEO Act.

Compliance with the Legal Services Directions 2017

The Attorney-General's Legal Services Directions 2017 require the AIHW to provide—within 60 days of the end of the financial year—to the Office of Legal Services Coordination, Australian Government Attorney-General's Department:

- a report of the AIHW's legal services expenditure for the financial year
- a certificate about the service of any documents in respect of legal proceedings involving the Commonwealth (if any).

The AIHW complied with its obligations for 2016–17. The AIHW's legal expenditure during the year was $67,973

Reporting requirements under the PGPA Rule

The following information relates to specific reporting requirements under the PGPA Rule that must be included in this annual report and which are not covered elsewhere in the report.

Ministerial directions

Section 7 of the *Australian Institute of Health and Welfare Act 1987* (AIHW Act) provides that the Minister for Health may give directions to the AIHW on the performance of its functions or the exercise of its powers. Before issuing such a direction, the minister must consult the AIHW Board Chair and relevant state and territory ministers. Clause 17BE(d) of the PGPA Rule requires that the AIHW provide details of any directions given to it by a minister under an Act; for example, under section 7 of the AIHW Act, or instrument of the Commonwealth.

No new ministerial directions were issued to the AIHW in 2016–17. No instances of non-compliance with current ministerial directions issued to the AIHW are known to have occurred in 2016–17.

Government policy orders

Under section 22 of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), Australian Government policy orders can be applied to the AIHW by the Minister for Finance. The AIHW Board must ensure compliance with government policy orders that are applied. Clause 17BE(e) of the PGPA Rule requires that the AIHW provide details of any government policy orders that are applicable to it under section 22 of the PGPA Act. Particulars of any non-compliance must also be detailed.

No government policy orders were applicable to the AIHW during 2016–17. No instances of non-compliance with government policy orders are known to have occurred in 2016–17.

Significant issues relating to finance law non-compliance

Paragraph 19(1)(e) of the PGPA Act requires the AIHW to notify the Minister for Health of significant issues that have affected it. Clause 17BE(h) of the PGPA Rule requires the AIHW to provide a statement of any such significant issue that relates to non-compliance with the finance law and an outline of the action that has been taken to remedy the non-compliance.

There were no significant issues relating to finance law non-compliance in 2016–17.

Related entity transactions

Clause 17BE(n) of the PGPA Rule requires the AIHW to disclose any related entity transactions. Related entity transactions are those where the AIHW Board approves payment for a good or service provided by another entity, or provides a grant to another entity; and a board member is also a director of that other entity; and a single transaction, or the aggregate value of transactions (if there is more than 1) to that entity in a reporting period exceeds $10,000. Where they have occurred, particulars of the decision-making process undertaken by the AIHW Board in relation to these transactions must also be reported.

There were no related entity transactions approved by the board in 2016–17.

Significant activities and changes affecting the entity

Under clause 17BE(p) of the PGPA Rule, the AIHW is required to provide details of significant activities and changes that affected the operations or structure of the entity during the period. During 2016–17, the AIHW launched our new *Strategic directions 2017–2021* which will strengthen our capabilities. The new strategic directions are explained on page vii.

Judicial or tribunal decisions affecting the entity

Clause 17BE(q) of the PGPA Rule requires the AIHW to provide details of judicial decisions and decisions of administrative tribunals that have had, or may have, a significant effect on the AIHW's operations.

In 2016–17, there were no legal actions lodged against the AIHW and no judicial decisions directly affecting the AIHW.

Reports by third parties

Clause 17BE(r) of the PGPA Rule requires the AIHW to provide details of reports made about the Institute by the Auditor-General, a Parliamentary committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner.

There were no reports made by the above-named organisations or committees about the AIHW in 2016–17.

Unobtainable information from subsidiaries

The AIHW does not have any subsidiaries; therefore, clause 17BE(s) of the PGPA Rule, which requires the AIHW to detail information that was unable to be obtained from subsidiaries, does not apply.

Indemnity applying to the entity and its officers

Clause 17BE(t) of the PGPA Rule requires the AIHW to provide details of any indemnity that applied to the AIHW Board, any member of the AIHW Board or officer of the AIHW against a liability (including premiums paid, or agreed to be paid, for insurance against the AIHW Board, member or officer's liability for legal costs).

The AIHW has insurance policies through Comcover and Comcare that cover a range of insurable risks, including property damage, general liability and business interruption.

In 2016–17, the Comcover insurance policy included coverage for directors and officers against various liabilities that may arise in their capacity as officers of the AIHW. Standard premiums were paid to Comcover, amounting to $19,136, excluding goods and services tax (GST), compared with $17,342 for 2015–16.

The AIHW made no claims against its directors and officers liability insurance policy in 2016–17.

Appendix 7 Financial statements

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Australian Institute of Health and Welfare for the year ended 30 June 2017:

(a) comply with Australian Accounting Standards – Reduced Disclosure Requirements and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Australian Institute of Health and Welfare as at 30 June 2017 and its financial performance and cash flows for the year then ended.

The financial statements of the Australian Institute of Health and Welfare, which I have audited, comprise the following statements as at 30 June 2017 and for the year then ended:

- Statement by the Accountable Authority, Chief Executive and Chief Finance Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement; and
- Notes to and forming part of the financial statements, comprising a Summary of Significant Accounting Policies and other explanatory information.

Basis for Opinion

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Australian Institute of Health and Welfare in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and his delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) to the extent that they are not in conflict with the *Auditor-General Act 1997*. I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Accountable Authority's Responsibility for the Financial Statements

As the Accountable Authority of the Australian Institute of Health and Welfare the Directors are responsible under the *Public Governance, Performance and Accountability Act 2013* for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Reduced Disclosure Requirements and the rules made under that Act. The Directors of the Australian Institute of Health and Welfare are also responsible for such internal control as it is necessary to enable the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Australian Institute of Health and Welfare's ability to continue as a going concern, taking into account whether the entity's operations will cease as a result of an administrative restructure or for any other reason. The Directors are also responsible for disclosing matters related to going concern as applicable and using the going concern basis of accounting unless the assessment indicates that it is not appropriate.

Auditor's Responsibilities for the Audit of the Financial Statements

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian National Audit Office Auditing Standards will always detect a material misstatement when

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it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with the Australian National Audit Office Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Directors;
- conclude on the appropriateness of the Directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern; and
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Australian National Audit Office

Lesa Craswell
Acting Executive Director

Delegate of the Auditor-General

Canberra
28 September 2017

Australian Government
Australian Institute of Health and Welfare

AIHW

STATEMENT BY ACCOUNTABLE AUTHORITY, CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER

In our opinion, the attached financial statements for the year ended 30 June 2017 comply with subsection 42(2) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and are based on properly maintained financial records as per subsection 41(2) of the PGPA Act.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the Australian Institute of Health and Welfare will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the directors.

Louise Markus	Barry Sandison	Andrew Kettle
Board Chair	Chief Executive	Chief Financial Officer
28 September 2017	28 September 2017	28 September 2017

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Australian Institute of Health and Welfare

STATEMENT OF COMPREHENSIVE INCOME

for the period ended 30 June 2017

	Notes	**2017** **$'000**	2016 $'000	Original Budget $'000
NET COST OF SERVICES				
Expenses				
Employee benefits	2A	**36,513**	33,817	37,678
Supplier	2B	**20,192**	12,844	20,315
Depreciation and amortisation	6C	**1,063**	1,015	1,000
Write-down and impairment of assets	2C	**—**	459	—
Total expenses		**57,768**	48,135	58,993
Own-Source Income				
Own-source revenue				
Sale of goods and rendering of services	3A	**29,628**	31,334	31,000
Interest	3B	**1,021**	759	600
Other revenues	3C	**277**	683	30
Total own-source revenue		**30,926**	32,776	**31,630**
Net cost of services		**26,842**	15,359	27,363
Revenue from government	3D	**26,918**	15,625	26,918
Surplus / Deficit		**76**	266	(445)
OTHER COMPREHENSIVE INCOME				
Change in asset revaluation reserve		**—**	122	—
Total other comprehensive income		**—**	122	—
Total comprehensive income attributable to the Australian Government		**76**	388	(445)

The above statement should be read in conjunction with the accompanying notes.

Australian Institute of Health and Welfare

STATEMENT OF FINANCIAL POSITION

as at 30 June 2017

	Notes	2017 $'000	2016 $'000	Original Budget $'000
ASSETS				
Financial assets				
Cash and cash equivalents	5A	**59,696**	27,220	26,690
Trade and other receivables	5B	**4,775**	6,435	6,586
Total financial assets		**64,471**	33,655	33,276
Non-financial assets				
Buildings	6A, 6C	**4,697**	4,800	4,327
Property, plant and equipment	6B, 6C	**3,073**	3,081	3,699
Intangibles	6D	**253**	—	—
Other non-financial assets	6E	**1,042**	1,076	817
Total non-financial assets		**9,065**	8,957	8,843
Total assets		**73,536**	42,612	42,119
LIABILITIES				
Payables				
Suppliers	7A	**(1,467)**	(1,372)	(2,340)
Other payables	7B	**(4,990)**	(4,767)	(3,872)
Contract income in advance	7C	**(24,041)**	(18,970)	(15,455)
Total payables		**(30,498)**	(25,109)	(21,667)
Provisions				
Employee provisions	8A	**(11,969)**	(11,678)	(12,154)
Other provisions	8B	**(139)**	(139)	3,967
Total provisions		**(12,108)**	(11,817)	(16,121)
Total liabilities		**(42,606)**	(36,926)	(37,788)
Net assets		**30,930**	5,686	4,331
EQUITY				
Contributed equity		**27,924**	2,756	2,756
Reserves		**2,410**	2,410	2,288
Retained surplus (accumulated deficit)		**596**	520	(713)
Total equity		**30,930**	5,686	4,331

The above statement should be read in conjunction with the accompanying notes.

Australian Institute of Health and Welfare

STATEMENT OF CHANGES IN EQUITY

for the period ended 30 June 2017

	Retained Earnings			Asset Revaluation Surplus			Contributed Equity/Capital			Total Equity		
	2017	2016	Original Budget	**2017**	2016	Original Budget	**2017**	2016	Original Budget	**2017**	2016	Original Budget
	$'000	$'000	$'000	**$'000**	$'000	$'000	**$'000**	$'000	$'000	**$'000**	$'000	$'000
Opening balance												
Balance carried forward from previous period	**520**	254	(268)	**2,410**	2,288	2,288	**2,756**	2,756	2,756	**5,686**	5,298	4,776
Adjusted opening balance	**520**	254	(268)	**2,410**	2,288	2,288	**2,756**	2,756	2,756	**5,686**	5,298	4,776
Other Comprehensive Income	**—**	—	—	**—**	122	—	—	—	—	**—**	122	—
Transfer from National Health Performance Authority (note 14)	**—**	—	—	**—**	—	—	**25,168**	—	—	**25,168**	—	—
Surplus (Deficit) for the period	**76**	266	(445)	**—**	—	—	**—**	—	—	**76**	266	(445)
Total comprehensive income attributable to the Australian Government	**76**	266	(445)	**—**	122	—	**25,168**	—	—	**25,244**	408	(445)
Closing balance at 30 June	**596**	520	(713)	**2,410**	2,410	2,288	**27,924**	2,756	2,756	**30,930**	5,686	4,331

The above statement should be read in conjunction with the accompanying notes.

Australian Institute of Health and Welfare

CASH FLOW STATEMENT

for the period ended 30 June 2017

	Notes	2017 $'000	2016 $'000	Original Budget $'000
OPERATING ACTIVITIES				
Cash received				
Receipts from government		**26,918**	15,625	26,918
Goods and services		**37,064**	32,087	31,000
Interest		**902**	727	600
Net GST received		**1,211**	452	—
Other		**275**	687	30
Total cash received		**66,370**	49,578	58,548
Cash used				
Employees		**(36,052)**	(34,154)	(37,678)
Suppliers		**(21,805)**	(13,821)	(19,598)
Total cash used		**(57,857)**	(47,975)	(57,276)
Net cash from (used by) operating activities		**8,513**	1,603	1,272
INVESTING ACTIVITIES				
Cash received				
NHPA – Lease Incentives & Makegood on Transition		—	406	0
Total cash received		—	406	0
Cash used				
Purchase of property, plant and equipment		**(752)**	(351)	(572)
Total cash used		**(752)**	(351)	(572)
Net cash from (used by) investing activities		**(752)**	55	(572)
FINANCING ACTIVITIES				
Cash received				
NHPA – Appropriation & Bank Account	14	**24,715**	—	—
Total cash received		**24,715**	—	0
Net cash from (used by) financing activities		**24,715**	—	0
Net increase (decrease) in cash held		**32,476**	1,658	700
Cash and cash equivalents at the beginning of the reporting period		**27,220**	25,562	25,990
Cash and cash equivalents at the end of the reporting period	5A	**59,696**	27,220	26,690

The above statement should be read in conjunction with the accompanying notes.

Australian Institute of Health and Welfare
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

Australian Institute of Health and Welfare
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

Note 1: Summary of Significant Accounting Policies

1.1 Objectives of the Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare (AIHW) is structured to meet a single outcome:

- A robust evidence-base for the health, housing and community sectors, including through developing and disseminating comparable health and welfare information and statistics. This outcome is included in the Department of Health's (Health) Portfolio Budget Statements.

1.2 Basis of preparation of the financial statements

The financial statements are general purpose financial statements and are required by section 42 of the *Public Governance, Performance and Accountability Act 2013*.
The financial statements have been prepared in accordance with:

a) Financial Reporting Rule (FRR) for reporting periods ending on or after 1 July 2014; and
b) Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.
The financial statements are presented in Australian dollars and values are rounded to the nearest thousand dollars unless otherwise specified.
Unless an alternative treatment is specifically required by an accounting standard or the FRR, assets and liabilities are recognised in the statement of financial position when and only when it is probable that future economic benefits will flow to the entity or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under executory contracts are not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the commitments note or the contingencies note.
Unless alternative treatment is specifically required by an accounting standard, income and expenses are recognised in the Statement of Comprehensive Income when and only when the flow, consumption or loss of economic benefits has occurred and can be reliably measured. Financial statements are general purpose financial statements and are required by section 42 of the *Public Governance, Performance and Accountability Act 2013*.

1.3 Significant accounting judgements and estimates

In the process of applying the accounting policies listed in this note, the AIHW has made the following judgements that have the most significant impact on the amounts recorded in the financial statements:

- the fair value of leasehold improvements and property, plant and equipment has been taken to be the depreciated replacement cost as determined by an independent valuer,

No accounting assumptions or estimates have been identified that have a significant risk of causing a material adjustment to carrying amounts of assets and liabilities within the next reporting period.

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NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

1.4 New Australian Accounting Standards

Adoption of new Australian Accounting Standard requirements

No Australian Accounting Standard has been adopted earlier than the application date as stated in the standard.

New standards, revised standards, interpretations or amending standards that were issued prior to the signing off date and are applicable to the current reporting period did not have financial impact and are not expected to have a future financial impact on the AIHW.

Future Australian Accounting Standard requirements

New standards, revised standards and interpretations that were issued by the Australian Accounting Standards Board prior to the signing off date and are applicable to the future reporting period are not expected to have a future financial impact on the AIHW.

1.5 Revenue

Revenue from the sale of goods is recognised when:

- the risks and rewards of ownership have been transferred to the buyer;
- the entity retains no managerial involvement nor effective control over the goods;
- the revenue and transaction costs incurred can be reliably measured; and
- it is probable that the economic benefits associated with the transaction will flow to the entity.

Revenue from rendering of services is recognised by reference to the stage of completion of contracts at the reporting date. The revenue is recognised when:

- the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- the probable economic benefits with the transaction will flow to the AIHW.

The stage of completion of contracts at the reporting date is determined by reference to the proportion that costs incurred to date bear to the estimated total costs of the transaction.

Receivables for goods and services, which have 30 day terms, are recognised at the nominal amounts due less any allowance for impairment. Collectability of debts is reviewed at balance date. Allowances are made when collectability of the debt is no longer probable.

Interest revenue is recognised using the effective interest method as set out in AASB 139 *Financial Instruments: Recognition and Measurement.*

Revenues from government

Funding received or receivable from Health is recognised as Revenue from government unless they are in the nature of an equity injection or a loan.

1.6 Gains

Resources received free of charge

Resources received free of charge are recognised as gains when and only when a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense.

Resources received free of charge are recorded as either revenue or gains depending on their nature.

Contributions of assets at no cost of acquisition or for nominal consideration are recognised as gains at their fair value when the asset qualifies for recognition, unless received from another government agency or authority as a consequence of a restructuring of administrative arrangements.

Australian Institute of Health and Welfare
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

Sale of assets

Gains from disposal of assets are recognised when control of the asset has passed to the buyer.

1.7 Transactions with the government as owner

Equity injections

Amounts that are designated as equity injections for a year are recognised directly in contributed equity in that year.

1.8 Employee benefits

Liabilities for services rendered by employees are recognised at the reporting date to the extent that they have not been settled.

Liabilities for 'short-term employee benefits' (as defined in AASB 119 *Employee Benefits*) and termination benefits due within twelve months of balance date are measured at their nominal amounts.

The nominal amount is calculated with regard to the rates expected to be paid on settlement of the liability.

Other long-term employee benefits are measured as the present value of the estimated future cash outflows to be made in respect of services provided by employees up to the reporting date.

Leave

The liability for employee benefits includes provision for annual leave and long service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of the AIHW is estimated to be less than the annual entitlement for sick leave.

The leave liabilities are calculated on the basis of employees' remuneration, including the AIHW's employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

The liability for long service leave is recognised and measured at the present value of the estimated future cash flows to be made in respect of all employees at 30 June 2016. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Separation and redundancy

Provision is made for separation and redundancy benefit payments. AIHW recognises a provision for termination when it has developed a detailed formal plan for the terminations and has informed those employees affected that it will carry out the terminations.

Superannuation

AIHW staff are members of the Commonwealth Superannuation Scheme, the Public Sector Superannuation Scheme or the Public Sector Superannuation Scheme accumulation plan.

The first two are defined benefit schemes for the Australian Government. The third is a defined contribution scheme.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported by the Department of Finance as an administered item.

The AIHW makes employer contributions to the employee superannuation scheme at rates determined by an actuary to be sufficient to meet the cost to the government of the superannuation entitlements of the AIHW's employees. The AIHW accounts for the

contributions as if they were contributions to defined contribution plans.

The liability for superannuation recognised as at 30 June represents outstanding contributions for the final fortnight of the year.

1.9 Leases

A distinction is made between finance leases and operating leases. Finance leases effectively transfer from the lessor to the lessee substantially all the risks and rewards incidental to ownership of leased assets. An operating lease is a lease that is not a finance lease. In operating leases, the lessor effectively retains substantially all such risks and benefits.

The AIHW has no finance leases.

Operating lease payments are expensed on a straight line basis which is representative of the pattern of benefits derived from the leased assets.

1.10 Borrowing costs

All borrowing costs are expensed as incurred.

1.11 Cash

Cash and cash equivalents includes notes and coins held and any deposits in bank accounts with an original maturity of 3 months or less that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value. Cash is recognised at its nominal amount.

1.**12** Financial assets

The AIHW classifies its financial assets as loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets are recognised and derecognised upon 'trade date'.

Effective interest method

The effective interest method is a method of calculating the amortised cost of a financial asset and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, or, where appropriate, a shorter period.

Receivables

Trade receivables and other receivables that have fixed or determinable payments that are not quoted in an active market are classified as 'receivables'. Receivables are measured at amortised cost using the effective interest method less impairment. Interest is recognised by applying the effective interest rate.

Impairment of financial assets

Financial assets are assessed for impairment at each balance date.

- Financial assets held at amortised cost: if there is objective evidence that an impairment loss has been incurred for loans and receivables held at amortised cost, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the asset's original effective interest rate. The carrying amount is reduced by way of an allowance account. The loss is recognised in the statement of comprehensive income.

1.13 Financial liabilities

Financial liabilities are classified as other financial liabilities.

Financial liabilities are recognised and derecognised upon ‘trade date’.

Other financial liabilities

Supplier and other payables are recognised at amortised cost. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).

1.14 Contingent liabilities and contingent assets

Contingent liabilities and contingent assets are not recognised in the balance sheet but are reported in the relevant notes. They may arise from uncertainty as to the existence of a liability or asset, or represent a liability or asset in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but not virtually certain, and contingent liabilities are disclosed when settlement is greater than remote.

1.15 Acquisition of assets

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken. Financial assets are initially measured at their fair value plus transaction costs where appropriate.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transferor authority's accounts immediately prior to the restructuring.

1.16 Property, plant and equipment

Asset recognition threshold

Purchases of property, plant and equipment are recognised initially at cost in the balance sheet, except for purchases costing less than $3,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'makegood' provisions in property leases taken up by the AIHW where there exists an obligation to restore the property to its original condition. These costs are included in the value of the AIHW's leasehold improvements with a corresponding provision for the makegood recognised.

Revaluations

Fair values for each class of asset are determined as shown below:

Asset class	Fair value measured at:
Buildings-leasehold improvements	Depreciated replacement cost
Property, plant and equipment	Market selling price

Following initial recognition at cost, property, plant and equipment are carried at fair value less accumulated depreciation and accumulated impairment losses. Valuations are conducted with sufficient frequency to ensure that the carrying amounts of assets do not materially differ from the assets' fair values as at the reporting date. The regularity of independent valuations depends upon the volatility of movements in market values for the relevant assets.

Revaluation adjustments are made on a class basis. Any revaluation increment is credited to equity under the heading of asset revaluation reserve except to the extent that it reverses a

previous revaluation decrement of the same asset class that was previously recognised through surplus and deficit. Revaluation decrements for a class of assets are recognised directly through surplus and deficit except to the extent that they reverse a previous revaluation increment for that class.

Any accumulated depreciation as at the revaluation date is eliminated against the gross carrying amount of the asset and the asset restated to the revalued amount.

A formal revaluation of assets was completed by Allbids.com.au Pty Ltd as at 30 June 2016.

Depreciation

Depreciable property, plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the AIHW using, in all cases, the straight-line method of depreciation.

Depreciation rates (useful lives), residual values and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

	2017	2016
Leasehold improvements	Lease term	Lease term
Property, plant and equipment	3 to 10 years	3 to 10 years

Impairment

All assets were assessed for impairment at 30 June 2017. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

The recoverable amount of an asset is the higher of its fair value less costs to sell and its value in use. Value in use is the present value of the future cash flows expected to be derived from the asset. Where the future economic benefit of an asset is not primarily dependent on the asset's ability to generate future cash flows, and the asset would be replaced if the AIHW were deprived of the asset, its value in use is taken to be its depreciated replacement cost.

1.17 Intangibles

The AIHW's intangibles comprise internally developed and purchased software for internal use. These assets are carried at cost less accumulated amortisation.

Intangibles are recognised initially at cost in the balance sheet, except for purchases costing less than $50,000, which are expensed in the year of acquisition.

Software is amortised on a straight-line basis over its anticipated useful life. The useful life of the AIHW's software is 3 to 5 years (2015–16: 3 to 5 years).

All software assets were assessed for indications of impairment as at 30 June 2017.

1.18 Taxation

The AIHW is exempt from all forms of taxation except Goods and Services Tax (GST) and Fringe Benefits Tax.

Revenues, expenses, assets and liabilities are recognised net of GST except:

- where the amount of GST incurred is not recoverable from the Australian Taxation Office; and
- for receivables and payables.

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	2017	2016
	$'000	$'000
Note 2: Expenses		
Note 2A: Employees benefits		
Wages and salaries	**(27,863)**	(25,702)
Superannuation:		
Defined contribution plans	**(2,295)**	(1,867)
Defined benefit plans	**(2,900)**	(3,008)
Leave and other entitlements	**(3,455)**	(3,240)
Total employee benefits	**(36,513)**	(33,817)
Note 2B: Suppliers		
Goods and services supplied or rendered		
Consultants and contractors	**(7,923)**	(3,745)
Collaborating centres	**(780)**	(1,078)
Information technology	**(3,766)**	(1,368)
Printing and stationery	**(182)**	(170)
Training	**(267)**	(227)
Travel	**(761)**	(579)
Telecommunications	**(215)**	(194)
Other	**(2,473)**	(2,277)
Total goods and services supplied or rendered	**(16,367)**	(9,638)
Other supplier		
Operating lease rentals—lease payments	**(3,355)**	(2,810)
Workers compensation premiums	**(470)**	(396)
Total other supplier expenses	**(3,825)**	(3,206)
Total supplier expenses	**(20,192)**	(12,844)

The Canberra office lease has a fixed annual 3% rent increase. This increase has been averaged over the 15 year term of the lease.

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	2017 $'000	2016 $'000
Note 2C: Write-down and impairment of assets		
Write off on disposal of property, plant and equipment	**–**	(459)
Total write down and impairment of assets	**–**	(459)

Note 3: Revenue

Note 3A: Sale of goods and rendering of services		
Sale of goods	**16**	4
Rendering of services	**29,612**	31,330
Total sale of goods and rendering services	**29,628**	31,334
Note 3B: Interest		
Deposits	**1,021**	759
Total interest	**1,021**	759
Note 3C: Other revenues		
NHPA – transition costs	**–**	680
Other	**277**	3
Total other revenues	**277**	683
Note 3D: Revenue from government		
Corporate Commonwealth entity payment item	**26,918**	15,625
Total revenue from government	**26,918**	15,625

Note 4: Fair Value Measurements

The following tables provide an analysis of assets and liabilities that are measured at fair value.
The different levels of the fair value hierarchy are defined below.

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at measurement date.
Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
Level 3: Unobservable inputs for the asset or liability.

Note 4A: Fair Value Measurements, Valuation Techniques and Inputs Used

Fair value measurements at the end of the reporting period by hierarchy for assets and liabilities in 2017

	Fair value		Level 1 inputs		Level 2 inputs		Level 3 inputs	
	2017	2016	**2017**	2016	**2017**	2016	**2017**	2016
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Fair value measurements at the end of the reporting period using								
Non-financial assets								
Leasehold improvements	**4,697**	4,800	**-**	**-**	**4,697**	4,800	**-**	**-**
Other property, plant and equipment	**3,073**	3,081	**-**	**-**	**3,073**	3,081	**-**	**-**
Intangibles	**253**	-	**253**	**-**	**-**	**-**	**-**	**-**
Total non-financial assets	**8,023**	7,881	**253**	-	**7,770**	7,881	**-**	**-**
Total fair value measurements of assets in the statement of financial position	**8,023**	7,881	**253**	-	**7,770**	7,881	**-**	**-**

Fair value measurements - highest and best use differs from current use for non-financial assets (NFAs)
The highest and best use of all non-financial assets are the same as their current use.

There are no liabilities measured at fair value

No assets were transferred between level 1 and level 2

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Note 4B: Valuation Technique and Inputs for Level 1 and Level 2 Fair Value Measurements

Level 1 and 2 fair value measurements - valuation technique and the inputs used for assets and liabilities in 2017

	Category (Level 1 or Level 2)	Fair value	Valuation technique(s)	Inputs used	Range (weighted average)
		$'000			
Non-financial assets					
Leasehold improvements	Level 2	4,697	Fair Market value	Revaluation by All Bids In 2016	N/A
Other property, plant and equipment	Level 2	3,073	Fair Market value	Revaluation by All Bids In 2016	N/A
Intangibles	Level 1	253	Fair Market value	Purchase Invoice	N/A

In 2016 the AIHW procured valuation services from All Bids and relied on valuation models provided by All Bids. All Bids provided written assurance to the entity that the model developed is in compliance with AASB 13. All assets were valued using the Fair Market Value Technique.

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	2017 $'000	2016 $'000
Note 5: Financial Assets		
Note 5A: Cash and cash equivalents		
Cash on hand or on deposit	**59,696**	27,220
Total cash and cash equivalents	**59,696**	27,220
Note 5B: Receivables		
Receivables are aged as follows:		
Not overdue	**4,712**	6,429
Overdue by:		
0 to 30 days	**60**	–
31–60 days	**3**	6
61-90 days	**–**	–
Greater 90 days	**–**	–
Total receivables (gross)	**4,775**	6,435
Receivables is expected to be recovered in:		
No more than 12 months	**4,775**	6,435
Total receivables (gross)	**4,775**	6,435

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	2017 $'000	2016 $'000
Note 6: Non-Financial Assets		
Note 6A: Buildings		
Leasehold improvements		
Fair value	**5,250**	4,800
Accumulated depreciation	**(553)**	—
Total buildings	**4,697**	4,800

No indicators of impairment were found for leasehold improvements.

Note 6B: Property, plant and equipment		
Property, plant and equipment		
Fair value	**3,570**	3,082
Accumulated depreciation	**(497)**	(1)
Total property, plant and equipment	**3,073**	3,081

No indicators of impairment were found for property, plant and equipment.

Note 6C: Intangibles		
Intangibles		
Fair Value	**267**	—
Accumulated depreciation	**(14)**	—
Total Intangibles	**253**	—

No indicators of impairment were found for intangibles

Revaluations of non-financial assets

A revaluation increment of nil (2016: $122,397) for leasehold improvements, nil (2016: nil) for restoration obligations assets and nil (2016: nil) for changes in provision for restoration obligations. Revaluation decrement for property, plant & equipment was nil (2016: $458,913)

	Buildings-leasehold improvements $'000	Property, plant and equipment $'000	Intangibles $'000	Total $'000
Note 6D: Analysis of property, plant and equipment				
TABLE A: Reconciliation of the opening and closing balances of property, plant and equipment (2016–17)				
As at 1 July 2016				
Gross book value	4,800	3,082	—	7,882
Accumulated depreciation	—	(1)	—	(1)
Net book value 1 July 2016	4,800	3,081	—	7,881
Additions				
by purchase	—	485	267	752
by restructure	450	3	—	453
Depreciation expense	(553)	(496)	(14)	(1,063)
Net book value 30 June 2017	4,697	3,073	253	8,023
Net book value as at 30 June 2017 represented by:				
Gross book value	5,250	3,570	267	9,087
Accumulated depreciation	(553)	(497)	(14)	(1,064)
Net book value 30 June 2017	4,697	3,073	253	8,023

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TABLE B: Reconciliation of the opening and closing balances of property, plant and equipment (2015–16)

As at 1 July 2015	**Buildings-leasehold improvements**	**Property, plant and equipment**	**Total**
	$'000	$'000	$'000
Gross book value	6,009	4,938	10,947
Accumulated depreciation	(972)	(1,093)	(2,065)
Net book value 1 July 2015	5,037	3,845	8,882
Additions			
by purchase	–	351	351
Disposals	–	(1)	(1)
Revaluations recognised in operating results	–	(2,207)	(2,207)
Revaluations recognised in Asset Revaluation Reserve	(596)	–	(596)
Depreciation expense	(360)	(655)	(1,015)
Write back of depreciation on revaluation	719	1,748	2,467
Net book value 30 June 2016	4,800	3,081	7,881
Net book value as at 30 June 2016 represented by:			
Gross book value	4,800	3,082	7,882
Accumulated depreciation	–	(1)	(1)
Net book value 30 June 2016	4,800	3,081	7,881

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Note 6E: Other non-financial assets

	2017	2016
	$'000	$'000
Prepayments	**1,042**	1,076
Total other non-financial assets	**1,042**	1,076

All other non-financial assets are expected to be recovered in no more than 12 months.

Note 7: Payables

Note 7A: Suppliers

Trade creditors	**(1,467)**	(1,372)
Total supplier payables	**(1,467)**	(1,372)

Note 7B: Other payables

Wages and salaries	**(266)**	(112)
Superannuation	**(43)**	(27)
Lease incentive - Canberra	**(3,000)**	(3,250)
Lease incentive – Sydney	**(128)**	(267)
Operating lease	**(1,553)**	(1,111)
Total other payables	**(4,990)**	(4,767)
Other payables expected to be settled in:		
No more than 12 months	**(437)**	(523)
More than 12 months	**(4,553)**	(4,244)
Total other payables	**(4,990)**	(4,767)

Note 7C: Contract income in advance

Contract income	**(24,041)**	(18,970)
Total contract income in advance	**(24,041)**	(18,970)

All income in advance payables is expected to be settled in 12 months.

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	2017	2016
	$'000	$'000

Note 8: Provisions

Note 8A: Employee provisions

Leave	**(11,969)**	(11,678)
Total employee provisions	**(11,969)**	(11,678)
Employee provisions expected to be settled in:		
No more than 12 months	**(2,236)**	(1,770)
More than 12 months	**(9,733)**	(9,908
Total employee provisions	**(11,969)**	(11,678)

Note 8B: Other provisions

Provision for make good - Sydney office	**(139)**	(139)
Total other provisions	**(139)**	(139)
Other provisions expected to be settled:		
No more than 12 months	**(139)**	–
More than 12 months	**–**	(139)
Total other provisions	**(139)**	(139)

Note 9: Contingent Assets and Liabilities

As at 30 June 2017, the AIHW has no contingent assets, remote contingencies or unquantifiable contingencies (2016: nil).

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Note 10: Key Management Personnel Remuneration

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the AIHW, directly or indirectly, including any director (whether executive or otherwise) of the AIHW. The AIHW has determined the key management personnel to be the Director, Board of Directors and Group Heads. Key management personnel remuneration is reported in the table below

	2017	2016
	$'000	$'000
Short-term employee benefits	**2,227**	1,457
Post-employment benefits	**325**	203
Other long term benefits	**133**	2
Total key management remuneration expenses	**2,685**	1,662

The total number of key management personnel included in the above table is 18 (2016: 17). In 2016, there were vacancies which led to a higher number of executives with part year service. Note 10 is prepared on an accrual basis.

Note 11: Related Party Disclosures

Related party relationships:

The AIHW is an Australian Government controlled entity. Related parties to this entity are the Minister for Health, Directors, Key Management Personnel and Executive, and other Australian Government entities.

Transactions with related parties:

Given the breadth of Government activities, related parties may transact with the government sector in the same capacity as ordinary citizens. The AIHW's arrangements with the government sector are conducted under contracts as normal business with the same conditions as with private enterprise. These transactions have not been separately disclosed in this note.

There were no related party transactions during the financial year (2015-16: $0)

Note 12: Remuneration of Auditors

	2017	2016
Remuneration for auditing the financial statements for the reporting period	**$35,000**	$35,000

No other services were provided by the Australian National Audit Office.

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Note 13: Financial Instruments	**2017**	2016
Note 13A: Categories of financial instruments	**$'000**	$'000
Financial assets		
Loans and receivables		
Cash at bank	**59,696**	27,220
Receivables for goods and services	**4,196**	6,040
Total loans and receivables	**63,892**	33,260
Total financial assets	**63,892**	33,260
Financial liabilities		
Financial liabilities measured at amortised cost		
Trade creditors	**1,467**	1,372
Financial liabilities measured at amortised cost	**1,467**	1,372
Total financial liabilities	**1,467**	1,372

The AIHW holds basic financial instruments in the form of cash and cash equivalents, receivables for goods and services and trade creditors. The carrying value of financial instruments reported in the balance sheet is a reasonable approximation of fair value.

Note 13B: Net gains and losses from financial assets		
Loans and receivables		
Interest revenue	**1,021**	759
Net gain loans and receivables	**1,021**	759
Net gain from financial assets	**1,021**	759

The AIHW is exposed to minimal credit risk as the majority of loans and receivables are receivables from other government organisations. The maximum exposure to credit risk is the risk that arises from potential default of a debtor. This amount is equal to the total amount of trade receivables (2017: $4,196,000 and 2016: $6,040,000). The AIHW has assessed the risk of the default on payment and has allocated $0 in 2017 (2016: $0) to an allowance for impairment account.

The AIHW has no significant exposure to any concentrations of credit risk.

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Note 13C: Credit Risk

Credit quality of financial instruments not past due or individually determined as impaired:

	Not past due nor impaired 2017	Not past due nor impaired 2016	**Past due or impaired 2017**	Past due or impaired 2016
	$'000	$'000	**$'000**	$'000
Cash at bank	**59,696**	27,220	**—**	—
Receivables for goods and services	**4,133**	6,034	**63**	6
Total	**63,829**	33,254	**63**	6

Ageing of financial assets that are past due but not impaired for 2017:

	0–30 days $'000	31–60 days $'000	61–90 days $'000	90+ days $'000	Total $'000
Receivables for goods and services	60	3	—	—	63
Total	**60**	**3**	**—**	**—**	**63**

Ageing of financial assets that are past due but not impaired for 2016:

	0–30 days $'000	31–60 days $'000	61–90 days $'000	90+ days $'000	Total $'000
Receivables for goods and services	—	6	—	—	6
Total	—	6	—	—	6

Note 13D: Liquidity risk

The AIHW is funded by appropriation and the sale of goods and services. It uses these funds to meet its financial obligations.

Note 13E: Market risk

The AIHW holds basic financial instruments that do not expose the AIHW to certain market risks. The AIHW is not exposed to 'currency risk' or 'other price risk'.

Australian Institute of Health and Welfare
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

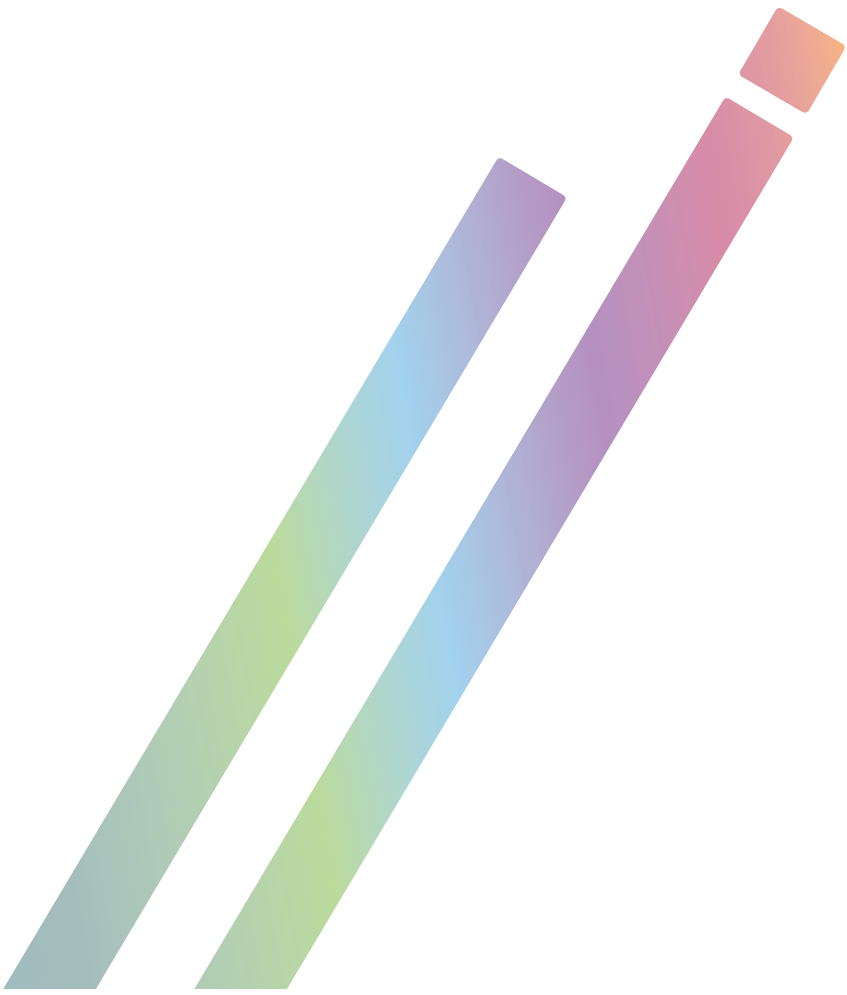
Note 14: Net assets transferred to the AIHW

During 2016-17 the National Health Performance Authority was abolished and its net assets transferred to the AIHW as follows:

	2017	2016
	$'000	$'000
Assets Recognised		
Cash	**24,715**	**—**
Leasehold Improvements	**450**	**—**
Property, Plant & Equipment	**3**	**—**
Total Assets Recognised	**25,168**	**—**

Note 15: Major budget variances

Explanations of major variances	**Affected line items (and statement)**
Financial assets	
Cash and cash equivalents have increased as the income received in advance was higher than budgeted.	Cash and cash equivalents and Contract Income in Advance (statement of financial position), Cash received (cash flow statement)
Equity	
Equity has increased due to assets received including cash from the closure of the NHPA.	Equity, Cash and cash equivalents (statement of financial position), Cash received (cash flow statement), Interest (statement of



Reader guides

These guides help readers find specific information in this annual report, as well as correcting errors and specifying omissions, if any, in the previous annual report.

Abbreviations, acronyms and symbols

Abbreviations and acronyms

ABDS	Australian Burden of Disease Study
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ADF	Australian Defence Force
AIHW	Australian Institute of Health and Welfare
AIHW Act	*Australian Institute of Health and Welfare Act 1987*
APS	Australian Public Service
BMI	body mass index
CEO	Chief Executive Officer
CIHI	Canadian Institute for Health Information
COAG	Council of Australian Governments
CSDA	Commonwealth/State Disability Agreement
CSTDA	Commonwealth state/territory Disability Agreement
DALY	disability-adjusted life years
DIPA	Data Integration Partnerships Australia
DSS	Australian Government Department of Social Services
EA	AIHW's Enterprise Agreement
EEO Act	*Equal Employment Opportunity (Commonwealth Authorities) Act 1987*
EL	Executive Level
NSW FACS	NSW Department of Family and Community Services
FaHCSIA	(former) Australian Government Department of Families, Housing, Community Services and Indigenous Affairs
FOI Act	*Freedom of Information Act 1982*
FRR	Public Governance, Performance and Accountability (Financial Reporting) Rule 2015
FTE	full-time equivalent
GST	goods and services tax
HTML	hypertext markup language
HPV	human papilloma virus
ICD-11	International Statistical Classification of Diseases and Related Health Problems, 11th Revision
ICOH	International Commission on Occupational Health
ICT	information and communications technology
Institute	Australian Institute of Health and Welfare
IPA	Individual Performance Agreement [for AIHW staff]
IT	Information technology
MBS	Medicare Benefits Schedule
METeOR	AIHW's Metadata Online Registry
MoU	memorandum of understanding
NABERS	National Australian Built Environment Rating System

Abbreviations and acronyms

NDI	National Death Index
NDSHS	National Drug Strategy Household Survey
NHPA	National Health Performance Authority
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Co-operation and Development
PAF	Performance Accountability Framework (for health services)
PBS	Pharmaceutical Benefits Scheme
PBS	Portfolio Budget Statements
PDF	portable document format
PGPA Act	*Public Governance, Performance and Accountability Act 2013*
PGPA Rule	Public Governance, Performance and Accountability Rule 2014
PHN	Primary Health Network
PIAC	Pathways in Aged Care
PM&C	Australian Government Department of the Prime Minister and Cabinet
Qld	Queensland
RACP	Royal Australasian College of Physicians
RMS	Rehabilitation Management System
SA	South Australia
SAAP	Supported Accommodation Assistance Program
SAMAC	AIHW's Statistical and Analytical Methods Advisory Committee
SES	Senior Executive Service
SHS	Specialist Homelessness Services
SHS-CP	specialist homelessness service and child protection
SHS-YJ	specialist homelessness service and youth justice
SHS-CP-YJ	specialist homelessness service, child protection and youth justice
Tas	Tasmania
Vic	Victoria
WA	Western Australia
WHO FIC	World Health Organization Family of International Classifications
WHS	work health and safety
WHS Act	*Work Health and Safety Act 2011*

Symbols

%	per cent
n.a.	not available (in tables)
—	not defined, nil or rounded to zero (in tables)
. .	not applicable (in tables)

Glossary

Term	Definition or explanation
Australian Health Ministers' Advisory Coucil	The Australian Health Ministers' Advisory Council (AHMAC) is the advisory and support body to the COAG Health Council. It operates to deliver health services more efficiently through a coordinated or joint approach on matters of mutual interest. The AHMAC is responsible for providing effective and efficient support to the COAG Health Council by advising on strategic issues relating to the coordination of health services across the nation and, as applicable, with New Zealand and operating as a national forum for planning, information sharing and innovation.
Australian Associated Press	An Australian news agency.
COAG	The Council of Australian Governments is the peak intergovernmental forum in Australia, comprising the Prime Minister, state premiers, territory chief ministers and the President of the Australian Local Government Association. See www.coag.gov.au for more information.
data linkage	The bringing together (linking) of information from 2 or more different data sources that are believed to relate to the same entity—for example, the same individual or the same institution. This can provide more information about the entity and, in certain cases, can provide a time sequence, helping to tell a story, show 'pathways' and perhaps unravel cause and effect. The term is used synonymously with 'data integration' and 'record linkage'.
energy consumption	The amount of energy used. Energy consumption can be measured, for example, in kilowatt hours, megajoules or gigajoules.
Energy Star	An international standard/program for energy-efficient electronic equipment. In Australia, the program applies to office equipment and home entertainment products. Australian Government policy for the procurement of office equipment requires departments and agencies to purchase only office equipment that complies with the 'Energy Star' standard, where it is available and fit for purpose. A key feature of Energy Star compliance is that the associated equipment will have power management features allowing it to meet a minimum energy performance standard.
financial results	The results shown in the financial statements of this AIHW annual report.
full-time equivalent (staff numbers)	A standard measure of the number of workers in an organisation, profession or occupation that also takes into account the number of hours each person works. During 2016–17, AIHW staff members considered full-time were committed to working 37 hours and 5 minutes per week.
GreenPower	An energy product purchased from an Australian Government accredited energy provider that supplies renewable energy.
indicator	A key statistical measure selected to help describe (indicate) a situation concisely, to track change, progress and performance, and to act as a guide to decision making.
Indigenous (person)	A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.
Indigenous status (of a person)	Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin.
Infographics	Infographics present complex information in a way that is visually stimulating and easily understandable. We produce infographics, posters and report profiles to highlight key information from our reports, which can be used as education resources.

Term	Definition or explanation
metadata	Information that describes data in relation to their structure, organisation and content.
METeOR	METeOR is Australia's repository for national metadata standards for the health, community services and housing assistance sectors. It operates as a metadata registry—a system or application where metadata are stored, managed and disseminated—based on the International Organization for Standardization/International Electrotechnical Commission's ISO/IEC 11179 international standard. METeOR was developed by the AIHW and provides users with a suite of features and tools, including online access to a wide range of nationally endorsed data definitions, and tools for creating new definitions based on existing already-endorsed components. Through METeOR, users can find, view and download data standards, and develop new ones.
National Australian Built Environment Rating System	A performance-based rating system for existing buildings. It rates a commercial office, hotel or residential building on the basis of its measured operational impacts on the environment. National Australian Built Environment Rating System (NABERS) ratings for offices include NABERS Energy (previously the Australian Building Greenhouse Rating), NABERS Water, NABERS Waste and NABERS Indoor Environment. The NABERS is a rating of a building's energy efficiency that takes into account consumption of electricity, gas and other products like fuels. The rating can be used to benchmark the greenhouse performance of office premises. The Australian Government's Energy Efficiency in Government Operations Policy advises that this rating scheme is suitable as an energy performance measurement tool for office buildings. The ratings scheme is also known as NABERS Office Energy.
national minimum data set	A minimum set of data elements agreed for mandatory collection and reporting at national level.
outcome (health outcome)	A health-related change due to a preventive or clinical intervention or service. The intervention may be single or multiple, and the outcome may relate to a person, group or population, and may be partly or wholly due to the intervention.
outcomes (of the AIHW)	The results, impacts or consequences of actions by the Australian Government public sector on the Australian community. This may include proposed or intended results, impacts or consequences of actions.
outputs	Goods or services produced by the AIHW for external organisations or individuals, including goods or services produced for areas of the Australian public sector external to the AIHW.
www.coag.gov.au (of the AIHW)	Measures that relate to the AIHW's effectiveness in achieving the Australian Government's objectives.
performance indicators (of the health system)	Measures that relate to the health system as a whole or to parts of it, such as hospitals and health centres. The measures include accessibility, effectiveness, efficiency and sustainability, responsiveness, continuity of care, and safety.
Portfolio Budget Statements	Statements prepared by Australian Government portfolios to explain the Budget appropriations in terms of outputs and outcomes. The AIHW contributes to the statements of the Health portfolio, usually published in May each year.

Annual report 2015–16 errors and omissions

There are no known errors or omissions in the *AIHW annual report 2015–16* to report.

List of tables

List of figures

Compliance index

The index that follows shows compliance with information requirements contained in legislation related to the preparation of annual reports of corporate Australian Government entities or other reporting requirements, as follows:

- *Public Governance, Performance and Accountability Act 2013* (PGPA Act), section 46 of which requires the AIHW Board to prepare this 2016–17 annual report and provide it to the Minister for Health by 15 October 2017. Subsection 46(3) of the PGPA Act permits rules for annual reports to be made. The PGPA Act is available at www.legislation.gov.au/Details/C2017C00269.
- Public Governance, Performance and Accountability Rule 2014 (PGPA Rule), clause 17B of which prescribes requirements for annual reports for corporate Australian Goverment entities. The PGPA Rule is available at www.legislation.gov.au/Details/F2017C00494.
- Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 (FRR), which relates to the preparation of financial statements. The FRR is available at www.legislation.gov.au/Details/F2017C00407.

The index is ordered by section, subsection or clause in the PGPA Act, the PGPA Rules or the FRR.

Index of annual report and other related reporting requirements

PGPA Act	Section or subsection of the PGPA Act	Page in this report
Annual report on the entity's activities prepared by the accountable authority	46(1)	iv–vi, 1–166
Financial statements prepared by the accountable authority, as given to the Auditor-General	42(1)	142–166
Statement that the financial statements comply with subsection 42(2)	42(3)	141
Auditor-General's report on the financial statements	43	139
Presentation to the responsible minister by 15 October	46(2)	n.a[(a)]
PGPA Rule	**Clause in the PGPA Rule**	
Approval of annual report by accountable authority (including the signature of a member, details of how and when approved and a statement of responsibility as per section 46 of the PGPA Act)	17BB	iii
Parliamentary standards of presentation	17BC	. .
Plain English and clear design, including:	17BD	
preparation with regard to the interests of Parliament and any others with an interest	17BD(1) 17BD(2)	. .
relevant, reliable, concise, understandable and balanced information using clear design, defined acronyms and technical terms, tables, graphs, diagrams and charts and any appropriate additional matters		
Enabling legislation	17BE(a)	102
Summary of the entity's objects and functions (as set out in legislation)	17BE(b)(i)	48

PGPA Rule	Clause in the PGPA Rule	
Entity's purposes (as included in its corporate plan)	17BE(b)(ii)	3
Responsible minister's name(s) and title(s) (current and during the year)	17BE(c)	viii
Ministerial directions given under an Act or instrument and, if any, non-compliance particulars	17BE(d) and 17BE(f)	135
Government policy orders that applied under section 22 of the PGPA Act and, if any, non-compliance particulars	17BE(e) and 17BE(f)	136
Annual performance statement for the entity as per paragraph 39(1)(b) of the PGPA Act and section 16F of the PGPA Rule	17BE(g)	4–17
Significant issues reported by the entity to the responsible minister under paragraph 19(1)(e) of the PGPA Act that relate to finance law non-compliance and an outline of action to remedy any such non-compliance	17BE(h) and 17BE(i)	136
Information on the accountable authority, including:		50–55
member names, qualifications, experience and whether executive or non-executive	17BE(j)(i)–(v)	
attendance at meetings	17BE(j)(iv)	117–118
Organisational structure (including subsidiaries)	17BE(k)	63–68, See also 137
Location of major activities and facilities	17BE(l)	97
Corporate governance practices	17BE(m)	55–56
Related entity transactions: process accountable authority uses to make a decision regarding paying for a good or service [or providing a grant] from [or to] another Commonwealth entity or company, where the entity is related to the other entity or company and the value of the transaction(s) is more than $10,000	17BE(n)	136
Significant activities and changes affecting the entity's operations or structure	17BE(p)	136
Judicial or tribunal decisions affecting the entity's operations	17BE(q)	136
Reports by third parties, specifically the Auditor-General, a parliamentary committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner	17BE(r)	137
Unobtainable information from subsidiaries which should be in this report	17BE(s)	137
Indemnity applying to the entity and its officers	17BE(t)	137
Index of annual report requirements	17BE(u)	177–179

FRR	Section in the FRR	
Requirements for the preparation of financial statements for reporting periods ending on or after 1 July 2014	3	139–166
Other related reporting requirements	**Authority**	
Advertising and market research organisations expenditure and statement on advertising campaigns	*Commonwealth Electoral Act 1918* (section 331A)	134
Ecologically sustainable development and environmental performance	*Environmental Protection and Biodiversity Conservation Act 1999* (section 516A)	97–99
Equal employment opportunity program annual report	*Equal Employment Opportunity (Commonwealth Authorities) Act 1987* (section 9)	134
Health and safety matters	*Work Health and Safety Act 2011* (Part 4 of Schedule 2)	95–97
Legal services expenditure	Legal Services Directions 2005	135

(a) At the time of printing this annual report, compliance with this requirement was expected to be achieved.

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Australian Institute of Health and Welfare

Annual report 2016–17

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AIHW

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better decisions,
improved health and welfare