

NHWI News

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G-G launches landmark Indigenous health and welfare report

The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, produced by the Darwin based Aboriginal and Torres Strait Islander Health and Welfare Information Unit (a joint project of the Australian Institute of Health and Welfare and the Australian Bureau of Statistics), was launched by the Governor-General, Sir William Deane, on 2 April 1997.

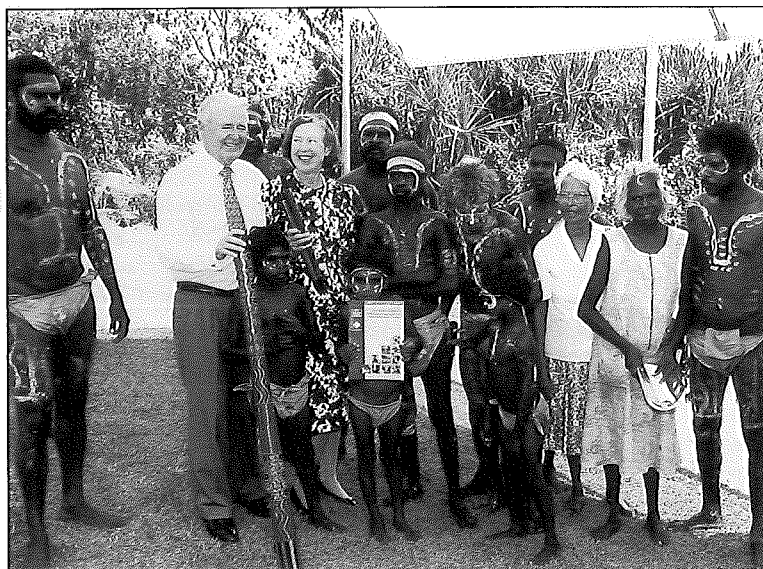
The venue was the picturesque Museum and Art Gallery of the Northern Territory, on the shores of Fannie Bay, Darwin.

A meeting of the AIHW Board was held at the Museum in conjunction with the launch. It was the first Board meeting to be held outside Canberra.

In his address Sir William made a plea for action on Indigenous health, saying that 'nothing can justify any delay in our doing whatever we can to address the overwhelming health problems of Aboriginal and Torres Strait Islander Australians...This report will hopefully do much to influence all Australians, both Indigenous and non-Indigenous, to approach the question of health and welfare of Aboriginal and Torres Strait Islander peoples, particularly children, on the basis of unprejudiced statistical facts'.

Sir William also noted the problem of smoking, saying that it 'had to be clear to any intelligent person prepared to listen and learn that smoking had an enormously damaging impact on the health of Australia's Indigenous people'. Sir William's comments were widely reported around Australia, generating a great deal of public and media discussion.

AIHW Board Chair, Professor Janice Reid, in her opening address, announced that the publication presented 'for the first time, in the one place, all current authoritative statistical material on Aboriginal and Torres Strait Islander health and welfare. It is as comprehensive as we can make it,



Governor-General, Sir William Deane, and Lady Deane with members of the Belyuen dance group and other representatives of the Larrakia people at the launch of The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples

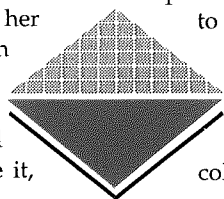
although we are the first to admit that a lot more needs to be done in the coming years'.

Professor Reid announced that Federal Health Minister Dr Michael Wooldridge had approved funding to the Darwin Unit continue for a further five years.

Professor Reid paid tribute to the Unit's staff, led by Tony Barnes, citing the Unit's exceptional achievements since its establishment only two years ago: 'Cooperative arrangements between two organisations such as the ABS and AIHW can work, and work well, to the point where the end result is greater than the sum of the two parts'.

Chair of the Aboriginal and Torres Strait Islander Commission, Gatjil Djerrkura, responded positively to the report on behalf of all Indigenous Australians. He said the report would not only be an important source of data for ATSIC regional councils and other policy makers, but would 'encourage State and Territory agencies to cooperate more fully in the collection of data'.

Deputy Australian Statistician Tim Skinner concluded proceedings by indicating that increasing emphasis was to be given by the ABS and the Institute, in collaboration with the States and Territories, to improving the identification of Aboriginal and Torres Strait Islander peoples in administrative data collections, and to improving welfare-related collections and statistics.





This newsletter reports on the launch of the flagship Australian Institute of Health and Welfare/Australian Bureau of Statistics report on the health and welfare of Indigenous Australians. The Institute is indebted to the Governor-General, Sir William Deane, for launching this report and giving its contents the publicity and context that was achieved.

Given the attention generated, the future availability of adequate data on the Indigenous population needs discussion. The report uses ABS census and survey data and administrative statistics such as State and Territory birth and death registrations, and perinatal and hospital morbidity data. The 1996 census data will soon be available, but the future of some survey data is uncertain. The ABS has approached other Commonwealth agencies to support a second national Aboriginal and Torres Strait Islander survey in 1999, but is not offering any contribution to the survey itself. Other agencies may offer assistance for material specific to their area of interest, but it is unlikely that the broad and interdependent array of data that made the 1994 survey such a unique chronicle of the Indigenous people in Australia could be funded only by agency contributions.

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NHWI News

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Second, data on Indigenous people have not been obtainable from Australia's major population surveys such as the 1989 National Health Survey or the 1993 Disability, Ageing and Carers Survey. For the first time, the ABS accepted additional funding from a consortium including the Aboriginal and Torres Strait Islander Commission (ATSIC) and Commonwealth, State and Territory health agencies to allow a sufficiently large Indigenous sample for reporting on Indigenous people, although the evaluation of this compromise strategy is yet to be undertaken. Regrettably the decision to increase the sample size came too late to allow any change in design or content to ensure the survey would be as effective as possible for Indigenous people.

The ABS plans to evaluate the 1995 experience and will make use of the results of the evaluation to assist decisions about including Indigenous samples in future surveys (regardless of funding source). Given the continuing burden of illness and disadvantage among Indigenous people, it is crucial that methods are found to maximise the information on Indigenous people that can be obtained through these major, resource intensive, national surveys.

Administrative statistics need a great deal more work. Death data are still not of publishable quality for New South Wales, Victoria, Queensland and Tasmania. Perinatal data do not identify as Indigenous the children of Indigenous fathers and non-Indigenous mothers, and the quality of identification in hospital data is uncertain.

The Australian Health Ministers' Advisory Council (AHMAC) has endorsed immediate efforts to overcome these data limitations, and the National Health Information Management Group is to oversee this process. The ABS will be spearheading birth and death data improvement, and the Institute will lead in perinatal and hospital data.

Of course, Indigenous data can only be improved with the consent and input of Indigenous people. The establishment of the Aboriginal and Torres Strait Islander Health and Welfare Information Unit in Darwin has included a broadly based advisory committee, representative of the key relevant Indigenous organisations, including ATSIC, the Torres Strait Regional Authority and National Aboriginal Community Controlled Health Organisations, and is chaired by Shane Houston, General Manager, Office of Aboriginal Health Division, Health Department of Western Australia. The work of that group contributed to the work program which resulted in the new flagship report; and is much appreciated.

Finally to the staff of the Unit in Darwin, great credit and thanks! Tony Barnes, Joan Cunningham, Tammy White, Barbara Gray, Frank Siciliano, Mary Beneforti, Paula Kearnes and Yin Paradies have done a magnificent job. The contribution of reviewers is also much appreciated. With the funding of the unit now secure for a further five years, the Institute and the ABS look forward to the continuing success and development of statistics on the health and welfare of Indigenous people.

Richard Madden, Director, AIHW



On the Nation

National Health Information Management Group

The National Health Information Management Group (NHIMG) is entering the final year of the current National Health Information Agreement (NHIA), with great interest in reviewing the value of the Agreement, and in looking ahead to applying past experience to improving the future. The Management Group's role has developed and matured since its inaugural meeting in June 1993. At its 19th meeting in March this year, the NHIMG took time for a strategic review of its role and priorities.

The NHIMG agreed that its principal areas of interest are:

- data collection, dissemination and sharing standards
- data definitions
- information dissemination
- policy development.

The NHIMG decided that in addressing these areas, it 'will give priority to work that supports the policy development, management and accountability needs of governments'.

The National Health Data Committee (NHDC) will continue as the sole standing subcommittee. Representation on the NHDC is much wider than the NHIA membership, and it was decided that similar wide access was important for other subsidiary committees as well. Other developments were to extend liaison with other common interest bodies, in particular, Standards Australia's IT/14 Committee.

A review of the National Health Information Work Program (NHIWP) and its priorities is a current strategic task of the NHIMG.

The NHIMG also gave some thought to the operations of the NHDC and confirmed at this meeting that the primary role for the NHDC would be in providing it with advice on compliance/consistency for candidate items developed through the NHIWP for the National Health Data Dictionary. A new role will be to oversight rules for the inclusion of information on the National Health Information Knowledgebase other than that endorsed by the Management Group. This will extend the scope of on-line access to information.

Among other decisions taken by the NHIMG were to add two projects to the Work Program. These are development

of National Health Data Dictionary definitions for Alcohol and Other Drug Treatment Services, and development of common code sets for use by community based health services.

A proposal on the collection of health labour force data was also agreed. In future, there will be an annual medical collection; a nursing collection every two years; and a rolling three-year survey program covering pharmacy, physiotherapy, clinical psychology, podiatry, occupational therapy and speech pathology. Together with optometry, these had been identified as priority occupations for national data in a survey of all Commonwealth, State and Territory health authorities.

At the March meeting all jurisdictions agreed and subsequently confirmed that collection of statistics for the Mental Health National Minimum Data Set would commence on 1 July 1997.

Ian Lester, AIHW, Ph. (06) 244 1126

National Health Data Dictionary

The 1997 National Health Data Dictionary (NHDD) will shortly be available in both hard copy (as in previous years) and in electronic form, via the National Health Information Knowledgebase.

Significant changes have been made in the presentation of NHDD data definitions in both products, especially the adoption of a revised format based primarily on the International Standards Organisation (ISO) standard no. 11179 *Specification and Standardisation of Data Elements*. Each data item will be described according to a set of attributes that explain its identifying, definitional, relational and representational details. This set of attributes comprises a set of 'metadata' standards which will have important ongoing application in future development and maintenance of high-quality data definitions underlying national data collections.

Joe Christensen, AIHW, Ph. (06) 244 1148

Community services update

The National Community Services Information Agreement has now received wide endorsement in the Commonwealth, the States and Territories, and among community services authorities, and implementation has commenced.

Management Group

The Management Group, chaired by Richard Deyell, Chief Executive of the South Australian Department of Family and Community Services, met for the second time in March 1997. The meeting identified those tasks that needed urgent action. One major issue is the need to coordinate data development in health and community services.



A small working group was set up to look at national information development priorities for community services and to identify the major factors that influence the development of, and the need for, community services information. The Management Group also took action on several recommendations made by the Standing Committee of Community Services and Income Security Administrators (SCCSISA) at its February meeting. It was agreed that the Institute prepare a report detailing data sources on youth homelessness, set up a group to look at the scope of national data development in child protection and related areas, and prepare a report on data development requirements and directions. In response to a SCCSISA request, the Management Group is providing advice on data quality in the community services sections of the *Report on Government Service Provision 1997*.

Data Committee

The National Community Services Data Committee (NCSDC) met for the first time in February 1997. The members comprise representatives from Commonwealth, State and Territory community services authorities; the National Health Data Committee; the Industry Commission; the Commonwealth Grants Commission; and non-government agencies. The chair is Ching Choi, head of the Institute's Welfare Division.

The Data Committee is responsible for new data development activities of national relevance and coordinating the development and maintenance of national community services data through the National Community Services Data Dictionary (NCSDD) and national minimum data sets. An overall objective of the Committee is to promote consistency between national health data and national community services data standards and definitions.

At this meeting the Committee put in place the data development work program for 1997. The most important task was the development of Version 1.0 of the NCSDD in conjunction with the development of a National Community Services Information Model. The first step in developing the NCSDD is an audit of national community services information development activities.

Joint membership has been established with the National Health Data Committee working group on the redevelopment of the Data Development Guidelines and Standards. Working relationships will also be established and maintained with other data development groups.

Tanya Wordsworth, AIHW, Ph. (06) 244 1119

Commonwealth, State and Territory news

Report on government service provision 1997

The *Report on Government Service Provision 1997* was released in February, and examines the effectiveness and efficiency of government services in significant areas of education, health, housing, community services and justice.

This is the only report internationally that provides comparative performance information across a wide range of human services. It reflects the commitment of governments in Australia to the reporting of reliable and valid information about the effectiveness and efficiency of government funded service delivery.

The report is published by the Steering Committee for the Review of Commonwealth/State Service Provision. The Committee now operates under the auspice of the Council of Australian Governments.

Information regarding the Review, including the report, are available from the review web site at:

<http://www.indcom.gov.au/research/service/index.htm>

The Review Secretariat can be contacted at Secretariat, Steering Committee for the Review of Commonwealth/State Service Provision, c/- The Industry Commission, Locked Bag 2, Collins Street East, Melbourne Vic 8003, Australia.

James Latham, Industry Commission, Ph. (03) 9653 2100

PROJECT REPORTS

HACC—Minimum Data Set

In February 1997, the Aged Care Unit of the Australian Institute of Health and Welfare was commissioned by the Home and Community Care (HACC) Officials Data Reform Working Group to undertake the refinement and further development of a minimum data set (MDS) for the HACC Program—the HACC MDS Project.

The project will build upon the outcomes of the National Review of the Data Requirements of the HACC Program. The draft HACC MDS developed by that process reflects the outcomes of wide ranging consultations with HACC service providers, Commonwealth, State and Territory government officers responsible for the HACC program, and consumer groups across the country. The need to improve the quality, consistency and client focus of data collected from the HACC program was recognised in the 1995 Efficiency and Effectiveness Review of the HACC program.

The HACC MDS Project comprises three stages. The first stage involves producing a draft data dictionary for the HACC program, reviewing and refining data definitions, and developing preliminary definitions for complex areas in the program. During this stage of the project, the Institute will also investigate and test ways of establishing linkages between client records within the program for statistical purposes. The second stage of the HACC MDS Project involves exploring the viability of the draft minimum data set through a series of pre-tests in a sample of HACC agencies in several States and



Territories. The third stage involves a final report that includes the draft data dictionary, a recommended sample structure and process for a full pilot test of the minimum data set, and recommendations on the specifications and feasibility of implementing a unique linkage key for statistical purposes in the HACC program.

Diane Gibson, AIHW, Ph. (06) 244 1190, or Trish Ryan, AIHW, Ph (06) 244 1109

Labour force

Female Participation in the Australian Medical Labour Force, a joint publication of the Institute and the Australian Medical Workforce Advisory Committee (AMWAC), was released in February. This report provides a comprehensive comparative statistical portrait of the male and female medical work force in Australia.

Of particular interest are the policy and planning issues that emerge from a rising proportion of the medical work force being female. Specific planning issues included relatively greater preferences by female practitioners for metropolitan practice; low numbers of females in most specialties; preferences, when training is still being undertaken, for part-time employment or temporary withdrawal from employment when caring for young children; and significantly lower lifetime hours worked on average by females compared to males.

Nursing Labour Force 1993 and 1994 was released in March 1997. It presents a national, State and Territory picture of the nursing labour force in 1993 and 1994 and also includes trend statistics from 1971 to 1996. The report shows that total nurse numbers in Australia since the late 1980s have been relatively stable. However, the structure of the work force changed significantly as nurse training moved from hospitals to universities between 1985 and 1993. The proportion of nurses aged less than 25 years declined from 33.3% in 1981 to 6.0% in 1994.

The nurse work force has become more experienced through this 'older' structure, additional training, a decline in the employment of less highly trained enrolled nurses, and a corresponding rise in the employment of registered nurses.

Pharmacy Labour Force 1994 was released in March 1997. Trends featured include strong annual growth in registration and employment numbers, an increasing female proportion of the work force, more pharmacists aged 65 and over, and a significant decline in the proportion of community pharmacists working as relievers.

The Australian Health Ministers' Advisory Council (AHMAC) held its second bi-annual one-day workshop on medical work force in Adelaide on 5 February and endorsed a continuation for the next five years of the annual national medical labour force survey conducted in conjunction with medical re-registration. It also developed a busy work program for AMWAC over the

next two years to examine work force requirements for 12 specialties, and to examine and report on other aspects of the medical work force, including planning benchmarks. The Institute will continue to provide data compilation and analysis support for these activities.

John Harding, AIHW, Ph. (06) 244 1153

Child Abuse and Neglect Australia 1995-96

Child Abuse and Neglect Australia 1995-96 presents statistics on notifications, finalised investigations and substantiations by State and Territory, type of abuse and neglect, Aboriginality, age and sex of child, and type of family in which the child resides. Report author Anne Broadbent warned that the statistics 'only represent the number of children who come into contact with community service departments as being in need of care and protection—they do not measure the actual incidence of child abuse and neglect in the community'.

Child abuse figures could be inflated because some jurisdictions include general child welfare concerns other than abuse or neglect in their statistics. On the other hand, there is an unknown level of unreported abuse and neglect in Australia. Individual abuse and neglect notifications and substantiations can cover a wide range of severity of injuries, emotional abuse and neglect, so that no one incident is necessarily the same as another.

Findings of the report include:

- In 1995-96 State and Territory community services departments recorded 91,734 notifications of child abuse and neglect, of which 61,383 resulted in a finalised investigation and 29,833 in a substantiation. The number of substantiations is 3% below the number in the previous year, due at least in part to changes in legislation, policy and practices in some States and Territories.
- Of those notifications that were substantiated 8,467 (28%) were for physical abuse, 9,265 (31%) for emotional abuse, 4,802 (16%) for sexual abuse and 7,299 (25%) for neglect.
- In 1995-96, 16.3 children per 1,000 aged 0-16 years were the subject of a child abuse and neglect notification, 11.6 per 1,000 were the subject of a finalised investigation and 5.8 per 1,000 were the subject of a substantiation.
- Aboriginal and Torres Strait Islander children are over-represented in the statistics. Cultural differences in attitudes to child rearing, higher rates of unemployment and poverty, higher incidences of health problems and lack of access or inability to access parental support services all contribute to this over-representation. Similar factors contribute to the over-representation of children from single female parent families in the statistics on notifications, investigations and substantiations.



- Most notifications of abuse or neglect were from friends/neighbours, parents/guardians, school personnel and the police. Notifications from the police or the subject child were most likely to be substantiated while, in particular, a low proportion of notifications from anonymous sources were substantiated.

Anne Broadbent, AIHW, Ph. (06) 244 1157



The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples—what the report did not say

As reported earlier in this newsletter, on April 2 Sir William Deane, Australia's Governor-General, launched a joint Australian Institute of Health and Welfare and Australian Bureau of Statistics report entitled the *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*.

Despite the extensive nature of the report, it should not be viewed as a complete account. Far from it, as the Introduction states the report provides a 'snapshot' of information. In fact, when the report was planned the gaps and deficiencies in available data were so ubiquitous that the report was, of necessity, constructed by asking the question 'what data are available and what do they tell us?' rather than 'what issues should be reported on?'. As a result some of the most relevant statistics about the health and welfare of Aboriginal and Torres Strait Islander peoples are not reported at all or are inadequately reported. It is useful to examine what the deficiencies in the statistics are and to explore the reasons behind them.

The most important, but to some extent masked, deficiency of the report is the reporting of mortality, the ultimate health outcome variable. Mortality is not reported for two-thirds of the Indigenous population, that is for those Indigenous people who live in the eastern States of Australia, from Queensland to Tasmania. The reason for the deficiency is the poor quality of data on deaths of Indigenous people which is recorded in these States. The ABS makes an assessment of the completeness with which deaths among Indigenous peoples are recorded. The latest available figures for New South Wales and Victoria suggest that approximately half the deaths in 1995 among the Indigenous population were not recorded as Indigenous. In Tasmania the situation was worse, with next to no Indigenous deaths being correctly recorded. Queensland, however, should be commended for the high quality of Indigenous mortality recording since the belated introduction of Indigenous identification in 1996.

There are just as important but more subtle omissions from the report concerning a wide range of diseases and

18th Conference of the HIMAA

**22–24 October 1997,
National Convention Centre, Canberra**

The field of health information management covers a wide variety of knowledge and skills which are essential in health services today. The conference program will cover this range with particular emphasis on exploring the move towards the electronic patient health record and the changing role of the profession.

The program will cover the following health information management issues.

- | | |
|---|---|
| • Information technology standards | • Health information linkage |
| • Casemix and classification | • Health information systems design, development and management |
| • Evaluation of data quality | • Health information management, education and training |
| • Health data warehousing | |
| • Privacy and security in electronic health information systems | |

All people interested in the collection, management and use of health information are invited to attend.

- | | |
|---|------------------------------|
| • Health information managers and medical record administrators | • Health service managers |
| • Clinical coders | • Data managers |
| • Clinicians | • Casemix coordinators |
| • Health planners | • Health department officers |
| • IT specialists | • Quality assurance managers |

Registration forms will be distributed to all Health Information Management Association of Australia members. Those interested in receiving further information about the conference are invited to contact the Conference Convenor, 18th Conference of the HIMAA, Locked Bag 2045, North Ryde NSW 2113, Australia, tel. (02) 9887 5001 or fax (02) 9887 5895.

conditions which are difficult or impossible to measure on a national scale, particularly among the Indigenous community.

The report relies heavily on hospital separation data, mainly from four States and Territories, for reporting on morbidity; consequently, any disease or condition which does not normally result in hospitalisation will be inadequately reported. Notable among these are the often undiagnosed and untreated infectious diseases of childhood which exhibit as cycles of repeating or even continuous episodes of disease among some groups of Indigenous children and diabetes among adults.

Similarly, it has proved impossible to collect national data on issues such as emotional and social wellbeing, or reliable data on patterns and levels of nutritional intake, or even the prevalence of different types of disability among Indigenous people.

Many of these diseases and conditions are often not life-threatening in themselves but taken together they can be responsible for very high levels of 'low grade' chronic morbidity and social disadvantage. They can also possibly give rise to very high levels of co-morbidity, another factor for which no national data exist for Indigenous peoples. It is important that the absence from the report of statistics on these diseases and conditions is not interpreted as implying that they or their effects are unimportant. This would be misleading.

It is well recognised that the causes of the poor state of Aboriginal health and high level of welfare dependence are, to a great extent, intimately linked with the social and cultural history of Indigenous people over the past 200 years. The linkage occurs through the consequent legacy of dispossession and disempowerment, leading to today's high levels of unemployment, poor educational attainment, and low self-esteem. All these factors are determinants of the health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. As such they all could have been considered legitimate issues and concerns for the report. Constraints on the overall length of the report and resources available for research led to a decision to exclude historical and current social and economic conditions from the scope of the report. Again, it is important that their exclusion is not interpreted as implying lack of importance or relevance to the current state of Indigenous health and welfare.

Space, and to a lesser extent the availability and quality of data, have precluded the presentation of extensive breakdowns of statistical information into the eight State and Territory jurisdictions. Similarly, the report only presents limited comparisons across the different geographical regions of Australia and does not, therefore, make extensive comparisons between the health and welfare of Indigenous peoples living more traditional lifestyles in remote communities or the residents of urban and metropolitan areas. Furthermore, the report is not the appropriate vehicle for reporting community-level information even though it is recognised that very substantial health and welfare differences exist at local

levels. Again, not reporting these differences does not imply their absence or unimportance.

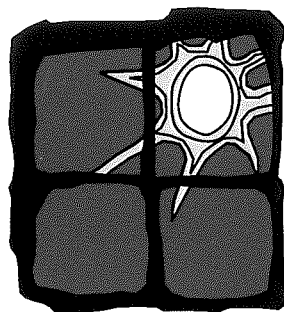
Other than some opening remarks, the report does not attempt to make any significant comparisons with other indigenous minority groups living within developed western societies. These comparisons are important and have, to some extent, been made by others. There are non-trivial definitional and data quality issues to be considered and more work needs to be done.

The report is the first of a series. A major aim has been to present a collection of baseline data from which time trends can be developed in future years. The current report, with the notable exception of mortality, does not report patterns of change over recent years. Future editions are intended to become increasingly digests of change over time in health status and service performance, as well as snapshots of the time.

In conclusion, despite the deficiencies and gaps discussed above the report is the most up-to-date, complete and integrated national statistical overview of Aboriginal and Torres Strait Islander health and welfare.

Tony Barnes, Director, NCATIS, Ph. (08) 8943 2190

FROM THE



INSIDE

Donovan's departure

Dr John Donovan joined the then Australian Institute of Health on 8 January 1989 as Principal Medical Adviser, following an already lengthy career in the Australian Public Service. He has stayed with the Institute through times of sunshine and times of change. The article below is a compilation of the thoughts and memories of some of John's friends and colleagues at the Australian Institute of Health and Welfare, and is a tribute and fond farewell to a solid part of the Institute's history.

John was immortalised young—at a Sydney meeting of the Statistical Society in 1974 to be precise. When the later-to-be-famous speaker lamented the lack of epidemiologists in Australia, John's former professor and mentor, Oliver Lancaster, rose to say that to his knowledge, there were at least one-and-a-half epidemiologists in Australia. Anyone who knew Oliver assumed Oliver had counted himself as one, so John Donovan had to be the half!



John arrived in the Commonwealth Health Department ready to change the world. It was some time after John's arrival that the Department started to experience the initial tremors of the almost continual restructuring of the past 18 years or so. John has seen the pendulum swing from the department having a plethora of medical advisers, through the amalgamation with Community Services, to becoming a Department with very few in-house sources of medical advice. John fought the battle for strengthening the range of medical advice, then decided to throw in his lot with the fledgling Australian Institute of Health. At the same time he became heavily involved in the politics of the Australian Medical Association.

John is probably best known in the Institute for his fostering and editing of *Australia's Health*—although his enactment of Long John arriving in splendid glory aboard a less than rock steady canoe at the foreshore of Acton Peninsula for an Institute Christmas Party is fondly remembered by many of the longer serving staff. His dry (or is it wry?) sense of humour has lightened many a dull meeting or staff farewell. In typical contrast though, John has always loved to tilt at windmills—and the health field has never been short of windmills both real and imagined.

In fact, John is a nosologist, an expert in health classification. He has been the linchpin of the Institute's role as a WHO Collaborating Centre for Classification of Disease, representing Australia at several meetings on ICD developments. He has been an expert adviser on cause of death coding in Australia for many years.

John and his wife Ann are also known for their Australian-style hospitality to overseas visitors. During the ICD meeting of 1995 they took their generosity to new heights, laying out a buffet dinner for a group of close to 50 at their home. Even before this, John was found to be a generous soul at the London School of Hygiene and Tropical Medicine—this despite the fact that he and this particular recipient were on opposite sides of the social divide (medical and 'other') in the workplace!

During his time as a senior medical bureaucrat, John has been bitten by the travel bug and has made adequate arrangements for satisfying this penchant in his retirement by buying a travel agency.

John's departure will certainly leave a void in the close knit community of the Australian Institute of Health and Welfare (his office always had the best art display—some of it his own) that will be felt strongly by his friends and colleagues. We wish him all the best in this new phase of his life, and urge him to go forth and conquer.

Staff of the AIHW

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Distribution Centre**

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PUBLICATIONS

- Aboriginal and Torres Strait Islander Peoples Injury-Related Hospitalisations 1991-92: A Comparative Overview* AIHW cat. no. INJ 4)
- Adult Dental Programs Survey report series: Cross-sectional 1995 & Cross-sectional 1996* (AIHW cat. nos. DEN 19, 20)
- Assisted Conception Australia and New Zealand 1994 and 1995* (AIHW cat. no. PER 3)
- Australian Injury Prevention Bulletin nos. 14, 15* (AIHW cat. no. INJ 3, 6)
- Breast Cancer in Australian Women 1921-1994* (AIHW cat. no. CAN 1)
- Child Abuse and Neglect Australia 1995-96* (AIHW cat. no. CWS 1)
- Child Dental Health Survey report series: Queensland 1994, Queensland 1995, and Victoria 1994* (AIHW cat. nos. DEN 15-17)
- Congenital Malformations Australia 1993 and 1994* (AIHW cat. no. PER 2)
- The Definition and Prevalence of Intellectual Disability in Australia* (AIHW cat. no. DIS 2)
- Dental Practitioner Statistics report series: Queensland 1995, South Australia 1995, Tasmania & Victoria 1995* (AIHW cat. nos. DEN 18, 21-23)
- Disability Support Services Provided Under the Commonwealth/State Disability Agreement: First National Data 1995* (AIHW cat. no. DIS 1)
- Female Participation in the Australian Medical Workforce* (AMWAC Report 1996.7)
- The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (AIHW cat. no. IHW 2)
- Health Labour Force nos. 7-9: Podiatry Labour Force 1994, Pharmacy Labour Force 1994, & Nursing Labour Force 1993 and 1994* (AIHW cat. nos. HWL 2-4)
- Health Outcomes Bulletin no. 8* (AIHW cat. no. HOC 2)
- Injury Issues Monitor no. 10* (AIHW cat. no. INJ 7)
- National Health and Welfare Information News no. 6* (AIHW cat. no. HWI 5)
- Open Employment Services for People with Disabilities 1995: the First Year of NIMS Data* (AIHW cat. no. DIS 3)
- Private Health Insurance and Community Rating: Who has Benefited?* (AIHW cat. no. HSE 1)
- Road Injury in Australia 1992* (AIHW cat. no. INJ 5)
- SAAP National Data Collection NDCA report series* (AIHW cat. nos. HOU 1-9)
- Surveillance of Cardiovascular Mortality in Australia 1983-1994* (AIHW cat. no. CVD 2)