

NHWI News

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From the Australian Institute of Health and Welfare

Public health information takes shape

Hobart was the scene of lively debate about public health information in September. On the 16th and 17th of the month the National Public Health Information Working Group (NPHIWG) conducted a workshop on the National Public Health Information Development Plan following the Public Health Association's annual conference.

Organised by the AIHW on behalf of NPHIWG, the workshop brought together over 100 key public health information planners, designers, providers and users to be involved in the development of a National Public Health Information Plan.

The workshop was designed to seek an agreed coordinated approach to our understanding of public health by considering a previously circulated draft plan for public health information development.

The workshop included plenary sessions and concurrent workshops, and a final a panel discussion on the topic 'Where to from here?'. A keynote address entitled 'Joined Up Government and Joined Up Statistics' by Dr John Fox, Group Director of Census Population and Health and Chief Medical Statistician at the Office for National Statistics in the UK, was the highlight of a working dinner.

In his welcoming address Dr Richard Madden set the scene by giving a brief description of developments in health information in Australia over the past 11 years.

Milestones he highlighted included the formation of the then Australian Institute of Health in 1987 and the National Health Forum in 1991, which led to the signing of the National Health Information Agreement in 1992; the organisation of a National Health Information Forum in 1994; the development in 1995 of the National Health Information Plan and National Health Information Model; the formation in 1996 of the National Public Health Partnership and its Working Groups; and in 1998 the signing of the National Health Information Agreement for a second 5-year period.

Speakers at the plenary sessions outlined perspectives of consumers, policy advisers, epidemiologists and researchers, and the purpose of the National Public Health Information Development Plan. Lively debate followed at the concurrent workshops which looked at gaps and redundancies in public health data collections, tested the National Public Health Information Development Plan against various areas of public health, for example child health monitoring, and rural and remote area populations. A wide variety of issues were raised during the concurrent sessions with the effect of intersectoral factors on public health being the most frequently raised. Points discussed in relation to intersectoral issues included



From left to right: Dr John Fox, UK Office of National Statistics, keynote speaker at the NPHIWG Workshop with Dr Merran Smith, WA Health; Ms Marion McEwin, ABS; Mr Brendan Gibson, DHFS; Dr Cathy Mead, DHFS; and Dr Richard Madden, AIHW

the need to link data from other sectors, most notably, environmental data. Housing, transport, justice and socioeconomic data were also considered important.

Another frequently raised issue was the need for a coordinated approach to the collection and use of public health data. Discussion recognised the tensions between the different data needs of various levels of government, and the need for the Plan to have a balance between national, state and local requirements.

The need for longitudinal data was also raised by a number of participants. Discussion of this issue covered different ways of achieving such data sets, including data linkages. Several participants suggested that more emphasis should be placed on dissemination of data to the communities where they are collected. It was suggested that much of the data already collected are not exploited.

The format and language of the Plan itself was also raised by some delegates. Some of the concepts of the public health information framework—which underpins the Plan—are new in the public health arena, and delegates suggested that they will take time to be accepted and understood. Several people suggested that the language could be more 'inclusive' and easy to understand.

In closing the workshop, Dr Madden thanked participants for taking the time to play an important part in the development of public health information in Australia.

What next?

The draft National Public Health Information Development Plan is now being revised to reflect the

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Australian Hospital Statistics 1996-97 was released on Tuesday 30 June 1998. This report showed an increase in the number of patients in private and public hospitals in Australia, but a decrease in the length of stay. The Institute should feel proud of what it has achieved with this report, as *Australian Hospital Statistics* is THE report of reference of Australian hospitals. This report was released on 30 June 1998.

I also acknowledge the crucial role the cancer registries play in helping the national statistical effort. Collecting cancer data is an enormous job, and without the cooperation of the registries we would not have the excellent coverage that we have. I should also thank the Institute staff, led by Dr Paul Jelfs, who manage the National Cancer Statistics Clearing House, and who produced the *Cancer in Australia* report.

In recognition of the timeliness of the cancer reports, there have been significant improvements recently. Two years ago we were able to produce *Cancer in Australia 1990*, and today we have *Cancer in Australia 1994*. By the end of this year we will have *Cancer in Australia* with 1995 data. The Institute is working with registries that have data supply problems, and its aim is to see the national collection effort match that now achieved in several States. Then national cancer statistics could be produced within two years of the reference period.

The AIHW Ethics Committee has produced a set of guidelines entitled 'Ethics Committee Requirements for

the Dissemination of the Results of Internal and External Research'. The guidelines set out a series of actions for the Australian Institute of Health and Welfare to enhance the dissemination of research results. The Ethics Committee and the Institute believe it is important that research using AIHW data is not done in a vacuum, and, where relevant, results should be available to the general public or communities that have taken part in the research. In December 1996, the AIHW Board endorsed the recommendation for a review of the Australian Institute of Health and Welfare Information Security and Privacy Policy and Procedures. The Chair of the review committee is Professor Holman and members include Ms Sophie Hill (Ethics Committee), and nominees from the NHIMG, AIHW and the Privacy Commissioner. At the June 1998 Board meeting the Board endorsed the final report on the Privacy Review which included 21 recommendations.

Most debate surrounded the issue of consent for data protected by the AIHW Act. The AIHW is well placed to balance the protection of individual confidentiality with the need for reliable information to improve health policy and services in Australia. No identifiable health data can be released from AIHW without the agreement of our Health Ethics Committee, and identifiable community services data cannot be released without consent of the data provider. Therefore it was agreed that most AIHW data sets did not need specific consent of the information subject, but that every effort should be made to inform people that their data were being used for statistical purposes and, where feasible, to offer an 'opt out' provision.

I am pleased to report that the recommendations from the report called *Aboriginal and Torres Strait Islander Health Information Plan... This Time Let's Make It Happen*, are actively being progressed by an NHIMG working group, chaired by NHIMG chair David Filby. The group includes representatives from:

- the Office of Aboriginal Health, Health Department of Western Australia
- Heads of Aboriginal Health Units
- the Aboriginal and Torres Strait Islander Health and Welfare Information Unit Advisory Committee
- the Office of Aboriginal and Torres Strait Islander Health Services
- the Aboriginal and Torres Strait Islander Commission
- the National Aboriginal Community-Controlled Health Organisations
- the Australian Bureau of Statistics
- the Commonwealth Department of Health and Family Services
- AIHW
- various State health departments.

This 'roll call' indicates the commitment that is behind this plan. The working group has met twice, and now has an implementation plan for the highest priority recommendations. I want to stress that virtually everyone in the health system will have a role to play if we are to achieve high quality Indigenous health information, and that this is a vital underpinning for real achievements in Indigenous health.

Incidentally, the NCSIMG draft Information Development Plan calls for a similar plan for Indigenous community services information.

Richard Madden, Director, AIHW

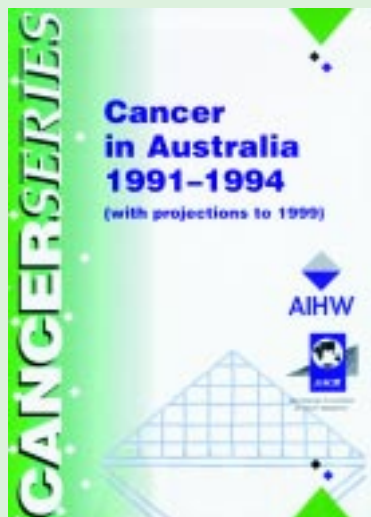
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views expressed during the Workshop and consultations with stakeholders. The revised draft Plan is expected to be available towards the end of this year.

When the Plan is finalised and endorsed by the National Public Health Partnership and the National Health Information Management Group it will be presented to the Australian Health Ministers' Advisory Council for adoption.



National Community Services Information

Since the publication of the last edition of *NHWI News*, members of the National Community Services Information Management Group (NCSIMG) have been consulting with interested parties from government and non-government organisations on the exposure draft of the National Community Services Information Development Plan. The Plan will be used to identify priorities and to provide the basis for national data collection on community services issues.

The draft Plan was endorsed by the Standing Committee of Community Service and Income Security Administrators (SCCSISA) at its meeting in March this year. Consultative meetings have been held with a range of interest groups representing areas covered by the National Community Services Information Agreement (aged care – including residential and community care; disability services; child care – including preschools; family support services; child welfare – including juvenile justice; supported accommodation assistance and emergency relief and crisis services). Indigenous people were identified in the draft Plan as the highest priority population sub-group and separate consultations have been held with representatives of Indigenous groups.

Representatives who have participated in the consultative process have generously given their time and ideas to ensure the quality of the final Plan.

NCSIMG members will meet towards the end of August to develop the final version of the Plan to be submitted to SCCSISA in October. When endorsed by SCCSISA, the National Community Services Information Development Plan will be published and widely distributed.

Contact: Margaret Fisher, National Information Policy and Coordination Unit, AIHW Ph. (02) 6244 1033. E-mail: margaret.fisher@aihw.gov.au



PROJECT REPORTS

Data development in HACC and related fields

From the early 1990s there was a growing awareness of the inadequacies of national data on the Home and Community Care (HACC) Program. As the program assumed an increasingly central role in national aged care policy, the need for better data for program planning and accountability purposes became more pronounced. As a consequence a number of projects have been sponsored or conducted recently by Commonwealth, State and Territory Governments concerned with improving HACC data. This process has gained pace in the last 12 months, with six national projects being brought to completion. Other data development activities are also taking place in the States and Territories. The following excerpts provide a brief illustration of the extent of current activity in the field, and a useful guide to resources and contact people for further information.

Community Care Classification Project

The Community Care Classification Project, funded by the National HACC program, commenced in August 1997. The project team, led by Professor Don Hindle, was asked to:

- review the options for classification of HACC clients and their care;
- consult widely with technical experts, care providers, and funding and purchasing authorities;
- identify a preferred approach; and
- recommend actions whereby the preferred approach might be tested, refined and implemented.

Reports

- *Classifying the Care Needs and Services Received by HACC Clients*, Don Hindle, Dremsel Pty Ltd, Aged and Community Care Service Development and Evaluation Report no. 33, April 1998. Copies available from Ms Christine Cole, Information and Training Section, Mail Drop 77, Aged and Community Care Division, Department of Health and Family Services, GPO Box 9848, Canberra ACT 2601. Ph. (02) 6289 5536. Cost: \$19.95
- *HACC on Track, A Summary of the Recent Review of Classification Options for the Home and Community Care Program*, Australian Government Publishing Service, 1998. Limited copies available free on request from Ms Dianne Thompson, HACC Outcomes Section, Mail Drop 32, Community Care Branch, Department of Health and Family Services, GPO Box 9848, Canberra ACT 2601. Ph (02) 6289 5117.

Contact: Dianne Thompson, HACC Outcomes Section, Department of Health and Family Services, Ph. (02) 6289 5117

Targeting of HACC services

The research study on targeting of HACC services, conducted under the leadership of Dr Anna Howe and Dr Len Gray, was funded by the National HACC Program in July 1995 to:

- consider the relative cost and social benefit of providing HACC services to people at different levels of dependency and with different levels of informal support; and
- develop service provider guidelines for determining priority of access for HACC services, in line with the HACC program objectives.

The first stage of the study, completed in mid-1996, comprised a critical appraisal of relevant literature, a discussion paper on approaches to targeting and a survey of 400 HACC projects to establish how resources were allocated to clients. The second stage of the study comprised three areas of investigation of which the first focused on the group of nursing home residents who have very long stays. The second area of investigation concerned the outcomes of community care, and the third a review of current HACC guidelines and service standards, and the development of further guidelines.

Reports

- *Survey of Access to Home and Community Care Services, Aged and Community Care Service Development and Evaluation Reports*, Australian Government Publishing Service, December 1996. Limited copies available on request from Ms Fiona Proctor, HACC Outcomes Section, Mail Drop 32, Community Care Branch, Department of Health and Family Services, GPO Box 9848, Canberra ACT 2601.
- The final report of the consultancy is expected to be available in late 1998.

Contact: Fiona Proctor, HACC Outcomes Section, Department of Health and Family Services, Ph. (02) 6289 5178

Carer Respite Centres minimum data set

The National Respite for Carers Program (NRCP) Minimum Data Set (MDS) is currently under development by staff of the Community Care Branch of the Department of Health and Family Services and will provide a framework for the reporting of national Carer Respite Centre activity on behalf of carers in each HACC planning region. The NRCP MDS must accommodate:

- the need to capture meaningful data to satisfy policy, accountability and program management requirements;
- comparability with HACC MDS;



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- the need to capture the intermediary role and functions of the respite centres, rather than the unit output information such as that to be captured by the HACC MDS, while still producing meaningful data about client outcomes;
- the need to capture the relationship between carers and care recipients, in order to gain an understanding of carer burden and the adequacy of the existing respite system in meeting the needs of carers; and
- the need to capture data (by service type) in an environment which includes a number of service provider constituencies such as disability services, the residential respite system, mental health, palliative care, and children's services.

Reports

Currently in draft stages only.

Contact: Jane Spittle, Carer Support Section, Community Care Branch, Department of Health and Family Services, Ph. (02) 6289 5421

HACC National Service Standards Instrument

A quality appraisal instrument, based on the HACC National Service Standards, which measures the extent to which agencies are complying with the Standards, was refined and tested by the Australian Institute of Health and Welfare (AIHW) during 1996-97.

The project was undertaken at the instigation of HACC Officials, and partially funded by the National HACC Program. The Instrument is an important component in the HACC Program's quality assurance framework. It will be the basis for monitoring, evaluating and reporting on the quality of service provision on a regional, state and national levels. National implementation of the Instrument is expected from 1 July 1998.

Linked to the Instrument is the use of consumer appraisal approaches to validate the outcomes from service reviews that use the Instrument. Some developmental work on testing consumer appraisal approaches occurred during the course of testing the Instrument. Further testing of consumer appraisal approaches will be undertaken by the AIHW from September 1998.

Report

- *Developing Quality Measures for Home and Community Care*, Anne Jenkins, Elizabeth Butkus and Diane Gibson, Aged Care Series No. 4, AIHW (forthcoming) 1998. Available (from September) from AusInfo. Freecall 132 447.

Contact: Marina Kern, Community Care Branch, Department of Health and Family Services, Ph. (02) 6289 5148

National framework for comprehensive assessment in the HACC Program

The Lincoln Gerontology Centre was funded in 1996 by the National HACC Program to develop an approach to assessment for people with more complex needs which is consumer focused, independent of service provider perspectives and broader in scope than a general or service-specific HACC assessment. The main objective of introducing this type of assessment in the HACC Program

is to improve the process and outcomes for people with medium-high and/or complex needs and to reduce the need for multiple assessments for this group.

The consultancy team, led by Dr Frank Charlton, produced a final report and an accompanying resource kit which describe key elements of the process for providing effective assistance to people with complex needs including the different types of assessment that these consumers may experience along the pathway to service delivery. These key elements include: a comprehensive framework; the core purposes, orientation and scope of an assessment; guidelines for identifying people with complex needs; the assessor's role; agency standards; and assessor competencies.

Work on the key elements is proceeding with a view to national implementation.

Report

National Framework for Comprehensive Assessment will be available later this year from Christine Cole, Information and Training Section, Mail Drop 77, Aged and Community Care Division, Department of Health and Family Services, GPO Box 9848, Canberra ACT 2601. Ph (02) 6289 5536.

Contact: Marina Kern, Community Care Branch, Department of Health and Family Services, Ph. (02) 6289 5148

HACC MDS Project

HACC Officials commissioned the AIHW to undertake further development of a draft HACC minimum data set (MDS), commencing in February 1997. The HACC MDS Project involved:

- reviewing and developing data elements for inclusion within the HACC MDS;
- undertaking comparisons with other relevant collections;
- field testing the proposed data elements;
- production of the HACC Data Dictionary;
- recommendations for a linkage key for statistical purposes; and
- recommendations for implementing the HACC MDS collection.

The HACC Data Dictionary Version 1.0 was completed in May 1998 and is the basis for the proposed HACC MDS, which is a client-centred data collection focusing on outputs and outcomes rather than processes and inputs. The project team, led by Trish Ryan, also prepared a final project report detailing the process of developing and testing the HACC MDS and the proposed statistical linkage key. The final report includes recommendations for implementing the HACC National MDS collection and statistical data linkage within the HACC Program.

Reports

- *HACC Data Dictionary Version 1.0*, Trish Ryan, Bella Holms and Diane Gibson, 1998.
- *Final Report: Home and Community Care Minimum Data Set Project*, AIHW.

For information on the availability of the Data Dictionary and the Final Report contact Dianne Thompson, HACC Outcomes Section, Ph. (02) 6289 5130.

Contact: Dianne Thompson, HACC Outcomes Section, Department of Health and Family Services, Ph. (02) 6289 5117



Community Nursing Minimum Data Set Australia Version 2.0

Version 2.0 of the Community Nursing Minimum Data Set Australia (CNMDSA) was completed in December 1997 following a two-year project in which the data items from Version 1.0, published in 1994, were fully reviewed and updated by the Australian Council of Community Nursing Services. This review and update project, funded by the National HACC Program, included expanding the data set from 28 items to 35, and altering the format of the Data Dictionary and Guidelines to achieve compatibility with the ISO Data Guidelines Standard.

A mapping table and individual data item histories are provided in the 230-page Version 2.0 publication to assist in the transfer from Version 1.0.

Registered as project no. B3 within the National Health Information Work Program, the CNMDSA currently has eight of its data items in the National Health Data Dictionary. Further items from the new Minimum Data Set will be submitted for approval by the National Health Data Committee of the National Health Information Management Group.

The CNMDSA project took place concurrently with the HACC MDS project. In view of the considerable client overlap for the two data sets, a high degree of interaction was maintained between the two projects with a view to ensuring consistency and compatibility.

Report

- *Community Nursing Minimum Data Set Australia*, Australian Council of Community Nursing Services. Available from The Secretary, Australian Council of Community Nursing Services, c/- 31 Alma Rd, St Kilda Vic 3182. Ph. (03) 9536 5222; Fax (03) 9536 5333.

Contact: Terry Gliddon, Australian Council of Community Nursing Services, Ph. (03) 9536 5222; Email: tgliddon@rdns.asn.au

New HACC collection in NT

The HACC Program in the Northern Territory conducted a revised version of the User Characteristic Survey over a two-week period in October–November 1997 to improve understanding of the numbers and profile of people accessing HACC services in the Northern Territory.

The survey provided valuable information that will direct the program to concentrate on specific areas, both in relation to service provision and project management. These target areas include:

- improved training and support for service providers to collect, record and manage consumer and service delivery information;
- carer availability and carer characteristics;
- increasing equity in the determination of fees levied and collected to inform the development of a Northern Territory HACC fees policy; and
- promotion of the development of culturally appropriate resource and training materials for Indigenous people with dementia.

The survey also underlined the difficulties experienced by many Northern Territory HACC agencies in meeting the data requirements of national collections.

Contact: Terrie Nicholson, Territory Health Services, Ph. (08) 8999 2898

Victoria's proposed HACC electronic data collection

A revised client data collection for HACC is being planned by the Aged Care Branch in Victoria's Department of Human Services (DHS). The new collection will replace the present paper-based 10% sample survey. Every six months, participating agencies will be asked to supply aggregated data, preferably on diskette, covering all clients assisted during the previous six months. The data items will accord with the nationally agreed MDS for the HACC Program. It is not proposed to create an online data link to funded agencies, nor to collect client records at the 'individual event' level. Rather, DHS will collect six-monthly aggregates from each agency.

The data will be used to create an annual data file in head office for subsequent analysis. The longer-term intention is to provide community care data suitable for inclusion in the Department's client data warehouse. All agencies will be encouraged to move to electronic management of their client and service provision data using currently available commercial software.

Contact: George Lau, Department of Human Services, Victoria, Ph. (03) 9616 7132

Expenditures on health services for Aboriginal and Torres Strait Islander people

The first comprehensive analysis of expenditures on health services for Aboriginal and Torres Strait Islander people was conducted in 1997 by the AIHW and the National Centre for Epidemiology and Population Health (NCEPH). The project was commissioned by the Office for Aboriginal and Torres Strait Islander Health Services (OATSIHS), Commonwealth Department of Health and Family Services. The final report, released in July 1998, provides government with better information with which to plan, monitor and evaluate the use of resources committed to improving the health of Aboriginal and Torres Strait Islander people. Some of the key findings are presented below.

Total health services expenditure

Total recurrent health services expenditure for Aboriginal and Torres Strait Islander people for all services and from all sources of funds, government and private, in 1995–96 was estimated at \$853 million or 2.2% of total Australian recurrent health expenditure. Total spending for and by Aboriginal and Torres Strait Islander people was \$2,320 per person, about 8% higher than for other Australians.

Health services expenditure through governments

Expenditure on health services for Aboriginal and Torres Strait Islander people in 1995–96 through government subsidised programs was estimated at \$822 million, and was mainly through State and local government subsidised programs (see Table 1, over page).

Commonwealth expenditure was relatively small (\$173 million), half of which was specific Indigenous funding from the Office for Aboriginal and Torres Strait Islander Health Services to community-controlled Aboriginal medical and substance abuse services, as well as for OATSIHS-funded specialist services, mental health, training relief and hearing services.

Non-specific Commonwealth government health expenditures for Aboriginal and Torres Strait Islander people were via Medicare and the Pharmaceutical Benefits Scheme (PBS) and some other minor programs. Estimated payments for Aboriginal and Torres Strait Islander people represented only 0.6% of all Medicare benefits in 1995-96 and only 0.4% of total PBS outlays. Medicare benefit payments were estimated at \$88 per Indigenous person, compared to \$331 for other Australians, while benefit payments through the Pharmaceutical Benefits Scheme were estimated at \$27 per Indigenous person, compared to \$123 for non-Indigenous people. The report also contains extensive information on expenditures on health services for Indigenous and non-Indigenous people through State and Territory government subsidised programs.

On a per person basis, funding through State and Territory programs was more than twice as high for Aboriginal and Torres Strait Islander people (\$1,753) as compared to other Australians (\$785). On average, Aboriginal and Torres Strait Islander peoples' use of hospital services was twice the rate of the rest of the population. They were also major users of community health services, and expenditure on patient transport was also high.

Government funded health services expenditure

Government funding of health services for Aboriginal and Torres Strait Islander people in 1995-96 was estimated at \$810 million. The Commonwealth and State/local governments contributed nearly equally - \$390 million from the Commonwealth and \$421 million from State and

local governments. Most of the Commonwealth funding contribution was through grants to the States. Government funding per Indigenous person was 52% higher compared to other Australians. The study found that government funding for Indigenous health services is similar to government funding for other Australians with similarly low incomes, but as the health status of Indigenous people is worse, the need for services is greater.

Contact: John Goss, Health and Welfare Expenditure Unit, AIHW, Ph. (02) 6244 1151. E-mail: john.goss@aihw.gov.au



Joe Christensen

Just who is Joe Christensen? The simple answer is that he's head of the AIHW National Information Development Unit, but that's too bland a description for someone like Joe. After all, he commenced his career in Hollywood - Hollywood Repatriation Hospital in Perth, Western Australia, that is! And now he's been appointed Australian delegate on International Standards Organisation (ISO) Sub-Committee 32 (Data Management and Interchange). Joe's interest in statistics dates back to before he knew what the word meant - he says he was one of those kids who liked to order and categorise everything from toys to record collections and sports results, and for whom maths was 'a breeze'. Joe's interest in the ISO, however, is more recent.

Table 1: Expenditures^(a) on health services for Indigenous and non-Indigenous people through government-subsidised programs, 1995-96

Delivery	Total expenditure on Indigenous people (\$m)	Proportion of Indigenous total (%)	Per person expenditure on Indigenous people (\$)	Per person expenditure on non-Indigenous people (\$)	Indigenous/non-Indigenous ^(b)
<i>Through State and local governments^(c)</i>	649	79.0	1,763	806	2.20:1
<i>All Commonwealth</i>	173	21.0	472	748	0.63:1
Through Medicare and the PBS ^(d)	47	5.7	128	535	0.24:1
Through Aboriginal health organisations and other Commonwealth programs	126	15.3	344	213	1.62:1
Total	822	100.0	2,235	1,554	1.44:1

(a) Includes all private out-of-pocket payments and funding from non government organisations. Services not covered are private hospitals, dentistry, optometry, private ancillary services (physiotherapy, chiropractic, etc.) and over-the-counter pharmaceuticals.

(b) Ratio of Indigenous to non-Indigenous per person expenditures.

(c) Includes Commonwealth government transfers and expenditure funded by patient contributions.

(d) Pharmaceutical Benefits Scheme.

Source: *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, DHFS, 1998.



It began in late 1997 when he attended a Standards Australia meeting about a revision to ISO 11179 standards for the interchange of client information. The ISO required Australian comment on proposed revisions and Joe was asked to coordinate the Australian response. 'While doing that I saw how relevant the ISO work is to the Institute's work, so I felt privileged when I was asked to be the Australian delegate.

'Attending the February 1998 meeting of Sub-Committee 32 in Washington, DC as Australian delegate was definitely a highlight of my career. I feel my involvement in this international group gives me an opportunity to advance Australia's national information interests—and maybe even the opportunity to expand ISO 11179 so it becomes the standard for metadata registries as well as for the data elements.'

As interim convenor of the Sub-Committee's Working Group 2 (Metadata), Joe chaired the Group's meeting in Brisbane in July this year. While an American delegate is the Group's convenor for the next three years, Joe is editor of Part 3 of ISO 11179—the part that deals with basic attributes of data elements.

Joe would like more people to know about the ISO's work. For example, how many of us know that the ISO Sub-Committee 32 (Data Management and Interchange) has five working groups? Working Group 2 (Metadata) covers approximately 20 international standards, including ISO 11179—Specification and Standardisation of Data Elements. ISO 11179 forms the basis of data elements used in all sorts of data dictionaries, including the Australia's national health and community services data dictionaries. It also forms the basis of environmental data dictionaries (for example, the US Environment Protection Agency has used the standard), housing, education, and human services—to name a few.

Before joining the Institute in 1996, Joe's career included 18 years with the ABS, prior to a 12-year stint commencing in what was then the Department of Community Services. When asked about career highlights, Joe said, in his typically modest way, that he was proud of the role he played in several major ABS population surveys and censuses, and his work on surveys covering health, disability and ageing, the National Aboriginal Survey and a survey of the community services industry.

Apart from having an ideal professional background for the work he is now doing, Joe must have the perfect temperament for someone involved in data development, a task that must surely require loads of patience and an ability to think logically; his sporting interests are fishing and golf!

And no doubt being the eldest of 10 children also helps Joe's diplomacy. He says family gatherings are now a mini-United Nations. His wife comes from a Slavic background, and his large extended family now includes members from Italian, Irish, Aboriginal, English, Scottish and Canadian backgrounds. So his 19- and 21-year-old children can truly claim to understand multiculturalism! But that's not all there is to Joe, he also loves classical music and is passionate about the important role the arts and culture play in our society.

We can therefore be confident that Australia's representative on International Standards Organisation Sub-Committee 32 brings a well-rounded Australian perspective to the world of international information development. Good luck Joe!



RECENT PUBLICATIONS

- Australian Hospital Statistics 1996–97 (AIHW cat. no. HSE 5)*
- Cancer Control—National Health Priority Areas (AIHW cat. no. PHE 4)*
- Cancer in Australia 1991–1994 (with Projections to 1999) (AIHW cat. no. CAN 2)*
- Characteristics of Students Entering Australian Medical Schools 1989 to 1997 (AIHW cat. no. HWL 6)*
- Child Protection 1996–97 (AIHW cat. no. CWS 5)*
- Community Housing Data Manual 1996–97 (AIHW cat. no. HOU 20)*
- Data Briefing for Open Employment Services No. 11*
- Disability Data Briefing no. 12*
- Disease Costing Methodology Used in the Disease Costs and Impact Study 1993–94 (AIHW cat. no. HWE 7)*
- Expenditures on Health Services for Aboriginal and Torres Strait Islander People (AIHW cat. no. HWE 6)*
- Health Outcomes Bulletin no. 9*
- Health System Costs of Diseases and Injury in Australia 1993–94 (AIHW cat. no. HWE 5)*
- Indigenous Disability Data: Current Status and Future Trends (AIHW cat. no. DIS 10)*
- Injury Prevention and Control—National Health Priority Areas (AIHW cat. no. PHE 3)*
- Medical Labour Force 1996 (AIHW cat. no. HWL 10)*
- National Biomedical Risk Factor Survey (AIHW cat. no. PHE 5)*
- New Zealand Medical Graduates in the Australian Medical Workforce (AIHW cat. no. HWL 7)*
- Open Employment Services for People with disabilities 1995–96 and 1996–97 (AIHW cat. no. DIS 11)*
- Pharmacy Labour Force 1995 (AIHW cat. no. HWL 9)*

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