

Aus Health 2000

'virtual' launch

Australia's Health 2000, the AIHW's seventh biennial health report, was launched with a difference by Health Minister Dr Michael Wooldridge MP in Canberra on 22 June.

The launch was part of the Australia's Health 2000 Conference convened by the AIHW.

The difference was that the Minister was not physically present at the conference venue at the Australian National University. Instead, his speech was relayed (in 'real time') by video link from a studio in Parliament House.

These contingency arrangements were put in place the day before the launch. The AIHW had been told that it was possible that the Minister's leave from the House to attend the launch would be revoked.

It was, and AIHW staffers organising the conference breathed a collective sigh of relief (combined with much inner cheering) when the relay worked perfectly. The Minister appeared on the giant screen precisely on cue after being introduced by AIHW Board Chair Professor Janice Reid.

In his speech Dr Wooldridge said that *Australia's Health 2000* was a special edition—special in that 'as well as giving us the usual excellent, comprehensive compendium of today's health statistics and related information, it also marks a century of dramatic improvements in the health of Australians'.

The Minister reflected on some of the major achievements reported in *Australia's Health 2000*:

'Death rates are now less than half what they were in 1900.

'There has been a 20-year gain in life expectancy, for men from 55 years in 1900 to 76 years today and for women from 59 years to 82 years.

'In 1900, perinatal death rates were 60 times worse than they are today.

'Infectious diseases such as tuberculosis, venereal diseases and influenza, so devastating early on this century, had become insignificant as a cause of death by the 1970s.

'In their place we saw the rise and partial fall of our two major chronic diseases, coronary heart disease and cancer.

'Coronary heart disease peaked in the late 1960s, but has fallen by over 60% since then.

'Cancer death rates peaked in 1980.

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(L to R) Dr Richard Madden, Professor Janice Reid, and Professor Peter Baume, at the launch of Australia's Health 2000

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The feature article in this edition of *AIHW Access* covers the launch by the Minister for Health and Aged Care, the Hon. Dr Michael Wooldridge MP, of *Australia's Health 2000*, and the very successful conference held in conjunction with the launch.

I want to take this opportunity to pass on my gratitude to the keynote speakers who led the plenary sessions, our Board Chair, Professor Janice Reid, and Professor Peter Baume, and also to staff members who led the concurrent sessions and panellists who participated in the final session. Thank you also to the numerous staff involved in the coordination of the entire conference program which included the Board dinner, conference and the launch. The launch of our key biennial publications, *Australia's Health* and *Australia's Welfare*, represents the culmination of sustained activity for the majority of Institute staff. I am sure that all staff share my pride in the success of this latest achievement.

Since the launch of *Australia's Young People: Their Health and Wellbeing 1999* in January of this year, the report has received favourable feedback from a range of agencies. Among the more notable reviews, I am pleased to see the positive comments made by *Choice Magazine*, the National Rural Health Alliance's *Partyline* and *Youth Studies Australia*. The report has been well received and these reviews reaffirm the value of the Institute's commitment to providing authoritative, timely information and analysis of the health and welfare of Australians.

On a regretful note: Mr Peter Plummer recently vacated the position of CEO of Northern Territory Health and subsequently relinquishes the position of Chair of the National Health Information Management Group (NHIMG). The Australian Health Ministers' Advisory Council has now appointed Mr Michael Reid, Director General, NSW Health, as the new Chair of NHIMG. Mr Reid is highly respected in health circles both in Australia and internationally; the Institute looks forward to forming a closer association with him in his new role with the NHIMG.

Richard Madden, Director, AIHW

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'For men they rose by around 75% compared with the early 1900s, while current cancer death rates for women are similar to the beginning of the century.'

Dr Wooldridge singled out Aboriginal and Torres Strait Islander health as the nation's 'single most spectacular failure' in health, while also placing rural health in the 'could do better' category. He outlined recent government initiatives on both fronts, but warned that measures being taken now in Aboriginal health would take at least 10 years to show their full impact.

The Minister dubbed the 21st century as 'a century to look forward to in terms of improved healthcare for Australian communities' and argued that quality information 'will be an essential part of these exciting developments'. The Minister also noted that one of the pleasing things about modern data is that 'they are showing up things we never knew before, or at least only suspected'.

Examples were given of the impacts of diabetes and depression:

'Our data show that diabetes contributes significantly to disability in the community, and stretches hospital resources because of the long stays in hospital required by diabetes patients. In future the National Diabetes Register, which is being developed at the AIHW, will show us more about diabetes incidence, and enable more focused research into this pervasive disease.'

'Another area that we are learning a lot about, in terms of its previously underestimated and unseen impact on the community, is mental health, particularly depression. About one million people in Australia suffer from a mental health problem or disorder, but only 40% seek help or have their problem diagnosed.'

'Depression is the most common mental health disorder, and is also the leading cause of non-fatal disease burden to the community. It is the fourth most common problem managed by GPs, with 68% of patients with depression being women.'

Dr Wooldridge said it was through better and more detailed national data, as well as specific medical research, that Australia had 'learned a lot about the risk factors for disease, and how so many risk factors are common to a range of diseases'.

'With this information, the way forward, as I see it, is to attack the problems at their roots through prevention and control of these risk factors.'

'We must look to control our health rather than waiting until we are sick to treat the symptoms, because so many of today's health problems are preventable.'

Risk factors mentioned included high fat intake, low fibre intake, lack of exercise, and high blood pressure.

The Minister said that controlling risk factors was highly data dependent but that this wasn't all that was needed:

'...we don't just need the data, we need people who can lead and develop the process of acquiring the data, and interpret the numbers in an objective and impartial way. And the Australian Institute of Health and Welfare is pre-eminent in this field.'

The launch of Australia's Health followed the Conference's first session, comprising keynote addresses by AIHW Board Chairperson Professor Janice Reid (see Soapbox article on page 10), and by Emeritus Professor Peter Baume.

Peter's address was entitled 'From health information to health action'.

In it, he said that Australia's academic community was 'in the debt of the Australian Institute of Health and Welfare' for *Australia's Health 2000*. He emphasised that in the areas of health information and health action 'knowing beats guessing', but added that some people in health preferred prejudice to evidence, or made decisions based on 'self-evident facts', custom or ideology. He applauded the current Health Minister for encouraging moves towards

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Some of the authors of Australia's Health 2000

evidence-based medicine 'so that some demonstration of advantage is now demanded before many new procedures are popularised'.

From his own political experience, no doubt, Peter outlined some of the forces that would act in a typical Cabinet room to stifle the translation of health information into health action. These included the 'zero sum game, in which everyone knows that the law of opportunity costs will work—more for "A" might mean less for "B" if the cake remains of a constant size'.

Professor Baume also considered the role of power as a commodity beyond the Cabinet setting: '...considering power a bit further, policy change often alters power relationships, and people, generally, will oppose any measure that promises to reject their power or their access to power'.

Peter also advocated the power of communication in maximising the chances of evidence being accepted and acted upon, lamenting that 'many in the health game are not skilful communicators'.

As a final point, Professor Baume urged a consideration of intersectoral action:

'For example, we might get greater returns, as a society, from designing better roads and better cars, improving our capacity for transporting people quickly, and reducing lead in petrol, than we would get from the same amount of money invested in purely curative clinical services.'

Peter conceded, however, that this could immediately spark opposition from 'those in clinical services who want no initiative promoted that might operate in opposition to them getting any available money, unless that money is an add-on with no adverse consequences for them'.

The keynote conference sessions were followed by three sets of two concurrent sessions, with each session involving either two or three presentations by report authors.

The conference concluded with a panel discussion, 'Health in Australia—a stakeholders perspective'. Panellists were:

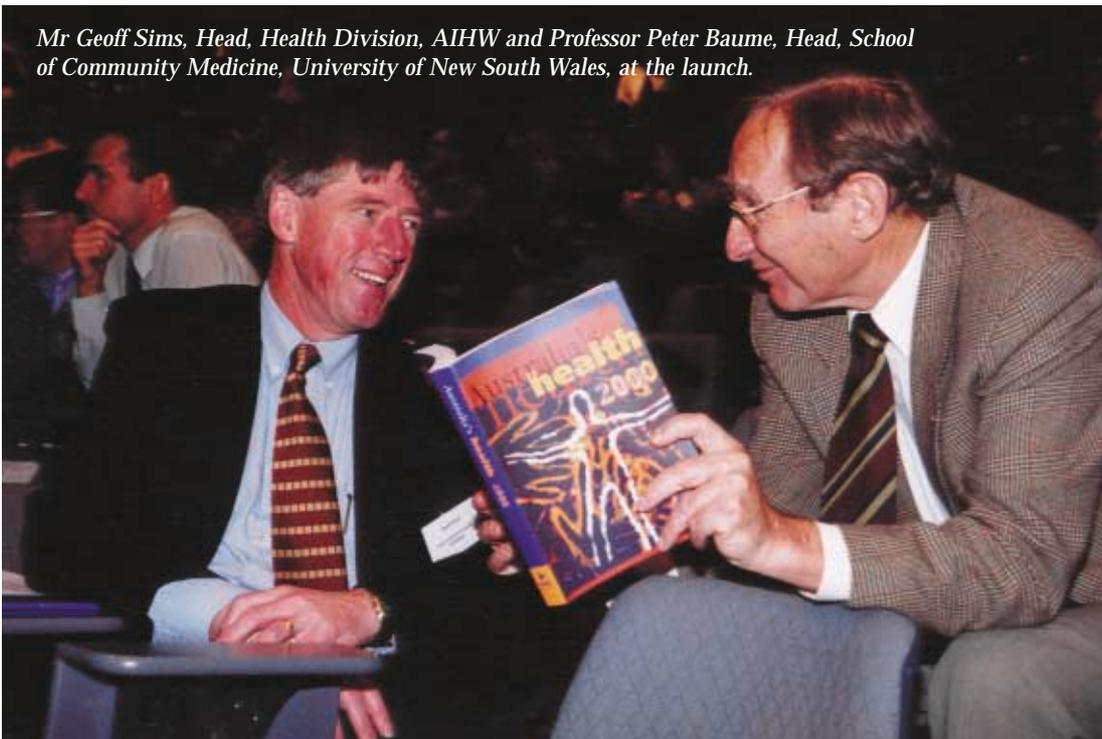
- Judith Dwyer (CEO, Southern Health Care Network, Vic.);
- Bruce Barraclough (President, Royal Australasian College of Surgeons and Chair, Australian Council for Safety and Quality in Health Care);

- Sandra Hacker (AIHW Board Member, and recently Australian Medical Association Vice-President);
- Andrew Tonkin (Director, Health, Medical and Scientific Affairs, National Heart Foundation); and
- Neil Johnston (Secretary, Department of Veterans' Affairs).

Conference exhibitors (in addition to AIHW) were the Australian Association for the Welfare of Child Health, the Australian Bureau of Statistics, the Commonwealth Department of Health and Aged Care (National Health Priority Areas), Diabetes Australia, and the Health Insurance Commission.

In summary it was a successful day for AIHW, and an enjoyable and informative day for conference attendees. The Australia's Health 2000 report received wide media coverage and subsequent discussion, and conference-goers, through their feedback responses, were overwhelmingly positive about having attended. Ninety-four percent of feedback respondents wanted to be informed of similar future AIHW conferences.

Mr Geoff Sims, Head, Health Division, AIHW and Professor Peter Baume, Head, School of Community Medicine, University of New South Wales, at the launch.



Australian Hospital Statistics 1998-99

Australian Hospital Statistics 1998-99 is the latest in the Institute's series of reports providing annual summaries of data collected for the six years from 1993-94 to 1998-99 as the National Hospital Morbidity Database and the National Public Hospital Establishments Database. It was published only about a year after the end of the period to which the data relate, so the information it contains is timely and relevant to a wide range of users. As for the 1997-98 report, this volume was compiled with the guidance of the Institute's Australian Hospital Statistics Advisory Committee, which includes representatives of the State and Territory data providers and other users of hospital statistics.

The report includes details on the hospital care of admitted patients in virtually all public and private hospitals in Australia. Over 3.8 million hospitalisations were reported for public hospitals, and over 1.8 million for private hospitals. The wealth of information reported includes the age, sex and diagnoses of patients, the procedures patients underwent in hospital, and their lengths of stay. The report also includes information on the numbers of hospitals and hospital beds in Australia, and key statistics on the resources, expenditure and revenue of public hospitals and on the services they provide.

The information on diagnoses, procedures, and external causes of injury and poisoning was reported for the first time using the new

International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM). This classification was developed in Australia, with the disease and external cause classifications based on the World Health Organization's ICD-10 (for diseases and external causes), and the Medicare Benefits Schedule (for procedures). It was adopted by New South Wales, Victoria, the Australian Capital Territory and the Northern Territory in July 1998, and in the other States from July 1999. Data from the latter four States were mapped forward to ICD-10-AM for the report, allowing the data from each group of jurisdictions to be presented as 'national' data. Some information on the new classification is included to assist readers in interpreting differences compared with previous years, and the differences that remain, after mapping, between data provided to the Institute in ICD-10-AM and data provided in ICD-9-CM.

Information on AR-DRGs (Australian Refined Diagnosis Related Groups) is included for the first time using version 4 of the AR-DRG classification. The classification summarises the 'casemix' of hospitals by grouping hospitalisations on the basis of types of patients, their diagnoses and treatments. Because hospitalisations in each AR-DRG therefore have similar resource usage, AR-DRG data are useful measures of hospital activity and can be used to inform health service administration and planning.

The report has a focus on hospital performance indicator information. A range of indicators is reported, based on the nationally agreed framework for public hospital performance indicators initially developed by the National Health Ministers' Benchmarking Working Group (NHMBWG). The indicators reported for each State and Territory assess hospital efficiency—for example, cost per casemix-

adjusted separation—and effectiveness—for example, proportions of hospital beds that were accredited.

As this performance indicator information is based on a framework and an analysis methodology that are nationally agreed, its timely publication in *Australian Hospital Statistics 1998–99* means that it is available for inclusion in other reports of health sector performance. In previous years, equivalent data have been republished by the NHMBWG, and in the *Report on Government Services*, published by the Steering Committee for the Review of Commonwealth State Service Provision. This year, the data are similarly available for the *Report*, and to the National Health Performance Committee, which has replaced the NHMBWG.

All the tables in the report (and additional tables reporting more detail on AR-DRGs, diagnoses and procedures) are available on the Internet in Excel format. This allows readers easy access to the data in a form amenable to further analysis. The report and the data that form the basis of it are under continuing review, so comments from readers are always welcome.

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Measures of health and health care delivery in general practice in Australia

In the BEACH (Bettering the Evaluation And Care of Health) program, a continuous national study of general practice activity, a sub-sampling method examines aspects of patient health and health care delivery through data collected in parallel to the BEACH encounter information. The first year's (April 1998–March 1999) results of SAND (Supplementary Analysis of Nominated Data) were recently released (Sayer et al. 2000).

SAND investigated patient-assessed health status; prevalence of a number of risk behaviours; prevalence of selected diseases; levels of disease prevention; consultation length; and GP satisfaction.

From sub-samples of about 30,000 encounters only 14% of patients assessed their own health as excellent and 25% as fair or poor; only 41% of

adult patients were normal weight (18% being obese, 32% overweight and 9% underweight); one in three adults reported alcohol intake of 'at-risk' levels (as defined by the NHMRC) and 19% of adults reported smoking daily.

Smaller sub-sample studies indicated that, in the previous 12 months, only one-third of patients reported doing sufficient exercise, as defined by Active Australia; one-quarter reported experiencing a depressive episode; and one-third had suffered a chronic musculoskeletal condition. Other aspects of patient health are described in the report.

Reference

Sayer GP, Britt H, Horn F, Bhasale A, McGeechan K, Charles J, Miller G, Hull B, Scahill S 2000. Measures of health and health care delivery in general practice in Australia. AIHW Cat. No. GEP 3. Canberra: Australian Institute of Health and Welfare (General Practice Series no. 3).

Project 2

Older overseas-born Australians: their social and financial circumstances

The Aged Care Unit recently completed a report on older overseas-born Australians, commissioned by the Department of Immigration and Multicultural Affairs as a contribution to the International Year of Older Persons. The report examines the social and economic circumstances of overseas-born Australians aged over 55 years.

The analysis uses English Proficiency Country Groups (EP Groups), a classification of birthplace developed by the Department of Immigration and Multicultural Affairs, to capture not only language proficiency but also the cultural diversity of immigrants to Australia. These groups are determined according to the English proficiency levels of recent immigrants from each country of origin.

In 1996 there were 1.1 million people aged 55 and over living in Australia who were born overseas, comprising some 31% of the total Australian population in this age group. Almost two-thirds were from non-English-speaking countries. Among those aged 55 and over, the overseas-born population is somewhat younger than the Australian-born. This reflects large numbers of post-war settlers recently reaching retirement. Over the next few decades the overseas-born population will experience significant growth in the oldest age groups, increasing the proportions in more vulnerable situations. There will be ongoing change in the ethnic composition of the population, reflecting past patterns of immigration.

Although diversity is a prominent feature, many population groups are small. In 1996 there were only 15 non-English-speaking birthplaces with more than 10,000 persons in Australia aged 55 and over. The largest groups, with 40,000 or more, were from Italy, Greece, Germany and the Netherlands.

While there is a universal increase in English proficiency over time, the EP Groups remain differentiated in terms of overall proficiency for any given cohort of arrivals. Substantial gender differences in English proficiency are also apparent among older migrants. Older women consistently report poorer English than older men, and these differences do not abate over time.

Substantial differences exist among the EP Groups for the range of social and economic variables considered in the report, which will continue to impact on the population groups as they age.

The report shows the potential advantages and disadvantages which characterise the life circumstances of different immigrant groups and demonstrates some of the variability within the older overseas-born population, as well as drawing attention to differences between the overseas-born and the Australian-born population.

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Performance indicators in the disability services field

In 1999–2000, the Disability Services Unit undertook a project for the National Disability Administrators, focusing on performance indicators. The work involved a large-scale review of indicators in use in the Australian disability services field, and the development of a national framework within which current practice can be viewed in the context of theoretical approaches to performance indication.

The disability services field is currently characterised by rapid change and development. New service funding and delivery models are emerging, and there is an increasing focus on accountability and a growing emphasis on consumer input into service planning. While there is a generally recognised lack of good, nationally comparable indicators for disability services, substantial data development activities and innovations are occurring in different jurisdictions across Australia.

Performance concepts, such as outputs, outcomes, efficiency and effectiveness, were originally developed primarily in the private,

for-profit sector. There is substantial variation in the way these concepts are understood and operationalised in the disability services field. In the course of this project, a set of conceptual models was developed to help examine relationships between performance concepts and service funding and delivery models in the field. These models were used to look at areas currently data rich and data poor, as a basis for identifying priorities for national indicator development. Three key, interrelated areas for indicator development were identified: outputs, outcomes and costs. These areas are highly policy relevant, and present substantial challenges for data development.

The report made suggestions to the National Disability Administrators as to how to advance indicator development in a way that is integrated with policy development. The report, *Integrating Indicators: Theory and Practice in the Disability Services Field*, will be published by AIHW in August/September 2000.

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Australia's health in the Statistics and the people

As Chair of the Australian Institute of Health and Welfare...I would like to launch this conference by going behind Australia's Health 2000, and the 80 or so other publications produced each year by the Institute, to give a sense of their genesis and significance.

All of these publications are really the result of an information cycle that starts with individual Australians and ultimately feeds back to them through public health programs and health care which, because they can be targeted using information such as the Institute provides, address needs we *know* are priorities for the people behind the statistics. In other words, from the people and to the people.

From the statistics which the AIHW compiles emerge comparative pictures of a spectrum of the health experiences and status of Australia's population, the utilisation of services both public and private, and the differentials between groups—between States, across years, by gender, age, ethnicity and so on. These are statistical 'facts'. But they also become policy facts, social facts and political facts as they are interpreted, contextualised and invoked to support debates and advocacy.

For all these reasons the Institute's staff and Board are committed to its *dispassion* – its role as an honest broker between agencies and jurisdictions. The Institute has earned the confidence and trust of government and the private sector over the last decade. This has allowed it, year after year, to produce the most comprehensive and authoritative pictures available on Australia's health and welfare. It's hard these days even to recall the reluctance

and mistrust that preceded the Institute's establishment; the unwillingness to share information so vital to government in setting health and welfare priorities, deploying resources and assessing outcomes.

The millions of data items which are grist to the Institute's mill each year are sometimes referred to as 'administrative byproduct data'. A more dreary description one could not find! But it *does* say something about the Institute's focus: on data that is generated by hospitals, welfare agencies, government departments, health services and so on in the course of their work of caring for people. The Institute doesn't undertake clinical, epidemiological or health service research as such, but its work is centrally informed by the findings of such research. Before the Institute counts and compares the numbers it has to know what things are *important* to count. The findings of original research are its signposts.

As we consider individual Australians, it is also important to remember that these valuable reports on Australia's health have a very real link to the other half of the Institute's agenda, that concerned with providing national information on the use and provision of welfare services—who needs them and who receives them and, by implication, who misses out. Next year the Welfare Division will be presenting its biennial update on Australia's welfare services. But clearly the welfare-related areas of disability services, aged care, child support, accommodation support and housing all have an overlapping relationship with the public's health. The Institute is very mindful of this relationship and is increasingly working at the boundary between the two domains to illuminate the linkages for various population groups. Since the last *Australia's Health*, the Institute has published several thematic reports which explore the mosaic of information about

AIHW Australia's Health 2000 Conference

ANU 22 June 2000—Professor Jan Reid

information age

the wellbeing of populations and the services which support them. These include *Australia's Children*, *Australia's Young People*, and *Health in Rural and Remote Australia*.

But let me return to the book of the moment, *Australia's Health 2000*. It contains invaluable information on the health status of Australians; the various factors that determine health; the determinants of the health of population groups; health resources and use of services; health service strategies, performance and monitoring; challenges for national health information; and a concluding chapter on Australia's health over the 20th century.

This publication, like its companion *Australia's Welfare*, portrays the health experiences of millions of individual Australians which, in aggregate, it describes. And it is those same millions whom the report is ultimately designed to benefit. The individuals behind the statistics are not identified, of course. The confidentiality of individual information is highly respected by statisticians everywhere and at the Institute it is enshrined in the legislation under which it works.

The speech creates a fictional Aboriginal person, Fred, to show the Institute's involvement in data development and reporting in the areas of hospital mortality, general practice statistics, people with diabetes, and Aboriginal and Torres Strait Islander Australians. It continues...

...it needs to be noted that identifying Aboriginality has now become an accepted part of many health data collections, the very collections that show that Indigenous Australians have a very high, a disproportionate, burden of many different diseases. It is only in the last few short years that we are even *in a position* to identify Aboriginal Australians in all major vital statistics and hospital-related collections. Reliable coverage is still a problem and even 'national' estimates of Indigenous mortality currently do not include New South Wales and Victoria!

Counting people hardly seems like a matter of social justice, but it is. People who are invisible to public agencies, as the referendum of 1967 underlined, can be ignored. A nation can plead ignorance, appeal to stereotypes, downplay the significance of small surveys or anecdotal evidence, and turn its back on suffering.

In 1997 the Institute and the Australian Bureau of Statistics produced a landmark report entitled *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. The report painted a stark picture of both ill health and overwhelming need. I was delighted that the Governor-General agreed to launch that report in Darwin to considerable national and local press coverage, sufficient in Darwin itself to supplant the coverage of one Ms Hanson, who rather disconcertingly arrived on our plane and stayed in our hotel!

That same year *The Aboriginal and Torres Strait Islander National Health Information Plan* ("This time, let's make it happen") was published by the Institute and the Australian Health Ministers' Advisory Council. The Institute, the ABS and others are now working under



the umbrella of the National Health Information Agreement to monitor the progress of Indigenous identification in vital statistics and in specific health programs and to address shortcomings. Through information such as this, a basic recognition has become part of national awareness—and that is that Aboriginal ill health is a matter for national shame. Perhaps in a small way these efforts have helped to build one of the pillars of reconciliation, a recognition that Australia cannot be secure in its nationhood while such differentials affront us and others.

But this is what I mean when I say that, while the Institute places high value on objectivity and dispassion, its statistics can also in the end become social, political and policy facts. As for other profoundly marginalised and disadvantaged groups, such as the homeless and prisoners, they underline the patterned inequities in life and health chances in this country, and the challenges of fairness, compassion and justice in the allocation of public resources.

The speech proceeds to describe another fictional person, Freda, to show how the Institute reports on national 'lifestyle' factors such as smoking, diet and exercise, other preventive practices such as immunisation of children, on participation rates in cancer screening programs and on socioeconomic problems in health. It continues...

We know that there is a remarkable health gradient with the worst health among the most socially and economically disadvantaged in Australian society and the best among the most advantaged. This is another great challenge to public health in Australia. The Institute's work brings home the message about these socially determined patterns of health. (I should also observe here that the subject of social inequality and health also forms a major bridge to the welfare side of the Institute's work.)

Fred and Freda's stories only touch upon the complex and extensive web of health information, and the Institute's involvement in many stages of the information process. This includes helping to decide what sort of data are important and how they will be defined and collected, as well as combining and analysing information from many sources. To that end, the Institute has helped bring together the major interested parties and forged many continuing partnerships with government and non-government health agencies, major government-funded committees such as the NHMRC, the ABS, and in special collaborations with university-based expert centres. It integrates facts and data across different fields and from multiple sources into the themes represented by more than a decade of reports and studies.

These statistics add to our national consciousness about health. They tell us how people are doing; what's causing concern and where there are improvements; which groups and individuals are in need and how well they are served; how Australia's health system is sailing and how Australia compares with other countries. They also help point to the continuing strong need for public health programs as well as for good treatment services.

The Institute's part in informing national health policy is now a significant one. Few people can now think of the Institute without automatically

Presentation to AIHW Australia's Health 2000 Conference

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thinking of the *Australia's Health* books as essential 'information infrastructure' for national health activities.

Australia is one of the best served nations for health and welfare information to guide action. The information is far from perfect, of course. There are many gaps and deficiencies and we would greatly appreciate hearing your suggestions at any time on how and where best to address these. Both through our Board members and through collaboration with colleagues throughout Australia, we receive the kind of requests and advice which shape the Institute's work program. Of course this work program does not just involve the Institute in Canberra, but also relies heavily on the independent, university-based, high-quality reports and data from the Institute's five collaborating units across Australia: injury surveillance; perinatal statistics; dental statistics and research; Aboriginal and Torres Strait Islander health and welfare information; and the General Practice Statistics and Classification Unit.

Australia's Health 2000 contains salutary messages for us as a nation. It powerfully paints a picture of the social differences in health and particularly the national tragedy that is Indigenous health. It identifies points along the spectrum of health issues that clearly need imaginative, but evidence-based, action. And in the questions it raises, but cannot answer, it highlights the promise of such innovations as electronic health records, of data linkages and of interagency information-sharing agreements. But at the same time it raises, if only by association, the key issue of the protection of the privacy and rights of those whose records coalesce to provide a volume such as the one being released today. These are matters of public interest. Inevitably, within the context of its mission and its strong legislative mandate, the Institute is drawn into complex considerations of the public good, issues that we all here today in some way appreciate and have to address.

...I join the authors and producers of Australia's Health 2000 in their hopes that it will inform and encourage all who have a concern to achieve health for all Australians.



on Geoff

Who says clothing doesn't make the man?

AIHW Health Division Head Geoff Sims' earliest memory of his working life at the Institute was that of himself and newly appointed AIHW director, Richard Madden, rolling up to their first day of work--wearing the same tie--'People thought they got a package deal', he said, 'when in fact Richard and I had made our decision to come to the AIHW independently. It was just a coincidence.'

In reality, Geoff's tie to the Institute had nothing to do with coincidence but was very much the product of a longstanding career in the Australian Bureau of Statistics (ABS)--combined with an interest and experience in social statistics.

'As somebody with a keen interest in music, I used to joke that late meetings interfered with my piano lessons. But I've since learned there's time in life for everything.'

More recently, much of Geoff's and his team's time has been devoted to planning and writing *Australia's Health 2000*, the Institute's seventh biennial report on the state of the nation's health and health services. This 2000 edition serves as a summary of Australia's health record at the end of the twentieth century. In addition, there is a special chapter on the changes in Australia's disease profile over the last 100 years.

'This time there's a special focus on determinants of health and on the national health strategies and performance matters--both prominent in the Australian Health Ministers' Advisory Council agenda in relation to the National Public Health Partnership, and the National Health Priority Areas', Geoff said. 'This focus on health determinants and performance signals the new direction future editions are likely to take.'

Geoff was raised in Westmead, New South Wales ('before the Westmead Hospital was built there'), and his introduction into the world of statistics and information was a rags to riches story. As a poor student in the late 1960s he was offered a lucrative scholarship to join the ABS as a cadet statistician. 'I went from being a poor to a rich student as my ABS scholarship allowance was a lot of money at the time. It also brought a commitment to work at the ABS, at least for a while.'

For the most part, Geoff stayed with the ABS for 26 years, apart from leaving briefly to work in the Commonwealth Grants Commission, and at the Department of Social Security--the year prior to the introduction of Medibank.

His first 'real management job', however, was as head of the ABS' Adelaide office from 1983 to 1987. Responsible for more than 200 staff, Geoff found that the position gave him more opportunities. 'I enjoyed the challenge of building the office's capacity to provide tailored services to the State Government.'

As Head of its Social Statistics Branch, Geoff said he enjoyed a lot of his work with the ABS, particularly his involvement in the user-pays surveys, such as the mental health, and national Aboriginal and Torres Strait Islander statistics surveys.

'And, of course, everything to do with AIHW has been a highlight. It's a professional group of people and I like the subject matter. At the ABS I worked in areas such as demography, crime, justice, and welfare; it's good to focus just on health.'

And when Geoff isn't focusing on the health of the nation, he's looking after his own--running, swimming and encouraging his three daughters to follow their own passions, which include scuba diving, dancing and callisthenics.

Sims

'As far as running goes, I still have the urge to chase a national title in my age group sometime.'

And what of his fledgling musical career, put on hold since he began working at the Institute?
'One day I'll listen to some more jazz and maybe even play some.'

'And, of course, everything to do with AIHW has been a highlight. It's a professional group of people and I like the subject matter.'



National Community Services Information Management Group (NCSIMG)

**The Standing Committee of Community
Service and Income Security Administrators
(SCCSISA) has agreed to funding of \$150,000
for the 2000–01 work program of NCSIMG.**

The funding is to cover work on three projects, each of which was identified as a priority in the NCSIMG Information Development Plan. The projects are:

- revision of the National Classification of Community Services;
- development of a proposal for the adoption of a linkage key/s for statistical and policy analysis in the community services sector, including examination of the privacy and technical issues involved; and
- updating of the national framework for reporting on child protection/child concerns data, and work on the development of guidelines to inform the interpretation of output data and related performance indicators for child protection. (This project has arisen from work done by the National Child Protection and Support Services Data Working Group, a working group of the NCSIMG.)

Each of the projects addresses key result areas identified by the SCCSISA in its draft Strategic Plan.

NCSIMG members recently established steering groups to manage the projects. The groups will submit refined project plans to the SCCSISA for endorsement before the projects get under way.

The NCSIMG is committed to involving representatives of national peak bodies in discussions about information development activities. These meetings have been held in Sydney and Canberra (as the centres where most such bodies are located). The next meeting is being organised for Thursday 10 August in Sydney. Invitations will be sent to Sydney-based national bodies in the community services sector. Please contact Margaret Fisher, NCSIMG Secretary, if you are interested in attending the meeting.

For further information, contact: Margaret Fisher, AIHW ph. (02) 6244 1033 or e-mail: margaret.fisher@aihw.gov.au

National Health Information Management Group (NHIMG)

In the last few months, the NHIMG has celebrated the arrival of Peter Plummer as Chair, and then lamented his resignation as Chair. Peter has left Territory Health Services to take over the helm of the Northern Territory Education Department. The NHIMG would like to thank Peter for his brief, but useful, stint as Chair.

The last NHIMG meeting was held on Friday 7 April 2000 in Melbourne. Key outcomes of the meeting were:

- The NHIMG is to contribute comments on key documents produced by National Health Information Management Advisory Council (NHIMAC) and its sub-committees.
- The NHIMG is to chair a new group set up by the Department of Health and Aged Care, called the HealthWIZ Dataset Production Group.

The NHIMG is to contribute comments on key documents produced by National Health Information Management Advisory Council (NHIMAC) and its sub-committees.

The NHIMG is to chair a new group set up by the Department of Health and Aged Care, called the HealthWIZ Dataset Production Group.

A report was given on the outcomes of a successful meeting of NHIMG representatives and National Aboriginal and Torres Strait Islander Health Council representatives.

For further information, contact: Margaret Fisher, AIHW ph. (02) 6244 1033 or e-mail: margaret.fisher@aihw.gov.au

Letter to the AIHW

John Walsh, an actuary and a member of the Institute's Disability Reference Advisory Group (DRAG) wrote:

Dear AIHW

My original comments are prompted by Colin Mathers' draft paper, 'The burden of disease and injury in Australia', which I received in September 1999. I have three specific issues with the estimation of Disability Adjusted Life Years (DALYs) as presented in Colin's draft report, which probably feed into other areas:

The use of 'disability' as the fundamental measure of years lost or adjusted.

This is in my view a major issue. Depending on the use to which an assessment of disability is being applied, the process of measuring disability is chronically subject to mis-statement. In particular, any measure of disability is subject to major uncertainty where a financial outcome is at issue. In the case of the person being measured, there is usually an incentive to maximise disability, with of course the opposite incentives applying to the funder of the entitlement being examined. The classic examples are the estimation of disability or impairment in compensation schemes, where 'bracket-creep' has shown to devalue the measure over time, and similar observations in Social Security systems where entitlement is based on assessed disability level.

In my view, a far preferable approach would be to use one of the measures of 'handicap' (or participation in the ICIDH terminology). These measures place far more emphasis on enabling qualifiers and support required. Therefore, I believe they are both more objective and also more directly linked to the 'resource allocation' which is intended to be measured by the burden of disease

The use of a single mortality table in estimating years lost due to death

Again, my comments are subject to 'what use is being made of the measure'. However, intuitively I believe the mortality used in estimation should be that appropriate to each country being measured. Without such an approach, I believe 'DALYs' for developing countries would be incorrectly measured in comparison with those of more developed countries.

The use of discounting at 3%

My question here relates to the intention of discounting. It appears from the report that the lifetime burden of disease is being brought to current dollar values through a process of discounted cashflow similar to that which we would use in estimating a liability in a *funded* social security or compensation system. Therefore, I believe a far more appropriate way of presenting the results would be to project the emerging burden of disease in life years over a cohort of the population. In this way, the relative significance of short-term issues versus long-term issues could be examined without an artificial single-digit approach.

*John Walsh
Price Waterhouse Coopers
13 April 2000*

In reply to:

Use of disability in Disability Adjusted Life Years

Richard Madden replies:

Use of 'disability' in Disability Adjusted Life Years

John Walsh raises a major dilemma that confronted the Institute in estimating the burden of disease for Australia using WHO methodology and also describing the needs of people with a disability. After much debate, the November 1999 Burden of Disease and Injury in Australia states (p. 9):

Following the GBD terminology, and consistent with the proposed revision to ICIDH, the term disability is used broadly...to refer to departures from good or ideal health in any of the important domains of health. These include mobility, self-care, participation in usual activities, pain and discomfort, anxiety and depression, and cognitive impairment...

The WHO is now attempting to decide which parts of the ICIDH should be associated with the measurement of health outcomes. It is a lively debate in which people with disabilities need to make their voices heard.

Use of a single mortality table in estimating years lost due to death

The Australian Burden of Disease study used an Australian projected cohort life table in estimating years lost due to death. This is a life table which is calculated to reflect the projected mortality experience of the cohort alive in 1996 (the study's base year). Hence, it does reflect mortality appropriate to Australia.

Mr Walsh is correct in identifying the key issue as the use to which the measure is to be put. For comparisons between groups within a country, a country-specific life table is appropriate. However, a standard life table would be more appropriate for comparisons between countries.

Use of discounting at 3% pa

The 3% discount value is taken from the recommendation of the US Panel on Cost-Effectiveness in Health and Medicine and is the current standard for discounting of health economic analyses.

Not discounting can cause anomalous results:

- Undiscounted measures give excessive weight to deaths at younger ages

Without discounting, a death at age zero results in 50% more YLL (years of life lost) than a death at age 25 and 100% more than a death at age 40.

- The disease eradication/research paradox

This paradox is best explained with an extreme example. Suppose there is a disease which can be treated now but not prevented. Suppose further that there is a research program which may develop a prevention strategy for the disease. The years of life saved by the research program all occur at some unspecified time in the future but are potentially infinite because the research may lead to all future cases of the disease being prevented. If future years of life saved by prevention are valued the same as present years of life saved by treatment (i.e. if the future benefits are not discounted), then resource allocation based on years of life saved would all go to the research program and none to treatment.

We acknowledge the issue is controversial. For this reason the Australian Burden of Disease Study also presented data on the undiscounted burden for each disease or injury group.

*Richard Madden,
Director AIHW
July 2000*



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What do cigarette smoking and social disadvantage have in common? The answer is that they both make almost nothing better and almost everything worse.

For social disadvantage, patterns of health ram this point home as well as anything. The health disadvantages of the have-nots, compared with the haves, are large, sweeping and worldwide. The problem has probably always existed. This applies no matter how we measure social advantage, whether by income, occupation, education level, where people live, or combinations of these.

For example, let's look at Australians aged 15–64 living in larger cities during the 1990s. Among the males, the most socially and economically disadvantaged fifth of the population had an 80% higher overall death rate than the most advantaged fifth. For females, the corresponding difference was about 40%.

A similar strong social pattern applies to many other aspects of health and disease for both males and females, young and older. This is just one of the points made by Gavin Turrell, the Institute's Colin Mathers and others in articles published in the 17 April and 1 May editions of the *Medical Journal of Australia*. They report that socially worse off Australians tend to have lower birthweight babies and more pre-term births. Their children have more developmental delays, chronic health problems, pedestrian injuries, behavioural problems and worse dental health. Disadvantaged adults give themselves much lower health ratings than the socially better off, report worse mental health and more chronic health conditions, and have more hospital admissions. They also have markedly higher death rates from such major killers as heart attack, lung cancer and motor vehicle accidents.

And so on. In fact, the pattern is so consistent and broad that the easiest way to remember it is through the very few diseases where there is no trend or it runs the other way: melanoma and cancers of the large bowel, breast and prostate.

Also, it is now clear that it is not just a matter of the poor and the rich but of a gradient between them. The better your social and economic advantage, the better your health is likely to be. This doesn't mean that Kerry Packer will live forever. But it does mean that, if we divide the population into a few grades ranging from most advantaged to most disadvantaged, each group down the scale is not as healthy as the one above

it. Even in a country like Australia, where so many of us are healthy and well off by international standards, this social health gradient still applies. It may also be that inequality in itself is bad for health. Some research in Europe and the US has found that, when nations or states with similar overall wealth are compared, those with greater income inequality among their people have higher death rates.

And the story doesn't stop there. It seems that the health gap between the haves and the have-nots in Australia may be widening on several counts, as reported for the US and UK.

This all raises a few obvious questions. What explains this trend? Why is it so strong? And what can be done about it? In response to the first question, we would probably all think of a few possibilities. Maybe people with advantages such as more education, money, and so on tend to be more careful with their 'lifestyle' by not smoking and by watching how much they drink. Maybe their working conditions are generally safer. And do less advantaged Australians somehow fail to get good medical care, a question of access?

The first guess is a good one. Low-income Australian men and women are three times more likely to be smokers than those with high incomes. The lower income group tends to have more heavy drinkers as well. But, at first glance, they don't have a problem getting equal access to health care in this country. After all, Medicare gives all Australians free or low-cost visits to GPs and free care in public hospitals. And we know that lower income Australians do not visit doctors less often than those who are better off, but more often. And studies around the world suggest that lifestyle factors, important though they certainly are, only go part of the way in explaining the social gradient in health.

Quality of life

So there must be more to the story than this. To explore the issue, let's consider an Australian who fits into the 'most disadvantaged' group, Kevin. He was the youngest in a family of four children. His mother did part-time receptionist work in a nearby hotel. His father worked in a large factory but was at home for several long spells on government assistance when the business was in trouble and laid off its workers. The parents got on well with each other and were loving to their children, but the family was almost always hard up and feeling the stress of it.

Kevin was born a little underweight and a few weeks early. This happens more often when a mother smokes during pregnancy, as in Kevin's case. This didn't seem to slow his early development but it can. Dad smoked too, and Kevin's smoky environment could well explain why he had chest infections fairly often as an infant and even had to go to hospital once.

Kevin was breast-fed for a few months. There is also the question of whether his mother got the best nourishment when she was carrying him in the womb. One popular scientific idea, known as the Barker hypothesis after the scientist who proposes it most strongly, is that conditions like these can lead to important changes in the developing baby's body. This is said to program the body, so that when the person is an adult, they are more susceptible to the effects of a Western diet and hence at greater risk of heart disease, high blood pressure and older onset diabetes.

Kevin's father was a bit of a philosopher. He would sit there, looking at the beer he held in one hand and the smoke in the other. 'Maybe a man should give these a rest. But what else can you do when you're in my position?' He pointed out that life was short and for living. You could step under a bus at any time. 'The fact is that when your number's up, your number's up.' He said this kind of thing much more often when he was laid off his job. It made plenty of sense to Kevin.

Kevin went to the local primary and high schools, as did many other children whose parents worked at the factory. Like most of his friends he started smoking in early high school and within a couple of years was also drinking

fairly often—pretty normal behaviour. He did quite well in class and wondered about university. But that wouldn't be easy, it would be a long time before he'd earn a dollar if he took that path, and his parents wouldn't be in much of a position to support him past school. He noticed that uni was automatic for Matthew, one of the few 'rich kids' in the class, and whom he beat at most subjects.

After toying with the idea of a trade, Kevin left in Year 11 and went into the factory like his dad (and his dad before him). He kept smoking, developed a pot belly as he entered his 20s, and became a family man. Kevin rose a couple of pegs in the factory over the years. He could handle his work there quite easily but never felt he had much say in what he did. In the jargon, he had little 'job control' and in truth he didn't feel he had much control over his circumstances generally. He felt controlled more by other people and outside events. Kevin's father used to say that it didn't really matter what they said, the system wasn't made for people like him and his family. It would get to Kevin now and then, especially the few times he ran into Matthew, who became a banker. At least Kevin had his beer and cigarettes, life's simple and dependable pleasures. After his father died of lung cancer he did try to quit smoking a couple of times.

In his mid-50s Kevin found out he had high blood pressure and started to have the odd spell of chest pain. Although he wasn't one for check ups he found he often had to visit the doctor for one reason or another. For a few months his doctor wasn't sure what the pain meant but he arranged a specialist appointment quickly when they became worse and more frequent. (Although Kevin didn't like making a fuss or bothering him, his doctor remembered one of Kevin's factory mates who died because he had a bowel obstruction one Friday night and didn't seek help for a day for fear of disturbing 'the Doctor' on his weekend off.) Kevin ended up having a coronary bypass operation for a blocked blood supply to his heart. At last count he was going well though still trying to quit the smokes and lose some weight.

What does Kevin's story tell us, then? First, it fits the fact that socially disadvantaged Australians have a higher rate of disease risk factors such as overweight and high blood



*Dr Paul Magnus,
AIHW Medical Advisor*

Continued on page 23

Aged Care Unit

The Aged Care Unit was established in 1993 with the appointment of Dr Diane Gibson as Unit Head. Since then, the Unit has engaged in a variety of projects: some descriptive statistics, some analytic statistics, and some data development.

Aged care statistics

One of the ongoing tasks of the Unit is the production of the Residential Aged Care Statistics Series. Produced annually, these compendiums of statistics provide a wealth of information on Australia's residential care provisions for older people. The production team is now led by Dr Peter Braun but was, in previous years, the responsibility of Mr Zhibin Liu (currently on leave from the Institute).

A related recent development is the production of a similar set of statistics on community care packages. The document was released in mid-2000 and will contribute a substantial amount of information to what is presently a poorly documented area of government activity. This project was undertaken by Ms Minh Bui.

In 2000, Unit staff undertook an analysis of residential care, community care package and HACC (health and community care) data at a regional level of analysis. The resulting working paper, co-authored by Diane Gibson, Peter Braun and Zhibin Liu, is scheduled for release shortly. It demonstrates a significant level of equity in the supply of aged care services when different service types are taken into account.

Collaborative work

The Unit undertakes a considerable amount of collaborative work with other government departments. Late 1999 saw the completion of a cohort-based analysis of older women, prepared for the Office of the Status of Women and published by them as part of their annual

publication *Women in Australia*. This work was undertaken by Diane Gibson, Christine Benham and Edith Gray.

A report on older ethnic Australians has also been recently released. The project was undertaken for the Department of Immigration and Multicultural Affairs by Christine Benham, Diane Gibson and Bella Holmes in collaboration with Dr Don Rowland of the Australian National University.

A related project on projections of older ethnic populations has commenced and is funded by the Department of Health and Aged Care. The project team consists of Peter Braun, Christine Benham, Diane Gibson and Minh Bui. The projections were generated by the Australian Bureau of Statistics. The report is scheduled for release in December 2000, and will include projections to the year 2026 for the largest 50 birthplace groups of older Australians from culturally and linguistically diverse backgrounds, presented at the national, State and Territory, and regional level.

Developing instruments to measure service quality in HACC

Dr Anne Jenkins has focused her attention in recent years on projects concerned with the regulation of service quality. She has completed, with other Unit staff, a project which developed the HACC Service Standards Instrument, currently scheduled for implementation nationally as the standard assessment instrument for measuring the quality of HACC services. More recently, she has been engaged in developing a Consumer Survey Instrument suitable for collecting data on client appraisals of HACC service quality. This project is nearing completion. These projects were carried out under the aegis of Commonwealth, State and Territory HACC officials.

Data development

The Aged Care Unit was a central player in the development of the new HACC minimum data set, intended for implementation from January 2001. Unit staff developed the minimum data set and produced the HACC data dictionary, as well as participating in the national pilot study as the trial data repository. A number of Unit staff were involved in the project, but particular expertise was provided by Patricia Ryan, Bella Holmes and Zhibin Liu.

Publications

The Unit maintains a busy publishing profile across a variety of types of publications. A list of publications can be found on the Institute's web page, www.aihw.gov.au.

For more information, contact
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diane.gibson@aihw.gov.au

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pressure and make less use of preventive services, as well as being more likely to suffer heart disease, lung cancer and many other serious problems. Second, it hints at possible answers to why these factors are more common among people with backgrounds like Kevin's. Some of it could be due to the direct physical effects of our very early environments. Some almost certainly comes from attitudes and behaviours that we learn from family and friends and that we develop from later experiences in work and society. Some will arise simply from a relative lack of information, quite apart from how we react to that information when we get it. And some may be due to how society and work treat us and how that directly affects our body through our emotions. A reasonable case can be made that feelings such as stress, insecurity, alienation and resentment can affect our nervous and hormonal systems in ways that make us sick.

It may also be that disadvantaged people don't really have the same access to services that others do. Are they a little more intimidated by doctors, less likely to ask them questions and seek second opinions, and more likely to feel somewhat lost in the health system? And the

fact that they see doctors more often doesn't mean they see them often enough. Certainly, research in the UK has found that lower income patients with symptoms of heart disease were less likely to be investigated by doctors, less likely to be referred for possible bypass surgery and had to wait longer for their bypass operations than patients with higher incomes.

But I especially hope that Kevin's story helps explain why the social gradient can be so strong. It shows that there can be many social influences that cluster in the one individual and when this occurs they can have a large cumulative effect over a lifetime. It is also not hard to see how this socially produced pattern can be passed on to the next generation, and so on.

The final question, what can be done, is not one for this column to answer, even if it were foolish enough to think it could. But we will not go far until we fully realise that the best health is not an equal opportunity experience. For society as a whole, the closer that social gradient comes to (as they say) a level playing field the better our health will be.

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