

Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare (AIHW) is a Commonwealth statutory authority providing high-quality, independent evidence on health and welfare in Australia for over 30 years. Our data, products and services enhance the delivery of health and welfare for Australians by enabling other organisations to design, review and improve their policies and services through the better use of reliable evidence.

Board Chair Chief Executive Officer
Mrs Louise Markus Mr Barry Sandison

Our vision: Stronger evidence, better decisions, improved health and welfare.

About this report

This report describes our performance from 1 July 2018 to 30 June 2019 in accord with objectives outlined in our Corporate Plan 2018–19 to 2021–22 and measures in the 2018–19 Health Portfolio Budget Statements.

It outlines what the AIHW has undertaken in 2018–19, presents financial statements, discusses our staffing profile and identifies plans to meet the challenges in the year ahead.

Cover design

The cover design incorporates AIHW branding. To illustrate our vision for stronger evidence, better decisions and improved health and welfare, the image on the front cover depicts an angular bar positioned in an upwards trajectory, representing the range of health and welfare topics we publish in charts and graphs. At the top of the bar, the image of an angular square represents a data point which is typically included in charts and graphs.

A range of icons have been embedded in the angular bar and square, each representing our data collections involving populations groups such as: adult males and females, children, babies, youth and people with disability. It also includes some of the topics covered in our products such as: housing, obesity, cardiovascular disease, exercise and diet which are accessible online.

The back cover shows a data point containing the same icons displayed on the front cover. It also presents our logo—the acronym of our name—sembled with a data point in each character.

Our branding elements have been used throughout the report.

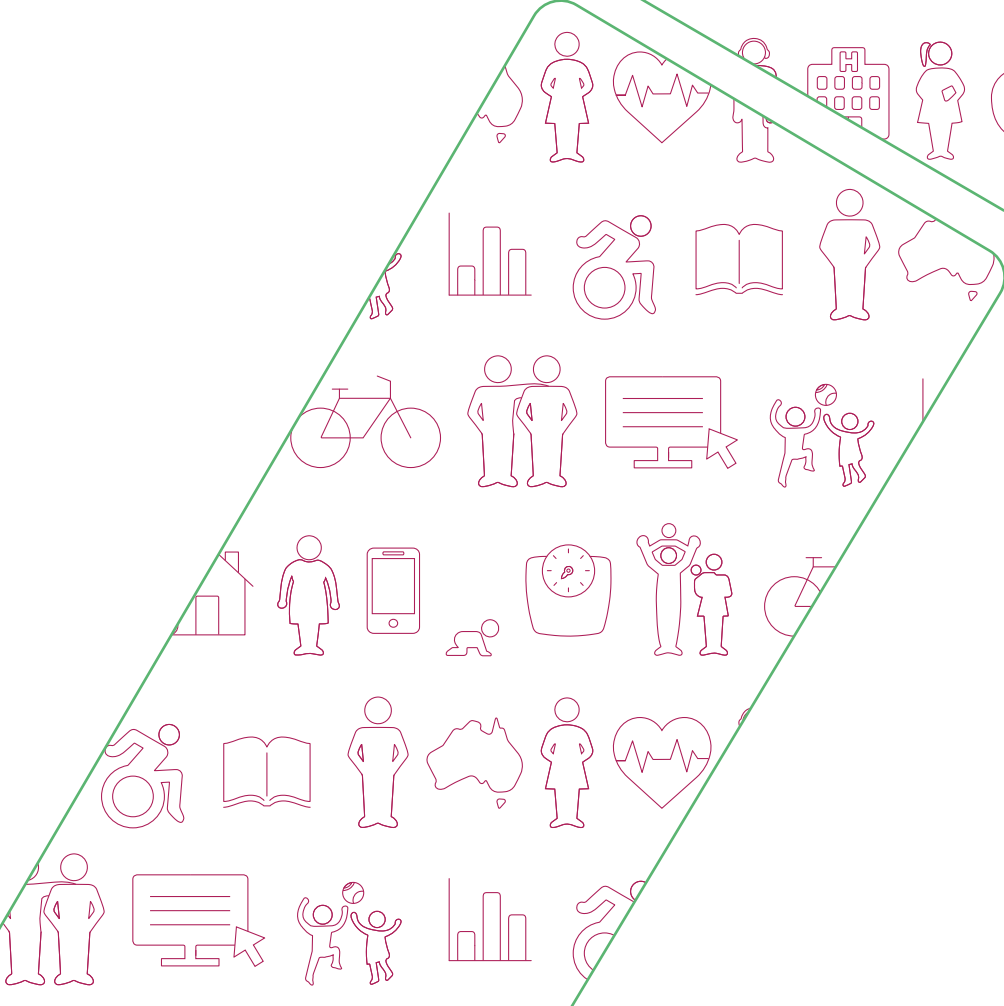
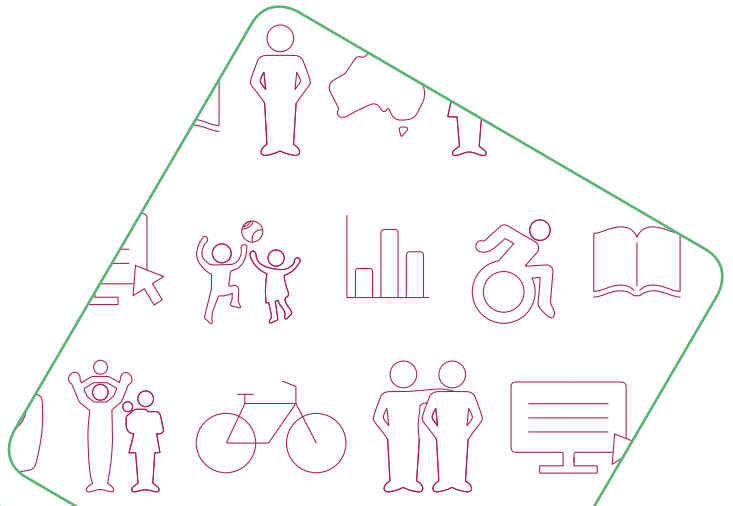
Our history

- 1984 Australian Institute of Health created within the Commonwealth Department of Health
- 1987 Australian Institute of Health established by legislation as an independent Commonwealth statutory authority
- 1988 First edition of *Australia's health*
- 1992 Welfare functions added and name changed to the Australian Institute of Health and Welfare
- 1993 First edition of *Australia's welfare*
- 2001 Ethics Committee enabled in the AIHW Act
- 2012 Accredited as an Integrating Authority to undertake linkage of sensitive Commonwealth data
- 2016 Took over reporting of the Performance and Accountability Framework following the closure of the National Health Performance Authority
- 2018 AIHW Act amended to enhance the composition of the Board and streamline operations

Australian Institute of
Health and Welfare

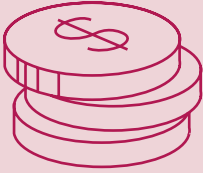
Annual report

2018–19

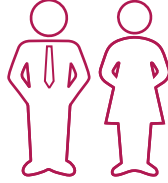


2018–19 highlights

Revenue
\$78.0 million



Staff
498



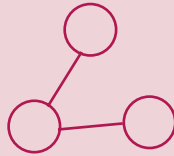
Data collections
>150



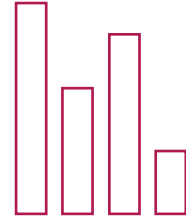
Products released
181



Data linkage activities
72



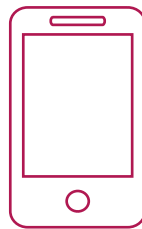
Custom data requests
208



Media mentions
6,167



Web hits
4.1 million



Twitter followers
18,200



Letter of transmittal



Australian Government
Australian Institute of
Health and Welfare

AIHW



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

Dear Minister

On behalf of the Board of the Australian Institute of Health and Welfare (AIHW), I am pleased to present the AIHW's annual report for 2018–19. This report was approved by the Board on 26 September 2019.

This report has been prepared in accordance with section 46 of the *Public Governance, Performance and Accountability Act 2013*, the Public Governance, Performance and Accountability Rule 2014 and other relevant legislation.

The report includes the AIHW's audited financial statements and annual performance statements for 2018–19.

I am satisfied that the AIHW has, in accordance with section 10 of the Public Governance, Performance and Accountability Rule 2014, prepared fraud risk assessments and a fraud control plan and has appropriate fraud prevention, detection, investigation, reporting and data collection mechanisms to meet the specific needs of the AIHW.

Yours sincerely

Louise Markus
Chair
26 September 2019

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Chair's report

On behalf of the AIHW Board, I am pleased to present the AIHW's annual report for 2018–19. The major achievements made by the AIHW are highlighted in this report.

This annual report demonstrates that the AIHW is continuing to increase the value it delivers to the Australian Government and the Australian Community.

Over the past 32 years, the AIHW has fostered and established many strategic and trusted partnerships across the health and welfare sectors. In collaboration with these partners, the AIHW has continued to develop and capture the data required to inform national policy and health and welfare priorities. This work supports good policymaking, research and the information needs of the broader community.

Amendments to the *Australian Institute of Health and Welfare Act 1987* came into effect in November 2018. The most significant change saw the representative-based structure of the AIHW Board replaced with membership comprising a collective mix of skills and experience from a range of different fields.

The amendments also created the position of Deputy Chair. I welcome the appointment of long-term board member Dr Erin Lalor to this role.

The board continued its journey to review and refine its Risk Management Framework (RMF). The board worked with the Risk, Audit and Finance Committee (RAFC) and senior executives to update the RMF and develop a new Strategic Risk Profile (SRP). Unsurprisingly, cybersecurity and general data security are central to the maintenance of trust. The board will pay particular attention to the investment needs of the AIHW in this area.

The updated RMF and SRP will be implemented in 2019–20.

It is pleasing to see strong growth in our budget appropriation and external revenue. This demonstrates the value of the AIHW's significant contribution to the evidence base of Australia's health and welfare.

I would like to thank Mr David Conry, Ms Caroline Edwards, Mr Andrew Goodsall, Ms Luise McCulloch and Ms Marissa Veld, who finished their terms as board members, for their valuable contributions.

I am proud to see the achievements of our Chief Executive Officer (CEO), Mr Barry Sandison and his senior team who are ably supported by our talented staff. I want to particularly mention their passion and commitment across the AIHW which the board has observed. It is an honour to be the Chair of Australia's leading agency for authoritative information and statistics on health and welfare.

In 2019–20, the board will continue to focus on the dynamic environment in which the AIHW operates. The board will also provide appropriate oversight and guidance to enable the AIHW to be innovative in meeting the growing demands for information and data products and services.

The board is excited about the AIHW's future, as it leads the way in a rapidly evolving health and welfare data landscape.

Louise Markus
AIHW Board Chair



CEO's report

2018–19 was a year that combined the continued delivery of our well regarded products and services with a growing role in advising on data related activities and developing new strategic assets. Our Vision for Stronger Evidence and our five strategic goals have maintained their relevance and guided our priorities. Importantly, with growing concerns over cybersecurity and data protection, privacy and strong governance have remained central to our work. The AIHW acknowledges that the data assets we manage contain large amounts of personal and sensitive data and we maintain rigorous controls to determine access to, and the release of, this information.

While the rising demand for our services and products reflect positively on the AIHW brand, these opportunities come with increased challenges and risks.

The Australian Public Service (APS) cap on staffing levels has led to a significant increase in the use of contract staff, almost 31% of active staff at the end of June 2019. The flexibilities that come with use of contractors also provide some challenges in terms of retaining corporate memory and capabilities.

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

In 2018–19 we continued our transformation from publishing traditional reports to more dynamic and interactive products and enhanced geospatial reporting, without compromising our rigorous standards of privacy and confidentiality.



Our operations

It was an eventful year for the AIHW in 2018–19. Our enabling legislation, the AIHW Act, was amended to improve our governance and operational efficiency. This was the first significant change to this legislation since the addition of the welfare functions in 1992.

We re-aligned our work units with existing and emerging work streams to foster greater collaboration across the AIHW and meet the needs of our stakeholders. This restructure included the establishment of a new Data Governance Group with a new unit to focus on My Health Record (MHR) data governance and the secondary use of MHR data. We also established a second data linkage unit to help meet the demand for data linking services.

Our staff continued to be engaged with the work of the AIHW. I was pleased that we had an 89% response rate for the APS Census and the extremely strong results compared very favourably with other APS agencies.

The high level of support for our purpose and the degree of willingness to 'buy in' to what we do, are a huge part of our organisational culture and what will continue to make us a high-performing organisation. This is also reflected in the large numbers of high quality applicants for vacancies at both the APS and executive level positions.

2018–19 highlights

Key achievements in 2018–19 included:

- establishment of the first version of the National Integrated Health Services Information Analysis Asset (NIHSI AA) to enable reporting on patient journeys through the health and aged care sectors
- an updated burden of disease suite of products that included analysis of the burden attributable to risk factors, burden for population groups and risk factor burden for socioeconomic groups
- the first Profile of Australia’s veterans to understand the factors that influence veterans’ health and welfare
- national consultations with stakeholders to inform the development of an enduring National Primary Health Care Data Asset
- a series of innovative longitudinal reports that analysed the use of homelessness services and inaugural release of regional data on the use of homelessness services
- playing a key role in the development of a proposed data improvement plan for the National Agreement on Housing and Homelessness Agreement
- drafting 10-year plans for improved data and information for both mental health and palliative care
- high level involvement in the Royal Commission into Aged Care Quality and Safety which drew heavily on data published on our GEN—Aged Care Data website
- further gains in working with Centrelink data, which are crucial to understand outcomes, particularly for vulnerable population groups
- publishing of a report on opioid harm authored with the Canadian Institute for Health Information (CIHI)

- collaboration with the Healing Foundation to undertake work focused on the Stolen Generations.

The 2019 federal election involved a significant focus on health and some of the debate was informed by our data and products. This use of our data assets demonstrated the independent role played by the AIHW and the high level of trust in the reliability of our data.

Acknowledgments

The success of the AIHW is the result of contributions and efforts of many people including:

- Australian and state and territory governments, non-government organisations, professional bodies and academics who participated on our advisory committees, provided subject matter expertise and reviewed our products
- our Board Chair, Mrs Louise Markus, as well as current and former members of the AIHW Board for their strategic guidance
- the senior executive and staff of the AIHW who have continued to show their commitment to improving the health and welfare of Australians through better evidence.



Looking ahead

In 2019–20 we will publish our biennial flagship reports on Australia’s health and Australia’s welfare. We will also launch a completely revised and updated Metadata Online Registry (METeOR).

Both the Prime Minister and Minister for Health have placed a high priority on mental health and suicide prevention. The AIHW received funding in the 2019–20 budget to create a new national suicide information system. In addition, funding has been provided to establish an Indigenous Mental Health and Suicide Prevention Clearinghouse.

We will play a significant role in reporting under the new Council of Australian Governments (COAG) National Health Agreement, through the ongoing development of the Australian Health Performance Framework (AHPF). During 2019–20 the AIHW will also lead the development of a National Health Information Strategy.

We are developing a Secure Remote Access Environment—a cloud-based researcher analytics environment built on the University of New South Wales’s ERICA researcher platform.

To achieve our goals for 2019–20, we will continue to build on the relationships with our partners in health, housing and community services across Australia to maintain our role as a major national agency for information and statistics.

Barry Sandison
AIHW CEO

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About the AIHW

Our enabling legislation

The AIHW was established in 1987 by the *Australian Institute of Health Act 1987*. Welfare functions were added in 1992 and our legislation was renamed the *Australian Institute of Health and Welfare Act 1987* (AIHW Act).

Our functions

Our functions are set out in section 5 of the AIHW Act. The role of the AIHW is to:

- collect and produce, and coordinate and assist the collection and production of, health- and welfare-related information and statistics
- conduct and promote research into Australians' health and their health services
- develop specialised standards and classifications for health, health services and welfare services
- publish reports on its work
- make recommendations to the Minister on prevention and treatment of diseases and improvement and promotion of the health awareness of Australians
- provide researchers with access to health- and welfare-related information and statistics, subject to confidentiality provisions.

Our vision



Our purpose

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

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

Our strategic goals

We continued to apply and strengthen our capabilities to be: leaders in health and welfare data; drivers of data improvements; expert sources of value-added analysis; champions for open and accessible data and information; and trusted strategic partners.

Leaders in health and welfare data

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

Drivers of data improvements

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

Expert sources of value-added analysis

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



Champions for open and accessible data and information

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



Trusted strategic partners

We will foster strategic partnerships and engage collaboratively with stakeholders to deliver program-specific expertise and enable others to achieve their strategic goals. More information about our capabilities is available at www.aihw.gov.au.

Overview of governance

The AIHW is a corporate Commonwealth entity under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) and is a body corporate with separate legal entity from the Commonwealth.

A 12-member board, chaired by Mrs Louise Markus, is the accountable authority of the AIHW. The AIHW Board sets our strategic directions and is responsible for fulfilling its functions under the AIHW Act.

The AIHW Act and the Australian Institute of Health and Welfare (Ethics Committee) Regulations 2018 establishes our Ethics Committee and sets out its functions and membership (see Chapter 4 Our governance).

Our values

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

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

Portfolio and ministerial oversight

The AIHW is part of the Health portfolio. We are accountable to the Australian Parliament through the Minister for Health, the Hon. Greg Hunt MP. We provide the Minister our corporate plan, annual report and other relevant information as required by the PGPA Act.

The Minister for Health, and other relevant ministers in the Australian Government and state and territory governments, have embargoed access to our products prior to public release (see Chapter 3 Our relationships).

Our people

At 30 June 2019, the AIHW had 498 staff (permanent and temporary) based in Canberra and Sydney (see Chapter 5 Our people).

Our strategic priorities for 2018–19

Our Corporate Plan 2018–19 to 2021–22 and the 2018–19 Health Portfolio Budget Statements set out the key strategic priorities and activities we strived to achieve.

Our performance against each measure is presented in this report (see Chapter 1 Our performance).

Financial

The AIHW's total revenue for 2018–19 was \$78.0 million. We are funded through a combination of an appropriation from the Australian Parliament (\$33.3 million), revenue from fee-for-service work (\$44.7 million) and interest from cash balances (\$2.0 million). State and territory government funding contributed \$6.2 million of the fee-for-service work. We reported an operating loss of \$239,000 (see Chapter 1 Our performance and the financial statements at Appendix 5).

Our operating environment

We publish extensive policy-relevant health and welfare information to assist policymakers, health care, housing and community service providers, researchers, and all levels of government (see Chapter 2 Our products and services). We develop, maintain and promote statistical information standards for the health, community services and housing assistance sectors.

Accurate statistical information, comprehensive data development and high quality analyses support an increased understanding of health and welfare issues. Our work creates an evidence base to drive changes in policy and service delivery, which has a direct impact on the lives of Australians. There is also interest in the generation of integrated information, obtainable through

data linkage and other data analytic techniques (see Chapter 2 Our products and services). The creation of expanded data sets improves our understanding of client or patient journeys and population outcomes.

Data assets

Our health and welfare data assets are substantial and includes more than 150 data sets. These essential statistical assets cover fields as diverse as housing assistance, homelessness, perinatal health, disability, cancer, hospitals and hospital activity, alcohol and other drugs, and mortality.

We operate as the access point for the sharing of Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) data for linkage projects and the provision of access to Centrelink data sets.

Our stakeholders

Our stakeholders are important to us as groups to which we are accountable, who fund us, and to whom we target our products (see Chapter 3 Our relationships). They include:

- the Australian Parliament and people of Australia
- the Australian Government and its departments and agencies
- state and territory governments and their departments with responsibilities for health, community services, housing assistance, education and justice
- health and welfare service providers, professionals and non-government organisations
- consumers of health, welfare and housing assistance services
- the research community.

The AIHW collaborates closely and has effective partnerships with many individual government entities, universities, research centres, non-government organisations and individual experts.

International partnerships

The AIHW has a role in information sharing with a number of international organisations, such as the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO). We also have informal collaborative arrangements with other international agencies and bodies, such as CIHI and the International Group for Indigenous Health Measurement.

Case study

1

How well does Australia's health compare internationally?

Our challenge

Needing a comparison tool

There was no Australia-specific tool that could be used to compare national health and health-care data with comparable data from other countries.

Our response

Delivering data visualisations

We published *International health data comparisons, 2018*—a novel set of interactive data visualisations that allow users to focus on Australia's performance in a range of health and health care indicators and compare with the OECD average and results for 36 OECD member countries.

The data visualisations show that Australia performs relatively well across most of the indicators, with the sixth highest life expectancy at birth of 82.5 years—above the OECD average of 80.6 years. Australia also had the sixth lowest percentage of daily smokers (12%) across OECD countries, well below the OECD average of 18%. However, the data also show there are some areas where Australia could be doing better. For example, Australia had the ninth highest rates of overweight and obesity overall at 63%; while men had the third highest rate of overweight and obesity (71%), behind the United States of America and Chile.

Our results

Making data comparisons more accessible to users

This product demonstrates how data and technological innovation support our strategic directions.

Release of this work generated considerable interest and mentions in the media. Comparing health and health care data between countries facilitates international comparative reporting, supports policy planning and decision-making, and enables health-related research and analysis.

Improving outcomes for vulnerable children

Our challenge

Improving national reporting on child protection

In Australia, state and territory departments responsible for child protection assist vulnerable children who are suspected of being abused, neglected or harmed, or whose parents are unable to provide adequate care or protection.

Following an investigation by authorities, children who received these services may be on a care or protection order and/or in out-of-home care (such as foster care).

Children may move in and out of the child protection system, or receive different types of, or combinations of, services at different points in time.

Our response

Better understanding child abuse and neglect

Building on earlier work relating to child abuse and neglect, we established national reporting on the child protection system, publishing *Child protection Australia 1996–97* over 20 years ago. The report outlined the extent to which child protection services are used at the national level, while also presenting differences between jurisdictions and particular groups of children.

Since then, the report has been an annual feature of our publication schedule, along with a range of specialised reports covering particular aspects of the child protection system and other children affected. This reporting includes analysis to better understand the relationship between child abuse and neglect and other issues such as youth crime, problematic alcohol and drug use, and homelessness.

Our results

Adding value to social policy

Continuous reporting and better data equip governments and policymakers with the evidence they need to drive real change in the lives of vulnerable children. Strong data and evidence can also help build greater community awareness of important issues. In the case of child welfare, this awareness has the potential to increase people's likelihood of reporting suspected child abuse and neglect to authorities.

This increased awareness (to which we have strongly contributed)—both in the community and among governments and policymakers—is clearly demonstrated by the establishment in 2009 of Australia's first-ever national plan endorsed by COAG to tackle child abuse and neglect and to enhance children's wellbeing.

The National Framework for Protecting Australia's Children 2009–2020 is underpinned by growing evidence, and the AIHW will continue to report on these issues to support better outcomes for vulnerable children and young people.

[The AIHW] has worked tirelessly to improve data quality and to ensure that new data collection supports and informs policy directions to better meet the needs of children and young people.

Dr Brian Babington, CEO, Families Australia

Chapter 1

Our performance

- Statement by accountable authority
- Integrated performance framework
- Our performance

Statement by accountable authority

On behalf of the Board of the Australian Institute of Health and Welfare (AIHW), the accountable authority, I present the AIHW's 2018–19 annual performance statements, as required under section 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

In our opinion, at the date of this statement, these annual performance statements accurately reflect the performance of the AIHW for 2018–19 and comply with section 39(2) of the PGPA Act.

On 26 September 2019, these statements were approved by a resolution of the AIHW Board.

Louise Markus
AIHW Board Chair
 26 September 2019

Integrated performance framework

Figure 1.1 provides an overview of our integrated performance framework.

Figure 1.2 shows the relationship between the Portfolio Budget Statements, our Corporate plan and annual performance statements.

Our purpose

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

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

Our products and services inform open debate and discussion aimed at securing a sustained increase in quality of life for Australians.

Outcome

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

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

External confidence in the AIHW is demonstrated by our exemplary reputation and achievements over more than 30 years. It is reflected in the high level of engagement with other organisations through strategic partnerships and the demand for, and use of, our services and products.

Program

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

Our corporate plan includes 5 strategic goals (see pages x–xi).

Our performance indicators reflect our strategic outlook and directly align with the 2018–19 Health Portfolio Budget Statements and our Corporate Plan 2018–19 to 2021–22 performance criteria.

2018–19 Health Portfolio Budget Statements

www.health.gov.au/internet/budget/publishing.nsf/content/2018-2019_Health_PBS.

Corporate Plan 2018–19 to 2021–22

www.aihw.gov.au/reports/corporate-publications/aihw-corporate-plan-2018-19-to-2021-2022/contents/table-of-contents.

Figure 1.1: Integrated performance framework
















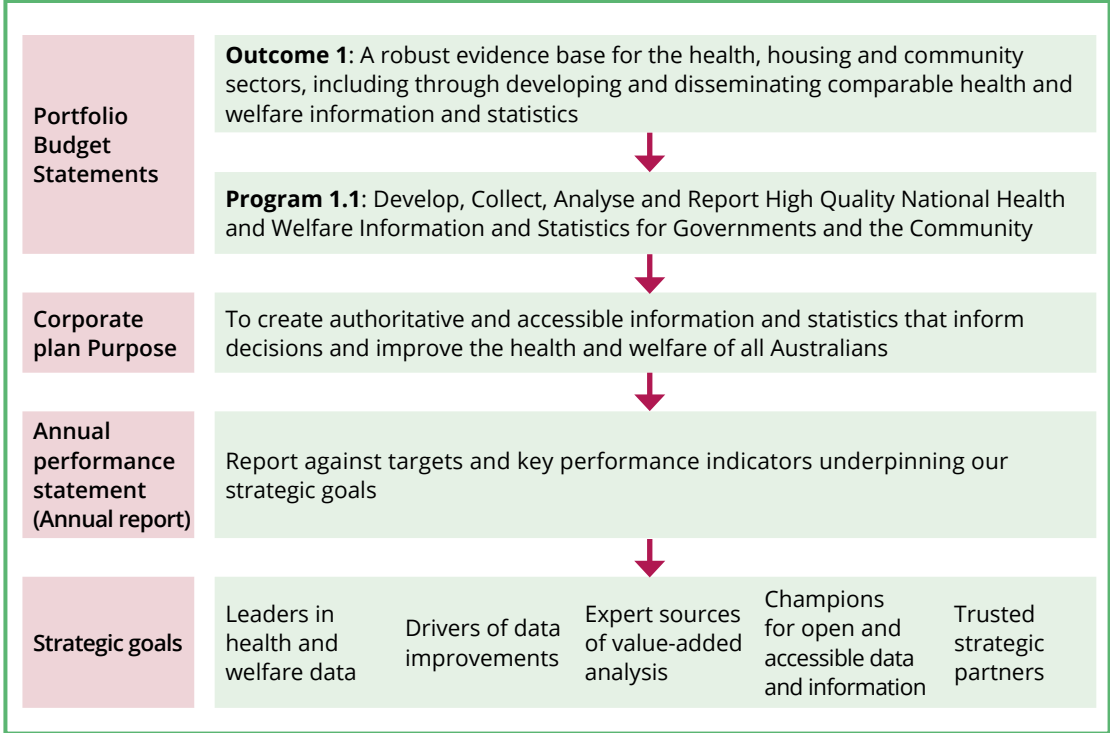
<p>Capability Capabilities required by the AIHW now and in the future (see Corporate plan)</p>	<p>Our purpose To create authoritative and accessible information and statistics that inform decisions and improve the health and welfare of all Australians</p>		<p>Environment External and internal factors we need to consider to achieve our strategic goals (see Corporate plan)</p>
	<p>Our vision Stronger evidence, better decisions, improved health and welfare</p>		
	<p>Strategic goals</p>		
	 Leaders in health and welfare data	 Drivers of data improvements	
	 Expert sources of value added analysis	 Champions for open and accessible data and information	
	 Trusted strategic partners		
	<p>Priority action areas</p>		
	 Our people	 Data gaps	
	 Data accessibility	 Data analysis capability	
	 Data management infrastructure	 Our processes	
 Stakeholder engagement	 Presentation of work and digital communication strategy		
 Data governance	 Timeliness		

Figure 1.2: Relationship between Portfolio Budget Statements, Corporate Plan and Annual Performance Statement



Our performance

Results against performance measures

In 2018–19, we met 18 of our 21 performance measures, partially met another 2 and did not meet 1 measure (Table 1.1). A summary of these results is provided in Table 1.2, with details in Table 1.3.


Table 1.1: Status of performance measure achievement by strategic goal category

Strategic goal	Number of measures	Met	Partially met	Not met
Leaders in health and welfare data	6	5	1	0
Drivers of data improvement	1	1	0	0
Expert sources of value-added analysis	7	6	0	1
Champions for open and accessible data and information	3	3	0	0
Trusted strategic partners	4	3	1	0
Total	21	18	2	1

Table 1.2: Summary of results against performance measures

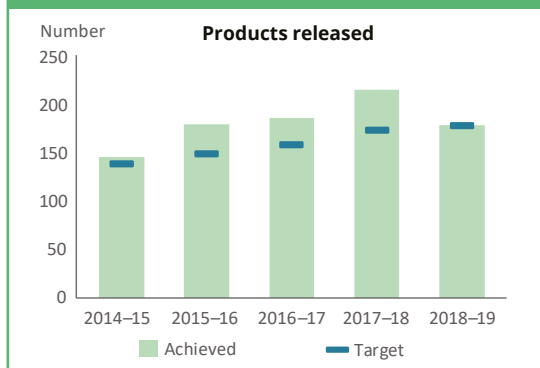
Performance measures	Results
Release of products by 30 June 2019 relating to 8 specified topics	Partially met
Release a range of data and information products relevant to key policy areas: <ul style="list-style-type: none"> • 181 products released • ≥71% statistical products relating to annual national collections for which data are reported less than 1 year after the end of their data collection period 	 Met Met
Supply data for performance indicators in the COAG national agreements on health care and Indigenous reform by 30 June 2019	Met
Supply data to timetables required for the Review of Government Service Provision's <i>Report on Government Services 2019</i> volumes on health, housing and homelessness, and community services	Met
Release products relating to local-level health performance indicators by 30 June 2019	Met
Add new data assets by 30 June 2019	Met
Release products presenting the results of linked data from 3 national cancer screening programs by 30 June 2019	Met
Complete the second of 3 work phases to improve storage, accessibility and analysis of locational data in AIHW data holdings	Met
Release a replacement of the METeOR by 30 June 2019	Not met
Establish the National Integrated Health Services Information Analysis Asset (NIHSI AA)	Met
Demonstrate, as case studies, AIHW contributions shown externally in 2018–19 of improved reporting of population or service-related health and welfare outcomes	Met
Disseminate AIHW analysis publicly through our website and the media: <ul style="list-style-type: none"> • 3.6 million sessions on the AIHW website • 4,600 references to the AIHW and its products in the media 	 Met Met
Continually improve the AIHW website and the provision of data, including that currently presented on the MyHealthyCommunities website	Met
Complete 60 data linkage projects as agreed under the National Collaborative Research Infrastructure Strategy 2013	Met
Release 95 statistical products that include data in a manipulable format	Met
Work with the ABS towards the Coordination of Health Care Study to continue with the release of a range of products including Hospital and Emergency Department Services data by 30 June 2019	Partially met
Release products by 30 June 2019 relating to under-identification of Indigenous people in key data sets	Met
Improve data in at least 1 subject area where there is a demonstrable data gap; for example, primary health care or disability	Met
Participate in and administer new health committees, as determined by the Australian Health Ministers' Advisory Council (AHMAC)	Met

Table 1.3: Details of results against performance measures

 A. Leaders in health and welfare data	
Measure	Release a range of data and information products relevant to key policy areas
Source of criterion	2018–19 Health Portfolio Budget Statements, page 223 Corporate Plan 2018–19 to 2021–22, page 17
Result	Partially met—Housing assistance in Australia was not released during the reporting period due to quality assurance processes resulting in a short delay in the production. The report was released on 18 July 2019. Data for this product was included in the Productivity Commission’s <i>Report on Government Services 2019</i> released on 22 January 2019.
Release of the following products by 30 June 2019 relating to:	Release dates:
• Health expenditure in 2016–17	28 September 2018
• Admitted patient care in 2017–18	23 May 2019
• Residential and community mental health services in 2016–17	11 October 2018
• Disability support services in 2017–18	28 May 2019
• Youth justice in 2017–18	10 May 2019
• Child protection in 2017–18	8 March 2019
• Aboriginal and Torres Strait Islander identification in key health data collections	24 June 2019
• Housing assistance in Australia	18 July 2019 (see ‘Result’ comments)
• National Social Housing Survey.	27 February 2019
See Appendix 1 on page 79 for publication titles.	
Measure	Assist reporting of, or report on, nationally agreed performance indicators
Source of criterion	2018–19 Health Portfolio Budget Statements, page 223
Result	✓ Met
Supply data for performance indicators in Council of Australian Governments (COAG) national agreements on health care and Indigenous reform by 30 June 2019	Data provided in accordance with agreed timeframes.

Measure	Assist reporting of, or report on, nationally-agreed performance indicators
Source of criterion	2018–19 Health Portfolio Budget Statements, page 223
Result	✓ Met
Supply data to timetables required for the Review of Government Service Provision's <i>Report on Government Services 2019</i> volumes on health, housing and homelessness, and community services	Data provided in accordance with timeframes agreed with the Productivity Commission.
Measure	Assist reporting of, or report on, nationally-agreed performance indicators
Source of criterion	2018–19 Health Portfolio Budget Statements, page 223
Result	✓ Met
Release products relating to local-level health performance indicators by 30 June 2019	<ul style="list-style-type: none"> • <i>Patients' out-of-pocket spending on Medicare services, 2016–17</i> was released on 16 August 2018 • <i>Potentially preventable hospitalisations in Australia by small geographic areas and age groups, 2016–17</i> was released on 31 October 2018 <p>Web update was released on 4 February 2019.</p>
Measure	Release a range of data and information products relevant to key policy areas
Source of criterion	2018–19 Health Portfolio Budget Statements, page 224
Result	✓ Met
Target: 181 products released	181 products released. A complete list of products is at Appendix 1 on page 79.

Figure 1.3: Products released, 2014–15 to 2018–19



Measure	Release a range of data and information products relevant to key policy areas
Source of criterion	2018–19 Health Portfolio Budget Statements, page 224
Result	✓ Met
≥71% statistical products relating to annual national collections for which data are reported less than 1 year after the end of their data collection period	<p>71% (15 out of 21 national collections). Data were not reported for the following annual national collections <1 year after the end of their data collection period:</p> <ul style="list-style-type: none"> • BreastScreen Australia monitoring report • Cervical screening in Australia • Health expenditure Australia • Mental health services in Australia online: Community Mental Health • Mental health services in Australia online: Residential Mental Health Care • Housing assistance in Australia. <p>We continue to work with stakeholders to reduce the time taken to supply and release data which will enable us to improve the timeliness of reporting annual collections within 1 year of the end of the data collection period.</p>



B. Drivers of data improvements

Measure	Enhance data resources with the addition of new data assets to the AIHW's data holdings measured by the number of such data assets approved by the AIHW Ethics Committee
Source of criterion	2018–19 Health Portfolio Budget Statements, page 224
Result	✓ Met
Addition of new data assets by 30 June 2019	<p>4 new data assets were added:</p> <ul style="list-style-type: none"> • Cancer and Treatment Linked Analysis Asset • National Cancer Screening Register data collection • 2019 National Drug Strategy Household Survey • Transition and Wellbeing Research Programme Data Collection.



C. Expert sources of value-added analysis

Measure

Source of criterion

Enhance data analysis capabilities

2018–19 Health Portfolio Budget Statements, page 224

Result

✓ Met

Release products presenting the results of linked data from three national cancer screening programs by 30 June 2019

Analysis of cancer outcomes and screening behaviour for breast, bowel and cervical national cancer screening programs in Australia was released on 14 September 2018 (see page 24). *Analysis of breast cancer outcomes and screening behaviour for BreastScreen Australia* was released on 26 November 2018.

Measure

Source of criterion

Enhance data analysis capabilities

2018–19 Health Portfolio Budget Statements, page 224

Corporate plan 2018–19 to 2021–22, page 18

Result

✓ Met

Complete the second of 3 work phases to improve storage, accessibility and analysis of locational data holdings, enabling better information on, for example, patterns and trends of service use

Second phase completed. We have configured the spatial reference data base and finalised documentation.

Measure

Source of criterion

Enhance data analysis capabilities

2018–19 Health Portfolio Budget Statements, page 224

Result

✗ Not met

Release a replacement to Metadata Online Registry (METeOR) by 30 June 2019

While substantial progress was made on the new METeOR system, further work is needed before it is ready for release in 2019–20.

Measure

Source of criterion

Enhance data analysis capabilities

2018–19 Health Portfolio Budget Statements, page 224

Result

✓ Met

Establishment of the National Integrated Health Services Information Analysis Asset (NIHSI AA)

The first version of the NIHSI AA has been built (see page 25).

Measure

Source of criterion

Enhance data analysis capabilities

2018–19 Health Portfolio Budget Statements, page 224

Result

✓ Met

Demonstrate, as case studies, AIHW contributions shown externally in 2018–19 of improved reporting of population or service-related health and welfare outcomes

Case studies are published in this report. See pages xiii, xiv, 28 and 34.

Measure

Source of criterion

Result

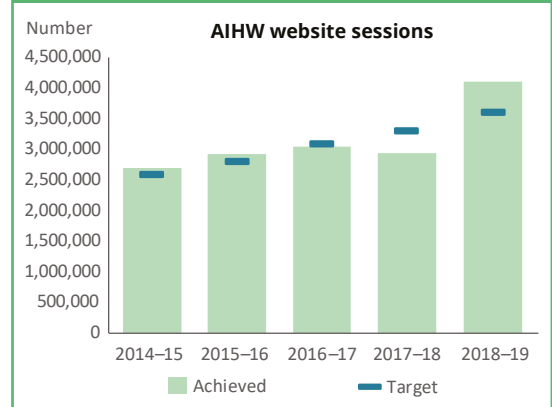
Target: 3.6 million sessions on the AIHW website

Disseminate AIHW analysis publicly through our website and the media

2018–19 Health Portfolio Budget Statements, page 225

✓ Met

4.1 million sessions on the AIHW website in 2018–19

Figure 1.4: AIHW website sessions, 2014–15 to 2018–19**Measure**

Source of criterion

Result

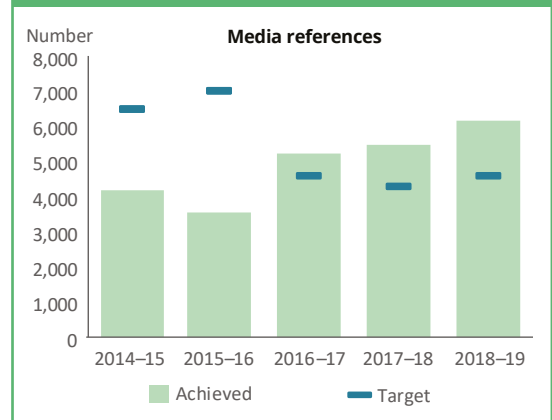
Target: 4,600 references to the AIHW and its products in the media

Disseminate AIHW analysis publicly through our website and the media

2018–19 Health Portfolio Budget Statements, page 225

✓ Met

6,167 media references in 2018–19

Figure 1.5: Media references to the AIHW and its products, 2014–15 to 2018–19



D. Champions for open and accessible data and information

Measure

Modernise presentation of national health and welfare-related data and analysis

Source of criterion

2018–19 Health Portfolio Budget Statements, page 225

Result

✓ Met

Continued improvement of the AIHW website and the provision of data, including that currently presented on the MyHealthyCommunities website

Developed new capability on the AIHW website to display indicators that were previously shown on the MyHealthyCommunities website. Development is underway to extend this technology to support releases of the Australian Health Performance Framework and the indicators for Australia's Welfare 2019.

Measure

Provide access to data and information in an environment that supports stringent governance, capability, data management and privacy requirements

Source of criterion

2018–19 Health Portfolio Budget Statements, page 225

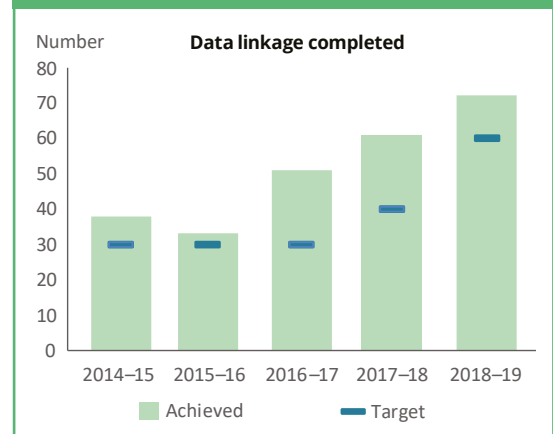
Result

✓ Met

Target: 60 data linkage projects completed as agreed under the National Collaborative Research Infrastructure Strategy 2013

72 data linkage projects completed in 2018–19

Figure 1.6: Requests for data linkage completed, 2014–15 to 2018–19



Measure

Release a range of data and information products that include data in a manipulable format

Source of criterion

2018–19 Health Portfolio Budget Statements, page 225

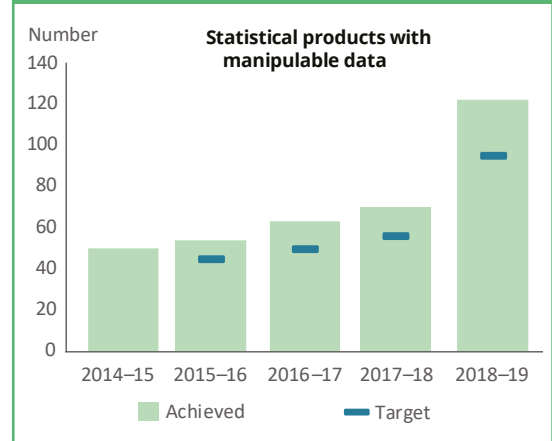
Result

✓ Met

Target: 95 statistical products released that include data in a manipulable format

122 statistical products were released in 2018–19 that included data in a manipulable format.

Figure 1.7: Statistical products released with manipulable data, 2014–15 to 2018–19



E. Trusted strategic partners

Measure

Work with partners to drive data improvement

Source of criterion

2018–19 Health Portfolio Budget Statements, page 226

Result

Partially met

Work with the ABS toward the Coordination of Health Care Study to continue with the release of a range of products including hospital and emergency department services data by 30 June 2019

The Coordination of health care: experiences with GP care among patients aged 45 and over 2016 was released on 26 July 2018.

The AIHW continues to work with the ABS on the Coordination of Health Care study to include linked hospital and emergency department data. This work is dependent on data acquisition from states and territories and a joint release with the ABS is scheduled for release in 2019–20.

<p>Measure</p> <p>Source of criterion</p> <p>Result</p> <p>Release of products by 30 June 2019 relating to under-identification of Indigenous people in key data sets</p>	<p>Work with partners to drive data improvement 2018–19 Health Portfolio Budget Statements, page 226</p> <p>✓ Met</p> <p>A report on best practice methods for <i>Improving Indigenous identification in mortality data</i> was released on 24 June 2019. <i>Aboriginal and Torres Strait Islander Stolen Generations and descendants: numbers, demographic characteristics and selected outcomes</i> was released on 15 August 2018.</p>
<p>Measure</p> <p>Source of criterion</p> <p>Result</p> <p>Improve data in at least 1 subject area where there is a demonstrable data gap; for example, primary health care or disability</p>	<p>Work with partners to drive data improvement 2018–19 Health Portfolio Budget Statements, page 226</p> <p>✓ Met</p> <p>Enhancement of the Specialist Homelessness Services collection was enhanced by publishing data which included an Australian Defence Force identifier, for the first time, as part of the collection’s annual report for 2017–18.</p> <p>The AIHW has been a major contributor to development of a business case for a new National Disability Data Asset. This work has been led by an Australian and state/territory government sub-group at the request of the Australian Digital Council. The new data asset would dramatically enhance information about the experiences of people with disability in Australia.</p>
<p>Measure</p> <p>Source of criterion</p> <p>Result</p> <p>Participate in and administer new health committees, as determined by AHMAC</p>	<p>Work with partners to drive data improvement 2018–19 Health Portfolio Budget Statements, page 226</p> <p>✓ Met</p> <p>Our CEO is a member of the Health Services Principal Committee of AHMAC. Our CEO, or his proxy, attended all 4 meetings of this committee held in 2018–19.</p>

Financial performance

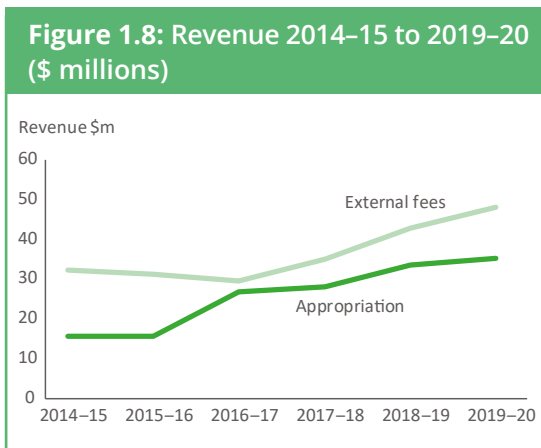
The AIHW's total revenue for 2018–19 was \$78.0 million (Table 1.4). This is an increase of \$12.9 million from 2017–18.

Table 1.4: Financial results, 2017–18 to 2018–19 (\$ million)

	2017–18	2018–19	Change (%)
Appropriation revenue	28.1	33.3	19
Other revenue	37.0	44.7	21
Operating expenses	64.9	78.2	20
Operating surplus (deficit)	0.1	(0.2)	..

.. not applicable

Since 2014–15, our total revenue has increased by 60% driven by growth in both appropriation revenue and operational revenue, as shown in Figure 1.8. We expect this growth to continue through 2019–20.



The small deficit in 2018–19 was due to an accrual adjustment on a lease and had been approved by the Minister for Finance.

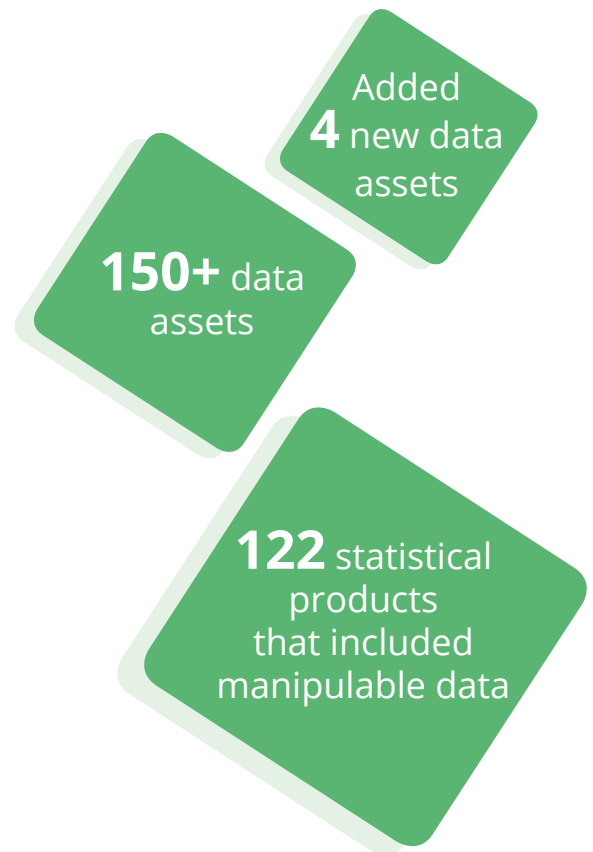
More details on our financial performance are provided in the audited financial statements in Appendix 5 on page 99.

Outlook for 2019–20

We will continue to provide high-quality, meaningful and timely national health- and welfare-related data and analysis across all relevant sectors. We will release our biennial flagship publications Australia's welfare 2019 in the second half of 2019 and Australia's health 2020 by 30 June 2020.

Our planned performance in 2019–20 is set out in the:

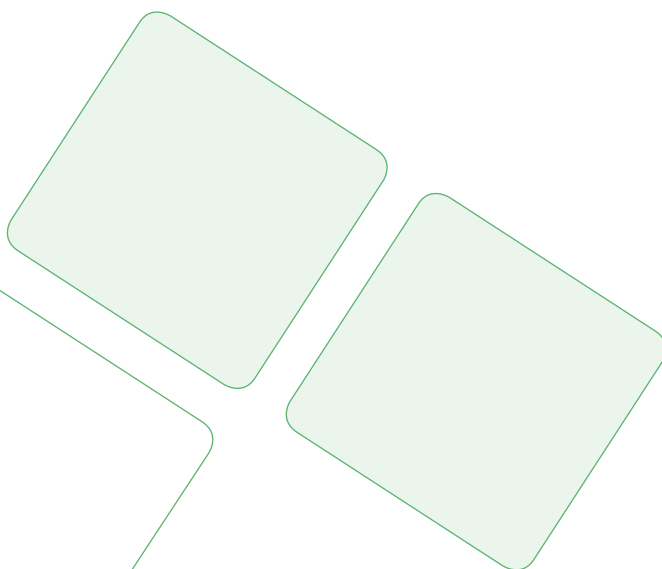
- 2019–20 Health Portfolio Budget Statements www.health.gov.au/internet/budget/publishing.nsf/Content/2019-2020_Health_PBS
- Corporate plan 2019–20 to 2022–23 www.aihw.gov.au/reports/corporate-publications/australian-institute-of-health-and-welfare/contents/table-of-contents.



Chapter 2

Our products and services

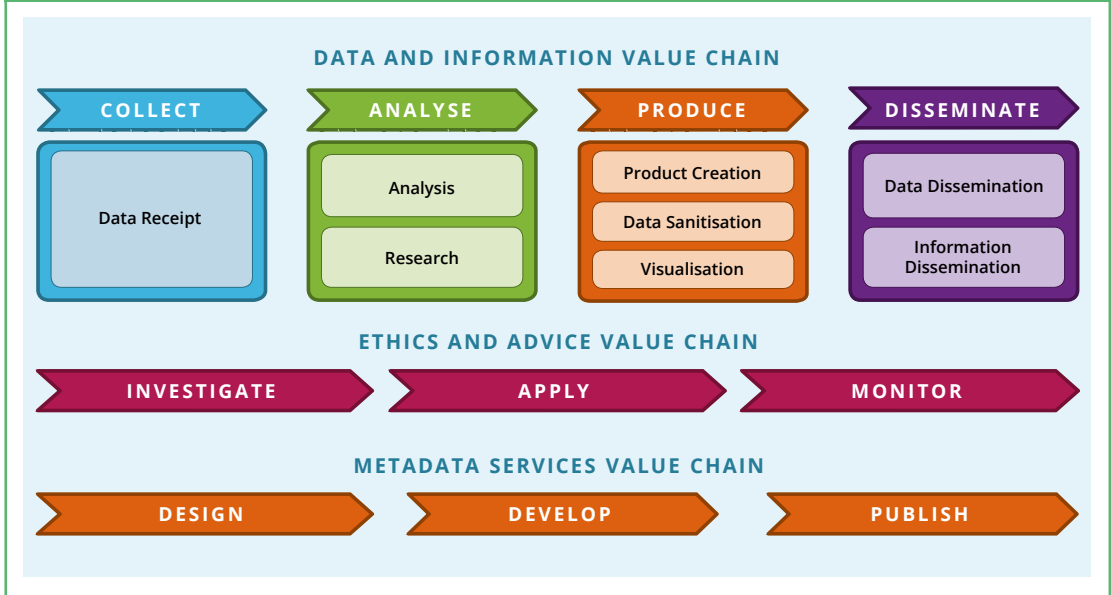
- Our value chain
- Our products
- Our services
- Spotlight on selected products



Our value chain

We publish a suite of products in different formats and provide a range of data services to clients. Figure 2.1 shows how we add value through the information cycle to create authoritative and accessible information and statistics.

Figure 2.1: AIHW value chain for data and information, ethics and advice and metadata services



Our products

In 2018–19, we published 181 products, including traditional reports as well as web products. In addition, most releases were supported by data and visual analytics products.

This chapter showcases some products released in 2018–19. These demonstrate how we achieved our strategic goals (see Chapter 1), filled data gaps and added value to the information landscape. Some of these products received significant attention in mainstream and industry-specific media. Feedback from stakeholders was also positive

as evidenced through Twitter mentions, requests to present at conferences (see Appendix 1 on page 86) and other formal and informal stakeholder interactions.

A list of released products is shown in Appendix 1 (see page 79). In 2019–20, we will continue to develop innovative products in health and welfare. These will include publishing our 2 biennial flagship reports—*Australia's welfare 2019* and *Australia's health 2020*—in diverse new formats to meet the needs of our audiences.



Jenny Hargreaves presenting at the Information Management Association Conference



Tylie Bayliss making a poster presentation at the Health Australasian Epidemiological Association Conference

AGILE framework

We are committed to making the information and statistics we produce widely accessible. We adopted what we call an 'AGILE' framework to deliver layered information to a variety of audience types (see Figure 2.2). We aimed to produce more high-level overviews to complement our traditional in-depth, policy-relevant reports for health and welfare policymakers and the public.

Figure 2.2: AGILE framework

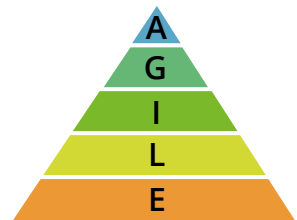
ATTRACT products are very short; they get people's attention. Infographics, posters and fact sheets are among our Attract products.

GRAB products are short, easy to find and use; they are for people in a hurry. Media releases, fact sheets, presentations and infographics are some of the products that will help Grab our audience.

IMPACT products have information organised in ways that are more meaningful. Infographics, fact sheets, and PDF and HTML reports (including In focus reports) are products with Impact.

LEARN products answer questions and explore ideas; they are tailored to the needs of specific audiences. Products like our PDF and HTML reports, data visualisations and data tables let the audience Learn.

EXPLORE products allow access to more detailed data; they are for those people with specific interests. Data visualisations, data tables and data cubes are among our products that allow our users to Explore.



Person-centred model

We use a person-centred model for reporting data, recognising that our personal circumstances are key drivers of our health and wellbeing (see Figure 2.3). This helps us better understand the relationships between these aspects of our lives—also known as social determinants—and our health and wellbeing. These different aspects of our lives are interconnected, with each having flow-on effects to others. We bring data from across multiple topics to create new insights into the health and wellbeing of Australians.

Figure 2.3: The AIHW's person-centred model



4.1 million
website
sessions

Our services

Data linkage

One of our core services is linking data sets to help researchers and policymakers tell a bigger story. Data linkage re-uses existing data and is non-intrusive because it avoids the need to re-contact people whose information has already been collected. We completed 72 data linkage projects in 2018–19 compared with 61 in 2017–18 (see Figure 1.6 on page 11).

Many of the products highlighted in this chapter would not have been possible without linking multiple data sets (for examples, see 'Outcomes of cancer screen programs' on page 24 and 'National Integrated Health Services Information Analysis Asset' on page 25 in this chapter).

All governments in Australia agree that, while protecting privacy, data should be more freely available so it is used more widely and efficiently. Australia's data collections are resources that offer great potential to understand health and welfare issues better and to improve and save lives. We collect and hold data assets on many subjects and from multiple administrative data sets. This means that we are in a unique position to link data across many health and welfare spheres.

We are an Australian Government accredited Integrating Authority and an international leader in data linkage. Legislation permits us to release data and we have the technical capability and governance arrangements to do so safely and securely. The AIHW Act enables us to provide researchers with secure access to data and information about vital health and welfare topics. We also comply with the *Privacy Act 1988* (Privacy Act).

Details of our robust data governance are on page 52.

Data requests

We provide data on request, which enables researchers to access data tables from our data assets on a cost-recovery basis. We completed 208 customised data requests in 2018–19 compared with 184 in 2017–18.

More information on our data request service is available at www.aihw.gov.au/our-services/data-on-request.

Metadata

We administer the METeOR—Australia’s repository for national data standards in the health, community services, housing assistance, homelessness and early childhood sectors.

Metadata are information about how data are defined, structured and represented. They are important because they can provide meaning and context to data by describing how data are captured and the business rules for collecting data. Metadata also assist in the interpretation of data and support consistency in the collection, analysis and reporting of data and understanding the comparability of results.

We also offer metadata support services for metadata developed or revised by a registration authority. Registration authorities are responsible for endorsing data standards for different sectors and can include Australian, state and territory government departments and non-government organisations.

We have been developing a replacement for the current METeOR system to improve the quality of information and the user experience. The new METeOR will be implemented in 2019–20 (see page 9).

Ethics application management

We have an Ethics Committee which has been established under the AIHW Act. Information on our Ethics Committee is in Chapter 4 (see page 48).

We launched our new Ethics Online System (EthOS) for managing applications to the Ethics Committee on 15 February 2019. EthOS allows researchers to:

- lodge applications for projects to be considered by the committee
- lodge monitoring reports
- lodge requests for information
- track the progress of their application.

Information on lodging and managing request to the committee are available at www.aihw.gov.au/our-services/committees/aihw-ethics-committee.

6,167
media
mentions

72 data
linkage
projects
completed

Spotlight on selected products

Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing

This inaugural report on the health and wellbeing of Aboriginal and Torres Strait Islander adolescents and young people



is important to understand how Australia's young Indigenous people are faring, provides an opportunity to celebrate successes and identifies areas where support is needed.

We released 3 products on this topic: comprehensive, short in-brief, and state and territory specific reports. The Hon. Ken Wyatt, AM, MP, launched the report at the National Aboriginal Community Controlled Health Organisation (NACCHO) Members' Conference on 31 October 2018.

The report contained some 'good news' stories. In 2014–15, the majority (63%) of young Indigenous people aged 10–24 rated their health as either 'excellent' or 'very good'. Three in 4 (76%) Indigenous youth aged 15–24 reported being happy all or most of the time. Between 2006 and 2016, the percentage of young Indigenous Australians aged 20–24 attaining year 12 or equivalent increased from 47% to 65%.

The report also noted areas of concern. In 2011, the leading contributors to the disease burden for Indigenous Australians aged 10–24 were suicide and self-inflicted injuries (13%) and anxiety disorders (8%). In 2014–15,

about 1 in 3 (33%) Indigenous Australians aged 15–24 reported experiencing high to very high levels of psychological distress in the previous month. Despite an increase in the percentage of Indigenous young people who had never smoked (56% in 2014–15 compared with 44% in 2002), 3 in 10 smoked daily.

The report received significant coverage on social media, and by media outlets such as the *Sydney Morning Herald*, *Koori Mail*, the NACCHO and the Royal Australian College of General Practitioners. Dr Fadwa Al-Yaman, Head of the AIHW's Indigenous and Maternal Health Group, discussed the report findings in a radio interview with the Central Australian Aboriginal Media Association.

The authoring team at the AIHW presented findings from the report at the 2018 Youth Health Conference.

The comprehensive report is available at www.aihw.gov.au/reports/indigenous-australians/atsi-adolescent-youth-health-wellbeing-2018/contents/table-of-contents.

Focus on the Stolen Generations

During the period between approximately 1910 and 1970, thousands of Aboriginal and Torres Strait Islander children were removed from their families as part of government policies across Australia. These individuals are now referred to as the Stolen Generations. Their forced removal and subsequent disconnection from Indigenous culture and land have had widespread negative impacts on their wellbeing and that of their families.

As part of a larger Action Plan for Healing project, The Healing Foundation commissioned us to undertake a demographic analysis and needs assessment aimed at identifying the size, characteristics and needs of the Stolen Generations and their descendants.

We released 3 reports on this work during 2018–19:

- *Aboriginal and Torres Strait Islander Stolen Generations and descendants: numbers, demographic characteristics and selected outcomes*—downloaded more than 2,500 times since its release in August 2018, as well as numerous hard copies distributed by The Healing Foundation
- *Aboriginal and Torres Strait Islander Stolen Generations aged 50 and over*—almost 800 downloads since its release in November
- *Children living in households with members of the Stolen Generations*—downloaded 360 times since its release in June.

The reports found that almost 21,000 (in 2014–15) surviving Stolen Generation members and their families were a particularly disadvantaged group within the Indigenous population, faring worse on a range of measures, including income, education, general health, and experiences of discrimination, imprisonment and violence. The Healing Foundation used these results to inform reports to government, submissions to inquiries and policy position papers.

According to The Healing Foundation:

The evidence paints a picture of complex needs and disproportionate disadvantage for the Stolen Generations who suffered profound childhood trauma when they were forcibly removed from their homes, isolated from their families and cultures and often institutionalised, abused and assaulted.

The reports also demonstrate that the negative impact of past atrocities is affecting later generations, creating an escalating cycle of disadvantage in the form of Intergenerational Trauma. The data supports what Stolen Generations survivors have been saying for many years—that unresolved and Intergenerational Trauma is the underlying cause of many of the social and health issues affecting Aboriginal and Torres Strait Islander communities today.

The reports are available at www.aihw.gov.au/reports-data/population-groups/indigenous-australians/reports.

Social housing— understanding tenant satisfaction



Every 2 years, we collect information about social housing tenants, the homes they live in and their housing experiences and satisfaction through the National Social Housing Survey.

In 2018–19, for the first time, we used regression analysis to analyse relationships between multiple variables and an outcome, to better understand differences in satisfaction between populations.

Findings from the *National Social Housing Survey 2018* show that tenant satisfaction is closely coupled to the condition of the home, with satisfaction falling significantly as structural problems increase. This relationship holds after accounting for a wide range of geographical, demographic and housing-related factors. Other factors that relate to satisfaction, independently of others, include access to 7 basic household facilities and time spent living in social housing.

Importantly, the results shed light on the lower satisfaction rates observed for certain populations, such as Indigenous households. This is best explained by variation in dwelling conditions between Indigenous and other households, as well as time in social housing and household living arrangements.

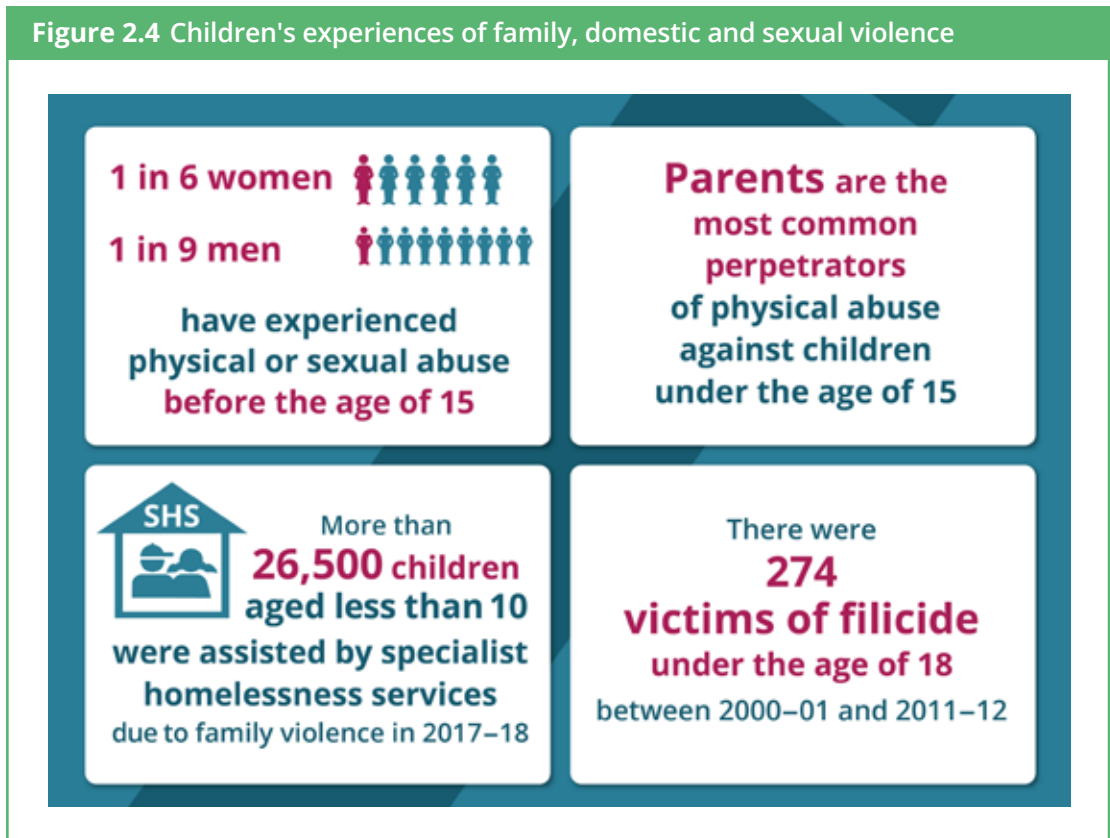
This report is available at www.aihw.gov.au/reports/housing-assistance/national-social-housing-survey-2018-key-results/contents/table-of-contents.

Improving the evidence base on family, domestic and sexual violence

The *Family, domestic and sexual violence in Australia: continuing the national story 2019* report is the second in the series on this topic. The report filled known information gaps by bringing together over 20 data sources to report on types of violence, with a particular focus on vulnerable populations (Figure 2.4).

It provided information to develop policies and services for preventing and responding to family, domestic and sexual violence. The report's extensive media coverage, including over 100 print, television and radio mentions, demonstrated the value of our role in the national discussion on family, domestic and sexual violence. Responses received from members of the public also show growing interest in our work, and the relevance of robust national data to the wellbeing of Australians.

Figure 2.4 Children's experiences of family, domestic and sexual violence



SHS—specialist homelessness services

This report is available at www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-australia-2019/contents/table-of-contents.

Opioid harm in Australia and Canada

A project on opioid harm was conducted in parallel with the CIHI with joint release and a co-authored chapter comparing the 2 countries. It brings together information from a range of data sources to tell the national story of opioid use and its harmful effects. All opioids—including codeine—can be addictive and their use can result in dependence, accidental overdose, hospitalisation or death.

The rising use of opioids and its associated harms are issues of great public health interest, both within Australia and internationally. Australia has the eighth highest opioid consumption of 167 countries and territories based on defined daily doses per capita per day.

A key theme emerging from the *Opioid harm in Australia: and comparisons between Australia and Canada* report is that pharmaceutical opioids contribute more to opioid harm than illicit opioids. Rates of opioid deaths nearly doubled in the 10 years to 2016, and opioid poisoning hospitalisations in Australia also increased. In 2016, pharmaceutical opioids were involved in more opioid deaths and opioid poisoning hospitalisations than heroin.

In Australia in 2016–17, 3.1 million people had 1 or more prescriptions dispensed for opioids—most commonly for oxycodone. Based on the National Drug Strategy Household Survey, in 2016 it was estimated that more than 1 in 10 people aged 14 and over had used any type of opioid for illicit or non-medical purposes in their lifetime—the most common being in the category of *Pain-killers/analgesics and pharmaceutical opioids*.

Men aged 35–44 experienced some of the highest rates of opioid harm. In 2016–17, they had the highest rate of opioid deaths; the highest rates of emergency department presentations for opioid poisoning and opioid dependence; and the highest rates of hospitalisations with a principal diagnosis of opioid poisoning or opioid dependence.

In both Australia and Canada, the greatest volume of harm treated in hospitals came from side effects from opioid use. The age distribution for people hospitalised for this reason was similar in Australia and Canada, with rates of hospitalisation rising with increasing age, reflecting the rates of prescription opioids in both countries.

The report received 99 mentions. The findings have been presented at an international conference, to the Department of Health and other agencies, and have contributed to OECD work on opioid harm internationally.

The report is available at www.aihw.gov.au/reports/illicit-use-of-drugs/opioid-harm-in-australia/contents/table-of-contents.

Estimating the burden of disease and disease expenditure

The Australian Burden of Disease Study (ABDS) 2015 provided estimates of disease burden for 216 diseases and injuries and 38 modifiable risk factors, with comparable data for 2011 and 2003. It also provided detailed analyses for both changes in disease burden and the burden attributable to risk factors between 2003 and 2015. The ABDS suite of products comprised 3 reports (detailed, summary and methods) and interactive data visualisations for disease burden and burden due to risk factors.

The study found that:

- in 2015, Australians lost 4.8 million years of healthy life due to living with illness (50.4% of total burden) and dying prematurely (49.6%)
- chronic diseases, such as cancer, cardiovascular diseases and musculoskeletal conditions, contributed the most burden
- 38% of the burden could have been prevented by eliminating exposure to risk factors such as tobacco use, overweight and obesity, and dietary risks.

Figure 2.5 provides details of changes in the burden of disease.

Figure 2.5: Changes in the burden of disease in Australia

There were **substantial improvements** in population health between 2003 and 2015 with:



Biggest **absolute reduction** in burden (DALY rate) came from:

- Cardiovascular diseases
- Cancer
- Musculoskeletal conditions
- Infant and congenital conditions



Biggest **absolute increase** in burden (DALY rate) came from:

- Neurological conditions



DALY—disability-adjusted life years

The findings of the disease expenditure in Australia study were released in conjunction with the ABDS reports and included expenditure according to ABDS disease groups and conditions:

- The musculoskeletal disorders group had the highest estimated expenditure, costing \$12.5 billion. The next highest expenditure groups were cardiovascular diseases (\$10.4 billion), injuries (\$8.9 billion) and mental and substance use disorders (\$8.9 billion).
- For males, the highest cost group was cardiovascular diseases (\$5.7 billion) followed by musculoskeletal disorders (\$5.5 billion).
- For females, the highest cost group was reproductive and maternal conditions (\$6.9 billion) followed by musculoskeletal disorders (\$6.7 billion).

These products, funded by the Department of Health, were launched on 13 June at the Public Health Association of Australia's Public Health Prevention Conference in Melbourne. Presentations by AIHW staff were well received, with great interest in the online interactive data as well as immediate uptake for editorials and the media. The Department of Health has funded us to undertake another edition of the ABDS for the year 2018.

These reports are available at www.aihw.gov.au/reports-data/health-conditions-disability-deaths/burden-of-disease/overview.



The burden of disease team at the Public Health Conference

Outcomes of cancer screening programs

Australia's 3 national cancer screening programs (BreastScreen Australia, National Cervical Screening Program and National Bowel Cancer Screening Program) aim to reduce deaths and illness due to cancer by actively recruiting and screening target populations for early detection or prevention of disease in individuals.

Analysis of cancer outcomes and screening behaviour for national cancer screening programs in Australia is the first report using extensive data linkage to examine whether participation in national cancer screening programs reduces the risk of death from the respective cancers.

The report showed that the majority of women diagnosed with cervical cancer between 2002 and 2012 were women who had never screened, or had not done so for some time.

Additionally, people who were diagnosed through the screening programs were more likely to survive than those who were diagnosed another way (for example, experienced symptoms and went to their doctor). Compared with those who were diagnosed during 2002–2012 with a breast, cervical or bowel cancer outside of the screening programs:

- women with screen-detected breast cancers were 42% less likely to die from breast cancer by 2015
- women with screen-detected cervical cancers were 87% less likely to die from cervical cancer by 2015
- people with a screen-detected bowel cancer were 40% less likely to die from bowel cancer by 2015.

The screening behaviour of women across these 3 programs was also investigated. Women who already participated in 1 screening program were more likely to participate in other programs for which they were eligible, suggesting that if barriers to participation in 1 screening program can be removed, there is potential to improve participation across other programs.

With this powerful evidence on the effectiveness of the programs, consumers can better understand the benefits of taking part in cancer screening, while policymakers can look for opportunities to expand the programs to reach more people and save more lives.

The report is available at www.aihw.gov.au/reports/cancer-screening/cancer-outcomes-screening-behaviour-programs/contents/table-of-contents.

National Integrated Health Services Information Analysis Asset

The first version of the National Integrated Health Services Information Analysis Asset (NIHSI AA) has been built. It contains de-identified data from 2010–11 to 2016–17 on admitted patient care services (in all public and, where available, private hospitals), emergency department services and outpatient services in public hospitals for the participating states (New South Wales, Victoria, South Australia and Tasmania). It also includes national data for the same period from the MBS, PBS and Repatriation Pharmaceutical Benefits Scheme as well as residential aged care data and National Deaths Index data. It contains data from almost 12 billion recorded events, which makes it potentially the largest health data linkage exercise ever conducted in Australia and represents the most comprehensive health data asset created.

The NIHSI AA will be managed under the AIHW's custodianship and will be available in mid-2019 to selected analysts in those state health authorities whose hospital data are included in the initial release, the Department of Health and the AIHW.

Work will continue on development of governance arrangements for access to the asset by jurisdictional and other users into the future, and incorporation of hospital data from other states and territories. Additional years of data across all component collections will be added in annual updates.

Estimates of female genital mutilation/cutting

Towards estimating the prevalence of female genital mutilation/cutting in Australia was commissioned by the Department of Social Services (DSS) to support its work on this complex and sensitive subject.

Female genital mutilation/cutting (FGM/C) is a collective term for a range of procedures involving partial or total removal of the external female genitalia, or other injury to female genital organs for non-medical reasons. FGM/C is most commonly performed on girls before the age of 15, and is associated with a range of social and cultural factors. In Australia, it is illegal to perform FGM/C, and Australian governments view FGM/C as an abuse of human rights, children's rights and a complex form of violence against women.

The report estimates that about 53,000 women and girls living in Australia in 2017 but born elsewhere may have undergone FGM/C. This estimate was calculated by combining available international FGM/C prevalence rates by country with Australian migration data. Although the methodology has several limitations, it provides an indication of the extent to which FGM/C may be relevant in Australia.

Relatively little is known about the health-care needs and health service utilisation patterns of the girls and women in Australia who have undergone FGM/C. Better understanding of FGM/C in Australia is important, particularly because of the:

- likelihood of high prevalence rates in some communities and the potential for the rate to rise due to migration trends
- potential impact on a female's physical, reproductive and psychological health throughout her life
- complexity and intersectional nature of FGM/C in Australia (that is, discrimination or disadvantage stemming from multiple roots; for example, age, sex, race and social class).

This report is available at www.aihw.gov.au/reports/men-women/female-genital-mutilation-cutting-australia/contents/summary.

A further report, *A discussion of female genital mutilation/cutting data in Australia*, will be released in 2019–20 and will identify and discuss what relevant data sources exist in Australia, the potential service contexts in which data are (or could be) captured, and what steps might be taken to improve the collection of data. It will include analyses from the National Hospital Morbidity Database on admitted patients where FGM/C was recorded as relevant to the patient's care (primarily episodes of care related to childbirth) for the 3-year period 2015–16 to 2017–18.

The health of Australia's prisoners

We have been reporting on the health of people in Australia's prisons since 2009, and Australia is unique in having such a long-running and comprehensive data collection. For the latest report, information was gathered from 62 prisons across Australia (except New South Wales). Data were collected from 803 people entering prison, and 335 who were due to be released in the following 4 weeks. They were asked about their cultural and family background, education, employment, living arrangements, and mental and physical health. Key findings from the report are presented in Figure 2.6.

Figure 2.6: Australia's prisoners, 2018

What do we know about the people entering prison?



More than **4 in 5** are male



Almost **2 in 5** are Indigenous



1 in 5 had a parent or carer in prison while they were growing up

Information was also collected on 8,000 people who visited the prison health clinic, and on another 8,000 who received medications while in prison. *The health of Australia's prisoners 2018* is a comprehensive view of the health, wellbeing and social factors that affect people before, during and after their time in prison.

This report is available at www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/contents/table-of-contents.

Australia's veterans



A profile of Australia's veterans 2018, released in partnership with the Department of Veterans' Affairs, is the first comprehensive report on Australian veterans' health and welfare.

Veterans of the Australian Defence Force (ADF) are an important group for health and welfare monitoring. The unique nature of military service means their needs and outcomes can differ from those of the general population.

The report explores the 'veteran-centred model' (Figure 2.7)—comprising 7 domains and based on the AIHW's people-centred model (Figure 2.3)—to understand the factors that influence veterans' health and welfare. Information from 30 diverse data sources has been compiled to build a profile of the whole veteran population, including information on veterans' families. The report also identifies opportunities to fill gaps in our understanding of veterans' health and welfare, particularly in the domains of housing, income and finance, and justice and safety.

The report found that ADF members are generally much healthier than the general population and various cohorts of veterans have lower all-cause mortality than the

general population. Encouragingly, in 2014–15, 78% of people who had served in the ADF rated their health as excellent, very good or good. However, veterans may be at greater risk of developing some cancers, and affective disorders, and the age-adjusted suicide rate for former serving men is higher than for all Australian men.

The report has been well received by the Department of Veterans' Affairs. An article on the report published in the VetAffairs newsletter on 8 April 2019 stated:

The report ... will serve as a benchmark, building the foundation for future work to address gaps in the understanding of veterans' health and welfare, and inform research and policy development to benefit veterans and their families.

This report is available at www.aihw.gov.au/reports/veterans/a-profile-of-australias-veterans-2018/contents/table-of-contents.

Figure 2.7: Veteran-centred model



Protecting older Australians from harm

Our challenge

Identifying gaps in aged care data

The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018. Although the AIHW has a strong track record of developing, analysing and reporting ageing and aged care statistics, there are data gaps that need to be filled.

Our response

Contributing to vital data

We made major contributions to the Royal Commission in November 2018. Our expertise was sought at a statistical roundtable, along with the Australian Bureau of Statistics (ABS), to provide Commissioner Lynelle Briggs, AO with an understanding of the relevant data sources and headline data gaps.

The AIHW was called on as an expert witness in the opening set of hearings in February 2019 which ‘set the scene’ for subsequent hearings and associated activities. The evidence provided by our staff drew heavily on material that Counsel Assisting the Royal Commission obtained from our GEN—Aged Care Data website and our witness statement comprised around 30 pages of statements and nearly 1,000 pages of attachments.

We provided data and advice to the Office of the Royal Commission to support its research. For example, we analysed the 2016 National Aged Care Workforce Census and Survey and presented information on:

- a detailed breakdown on culturally and linguistically diverse care workers
- the driving distance between the location where a person was assessed for aged care services and the location where they first took up permanent residential aged care.

We are building and analysing a large linked data set covering all aged care programs, MBS, PBS, and deaths—all national—plus public and private hospital activity (admitted patient and emergency department) for Victoria and Queensland. This data set is designed to enable a comprehensive view of the interaction between the aged care and health systems. With the funding support from the Department of Health, we will publish a series of reports over the next 2 years on various aspects of this interaction.

Throughout our involvement with the Royal Commission we have collaborated closely with the Attorney-General’s Department, the Department of Health, the ABS, the Office of the Royal Commission, and solicitors assisting the Australian Government.

Our results

Adding value to social policy

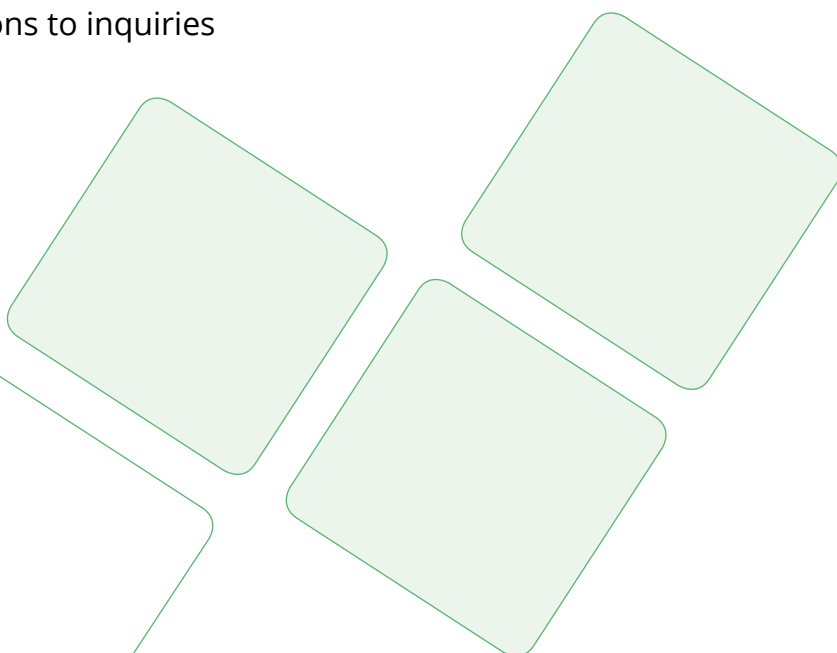
Our involvement with the Royal Commission has provided us with the opportunity to showcase and demonstrate the value of our work for informing core social policy.

We continue to provide data, information and statistical advice to support the work of the Office of the Royal Commission.

Chapter 3

Our relationships

- Our communications
- Collaborating with our stakeholders
- Reaching our audiences
- Social media
- Media coverage
- Our websites
- Submissions to inquiries



Our communications

Stakeholder engagement

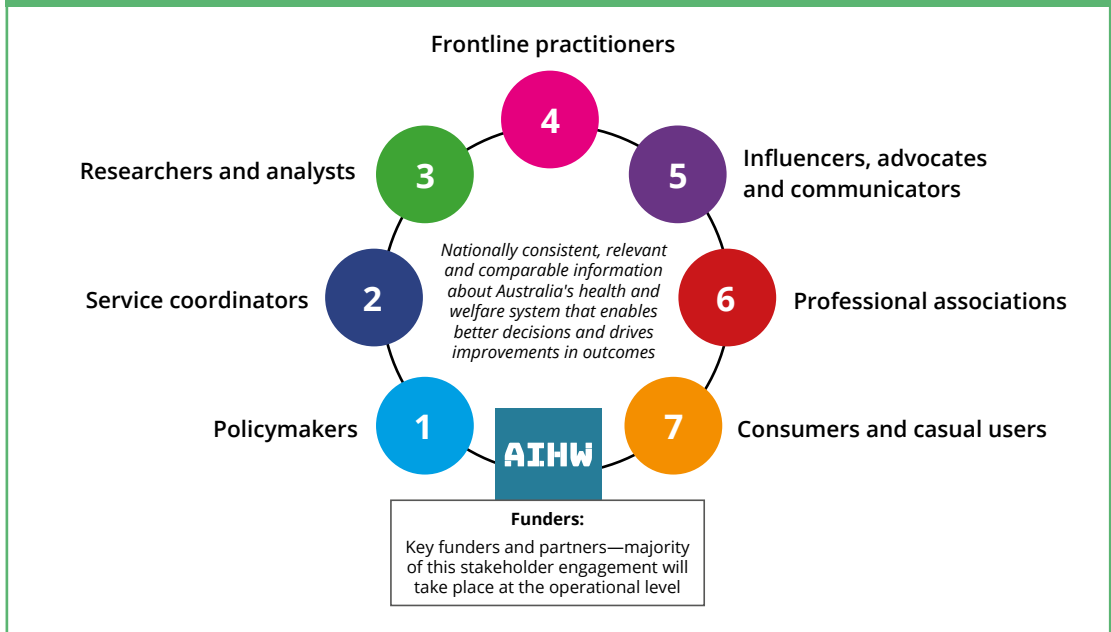
All our work is driven by the needs of our stakeholders (Figure 3.1). Strengthening relationships with stakeholders and using technology to build audiences for our reports and data were a strong focus in 2018–19.

Our new Stakeholder Engagement Strategy has a clear goal—‘to continue to be recognised as the trusted source of Australian health and welfare data, and that our data drives better decisions and improved outcomes for Australians’.

We undertook an extensive stakeholder engagement project that involved a strategic planning workshop and in-depth interviews with key stakeholders. As a result of the project, we have expanded our engagement with state and territory departments and non-government organisations through consultations and briefings on forthcoming releases. We also increased our engagement by attending and presenting at conferences and inviting experts to speak to AIHW staff (see Table 3.3).

We also continued our strong engagement through our network of more than 100 advisory groups and through our websites and social media platforms.

Figure 3.1: AIHW's stakeholders



1. Policymakers

Government policymakers at all levels (local, state, commonwealth) including policy officials and agencies with similar or complementary responsibilities

2. Service coordinators

Governments and other organisations conducting service-level planning and looking to benchmark and improve their performance

3. Researchers and analysts

Academics and professionals looking to ‘deep dive’ into issues and build stronger evidence

4. Frontline practitioners

Health and welfare practitioners and providers looking to use local area data in their day-to-day work (e.g. GPs, nurses, clinicians, preventative health sector)

5. Influencers, advocates and communicators

Journalists, consumer groups, non-government organisations (NGOs) and others looking to influence health and welfare policy or local planning, and educate consumers

6. Professional associations

Professional associations (e.g. Australian Medical Association, Australian Council of Social Service) that advocate on behalf of their members to governments, research institutions and other bodies on issues of health and welfare

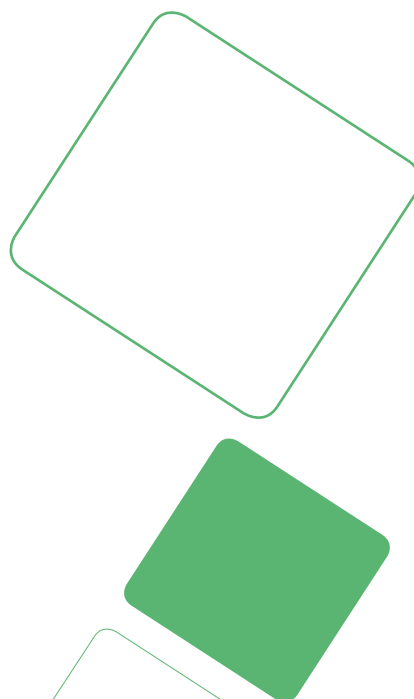
7. Consumers and casual users

Consumers looking to use data to inform their decisions and casual users looking for 'quick grabs' (e.g. service users, students and schools, parents looking for data on immunisations).

Communication strategies

We began developing an overarching Digital Communication Strategy which looked at our digital communication assets—including multiple websites, applications (apps) and social media platforms. The discovery phase, completed in January 2019, involved workshops with all staff and an audit of all our digital assets. The concept was split into 2 strategies: social media and website.

These strategies will enable us to better organise content and create clear pathways to data. The goal of the website strategy is to develop a more data-centric website and to enable geographical exploration across all topics. The social media strategy will act as a blueprint for the role and growth of social media. It focuses on implementing best practice for our social media platform outputs to improve the quality of our messages, increase our audience reach and build on the depth of engagement with our stakeholders.



Collaborating with our stakeholders

To successfully perform our functions, we rely on forging and maintaining positive, productive relationships with many agencies and organisations across the Australian, state and territory governments, and non-government sectors. The multisectoral nature of our work is reflected in the statutory composition of the AIHW Board and Ethics Committee and the diverse range of entities with which we have entered into an agreement or a memorandum of understanding (MoU).

Australian Government

Department of Health

As an independent corporate Commonwealth entity in the Health portfolio, we have a strong relationship with the Department of Health.

Our work for the department is guided by a formal deed between the 2 organisations, except where that work is required to be put out to competitive tender. The department provides funding for significant additional projects beyond work funded through appropriation.

We provide the department with copies of all our publications in advance of public release.

Department of Social Services

Our relationship with the DSS focuses in areas such as housing and homelessness, disability services, child protection and income support.

We are the data custodian of the department's Australian Government Housing Data Set and a member of a panel of experts established to support organisations funded under the DSS's Families and Children Activity. We act as a release point for the DSS's researchable Centrelink data asset (DOMINO—Data Over Multiple Individual Occurrences).

The 2 organisations have established a collaborative work arrangement to support enhanced use of income-support data for understanding population health and welfare outcomes.

We provide the DSS with copies of our publications that are relevant to DSS functions in advance of public release.

Australian Digital Health Agency

We are working with the ADHA and the Department of Health to prepare for the AIHW to become the data custodian for the MHR system data for research and public health purposes. This has involved the establishment of an Implementation Working Group comprising the 3 agencies where we are collaborating to establish the necessary data governance arrangements and implement the technical and physical structure required.

Department of Veterans' Affairs

The AIHW and the department are parties to an MoU that reflects their commitment to the development of information sources for the delivery of world-class health-care policies and services to veterans. The overarching aim of this partnership is to develop a comprehensive profile of the health and welfare of Australia's veteran population. It also aims to facilitate a coordinated, whole-of-population approach to monitoring and reporting on the current status and future needs of veterans and their families.

Other agencies

We continued to work with many agencies in developing, collecting, compiling, analysing, managing and disseminating health and welfare data and information, including:

- Australian Bureau of Statistics
- Australian Commission on Safety and Quality in Health Care
- Australian Taxation Office
- Cancer Australia
- Department of Education
- Department of Human Services
- Department of Infrastructure, Transport, Cities and Regional Development
- Department of the Prime Minister and Cabinet
- Independent Hospital Pricing Authority
- National Health Funding Body
- National Mental Health Commission
- Safe Work Australia.

State and territory governments

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

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

We collaborated with all states and territories, the Department of Health, and other key agencies and stakeholders through our committees, the Strategic Committee for

National Health Information and the National Health Data and Information Standards Committee. Through these committees, we maintained relationships with AHMAC, primarily through its Health Services Principal Committee. An MoU has been established to formalise our relationship with AHMAC.

We contributed to the development of a draft National Housing and Homelessness Agreement Data Improvement Plan through our role on the Housing and Homelessness Senior Officials Network and data working group, in particular, strengthening our role as a national leader in data integration. We also worked with state and territory partners to secure the continued stability of systems underpinning national specialist homelessness services data.

Non-government organisations

We have expanded our engagement with NGOs by providing more consultations and briefings on forthcoming releases (including providing embargo access to reports). We are collaborating with several NGOs from the community services sector on a data insights workshop that will be held early in 2019–20.

International collaboration

We play an important role in data standards and classifications work through the WHO's Family of International Classifications and report Australian health statistics to the OECD. Information on our engagement with these bodies can be found at www.aihw.gov.au/our-services/international-collaboration.

We have a staff exchange program with CIHI (see page 73). We also worked with CIHI on a publication comparing opioid-related harm in Australia with Canada. Further information on this work can be found on page 23.

Engagement with stakeholders—primary care consultations

We received ongoing funding in the 2018 Federal Budget to develop an enduring National Primary Health Care Data Asset. It is envisaged that the data asset will contain reliable, detailed, high-quality data about primary health care which will assist in the creation of a comprehensive understanding of the system and a patient's journey and experiences within it. It has the potential to create new avenues of analysis to enable better population health planning, help identify gaps in primary health care services and ultimately improve patient health outcomes.

We created a draft of a data development plan to form the basis for nationwide consultation. The initial consultation phase included a series of facilitated workshops convened in each state and territory capital city and an online public submission process.

We launched the AIHW's Consultation Hub, Citizen Space, on 13 March 2019, with this new public submission process used for gathering feedback on the draft plan.

A total of 163 participants representing 115 invited organisations attended the 8 workshops. Participants included clinicians, consumers, medical software industry partners, commissioners of health services such as Primary Health Networks (PHNs), representatives from peak bodies, researchers, medical colleges and state and territory health departments. The overwhelming majority of participants supported the need for primary health care data that can inform planning and population health. Specific benefits of the data asset were identified as including:

- raising the public awareness of the importance of primary health care to the health of Australians
- improving the visibility of primary health service needs in remote communities
- providing greater visibility of all professions that operate in the primary health care sector.

The biggest and most consistent challenge for the data asset was the need to develop community trust through building consumer interest in the benefits, and providing reassurance that privacy will be maintained.

We received 40 submissions through the consultations process—33 from organisations and 7 from individuals—through online submissions.

Following the completion of this initial phase of stakeholder engagement we will consolidate, analyse and report on feedback.



Penny Gregory and Michael Frost facilitating at the Primary Health Care Data Asset workshop

Reaching our audiences

We continued to make our work widely available and easy to understand through increased use of short reports, data visualisations and infographics. Our information is available free of charge on our website in a variety of formats to suit the needs of users. All publications are available in alternative formats, upon request.

Notification services for stakeholders

One of our communication channels is an on-the-day email notification service alerting subscribers to new AIHW product releases. As at 30 June 2019, more than 32,600 people subscribed to this service. Subscriptions to these notifications rose by 25% in 2018–19 compared with the previous year (Table 3.1). Two new lists created in 2018–19, Mental Health Services and Primary Health Care, account for much of the marked increase in subscribers compared with previous years.

Table 3.1: Email notification service subscriptions by category, 2014–15 to 2018–19

Year at 30 June	2014–15	2015–16	2016–17	2017–18	2018–19	Change (%) 2017–18 to 2018–19
Health-related products	5,984	6,308	6,650	7,234	8,682	▲ 20.0
Welfare-related products	4,670	4,947	5,250	5,649	6,135	▲ 8.6
Education resources	4,144	4,573	5,010	5,617	5,030	▼ 10.5
AIHW Access online newsletter	5,609	6,499	7,299	7,519	8,769	▲ 16.6
Mental Health Services ^(a)	..	..	..	..	3,255	..
Primary Health Care ^(a)	..	..	..	..	780	..
Total	20,407	22,327	24,209	26,019	32,561	▲ 25.1

(a) New lists added in 2018–19.

.. not applicable.

Social media

Twitter

Twitter (@aihw) was our primary social media platform for communicating with our stakeholders in 2018–19. We published 220 tweets and had 18,200 followers as at 30 June 2019—an increase of about 15% compared with the previous year (15,800 in 2017–18). The number of views of our tweets rose slightly (2%), with 869,400 ‘impressions’ (see Box 3.1) compared with 852,000 in 2017–18. The topics and reports with the highest level of engagement in 2018–19 are detailed in Table 3.2 and figures 3.2 and 3.3.

Table 3.2: Top AIHW topics/reports based on Twitter engagement, 2018–19

Rank	Topic
1	Family, domestic and sexual violence
2	Housing and homelessness
3	Physical activity/nutrition across the life stages
4	Cancer
5	Overweight and obesity
6	Burden of disease and disease expenditure
7	Cardiovascular disease and chronic conditions
8	Health and welfare of Indigenous people
9	Alcohol, tobacco and other drugs
10	Disability

Box 3.1: Twitter analytics terms

impressions:

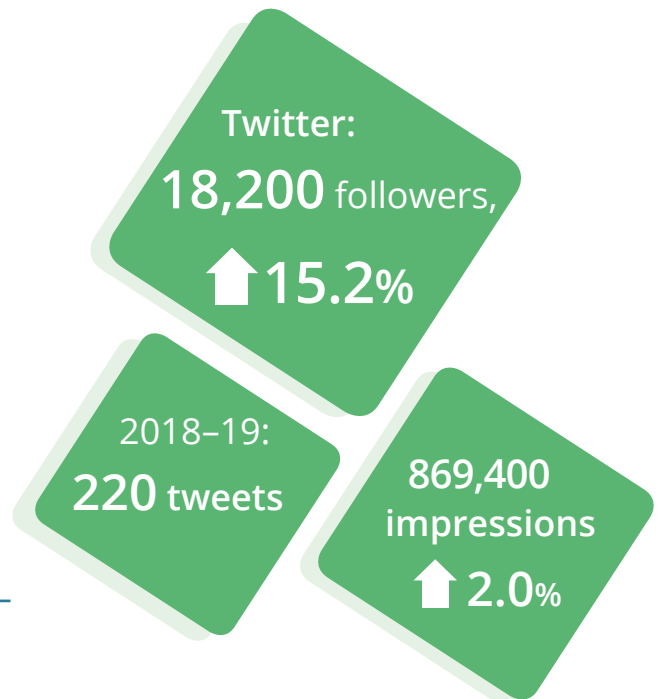
Number of times users saw the tweet on Twitter.

engagements:

Total number of times a user has interacted with a tweet, including retweets, replies, follows, likes and clicks on hashtags, links, avatar, username and tweet expansion.

engagement rate:

Number of engagements divided by the total number of impressions. Rates between 33 and 100 reactions for every 1,000 followers (0.33% and 1%) are considered to be very high.



15,800 Twitter followers

Figure 3.2: Top 5 topics by Twitter impressions, 2018–19

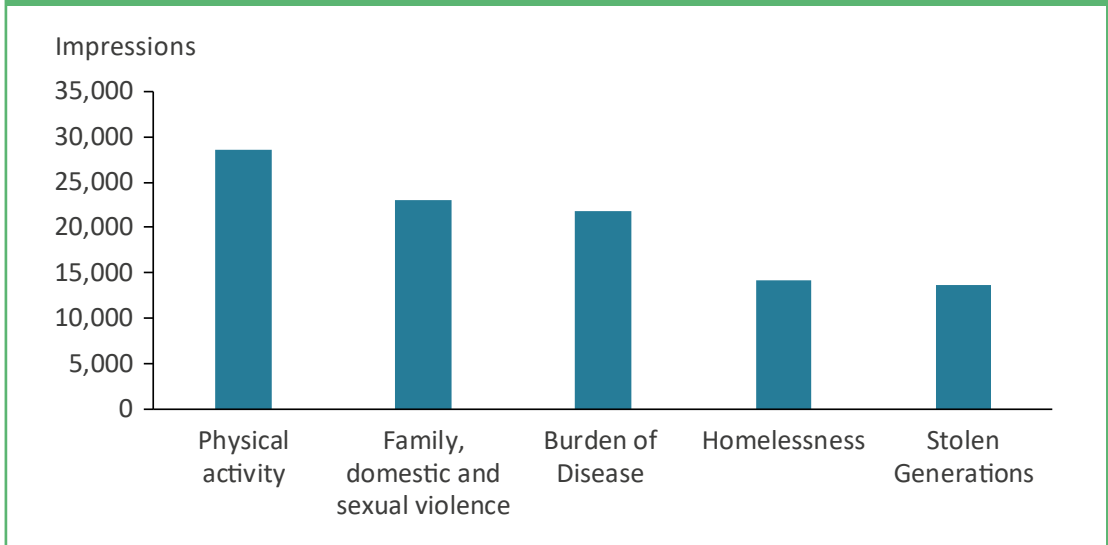
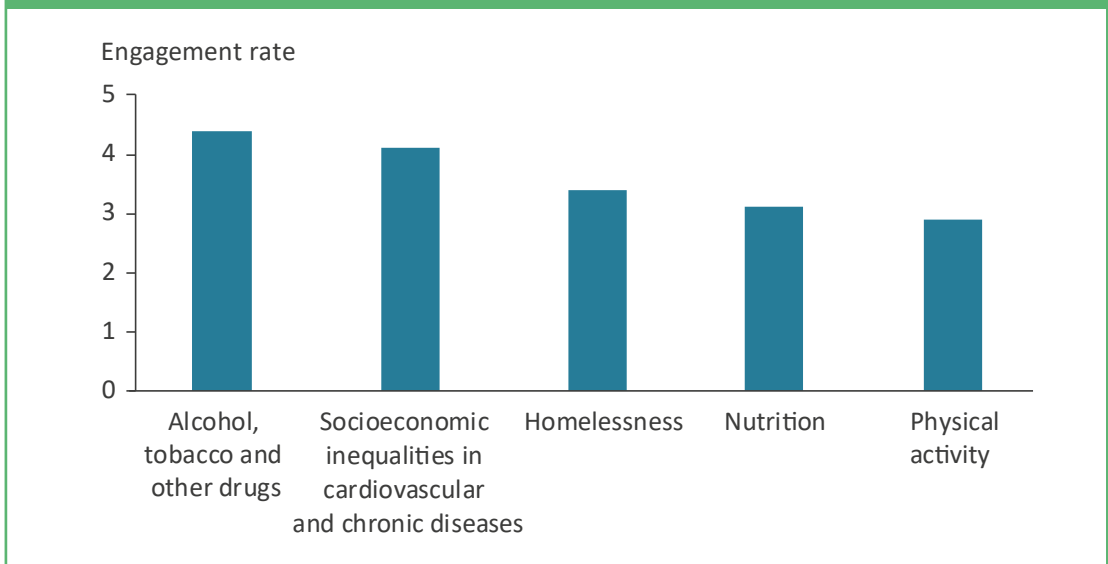


Figure 3.3: Top 5 topics by Twitter engagement rates, 2018–19



LinkedIn

The social media platform LinkedIn was introduced as a communication tool in 2018–19. Senior executives posted articles and discussion pieces to help broaden our reach and develop networks. LinkedIn was also used to notify vacant positions, with staff able to share job vacancies through their networks.

In 2019–20, we will build on our social media presence through the implementation of our new Social Media Strategy and policy. We will continue to use Twitter for targeted communication and increase content on our secondary channels, LinkedIn and YouTube. We will create more visual content, including graphics, video and audio content to better reflect current social media trends.

Guest speakers

Our guest speaker series aims to bring in external speakers to talk to staff about interesting and relevant topics. In 2018–19, 8 experts spoke about a range of topics (see Table 3.3).

Table 3.3: Guest speaker topics, 2018–19

Topic
Three questions about data and the future of public health
Privacy Awareness Week
Big data and artificial intelligence
Data from the Australian Longitudinal Study on Women's Health
Public attitudes towards data governance in Australia
Legal and ethical challenges and solutions in the era of big data: a UK perspective
Role of data in the Royal Commission into Institutional Responses to Child Sexual Abuse
Mental Health Month

Insights workshop series

In February, our inaugural insights workshop provided an opportunity for health and welfare analytics centres across Australia to share and exchange ideas and experiences and forge new collaborations.

Attendees were presented with information about our data resources, insights into new and innovative projects and a 'show and tell' of our data tools. External guest speakers shared case studies and other tools. In 2019–20, we will host further workshops, with an NGO-focused seminar in development.

Media coverage

We issued 36 media releases in 2018–19, similar to 2017–18. Media coverage increased steadily over this period due to several high-profile releases, including reports on patients' out-of-pocket costs and family and domestic violence. The inclusion of regional-level data in some publications also contributed to increased coverage by local media outlets.

Compared with 2017–18, our coverage increased most notably in 2018–19 for online reporting (up 27.6%) and television (up 19.8%). Radio coverage also saw an increase of 10.4%, while print coverage dropped by 16.7%. Table 3.4 shows the trend of media mentions from 2014–15 to 2018–19. Table 3.5 shows the top 10 products for total media mentions.

36 media releases issued

Made **83** presentations at conferences (see Appendix 1).

Table 3.4: Media coverage and media releases, 2014–15 to 2018–19

Media type	2014–15	2015–16	2016–17	2017–18	2018–19	Change (%) 2017–18 to 2018–19
Online	1,650	1,496	1,822	1,645	2,222	▲ 35.1
Print	426	798	1,694	1,923	1,695	▼ 11.9
Radio	1,826	1,106	1,617	1,629	1,904	▲ 16.9
Television	230	129	221	273	346	▲ 26.7
Total	4,132	3,529	5,354	5,470	6,167	▲ 12.7
Media releases	82	57	35	37	36	▼ 2.7

Table 3.5: Top 10 products for media coverage 2018–19

Rank	Title	Media mentions
1	<i>MyHealthyCommunities: Patients' out-of-pocket spending on Medicare services 2016–17</i>	259
2	<i>Elective surgery waiting times 2017–18—Australian hospital statistics</i>	137
3	<i>Family, domestic and sexual violence in Australia: continuing the national story 2019—in brief</i>	117
4	<i>Opioid harm in Australia: and comparisons between Australia and Canada</i>	115
5	<i>Pedal cyclist deaths and hospitalisations, 1999–00 to 2015–16</i>	97
6	<i>Couch surfers: a profile of Specialist Homelessness Services clients</i>	83
7	<i>Health expenditure Australia 2016–17</i>	70
8	<i>Nutrition across the life stages</i>	70
9	<i>Overlap between youth justice supervision and alcohol and other drug treatment services: 1 July 2012 to 30 June 2016</i>	67
10	<i>Palliative care services in Australia—tranche 1, 2019</i>	67

Our websites

Our website at www.aihw.gov.au



is our main channel for AIHW information including our PDF and HTML reports, other data related outputs, our services and corporate information. Many of our reports include interactive data tables and other visual displays of information.

There were 4.1 million user sessions on our website in 2018–19—an increase of 1.2 million from 2017–18.

We managed 4 other websites in 2018–19—MyHospitals, GEN—Aged Care Data, the Australian Mesothelioma Registry (AMR) and MyHealthyCommunities. There were a total of 5.3 million sessions across all 5 websites. The MyHealthyCommunities website was decommissioned on 30 June 2019 and content is now available on our main website.

MyHospitals



The MyHospitals website at www.myhospitals.gov.au provides nationally consistent, locally relevant information that allows fair comparisons to be made between individual hospitals. Performance information is available on more than 1,000 public and private hospitals.

There were 1,033,600 sessions on the MyHospitals website compared with 868,000 in 2017–18, an increase of 19%.

GEN—Aged Care Data



Our GEN website at www.gen-agedcaredata.gov.au is designed to cater for all levels of users, from people seeking basic information through to data modellers and actuaries. Each section on the website begins with an overview and ‘fast facts’ on the topic, followed by greater detail and the ability to interact with the data. Data underpinning each topic are available for further analysis.

There were 92,700 sessions on the GEN website compared with 52,300 in its launch year of 2017–18.

Australian Mesothelioma Registry



We manage the AMR at www.mesothelioma-australia.com on behalf of Safe Work Australia. The AMR contains information about people with mesothelioma, monitors new cases diagnosed in Australia from 1 July 2010 and collects information about asbestos exposure. There were 3,800 sessions on the AMR website. Comparable data on AMR sessions are not available for 2017–18.

MyHealthyCommunities



The MyHealthyCommunities website remained live until 30 June 2019, with the last data update in October 2018. Users accessing the MyHealthyCommunities website are automatically redirected to the Healthy community indicators section of our website, reducing our ongoing operational costs and improving user access to a wider range of our products.

There were 66,700 sessions on the MyHealthyCommunities website.

Submissions to inquiries

We made 5 submissions to parliamentary and government inquiries in 2018–19:

- Royal Commission into Aged Care Safety and Quality
- Senate Select Committee into the obesity epidemic in Australia
- Review of the National Regulatory System for Community Housing
- Select Committee into alternative approaches to reducing illicit drug use and its effects on the community (Western Australia)
- Productivity Commission's Inquiry into the Economic Impacts of Mental Ill-Health.

Chapter 4

Our governance

- Legislation
- AIHW Board
- AIHW Ethics Committee
- Protecting privacy
- Data governance
- ICT and data security
- Financial management
- Risk oversight and management
- Reporting requirements under the PGPA Rule

Legislation

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

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

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

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

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

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

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

Amendments to the AIHW Act

The amended AIHW Act commenced on 27 November 2018 which implemented the recommendations of the independent review of the AIHW undertaken in 2015. These amendments streamlined AIHW governance and administration:

- Established a board of up to 12 members who have a collective range of skills to ensure effective strategic governance. This amendment replaced the representative nature of the previous board structure where members were aligned to a single specific criterion in the Act.
- Members are appointed by the Minister for Health instead of the Governor General. This change is consistent with similar organisations and provides greater administrative efficiency for appointments, resignations or terminations.
- The title of the head of the AIHW changed to Chief Executive Officer (CEO) in line with other similar government agencies. The

previous title of Director was ambiguous as it can be associated with a range of different positions in government.

- The CEO is appointed by the board to provide a clearer line of accountability. Previously, the CEO (Director) was appointed by the Minister for Health.
- The AIHW needs to consult with the ABS to collect health and welfare information. Previously the ABS’s approval was needed which imposed an unnecessary administrative requirement.
- The AIHW no longer needs to seek the approval of the Minister to enter contracts above a prescribed amount.

Accountability to the Minister and Parliament

The AIHW Board is accountable to the Parliament of Australia through the Minister for Health. It informs the minister of its activities as required by the AIHW Act and the PGPA Act.



*The Hon. Greg Hunt, MP
Minister for Health*

The Minister for Health—and other relevant ministers in the Australian Government and state and territory governments—have early access to our products under embargo arrangements.

Senior AIHW staff may also be required to attend Senate estimates hearings as part of the Health portfolio. In 2018–19, the CEO appeared as a witness at the Senate Standing Committee on Community Affairs additional estimates hearings on 20 February 2019.

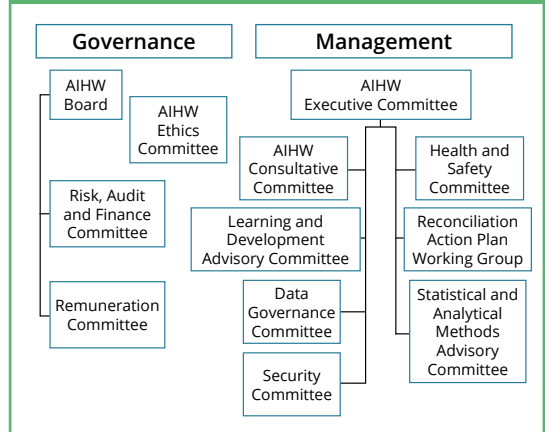
Ministerial directions

No Ministerial directions under section 7 of the AIHW Act were received in 2018–19.

Government policy orders

No government policy orders under section 22 of the PGPA Act were applied to the AIHW in 2018–19.

Figure 4.1 Governance and management committees, 30 June 2019



AIHW Board

The AIHW Board is the accountable authority for the AIHW under the PGPA Act. Its main function under the AIHW Act is to ensure the proper, efficient and effective performance of the AIHW (see Figure 4.1).

The board’s composition is set out in section 9 of the AIHW Act.

The CEO is an ex-officio board member. Under section 18F of the AIHW Act, the CEO is not allowed to be present at any deliberation of the board, or take part in any decision, that relates to their appointment, remuneration or performance.

Other board members are appointed by the Minister for Health and hold office for a specified term not exceeding 5 years.

The AIHW Board met 4 times in 2018–19. Appendix 2 on page 91 provides details of the meetings attended by individual board members and lists outgoing board members during 2018–19.

The AIHW Act requires that the Board meets at least every 4 months. Due to the amended AIHW Act requiring appointment of a new Board, the scheduled December 2018 meeting was deferred to February 2019. The AIHW Board operates under a Charter of Governance www.aihw.gov.au/about-us/our-governance/our-charter.

Information about individual board members is current as at 30 June 2019 and includes their qualifications, current positions and professional affiliations.

Louise Markus BSocWk
Chair

Term: 14 December 2016–13 December 2019

Mrs Markus was elected to the House of Representatives in 2004 and 2007 for the seat of Greenway and in 2010 for the seat of Macquarie. During her time in the Parliament of Australia, she held the positions of shadow parliamentary secretary for immigration and citizenship and shadow minister for veterans' affairs. Mrs Markus left the House of Representatives on 2 July 2016.

During her career as a social worker, she worked at the Department of Social Security, Wesley Mission and as a Technical and Further Education teacher. Mrs Markus is passionate about developing and delivering programs that provide opportunities for young people and being a strong voice for those in her community.



Erin Lalor AM BSc (Hons)
(Speech and Hearing), PhD,
GCCM

Deputy Chair

Term: 3 December 2018–2 December 2021

Board member

Previous terms: 21 November 2012–20 February 2013; 1 March 2013–29 February 2016; 23 March 2016–22 March 2017; 24 March 2017–23 March 2018; 24 March 2018–23 June 2018

Dr Lalor was appointed CEO of the Alcohol and Drug Foundation in November 2017. She has over 20 years of leadership experience in the health sector, working in clinical, academic and executive roles, and was



previously the CEO of the National Stroke Foundation and a director of the World Stroke Organization.

Dr Lalor was the Chair of the AIHW's former National Vascular Disease Monitoring Advisory Group. Dr Lalor is a former board member of VincentCare Victoria, and a member of the Victorian Liquor Control Advisory Council, VicHealth Alcohol Taskforce and the National Alliance for Action on Alcohol.

She was awarded a Member of the Order of Australia in January 2019 for her services to health through the not-for-profit sector and to people with stroke.

Barry Sandison BBusMgt, FANZSG
CEO AIHW

Term: 5 May 2016–4 May 2021;
Ex-officio appointment

Mr Sandison's biography can be found at page 58.



Zoran Bolevich DM, MBA, FRACMA
Non-executive Director

Terms: 11 February 2016–27 November 2018; December 2018–2 December 2019

Dr Bolevich is the Chief Executive of eHealth New South Wales. During his 25-year career in health, he has worked in a range of senior health management and ICT leadership roles in Australia and New Zealand.

Before joining eHealth NSW, he worked at the NSW Ministry of Health as executive director for health system information and performance reporting and, most recently, as acting deputy secretary for system purchasing and performance.



Christine Castley LLB, BA,
MA, MPA

Non-executive Director

Term: 3 December 2018–
2 December 2019



Ms Castley has served in multiple senior leadership roles across the Queensland Government, with significant experience in strategic policy, governance and service delivery. She is Deputy Director-General in the Department of the Premier and Cabinet. Previously, she was deputy director-general, housing, homelessness and sport in the Department of Housing and Public Works. In 2014 and 2015, she led the Secretariat to the Taskforce on Domestic and Family Violence, working with the Chair of the Taskforce, the Hon. Dame Quentin Bryce AD CVO, government, opposition and independent members of Parliament, as well as community sector representatives. She has also worked in a variety of agencies including Natural Resources and Mines, State Development and the Queensland Performing Arts Trust.

Marilyn Chilvers BEc (Hons),
MAppStat, GradDipTertEd

Non-executive Director

Terms: 18 January 2016–17
January 2017; 19 January 2017–
18 January 2018; 19 January 2018–18 April
2018; 19 April 2018–30 June 2018;
3 December 2018–2 December 2019



Ms Chilvers is the Executive Director at the New South Wales Department of Family and Community Services (FACS) and Data Analytics Centre, New South Wales Treasury (dual role). Ms Chilvers leads data integration and analysis activities to improve outcomes for vulnerable and at-risk citizens. She has led the design, development and implementation of the New South Wales Human Services Outcomes Framework to guide government investment and service design through data and evidence. She is a partner investigator in

a range of linkage research projects, including the FACS Pathways of Care Longitudinal Study of children and young people in out-of-home care and the University of New South Wales Child Development Study.

Christine Gee MBA

Non-executive Director

Term: 3 December 2018–
2 December 2023



Ms Gee is the CEO of the Toowong Private Hospital. She is a member of the Toowong Private Hospital Board, Treasurer of the Private Hospitals Association of Queensland and Chair of its Psychiatric Sub-committee. She is a past national president and current board member of the Australian Private Hospitals Association, a member of its Private Psychiatric Hospitals Data Reporting and Analysis Management Committee and Chair of its Policy and Advocacy Taskforce and Psychiatric Committee.

Ms Gee is a member of the Board of the Australian Commission on Safety and Quality in Health Care. She is a member of the Queensland Medical Board and Chair of the Medical Board of Australia's Sexual Boundaries Notifications Committee.

Romlie Mokak BSocSc,
PGDipSpEd

Non-executive Director

Term: 3 December 2018–
2 December 2023



Mr Mokak is a full-time Commissioner with the Productivity Commission.

He is a Djugun man and a member of the Yawuru people.

Mr Mokak was the CEO of the Lowitja Institute. Previously, Mr Mokak was the CEO of the Australian Indigenous Doctors' Association. Earlier roles included director, substance use, and manager of the National Eye Health Program for the Australian Government's Office for Aboriginal and

Torres Strait Islander Health. He was the first Aboriginal policy officer in the New South Wales Government Department of Ageing and Disability.

Mr Mokak is a past chair of the National Health Leadership Forum. He also convened the first Lowitja Institute International Indigenous Health and Wellbeing Conference, and delivered the 2016 Cranlana Program Medicine and Society Oration.

Christine Pascott MBBS, FRACGP, GAICD, AFACHSM
Non-executive Director

Term: 3 December 2018–2 December 2023



Dr Pascott is the Director of the University Medical Centre at the University of Western Australia. She is a practising clinician with a focus on holistic health care of young adults, encompassing both physical and mental health aspects. For over 20 years, Dr Pascott has led a team of general practitioners, registered and mental health nurses, visiting specialists and health promotion officers. She has been the Infection Control Officer for the Faculty of Health and Medical Sciences since 2015.

Dr Pascott is a member of the Medical Defence Association National Board and of its Audit and Risk Committee and is a Clinical Reference Lead for the Australian Digital Health Agency.

Michael Perusco BBus (Acc)
Non-executive Director

Terms: 20 November 2012–20 February 2013; 1 March 2013–29 February 2016; 23 March 2016–22 March 2017; 24 March 2017–23 March 2018; 24 March 2018–23 June 2018; 3 December 2018–2 December 2023



Mr Perusco commenced as CEO of Berry Street in February 2018.

Prior to that he was CEO of a number of organisations in the housing and

homelessness sector: Unison, St Vincent de Paul Society (New South Wales) and Sacred Heart Mission. He has worked at the Department of Prime Minister and Cabinet leading the social inclusion agenda, not-for-profit reform agenda and other social policy areas. He has also worked in the commercial sector at KPMG and Arthur Andersen.

Mr Perusco's career in the community sector has focused on people who are chronically homeless. He is a member of the Victorian Government's Roadmap Implementation for Reform Ministerial Advisory Group, the Aboriginal Children's Forum and the Centre for Excellence in Child and Family Welfare. He was a finalist in the 2010 Victorian Australian of the Year awards.

Cathryn Ryan RN, BEd, GDipHlthAdmin, GDipENT (UK), GCertCritCare(Emerg), GAICD

Non-executive Director

Term: 3 December 2018–2 December 2023



Ms Ryan has worked for over 35 years in the public and private health sectors in both Australia and the United Kingdom. She has held a wide range of operational and senior managerial roles, focusing on care outcomes, efficiency, productivity and funding.

With a national role as General Manager - Health Funding, Strategy and Performance at Australia's largest not-for-profit private/public hospital operator, St John of God Health Care, she heads up an integrated team responsible for funding, health information, audit and related analytics. Ms Ryan also has over 10 years' experience as a non-executive director of a not-for-profit organisation for children with special needs. She is a member of Catholic Health Australia's Senior Executive Forum and a current member of the Prostheses Listing Advisory Committee.

Simone Ryan BMedSci, MBBS, FAFOEM (RACP), MOccEnvHlth, ACCAM, DAME

Non-executive Director

Terms: 1 September 2016–31 August 2017; 1 September 2017–30 March 2018; 31 March 2018–30 June 2018; 3 December 2019–2 December 2021

Dr Ryan is a medical specialist and pioneer in her field; well-known for her passion and dedication to ensuring optimum health for every Australian worker. With her main professional objective to educate corporate Australia around realising the health benefits of work and how this boosts the bottom line, 'One Life. Live It', was born.

Dr Ryan is the Founder and CEO of One Life. Live It. In addition she is the founder of Hang Loose Foundation, former board and risk director at the Royal Australasian College of Physicians, Consultant to Australian Securities Exchange companies on occupational health and safety and member of Women on Boards.



Maxwell Shanahan BA, FCPA, CGEIT, CISA, MACS (Senior), MIIAA

Independent member

Term: from 8 December 2011

Mr Shanahan is the Director of Max Shanahan & Associates. He is currently Chair of the Snowy Mountains Regional Council Audit Committee, a member of the Queanbeyan-Palerang Regional Council Audit, Risk and Improvement Committee and was an independent member of the Australian Bureau of Statistics Audit committee from 2009 until mid-2017.

Mr Shanahan continues to be active in the development of standards for the governance of IT, attending International Organizations for Standardization meetings (ISO) as an Australia subject matter expert.



Risk, Audit and Finance Committee

This committee authorises and oversees the AIHW's audit program and reports to the board on strategic, financial and data audit matters (see 'Financial management' on page 53 and 'Risk oversight and management' on page 54).

As at 30 June 2019, the committee comprised:

- 3 non-executive board members— Mr Michael Perusco (Chair), Dr Erin Lalor, and Dr Simone Ryan. Details of their professional experience and qualifications are available under 'AIHW Board' earlier in this chapter
- 1 independent member— Mr Max Shanahan.

Auditors

Senior representatives from our internal auditors (Protiviti) and external auditors (ANAO) attend meetings of the committee. The committee received the ANAO's audit report on the 2017–18 financial statements. It also reviewed recommendations from internal audits on:

- the implementation of the Data Custodian Checklist—to provide assurance of the effectiveness of design and operating effectiveness of the checklist following its first year of implementation
- privacy of information at the AIHW—to provide assurance of the adequacy of design and operating effectiveness of controls related to the management of privacy of information at the AIHW including preparedness to comply with the new Privacy Code which commenced on 1 July 2018.

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

Protiviti began internal audits in 2018–19 on:

- following up the AIHW's accreditation as an Accredited Integrating Authority
- procurement to payment controls
- IT asset management
- IT access management
- the National Aged Care Data Clearinghouse.

Remuneration Committee

The AIHW Board is the employing body of the CEO. The CEO position is in the Principal Executive Office structure administered by the Remuneration Tribunal.

The Remuneration Committee advises the board on the CEO's performance and remuneration, within the parameters set in the Remuneration Tribunal's *Determination 2018/07: Principal Executive Office—classification structure and terms and conditions*.

At 30 June 2019, the committee comprised:

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

AIHW Ethics Committee

The AIHW Ethics Committee is established under section 16(1) of the AIHW Act. Its main responsibility is to advise on the ethical acceptability or otherwise of current or proposed health- and welfare-related activities of the AIHW, or of bodies with which we are associated. The Australian Institute of Health and Welfare (Ethics Committee) Regulations 2018 prescribe the committee's functions and composition and can be found at www.legislation.gov.au/Details/F2018L00317.

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

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

Committee members

Information about individual board members is current as at 30 June 2019 and includes qualifications, current positions and professional affiliations. Information on attendance at Ethics Committee meetings is at Appendix 2 (see page 92).



AIHW Ethics Committee.

Front row (left to right): Damien Tillack, Margaret Reynolds and Tim Driscoll.

Middle row (left to right): Barbara Anderson and Barry Sandison.

Back row (left to right): Owen Bradfield, Nicholas White, Wayne Jackson, Amanda Ianna and Maryjane Crabtree.

Wayne Jackson PSM BEc (Hons)

Chair

Terms: 1 July 2013–30 June 2016; 1 July 2016–30 June 2019; July 2019–30 June 2022



Mr Jackson is a retired Australian Government public servant, having served as deputy secretary in the Department of Prime Minister and Cabinet and the (then) Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). He chaired a wide range of interdepartmental and corporate committees, including the FaHCSIA Risk Assessment and Audit Committee and the Research Committee, and was a member of the Australian Statistics Advisory Council.

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

Barry Sandison BBusMgt, FANZSG

Chief Executive Officer

Ex-officio appointment. Information about Mr Sandison is provided on page 58.



Barbara Anderson BPsych (Hons), MPsych (Clinical)

Person experienced in the professional care, counselling and treatment of people

Term: 27 June 2019–26 June 2022

Ms Anderson is a clinical psychologist with 16 years' experience, currently working in a community youth-based mental health service and a private practice in Townsville.



Owen Bradfield MBBS (Hons), BMedSc (Hons), LLB, MBA, FRACGP

Person experienced in the professional care, counselling and treatment of people

Term: 27 June 2019–26 June 2022

Dr Bradfield is a registered medical practitioner and lawyer.

He is Deputy Chairperson of the Patient Review Panel, a Lawyer Member of the Victorian Department of Health and Human Services Human Research Ethics Committee and a member of the Suitability Panel. He is a former Chairperson of the Health Law Committee of the Law Institute of Victoria.



Tim Driscoll FAVOEM, FAFPHM, PhD, MOHS, MBBS, BSc (Med)

Person experienced in areas of research regularly considered by the committee

Terms: 1 July 2016–30 June 2019; 1 July 2019–30 June 2022

Professor Driscoll is an occupational epidemiologist and a specialist physician in occupational and environmental medicine and public health medicine. He is a Professor in epidemiology and occupational medicine in the Sydney School of Public Health at the University of Sydney and is Director of the Master of Public Health.



Amanda Ianna GradCert-ChangeMgt, AGSM

Nominee of Registrars of Births, Deaths and Marriages

Term: Ex-officio appointment

Ms Ianna has extensive experience in the field of civil registration, organisational change and leadership. She is currently the 17th Registrar (since 1856) at the New South Wales Registry of Births Deaths and Marriages which she commenced in 2014, one of only two women to hold this position.



Nicholas White BA (Hons),
GradDipEd, PhD
Person who is a minister
of religion



Term: 12 December 2017–
11 December 2020

The Reverend Dr White is a social anthropologist and Anglican priest, currently Archdeacon for Diocesan Partnerships with the Anglican Diocese of Melbourne. Dr White has held social policy roles in the Victorian Department of Premier and Cabinet and the Department for Victorian Communities. Dr White also serves on the Ethics Committee of the Brotherhood of St Laurence.

Maryjane Crabtree BA/LLB,
GAICD



Person who is a lawyer

Terms: 14 April 2016–13 April 2019;
14 April 2019–13 April 2022

Ms Crabtree was a partner of Allens Linklaters, until her retirement in 2016. She is currently the President of the Epworth HealthCare Board of Management, Deputy Chair of the Racing Analytical Services Board and a member of Chief Executive Women, the Victorian Legal Admissions Board, the Board of Ormond College, the Coronial Council of Victoria and the Board of Rugby Victoria.

Damien Tillack BA, BEd (Grad)(Sec)
Male representing general
community attitudes



Term: 28 March 2019–
27 March 2022

Mr Tillack is a primary school principal. His most recent appointment is principal at Townsville Central State School. He has been an educator for over 20 years and is currently completing a Master of Educational Leadership at the University of Queensland. Mr Tillack's previous appointment was principal, Vincent State School.

Margaret Reynolds BA,
Dip Special Ed
Female representing general
community attitudes



Terms: 17 August 2011–16 August 2014;
17 August 2014–16 August 2017;
17 August 2017–16 August 2020.

The Hon. Margaret Reynolds has had a career in education and social issues public policy. She is a former senator for Queensland and served as minister for local government and the status of women.

She was CEO of National Disability Services in Tasmania and was an inaugural member of the Council for Aboriginal Reconciliation.

58
new Ethics
applications

4
Board
meetings

5
Ethics
Committee
meetings

Work of the committee

The committee met 5 times in 2018–19. It provided approvals regarding the ethical acceptability of 257 new or modified projects and data collections.

New project applications

In 2018–19, the committee considered 58 new project applications compared with 76 and 62 in the previous 2 years. Of these, 45 were approved and 2 were declined.

Of the 58 new applications, 46 were submitted by researchers from external organisations, such as departments and research centres affiliated with universities or large metropolitan teaching hospitals. For example, applications were received from the University of Queensland, University of Tasmania, the Centre for Big Data Research in Health (University of NSW), Curtin University, the University of Melbourne, Sir Charles Gairdner Hospital, the Fiona Stanley Hospital and other major Australian universities.

The committee also received applications from research organisations such as the Kirby Institute, Peter MacCallum Cancer Centre, the South Australian Health and Medical Research Institute and various government agencies, including Civil Aviation Safety Authority, the Australian Bureau of Statistics,

the Australian Government Department of Health and the Victorian Department of Health and Human Services. The AIHW submitted 12 new applications.

There were 33 applications that sought approval for linkage to the National Death Index (NDI) which is held at the AIHW.

Increasingly, researchers are requesting NDI linkage with MBS and PBS data.

Other AIHW-held databases to which access was sought included the Specialist Homelessness Services Collection, the National Aged Care Data Clearinghouse and hospitals data.

Monitoring projects

The committee monitors approved projects to their completion, and considers requests for modifications to previously approved projects. Researchers submitted 402 annual monitoring reports in 2018–19.

Requests for modification or extension

In all, 213 requests for amendment were considered during the year (Table 4.1). Approximately 57% (121) were requests for an extension of time and/or proposed research staff changes.

Finalised projects

To ensure that research outcomes are freely

Table 4.1: Research project applications considered by the AIHW Ethics Committee, 2018–19

	Considered	Approved	Rejected/ Withdrawn	Decision pending
Applications for approval				
AIHW	12	12		
External researchers	46	33	2	11
<i>Subtotal</i>	58	45	2	11
Applications for modification or extension				
AIHW	19	19		
External researchers	194	193		1
<i>Subtotal</i>	213	212		1
Total	271	257	2	12

available, the committee requires public dissemination of the results of approved projects. In 2018–19, it received 21 final project reports accompanied by associated research results, most of which were published in peer-reviewed journals or other publicly available reports.

There are some limited exceptions where results are not released into the public domain: an example is when data are provided to a government department to enable it to create a model for internal use. In this situation, it is expected that any learnings are shared among other interested government agencies.

Protecting privacy

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

For a general overview of how we protect the privacy of individuals, our legal obligations and our data custody and governance arrangements, see our Privacy Policy on our website at www.aihw.gov.au/privacy-policy.

The Five Safes Framework, adopted in November 2018, is a risk assessment framework, which considers strategic, privacy, security, ethical and operational risks when sharing or releasing our data. The framework supports the provision of safe and appropriate access to our data, and is progressively being fully integrated into our operations.

Data governance

We manage data professionally, with due respect for its sensitivity, and with privacy and confidentiality assured through legislation, robust data policies and procedures.

This includes use of rigorous controls to determine access and release arrangements, and the scrutiny of a legally-constituted and independent AIHW Ethics Committee.

Data governance framework

Our Data Governance Framework provides an overview of our robust data governance arrangements, including:

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

The framework and a short overview document, *Data governance—in-brief*, are available at www.aihw.gov.au/about-our-data/data-governance.

Our Data Governance Committee establishes an annual work plan of data governance activities, makes operational decisions, and provides advice and recommendations to our Executive Committee on significant data governance matters. In 2018–19, the Data Governance Committee met 6 times, convened 4 data custodian forums to discuss matters of interest and issues affecting AIHW data custodians, and reported regularly to the Executive Committee on the delivery and/or progress on a range of projects in its work plan. These included:

- updating policies and delegations around the release of data
- integrating the use of Five Safes, including development of Five Safes Access Control Profiles
- development of guidance to support provision of external researchers with ‘live’ access to our data for their research projects (e.g. by remote access or co-located in an AIHW unit)

- publishing enhanced information about our data holdings on our website
- advising data custodians
- undertaking a review of the operation of a checklist for data custodians designed to provide greater guidance on key responsibilities and the documentary evidence required for data audits
- updating the Data Governance Framework for currency
- enhancing our internal data catalogue.

ICT and data security

We made a significant investment in the security of our data and technology to comply with relevant legislation and our policies.

We developed new policies, frameworks and where appropriate, updated the existing policies in accordance with the Australian Government's Security Framework and Guidelines. Our ICT Framework was developed to meet the legislative and regulatory requirements and to ensure the technology used by us is robust and secure. The framework now enables us to undertake certification and accreditation of all systems to provide surety for stakeholders. Our 2019 Security Plan was developed to ensure the privacy, confidentiality, integrity and availability of our data and the protection of our staff and assets.

Recognising the ever-changing threat landscape related to data and assets, we are continuing to invest in people, processes and technologies to ensure the protection of our data and reputation.

Financial management

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

- AIHW Act
- PGPA Act
- Auditor-General Act 1997.

Our internal operations are funded by:

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

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

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

Our externally funded project work is undertaken by our statistical groups. Fees charged for each project are determined using a pricing template set to cover salaries and on-costs, other direct costs and a corporate cost-recovery charge for infrastructure and corporate support. The pricing template is updated each year. Expenditure incurred in each project is accounted for separately and monitored monthly.

Procurement requirements

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

We comply with the mandatory procedures for all procurements above the \$400,000 threshold. We complied with our obligations under the procurement rules in 2018–19.

Purchase contracts

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

Purchase contract payments are typically linked to the successful delivery of services.

Revenue contracts

Most revenue contracts were for provision of services related to projects being managed by our statistical units. Our revenue contracts and standard schedules for memoranda of understanding detail the scope, timing, deliverables and budget for most externally funded projects.

Contract approval

Any contract over \$200,000 must be approved by the CEO.

Risk oversight and management

The AIHW Board continued to review and refine its Risk Management Framework (RMF). An independent consultant conducted workshops with members of the AIHW Board, the Risk, Audit and Finance Committee and senior executives to update the RMF and develop a Strategic Risk Profile (SRP).

Improvements to the RMF included: enhancement of policy objectives, articulating risk governance including responsibilities and accountabilities, embedding the role of the

AIHW Ethics Committee, refinement of risk appetite and tolerances and the development of new templates for risk assessment and reporting.

Eight strategic and high-level operational risks were identified in the SRP. These are:

- breach of cybersecurity
- externally driven disruption
- major project failure
- growing pains
- preparedness of IT systems to handle very large, complex data sets
- data governance and privacy
- key person risk
- loss of reputation with stakeholders.

The updated RMF and new SRP will be implemented in 2019–20.

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

Reporting requirements under the PGPA Rule

We have specific annual reporting requirements under the PGPA Rule. An index of compliance with our mandatory reporting requirements is at Appendix 4 on page 96.

Finance law non-compliance

The AIHW had no significant issues relating to finance law non-compliance in 2018–19.

Related entity transactions

The AIHW had no related entity transactions in 2018–19.

Judicial or tribunal decisions

There were no legal actions lodged against the AIHW and no judicial decisions directly affecting us in 2018–19.

Reports by other bodies

No reports were made by the Auditor-General, a Parliamentary Committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner in relation to the AIHW in 2018–19.

Unobtainable information from subsidiaries

The AIHW does not have any subsidiaries.

Indemnity applying to the entity and its officers

We have insurance policies through Comcover and Comcare that cover a range of insurable risks, including property damage, general liability and business interruption.

In 2018–19, the Comcover insurance policy included coverage for directors and officers against various liabilities that may occur in their capacity as officers of the AIHW.

Standard premiums of \$22,680 excluding goods and services tax (GST) were paid to Comcover in 2018–19, compared with \$20,025 for 2017–18.

The AIHW made no claims against its directors and officers liability insurance in 2018–19.

Compliance with the Legal Services Directions 2017

The Legal Services Directions 2017 requires us to provide the Attorney-General's Department within 60 days of the end of the financial year:

- a report of our legal services expenditure for the financial year
- a certificate about the service of any documents in respect of legal proceedings involving the Commonwealth (if any).

We complied with our obligations for 2018–19 and our legal expenditure was \$162,969.70.

Advertising and market research

Section 311A of the *Commonwealth Electoral Act 1918* requires us to report payments of \$13,800 and above for advertising and market research. In 2018–19, the AIHW did not undertake any advertising campaigns or make individual payments for advertising that exceeded the prescribed threshold.

Modern slavery

Section 6 of the *Modern Slavery Act 2018* requires entities based, or operating, in Australia, which have an annual consolidated revenue of more than \$100 million, to report annually on the risks of modern slavery in their operations and supply chains, and actions to address those risks.

The AIHW's consolidated revenue was below the \$100 million threshold.

Freedom of information

In accordance with section 11C of the *Freedom of Information Act 1982* (FOI Act), the AIHW is required to publish information that has been released in response to a freedom of information access request.

The AIHW is not required to publish:

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

In 2018–19, the AIHW received 7 requests made under the FOI Act.

Information Publication Scheme



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

The required information is published on our website www.aihw.gov.au/about-us/freedom-of-information/information-publication-scheme-ips.

Enquiries

Freedom of information requests and enquiries should be sent to:

FOI Contact Officer

Ethics, Privacy and Legal Unit

Australian Institute of Health and Welfare

GPO Box 570

Canberra ACT 2601

or emailed to foi@aihw.gov.au.

Chapter 5

Our people

- Challenges and opportunities
- Organisational structure
- Staff profile
- Workforce management
- Employment frameworks
- Engaging with staff
- Recognising and building expertise
- Encouraging workplace health and safety
- Accommodation

Challenges and opportunities

The AIHW continues to depend on highly skilled and competent people to achieve its strategic goals and is committed to the ongoing development of all staff, especially in relation to retaining and enhancing critical capabilities. We have continued to rely on engaging contract staff to complete our expanded work program and deliver our commitments while managing staff numbers within the Average Staffing Level (ASL) cap that has been set for all APS agencies. At the end of June 2019 we had a total of 498 active staff including 157 contract staff (31%). While this is a challenge and there is a risk to having such a high proportion of contract staff, we are actively managing this by engaging appropriately skilled people, offering long-term contracts where possible, providing meaningful and challenging work, and offering contract staff with the same opportunities as ongoing staff. Overall the integration of contract staff across the AIHW has proven to be exceptionally successful.

We strive to provide a workplace that offers unique, fulfilling and challenging work, in a friendly and nurturing environment that promotes the professional and personal development of all individuals. Results from the 2019 APS Employee Census validated that we have an excellent workplace culture and that all staff value the organisation and take pride in the work we do. Employee engagement at the AIHW remains high, and ahead of similar-sized agencies, specialist agencies and the overall APS.

In the APS Census, Employee Engagement is titled 'Say, Stay, Strive'. Under this section, 93% of staff stated they were proud to work for the AIHW, 93% would recommend it as a good place to work, and 96% were happy to go the 'extra mile' at work when required. We also received positive results for wellbeing, and workplace culture. In terms of wellbeing, we received a wellbeing index score of 80%.

The wellbeing score provides an indication of the state of emotional and physical health and wellbeing among employees. It measures both the practical and cultural elements that allow for a sustainable and healthy working environment. Both APS and contract staff were invited to participate in the Census this year and the response rate achieved was 89%, an extremely positive result given the significant growth of the AIHW in the last 12 months.

Organisational structure

Our people are our greatest strength and we are committed to ensuring that AIHW's workplace continues to attract, develop and retain the right people with the right skills. The AIHW is headed by its CEO and comprises 9 groups, with each group headed by a senior executive who is responsible for leading a number of units. Each unit is led by an APS Executive Level 2 officer or equivalent. A new structure commenced on 1 July 2018. Figure 5.1 (on page 60) provides our organisational chart, which shows the group and unit structure as at 30 June 2019.

Chief Executive Officer

Barry Sandison was appointed as the AIHW's CEO in May 2016 and manages its day-to-day operations. He has extensive public sector experience, with previous roles in both policy and service delivery. Most recently, he was the deputy secretary, health and information, in the Australian Government Department of Human Services where he was responsible for the administration and delivery of a range of programs in the health, government and business areas.



Before this, Mr Sandison was a deputy chief executive at Centrelink and held senior executive roles in the former Department

of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the Department of Employment and Workplace Relations. Mr Sandison is a board member of L'Arche Genesaret, an Australian Capital Territory community organisation for people with intellectual disabilities.

Deputy Chief Executive Officer



Matthew James is the AIHW's Deputy CEO and has also led the Housing and Specialised Services Group since November 2016. Before joining the AIHW, he held leadership roles in performance, information and evaluation as assistant secretary, Indigenous Affairs Group in PM&C, and as a branch manager within FaHCSIA. Mr James was also a branch manager in the former Department of Education, Employment and Training, where he worked on employment policy and implementation as well as workplace relations policy and analysis. From 2002 to 2004, he was counsellor—Employment, Education, Science and Training in the Australian delegation to the OECD in Paris. Mr James was awarded the Public Service Medal in 2016.

Housing and Specialised Services Group

This group produces statistics, analysis and information on: homelessness, community housing, housing assistance, mental health and palliative care services, and drug use and treatment services, including tobacco and alcohol.

The group is responsible for the administration, data analysis and reporting of 2 national surveys:

- the National Drug Strategy Household Survey—a large triennial survey which collects information on alcohol and tobacco consumption, illicit drug use and attitudes and perceptions relating to tobacco, alcohol and other drug use

- the National Social Housing Survey—a biennial survey of tenants in selected housing programs, designed to collect information for national reporting about tenant satisfaction with housing amenities, facilities and services.

Business and Communications Group

This group provides services and advice to enable optimal use of our financial and human resources to achieve the following business objectives:

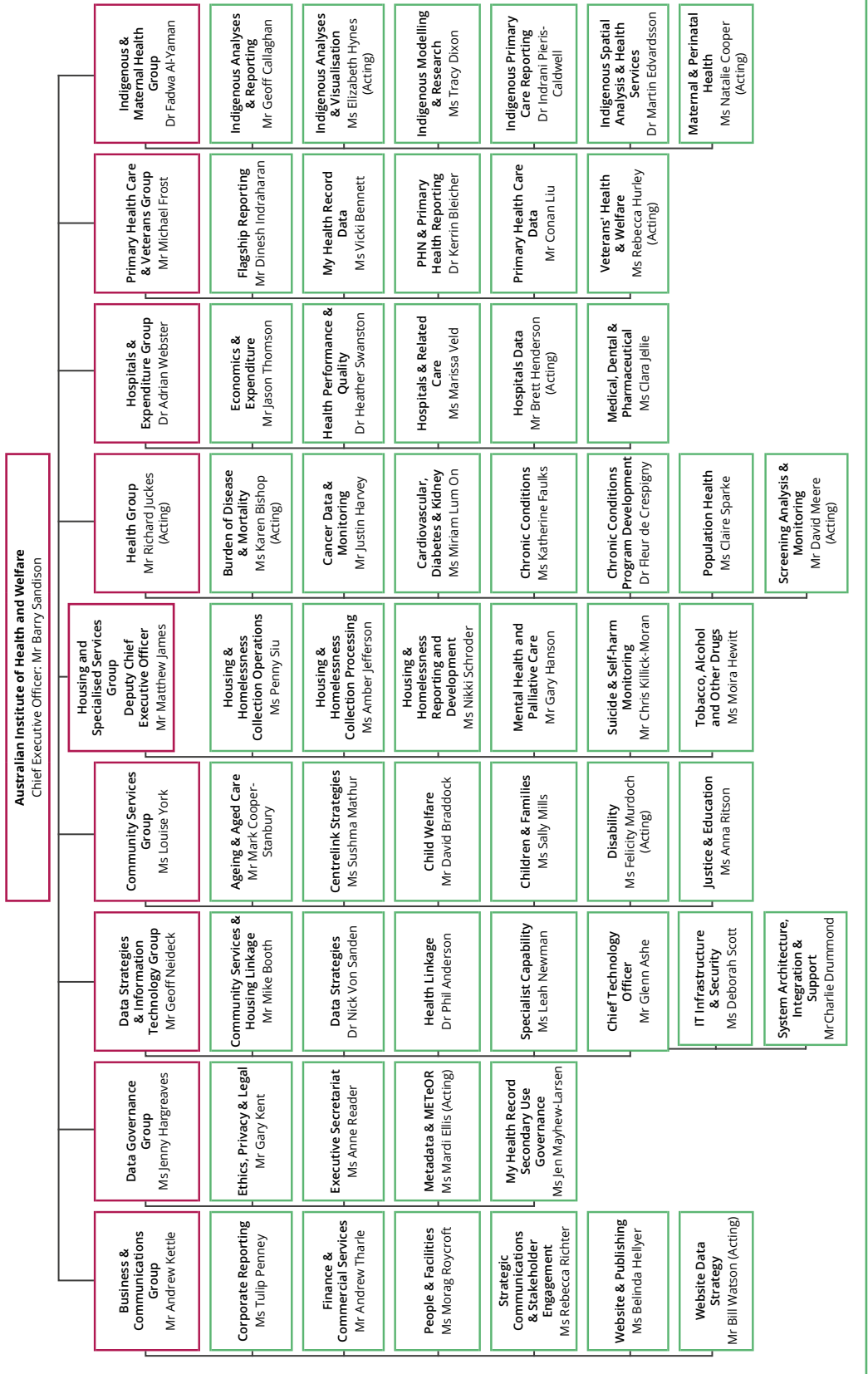
- strategic management of Parliamentary, internal and external relationships
- preparation of key planning and reporting documents, including annual reports and corporate plans
- pricing and contract advice, business analysis and preparation of financial statements
- risk management and internal audit
- strategic external communications, including stakeholder engagement, and print and online services
- recruitment, learning and development, workforce planning, performance management support, workplace health and safety, facilities and accommodation.

Senior Executive, Business and Communications Group



Andrew Kettle has held a senior executive position since 2006. Mr Kettle qualified as a chartered accountant in the United Kingdom. He worked as a professional accountant for Coopers and Lybrand in Canada and Australia and was chief financial officer at the Australian Fisheries Management Authority. Mr Kettle acted as director of the AIHW for 6 months in 2015–16.

Figure 5.1: Organisational chart, 30 June 2019



Data Governance Group

This group works to protect the confidentiality and privacy of our data holdings, through provision of data governance leadership, and supports the work of the AIHW Ethics Committee. It also works to build and enhance national data and information governance infrastructures, and leads our engagement with AHMAC on national health data and information strategic directions. The group provides expert assistance for national health and welfare metadata and manages METeOR, our online national metadata repository. It also provides leadership with national and international work on health classifications, supporting our role as the Australian Collaborating Centre for the WHO's Family of International Classifications.

Senior Executive, Data Governance Group

Jenny Hargreaves has led this group since July 2018. Ms Hargreaves has served on the AIHW senior executive team since 2006 and was previously responsible for the AIHW's work to develop, analyse and disseminate policy-relevant statistical information about hospitals, human and financial resources in the health and welfare sectors, health sector performance and injury.



Data Strategies and Information Technology Group

This group works with Australian Government agencies, state and territory governments and other key stakeholders to promote access to health and welfare data for policy, research and community information. The group aims to increase the information value of existing data collections through data integration (linkage)

work and data-sharing arrangements—for the AIHW and external researchers that support innovative analyses. Examples of work supported in this way include patient and client pathways analysis and movements of people between health and welfare services. The group also identifies, develops and promotes business process innovations, computing and communications infrastructure and technological leadership in support of our strategic directions and supports our ICT requirements.

Senior Executive, Data Strategies and Information Technology Group



Geoff Neideck has led the group since December 2015. Prior to that, he headed the former Housing and Specialist Services Group. Before joining the AIHW, Mr Neideck managed large national social and economic statistics programs at the ABS and Statistics Canada, where he gained experience in data design and statistical infrastructure projects.

Community Services Group

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

- the health and welfare of key subpopulations, including children and youth, older Australians, people with disability, and victims and perpetrators of family, domestic and sexual violence
- use of services within a range of health and welfare sectors, including community-based services focused on aged care, child protection, juvenile justice and disability
- pathways and outcomes for the general population, key subpopulations and health and welfare service users, including the role of education and income support.

Senior Executive, Community Services Group

Louise York has led this group since January 2017. She has over 20 years' experience at the AIHW, including leadership positions in both health and welfare areas, and 1 year at the Telethon Institute for Child Health Research.



Health Group

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

- chronic diseases, both as a group and in relation to some key diseases such as cardiovascular disease, diabetes, kidney disease, cancer, musculoskeletal conditions and respiratory conditions
- population health issues, such as health inequalities, broader determinants such as social and environmental, international health comparisons, mortality and burden of disease
- specific population groups, such as men and women and people living in rural areas.

Senior Executive, Health Group

Richard Jukes was the Acting Head of this group from April 2019. He joined the AIHW in 2018. Mr Jukes has been working in health policy and health data roles for over 20 years, primarily at the Australian Government Department of Health.



Hospitals and Expenditure Group

This group creates authoritative and accessible information relating to the activity, performance, quality and financing of the

Australian health system. This includes the hospital system as well as the non-hospital and primary health systems. The national hospitals databases, *Australian hospital statistics* reports and *MyHospitals* website information are major products, as are the national health expenditure database and *Health expenditure Australia* reports. The group is responsible for implementing the Australian Health Performance Framework, the creation and management of the NIHSI AA and our relationship with the National Injury Surveillance Unit—our collaborating centre.

Senior Executive, Hospitals and Expenditure Group

Adrian Webster has headed the Hospitals and Expenditure Group since July 2018. Dr Webster is a sociologist with more than 20 years' experience in the health and welfare sectors in Australia and overseas and joined the AIHW in 2009. His experience includes leading evaluation and research in an international aid organisation, consulting services to government agencies in Australia, such as Medicare Australia, and reporting on hospital performance at ACT Health.



Primary Health Care and Veterans Group

The group produces the biennial flagship series, *Australia's welfare* and *Australia's health*. The group has also recently established a work program to enhance the AIHW's capabilities in digital health and, for part of the year, undertook geospatial analysis and data visualisation. This group provides PHNs with data to meet their performance frameworks. It is also responsible for leading a drive for improvements in primary care data, developing the MHR data for research purposes, and reporting on veterans' health and welfare data across Australia.

Senior Executive, Primary Health Care and Veterans Group



Michael Frost transferred to the AIHW in April 2016 from his position as executive director, strategic initiatives, in the former National Health Performance Authority. Mr Frost has led this group since July 2018. His experience in policy advice, performance reporting and administrative roles spans more than 20 years in federal and state governments, including as the deputy head, Secretariat for the COAG Reform Council.

Indigenous and Maternal Health Group

This group leads the development, monitoring and reporting of information and statistics in 2 main areas: the health and welfare of Aboriginal and Torres Strait Islander people, and maternal and perinatal health. The work of this group includes:

- analysing and reporting on performance measures based on the Aboriginal and Torres Strait Islander Health Performance Framework, at the national and jurisdictional levels, in collaboration with PM&C and states and territories
- working with Indigenous primary health-care services and other service providers to improve the quality and usefulness of their data to support better outcomes for clients
- modelling geographical variation in access to services relative to need, with a particular focus on identifying areas where Indigenous Australians experience service gaps
- analysing and reporting on national data about pregnancy and childbirth of mothers, and the characteristics and outcomes of their babies.

Senior Executive, Indigenous and Maternal Health Group



Fadwa Al-Yaman has headed this group since 2008. Dr Al-Yaman holds a PhD in Immunology from the John Curtin School of Medical Research and a Masters of Population Studies from the Australian National University. Dr Al-Yaman was awarded a Fulbright Fellowship in 1990 and the Australian Public Service Medal in 2008.

Staff profile

At 30 June 2019, there were 534 people, including contract (labour hire) staff, who worked at the AIHW compared with 449 at 30 June 2018. Contract staff numbers increased significantly to meet the needs of externally-funded projects and comply with the cap on the number of APS staff we are allowed to employ.

Table 5.1 shows staff engaged under the *Public Service Act 1999* (APS staff) and contract (labour hire) staff.

Of our 341 active APS staff at 30 June 2019:

- 336 (99%) were ongoing employees—an increase of 7.4% compared with 30 June 2018
- 5 were non-ongoing employees, compared with 11 in June 2018
- 84 (25%) worked part-time, compared with 83 in June 2018
- 229 (67%) identified as female, compared with 220 (68%) in June 2018 (see Table 5.2).

Further information on ongoing and non-ongoing staff is at Appendix 6.

Table 5.1: Staff numbers, 2015–2019

	30 June 2015	30 June 2016	30 June 2017	30 June 2018	30 June 2019
Number					
Active APS staff	308	310	344	324	341
APS staff on long-term leave	31	37	25	23	36
Contractors	..	..	17	102	157
Total staff	339	347	386	449	534
Full-time equivalent					
Active APS staff	284.8	286.6	318	302.8	320.3
APS staff on long-term leave	29.1	35.0	24.2	21.3	31.8
Contractors	..	..	15.9	89.9	134.8
Total staff	313.9	321.6	358.1	414.0	486.9

.. not applicable.

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

Table 5.2: Gender identification of active staff, 2015–2019

	30 June 2015	30 June 2016	30 June 2017	30 June 2018	30 June 2019
Number					
Active APS staff					
Female staff	237	241	234	220	229
Male staff	102	105	110	104	112
Staff who do not exclusively identify as male or female	—	—	—	—	—
Total	339	346	344	324	341
Contractors					
Female staff	..	..	8	52	91
Male staff	..	..	9	50	66
Staff who do not exclusively identify as male or female	—	—	—	—	—
Total			17	102	157
Total all staff (Including contractors)	339	346	361	426	498

.. not applicable.

— not available.

Classification level

Of our active APS staff at 30 June 2019, 37% (126 staff) were classified and employed as Executive Level 1 (EL 1) officers and 23% (80 staff) were employed as APS 6 officers (see Table 5.3).

The percentage of active APS (2–6) level decreased to 45% in comparison with 54% as at 30 June 2018. Executive level staff increased to 53% compared with 44% at the same time last year. The percentage of APS 4 staff decreased slightly. All other classification levels remained relatively stable.

Table 5.3: Number of active staff by classification level, 2017–18 to 2018–19

Level	30 June 2018	30 June 2019
APS 2–3	2	2
APS 4	46	33
APS 5	40	37
APS 6	86	80
EL 1	102	126
EL 2	39	54
Senior Executive Services (SES) Band 1	7	7
SES Band 2	1	1
CEO	1	1
Total	324	341

Note: Excludes contract staff.

Role of staff

As at 30 June 2019:

- 418 (84%) of our active staff performed statistical work
 - 293 (86%) of our active APS staff
 - 125 (80%) of our contract staff.
- 80 (16%) were employed in corporate support functions, including IT, finance, governance, publications, media and communications
 - 48 (14%) of our active APS staff
 - 32 (20%) of our contract staff.

Workforce management

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

Staff commencements and turnover

Sixty-eight new employees commenced ongoing employment at the AIHW during 2018–19 (Table 5.4), of which 19 were in our 2018–19 graduate intake (Table 5.5), and 32 ongoing employees left the AIHW during 2018–19. This equates to a 9.0% turnover rate for ongoing staff in 2018–19, which is similar to the 9.1% turnover rate in 2017–18.

Table 5.4: Commencements and separations of ongoing staff, 2018–19

Type	Number
Ongoing staff at 30 June 2018	336
Staff engaged from outside the APS	45
Staff moving from another APS agency	23
Total commencing staff	68
Staff separating through resignation	18
Staff separating through retirement	6
Staff who moved to another APS agency on transfer	6
Staff who moved to another APS agency on promotion	2
Total exiting staff	32
Ongoing staff at 30 June 2019	372

Notes

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

Contract staff turnover

As at 30 June 2019, the AIHW had 157 contract staff engaged for periods of between 1 and 4 years. Last year, 18 contractors transitioned to ongoing APS employees with the AIHW. An additional 49 contractors ceased working with the AIHW, of which, 31 were as a result of their contract ending, as they were engaged for a specific task and/or period of time. One contract was terminated by us and 4 contractors resigned. A further 13 contractors ceased, however the reason for cessation was not recorded. Those who ceased working at the AIHW had an average tenure of 7.4 months.

Graduate intake

Our annual graduate intake remains a key strategy for building our workforce capability. We offer excellent employment opportunities for suitable graduates seeking to apply their qualifications in the fields of health and welfare information. Of the 19 graduates employed in the 2018–19 intake, 10 relocated from interstate. Of the 8 graduates employed in the 2014–15 intake, 3 have remained at the AIHW (Table 5.5).

Table 5.5: Graduate recruitment intake and outcomes, 2014–15 to 2018–19

	2014–15	2015–16	2016–17	2017–18	2018–19
Graduate intake (all at APS 4 level)	8	21	14	18	19
Graduates remaining at the AIHW at 30 June 2019	3	12	9	13	18
As an APS 4	0	0	0	11	18
Promoted to APS 5	1	1	8	2	0
Promoted to APS 6	2	11	1	0	0



AIHW 2019 graduates

Managing performance and behaviour

Our Managing for Performance Policy recognises that regular constructive feedback encourages good performance. It enhances continuing development and facilitates employees and managers to communicate with each other informally and regularly

about performance matters. The policy also affirms that performance management is a core activity that is embedded in all management functions.

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

We designed and launched a new Executive Level Leadership program to raise capabilities in strategic and people/performance management. Over 120 EL 1 and EL 2 staff

participated in the program. To support the development of our part-time and remote workers, a 4-day intensive leadership program was also delivered. In addition, programs focusing on strategic thinking, nurturing performance, having authentic conversations and working effectively at level were also provided to staff. These programs aim to assist in raising and maintaining capabilities to achieve goals and maintain our culture of high performance.

Institute Awards

Institute Awards recognise exceptional individual and team contributions. The criteria for assessing nominations are linked to excellence in supporting strategic goals and excellence in delivering and/or supporting services and products. Institute Awards were given to 33 staff in 2018–19 (Table 5.6).

Table 5.6: Institute Award recipients, 2018–19

Simone Brown
Katrina Burgess, Jane McIntyre and Alexei Dukhnovski
Sam Chambers, Eileen Patterson, Angus Harding, Georgina Jepsen and Anne Broadbent
Julianne Garcia
Jenna Haddin
Nicole Hunter
Miranda Laws
Michael Metz
David Meere, Alison Budd, Chris Rompotis and Natasha Bartlett
Emily Norton, James Bignold, Rachel Aalders, Chwee Von Sanden and Cynthia Parayiwa
Bronwen Phillips and Angus Harding
Jaya Rawat
Emily Ross
Morag Roycroft
Marissa Veld, Josh Sweeney and Lachlan Facchini
Bill Watson
Damian Welsh

Recognising diversity

We continued to recognise and support the diversity of our staff. Our Enterprise Agreement (EA) provides flexible working and leave arrangements to support employees' caring responsibilities, religious commitments and attendance at cultural events.

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

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

In 2018–19, we continued to support the Pride network, which provides peer support and visibility for our lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) staff.



Sydney staff at the permanent rainbow pedestrian crossing



Veronica Jordan of Culture on the Move presenting a workshop on traditional weaving for AIHW staff during National Reconciliation Week, May 2019



Wally Bell, Ngunnawal Elder of Buru Ngunnawal Aboriginal Corporation leading a walking tour of culturally significant sites on Black Mountain for AIHW staff during NAIDOC week, July 2018

In addition, we delivered cultural awareness training, which included face-to-face and e-learning programs designed to educate staff about the cultural significance of the traditional owners of the land in the Canberra region. The AIHW is now a member of the Australian Public Service Commission's (APSC) Indigenous Employment Strategy which provides access to a range of employment programs aimed at increasing the representation of Indigenous Australians.

The AIHW has a Reconciliation Action Plan and has appointed 3 members of the senior executive group to the roles of Disability Champion, Indigenous Champion and the Pride Network Champion. We also joined the Australian Network on Disability (AND). This assists us to become a disability-confident employer by providing access to programs and resources to support managers and staff in supporting employees with disability.

Figure 5.2 compares AIHW staff with APS staff in terms of identifying as being of Aboriginal and/or Torres Strait Islander heritage, having disability, and/or being from a non-English-speaking background. It also identifies staff who are women and staff aged 50 and over. We continue to exceed the APS average for employment of women but we are below average for employment of staff aged 50 and over, Indigenous staff and staff with disability. We hope that with our participation in initiatives such as the Indigenous Employment Strategy and the AND, we will see improvements in these areas.

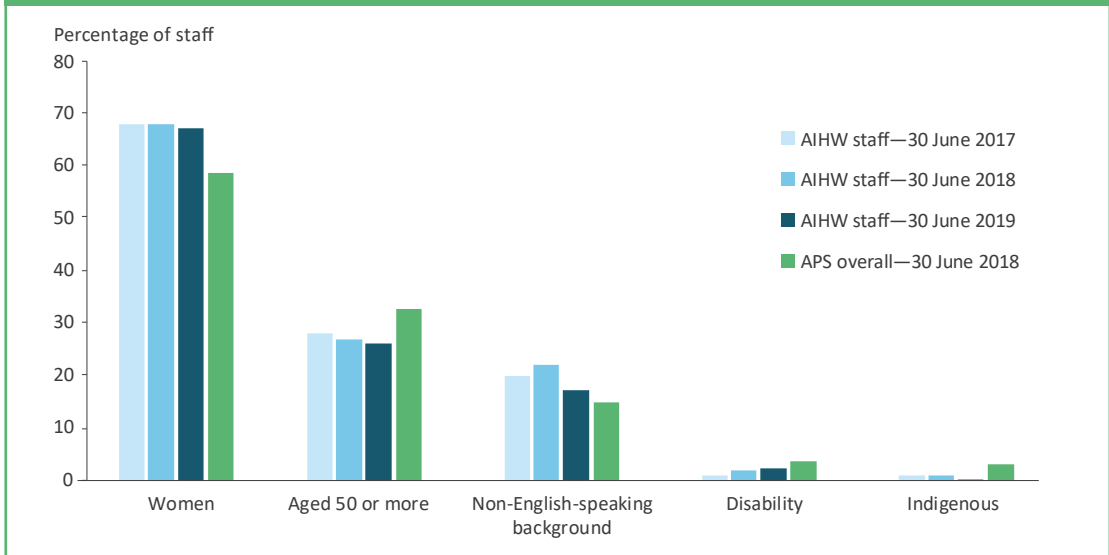


CEO Barry Sandison speaking at NAIDOC week



Patricia Turner AM, CEO of National Aboriginal Community Controlled Health Organisation and Jamie Penny attending the launch of AIHW's 4th Reconciliation Action Plan

Figure 5.2: AIHW staff diversity groups, 2017–2019, compared with the APS overall, 2018



Among our active staff, women comprise:

- 67% of total active APS staff
- 44% of substantive SES staff
- 66% of EL staff.

Inclusive of contractors, women make up 64% of the AIHW, of which, 62% of ELs are women.

Equal employment opportunities

Section 5 of the *Equal Employment Opportunity (Commonwealth Authorities) Act 1987* (EEO Act) requires that the AIHW develop and implement an equal employment opportunity program. The program should ensure that, in relation to employment matters, appropriate action is taken to eliminate discrimination by the AIHW against women and persons in designated groups and promote equal opportunities for people in these groups. Under section 9 of the EEO Act, the AIHW must report annually on the development and implementation of its program. The report may be submitted to the AIHW's responsible minister through its annual report. A report should include:

- a detailed analysis of action taken to develop and implement its program
- an assessment of how well program implementation is monitored and evaluated

- an assessment of the effectiveness of the program
- details of each direction given by the minister about the AIHW's performance
- obligations under the EEO Act.

The AIHW adopts equal employment opportunity practices common across the APS, including access to paid parental leave and maternity leave, and recruitment opportunities specifically for Indigenous people. The AIHW accommodates reasonable requests for flexible working arrangements so that staff can meet family commitments, and seeks to remove obstacles that might discourage people with disability or whose first language is not English from seeking employment at the AIHW.

The AIHW signed an MOU with the APSC in May 2019 to participate in APSC Indigenous Employment Programs. Through this MoU the AIHW has the opportunity to participate in a range of initiatives aimed to support the Commonwealth Aboriginal and Torres Strait Islander Employment Strategy. These initiatives include the 3 Pathways programs, which support employment opportunities for interns, graduates and APS 5 to EL 2 candidates. The AIHW hopes to be able

to engage a number of staff through these programs.

The AIHW became a member of the AND in April 2019. AND provides support, conducts training, shares knowledge and resources and facilitates networking opportunities to assist organisations in becoming a disability-confident employer. Through our membership with AND we have participated in employment initiatives which provide opportunities for people with a disability to gain meaningful employment.

The AIHW monitors and evaluates its equal employment opportunity policies by comparing itself against other agencies that similarly contribute information on diversity to the APSC's annual State of the Service report to the Parliament of Australia. The AIHW is comparable with other APS agencies; however, notably in relation to equal employment opportunity, it has a higher than average proportion of female employees.

The AIHW has not received any ministerial directions about its performance obligations under the EEO Act.

Employment frameworks

As at 30 June 2019, all non-SES APS staff were employed under our EA. Nine SES staff members were employed under common law contracts.

Enterprise Agreement

Our EA outlines the terms and employment conditions of non-SES employees. The current EA commenced on 19 October 2016 and has a nominal expiry date of 18 October 2019.

Remuneration

Salary ranges based on classification level from our current EA are shown in Table 5.7. The AIHW's remuneration arrangements do not provide access to, or include, performance pay.

Table 5.7: EA salary range for APS and EL employees, 30 June 2019

	Salary points (\$)	
	Lowest	Highest
APS 1	44,670	50,111
APS 2	51,945	56,900
APS 3	59,078	64,640
APS 4	66,218	71,719
APS 5	73,824	79,073
APS 6	82,801	91,534
EL 1	101,275	112,974
EL 2	123,941	139,288

Individual flexibility arrangements

Our EA contains provisions for flexible arrangements to enable tailoring of remuneration and conditions for individual employees in particular circumstances. As at 30 June 2019, 1 non-SES staff had individual flexibility arrangements in place.

SES terms and conditions

The terms and conditions of employment for SES staff, including remuneration, are contained in common law contracts. They provide for salary entitlements and non-salary benefits relating to leave arrangements and entitlements, superannuation, salary sacrifice, travel and allowances.

At 30 June 2019, the ranges within which the CEO could set salaries were \$169,777 to \$198,305 for SES Band 1 and \$220,000 to \$244,000 for SES Band 2 (see Table A6.7).

Engaging with staff

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

Consultative Committee

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

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

The committee met 4 times in 2018–19. A key focus was discussion of proposed changes to a number of human resources policies, accommodation to support the increase in staff numbers and car-parking facilities.

Health and Safety Committee

We maintained a Health and Safety Committee during 2018–19 as required by ss.75–79 of the *Work Health and Safety Act 2011* (WHS Act). The committee facilitates cooperation between management and employees in initiating, developing and carrying out measures designed to ensure the health and safety of our people.

The committee met 4 times during the year and reviewed and supported the implementation of a new Work Health and Safety (WHS) Risk Register, Health and Safety Management Arrangements, WHS Policy and implementation of a Healthier Work Program. In addition, the committee supported health and safety arrangements for staff, following the relocation of a work group to a new building, and testing and tagging of electrical and fire safety equipment.

Learning and Development Advisory Committee

This committee provides strategic direction for, and enables staff input to, the planning and delivery of the learning and development program and initiatives. The committee comprises representatives from each group. The committee met 3 times during 2018–19

and discussed the implementation and subsequent review of the Learning and Development Strategy, development of specific technical training to support current and future work programs, the efficient use of the learning management system, and delivery of training to staff located in Sydney.

Social Club

Our active Social Club coordinates social activities and events to help foster a positive and collaborative workplace environment. The club comprises members that include a senior executive sponsor and staff from the latest graduate intake. Members take the lead in organising the annual staff Christmas party and other events.

Corporate social responsibility

We continued to foster stakeholder partnerships and engage with community organisations. We recognise the importance of giving back to the community by holding a range of events throughout the year to raise funds for charities. All staff are encouraged to support the Australian Red Cross Blood Service. Under our EA, staff have approved time off work to donate blood without needing to use leave.

A number of fundraising events were held during the year to support a range of local and national charities, including Karinya House, the Winter Coat Project, Cancer Council Relay for Life, RSPCA Giving Tree, Smith Family Toy and Book Appeal, AIDS Action Council, Pegasus, Wear it Purple Day and Jeans for Genes Day.

We promote major health and welfare activities through Tellagraph, our internal noticeboard. Activities included: Movember; DonateLife Week; Dry July; Men's Health Week; R U OK Day; International Day Against Homophobia, Biphobia, Interphobia and Transphobia; World AIDS Day; White Ribbon Day and World Mental Health Day.

White Ribbon Workplace Accreditation



After an 18-month journey, the AIHW is now a White Ribbon Accredited Workplace. The world-first program focuses on gender

discrimination and domestic violence, and provides organisations with a structured framework to examine current policies, procedures, training and communication. We have established a new Family and Domestic Violence Policy and supporting material, delivered several awareness workshops to staff and managers, collaborated with external organisations and APS agencies to share information and ideas, and amended our leave guidelines to provide improved guidance for staff who may be affected by family or domestic violence.

We believe that all forms of violence are unacceptable, and acknowledge that both men and women can be victims and the positive role that men play alongside women in preventing violence against women.

Recognising and building expertise

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



Charles Hudson at the Australian National University's Employer Visits program

Staff qualifications

We value the professional capability of staff. At the end of June 2019, a high percentage of staff (76%) had tertiary qualifications and 43% had a postgraduate qualification, which includes graduate diplomas, masters and doctorates.

External study

A study assistance scheme is available to reimburse employees for approved courses of study for a recognised qualification relevant to their work. Nineteen staff received assistance for formal study. Areas of study included rehabilitation case management, social sciences, economics, statistics, public health, nutrition and dietetics, clinical psychology and business administration.

Corporate learning and development program

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

Our program of in-house training sessions complements on-the-job training and helps ensure that staff develop and maintain specialised knowledge and skills. We provided 169 in-house courses in 2018–19 (compared with 75 in 2017–18) as part of our corporate learning and development program. These courses were attended by 2,411 staff with many staff attending more than 1 course (compared with 1,073 in 2017–18). Our learning and development program continued to focus on learning activities related to our work, including technical training, written communication, report writing, statistical and data analysis, project management, leadership and WHS. In addition, we made a significant investment in the continued development of our middle- and senior-level managers with the EL 1 and EL 2 Leadership Programs. More than 120 staff have completed the programs.



AIHW Board member Simone Ryan speaking to staff as part of Mental Health Week

The AIHW also provided mandatory e-learning for all staff to complete, which covers content related to legislation or Australian Government guidelines, such as fraud awareness, privacy awareness, respectful workplaces, cultural awareness and WHS. Completion rates range from 70%–80% across the suite of modules. Staff were also provided with regular opportunities to attend other training courses, conferences and seminars relevant to their roles.

SAMAC conversations

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

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

Four conversations were held in 2018–19 at which the topics discussed included:

- machine-learning proof-of-concept project and beyond

- assessing re-identification risk
- enabling advanced spatial health research through industry academic partnership
- the Holly Index—a new set of people-centred spatial data resources and exploration tools.

Staff exchanges

In April 2018, we entered into a new MoU with CIHI for a further 5 years. Both organisations seek to provide for the reciprocal exchange of specialised knowledge about business practices and processes, the sharing of initiatives and the transfer of expertise, primarily through a 12-month exchange of employees.

The AIHW welcomed 2 CIHI employees on secondment to the AIHW and supported 1 AIHW staff member to undertake a secondment to CIHI’s office in British Columbia, Canada.

We also supported a staff member to undertake a 6-month secondment with the OECD, located in the OECD’s headquarters in Paris, France.

Encouraging work health and safety

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



AIHW staff participating in the ABS fun run

Initiatives and outcomes

We continued to focus on early prevention strategies. We introduced initiatives to raise knowledge and capabilities in managing WHS. Table 5.8 provides a summary of key WHS initiatives.

Table 5.8: Key WHS initiatives and staff participation, 2018–19

Initiative	Outcomes
Mini induction	All staff participate in a face-to-face mini induction within the first 2 weeks of commencement. This initiative includes an overview of WHS management and support services.
Workstation assessments	All staff, upon commencement (or request) are provided with a workstation assessment to mitigate the risk of ergonomic injury.
Mental health e-learning programs	Online learning modules on subjects such as managing mental health risks, mental health awareness and respectful workplaces.
Work Health and Safety (e-learning module)	70% of staff have completed this module.
Work Health and Safety for managers (e-learning module)	37% of managers have completed this module.
Wellbeing support	An intranet page detailing support services to assist all staff.
Executive Level 1 and Executive Level 2 Leadership Program	Modules to raise awareness and capability about WHS, resilience and mental health. More than 120 EL staff have participated in this program.
Mental Health Strategy	Continued to deliver programs associated with the Mental Health Strategy.
Mental Health Week and R U OK Day?	Hosted guest speakers in relation to mental health.
Workplace harassment contact officers	Maintained a network of officers.
White Ribbon Australia Accreditation	Obtained accreditation with White Ribbon Australia.
Employee Assistance Program	Staff utilisation rate: 11.4% (for 1 March 2018 to 28 February 2019).
Flu vaccinations	295 vaccinations were administered to 59% of total active staff and contractors.
Discounted gym membership	70 staff are current members.
Yoga and meditation	These are programs managed by staff.
Cultural appreciation	5 courses, 78 attendees.
Cultural awareness (e-learning module)	73% of staff have completed this module.

Rehabilitation management system self-assessment

As the AIHW is considered a 'low-risk' agency, consistent with Comcare's Guidelines for Rehabilitation Authorities 2012, an annual audit was not required. We continue to meet the applicable criteria of the rehabilitation management system and conform with the guidelines.

Incidents and compensation

No compensation claims were lodged with Comcare in 2018–19. Table 5.9 shows an overview of claims lodged since 2015–16.

Table 5.9: Compensation claims lodged with Comcare, 2015–16 to 2018–19

Year	Claims lodged	Claims accepted
2018–19	0	0
2017–18	3	2
2016–17	5	3
2015–16	5	3

Notifiable incidents and investigations

Under the WHS Act, we are required to notify Comcare when incidents occur that involve the death of a person, a serious injury or illness, or a dangerous incident.

No incidents were notified to Comcare during the year.

Workplace inspections, Comcare investigations and Comcare audits

Our Health and Safety Representatives and staff responsible for facilities carried out 4 workplace inspections. These inspections occur about a fortnight before Health and Safety Committee meetings to enable findings and recommendations to be considered and actioned. Issues notified were minor, such as the removal of trip hazards,

an audit of fire and safety equipment, and environmental measures, such as adjustments to the air conditioning and assessment of new work environments.

No investigations by Comcare were conducted in 2018–19 and no directions, notices, offences or penalties were served under the WHS Act.

An audit of our work health and safety management system was conducted by Comcare in August 2017. The AIHW was found to be highly compliant in the practical management of all WHS functions. Improvements identified included documenting formal processes, an annual review of policies and the development of new initiatives such as a WHS Risk Register. All improvements requiring action were finalised in 2018–19 to ensure we were compliant.

Accommodation

We operated from 2 office buildings in Canberra: 1 Thynne Street, Bruce (T1) and 26 Thynne Street, Bruce (T26).

We are in the fifth year of a 15-year lease on a purpose-built 3-storey building at T1 and the first year of a 3-year lease at T26.

T1 is designed to achieve a 4.5-star National Australian Built Environment Rating System (NABERS) rating.

Our Sydney-based office is in the second year of a 3-year lease and continued to operate from Level 9, 1 Oxford Street, Darlinghurst. This office space accommodates up to 35 staff.

Tables 5.10 and 5.11 provide more information on our efforts to reduce our impact on the environment.

Table 5.10: Ecologically sustainable development reporting, 30 June 2019

Reporting area	Activities undertaken by the AIHW
Legislation administered during 2018–19 accords with the principles of ecologically sustainable development	The AIHW does not administer this legislation.
The effect of the AIHW's activities on the environment	Our key environmental impacts relate to the consumption of energy and goods, and waste generated in the course of business activities. Table 5.11 includes available information on energy consumption and waste recycling.
Measures taken to minimise the impact of AIHW activities on the environment in our main office in Canberra	<p>Provision of amenities for staff who ride bicycles to work.</p> <p>Use of energy-efficient lighting, including the installation of light-emitting diode lighting in selected areas.</p> <p>Purchasing 10% GreenPower electricity.</p> <p>Purchasing only energy-efficient equipment that is Energy Star compliant.</p> <p>'Shutting-down' multifunctional devices when they are left idle for long periods.</p> <p>Movement-activated lighting that turns off after 20 minutes of no movement being detected.</p> <p>Double-glazed windows to increase the efficiency of heating and cooling.</p> <p>Installation of a modern, efficient air-conditioning system.</p> <p>Installation of a rainwater tank system to supply the toilets, urinals and external taps.</p> <p>Recycling of toner cartridges and paper.</p> <p>Purchasing paper with at least 50% recycled content for printing and copying.</p> <p>Re-use of stationery items such as ring binders.</p> <p>Recycling bins in kitchens for collection of organic waste for worm farming.</p> <p>Printing of our publications using 'print-on-demand' processes using paper sourced from sustainably managed, certified forests in accordance with ISO14001 Environmental Management Systems and ISO9001 Quality Management Systems.</p> <p>Trialling the provision of soft plastic disposal, an initiative managed by staff.</p>
Mechanisms for reviewing and improving measures to minimise the impact of the AIHW on the environment	We worked to comply with benchmark environmental impact indicators at 1 Thynne St, which is designed to achieve a 4.5-star NABERS rating.

Table 5.11: Electricity and paper consumption and recycled waste, 2014–15 to 2018–19

	2014–15	2015–16	2016–17	2017–18	2018–19
Electricity consumption					
Canberra office (kilowatt hours, as office tenant light and power) ^(a)	630,093	689,494	701,147	794,091	725,447
Sydney office	..	..	69,238	63,345	35,548
Paper consumption (reams)					
Canberra office	1620	1605	1927	2375	1657
Sydney office	..	..	55	50	25
Recycled waste					
Organics from kitchens (tonnes) ^(b)	2.5	2.3	2.3	2.6	3.3
Toner cartridges Canberra (number)	74	81	70	118	73
Toner cartridges Sydney office	..	..	8	4	4

.. not applicable.

(a) Office air-conditioning is metered to the base building while light and power are separately metered.

(b) Figures are for all 3 offices.

Government greenhouse and energy reporting

The Australian Government's Energy Efficiency in Government Operations policy helps government agencies to identify opportunities to save energy. We are required to comply with the policy because we derive more than half the funds for our operations from the Australian Government, either directly or indirectly.

The policy requires agencies to comply with certain minimum energy performance standards, including that eligible new leases contain a Green Lease Schedule with at least a 4.5-star NABERS energy requirement. The lease agreement for our main Canberra office at T1 meets this requirement. The Sydney and T26 offices are exempt from this policy as the area leased is less than 2,000 square metres.

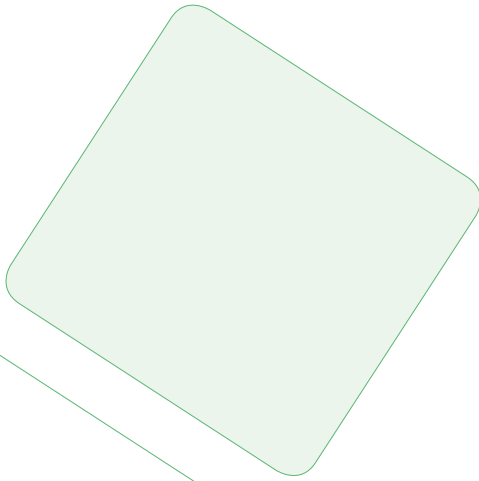
Ecological sustainable development

We uphold the principles of ecologically sustainable development outlined in the *Environment Protection and Biodiversity Conservation Act 1999* and are committed to making a positive contribution to achieving its objectives (see tables 5.10 and 5.11). Section 516A(6) of this Act requires us to report on environmental matters, including ecologically sustainable development.

We continued to manage our toner cartridge recycling and use of paper through central printing pools, increased use of our online project management system and increased staff use of a redeveloped intranet site. In addition, we utilised an e-Recruit system which assists in reducing paper consumption. EL staff and staff working from T26 were allocated tablets to reduce the requirement to print documents and create a more mobile workforce. We are also reducing the volume

of paper-based publications and transitioning content to online platforms. In 2018–19, we consumed our lowest volume of toner and paper in the last 3 financial years, while staffing numbers have increased by almost 40%. We are progressing with plans to support broader Australian Government initiatives in relation to digital transition, which will see a further reduction in toner and paper consumption.

We collected 3.3 tonnes of organic waste, the highest volume in the past 5 years, as part of our green initiative. This waste was subsequently fed to worms and recycled into organic fertiliser by an external provider.



Appendix 1: Products, journal articles and presentations

Products

We published 181 products in 2018–19.

We released 109 print and/or print-ready publications and 72 web products, including new and updated web snapshots, dynamic data displays and reports in HTML format. Web versions of print products are not included in these figures to avoid double counting.

All print-ready publications are available free of charge on our website as accessible PDF documents. Increasingly, key publications are being made available in HTML format. Users are invited to contact us if they need information from the website presented in an alternative format for accessibility reasons.

Printed copies of our 2 flagship products, *Australia's health* and *Australia's welfare*, can be purchased online. Other publications can be printed on demand, at a cost to the customer. Some printed publications, such as the AIHW annual report series, are available free of charge. For further details about obtaining our products, see www.aihw.gov.au/publications.

Adoptions

Adoptions Australia 2017–18

Adoptions Australia data visualisations (web)

Ageing and aged care

GEN—Aged Care Data: Aboriginal and Torres Strait Islander Australians using aged care (web)

GEN—Aged Care Data: Admissions into aged care (web and fact sheet)

GEN—Aged Care Data: Commonwealth Home Support Programme (CHSP) (web and fact sheet)

GEN—Aged Care Data: Government spending on aged care (web and fact sheet)

GEN—Aged Care Data: My aged care region (web and fact sheet)

GEN—Aged Care Data: People leaving aged care (web and fact sheet)

GEN—Aged Care Data: People using aged care (web and fact sheet)

GEN—Aged Care Data: People's care needs in aged care (web and fact sheet)

GEN—Aged Care Data: Services and places in aged care (web and fact sheet)

Older Australia at a glance 2017 (web)

Alcohol and other drug treatment services

Aboriginal and Torres Strait Islander health organisations: alcohol and other drug treatment services (web)

Alcohol and other drug treatment services in Australia 2017–18: key findings (web)

Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment 2016–17

Alcohol, tobacco and other drugs in Australia (web)

Alcohol, tobacco and other drugs in Australia update (web)

Drug related hospitalisations (web)

National Opioid Pharmacotherapy Statistics Annual Data collection (NOPSAD) 2018–19 (web)
 Opioid harm in Australia: and comparisons between Australia and Canada
 Specialist homelessness services: drug and alcohol related issues (web)

Arthritis and musculoskeletal conditions

Hip fracture incidence and hospitalisations in Australia 2015–16
 Musculoskeletal conditions and comorbidity in Australia

Burden of disease

Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015—summary report
 Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015
 Australian Burden of Disease Study 2015: interactive data on disease burden (web)
 Australian Burden of Disease Study: methods and supplementary material 2015
 Impact of risk factors on the burden of disease in Australia (web)

Cancer

Analysis of breast cancer outcomes and screening behaviour for BreastScreen Australia
 Analysis of cancer outcomes and screening behaviour for national cancer screening programs in Australia
 BreastScreen Australia data dictionary: version 1.2
 BreastScreen Australia monitoring report 2018
 Cancer compendium: information and trends by cancer type (web)
 Cancer data in Australia (web)
 Cancer in Australia 2019
 Cancer in Australia 2019: in brief
 Cervical screening in Australia 2019
 Colorectal and other digestive-tract cancers
 Mesothelioma in Australia 2017
 National Bowel Cancer Screening Program: monitoring report 2019
 National cancer screening programs participation data (web)

Cardiovascular disease

Acute rheumatic fever and rheumatic heart disease 2016–17 (web)
 Cardiovascular disease in Australian women: a snapshot of national statistics
 Transition between hospital and community care for patients with coronary heart disease: New South Wales and Victoria 2012–2015

Child protection

Child protection Australia 2017–18
 Children’s Headline Indicators 2017–18 (web)
 National Framework for the Protection of Australia’s Children 2018–19 (web)
 The views of children and young people in out-of-home care: overview of indicator results from second national survey, 2018

Chronic diseases

A collaborative approach to national surveillance for respiratory epidemics, including thunderstorm asthma epidemics

A scoping study on data sources to assess the impact of chronic respiratory and musculoskeletal conditions on workplace productivity

Chronic conditions and disability 2015

Chronic conditions 2017–18 (web)

Chronic kidney disease prevalence among Australian adults over time

Indicators of socioeconomic inequalities in cardiovascular disease, diabetes and chronic kidney disease

Using PBS and MBS data to report on the treatment and management of chronic respiratory conditions 2016–17

Corporate publications

Australian Institute of Health and Welfare Annual report 2017–18

Australian Institute of Health and Welfare Corporate Plan 2018–19 to 2021–22

Reconciliation Action Plan 2018–2020

Data standards

ICD-11 Review Pre-consultation paper

Deaths

General Record of Incidence of Mortality (GRIM) data update (web)

Mortality Over Regions and Time (MORT) books data update (web)

Dental health

Oral health and dental care in Australia (web)

Oral health and dental care in Australia update (web)

Diabetes

Diabetes indicators for the Australian National Diabetes Strategy 2016–2020 (web)

Diabetes in pregnancy 2014–2015

Improving national reporting on diabetes in pregnancy: technical report

Incidence of insulin-treated diabetes in Australia (web and fact sheet)

Disability

Disability support services: services provided under the National Disability Agreement 2017–18

Experiences of people with disability in Australia (web)

Domestic violence

Family, domestic and sexual violence in Australia: continuing the national story 2019

Expenditure

Australia's health expenditure: an international comparison

Disease expenditure in Australia (web)

Disease Expenditure Study: overview of analysis and methodology 2015–16

Health expenditure Australia 2016–17

Health expenditure Australia 2016–17 (web)

Food and nutrition

Nutrition across the life stages

Health indicators

A potentially preventable hospitalisation indicator specific to general practice

Radiotherapy in Australia 2016–17 (web)

Homelessness

Couch surfers: a profile of Specialist Homelessness Services clients

People in short-term or emergency accommodation: a profile of Specialist Homelessness Services clients

Sleeping rough: a profile of Specialist Homelessness Services clients

Specialist homelessness services 2017–18: Australian Capital Territory

Specialist homelessness services 2017–18: New South Wales

Specialist homelessness services 2017–18: Northern Territory

Specialist homelessness services 2017–18: Queensland

Specialist homelessness services 2017–18: South Australia

Specialist homelessness services 2017–18: Tasmania

Specialist homelessness services 2017–18: Victoria

Specialist homelessness services 2017–18: Western Australia

Specialist homelessness services collection 2017–18 (SAS data cubes) (web)

Specialist homelessness services (SHS) annual report 2017–18 (web)

Hospitals

Admitted Patient Care 2017–18: Australian hospital statistics (web)

Admitted patient care 2017–18: Australian hospital statistics data cubes (web)

Bloodstream infections associated with hospital care 2017–18: Australian hospital statistics (web)

Elective surgery waiting times 2017–18: Australian hospital statistics (web)

Emergency department care 2017–18: Australian hospital statistics (web)

Hospital resources 2017–18: Australian hospital statistics (web)

Non-admitted patient care 2017–18: Australian hospital statistics (web)

Housing

Aboriginal and Torres Strait Islander people: a focus report on housing and homelessness

National Social Housing Survey 2018: key results

Indigenous health and welfare

Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018

Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018: in brief

Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2016–17

Aboriginal and Torres Strait Islander Stolen Generations aged 50 and over

Aboriginal and Torres Strait Islander Stolen Generations and descendants: numbers, demographic characteristics and selected outcomes

Better Cardiac Care measures for Aboriginal and Torres Strait Islander people: third national report 2017
Children living in households with members of the Stolen Generations
Improving Indigenous identification in mortality estimates
Indigenous health check data tool 2019 (web)
Insights into vulnerabilities of Aboriginal and Torres Strait Islander people aged 50 and over: in brief
National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results for 2017
Northern Territory Outreach Hearing Health Program: July 2012 to December 2017
Northern Territory Remote Aboriginal Investment: Oral Health Program July 2012 to December 2017
Regional variation in uptake of Indigenous health checks and in preventable hospitalisations and deaths
Tracking progress against the Implementation Plan goals for the Aboriginal and Torres Strait Islander Health Plan 2013–2023 (web)

Injury

Electrical injuries: hospitalisations and deaths 2014–15 and 2015–16
Hospitalised assault injuries among men and boys
Hospitalised injury among Aboriginal and Torres Strait Islander people 2011–12 to 2015–16
Hospitalised injury due to land transport crashes
Injury of Aboriginal and Torres Strait Islander people due to transport, 2010–11 to 2014–15
Mobility scooter-related injuries and deaths
Pedal cyclist deaths and hospitalisations, 1999–00 to 2015–16
Spinal cord injury Australia 2015–16
Trends in injury deaths, Australia: 1999–00 to 2014–15
Use of emergency department data to improve routine injury surveillance: technical report 2013–14

Life expectancy

International health data comparisons 2018

Mental health

Mental health services in Australia: in brief 2018
Mental health services in Australia—tranche 3, 2018 (web)
Mental health services in Australia—tranche 4, 2018 (web)
Mental health services in Australia—tranche 5, 2018 (web)
Mental health services in Australia—tranche 1, 2019 (web)
Mental health services in Australia—tranche 2, 2019 (web)

Mothers and babies

Australia's mothers and babies 2016: data visualisations (web)
Australia's mothers and babies 2016—in brief

Australia's mothers and babies 2017 data visualisations (web)
 Australia's mothers and babies 2017—in brief
 Child and maternal health in 2014–2016 (web)
 Maternal deaths in Australia 2016 (web)
 National Core Maternity Indicators (web)
 Perinatal National Minimum Data Set compliance evaluation 2010–2015
 Resources for supporting psychosocial health in pregnancy (web)
 Resources for supporting psychosocial health in pregnancy update (web)

MyHealthyCommunities

Life expectancy and potentially avoidable deaths in 2014–2016 (web)
 Patient experiences in Australia in 2016–17 (web)
 Patients' out-of-pocket spending on Medicare services 2016–17

My Hospitals

MyHospitals: Costs of acute admitted patients in public hospitals from 2012–13 to 2014–15
 MyHospitals: Healthcare-associated *Staphylococcus aureus* bloodstream infections in public and private hospitals in 2017–18 (web)
 MyHospitals: Time spent in emergency departments in 2017–18 (web)
 MyHospitals: Waiting times for elective surgery in 2017–18 (web)

Overweight and obesity

Data sources for monitoring overweight and obesity in Australia

Palliative care

Palliative care services in Australia—tranche 2, 2018 (web)
 Palliative care services in Australia—tranche 1, 2019 (web)

Population health

Coordination of health care: experiences with GP care among patients aged 45 and over 2016
 Coordination of health care study: use of health services and medicines, Australia, 2015–16
 Physical activity across the life stages
 Physical activity during pregnancy 2011–12
 The health of Australia's females (web)
 The health of Australia's males (web)
 Towards estimating the prevalence of female genital mutilation/cutting in Australia

Primary health care

National primary health care data asset: data development plan
 Potentially preventable hospitalisations by condition and age group 2016–17 (web)
 Potentially preventable hospitalisations in Australia by small geographical areas (web)
 Vaccine-preventable diseases fact sheets

Prisoner health

The health of Australia's prisoners 2018

Veterans

A profile of Australia's veterans 2018

Causes of death among serving and ex-serving Australian Defence Force personnel 2002–2015

Development of a veteran-centred model: a working paper

National suicide monitoring of serving and ex-serving Australian Defence Force personnel: annual update 2018 (web)

Youth justice

Overlap between youth justice supervision and alcohol and other drug treatment services: 1 July 2012 to 30 June 2016

Young people in child protection and under youth justice supervision: 1 July 2013 to 30 June 2017

Young people returning to sentenced youth justice supervision 2016–17

Youth detention population in Australia 2018

Youth justice in Australia 2017–18

Youth justice in the Australian Capital Territory 2017–18

Youth justice in New South Wales 2017–18

Youth justice in the Northern Territory 2017–18

Youth justice in Queensland 2017–18

Youth justice in South Australia 2017–18

Youth justice in Tasmania 2017–18

Youth justice in Victoria 2017–18

Youth justice in Western Australia 2017–18

Journal articles

Griffiths K, Coleman C, Al-Yaman F, Cunningham J, Garvey G, Whop L et al. 2019. The identification of Aboriginal and Torres Strait Islander people in official statistics and other data: critical issues of international significance. *Statistical Journal of the International Association for Official Statistics* 35(1):91–106. doi.org/10.3233/SJI-180491.

Hsu B, Bleicher K, Waite LM, Naganathan V, Blyth FM, Handelsman DJ et al. 2018. Community-dwelling older men with dementia are at high risk of hip fracture, but not any other fracture: The Concord Health and Aging in Men Project. *Geriatrics and Gerontology International* 18(10):1479–84. doi.org/10.1111/ggi.13516.

Kilkenny MF, Kim J, Andrew NE, Sundararajan V, Thrift AG, Katzenellenbogen JM et al. 2019. Maximising data value and avoiding data waste: a validation study in stroke research. *Medical Journal of Australia* 210(1) 27–31. doi: 10.5694/mja2.12029.

Mashford-Pringle A, Ring I, Al-Yaman F, Waldon J & Chino M 2019. Rethinking health services measurement for Indigenous populations. *Statistical Journal of the International Association for Official Statistics* 35(1):139–46. doi.org/10.3233/SJI-180465.

Moon L, Garcia J, Laws P, Dunford M, Lum On M, Bishop K et al. 2019. Measuring health loss in Australia: the Australian Burden of Disease Study. *Journal of Korean Medical Science* 34(Suppl1):e61. doi.org/10.3346/jkms.2019.34.e61.

Peel R, Ren S, Hure A, Evans T-J, D'Este CA, Abhayaratna WP et al. 2019. Evaluating recruitment strategies for AUSPICE, a large Australian community-based randomised controlled trial. *Medical Journal of Australia* 210(9) 409–15. doi: 10.5694/mja2.50117.

Tibble H, Law HD, Spittal MJ, Karmel R, Borschmann R, Hail-Jaresa K, Thomas LA & Kinner SA 2018. The importance of including aliases in data linkage with vulnerable populations. *BMC Medical Research Methodology* 18:76. doi: 10.1186/s12874-018-0536-4.

Presentations

Al-Yaman F 2018. Access to and provision of community level data and building community capacity to collect the data and utilise it to progressively improve suicide prevention programs. Invited speaker at the 2nd National Aboriginal and Torres Strait Islander Suicide Prevention Conference, Perth, 20 November.

Al-Yaman F 2018. Cultural safety monitoring framework. Presentation to the Implementation Plan Advisory Group, Canberra, 25 September & 12 December; National Aboriginal and Torres Strait Islander Health Standing Committee, Brisbane, 10 April 2019.

Al-Yaman F 2019. Introduction to the AIHW. Presentation to the National Congenital Anomalies Advisory Group, Sydney, 6 March.

Al-Yaman F & Dugbaza T 2018. AIHW life table methodology. Presentation at the Aboriginal and Torres Strait Islander Demographic and Statistics Expert Advisory Group meeting, Australian Bureau of Statistics, Canberra, 5 July.

Al-Yaman F & Howle T 2019. The importance of good quality data. Presentation at the 2019 Queensland Aboriginal and Islander Health Council Data Systems and Reports Workshop, Cairns, 4 April.

Anderson P 2018. Data linkage to national Australian health insurance data to investigate exposure to environmental hazards: the example of residential asbestos. Presentation at the International Population Data Linkage Conference, Banff, Canada, 12–14 September.

Ashe G 2019. Challenges and solutions in the hybrid/multi-cloud world. Presentation at the Singapore OpenGov Leadership Forum 2019, Singapore, 16 May.

Bayliss T 2018. Leading causes of death among serving and ex-serving ADF personnel. Poster presented at the Annual Scientific Meeting of the Australasian Epidemiological Association, Fremantle, 22–24 October.

Bayliss T 2018. Monitoring suicide rates with linked data: findings from a study of Australian Defence Force personnel. Presentation at the Australasian Vital Statistics Interest Group workshop, Sydney, 21 November.

Bayliss T & Grange N 2018. Leading causes of death and suicide monitoring among serving and ex-serving ADF personnel. Presentation at the Australian Military Medicine Association Conference, Canberra, 12–14 October.

Bennett V 2018. Harnessing eHealth for improved health service delivery in the western Pacific region. Presentation at the Health Information Management Association of Australia Conference, Hobart, 31 October–2 November.

Bennett V 2019. Discovering the potential of Australia's first person-centric health data set. Presentation at the Health Informatics and Knowledge Management Conference, Sydney, 29–30 January.

- Budd A, Meere D, Rompotis C, Bartlett N & Harvey J 2018. Analysis of mortality outcomes for national cancer screening programs. Presentation at the Annual Scientific Meeting of the Australasian Epidemiological Association, Fremantle, 22–24 October.
- Budd A, Meere D, Rompotis C, Bartlett N & Harvey J 2018. Cancer and screening data linkage. Presentation at the Annual Scientific Meeting of the Australasian Epidemiological Association, Fremantle, 22–24 October.
- Connell E, Bartlett N, Ranjithakumaran, Wong H, Harvey J & Moon L 2018. Statistics on gastrointestinal cancers diagnosed in Australia. Poster presented at the Clinical Oncology Society of Australia Annual Scientific Meeting, Perth, 13–15 November.
- Cooper-Stanbury M 2018. Defining and mapping the aged care data universe. Presentation to the Melbourne Ageing Research Collaboration, Melbourne, 20 July.
- Cooper-Stanbury M 2018. Dependency trends in Australia. Presentation at the 4th International Conference on Long Term Care Directors and Administrators, Sydney, 1–3 August.
- Cooper-Stanbury M 2018. GEN—Aged Care Data. Practical workshop conducted in association with the 51st Australian Association of Gerontology Conference, Melbourne, 20 November.
- Cooper-Stanbury M 2018. Navigating the aged care data minefield. Presentation at the 51st Australian Association of Gerontology Conference, Melbourne, 23 November.
- de Looper M 2019. Indicators of socioeconomic inequalities in chronic diseases. Presentation at the Public Health Prevention Conference 2019, Melbourne, 12–14 June.
- Dixon T 2019. The burden of vaccine preventable diseases in Australia. Presentation to the Communicable Disease Network Australia and the Australian Technical Advisory Group on Immunisation, Canberra, 13 June.
- Dugbaza T 2019. Developing life tables for the Indigenous population: a journey in learning. Presentation at the Australian National University School of Demography Seminar, Canberra, 11 June.
- Dunford M & Prescott V 2018. Burden of Disease workshop: maximising the use of data to generate policy-relevant evidence. Presentation/workshop at the Annual Scientific Meeting of the Australasian Epidemiological Association, Fremantle, 22–24 October.
- Dunford M & Prescott V 2018. Introduction to burden of disease. Presentation at the Annual Scientific Meeting of the Australasian Epidemiological Association Conference, Fremantle, 22–24 October.
- Edvardsson M 2019. Access to GPs relative to need—ARN index. Presentation to the Implementation Plan Advisory Group, Canberra, 8 March.
- Edvardsson M 2019. Indigenous health checks and follow ups. Presentation at the Aboriginal and Torres Strait Islander Health Services Data Advisory Group Meeting, Canberra, 13 June.
- Garcia J, Prescott, V & Thomson J 2019. Burden of disease and health expenditure in Australia: Australian Burden of Disease Study 2015. Presentation at the Public Health Prevention Conference, Melbourne, 12–14 June.
- Grange N 2018. Incidence of suicide in Australian Defence Force Personnel: 2001–2016. Presentation at the Annual Scientific Meeting of the Australasian Epidemiological Association, Fremantle, 22–24 October.
- Grange N 2019. Incidence of suicide in among serving and ex-serving ADF personnel. Presentation at the Royal Australian and New Zealand College of Psychiatrists Congress, Cairns, 12–16 May.

- Guo S 2018. Deaths among people with diabetes in Australia, 2009–2014. Presentation at the Australasian Diabetes Congress 2018, Adelaide, 22–24 August.
- Hargreaves J 2018. Australian Institute of Health and Welfare: governance of secondary use of electronic health records. Presentation to Canada Health Infoway, Toronto, Canada, 10 October.
- Hargreaves J 2018. Coded data and national health statistics. Presentation at the National Centre for Classification in Health National Conference, Hobart, 1 November.
- Hargreaves J 2018. Data governance at the Australian Institute of Health and Welfare. Presentation at the Canadian Institute for Health Information Privacy Seminar, Toronto, Canada, 11 October.
- Hargreaves J 2018. Secondary use of My Health Record data. Presentation to Positive Life NSW, Sydney, 31 July.
- Hargreaves J 2018. Towards national patient-centred health information and statistics. Presentation to the Australian Pharmaceutical medical and scientific Pharmaceutical Professionals Association, Sydney, 6 December.
- Hargreaves J 2019. Australian health data—moving towards: patient-centred health information, ICD-11 and National Health Information Strategy. Presentation to the Danish Health Data Authority, Copenhagen, Denmark, 2 April.
- Hargreaves J, Macpherson B & Katte J 2018. ICD-11 MMS field testing for morbidity: phase 3 preliminary findings from Australia. Presentation to the World Health Organization Family of International Classifications Network Annual Meeting, Seoul, South Korea, 25 October.
- Harrison J & Jellie C 2019. Injury in Australia. Presentation at the National Injury Prevention Strategy Round Table consultation, Sydney, 18 March; Melbourne, 26 March.
- Howle T & Dangol P 2018. The Indigenous adolescent and youth health and wellbeing report: findings. Presentation at the 2018 Youth Health Conference, Surfers Paradise, 8 November.
- Hunt A 2018. Improving domestic violence information in national hospitals data. Presentation at the International Domestic Violence and Health Conference 2018, Melbourne, 21–22 November.
- James M 2018. Advancing your data and analytics strategy. Panellist at the 3rd Annual Cloudera Government Data & Analytics Forum, Canberra, 4 December.
- James M 2018. Balancing open data networks with the need to protect sensitive data. Presentation at the Evidence Based Policy Summit, Canberra, 25–28 September.
- James M 2018. Data services transformation. Presentation at the 7th Annual GovInnovate Summit, Canberra, 9 October.
- James M 2018. Health and social data—the central role that people’s health and well-being play in social cohesion and community change. Presentation at the Health Information Conference, Sydney, 30 July.
- James M 2019. Data, evidence and policy. Presentation at the 12th Policy Professionals Summit, Canberra, 26 June.
- James M 2019. Embedding activity in the policy context. Panellist at the Black Dog National Suicide Prevention Symposium, Canberra, 21 May.
- Jones S 2018. A retrospective, prospective data linkage study. Poster presented at the Annual Scientific Meeting of the Australasian Epidemiological Association, Fremantle, 22–24 October.
- Juckles R 2018. The burden of disease and injury on working age Australians. Presentation at the Comcare National Conference, Melbourne, 18–19 September.

- Juckes R & Moon L 2018. The burden of disease and injury on working age Australians. Presentation at the Comcare National Conference, Melbourne, 18–19 September.
- Kerrigan J 2018. Comparing opioid harms in Australia and Canada. Poster presented at the APSAD (Australasian Professional Society on Alcohol and other Drugs) Scientific Alcohol and Drug Conference, Auckland, New Zealand, 4–7 November.
- Kerrigan J 2018. Physical activity. Presentation at the Movement to Move: Global Insights to Get Our Kids Moving event, Adelaide, 26–29 November.
- Kerrigan J 2019. Patient reported information continuity between providers. Presentation at the Public Health Prevention Conference, Melbourne, 12–14 June.
- Leake M 2019. Suicide prevention in the Australian Defence Force. Presentation at the Suicide Prevention in Australia: Challenges and Strategies workshop, Canberra, 5 February.
- Lee-Koo C & Barker S 2018. The Australian Mesothelioma Registry. Poster presented at the Clinical Oncology Society of Australia Annual Scientific Meeting, Perth, 13–15 November.
- Lum On M 2019. An overview of the framework to guide the secondary use of the My Health Record system data in Australia. Presentation at the Meeting on Strengthening Health Information Systems for Sustainable Development Goals and Universal Health Care Monitoring in the Western Pacific Region, Manila, Philippines, 22–24 January.
- Lum On M 2019. Cardiovascular disease in women—a snapshot of national statistics. Presentation at the Women and Heart Disease Forum, Sydney, 19 June.
- Lum On M 2019. Data quality practices at the Australian Institute of Health and Welfare. Presentation at the Meeting on Strengthening Health Information Systems for Sustainable Development Goals and Universal Health Care Monitoring in the Western Pacific Region, Manila, Philippines, 22–24 January.
- Macpherson B 2018. Considerations for the implementation of ICD-11 in Australia: the morbidity perspective. Presented to the Australian Vital Statistics Interest Group, Brisbane, 21 November.
- Moon L 2018. Improving dementia statistics to support research on dementia. Presentation at the NHMRC (National Health and Medical Research Council) National Institute for Dementia Research, National Dementia Epidemiology and Statistics Business Case Roundtable, Canberra, 23 November.
- Moon L & James M 2019. Recent trends in Australian suicide rates. Presentation at the Suicide Prevention in Australia: Challenges and Strategies workshop, Canberra, 5 February.
- Muecke S 2019. Working with the AIHW: Accessing data for linkage projects. Presentation at the AIHW Insights Workshop with external participants, Canberra, 27 February.
- Neideck G 2018. Data linkage and researcher access. Presentation at the Public Health Seminar, Melbourne, 26 July.
- Neideck G 2018. Expanding research possibilities to build an effective evidence base. Panel member at the Evidence Based Policy Summit, Canberra, 26–28 September.
- Neideck G 2018. National Master Linkage Key. Presentation at the Population Health Research Network Participant Council, Sydney, 26 October.
- Neideck G 2018. Balancing the safety and opportunities provided by national data system. Panel member at the FST Government Australia 2018, Canberra, 8 November.
- Neideck G 2019. Achieving true agility for a responsive government. Presentation at the 5th Australian Government Data Summit, Canberra, 19 March.

- Neideck G 2019. The AIHW: Data linkage, data infrastructure and its value to health economists. Presentation at the Research Australia Health Economics Roundtable, Sydney, 1 April.
- Neideck G 2019. Advancing your data and analytics strategy: Managing and making sense of all the data for actionable outcomes. Presentation at the 2019 Data Management and Analytics Roadshow, Canberra, 3 April.
- Neideck G 2019. Transforming your departmental operations by leveraging smart data and analytics strategies. Presentation at the Chief Data and Analytics Officer Public Sector 2019, Canberra, 8–9 May.
- Neideck G 2019. Digital transformation to support research and analysis. Presentation at the Singapore OpenGov Leadership Forum 2019, Singapore, 16 May.
- Neideck G & Booth M 2019. Data Integration at AIHW. Presentation at the AIHW Insights Workshop with external participants, Canberra, 27 February.
- Prescott V, Garcia J & Thomson J 2019. Australian Burden of Disease Study 2015 and associated health expenditure by disease results. Presentation at the Public Health Prevention Conference, Melbourne, 13 June.
- Reid R 2019. Presentation on who is over-represented in youth justice statistics. Presentation at the Australasian Youth Justice Conference, Sydney, 30 April–2 May.
- Sandison B 2018. Measuring progress of the Australian National Diabetes Strategy. Presentation at the National Diabetes Forum, Canberra, 15 October.
- Thomson J 2019. Disease expenditure in Australia. Presentation at the Public Health Prevention Conference 2019, Melbourne, 12–14 June.
- Thomson J 2019. Tracking pharmaceutical expenditure in Australia. Presentation at the 15th Annual Meeting of Asia-Pacific Health Accounts Experts, Seoul, South Korea, 26–28 March.
- Vu T 2018. CKD prevalence among Australian adults over time 1999–2000 and 2011–12. Presentation at the Australian and New Zealand Society of Nephrology Annual Scientific Meeting, Sydney, 10–12 September.
- Vu T 2018. Geographical variation in chronic kidney disease. Presentation at the Australian and New Zealand Society of Nephrology Annual Scientific Meeting, Sydney, 10–12 September 2018.
- Watson M & Evans E 2019. The health of rural and remote health Australians. Poster presented at the 15th National Rural Health Alliance Conference, Hobart, 24–27 March.
- Watters A 2019. Voices of children and young people in out-of-home care: what are they saying? Presentation at the 2019 Child Aware Conference, Brisbane, 16–17 May.
- Xu D 2019. Coordination of health care study—barriers to health care access among people 45 years and over. Poster presented at the 2019 Patient Experience Symposium, Sydney, 29–30 April.
- York L 2018. Every Child Workshop. Panellist at the 15th Biennial AIFS Conference, Melbourne, 25–27 July.
- York L, Ritson A, Phillips B & Harding A 2019. Headline results from the 2018 Prisoner Health Survey. Presentation at the Justice Health Conference, Sydney, 9–10 April.

Appendix 2: Meeting attendance—AIHW Board and AIHW Ethics Committee, and outgoing members

Table A2.1: Attendance at AIHW Board meetings

Name	Position	Meetings attended	Eligible meetings
Mrs Louise Markus	Chair	4	4
Dr Erin Lalor	Deputy Chair	4	4
Mr Barry Sandison	CEO/Executive director	4	4
Mr Michael Perusco	Non-executive director	3	4
Dr Zoran Bolevich	Non-executive director	3	4
Ms Marilyn Chilvers	Non-executive director	4	4
Ms Christine Castley	Non-executive director	2	3
Dr Simone Ryan	Non-executive director	3	4
Dr Christine Pascott	Non-executive director	2	3
Mr Romlie Mokak	Non-executive director	2	3
Ms Cathryn Ryan	Non-executive director	3	3
Ms Christine Gee	Non-executive director	2	3
Ms Caroline Edwards	Nominee of the Health Secretary ^(a)	1	1
Ms Luise McCulloch	Nominee of the Australian Statistician ^(a)	1	1
Mr Andrew Goodsall	Nominee of the Minister ^(a)	1	1
Mr David Conry	Member with knowledge of the needs of consumers of welfare services ^(a)	1	1
Ms Marissa Veld	Staff elected member ^(a)	1	1

(a) Position expired upon the commencement of the amended AIHW Act on 27 November 2018.

Outgoing members of the AIHW Board in 2018–19

Ms Caroline Edwards

Nominated by the Secretary,
Department of Health
Non-executive Director

Term: Ex-officio appointment from
24 November 2017–27 November 2018

Ms Luise McCulloch

Nominated by the Australian Statistician
Non-executive Director

Term: Ex-officio appointment from
4 August 2016–27 November 2018

Ms Marissa Veld

Staff elected member
Non-executive Director

Terms: 26 May 2017–25 May 2018;
26 May 2018–27 November 2018

Mr David Conry

Member with knowledge of the needs of
consumers of welfare services
Non-executive Director

Terms: 19 December 2014–30 June 2015; 1 July
2015–18 December 2015; 18 January 2016–17
January 2017; 19 January 2017–18 January 2018;
19 January 2018–18 April 2018; 19 April 2018–
30 June 2018; 1 July 2018–30 September 2018

Mr Andrew Goodsall

Nominee of the Minister
Non-executive Director

Terms: 19 December 2014–30 June 2015; 1 July
2015–18 December 2015; 18 January 2016–17
January 2017; 19 January 2017–18 January 2018;
18 January 2018–18 April 2018; 19 April 2018–
30 June 2018; 1 July 2018–30 September 2018

Table A2.2: Attendance at Remuneration committee meetings

Name	Position	Meetings attended	Eligible meetings
Mrs Louise Markus	Chair	2	2
Mr Michael Perusco	Member	2	2
Dr Christine Pascott	Member	1	2

Table A2.3: Attendance at Risk, Audit and Finance Committee meetings

Name	Position	Meetings attended	Eligible meetings
Mr Michael Perusco	Chair	2	3
Dr Erin Lalor	Board member	1	3
Mr Max Shanahan	Independent member	3	3
Mr Andrew Goodsall	Board member	1	1 to November 2018
Dr Simone Ryan	Board member	2	2 from February 2019

Table A2.4: Attendance at AIHW Ethics Committee meetings

Name	Position	Meetings attended	Eligible meetings
Mr Wayne Jackson PSM	Chair	5	5
Mr Barry Sandison	CEO AIHW	5	5
Dr Purnima Bhat	Person experienced in professional care, counselling and treatment of people	4	5
Professor Tim Driscoll	Person experienced in areas of research regularly considered by the committee	5	5
Ms Amanda Ianna	Nominee of Registrars of Births, Deaths and Marriages	4	5
The Reverend Dr Nicholas White	Person who is a minister of religion	5	5
Ms Maryjane Crabtree	Person who is a lawyer	4	5
Mr David Garrett	Male representing general community attitudes	4	4
The Hon Margaret Reynolds	Female representing general community attitudes	5	5
Mr Damien Tillack	Male representing general community attitudes	1	1
Ms Barbara Anderson ^(a)	Person experienced in professional care, counselling and treatment of people	-	-
Dr Owen Bradfield ^(a)	Person experienced in professional care, counselling and treatment of people	-	-

(a) No meetings were held in 2018–19 following the commencement of their term.

Outgoing member of the AIHW Ethics Committee, 2018–19

Mr David Garrett

Male representing general community attitudes

Terms: 26 March 2010–25 March 2013;
26 March 2013–25 March 2016;
26 March 2016–25 March 2019

Dr Purnima Bhat

Person experienced in the professional care, counselling and treatment of people

Terms: 25 September 2014–24 September 2017;
25 September 2017–26 June 2019

Appendix 3: Senior executive and unit heads

Chief Executive Officer

Barry Sandison BBusMgt, FANZSG

Deputy Chief Executive Officer

Matthew James PSM BEc (Hons)

Business and Communications Group

Senior Executive

Andrew Kettle MA (Hons), CA

Corporate Reporting

Tulip Penney BA, BPsych (Hons), MBA

Finance and Commercial Services

Andrew Tharle BComm, CPA

People and Facilities

Morag Roycroft Cert IV HR, level 1 coaching

Strategic Communications and Stakeholder Engagement

Rebecca Richter BSc/BComm, GradCertAppFin&Inv, GradCertPubPol&Gov

Website and Publishing

Belinda Hellyer BA, MA

Website Data Strategy

Bill Watson (Acting) BSc (IT)

Data Governance Group

Senior Executive

Jenny Hargreaves BSc (Hons), GradDipPopHealth, GAICD

Ethics, Privacy and Legal

Gary Kent LLB, BComm, GradDipPubLaw, GAICD

Executive Secretariat

Anne Reader BA (Hons), MSc, DipIndSt, GAICD

Metadata and METeOR

Mardi Ellis (Acting) BSc

My Health Record Secondary Use Governance

Jennifer Mayhew-Larsen BEc, BA, MBA

Data Strategies and Information Technology Group

Senior Executive

Geoff Neideck BBusStudies, GradCertMgt

Community Services and Housing Linkage

Mike Booth BSc IT

Data Strategies

Nick von Sanden BEc, BSc (Hons), PhD

Health Linkage

Phil Anderson BA, BSc (Hons), PhD

Specialist Capability

Leah Newman GradDipSocResearch, MCLinEpid

Chief Technology Officer

Glenn Ashe DipHRDev, DipMilSatEng, DipElecEng, AFAIM, GAICD

IT Infrastructure and Security

Deborah Scott BSc, BComm

System Architecture, Integration and Support

Charlie Drummond BSc (Hons), GradDipCompSc

Community Services Group

Senior Executive

Louise York BEc, BSc, GradDipPopHealth

Ageing and Aged Care

Mark Cooper-Stanbury BSc

Centrelink Strategies

Sushma Mathur BMath

Child Welfare

David Braddock BSc (Hons)

Children and Families

Sally Mills BSc, MPubHealth

Disability

Felicity Murdoch (Acting) BA, BIT

Justice and Education

Anna Ritson BA

Housing and Specialist Services Group

Senior Executive

Matthew James PSM BEc (Hons)

Housing and Homelessness Collection Operations

Penny Siu BA, MBA

Housing and Homelessness Collection Processing

Amber Jefferson BSc

Housing and Homelessness Reporting and Development

Nikki Schroder BAppSc, MBA

Mental Health and Palliative Care

Gary Hanson BPsych, MA

Suicide and Self-harm Monitoring

Chris Killick-Moran BA (Hons)

Tobacco, Alcohol and Other Drugs

Moira Hewitt BHealthSc, MA, MAppEpid, MAppSc

Health Group

Senior Executive

Richard Jukes (Acting) BA (Hons)

Burden of Disease and Mortality

Karen Bishop (Acting) BSc (Hons), GradDipPopHealth, MBiostat

Cancer Data and Monitoring

Justin Harvey BSc

Cardiovascular, Diabetes and Kidney

Miriam Lum On BAppSc (HIM), GradCertAppEpid, MIntPH

Chronic Conditions

Katherine Faulks BMedSc (Hons), GradDipClinEpid

Chronic Conditions Program Development

Fleur de Crespigny BSc (Hons), PhD

Population Health

Claire Sparke BSc, GradDipClinEpid

Screening Analysis and Monitoring

David Meere (Acting) BHumanNutr, BAppSc (Hons), GradDipDietet, AssocDipAppComp

Hospitals and Expenditure Group

Senior Executive

Adrian Webster BA (Hons), BSc, PhD

Economics and Expenditure

Jason Thomson BAppSc, MPH, MHP

Health Performance and Quality

Heather Swanston BSc (Hons), PhD

Hospitals and Related Care

Marissa Veld BAppSc, MBA

Hospitals Data

Brett Henderson (Acting) BAppSc (MedRad), MTech (IT)

Medical, Dental and Pharmaceutical

Clara Jellie BA, GradDipBehStud (Healthcare), MPopHealth

Primary Health Care and Veterans Group

Senior Executive

Michael Frost BEc (Soc Sc) (Hons),
GradDipPubAdmin

Flagship Reporting

Dinesh Indrharan BBiomedSc (Hons),
GradDipBiostat

My Health Record Data

Vicki Bennett BAppSci(HIM), MHSci(HI)

PHN and Primary Health Reporting

Kerrin Bleicher BSc, PhD, GradDipPhysio,
GradDipMusculoskeletalPhysio

Primary Health Care Data

Conan Liu BA (Hons), MAppMedSc

Veterans' Health and Welfare

Rebecca Hurley (Acting) BSc (Human Life Sci)

Indigenous and Maternal Health Group

Senior Executive

Fadwa Al-Yaman PSM BSc, MA, PhD

Indigenous Analyses and Reporting

Geoff Callaghan BComm, BHealthSc

Indigenous Analyses and Visualisation

Elizabeth Hynes (Acting) BEc, BComm

Indigenous Modelling and Research

Tracy Dixon BMath, BSc (Hons), MAppStats

Indigenous Primary Care Reporting

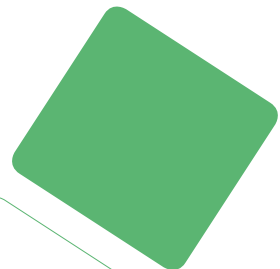
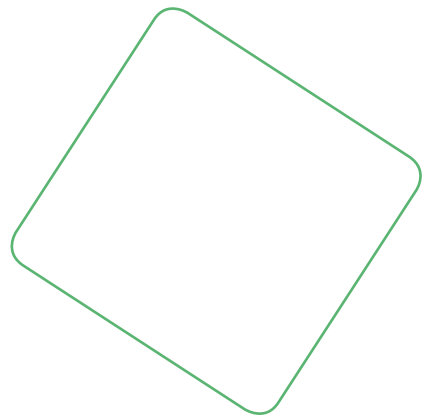
Indrani Pieris-Caldwell BA, GradDipDemog,
PhD

Indigenous Spatial Analysis and Health Services

Martin Edvardsson MSc, PhD

Maternal and Perinatal Health

Natalie Cooper (Acting) BMusEd



Appendix 4: Compliance index

Index of PGPA Act requirements

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Prepare and give an annual report to the responsible Minister on the entity's activities during the period	46	i-138
Prepare annual financial statements and give the statements to the Auditor General	42	99
Auditor General's report on the financial statements	43	99

Index of PGPA Rule requirements

Description	PGPA Rule Reference	Page
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Compliance with guidelines for presenting documents to Parliament	17BC	i-138
Annual report published using the digital reporting tool	17BCA	inside back cover
Annual report prepared using plain English and clear design	17BD	i-138
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A summary of the objects and functions of the entity as set out in legislation	17BE(b)(i)	x, 42
The purposes of the entity as included in the entity's corporate plan for the reporting period	17BE(b)(ii)	x
The names of the persons holding the position of responsible Minister or responsible Ministers during the reporting period, and the titles of those responsible Ministers	17BE(c)	43
Directions given to the entity by the Minister under an Act or instrument during the reporting period	17BE(d)	43
Any government policy order that applied in relation to the entity during the reporting period under section 22 of the Act	17BE(e)	43
Particulars of non-compliance with: (a) a direction given to the entity by the Minister under an Act or instrument during the reporting period; or (b) a government policy order that applied in relation to the entity during the reporting period under section 22 of the Act	17BE(f)	Not applicable
Annual performance statements in accordance with paragraph 39(1)(b) of the Act and section 16F of the rule	17BE(g)	2
A statement of significant issues reported to the Minister under paragraph 19(1)(e) of the Act that relates to non-compliance with finance law and action taken to remedy non-compliance	17BE(h) 17BE(i)	54
Information on the accountable authority, or each member of the accountable authority, of the entity during the reporting period	17BE(j)	43-47, 117-118, 123

Description	PGPA Rule Reference	Page
Outline of the organisational structure of the entity (including any subsidiaries of the entity)	17BE(k)	60
Statistics on the entity's employees on an ongoing and non-ongoing basis, including the following: (a) statistics on full-time employees; (b) statistics on part-time employees; (c) statistics on gender; (d) statistics on staff location	17BE(ka)	65, 119–120
Outline of the location (whether or not in Australia) of major activities or facilities of the entity	17BE(l)	75
Information relating to the main corporate governance practices used by the entity during the reporting period	17BE(m)	52–54
For transactions with a related Commonwealth entity or related company where the value of the transaction, or if there is more than one transaction, the aggregate of those transactions, is more than \$10,000 (inclusive of GST): (a) the decision-making process undertaken by the accountable authority to approve the entity paying for a good or service from, or providing a grant to, the related Commonwealth entity or related company; and (b) the value of the transaction, or if there is more than one transaction, the number of transactions and the aggregate of value of the transactions	17BE(n) 17BE(o)	54
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Particulars of judicial decisions or decisions of administrative tribunals that may have a significant effect on the operations of the entity	17BE(q)	55
Particulars of any reports on the entity given by: (a) the Auditor-General (other than a report under section 43 of the Act); or (b) a Parliamentary Committee; or (c) the Commonwealth Ombudsman; or (d) the Office of the Australian Information Commissioner	17BE(r)	55
An explanation of information not obtained from a subsidiary of the entity and the effect of not having the information on the annual report	17BE(s)	Not applicable
Details of any indemnity that applied during the reporting period to the accountable authority, any member of the accountable authority or officer of the entity against a liability (including premiums paid, or agreed to be paid, for insurance against the authority, member or officer's liability for legal costs)	17BE(t)	55
Information about executive remuneration	17BE(ta)	124

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Advertising and market research organisations expenditure and statement on advertising campaigns	s331A <i>Commonwealth Electorate Act 1918</i>	55
Ecologically sustainable development and environmental performance	s516A <i>Environment Protection and Biodiversity Conservation Act 1999</i>	76–78
Legal services expenditure	Paragraph 12.3, <i>Legal Services Directions 2017</i>	55
Modern slavery statement	s6 <i>Modern Slavery Act 2018</i>	55

Appendix 5: Financial statements



INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Australian Institute of Health and Welfare ('the Entity') for the year ended 30 June 2019:

- (a) comply with Australian Accounting Standards – Reduced Disclosure Requirements and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and
- (b) present fairly the financial position of the Entity as at 30 June 2019 and its financial performance and cash flows for the year then ended.

The financial statements of the Entity, which I have audited, comprise the following statements as at 30 June 2019 and for the year then ended:

- Statement by the Accountable Authority and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement; and
- Notes to the financial statements, comprising a summary of significant accounting policies and other explanatory information.

Basis for opinion

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Entity in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and his delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) to the extent that they are not in conflict with the *Auditor-General Act 1997*. I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Accountable Authority's responsibility for the financial statements

As the Accountable Authority of the Entity, the Board is responsible under the *Public Governance, Performance and Accountability Act 2013* (the Act) for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Reduced Disclosure Requirements and the rules made under the Act. The Board is also responsible for such internal control as the Board determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Board is responsible for assessing the ability of the Entity to continue as a going concern, taking into account whether the Entity's operations will cease as a result of an administrative restructure or for any other reason. The Board is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the assessment indicates that it is not appropriate.

GPO Box 707 CANBERRA ACT 2601
19 National Circuit BARTON ACT
Phone (02) 6203 7300 Fax (02) 6203 7777

Auditor's responsibilities for the audit of the financial statements

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian National Audit Office Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with the Australian National Audit Office Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Accountable Authority;
- conclude on the appropriateness of the Accountable Authority's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Entity to cease to continue as a going concern; and
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Accountable Authority regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Australian National Audit Office



Colin Bienke
Senior Director

Delegate of the Auditor-General

Canberra
26 September 2019



Australian Government
 Australian Institute of
 Health and Welfare



STATEMENT BY THE ACCOUNTABLE AUTHORITY AND CHIEF FINANCIAL OFFICER

In our opinion, the attached financial statements for the year ended 30 June 2019 comply with subsection 42(2) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and are based on properly maintained financial records as per subsection 41(2) of the PGPA Act.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the non-corporate Commonwealth entity will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the directors.

Louise Markus
 Board Chair
 26 September 2019

Barry Sandison
 Chief Executive Officer
 26 September 2019

Andrew Kettle
 Chief Financial Officer
 26 September 2019

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Statement of Comprehensive Income

for the period ended 30 June 2019

	Notes	2019 \$'000	2018 \$'000	Original Budget \$'000
NET COST OF SERVICES				
Expenses				
Employee Benefits	1.1A	42,186	38,253	38,843
Suppliers	1.1B	34,882	25,176	28,691
Depreciation and amortisation	2.2A	1,123	1,225	1,400
Revaluation decrement		-	288	-
Total expenses		78,191	64,942	68,934
Own-source Income				
Own-source revenue				
Sale of Goods and Rendering of Services	1.2A	42,669	35,096	34,000
Interest	1.2B	1,961	1,759	1,300
Other Revenue		-	142	30
Total own-source revenue		44,630	36,997	35,330
Net cost of services		33,561	27,945	33,604
Revenue from Government	1.2C	33,322	28,078	33,322
Surplus/(deficit)		(239)	133	(282)
OTHER COMPREHENSIVE INCOME				
Change in asset revaluation reserve		-	(433)	-
Total other comprehensive income		-	(433)	-
Total comprehensive surplus/(deficit)		(239)	(300)	(282)

The above statement should be read in conjunction with the accompanying notes.

Budget Variances Commentary

Supplier and employee costs have increased to service the higher than budgeted fee-for-service work. The majority of the increase in fee-for-service work is for Australian Government Departments.

Statement of Financial Position

as at 30 June 2019

	Notes	2019 \$'000	2018 \$'000	Original Budget \$'000
ASSETS				
Financial assets				
Cash and Cash Equivalents	2.1A	80,072	74,655	60,606
Trade and Other Receivables	2.1B	16,143	10,456	4,449
Total financial assets		96,215	85,111	65,055
Non-financial assets				
Buildings	2.2A	3,991	3,907	4,147
Plant and equipment	2.2A	3,816	3,063	3,392
Intangibles	2.2A	75	164	253
Prepayments		2,000	1,430	1,042
Total non-financial assets		9,882	8,564	8,834
Total assets		106,097	93,675	73,889
LIABILITIES				
Payables				
Suppliers		3,862	2,622	3,530
Contract income in advance		51,755	42,770	26,978
Other payables	2.3A	5,154	5,008	-
Total payables		60,771	50,400	30,508
Provisions				
Employee Provisions	2.3B	14,190	12,525	11,969
Make good Provision		120	120	505
Total provisions		14,310	12,645	12,474
Total liabilities		75,081	63,045	42,982
Net assets		31,016	30,630	30,907
EQUITY				
Contributed equity		28,549	27,924	28,549
Reserves		1,977	1,977	2,410
Retained surplus/(Accumulated deficit)		490	729	(52)
Total equity		31,016	30,630	30,907

The above statement should be read in conjunction with the accompanying notes.

Budget Variances Commentary

Cash and cash equivalents and receivables have increased as the contract income received in advance was higher than budgeted. The higher than budgeted cash balances during the year also reflected an increase in interest income.

Employee provisions are higher due to a salary increase under the AIHW Enterprise Agreement and a present value adjustment of the long-service leave balances arising from a fall in the 10-year bond rate.

Statement of Changes in Equity

for the period ended 30 June 2019

Notes	2019 \$'000	2018 \$'000	Original Budget \$'000
CONTRIBUTED EQUITY			
Opening balance			
Balance carried forward from previous period	27,924	27,924	27,924
Transactions with owners			
Contributions by owners			
Equity injection - Appropriations	625	-	625
Total transactions with owners	625	-	625
Closing balance as at 30 June	28,549	27,924	28,549
RETAINED EARNINGS			
Opening balance			
Balance carried forward from previous period	729	596	230
Comprehensive income			
Surplus/(Deficit) for the period	(239)	133	(282)
Total comprehensive income	(239)	133	(282)
Closing balance as at 30 June	490	729	(52)
ASSET REVALUATION RESERVE			
Opening balance			
Balance carried forward from previous period	1,977	2,410	2,410
Other comprehensive income	-	(433)	-
Total comprehensive income	-	(433)	-
Closing balance as at 30 June	1,977	1,977	2,410
TOTAL EQUITY			
Opening balance			
Balance carried forward from previous period	30,630	30,930	30,564
Comprehensive income			
Surplus/(Deficit) for the period	(239)	133	(282)
Other comprehensive income/(loss)	-	(433)	-
Total comprehensive income	(239)	(300)	(282)
Transactions with owners			
Contributions by owners			
Equity injection - Appropriations	625	-	625
Total transactions with owners	625	-	625
Closing balance as at 30 June	31,016	30,630	30,907

The above statement should be read in conjunction with the accompanying notes.

Cash Flow Statement

for the period ended 30 June 2019

Notes	2019 \$'000	2018 \$'000	Original \$'000
OPERATING ACTIVITIES			
Cash received			
Appropriations	33,322	28,078	33,322
Sale of goods and rendering of services	46,525	49,397	34,000
Interest	2,304	1,344	1,300
GST received	2,773	1,503	-
Other	5	142	30
Total cash received	84,929	80,464	68,652
Cash used			
Employees	40,495	37,701	38,843
Suppliers	37,770	26,748	28,409
Total cash used	78,265	64,449	67,252
Net cash from operating activities	6,664	16,015	1,400
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment	(1,872)	(1,056)	(1,597)
Total cash used	(1,872)	(1,056)	(1,597)
Net cash from investing activities	(1,872)	(1,056)	(1,597)
FINANCING ACTIVITIES			
Cash received			
Contributed Equity	625	-	625
Total cash received	625	-	625
Net cash from financing activities	625	-	625
Net increase in cash held	5,417	14,959	428
Cash and cash equivalents at the beginning of the reporting period	74,655	59,696	60,178
Cash and cash equivalents at the end of the reporting period	80,072	74,655	60,606

The above statement should be read in conjunction with the accompanying notes.

Budget Variances Commentary

Supplier and employee costs have increased to service the higher than budgeted fee-for-service work.

Sale of goods and rendering services are higher than budget as the contract income received in advance was higher than budgeted. The higher than budgeted cash balances

Overview

The Basis of Preparation

The financial statements are general purpose financial statements and are required by section 42 of the *Public Governance, Performance and Accountability Act 2013*.

The financial statements have been prepared in accordance with:

- a) Public Governance, Performance and Accountability (Financial Reporting Rule 2015) and
- b) Australian Accounting Standards and Interpretations – Reduced Disclosure Requirements issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

All new/revised/amending standards and/or interpretations that were issued prior to the sign-off date and are applicable to the current reporting period did not have a material effect on the AIHW's financial statements.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

The financial statements are presented in Australian dollars and values are rounded to the nearest thousand dollars.

Unless an alternative treatment is specifically required by an accounting standard or the Financial Reporting Rule (FRR), assets and liabilities are recognised in the statement of financial position when and only when it is probable that future economic benefits will flow to the entity or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured.

Unless alternative treatment is specifically required by an accounting standard, income and expenses are recognised in the Statement of Comprehensive Income when and only when the flow, consumption or loss of economic benefits has occurred and can be reliably measured. Financial statements are general purpose financial statements and are required by section 42 of the *Public Governance, Performance and Accountability Act 2013*.

Significant accounting judgements and estimates

In the process of applying the accounting policies listed in this note, the AIHW has made the following judgments that have the most significant impact on the amounts recorded in the financial statements:

- the fair value of leasehold improvements and property, plant and equipment has been taken to be the depreciated replacement cost as determined by an independent valuer.

No accounting assumptions or estimates have been identified that have a significant risk of causing a material adjustment to carrying amounts of assets and liabilities within the next reporting period.

Revenue

Revenue from the sale of goods is recognised when:

- the risks and rewards of ownership have been transferred to the buyer
- the entity retains no managerial involvement nor effective control over the goods
- the revenue and transaction costs incurred can be reliably measured and
- it is probable that the economic benefits associated with the transaction will flow to the entity.

Revenue from rendering of services is recognised by reference to the stage of completion of contracts at the reporting date. The revenue is recognised when:

- the amount of revenue, stage of completion and transaction costs incurred can be reliably measured and
- the probable economic benefits with the transaction will flow to the AIHW.

The stage of completion of contracts at the reporting date is determined by reference to the proportion that costs incurred to date bear to the estimated total costs of the transaction.

Receivables for goods and services, which have 30 day terms, are recognised at the nominal amounts due less any allowance for impairment. Collectability of debts is reviewed at balance date. Allowances are made when collectability of the debt is no longer probable.

Interest revenue is recognised using the effective interest method.

Revenues from Government

Amounts appropriated for departmental appropriations for the year are recognised as Revenue from Government when the entity gains control of the appropriation, except for certain amounts that relate to activities that are reciprocal in nature, in which case revenue is recognised only when it has been earned. Appropriations receivable are recognised at their nominal amounts. Funding received or receivable from non-corporate Commonwealth entities is recognised as Revenue from Government by the AIHW unless the funding is in the nature of an equity injection or a loan.

Gains

Sale of assets

Gains from disposal of assets are recognised when control of the asset has passed to the buyer.

Transactions with the government as owner

Equity injections

Amounts that are designated as equity injections for a year are recognised directly in contributed equity in that year.

Cash

Cash and cash equivalents include notes and coins held and any deposits in bank accounts that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value. Cash is recognised at its nominal amount.

Financial assets

With the implementation of AASB 9 Financial Instruments for the first time in 2019, the entity classifies its financial assets in the following categories:

- a) financial assets at fair value through profit or loss
- b) financial assets at fair value through other comprehensive income and
- c) financial assets measured at amortised cost.

Financial assets are recognised when the entity becomes a party to the contract and, as a consequence, has a legal right to receive or a legal obligation to pay cash and derecognised when the contractual rights to the cash flows from the financial asset expire or are transferred upon trade date.

Comparatives have not been restated on initial application.

Financial Assets at Amortised Cost

Financial assets included in this category need to meet two criteria:

1. the financial asset is held in order to collect the contractual cash flows and
2. the cash flows are solely payments of principal and interest (SPPI) on the principal outstanding amount.

Effective Interest Method

Income is recognised on an effective interest rate basis for financial assets that are recognised at amortised cost.

Impairment of financial assets

Financial assets are assessed for impairment at the end of each reporting period based on Expected Credit Losses, using the general approach which measures the loss allowance based on an amount equal to lifetime expected credit losses where risk has significantly increased, or an amount equal to 12-month expected credit losses if risk has not increased.

The simplified approach for trade, contract and lease receivables is used. This approach always measures the loss allowance as the amount equal to the lifetime expected credit losses.

Employee benefits

Liabilities for services rendered by employees are recognised at the reporting date to the extent that they have not been settled.

Liabilities for 'short-term employee benefits' (as defined in AASB 119 Employee Benefits) and termination benefits due within twelve months of balance date are measured at their nominal amounts.

The nominal amount is calculated with regard to the rates expected to be paid on settlement of the liability.

Other long-term employee benefits are measured as the present value of the estimated future cash outflows to be made in respect of services provided by employees up to the reporting date.

Leave

The liability for employee benefits includes provision for annual leave and long-service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of the AIHW is estimated to be less than the annual entitlement for sick leave.

The leave liabilities are calculated on the basis of employees' remuneration, including the AIHW's employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

The liability for long-service leave is recognised and measured at the present value of the estimated future cash flows to be made in respect of all employees at 30 June 2019. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Separation and redundancy

Provision is made for separation and redundancy benefit payments. AIHW recognises a provision for termination when it has developed a detailed formal plan for the terminations and has informed those employees affected that it will carry out the terminations.

Superannuation

AIHW staff are members of the Commonwealth Superannuation Scheme, the Public Sector Superannuation Scheme or the Public Sector Superannuation Scheme accumulation plan.

The first two are defined benefit schemes for the Australian Government. The third is a defined contribution scheme.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported by the Department of Finance as an administered item.

The AIHW makes employer contributions to the employee superannuation scheme at rates determined by an actuary to be sufficient to meet the cost to the government of the superannuation entitlements of the AIHW's employees. The AIHW accounts for the contributions as if they were contributions to defined contribution plans.

The liability for superannuation recognised as at 30 June represents outstanding contributions for the final fortnight of the year.

Leases

Operating lease payments are expensed on a straight-line basis which is representative of the pattern of benefits derived from the leased assets.

Financial liabilities

Financial liabilities are classified as either financial liabilities 'at fair value through profit or loss' or other financial liabilities. Financial liabilities are recognised and derecognised upon 'trade date'.

Financial Liabilities at Fair Value Through Profit or Loss

Financial liabilities at fair value through profit or loss are initially measured at fair value. Subsequent fair value adjustments are recognised in profit or loss. The net gain or loss recognised in profit or loss incorporates any interest paid on the financial liability.

Financial Liabilities at Amortised Cost

Financial liabilities, including borrowings, are initially measured at fair value, net of transaction costs. These liabilities are subsequently measured at amortised cost using the effective interest method, with interest expense recognised on an effective interest basis. Supplier and other payables are recognised at amortised cost. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).

Contingent liabilities and contingent assets

Contingent liabilities and contingent assets are not recognised in the balance sheet but are reported in the relevant notes. They may arise from uncertainty as to the existence of a liability or asset, or represent a liability or asset in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but not virtually certain, and contingent liabilities are disclosed when settlement is greater than remote.

Acquisition of assets

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken. Financial assets are initially measured at their fair value plus transaction costs where appropriate.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transfer or authority's accounts immediately prior to the restructuring.

Property, plant and equipment

Asset recognition threshold

Purchases of property, plant and equipment are recognised initially at cost in the balance sheet, except for purchases costing less than \$3,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'makegood' provisions in property leases taken up by the AIHW where there exists an obligation to restore the property to its original condition. These costs are included in the value of the AIHW's leasehold improvements with a corresponding provision for the make good recognised.

Revaluations

Fair values for each class of asset are determined as shown below:

Asset class	Fair value measured at:
Buildings-leasehold improvements	Depreciated replacement cost
Property, plant and equipment	Market selling price

Following initial recognition at cost, property, plant and equipment are carried at fair value less accumulated depreciation and accumulated impairment losses. Valuations are conducted with sufficient frequency to ensure that the carrying amounts of assets do not materially differ from the assets' fair values as at the reporting date. The regularity of independent valuations depend upon the volatility of movements in market values for the relevant assets.

Revaluation adjustments are made on a class basis. Any revaluation increment is credited to equity under the heading of asset revaluation reserve except to the extent that it reverses a previous revaluation decrement of the same asset class that was previously recognised through surplus and deficit. Revaluation decrements for a class of assets are recognised directly through surplus and deficit except to the extent that they reverse a previous revaluation increment for that class.

Any accumulated depreciation as at the revaluation date is eliminated against the gross carrying amount of the asset and the asset restated to the revalued amount.

A formal revaluation of assets was completed by AllBids as at 30 June 2018.

Depreciation

Depreciable property, plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the AIHW using, in all cases, the straight-line method of depreciation.

Depreciation rates (useful lives), residual values and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

	2019	2018
Leasehold improvements	Lease term	Lease term
Property, plant and equipment	3 to 10 years	3 to 10 years

Impairment

All assets were assessed for impairment at 30 June 2019. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

The recoverable amount of an asset is the higher of its fair value less costs to sell and its value in use. Value in use is the present value of the future cash flows expected to be derived from the asset. Where the future economic benefit of an asset is not primarily dependent on the asset's ability to generate future cash flows, and the asset would be replaced if the AIHW were deprived of the asset, its value in use is taken to be its depreciated replacement cost.

Intangibles

The AIHW's intangibles comprise internally developed and purchased software for internal use. These assets are carried at cost less accumulated amortisation.

Intangibles are recognised initially at cost in the balance sheet, except for purchases costing less than \$50,000, which are expensed in the year of acquisition.

Software is amortised on a straight-line basis over its anticipated useful life. The useful life of the AIHW's software is 3 to 5 years (2017–18: 3 to 5 years).

All software assets were assessed for indications of impairment as at 30 June 2019.

Taxation

The AIHW is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Revenues, expenses, assets and liabilities are recognised net of GST except:

- where the amount of GST incurred is not recoverable from the Australian Taxation Office and
- for receivables and payables.

Events After the Reporting Period

There were no subsequent events that had the potential to significantly affect the ongoing structure and financial activities of the AIHW.

1.1 Expenses

	2019	2018
	\$'000	\$'000
1.1A: Employee Benefits		
Wages and salaries	31,289	29,099
Superannuation		
Defined contribution plans	3,084	2,793
Defined benefit plans	3,051	2,666
Leave and other entitlements	4,762	3,695
Total employee benefits	42,186	38,253
1.1B: Suppliers		
Consultants	4,706	4,037
Contractors	15,954	8,265
Collaborating centres	694	1,273
IT services	3,590	3,493
Printing & stationery	175	163
Training	608	463
Travel	1,095	839
Telecommunications	233	206
Other	3,742	2,717
Total goods and services supplied or rendered	30,797	21,456
Other suppliers		
Operating lease rentals	3,597	3,290
Workers compensation expenses	488	430
Total other suppliers	4,085	3,720
Total suppliers	34,882	25,176
Commitments for minimum lease payments in relation to non-cancellable		
Within 1 year	4,075	3,595
Between 1 to 5 years	14,539	14,263
More than 5 years	19,377	22,921
Total operating lease commitments	37,991	40,778

Operating lease payments are expensed on a straight-line basis which is representative of the pattern of benefits derived from the leased assets.

1.2 Own-Source Revenue and gains

	2019	2018
	\$'000	\$'000

Own-Source Revenue

1.2A: Sale of Goods and Rendering of Services

Sale of goods	5	3
Rendering of services	42,664	35,093
Total sale of goods and rendering of services	42,669	35,096

1.2B: Interest

Deposits	1,961	1,759
Total interest	1,961	1,759

1.2C: Revenue from Government

Department of Health		
Corporate Commonwealth entity payment item	33,322	28,078
Total revenue from Government	33,322	28,078

2.1 Financial Assets

	2019	2018
	\$'000	\$'000

2.1A: Cash and cash equivalents

Cash at bank	4,572	4,155
Term deposits - cash equivalents	75,500	70,500
Total cash and cash equivalents	80,072	74,655

2.1B: Trade and Other Receivables

Goods and services receivables

Goods and services	16,143	10,456
Total goods and services receivables	16,143	10,456

Total trade and other receivables

16,143	10,456
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Credit terms for goods and services were within 30 days (2018: 30 days).

All trade and other receivables were assessed for impairment at 30 June. No indicators of impairment were identified for trade and other receivables.

2.2 Non-Financial Assets**2.2A: Reconciliation of the Opening and Closing Balances of Property, Plant and Equipment and Intangibles****Reconciliation of the opening and closing balances of property, plant and equipment for 2019**

	Buildings \$'000	Plant and equipment \$'000	Intangibles \$'000	Total \$'000
As at 1 July 2018				
Gross book value	3,914	3,064	267	7,245
Accumulated depreciation, amortisation and impairment	(7)	(2)	(103)	(112)
Total as at 1 July 2018	3,907	3,062	164	7,133
Additions				
Purchase	538	1,334	-	1,872
Depreciation and amortisation	(454)	(580)	(89)	(1,123)
Total as at 30 June 2019	84	754	(89)	749
Total as at 30 June 2019 represented by				
Gross book value	4,452	4,398	267	9,117
Accumulated depreciation, amortisation and impairment	(461)	(582)	(192)	(1,235)
Total as at 30 June 2019	3,991	3,816	75	7,882

2.3 Payables

	2019	2018
	\$'000	\$'000
2.3A: Other Payables		
Salaries and wages	286	261
Superannuation	46	43
Lease incentive - Canberra	2,500	2,750
Operating lease	2,322	1,954
Total other payables	5,154	5,008
2.3B: Employee Provisions		
Annual leave	4,065	3,621
Long service leave	10,125	8,904
Total employee provisions	14,190	12,525

3.1 Key Management Personnel Remuneration

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the AIHW, directly or indirectly, including any director (whether executive or otherwise) of the AIHW. The AIHW has determined the key management personnel to be the Chief Executive Officer, Board of Directors and Group Heads. Key management personnel remuneration is reported in the following table.

	2019	2018
	\$'000	\$'000
Short-term employee benefits	2,657	2,423
Post-employment benefits	401	361
Other long-term employee benefits	131	33
Total key management personnel remuneration expenses	3,189	2,817

The total number of key management personnel included in the above table is 22 (2018: 17).

1. The above key management personnel remuneration excludes the remuneration and other benefits of the Portfolio Minister. The Portfolio Minister's remuneration and other benefits are set by the Remuneration Tribunal and are not paid by the entity.

3.2 Related Party Disclosures

Related party relationships:

The AIHW is an Australian Government controlled entity. Related parties to this entity are the Minister for Health and Executive, Directors, Key Management Personnel and AIHW Executive, and other Australian Government entities.

Transactions with related parties:

Given the breadth of Government activities, related parties may transact with the government sector in the same capacity as ordinary citizens. The AIHW's arrangements with the government sector are conducted under contracts as normal business with the same conditions as with private enterprise. These transactions have not been separately disclosed in this note.

There were no related party transactions during the financial year (2017–18: \$0)

4.1 Financial Instruments

	2019	2018
	\$'000	\$'000
4.1A: Categories of Financial Instruments		
Financial Assets under AASB 139		
Loans and receivables		
Cash and Cash Equivalents		74,655
Trade and Other Receivables		10,456
Total loans and receivables		85,111
Financial Assets under AASB 9		
Financial assets at amortised cost		
Cash and Cash Equivalents	80,072	
Trade and Other Receivables	16,143	
Total financial assets at amortised cost	96,215	
Total financial assets	96,215	85,111
Financial Liabilities		
Financial liabilities measured at amortised cost		
Trade Creditors	3,786	4,011
Total financial liabilities measured at amortised cost	3,786	4,011

4.2 Fair Value Measurements

The following tables provide an analysis of assets and liabilities that are measured at fair value.

4.2A: Fair Value Measurements, Valuations Techniques and Inputs Used

The following tables provide an analysis of assets and liabilities that are measured at fair value.

	Fair Value (\$'000)	
	2019	2018
Leasehold improvements	3,991	3,907
Other property, plant and equipment	3,816	3,062
Total non-financial assets	7,807	6,969
Total fair value measurements of assets in the statement of financial position	7,807	6,969

Fair value measurements - highest and best use differs from current use for non-financial assets (NFAs)

The highest and best use of all non-financial assets are the same as their current use.

There are no liabilities measured at fair value.

In 2018 the AIHW procured valuation services from AllBids and relied on valuation models provided by AllBids. AllBids provided written assurance to the entity that the model developed is in compliance with AASB 13 - Fair Value Measurement. All assets were valued using the Fair Market Value Technique.

5.1 Aggregate Assets and Liabilities

	2019	2018
	\$'000	\$'000
5.1A: Aggregate Assets and Liabilities		
Assets expected to be recovered in:		
No more than 12 months	98,215	86,541
More than 12 months	7,882	7,134
Total assets	106,097	93,675
Liabilities expected to be recovered in:		
No more than 12 months	66,672	55,505
More than 12 months	8,408	7,540
Total liabilities	75,080	63,045

Appendix 6: Digital Annual Reporting Information

Amendments to the PGPA Rule 2014 require entities to publish their annual reports on the Australian Government's transparency portal www.transparency.gov.au.

The PGPA Rule also requires the following tables to be published in the annual report:

- Details of Accountable Authority during the reporting period Current Report Period (2018–19)
- All Ongoing Employees Current Report Period (2018–19)
- All Non-Ongoing Employees Current Report Period (2018–19)
- All Ongoing Employees Previous Report Period (2017–18)
- All Non-Ongoing Employees Previous Report Period (2017–18)
- Information about remuneration for key management personnel
- Information about remuneration for senior executives
- Information about remuneration for other highly paid staff.

Table A6.1: Details of Accountable Authority during the Current Report Period (2018–19)

Name	Qualifications of the Accountable Authority	Experience of the Accountable Authority	Position Title/ Position held/ Executive/ Non-Executive	Period as the accountable authority or member		Number of board meetings attended
				Date of Commencement	Date of cessation	
Louise Markus	BSocWk	Former shadow parliamentary secretary for immigration and citizenship and shadow minister for veterans' affairs	Chair/Non-Executive	14 December 2016	13 December 2019	4
Erin Lalor	BSc (Hons) (Speech and Hearing), PhD, GCCM	CEO, Alcohol and Drug Foundation	Deputy Chair/ Non-Executive	21 November 2012	2 December 2021	4
Barry Sandison	BBusMgt, FANZSG	CEO, AIHW	CEO, AIHW/Executive	5 May 2016	4 May 2021	4
Michael Perusco	BBus (Acc)	CEO, Berry Street	Member/Non-Executive	21 November 2012	2 December 2023	3
Zoran Bolevich	DM, MBA, FRACMA	Chief Executive of eHealth, New South Wales	State and Territory member/Non-Executive	11 February 2016	2 December 2019	3
Marilyn Chilvers	BEc (Hons), MAppStat, GradDipTertEd	Executive Director, New South Wales Department of Family and Community Services and Data Analytics Centre, New South Wales Treasury	State and Territory member/Non-Executive	18 January 2016	2 December 2019	4
Christine Castley	LLB, BA, MA, MPA	Deputy Director-General, Queensland Department of the Premier and Cabinet	State and Territory member/Non-Executive	3 December 2018	2 December 2019	2
Simone Ryan	BMedSci, MBBS, FAOEM (RACP), MOccEnvHlth, ACCAM, DAME	CEO, One Life. Live It	Member/Non-Executive	1 September 2016	2 December 2021	3

(continued)

Table A6.1 (continued): Details of Accountable Authority during the Current Report Period (2018–19)

Name	Qualifications of the Accountable Authority	Experience of the Accountable Authority	Period as the accountable authority or member			
			Position Title/ Position held/ Executive/ Non-Executive	Date of Commencement	Date of cessation	Number of board meetings attended
Romlie Mokak	BSocSc, PGDipSpEd	Commissioner, Productivity Commission	Member/Non-Executive	3 December 2018	2 December 2023	2
Cathryn Ryan	RN, BEd, GDipHlthAdmin, GDipENT (UK), GCertCritCare (Emerg), GAICD	General Manager - Health Funding, Strategy and Performance, St John of God Health Care	Member/Non-Executive	3 December 2018	2 December 2023	3
Christine Gee	MBA	CEO, Toowoong Private Hospital	Member/Non-Executive	3 December 2018	2 December 2023	2
David Conry	BBus (Marketing)	Managing Director, Damarcon	Member/Non-Executive	19 December 2014	30 September 2018	1
Caroline Edwards	BA (Law) (Hons)	Deputy Secretary, Australian Government Department of Health	Member nominated by the Secretary, Department of Health/ Non-Executive	24 November 2017	27 November 2018	1
Andrew Goodsall	BA (Hons), MBA, GradDipAsianStudies,	Managing Director (Healthcare Analyst), UBS Australia	Member/Non-Executive	19 December 2014	30 September 2018	1
Luise McCulloch	BA (Hons)	Deputy Statistician	Member nominated by the Australian Statistician/ Non-Executive	4 August 2016	27 November 2018	1
Marissa Veld	BAppSc, MA (Bus)	Unit Head, Hospitals and related care	Member/Non-executive	26 May 2018	27 November 2018	1

Table A6.2: All Ongoing Employees Current Report Period (2018–19)

	Male			Female			Indeterminate			Total
	Fulltime		Total Male	Part Time		Total Female	Fulltime		Total Indeterminate	
	Part Time	Fulltime	Part Time	Fulltime	Part Time	Fulltime	Part Time	Indeterminate		
NSW	2	0	2	11	2	13	0	0	0	15
Qld	0	0	0	0	0	0	0	0	0	0
SA	0	0	0	0	0	0	0	0	0	0
Tas	0	0	0	0	0	0	0	0	0	0
Vic	0	0	0	0	0	0	0	0	0	0
WA	0	0	0	0	0	0	0	0	0	0
ACT	102	10	112	165	80	245	0	0	0	357
NT	0	0	0	0	0	0	0	0	0	0
External territories	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0
Total	104	10	114	176	82	258	0	0	0	372

Table A6.3: All Non-Ongoing Employees Current Report Period (2018–19)

	Male			Female			Indeterminate			Total
	Fulltime		Total Male	Part Time		Total Female	Fulltime		Total Indeterminate	
	Fulltime	Part Time		Part Time			Part Time	Indeterminate		
NSW	0	0	0	0	0	0	0	0	0	0
Qld	0	0	0	0	0	0	0	0	0	0
SA	0	0	0	0	0	0	0	0	0	0
Tas	0	0	0	0	0	0	0	0	0	0
Vic	0	0	0	0	0	0	0	0	0	0
WA	0	0	0	0	0	0	0	0	0	0
ACT	4	0	4	1	0	1	0	0	0	5
NT	0	0	0	0	0	0	0	0	0	0
External territories	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0
Total	4	0	4	1	0	1	0	0	0	5

Table A6.4: All Ongoing Employees Previous Report Period (2017–18)

	Male			Female			Indeterminate			Total
	Fulltime		Total Male	Part Time		Total Female	Fulltime		Total Indeterminate	
	Fulltime	Part Time		Part Time	Indeterminate		Fulltime	Indeterminate		
NSW	2	0	2	7	1	8	0	0	0	10
Qld	0	0	0	0	0	0	0	0	0	0
SA	0	0	0	0	0	0	0	0	0	0
Tas	0	0	0	0	0	0	0	0	0	0
Vic	0	0	0	0	0	0	0	0	0	0
WA	0	0	0	0	0	0	0	0	0	0
ACT	92	11	103	150	73	223	0	0	0	326
NT	0	0	0	0	0	0	0	0	0	0
External territories	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0
Total	94	11	105	157	74	231	0	0	0	336

Table A6.5: All Non-Ongoing Employees Previous Report Period (2017–18)

	Male			Female			Indeterminate			Total
	Fulltime	Part Time	Total Male	Fulltime	Part Time	Total Female	Fulltime	Part Time	Indeterminate	
NSW	0	0	0	1	0	1	0	0	0	1
Qld	0	0	0	0	0	0	0	0	0	0
SA	0	0	0	0	0	0	0	0	0	0
Tas	0	0	0	0	0	0	0	0	0	0
Vic	0	0	0	0	0	0	0	0	0	0
WA	0	0	0	0	0	0	0	0	0	0
ACT	5	0	5	2	3	5	0	0	0	10
NT	0	0	0	0	0	0	0	0	0	0
External territories	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	0
Total	5	0	5	3	3	6	0	0	0	11

Table A6.6: Information about remuneration for key management personnel

Name	Position title	Short-term benefits			Post employment benefits		Other long term benefits			Termination benefits	Total remuneration
		Base salary*	Bonuses	Other benefits and allowances	Superannuation contributions	Long service leave	Other long term benefits				
Barry Sandison	CEO	316,803	0	69,932	58,170	45,106	0	0	0	490,011	
Matthew James	Deputy CEO	248,546	0	33,667	44,520	39,238	0	0	0	365,971	
Louise Markus	Chair	74,352	0	0	7,063	0	0	0	0	81,415	
Erin Lalor	Deputy Chair	30,460	0	0	2,894	0	0	0	0	33,354	
Simone Ryan	Board Member	30,746	0	0	2,921	0	0	0	0	33,667	
Michael Perusco	Board Member	30,460	0	0	2,894	0	0	0	0	33,354	
Cathryn Ryan	Board Member	22,594	0	0	2,146	0	0	0	0	24,740	
Christine Pascott	Board Member	22,594	0	0	2,146	0	0	0	0	24,740	
Christine Gee	Board Member	22,594	0	0	2,146	0	0	0	0	24,740	
Romlie Mokak	Board Member	13,013	0	0	1,236	0	0	0	0	14,249	
David Conry	Board Member	9,581	0	0	910	0	0	0	0	10,491	
Andrew Goodsall	Board Member	9,581	0	0	910	0	0	0	0	10,491	
Lyn Roberts	Board Member	572	0	0	54	0	0	0	0	626	
Gillian Adamson	Board Member	286	0	0	27	0	0	0	0	313	
Andrew Kettle	Group Head	210,585	0	25,917	36,740	17,787	0	0	0	291,029	
Geoff Neideck	Group Head	200,287	0	25,917	35,334	15,488	0	0	0	277,026	
Fadwa Al-Yaman	Group Head	197,090	0	25,917	36,157	16,727	0	0	0	275,891	
Jenny Hargreaves	Group Head	195,398	0	25,917	35,541	447	0	0	0	257,303	
Michael Frost	Group Head	185,528	0	25,917	35,108	14,951	0	0	0	261,504	
Louise York	Group Head	178,487	0	25,917	32,608	9,428	0	0	0	246,440	
Lynelle Moon	Group Head	175,921	0	25,917	33,044	(49,611)	0	0	0	185,271	
Adrian Webster	Group Head	171,573	0	23,360	27,988	21,777	0	0	0	244,698	

*Base salary is shown on an accrual basis, which means it has been adjusted to reflect how much annual leave each person took during the year.

Table A6.7: Information about remuneration for senior executives

Total remuneration bands	Short-term benefits		Post-employment benefits		Other long-term benefits	Termination benefits	Total remuneration
	Number of senior executives	Average base salary	Average other benefits and allowances	Average superannuation contributions			

The remuneration of all senior executives has been included in Table A6.6.

Table A6.8: Information about remuneration for other highly paid staff

Total remuneration bands	Number of senior executives	Short-term benefits			Post-employment benefits		Other long-term benefits		Termination benefits	Total remuneration
		Average base salary	Average bonuses	Average other benefits and allowances	Average superannuation contributions	Average long service leave	Average other long-term benefits	Average termination benefits			Average total remuneration
\$220,001–\$245,000	0	0	0	0	0	0	0	0	0	0
\$245,001–\$270,000	0	0	0	0	0	0	0	0	0	0
\$270,001–\$295,000	0	0	0	0	0	0	0	0	0	0
\$295,001–\$320,000	0	0	0	0	0	0	0	0	0	0
\$320,001–\$345,000	0	0	0	0	0	0	0	0	0	0
\$345,001–\$370,000	0	0	0	0	0	0	0	0	0	0
\$370,001–\$395,000	0	0	0	0	0	0	0	0	0	0
\$395,001–\$420,000	0	0	0	0	0	0	0	0	0	0
\$420,001–\$445,000	0	0	0	0	0	0	0	0	0	0
\$445,001–\$470,000	0	0	0	0	0	0	0	0	0	0
\$470,001–\$495,000	0	0	0	0	0	0	0	0	0	0
\$495,001 and over	0	0	0	0	0	0	0	0	0	0

Abbreviations, acronyms and symbols

Abbreviations and acronyms

AASB	Australian Accounting Standards Board
ABDS	Australian Burden of Disease Study
ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
ADHA	Australian Digital Health Agency
AGILE	Attract, Grab, Impact, Learn, Explore
AHMAC	Australian Health Ministers' Advisory Council
AHPF	Australian Health Performance Framework
AIHW	Australian Institute of Health and Welfare
AIHW Act	<i>Australian Institute of Health and Welfare Act 1987</i>
AMR	Australian Mesothelioma Registry
ANAO	Australian National Audit Office
AND	Australian Network on Disability
AO	Order of Australia
apps	applications
APS	Australian Public Service
ASL	Average Staffing Level
CEO	Chief Executive Officer
CIHI	Canadian Institute for Health Information
COAG	Council of Australian Governments
DALY	Disability Adjusted Life Years
DOMINO	Data Over Multiple INdividual Occurrences
DSS	Australian Government Department of Social Services
EA	AIHW's Enterprise Agreement
EEO Act	<i>Equal Employment Opportunity (Commonwealth Authorities) Act 1987</i>
EL	Executive Level
EthOS	AIHW's Ethics Online System
ERICA	Electronic Research Institutional Cloud Architecture
FACS	New South Wales Department of Family and Community Services
FaHCSIA	Former Australian Government Department of Families, Housing, Community Services and Indigenous Affairs
FBT	Fringe Benefits Tax
FGM/C	Female genital mutilation/cutting
FOI Act	<i>Freedom of Information Act 1982</i>
FRR	Financial Reporting Rule
FTE	full-time equivalent
GP	general practitioner
GST	goods and services tax
HTML	hypertext markup language

ICT	information and communications technology
Institute	Australian Institute of Health and Welfare
IPA	Individual Performance Agreement [for AIHW staff]
ISO	International Organization for Standardization
IT	information technology
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
MBS	Medicare Benefits Schedule
METeOR	AIHW's Metadata Online Registry
MHR	My Health Record
MoU	Memorandum of Understanding
MP	Member of Parliament
NABERS	National Australian Built Environment Rating System
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIDOC	National Aborigines and Islanders Day Observance Committee
NDI	National Death Index
NGO	Non-government organisation
NIHSI AA	National Integrated Health Services Information Analysis Asset
NSHS	National Social Housing Survey
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PBS	Portfolio Budget Statements
PDF	portable document format
PGPA Act	<i>Public Governance, Performance and Accountability Act 2013</i>
PGPA Rule	Public Governance, Performance and Accountability Rule 2014
PHN	Primary Health Network
PM&C	Department of Prime Minister and Cabinet
Privacy Act	<i>Privacy Act 1988</i>
RAFC	Risk, Audit and Finance Committee
RMF	Risk Management Framework
SAMAC	AIHW's Statistical and Analytical Methods Advisory Committee
SES	Senior Executive Service
SPPI	solely payments of principal and interest
SRP	Strategic Risk Profile
T1	1 Thynne Street, Bruce
T26	26 Thynne Street, Bruce
WHO	World Health Organization
WHS	work health and safety
WHS Act	<i>Work Health and Safety Act 2011</i>

Symbols

%	per cent
-	not available
..	not applicable

Glossary

Term	Definition or explanation
Australian Health Ministers' Advisory Council (AHMAC)	AHMAC is the advisory body to the COAG Health Council. It operates to deliver health services more efficiently through a coordinated or joint approach on matters of mutual interest. The AHMAC is responsible for providing effective and efficient support to the COAG Health Council by advising on strategic issues relating to the coordination of health services across the nation and, as applicable, with New Zealand and operating as a national forum for planning, information sharing and innovation.
COAG	The Council of Australian Governments is the peak intergovernmental forum in Australia, comprising the Prime Minister, state premiers, territory chief ministers and the President of the Australian Local Government Association. See www.coag.gov.au for more information.
COAG Health Council	The COAG Health Council comprises all Australian health ministers provides a forum for continued cooperation on health issues, especially primary and secondary care, and consider increasing cost pressures.
full-time equivalent (staff numbers)	A standard measure of the number of workers in an organisation, profession or occupation that also takes into account the number of hours each person works. During 2018–19, AIHW staff members considered full-time worked 37 hours and 5 minutes per week.
Health Services Principal Committee (HSPC)	HSPC advises AHMAC on health services reform that requires national collaboration. In addition, HSPC promotes national population health initiatives to improve key interfaces between national and state and territory funding and management of services, particularly: primary/acute hospital interface, care of older persons and the public/private interface.
Indigenous (person)	A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.
Indigenous status (of a person)	Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin.

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

ISSN 2205-4960 (Online) ISSN 1321-4985 (Print)

ISBN 978-1-76054-620-5 (Online) ISBN 978-1-76054-621-2 (Print)

Suggested citation

Australian Institute of Health and Welfare 2019. Australian Institute of Health and Welfare Annual report 2018–2019. Cat. no. AUS 230. Canberra: AIHW.

Australian Institute of Health and Welfare

Board Chair Chief Executive Officer
Mrs Louise Markus Mr Barry Sandison

Any enquiries relating to copyright or comments on this publication should be directed to:
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Canberra ACT 2601
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Published by the Australian Institute of Health and Welfare.



Australian Institute of
Health and Welfare

Annual report

2018–19



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