

access

Issue 15 December 2003

Seasons Greetings

Australia's Welfare 2003 indicators chapter gets Ministerial nod

'Last month I was in Melbourne talking about the need for welfare reform. And I stressed that the term "welfare" suggests a policy on its own, one in isolation from the rest of the economy.'

'This is too simplistic. Welfare is intricately linked with what happens in taxation, what happens in employment, in healthcare, education and housing...

...'This year, for the first time, *Australia's Welfare* includes data under 13 indicator topics, which give us an extremely useful context for the chapters which follow—indicators such as housing, health, education, employment, recreation and social and support networks.

'And I'm looking forward to how this will improve analysis of trends and changes in these indicators, flagged for the next report, *Australia's Welfare 2005*.'

It was a strong endorsement by Family and Community Services Minister Kay Patterson for the 'Indicators of Australia's welfare' chapter in the AIHW's sixth biennial welfare report, *Australia's Welfare 2003*.

The report was launched by the Minister at Parliament House on 4 December, the last sitting day for 2003.

The indicators chapter, which, as acknowledged by the Minister, will now be a regular feature in *Australia's Welfare*, views welfare in terms of concepts such as healthy living, autonomy and participation, and social cohesion, which can all be influenced by personal and environmental factors as well as the service system.

In her speech Senator Patterson revealed her in-depth knowledge of what goes into the preparation of large reports such as *Australia's Welfare* (which is 517 pages in length).

'It's just like the Olympic Games. People see a gold medal being won, but few really know the true extent of what lies behind that one gold medal performance—the years of training and the many real sacrifices that that have been made.'

Senator Patterson said few people knew of the sweat and effort lying behind every number in a report such as *Australia's Welfare*. She alluded to days when, as an author, not a single word seemed to come out right, while at other times you could be prolific for hours at a stretch. She also mentioned the hidden work and expertise that went into production aspects of the volume, such as producing a decent index. Staff members from the AIHW's publishing team nodded knowingly, thankful that the work of the report's indexer, Michael Harrington, had been noticed.

In discussing the ageing and aged care chapter and the special chapter on informal carers, Senator Patterson recalled how, as an academic in Victoria, she noticed how there were many courses available on the positive aspects of child development, but none on the positive aspects of ageing.

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AIHW Director Richard Madden, Minister for Family and Community Services Senator Kay Patterson, AIHW Chair Sandra Hacker and AIHW Welfare Division Head Diane Gibson admire *Australia's Welfare 2003*.



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Australia's Welfare 2003

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'The courses on ageing were all about geriatrics rather than gerontology', Senator Patterson said. She recalled that with the help of colleagues she was successful in getting the first postgraduate gerontology course in Victoria up and running (at the Lincoln Institute of Health Sciences, now amalgamated with Latrobe University).

AIHW Board Chair Dr Sandra Hacker drew attention to the second special chapter in *Australia's Welfare 2003* by saying that it covered 'the unpaid and sometimes unsung welfare services labour force—the two-and-a-half million family members and friends that make up the nation's informal carers'.

'Carers are the nation's primary providers of welfare services to people with a disability and frail older people, and we have provided as much relevant data as we can in the report about carers and those they care for', Dr Hacker said.



Sandra Hacker and Senator Kay Patterson launch *Australia's Welfare 2003*.

'But, as we say in the report, many things are changing in our society, all of which can affect the need for and provision of informal care.

'Women are more likely to work, and people marry later. They have fewer children, later. Blended families are more common, and families are more mobile. The boundary

between full-time work and retirement is becoming blurred as

more people elect to work part-time both before and after so-called "retirement".

'Support for carers will need to align with these changes, as well as with the great variety of individual carer needs, in order to maintain the in-home care that people generally prefer, while avoiding unnecessary increases in the number of formal paid services.'

Sandra concluded that the two special chapters were 'evidence of how keen we are at the Institute to be curious, to explore further, to innovate where we can, and to create and follow opportunities'.

In addition to its special chapters *Australia's Welfare 2003* contains its now-traditional chapters on children's and family services, ageing and aged care, disability and disability services, assistance for housing, homelessness, and welfare services resources (including the welfare services labour force).

***Australia's Welfare 2003* can be purchased over the counter at AIHW for \$35, or via phone order from Canprint for \$45 (telephone 1300 889 873). It is also available in full text free of charge on the Institute's web site (www.aihw.gov.au).**



from the Director

Welcome to our final edition of *AIHW Access* for the year. It has been quite a year—a year when we said goodbye to some long-serving colleagues and friends, and equally a year where we welcomed new Board and Committee members as well as more staff. Significantly, in 2003 we released more publications into the public domain than ever before. Thank you to all the staff of the AIHW for your commitment and dedication, and to our colleagues and collaborators for the guidance, support and expertise you have given to us throughout the year.

There has been much activity and some notable developments in the final quarter of the year.

We are always very proud of our biennial reports on the health and welfare of Australians. *Australia's Welfare 2003* was launched at Parliament House recently by Senator Kay Patterson, Minister for Family and Community Services. This year's edition includes more information than previously, with special chapters on Indicators of Australia's Welfare, and Informal Care. You can read more about this in our lead article.

The first meeting of the newly established National Health Information Group (NHIG) was held in October. NHIG, chaired by Patricia Faulkner, Secretary of the Victorian Department of Human Services, has been established to advise AHMAC on planning and management requirements, and to manage and allocate resources to health information projects and working groups. Within this new structure the Statistical Information Management Committee (SIMC) has replaced the National Health Information Management Group. The role of the Committee will remain essentially the same as the NHIMG and continue on with its work. Dr Ric Marshall, the long-standing Victorian representative on NHIMG, has been appointed as the Chair.

Following the creation of the Institute's unit dedicated to Indigenous health and welfare statistics, the AIHW, supported by the ABS, hosted a workshop on Measures of Social and Emotional Wellbeing for Aboriginal and Torres Strait Islander Peoples. A wide range of groups and experts were represented at the workshop, including national organisations such as NACCHO, SCATSIH, OATSIH and ATSIH. The workshop agreed on a number of general conclusions, with a range of questions to be trialled by the ABS for inclusion in their Indigenous Social Survey.

Our latest report on Australia's youth—*Australia's Young People: Their Health and Wellbeing 2003*—has provided an updated snapshot of the lifestyle of our nation's 12 to 24 year-olds. It follows our original 1999 report on this topic. At a glance the findings show that in 2001, 94% of young Australians aged 15–17 years and 89% of those aged 18–24 years rated their health as 'excellent', 'very good' or 'good'. More information on the report is available on our web site.

The Institute continues to receive excellent media coverage for its publications. The response to the *Australia's Young People* report is a good example, with numerous media interviews conducted following the report's release.

The new five-year Commonwealth–State Housing Agreement, signed in June 2003, brought with it a continued commitment to the National Housing Data Agreement. The Housing Ministers' Advisory Committee also undertook a review of the work of the National Housing Data Agreement under the 1999 CSHA. The review, tabled at the August 2003 HMAAC meeting, noted the success of the work undertaken by the AIHW with the strong support of Commonwealth, state and territory governments and the ABS. There is now agreement-in-principle to fund work at the AIHW over the life of the new CSHA. This will allow AIHW to continue to improve housing assistance data across both mainstream and Indigenous housing assistance areas.

I'd like to finish off this last column of 2003 by highlighting some of the healthy and active pursuits of our staff during the year.

This year staff participated in the annual walk to work (or as we did—walk from work!), which was held one sunny lunchtime and led by our Medical Adviser (that doyen of walkers, Dr Paul Magnus). We also had many staff involved in the recent Australian Masters Games held in Canberra, both as athletes (winning several medals) and as volunteers.

The AIHW's own commitment to encouraging events that promote fitness and fun continued with the annual Melbourne Cup walk, run and cycle races, which most staff were involved in, and our annual soccer match. This year NHMRC conceded AIHW a hard-earned victory.

To all our staff, their families, our colleagues Australia-wide, and our readers, please have a healthy, safe and joy-filled holiday season.

Director

Update on diabetes monitoring at AIHW

Diabetes monitoring at AIHW is now centrally undertaken in one unit—the Cardiovascular Disease, Diabetes and Risk Factor Monitoring Unit. Our work in diabetes continues to expand in three main areas:

- developing, analysing and disseminating national data on diabetes across the health continuum
- managing the National Diabetes Register (NDR)
- identifying and addressing data gaps and deficiencies.

Our 'flagship' diabetes publication was released 12 months ago—*Diabetes: Australian Facts 2002*. It contains national data and trends across the spectrum of disease—levels in the population, contributing factors, major complications, and treatment and preventive programs that aim to combat it.

A major component of our work is the NDR, a significant national data collection providing vital information on new cases of insulin-treated diabetes. Approximately 35,000 people have been registered on the NDR since it began operating in 1999: 30% of these people have Type 1 diabetes, 60% have Type 2 diabetes and 7% have gestational diabetes. During 2000–2001, there were close to 1,600 new cases of insulin-treated diabetes among people aged less than 15 years—people of this age predominantly have Type 1 diabetes. These results were released in August in the report *National Diabetes Register: Statistical Profile, December 2001*. Results for 2002 will be released early next year. The significance of the NDR data will continue to grow as the register ages, providing vital information on all types of insulin-treated diabetes.

Hot off the press is a new bulletin, *A Picture of Diabetes in Overseas-born Australians*, which compares the impact of diabetes (as measured by incidence, prevalence, hospitalisations and deaths) in Australians born overseas with that for the Australian-born population. A key finding

is that proportionately more Australians born overseas report having diabetes than their Australian-born counterparts: 28% of Australians are born overseas, yet 35% of people reporting having diabetes were born overseas. Groups with the highest risk and impact from diabetes were those born in the South Pacific Islands, North Africa/Middle East, Southern Asia, and Southern Europe.

We have three more diabetes reports coming out over the next few months:

- *How Much does the Increase in Australia's Weight Account for our Increase in Diabetes?*—a bulletin that estimates the extent to which the rise in the prevalence of diabetes over the last 20 years can be attributed to the rise in body mass index over the same period.
- *The Impact of ICD Coding Standard Changes on Diabetes Hospital Morbidity Data*—a technical paper outlining important issues for analysts using hospital data.
- *Diabetes and Allied Health Services*—an information paper that includes a discussion of recent mapping projects showing the interactions between allied health services and diabetes in the community.

For more information on our diabetes work, please contact Anne-Marie Waters, ph. (02) 6244 1102 or email diabetes@aihw.gov.au

Health and community services labour force

Health and Community Services Labour Force 2001 is the second in a five-yearly series that presents and analyses workforce data from the Census of Population and Housing. This joint AIHW/ABS report was released on 30 September 2003.

The report provides a rich statistical base that will inform discussion about the capacity of the health and community services workforces to meet service requirements now and in the future. It provides detailed data on the numbers and characteristics of workers in individual occupations. The report also addresses issues such as the changing age structure and geographic distribution of the workforce and of the general Australian population.

The report shows that there was substantial growth in the health and community services occupations (of 11.4% and 26.8% respectively) between 1996 and 2001. The largest growth occurred among aged/disabled care workers (up by almost 16,000 workers, or 44.1%) and child care workers (up by nearly 14,000, or 44.8%). This growth was accompanied

by a degree of restructuring, as reflected in changes in the occupational mix. For example, there was a 5.8% increase in registered nurses, but this was accompanied by a 20.7% decrease in enrolled nurses and an 18.8% increase in lower paid carers and aides.

The supply of workers in health and community services industries decreased with increasing remoteness, from 3,055 and 1,008 per 100,000 population respectively in the Major cities, to 1,498 and 796 per 100,000 population respectively in Very remote Australia in 2001. The report also finds that some of the rapidly growing regions on the outskirts of the major capital cities had the lowest supply of health and community services professionals of any region within their respective states.

The publication will be of interest to workforce planners in state and territory governments, which are major suppliers of health and community services. It will also interest professional associations and industrial organisations.

New Reports

Australia's Young People: Their Health and Wellbeing 2003

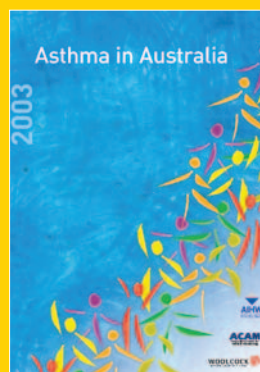
Australia's Young People: Their Health and Wellbeing 2003 is the second national report on the health and wellbeing of young people in Australia. It provides comprehensive information on the health status of young people including causes of hospitalisations and deaths, chronic diseases, infectious diseases, injury, disability, reproductive and sexual health. The behavioural risk and protective factors influencing young people's health and wellbeing that are covered in this report include substance use, diet and nutrition, physical activity and overweight and obesity. Social conditions are also important determinants of health. The report therefore includes information on the family environment, relationships and social participation, education, employment and income. An overview of the health and welfare of Aboriginal and Torres Strait Islander young people is also presented.

AIHW Catalogue No. PHE 50,

Available over the counter at AIHW (\$10 discount applies) and from CanPrint (Ph:1300 889 873); \$40.00

Asthma in Australia 2003

Asthma is an important health problem in Australia. This report brings together data from a wide range of sources to describe the current status of asthma in Australia. It includes information on the number of people who have asthma, who receive various treatments for asthma, who have written asthma action plans, and who visit their GP, are hospitalised or die due to asthma.



AIHW Catalogue No. ACM 1,
Available over the counter at
AIHW (\$10 discount applies)
and from CanPrint
(Ph:1300 889 873); \$33.00

Cancer in Australia 2000

In 2000, there were 85,231 new cases of malignant cancer in Australia and 35,466 deaths primarily due to cancer. In addition there were an estimated 374,000 new cases of non-melanocytic skin cancer in 2002; these cancers are not notifiable to cancer registries.

Currently 1 in 3 men and 1 in 4 women can be expected to be diagnosed with a malignant cancer in the first 75 years of life. The average age of first diagnosis is 66 years for males and 64 years for females, with the median age 69 years for males and 65 years for females. Hence cancer is predominantly a disease that emerges later in life. A consequence of this is that relatively rapid growth of the population aged 55 years and over is driving growth in demand for cancer services well in excess of population growth. Between 1990 and 2000, the number of new cases of malignant cancer per year increased by 36% compared with an increase in the population of 12%, despite a small decline in recent years in age-standardised incidence rates.

These and other important statistics profiling cancer can be found in *Cancer in Australia 2000*. Provided by the Health Registers and Cancer Monitoring Unit, it is the latest in the series of cancer publications produced by the Institute with the assistance of the Australasian Association of Cancer Registries.

In this latest and the previous *Cancer in Australia* report the content has expanded significantly beyond the incidence and mortality statistics found in earlier editions. In *Cancer in Australia 1999*, summary statistics were included for cancer survival, general practitioner consultations, hospital inpatients for the National Health Priority cancers, the cancer workforce and cancer risk factors.

In *Cancer in Australia 2000*, there is a profile of bowel cancer, which is currently of major policy interest due to pilot tests being conducted for a national bowel cancer screening program. Data from the 2001 National Health Survey (ABS) on the numbers and characteristics of women who receive mammography and Pap smears have been analysed and those who miss out on these services are profiled. There is a detailed analysis of trends in hospital separations for persons with a principal diagnosis of cancer. This shows the numbers of separations for cancers increasing by 4.7% per year in recent years, and an increasing proportion of cancer treatment in private hospitals.

Supplementing the *Cancer in Australia* reports are additional tables on the Institute's web site and a data cube where users can produce their own age and sex trend statistics for the various cancers.

Cancer in Australia 2001, due to be released in mid-2004, will be a landmark publication, as it will represent 20 years of national cancer incidence data in Australia. The Institute is planning to further improve its coverage of cancer statistics with an updated burden of disease analysis and new indicators such as cure rates, a statistical technique learnt by AIHW cancer statistician Dr Chris Stevenson at the annual conference of the International Association of Cancer registries in June.

Linking research, policy and practice

The AIHW and Department of Health and Ageing co-hosted the National Symposium on Ageing Research: Building Evidence, Policy and Practice on 23–25 September at the Australian National University in Canberra. Over 250 delegates from research, policy, practitioner, industry and provider associations gathered over the 2-day event to discuss strategies for strengthening the translation of research findings, statistics and evidence into policy decision making, service programs and networking structures.

The symposium began with the launch of the new Ageing Research Online (ARO) web site (www.aro.gov.au) by the Minister for Ageing, the Hon. Kevin Andrews MP. An interactive database of ageing-related research activity in Australia, it is hoped that the ARO website will provide a key resource for researchers, policy makers and practitioners.

The Minister was followed by a diverse and eminent collection of speakers who raised critical issues relevant to the ageing research field. Speakers included Professor Sir Michael Marmot from University College, London, Dr Robin Batterham, Chief Scientist to the Australian Government and Professor Stephen Duckett, Professor of Health Policy at La Trobe University.

Professor Marmot delivered a compelling keynote address identifying some of the factors that contributed to the successful impact of the Whitehall studies of British civil servants on the government's approach to the issue of health inequality. Professor Marmot stressed the utility and importance of longitudinal studies of ageing in efforts to bring quality evidence to bear on the policy decision making process.

Over the following two days of the symposium, speakers tackled a number of questions crucial to improving the translation of research findings to policy and practice:

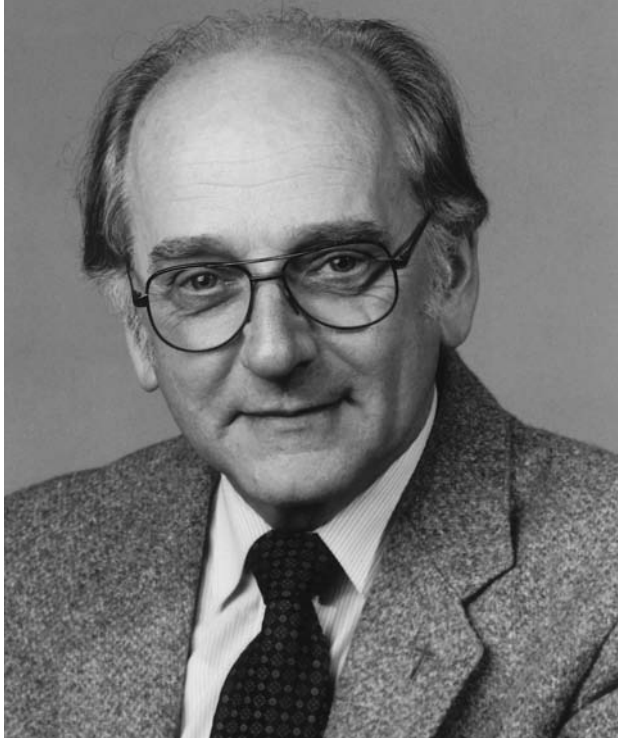
- What are the impediments to, and catalysts for, successful development of responsive and policy-relevant ageing research and the necessary mechanisms to support stakeholder engagement?
- What has changed in the external environment that may assist or hinder this process?
- What is the appropriate role for stakeholders (i.e., researchers, government, policy makers, and community and industry bodies)?
- What lessons can be learned from past experience?
- What is the difference, or relative value, in pursuing 'ageing research versus more general research which acknowledges the significance of age differentials?

The presentations made by a number of the speakers are available on the ARO website (http://www.aro.gov.au/WebStreamer?page_id=1424).

The range of views and approaches taken by speakers and the intense engagement of delegates indicated that the questions are relevant to stakeholders. Further work is being undertaken to take into account the input from speakers and delegates in order to move the process forward. The ARO will (in coming months) provide information on further outcomes of the symposium, including material relating to the ongoing development of the Australian Ageing Research Agenda.

PROJECT
reports

on D'Arcy Wood



As the longest-serving member of the AIHW's Ethics Committee, Rev. Dr D'Arcy Wood has not only seen AIHW Directors and Committee Chairs come and go since 1993, but has also witnessed some significant shifts in ethical approaches to various research issues and projects.

'As well as focusing on issues of privacy and informed consent, the Committee at times discusses the social context of particular research. I find particularly interesting the differences between Western and Indigenous approaches to ethical matters. We have seen a very positive move in recent years towards respecting Indigenous culture and values. For example, for a long time Aboriginal people were supposed to conform to Western society, and were not encouraged to develop their own culture. Now the differences between the two approaches are better understood and respected, for example, the fact that Indigenous societies put community values first, whereas in Western societies the emphasis is on individual human rights.'

Dr Wood thinks that we need to be very careful when discussing the possibility of an absolute, or universal, approach to ethical questions. 'The more abstract you become in ethics, the more general you get. Cultures differ, and we are more careful now with ethical issues. In general terms there are universal ethics, but they encompass various ethical systems that all have to be taken into account. The Universal Declaration of Human Rights would probably be very different if it were written now, and not some 50 years ago, in times when it was assumed that ethical values were universal and built into all human societies.'

A theme Dr Wood has always been particularly interested in is the need for two-way traffic between theory and practice. 'If there is dissonance between theory and practice in ethical matters, then theory needs to be adjusted. Norms have to be flexible. A good example is the right to life, which pretty much rules out any form of warfare, or taking of life in order to save another life, as in some cases of mothers and babies. If you start to apply rigid norms to these situations, then you are in immediate trouble.'

'I think that there are a number of prima-facie moral rights, but they need to be applied in combination with other rights and goods in each particular situation.'

As the Minister of Religion member on the AIHW's Ethics Committee, Dr Wood is confident that although some people fear that those with strong religious beliefs will be inflexible in ethical matters, this need not be the case.

'All ethics should be grounded in actual personal, social, economic and political circumstances. Ministers of religion are not removed from people and everyday life. Many people do not have religious beliefs nowadays, and have misconceptions about ministers of religion.'

'Ministers of religion have very strong connections with people through their work and are trained to deal with personal and family problems. On the other hand, they are trained in using a theological framework, have a strong ethical background, and do not tend to judge a situation by the lowest common denominator.'

Dr Wood's longstanding interest in ethics comes from the time when, uncertain as to what career path to follow during his last year in school, he decided to study something general at university—and did a combined Honours degree in history and philosophy at the University of Melbourne.

'I particularly enjoyed the ethics component of my philosophy studies, as it had to do with universal issues of right and wrong, values and conduct. While my professional life has taken other directions, I have followed up my study in ethics in two ways. The first was to write an MA thesis on the relationship between theory and practice in ethics, and the second was to become a member of the AIHW Ethics Committee about 10 years ago.'

Born to Methodist missionary parents, Dr Wood was brought up in the church. 'While doing the compulsory three-month military service as an undergraduate, it came to me strongly that I was being called to take on the role of a minister. In 1959 I started theological studies at the Melbourne College of Divinity. I was 22 at the time, quite an early starter by modern standards.'

Dr Wood obtained his Bachelor of Divinity degree in 1962, but wasn't ordained for a few years, since he decided to do postgraduate studies. 'At that time there were not many opportunities to pursue that in Australia, so I chose to go to Princeton Theological Seminary to do a PhD in Doctrinal Theology.'

After four years in the USA, Dr Wood and his young family returned to Australia in 1966. He was ordained into the Methodist Ministry in Melbourne and took up his first parish appointment, for three years, in Ballarat.

Dr Wood's career then turned to theological teaching, chiefly in Adelaide, but also to some extent in Sydney, Canberra and Melbourne. 'Although it may sound immodest of me, I think I have a natural gift for teaching. I started teaching as an undergraduate student and found that I had the ability to communicate with students. I combined theological research with teaching for 15 years in Adelaide. The responsibility of preparing graduates and some undergraduates for pastoral ministry in local churches is a heavy one, but one I enjoyed.'

Dr Wood's teaching also took him into the field of liturgy, and then into church music.

His interest in liturgy was put to practical use in preparing worship resources for the Uniting Church, which was formed in 1977 and needed new resources as it entered a new era. 'For 13 years I chaired the relevant Commission and we produced substantial resource books. It is satisfying to know that the material which my colleagues and I wrote is currently used week by week at weddings and funerals, and in homes, as well as in Sunday worship.'

Dr Wood eventually gave up teaching to return to parish work, first in Canberra (City Church, Civic) and then in Melbourne. While in Canberra he also served as National President of the Uniting Church, travelling extensively throughout Australia and overseas.

He was also eager to dedicate more time to music, one of his life's great passions.

'My parents encouraged their six children to study music and I began piano at the age of eight. Later I studied organ, and for a short time the cello. My father was a very good pianist, but as he got older, his beautiful 1939 Bosendorfer grand piano was a bit neglected. I inherited the piano, had it restored and still play it regularly. The piano has moved with the family everywhere we went over the years.'

'I have also conducted church choirs in Melbourne and in the USA, and sung bass in concert choirs in Melbourne and Sydney, performing the large works of Bach and Handel as well as modern works. My musical training has also been put to use in the preparation of three ecumenical hymn books, in 1977, 1987 and 1999. The first sold well over 1 million copies. The 1999 book serves five of the major churches in Australia: Anglican, Churches of Christ, Lutheran, Roman Catholic and Uniting.'

The work on hymn books combined three of Dr Wood's main interests: theology, liturgy and music. He is currently writing a commentary on the 1999 hymnal *Together in Song*, which is promising to be a very large volume. 'This is my biggest project since retiring three years ago', he says.

'The Ethics Committee work, on the other hand, helps to keep my interests broad, and keeps me in touch with areas of work different from my immediate projects. I am glad that when I handed in my letter of resignation on leaving Canberra in 1996, Director Richard Madden and the then Committee Chair Sid Sax thought it would be good to have non-Canberrans on the Committee, and persuaded me to stay. I am still enjoying it!'

Dr Wood and his wife Janet live in Gisborne, north of Melbourne. Janet is a Member of the Commonwealth Refugee Review Tribunal. They have two children and three grandchildren.



Statistical Information Management Committee

You might notice that the heading for this segment has changed. The previous National Health Information Management Group (NHIMG) is no more. It is now, as part of a broad restructure of national health information governance agreed by Health Ministers, the Statistical Information Management Committee. The story is as follows:

On 31 July 2003 the Australian Health Ministers' Council endorsed new arrangements for national development of health information management and information technology. The new arrangements have been designed to enable more coordinated, coherent governance of national data collection, data standards and information technology.

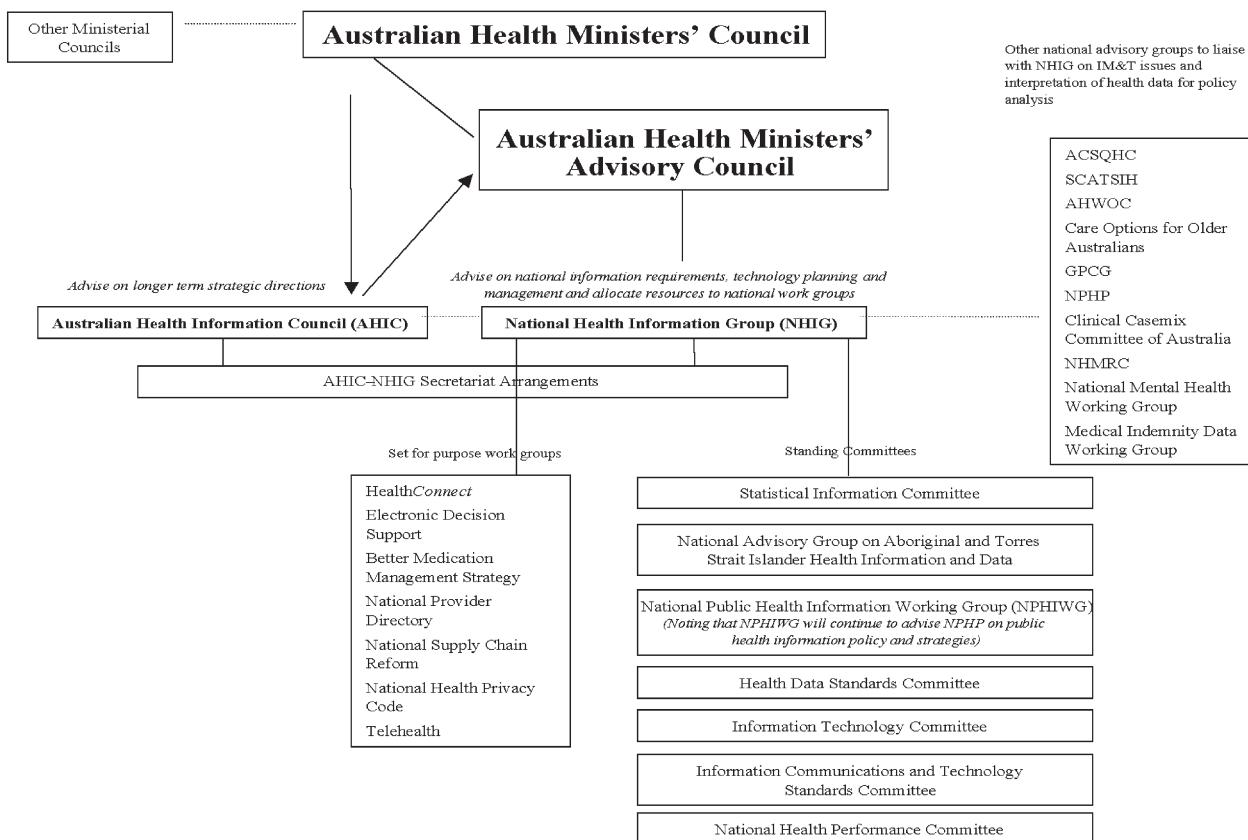
The National Health Information Group (NHIG) was established to advise the Australian Health Ministers'

Advisory Council on planning and management requirements and to allocate resources to health information projects and working groups.

In order to streamline and better coordinate ongoing information management and technology planning and development, a new committee and working group structure sitting underneath NHIG were created. Ministers agreed to the establishment of:

- a Statistical Information Committee;
- a Health Data Standards Committee;
- an Information Technology Committee; and
- an Information Communications and Technology Standards Committee.

New National Structure



In addition, Ministers agreed that the existing **National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data**, **National Public Health Information Working Group** and the **National Health Performance Committee** would become standing committees of NHIG. The chart shows the new national structure.

Dr Ric Marshall, who previously represented the Victorian Department of Human Services on the NHIMG, has been appointed Chair of the Statistical Information Management Committee. Membership of the group has been extended to include a representative of the Department of Veterans' Affairs.

The first meeting of the newly-established group was held on 14 November. As well as continuing with its existing role to endorse for collection a range of national minimum data sets cleared by the Health Data Standards Committee, members reviewed the terms of reference for the group, and put in place processes for the renewal of the National Health Information Agreement.

For further information, please contact Margaret Fisher, Secretary, Statistical Information Management Committee, email margaret.fisher@aihw.gov.au

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Services Information Management Group (NCSIMG)

The key news from this group is the agreement in principle by the Community Services Ministers' Advisory Council (CSMAC), at their meeting in October, of the proposal by Dr David Filby, Chair of NCSIMG, that a new National Community Services Information Agreement covering the period from 2004 to 2009 should be developed.

David consulted widely with both government and NGO representatives of the community services sector when he prepared his report to CSMAC. He will hold further consultations, including discussions at NCSIMG meetings, as part of his work on the new Agreement.

CSMAC also agreed that the new Agreement should provide for the continuing involvement of the non-government sector through its membership of the National Community Services Data Committee and that New Zealand be invited to join NCSIMG.

Version 3 of the National Community Services Data Dictionary is soon to be released on the AIHW web site and will be published in January 2004. Version 3 introduces common metadata items for both the National Community Services and the National Health Data Dictionaries.

For further information, please contact Margaret Fisher, Secretary, National Community Services Information Management Group, email margaret.fisher@aihw.gov.au

5 ways to buy

Customers wishing to purchase AIHW publications have the following options:

1. Over the counter at the Australian Institute of Health and Welfare (AIHW)

6A Traeger Court, Fern Hill Park Bruce ACT 2617
Contact: Publications officer,
AIHW, tel. 02 6244 1032

AIHW publications purchased from AIHW reception will receive a \$10 discount (AIHW Bulletins \$5 discount)

2. Over the phone:

(CanPrint) Ph. 1300 889 873

3. CanPrint Mail Order Sales:

PO Box 7456, Canberra MC ACT 2610

4. Fax order: Ph. 02 6293 8333

5. Email: sales@infoservices.com.au

Coming soon, commencing from January 2004, AIHW publications will be available for sale from the AIHW web site at www.aihw.gov.au



Australian hospital statistics: what can they tell us about our health status?

Part 1: a case for hospitals or a hospital case?

Statistics galore

You all knew, of course, that in 2001–02 Australia's public hospitals did 46,568 procedures on the knee, patella, tibia and fibula. And that they had 58,711 admissions for diseases of the eye and adnexa that same year. And that our hospitals provided 19,691 records of care provided for haemorrhoids among males.

These are the kinds of statistics that journalists love to quote in health articles. They're large enough to sound spectacular in their own right. They look like there's a lot of pain going down and medical work going on. Did you know that! Say no more.

But what statistics like these really tell us, apart from their gee-whiz impact, can be quite another matter. We need to put them in context with other information so we can see how they vary and then make comparisons. Is the number of procedures on the knee, patella etc. higher in public hospitals or private ones, for example? Does the rate (e.g. number per thousand of population) of public hospital admissions for eye diseases vary from state to state; and if so is this balanced out by the pattern of admissions to private hospitals in those states? Do females have the same rate of haemorrhoid admissions as men? What were the figures in past years and is it possible to compare Australian statistics with those of other countries? And when we find differences, why might that be?

The scope for questions like these, and their answers, is enormous. And the lead to them can be found in the Institute's two national databases covering hospitals. The National Hospital Morbidity Database contains a vast store of annual data about the health problems that public and private hospitals deal with, the basic features of the patients they admit and the surgical and other procedures they carry out for those patients. The National Public Hospital Establishments Database records the number and size of public hospitals around Australia, the specialised services they offer, the number and type of staff they employ and their expenditure and revenue. The original records are made by hospitals

mainly for internal administrative purposes, so when they are adapted to produce state and national databases the result is sometimes known as 'administrative byproduct' data.

Along with some other sources, data from these collections are neatly summarised each year in the Institute's publication *Australian Hospital Statistics*. This valuable report tells us much about our hospitals, what's going on in them and how they may be performing in some key areas. We often modestly summarise what these statistics can tell us as 'hospital use'. But as you can see, this doesn't do them enough justice.

But is there even more?

More than just use, hospital statistics can obviously tell us a lot that relates to health itself, at least to health that is bad enough to warrant a visit to hospital. Researchers have shown how we could use the statistics in building a picture from people's contact with various parts of the health system, including how we might link their hospital experience with later outcomes, even death. This would depend on a technique that is usually not possible at the national level, namely record linkage—being able to link up various health databases that were not originally designed for that purpose.

And there is the question of whether hospital statistics also help as a barometer of Australia's *levels* of health—to whether our overall health is good, bad or indifferent, to whether it is improving or not, to trends in the onset and prevalence of major diseases, and so forth. In short, what can they tell us about our health status?

Statistically speaking, Australia is fortunate enough to have good data about the bad news—namely how many people die of what causes each year. But data are thin on the ground about the rate at which people are actually *getting* diseases and other health problems each year, on the incidence of these things. Our best information on incidence comes from disease registers, such as we have for cancer. But registers are not cheap and there are very few of them in comparison to the vast number of diseases. We don't have a national register for a major killer like heart attack, for example.

If we don't know the rates of onset as well as mortality, we can't so easily sort out, for example, what a high-ish number of deaths each year tells us on its own. Does it just reflect that there are many cases arising, or that there are not so many cases but they are usually serious when they occur, or that the cases are both serious and frequent... and so forth? This makes it harder to gauge whether the challenge is mainly one for prevention, for better treatment, or a mixture.

Obstacles we can't ignore

But when we turn to hospital statistics for help with this kind of question, we run headlong into some big limitations. We shouldn't be surprised or blame anyone for this, of course. The records were not designed for this purpose in the first place.

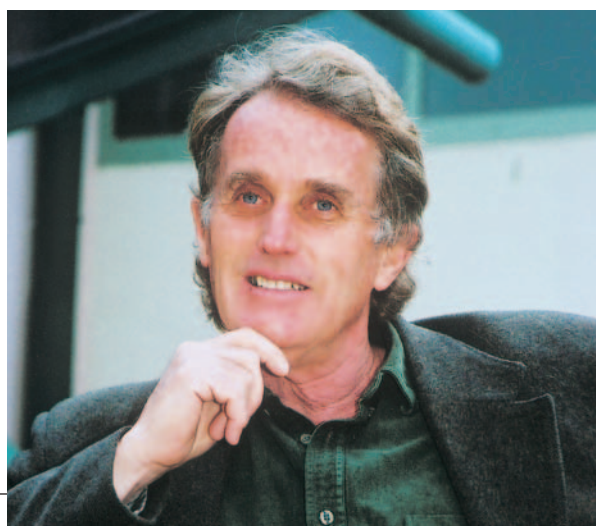
First, there's the question of which health problems would be worth examining. We all know that most people with a problem don't need to go to hospital (thankfully) so the statistics can't cover their cases. Many disorders will almost never need hospital attention while in other cases some will and some won't.

So what if we focused on only more serious disorders that usually involve at least one visit to hospital? Even then there may not be a precisely consistent relationship with hospitalisation. It may vary from place to place and year to year, just enough to complicate our interpretations. Policies and practices can vary. In a particular year some hospitals may be more inclined to admit patients for a problem of a particular type or severity, while others tend to feel it can be well handled outside. Similarly with the attitudes of those who refer patients to hospitals, such as GPs.

This variation between hospitals wouldn't matter for *national* statistics about a disorder, of course, provided we had a very confident handle on the overall proportion of cases that are admitted and this didn't change from year to year. But the next year, practices may change widely after the publication of strong new guidelines for treatment or the results of clinical trials. Or, as medical experience grows, there may be an increasing general willingness to do certain procedures that involve hospitalisation.

For example, take coronary revascularisation procedures—coronary artery bypass grafting (CABG) or angioplasty, both of which aim to overcome a critically blocked blood supply to the heart and restore good blood flow to it.

What if we tried to use revascularisation statistics to get an idea of population rates of heart diseases—heart attacks or angina cases? The Institute has shown that revascularisation rates have been rising for many years, so we might be tempted to conclude that the heart disease rates are increasing apace. In fact there is good evidence that rates of heart attack, at least, are actually *declining*.



Dr Paul Magnus, AIHW Medical Adviser

The discrepancy is probably because doctors are becoming more and more adept at revascularisation procedures and convinced about their benefits, so they are doing them on a growing proportion of people with blocked arteries.

Then there's the challenge of using hospital statistics to measure incidence. This can be defined as the number of new cases of an illness or health event occurring within a specified period. And things can become complex, even assuming we can find suitable health problems to examine in this context.

Say we want to count *people* as new cases and our period of interest is one year, the period covered by *Australian Hospital Statistics*. We need to remember that an individual may have multiple admissions during the 12-month period. For example, some people will have the onset of a chronic problem such as diabetes while others may have one or more of what can be called an acute event, such as a heart attack or a broken leg.

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Australian Hospital Statistics:

The diabetes may be diagnosed in hospital early in the 12-month period, involve a second admission to assess and stabilise treatment, and yet a later one if further tests are required down the line. A person who has two heart attacks in the one year will be admitted at least twice and the same for a jockey who breaks his leg twice. If we can't take these situations into account there is the risk of over-counting people.

Similarly, if we want to count 'new' or 'onset' *events* as a measure of incidence, there is risk of over-counting the events. In the example of diabetes above, it can have only one onset despite several admissions. Heart attack is a more complex example. The *attack* itself is a new event and can be treated as such, even though the underlying disorder it represents—coronary heart disease—is regarded as a chronic disease. So if you want to be sure of counting only the 'events' you would want to distinguish (within a series of admissions, say) between admissions for new attacks and admissions for other reasons such as complications, follow-up, or further investigations. You would then count each 'heart attack admission' as a new event.

But when we look at the hospital records to see if we can sort these things out, they certainly don't provide any neat guide to incidence. In the jargon, they are 'separation based' and not patient based. A separation marks the completion of an 'episode of care', which means it occurs whenever there is either a transfer in-hospital to another type of care (say from acute care to rehabilitation), a discharge out of hospital, a transfer to another hospital, or death in hospital.

In other words, Australia's hospitals could have 100 separation records for a particular condition over a year. But you would need extra facts to tell if this reflected 100 different people, 90 who were admitted only once and one who was admitted 10 times, or many other combinations. And even more facts to separate onset events from other reasons for admission. If we can't sort out these issues we will over-count.

We hope in the future sometime to be able to link multiple separations for the one disease experience. This would certainly simplify interpretation and analysis.

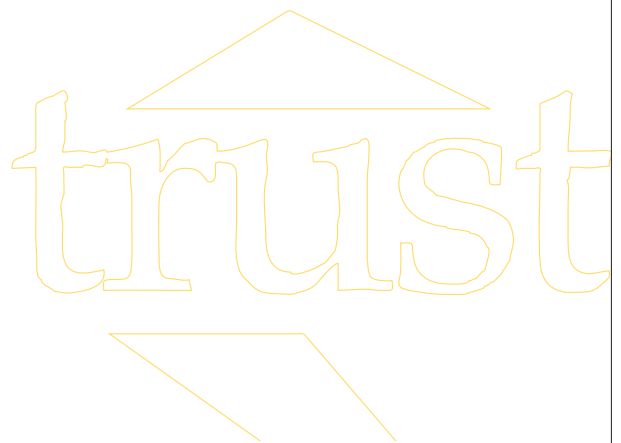
Questions to explore (next time)

So in the light of these obstacles, is it realistic to think that hospital statistics might help tell us about our levels of health? I think it is.

In the next issue of *Access* I want to explore the following questions:

- What health problems might be candidates for using hospital statistics to decide their incidence, and why?
- Can we overcome the obstacles posed by separation-based records in our efforts to obtain counts of people with onset events, or of the new events themselves?
- How are hospital statistics used in other ways to shed light on our overall health status?

Postscript: thanks to Jenny Hargreaves for a lot of helpful guidance on this subject.



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