



access

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AIHW's work in ICF showcased at Forum

'Improving Information on Disability and Functioning: A Forum for People Who Need, Use or Develop Information' attracted over 120 participants in February.

The centrepiece of the forum held in Sydney was the International Classification of Functioning, Disability and Health (ICF) which was developed by the World Health Organization (WHO) and endorsed by the World Health Assembly for use in describing functioning and disability. The ICF provides a framework to support the development of quality data on functioning and disability and to improve the consistency and comparability between clinical, administrative and population data collections. The classification is now recognised as a reference member of both the WHO and Australian families of international classifications, and is complementary to the International Classification of Diseases and Related Health Problems (ICD).

The AIHW, as a Collaborating Centre of the WHO, has been involved for more than a decade, firstly with the preparation of

the ICF, and subsequently with the operationalisation of the ICF in Australia. Ros Madden, Head of the Functioning and Disability Unit in the Institute, has been leading the work. She instigated the forum to enable people interested in and working with the classification to share information, build up understanding of the state of implementation of the ICF in Australia, and help point to future directions.

Speakers and participants were from a broad range of disciplines, with representatives from the WHO, non-government organisations, consumer groups, public and private agencies, clinical specialties, and Australian and international universities in attendance. Delegates came from all over Australia and as far away as Canada, Thailand, the United States and the Netherlands.

Speakers presented information on a wide range of applications including:

- ICF in rehabilitation
- measurement and data capture in service delivery and information systems
- ICF and connecting with what matters
- the environment and participation
- measuring health and disability in surveys.

One of the key objectives of the event was for participants to share information and learn more about the ICF. In this regard, the forum proved extremely successful. Over the two days, useful insight into ICF implementation work and challenges was provided. The forum highlighted:

- a broad understanding of the ICF framework across clinical and administrative areas
- the significant work already under way in applying the ICF within Australia and internationally
- some challenges regarding the coding of ICF
- the importance of ongoing involvement of non-government agencies and people with disabilities in discussions on the quality of, and access to, functioning and disability data

Farewell from Ching Choi

Ching looks back
on his years at
AIHW (story page 10)



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from the Director



Welcome to my first edition of AIHW Access as Director of the Institute.

I'm now in my fourth month at the AIHW, and am really enjoying my new role. The Institute is a great organisation to lead, and I am most impressed by the culture and expertise here. Australia is very fortunate to have a national organisation created by legislation to ensure there is a sound evidence base of data and information that informs policy in the broad health and welfare arenas. I am also very fortunate to be able to build on the work of my predecessor, Professor Richard Madden, who has fostered the Institute's reputation for quality and objectivity.

Accessibility, or making our work available to all Australians, is one of the Institute's core values and *Access* magazine provides an important opportunity for us to reach out to our stakeholders in the community.

The months since I arrived have been very busy and productive ones. There have been important gains—and losses—of staff. In January, just before my arrival, the AIHW welcomed a new intake of nine graduates. A month or so ago, the Head of the Health Division, Dr Ching Choi, retired, after 14 years in leadership roles at the Institute, initially establishing the Welfare Division and then leading the Health Division for the past four years. Ching has also been a major force on the national scene, driving the development of national data standards, particularly in the field of health. It is therefore fitting that he has the opportunity to share his views on the work of the Institute and national health and welfare information in the *Soapbox* article for this issue of *Access*.

The forum on the International Classification of Functioning and Health (ICF) held in Sydney on 6 and 7 February was very successful. To read more about the forum see the cover story.

Also in February, the Institute hosted a delegation from the Republic of Korea. The delegation was interested to learn more about the Institute's work in relation to national data dictionaries for health and welfare and the role they play in promoting the collection of nationally consistent, comparable data. They were impressed with the arrangements and progress that have been made in this area in Australia.

I have been busy meeting as many of the Institute's partners and stakeholders as I can, getting to know the staff and identifying the key issues that we should be focusing on in the year to come.

Looking forward, the launch of *Australia's health 2006*—the 10th biennial report on this topic—and the associated one-day conference are on the horizon. The launch will be held at Canberra's Hyatt Hotel on 21 June 2006. Information on the launch and the conference is in this issue and I encourage you all to attend this important event.

Penny Allbon

Mental health services in Australia 2003–04

Project 1

In December 2005 the Institute released the latest in its series of comprehensive reports on mental health services in Australia.

Mental health services in Australia 2003–04 is a detailed annual report on Australia's mental health services, the seventh of its kind, and includes data on patients admitted to hospital from the Institute's National Hospital Morbidity Database; data on service contacts for patients treated in community-based mental health services and public hospital outpatient clinics from the National Community Mental Health Care Database; and resource and expenditure information on community mental health services and public psychiatric hospitals from the National Community Mental Health Establishments Database and National Public Hospital Establishments Database, respectively.

A wide range of other data is also included, to provide a picture of the range of mental health-related services provided in the health and community services sectors. Information is presented on private psychiatrist services, on mental health-related care provided by general practitioners and on mental health-related disability support services funded by the Commonwealth, State/Territory Disability Agreement. Included for the first time is information on mental health-related supported accommodation services from the AIHW's Supported Accommodation Assistance Program National Data Collection.

In 2003–04, there were over 4.9 million mental health service contacts in community-based mental health services and public hospital outpatient clinics. There were 197,712 mental health-related hospital separations for admitted patients, having increased at an average annual rate of just over 2.0% since 1999–2000.

An interesting pattern which appeared in the report was mental health-related hospital separations differing according to where the patient usually resided. For patients who received specialised psychiatric care while hospitalised, the number of separations per 1,000 people was highest for those living in major cities (5.9) and lowest for those living in remote areas (2.7). The opposite was true for patients who did not receive specialised psychiatric care when hospitalised for mental health-related care. The number of separations per 1,000 people was highest for patients living in remote areas (8.0) and lowest for those living in major cities (3.4). These patterns

may reflect differing roles of hospital and non-hospital care, and/or differing needs for care in different parts of the country.

Schizophrenia accounted for the highest number of hospital separations with specialised psychiatric care (19.0%), followed by depressive episode (16.6%). For hospitalised patients who did not receive specialised psychiatric care the most common diagnosis was mental and behavioural disorders due to use of alcohol (17.3%), followed by depressive episode (13.8%).

In 2003, there were an estimated 2,810 full-time equivalent psychiatrists (including psychiatrists in training)—14.1 per 100,000 people—and there were an estimated 12,883 mental health nurses—64.8 per 100,000 people. Major cities had a relatively high number of full-time equivalent psychiatrists and mental health nurses per 100,000 people (18.5 and 65.7 respectively) while remote and very remote areas had the fewest (2.5 and 12.7 respectively).

In the coming year, the nature of *Mental health services in Australia* will be reviewed with the aim of making the report an even more useful resource. It is likely to be streamlined to focus more sharply on the information that is most useful for mental health service providers, planners and consumers, and other stakeholders; and to better reflect directions of the National Mental Health Strategy and the associated *National Mental Health Information Priorities 2nd edition*.

As part of this review, work will be undertaken to plan the inclusion of data from the new Residential Mental Health Care National Minimum Data Set (NMDS) and in preparation for reporting of the new Mental Health Establishments NMDS. With data from these two new data sets, the report will then incorporate information on specialised residential mental health care not previously available for Australia, and policy-relevant detail on government expenditure on the full range of specialised mental health services.

Comments regarding the future content of *Mental health services in Australia* are welcome.

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General practice activity in Australia

The BEACH (Bettering the Evaluation and Care of Health) program, a continuous cross-sectional national study of general practice activity, is now nearing the end of its eighth year. The study represents a successful long-term collaboration of the Institute and the University of Sydney through the Australian GP Statistics and Classification Centre (GP Stats). The Centre regularly reports current status of, and changes in, the characteristics of practising general practitioners (GPs), the patients they see, the problems they manage and the management choices for common problems dealt with in general practice.

About 1,000 GPs participate in BEACH each year and each participant completes details regarding 100 consecutive GP-patient encounters, giving a sample of around 100,000 records per year.

In measuring the health of the population, mortality and hospitalisation statistics are useful outcome indicators. However, while only a small proportion of the population dies or becomes hospitalised in any one year, about 85% of Australians attend a GP at least once in a year. In the 2004-05 financial year, there were about 94 million unreferral attendances paid by Medicare at an average rate of 4.5 GP visits per person, the primary cost to Medicare for GP services being over \$2 billion with additional secondary costs of over \$4 billion being generated.

BEACH provides insight into how these costs are distributed across population groups (e.g. Indigenous people, older patients), specific morbidity types (e.g. arthritis, heart disease, cancers) and management actions (e.g. prescribed medications, pathology orders). Since all these data elements are linked in the BEACH database, management of a specific problem group for a selected patient group is measurable.

The BEACH program has now involved about one-third of all practising GPs in Australia, and the database includes details of about 800,000 GP-patient encounters from over 7,000 individual GPs. The GPs are randomly selected from Health Insurance Commission records of active general practitioners, and in each year of the program the final sample has been demonstrated to represent all active GPs. The sample of encounters reflects well the Medicare claims data in terms of the age-sex distribution of the patients encountered.

The most recent publication from BEACH was the 2004-05 annual report (*General practice activity in Australia*

2004-05), which demonstrated some significant changes occurring in the characteristics of the current GP workforce, changes in the management frequency of some disease groups, and changes in management choice for selected conditions. Some of these findings feed into workforce planning, and others reflect the impact of policy changes made by the Australian Government Department of Health and Ageing. Patient-reported current smoking status, alcohol intake and height and weight (from which BMI or body mass index is calculated) are also reported for a sub-sample of more than 30,000 patients.

The GP Stats centre also published a comparative report of the practice patterns of GPs in each class of the Rural, Remote Metropolitan Area (RRMA classification) and by each class of the Australian Standard Geographic Classification (ASGC) (*Locality matters: the influence of geography on general practice activity in Australia 1998-2004*). The report clearly demonstrates that compared with the RRMA, the ASGC far more clearly differentiates GP activity between the remote areas of Australia, and more clearly defines the needs of the increasing 'sea change' population.

There are many sub-studies conducted as part of BEACH. These are reported in abstract form at http://www.fmrc.org.au/publications/SAND_abstracts.htm. Sample sizes range from about 2,800 to 10,000 and the topics are patient-based, the GP acting as an expert interviewer in conjunction with their own knowledge of the patient and with the medical record. This may be a more reliable measure than patient self-report alone. Topics covered in the sub-studies range from prevalence of selected diseases, current management and outcomes of management, prevalence of selected risk factors, and period prevalence of pharmacological adverse events.

Data from the BEACH program round off many AIHW reports of specific population groups or disease management and are used by the AIHW in disease cost analysis, Indigenous health cost estimates, and in reporting the health of the community in *Australia's health*.

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National Public Health Expenditure

Project 3

Expenditure on public health activities is an important investment that all governments in Australia undertake, as a means of avoiding or reducing reliance on more costly interventions to treat preventable illness or injury in both the short and the long term.

Public health activities are defined by the National Public Health Partnership (NPHP) as being: *the organised response by society to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole, or population subgroups.*

The National Public Health Expenditure Project (NPHEP) was established in the late 1990s as a joint project of the AIHW and the NPHP. It is largely funded by the Australian Government through the Department of Health and Ageing (DoHA) and its aim is to identify and report on public health expenditure and funding by DoHA and the state and territory health departments.

The framework adopted by the NPHEP for reporting expenditure on public health activities is made up of nine activity categories: communicable disease control, selected health promotion, organised immunisation, environmental health, food standards and hygiene, breast cancer screening, cervical screening, prevention of hazardous and harmful drug use, and public health research.

Since 1998 the NPHEP has released five reports—the latest, *National Public Health Expenditure Report 2001–02 to 2003–04*, was released in March 2006.

This report indicated that expenditure on public health activities by governments in Australia changed little over that period with per person expenditure having grown, in real terms, by an average of 2.8% per year over the two years.

From 1999–2000 to 2003–04 growth in government expenditure on public health activities almost kept pace with growth in total health expenditure. This meant that in 2003–04 expenditure on public health activities represented a marginally lower share of total health expenditure (1.7%) than in 1999–2000, when it was 1.8%.

Three activity categories accounted for more than half (54.3%) of the expenditure in 2003–04. These were

organised immunisation (\$268.0 million or 21.2%), selected health promotion (\$214.6 million or 17.0%) and communicable disease control (\$203.9 million or 16.1%).

Over half (51.9% or \$657.4 million) of the funding during 2003–04 came from the Australian Government. In 2002–03 and 2001–02, the Australian Government's share of funding was \$706.6 million (58.9%) and \$572.9 million (52.5%), respectively. Funding by states and territories from their own sources was estimated at \$608.5 million (48.1%) in 2003–04, \$493.2 million (41.1%) in 2002–03, and \$518.0 million (47.5%) in 2001–02.

Different patterns of state/territory government expenditure are evident across jurisdictions during 2003–04, reflecting the different public health priorities. New South Wales and Victoria, the most populous states, allocated the highest proportion of their public health expenditure to organised immunisation (32.5%) and selected health promotion (28.3%), respectively. Organised immunisation also attracted the highest share of the state governments' public health expenditures in both Queensland (24.8%) and Western Australia (20.3%). In South Australia, communicable disease control (20.3%) received the highest share of expenditure, while in Tasmania, the Australian Capital Territory and the Northern Territory, it was selected health promotion (22.6%), prevention of hazardous and harmful drug use (27.6%) and communicable disease control (35.7%), respectively.

The 2003–04 expenditure estimates show that the Northern Territory and the Australian Capital Territory had the highest average expenditure per person (\$252.52 and \$115.42 respectively), compared with the national average of \$63.31 per person. Broadly speaking, average expenditure per person appeared to have an inverse correlation with the population size, with the larger states generally incurring lower average costs than smaller ones.

The collection and processing of funding and expenditure data for 2004–05 are currently in progress. The 2004–05 report is planned for release in late 2006.

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New AIHW report on juvenile justice

Project 4

The involvement of juveniles in the criminal justice system is a matter of keen interest to many stakeholders. Governments, policy makers, community groups and researchers alike seek information about this group of young people—particularly about the extent of and reasons for their involvement with the criminal justice system, and their experiences within it. However, with responsibility for juvenile justice resting at the state and territory level in Australia, until now nationally comparable data have been scarce.

The Australian Institute of Health and Welfare recently produced a report *Juvenile justice in Australia 2000–01 to 2003–04*. This report is the first to be based on the Juvenile Justice National Minimum Data Set (NMDS), a joint project between the Australasian Juvenile Justice Administrators (AJJA) and the AIHW. The Juvenile Justice NMDS will contribute to the national monitoring of juvenile justice policies and programs.

During 2003–04 there were 12,992 young people under juvenile justice supervision in Australia. The number has declined by about 5% since 2000–01. About 83% of young people under juvenile justice supervision were male and approximately two-thirds (67%) were aged 16 years or older. Less than 8% were aged 13 years or younger.

About 30% of young people under juvenile justice supervision were of Aboriginal and Torres Strait Islander origin. The rate for Indigenous young people aged 10–17 years who were under juvenile justice supervision was over 10 times that of their non-Indigenous counterparts—approximately 34 per 1,000 for Indigenous youth compared with about 3 per 1,000 for non-Indigenous young people.

The focus of the Juvenile Justice NMDS is the experience of the young person under the supervision of juvenile justice departments in Australia, including pre-sentence and sentenced supervision both within the community and in detention centres. The report examines periods of time young people across Australia spent in detention and under community-based supervision, and how those periods were managed. In 2003–04 the majority of juvenile justice sentenced supervision was community-based, which included probation, recognisance and community

service orders, with just 9% of periods containing episodes of sentenced detention. A supervision period is a period of continuous supervision made up of one or more episodes, representing specific types of supervision.

About 20% of young people under supervision had more than one supervision period during the year. Almost a quarter (23%) of supervision periods were less than seven days, but 18% were 12 months or longer.

In cases where the young person was taken into custody, over 59% of offenders were released on bail and less than 10% were sentenced and immediately commenced a period of detention.

In addition to providing statistics on young people within the juvenile justice system, the report also describes existing diversity in legislation, policy and practices. As responsibility for juvenile justice rests with state and territory governments, the age when young people are considered juveniles or adults by the justice system, policy directions, diversionary options, possible court outcomes, and specific programs and services available to young people differ throughout Australia.

Now for the first time, states and territories have a common resource to consult when comparing their policies and legislation and those of other jurisdictions.

The decision to create a Juvenile Justice NMDS was made in April 1999 when what is now the Community Services Ministers' Advisory Council agreed to fund the National Community Services Information Management Group for its establishment. A draft NMDS was field- and pilot-tested during 2002 and 2003, with subsequent changes and refinements to the data items and collection methods. The data dictionary for the Juvenile Justice NMDS was finalised in early 2004 and the first data were collected from the states and territories in 2005. It has been a long process and thanks are due to all of the many AIHW staff who have worked on this project over the years, particularly the project managers over that time: Anne Broadbent, Jeff McKenzie, Euan Kennedy, Ingrid Johnston and Brendan Brady.

New asthma monitoring agreement – we can all breathe a little easier now!

It may not be bird flu—that big bad wolf huffing and puffing at our door, threatening to blow away a big chunk of humanity at one fell swoop, so to speak—but asthma is a respiratory disease that affects the lives of 1 in 7 children and 1 in 9 adults, causing considerable health burden to the individual and the nation. Asthma has never been a major cause of death in Australia, and thanks to improved management of the disease the number of deaths due to asthma has been steadily decreasing since the late 1980s. However, there is no room for complacency as Australia still has the reputation of being one of the world's asthma hot spots.

In recognition of the high prevalence and impact of the disease and the availability of effective management strategies, asthma was declared a National Health Priority Area by Australian Health Ministers in 1999. This was the impetus for the AIHW, with support from the Department of Health and Ageing and the National Asthma Council, to establish the Australian System for Monitoring Asthma (ASMA) in 2001. ASMA is now in its sixth year of operation and with the recent signing of a new schedule under the memorandum of understanding with the Department, funding has been made available up to 30 June 2009. ASMA's major objectives over the next three years will be to:

- monitor and report on disease levels, burden, and trends associated with asthma in the general population and specific population groups
- identify potential for improved asthma prevention and management strategies
- generate data to track the impact of asthma policy and prevention and management strategies
- oversee the systematic development of national asthma data sets, which includes the identification of gaps and deficiencies in existing collections, and to develop and standardise data elements.

ASMA comprises the Australian Centre for Asthma Monitoring (ACAM)—a collaborating unit of the AIHW established in February 2002 and based at the Woolcock Institute of Medical Research (WIMR)—and the Asthma Surveillance and Monitoring Team located in the National Health Priorities and Environmental Health Unit (aka the AIHW Team). This collaboration capitalises on the Institute's expertise in health data and the WIMR's expertise in epidemiology and in asthma. The AIHW Team currently consists of Kuldeep Bhatia, Perri Timmins and Gabrielle Hodgson, with valuable contributions

from Vanessa Prescott and Krys Sadkowski. ACAM staff include Associate Professor Guy Marks, Patty Correll, Margaret Williamson, Leanne Poulos, Rose Ampon, Wei Xuan, Elena Belousova and Ursula Majkut. Apart from being prolific report writers, the ACAM members are frequent presenters at respiratory disease conferences and often contribute to refereed academic journals.

ASMA is committed to putting all relevant information into the public domain, through both print and electronic media. Through its biennial reports, *Asthma in Australia*, ACAM has provided considerable information on the prevalence and management of asthma nationally. Other output includes reports on:

- measuring the impact of asthma on quality of life in the Australian population
- health care expenditure and burden of disease due to asthma in Australia
- enhancing asthma-related information for population monitoring (asthma data development plan 2005)
- review of proposed National Health Priority Area asthma indicators and data sources.

Soon to join this list are reports from the AIHW Team on statistical profiles of people with asthma and an overview of genetic, environmental and occupational risk factors for asthma.

There is much still to learn about asthma in Australia. Future outputs of ASMA will endeavour to fill as many gaps in our knowledge as possible while maintaining a high level of detailed and timely asthma surveillance and monitoring. These outputs will include a report on the burden of disease of asthma in Australia, the development of the Australian asthma survey, a database and analysis of data on the use of pharmaceuticals for asthma and other respiratory diseases, and the 2008 edition of *Asthma in Australia*.

In an age when monitoring chronic diseases is becoming more and more important, it is perhaps not too trite to suggest that the prospect of ongoing asthma surveillance and monitoring comes as a breath of fresh air.

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The SAAP NDCA Turns Ten

Project 6

Late in 2005 the Supported Accommodation Assistance Program (SAAP) Coordination and Development Committee agreed to extend the contract with the AIHW to manage the SAAP national data collection (SAAP NDC) until 31 December 2010. The announcement preceded two important milestones for the major program supporting people who are homeless or at risk of homelessness. The first was the 21st anniversary of SAAP itself on 1 January 2006. The second, on 24 January, was the 10th anniversary of the agency responsible for the Program's major evidence base, the SAAP National Data Collection Agency (NDCA), at the AIHW.

The AIHW celebrated the anniversary with a large morning tea. The two previous Heads of the Supported Accommodation and Crisis Services Unit, Glenn Foard and Roseangela Merlo, attended the celebration along with a number of important supporters of the NDCA and the then Head of the Business Services Division, Peter White.

Ching Choi, Head of the Welfare Division at the time the collection was established, and Glenn Foard

regaled the audience with anecdotes of the early difficulties of setting up the data collection, including convincing a skeptical provider community of the value of a national data collection, the miles travelled training in remote and exotic locations and examples of the monumental commitment to the project displayed by the original staff.

The current Unit Head, Justin Griffin, provided a statistical perspective of the work done over the years (approximately 65 staff, 1,403,596 forms processed, over 100,000 telephone calls to and from the SAAP Hotline) and Diane Gibson toasted (with orange juice) the future success of the NDCA.

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ICF Forum

Continued from page 1

- the importance of education and promotion of the ICF across clinical and administrative areas (both generally and specifically, i.e. coding)
- the need for consistency of terminology, particularly between the ICD and ICF
- future areas of work, including greater consideration and operationalisation of environmental factors.

The forum featured keynote speakers including Dr Bedirhan Üstün, World Health Organization; Philip French, Disability Studies and Research Institute; Maryanne Diamond, Australian Federation of Disability Organisations; Rune Simeonsson, University of North Carolina; Linda Worrall, University of Queensland; Lenore Manderson, Monash University; Gavin Andrews, University of New South Wales; and Ros Madden, AIHW.

All presentations generated some lively questions and discussion and a great deal of interest in the ICF publications. A final panel session on the future of the ICF saw delegates and speakers exchange a wealth of ideas on the way forward for people who need, use or develop information.

The AIHW would like to acknowledge the principal supporting sponsor, the Department of Families and Community Services and Indigenous Affairs, as well as support from the Department of Health and Ageing, the Australian Bureau of Statistics and Sydney University Faculty of Health Sciences.

Initial feedback from the event has been positive, with participants expressing interest in receiving further information on AIHW work related to functioning and disability, and general enthusiasm for a similar event in the future.

New arrangements drive further work in priority areas for housing assistance information

Following the introduction of the 2003 Commonwealth-State Housing Agreement (CSHA) in July 2003 a joint review was undertaken of the National Housing Data Agreement (NHDA) and the Agreement on National Indigenous Housing Information (ANIHI). The extensive review process reported back to the Housing Ministers' Advisory Committee in August 2004. It recommended that the NHDA developed in 1999 be retained for the 2003 CSHA which is a five-year agreement. It also recommended retention of the ANIHI.

A key change implemented under the new arrangements is that the National Housing Data Development Committee (NHDDC) now reports to both the National Housing Data Advisory Management Group (NHDAMG) and the National Indigenous Housing Information Implementation Committee (NIHIIC).

These changes, along with the increased emphasis by Housing Ministers at their December 2004 meeting relating to Indigenous access to mainstream housing assistance, have helped form a closer relationship between the mainstream and Indigenous-specific data groups. A number of new key work areas were undertaken in 2005.

The two groups were responsible for the successful conduct in 2005 of three national social housing surveys that provided important information gathered from housing tenants. The surveys covered public rental housing, state owned and managed Indigenous housing as well as the CSHA community housing programs. Data from these three surveys were used for the 2006 Council of Australian Governments' Report on Government Services as well as for the national performance indicator reports for the CSHA and the Indigenous housing National Reporting Framework. In addition in 2005-06 the NHDDC, supported by the AIHW staff, undertook the development and collection of the first separate CSHA National Financial Reporting Framework data collection for 2004-05 reporting.

To further strengthen this coordinated approach to data development between Indigenous-specific areas of

housing assistance and mainstream areas the two groups will for the first time develop a joint work program for 2006-07. At the 2005 joint NHDAMG and NIHIIC meeting the following areas for joint work were discussed:

- improving the quality of data on Indigenous households accessing mainstream housing assistance through each jurisdiction preparing an action plan and implementing the areas identified. Supporting this work are a national emphasis on training service providers to improve the collection of Indigenous identifiers in their data, and an emphasis on raising the awareness of the importance of tenant involvement in the ABS Census of population and housing
- reviewing several measures to ensure they are appropriate and practical for monitoring progress on improving assistance particularly in the areas of overcrowding, dwelling condition, quality of housing and sustainability of assistance
- ensuring where possible that performance indicator frameworks across areas of housing assistance be consistent for mainstream or targeted assistance
- developing community housing data using comparable approaches to those being implemented in public housing data collections, in particular assessing how to support and facilitate the growth of unit record administrative data at the dwelling and organisation level to improve quality and comparability of information.

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Farewell from Ching Choi

It is a great honour to be asked to write something about my experience at AIHW on the eve of my departure. Fourteen years have been a long time, but the AIHW experience has been most enjoyable and stimulating. In these 14 years, the Institute has grown from fewer than 50 people to over 200. We have moved from Bennett House in fabulous surroundings on the shores of Lake Burley Griffin to the modern facilities in Fern Hill. Our external collaborations with universities have also expanded. With our credibility and reputation recognised, we have certainly come of age.

When I first arrived in 1992 to establish the Welfare Division, the first task I had was to standardise data on child protection and to publish regular reports on the extent of child abuse and neglect. This was a 'life and death' mission that had to be accomplished over any others. The states and territories were very keen for their data to be collated and offered cooperation and funds. It seemed an easy task until it became clear very quickly that notifications of child protection cases were affected by ever-changing policy and administrative context. Another early task was to set up a data system to monitor the then new Commonwealth/State Disability Agreement, as it was called. This too seemed easy until it became clear that states and territories deliver slightly different arrays of services and faced different challenges in re-aligning services with the Commonwealth under the new agreement.

Much of the data the Institute dealt with were from program administration, and I realised very soon that to do my job properly I needed to understand the history of the programs and the sensitivities of Commonwealth–state relationships. There was a need to learn to deal effectively with inconsistent and non-comparable data. This is in fact where the strength of the Institute was and still is—the ability to deal with data that are not perfect and to distil from them respectable conclusions. Developing better data would naturally follow and I soon found myself chairing national data committees on community services and housing, and then later health.

It has been very rewarding to see the Institute's work resulting in better data and in publications that throw light

on the progress of government health and welfare services programs. In the Welfare Division, the Disability Services Unmet Demand Study is a good example of the Institute actually making a difference to the services provided to people with disabilities. The Supported Accommodation Assistance Program data collection is another example. There are also examples in other sectors such as housing, child care and aged care.

I experienced similar satisfaction when I moved over to the Health Division. Population health and diseases monitoring have been the main functions. There is no doubt that the Institute's work in monitoring disease trends and patterns has much relevance to the work of National Health Priority Action Council and the development of the National Chronic Disease Strategy. The work on cancer screening at the Institute is first-rate and it is so good to see it used for policy debate. The Institute has also published first-ever reports on asthma, kidney diseases and arthritis, and has continued the highly respected reports on cardiovascular diseases and diabetes.

The National Death Index is used by many for very worthwhile epidemiological research and the General Record of Incidence of Mortality books on long-term mortality are a must for anyone who does research on Australian mortality. And we have now established the National Diabetes Register, probably the world's first national register of people with insulin-treated diabetes. In years to come, the diabetes register will be able to be used in conjunction with the death index and other disease registers to monitor the survival of people with diabetes and their comorbidity in much the same way the national cancer register is being used. This is an immensely useful database for diabetes research.

The joint work with the Department of Veterans' Affairs on veterans' health and mortality is also fascinating and very important. And I have also enjoyed very much reading publications from our collaborating centres on perinatal health, dental health and injuries.

I know there is a very high level of expertise in the health statistics field; it is well established. Epidemiology is a mature discipline and bio-statistics has also existed for some time.

But there are still fundamental concepts in health that require fresh debate. Much of health research is based on statistics on diseases—incidence, prevalence and deaths arising from the diseases. But what is a disease or a health condition? How do we or the doctor know and decide we have a disease? There is rapid advance in medical knowledge and there is also great improvement in the ability to screen or test for abnormalities. With daily reports on health in the print media and on TV by knowledgeable reporters, the general public is also becoming more aware of their health. Are we discovering more diseases because we can more easily discover them? Do the health professions ‘create’ diseases and conditions because they now know about them and can do something about them? Are reported disease incidence and prevalence trends real, given the rapid advance in medical knowledge?

And then there is the interesting debate on functioning and health. Does it really matter if we have a condition that does not kill us or affect our functioning? Should the Institute be concentrating on measuring reduced life expectancy and loss of function due to diseases? Methods are available to summarise health measures such as these, and it has been very exciting to have participated in Institute debates on such conceptual and methodological issues for the improvement of these measures.

I have really enjoyed my time at the Institute. The discussions I have had with colleagues have always been stimulating and challenging. And I have learned much. The preparation of the biennial volumes of *Australia’s welfare* and *Australia’s health* has always been challenging. It is much like childbirth—the pregnancy is always difficult and too long, and the delivery painful (not that I know). But the baby is always so beautiful. I have been so proud of those volumes each time they came out. I know they are used everywhere by everyone—politicians, the Parliament, public servants, journalists, academics, students and the public.

I am also very proud of the national data dictionaries that the Institute produces. They are national treasures that many other countries are envious of, I know. These dictionaries are produced by data committees supported by Institute secretariats. People usually do not believe me when I say I actually enjoyed chairing the various data committees, especially the very large and involved Health Data Standards Committee. But people often forget that

I have been supported by a very able and committed secretariat and data standard staff.

The wealth of expertise in the Institute is immense and it has been a privilege to have worked with such highly talented people. The dedication of all staff, and in particular Unit Heads, is something special at the Institute. We all helped each other and the working environment has been just fabulous.

I have also been supported by very able corporate staff. The IT services, the library, the human resources services, publications and media, and, importantly, the finance support services have never failed me in my 14 years at the Institute—not a mean feat.

Many thanks for the tremendous support that I have received in these 14 years, from the Board, the Directors and all my colleagues. I wish the new Director, Dr Penny Allbon, and everyone at AIHW all the best for the future.

Ching Choi
April 2006





Spotlight on Penny Allbon



The new Director of the AIHW, Penny Allbon, loves nothing more than 'going bush'. Growing up on New Zealand's beautiful North Island, where her father was a school teacher, there was plenty of opportunity to explore the small, mostly Maori, community in which she lived, and to 'tramp' through New Zealand's breathtaking landscape. Penny's interest in other cultures and her love of the outdoors have remained a huge part of who she is and how she looks at life today.

Penny spent most of her school and university years in Palmerston North, completing her Honours degree at Massey University. Her sense of adventure and love of travel then took her, under the volunteer abroad program, to Tonga. There she immersed herself in the culture, taught English and learned to speak Tongan.

This Pacific Island experience led her in turn to Canberra and, in particular, the Australian National University (renowned for its Pacific Studies program), where she earned a Doctorate degree for her thesis on the colonial relationship between Tonga and England.

Although Penny has lived in Canberra ever since, she keeps close ties with New Zealand where her father and sisters still live, and she loves to 'get home' whenever she can.

After completing her thesis, Penny took her first step into the public sector with a job in the Department of Finance (as it was then known). This move provided a solid grounding for her future career.

'Working in the Budget area of Finance gave me a good understanding of how government works and the rationale that needs to be in place before dollars can be allocated', says Penny.

'I spent seven years in the finance area and would say that one of the best things about that experience is that it teaches you how to ask questions.'

After her time at Finance, Penny moved on to the ACT Treasury, which, in 1989, was small, but in the process of preparing for ACT self-government. This experience gave her a good understanding of whole-of-government issues. 'It was a very exciting time to be there and I was able to help develop systems and build the organisation', she says.

'I carried out many different reviews, so getting to the core of an issue was something I learned to do. I also learned how

important it is to take the time to set a system up correctly in the first place. If you do that, it can save many headaches later.'

As an aside, Penny commented that the ACT Treasury is obviously an excellent preparation for leadership at the AIHW, as Penny's predecessor as Director, Richard Madden, also worked at the ACT Treasury at that time, as Under Treasurer.

From the Treasury, Penny moved into the areas responsible for health policy and data management in the ACT Government, eventually becoming Chief Executive of the ACT Department of Health and Community Care. Like the AIHW, this was an agency with a broad range of responsibilities spanning health, community services and housing issues. As Chief Executive, Penny was responsible for policy and services delivery in the areas of health and disability and drug and alcohol services. She was also ACT Commissioner for Housing for 18 months.

At a national level, Penny provided leadership to the National Mental Health Working Group and the National Medical Indemnity Working Group reporting to the Australian Health Ministers' Advisory Council (AHMAC). Her interest in the national agenda also saw her take on the role of AHMAC representative on the AIHW Board, an experience that provided her with a thorough knowledge of the work and operations of the AIHW and its strengths and values.

After leaving the ACT Government, Penny spent time working as a consultant both in Australia and in a number of Pacific countries.

These career moves were all steps in the journey that would ultimately see her taking on the role of Director of the

'I am particularly interested in translating the needs of policy makers into relevant data analysis and ensuring that the data is user-friendly, timely and relevant.'

AIHW. Penny feels that her broad experience has left her well equipped to take on the leadership of the AIHW, and particularly to ensure the Institute's research and findings contribute to informed policy across all the spectrum of health, community services and housing issues.

Like many of the adventures she's embarked upon, she sees this latest one as 'familiar, but exciting and challenging' and says 'Australia is very fortunate to have a national institute like this set up under legislation to ensure that there is a strong evidence base for policy'.

So where does Penny see the Institute travelling under her direction?

'If I had to name three things, first would be to maintain the quality of the Institute's data analysis and its reputation for integrity and objectivity. This is fundamental to our role in providing health and welfare data to policy makers, other researchers and the community.

'Second, I would like to see the Institute stay at the forefront of infomatics and ensure it moves forward with the e-health expansion. I'd also like to see the Institute develop its capacity to link data in a secure way to enable a more holistic approach to data collection and usage.

'And finally, I feel there is important work to be achieved in advancing and expanding AIHW's relationships. There is definite scope for us to be working more closely with partners, to be responsive and deliver what's required for policy debate'.

Ask Penny what she believes in and she'll tell you: 'I strongly believe in the value of information, as information leads to empowerment, and that is a large part of what makes this new role so exciting for me. I hope to ensure that the health and welfare debate continues to be well informed.'

With Penny's open-door, candid and straightforward approach, you can be sure there will be a well-worn path to her door before long.

'Taking over from Richard Madden, who did such a great job in the role of Director for such a long time, is a big challenge, but one that I'm looking forward to. I am particularly interested in translating the needs of policy makers into relevant data analysis and ensuring that the data is user-friendly, timely and relevant.'

When not in the office, Penny likes to keep fit, leading by example when it comes to health and welfare. 'I am committed to the concept of home-work life balance. Fitness is really important to me. I like to bike and swim as often as possible, and I walk every day. I also like to travel and have done a lot over the last three years. I especially love getting out into the great outdoors. I believe there always needs to be balance in life, and going bush, for me, provides the perfect antidote to my working life.'

Penny's motto 'Turn your face to the sun and all shadows will fall behind you' is apt; it sums up the way she looks at life, approaches problems, and even tackles the bush!

Australia's health 2006 conference

Presented by Australian Institute of Health and Welfare

Wednesday 21 June — Hyatt Hotel, Canberra

The Australia's health 2006 conference, to be held in the nation's capital, provides the opportunity to discuss and learn about the most important health issues facing Australia. A panel of experts will present sessions on chronic diseases, population health, and health services and resources at this not-to-be missed conference.

The conference program includes keynote addresses by eminent speakers, with sessions being held in a broad spectrum of health arenas including:

- Socioeconomic inequalities
- Workforce planning
- Aboriginal and Torres Strait Islander health
- Changing face of primary healthcare
- Chronic diseases
- Health as a growing sector of the economy
- Rural health

Speakers will include:

Hon. Tony Abbott MP, Minister for Health and Ageing

Hon. Peter Collins AM QC, Chair of the Australian Institute of Health and Welfare

Ms Jane Halton, Secretary, Department of Health and Ageing

Dr Penny Allbon, Director of the Australian Institute of Health and Ageing

Professor Terry Dwyer AM, Director, Murdoch Childrens Research Institute

The one-day conference registration fee of \$330 includes lunch, morning and afternoon tea and a copy of **Australia's health 2006**—the tenth biennial health report by the Australian Institute of Health and Welfare.

For more details, visit www.aihw.gov.au, or contact Kristy Leversha on phone (02) 6244 1032, fax (02) 6244 1045 or email conference2006@aihw.gov.au.

New pages on Safety and Quality of Health Care

The Institute has recently added new pages on Safety and Quality of Health Care in Australia to its Internet site. They are available at <http://www.aihw.gov.au/safequalityhealth/index.cfm>, or via the 'Subject areas' button from the home page.

Australia has a high quality health care system which rates well internationally and serves the bulk of the population well. Nevertheless, the safety and quality of health care in Australia is of interest to health care planners, providers and users, as efforts continue to maintain and improve health care performance.

The web pages briefly describe how 'safety' and 'quality' can be defined in the context of health care services:

- The **safety** of the health care system has been defined as relating to the avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered, or as the degree to which the potential risk and unintended results are avoided or minimised.
- **Quality** is usually regarded as a multi-faceted concept which can be defined in different ways. It can be defined simply as the extent to which the properties of a service or product produce a desired outcome. In more detail, it can be defined as the extent to which services are effective, appropriate, accessible, responsive and provided equitably.

Over the last few years, a range of different performance indicator reports and other statistical reports on Australian

health care services have been produced by the Institute and others. Until now, however, there has been no central repository of these reports that would allow easy access to published information on the safety and quality of the health care system. These new web pages have therefore been designed to bring together a comprehensive array of health care safety and quality statistical information from a wide range of Australian sources.

Included in the safety and quality pages are:

- links to AIHW statistical information on the safety and quality of health care in Australia, including links to publications related to health care safety and quality within a wider range of information focused on a type of health care provider (e.g. hospitals), a type of disease or health condition (e.g. cardiovascular disease), or the health of a population group (e.g. Aboriginals and Torres Strait Islanders)
- links to other Australian statistical information on the safety and quality of health care, including reports published by the (former) Australian Council for Safety and Quality in Health Care, the Department of Health and Ageing, state and territory health authorities, and professional organisations

The Institute aims to keep these web pages up to date so that they can continue to be a useful central resource for those interested in Australian statistical information on health care safety and quality. Feedback, and information on other statistical reports that could be included, is welcome, at safetyandquality@aihw.gov.au.

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