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Dear readers

Twenty years ago when the Australian Institute of Health was established, there were some sceptical voices to be heard. During the debate in the Senate in 1987 there was one particularly choice description of what we might become:

> The Intention is quite obvious – that is, to consolidate the little nest of number crunchers that are already scattered throughout the Health Department. It is intended to create a single unit of bovver boys and health restricters.
>
> It (the government) needs figures, so it invents these nests of number crunchers, bovver boys, health restricters and controllers, subject of course to the usual pious privacy provisions, which everyone knows are basically a sham.


Photo: Irene Dowdy

Penny Allbon

So here we are, 20 years later, and I'm pleased to say that the bovver boys (who are more often girls) seem to be of the mild-mannered kind. And our privacy arrangements are neither pious nor a sham.

What's more, we seem to have met the expectations of the Health minister of the time, The Hon Neil Blewett. He noted that there was agreement on all sides that the level of health statistics and basic health data in Australia was very poor (Australia was ranked last in a WHO comparison of the hospital collections of 16 developed countries). He saw the creation of a statutory authority as a way of achieving three key objectives: Firstly it would help to ensure state and territory confidence. Secondly, such a body would be able to concentrate on the longer-term aspects, rather than the immediate, short-term problems. And thirdly, it would be able to attract researchers of very top quality. As he said:

> The collection of health data is not just a matter of collecting statistisc; it involves very difficult debates about how we categorise these statistics…We need top class people with top class research backgrounds.

It has been important to take the time to not only reflect on the achievements of the Institute over the last 20 years, but to celebrate them, which we did with an evening of fun that brought together current and past staff and supporters. We received goodwill messages from many past Board Chairs and Directors. One such was Emeritus Professor Peter Karmel, the first Chair of the AIH Board, whose daughter, Rose, still carries the statistical gene within the Institute. In Professor Karmel's view the AIHW has grown in influence well beyond any early expectations. Professor Janice Reid, chair of the Board 1995–2001, told us that being part of the AIHW for 6 years was a special time for her and a highlight of her professional life: 'I felt very lucky to be involved with such a significant, valuable and committed organisation'.

Other messages of goodwill came from previous Directors Len Smith, the first Director, and Professor Bruce Armstrong, Director 1994–96. Professor Richard Madden, Director 1996–2006, took part in the celebrations with a great bed-time story from Uncle Richard, starring Gandalf the Choi (otherwise known as Dr Ching Choi, recently retired from AIHW).

The Executive did a great rendition of one of the core elements of the Institute's business—a meeting of state, territory and commonwealth players. Happily, no legal actions have resulted.

Celebrating our achievements over the twenty years gives us a strong impetus to keep moving forward, to keep delivering information that goes to the heart of issues important to the community.

I have no doubt that the next 20 years will see the Institute grow and achieve even more.

Dr Penny Allbon
Director

New strategic directions

What do you do when you're turning 20? You throw a big party, of course (see page 30). And that's an occasion the AIHW sure hasn't missed. On another note, though, there are those more serious matters of business, of opportunities and how you plan to make the most of them. And for that we welcome the AIHW's new corporate plan, *Strategic directions 2007–2010*.

Strategic directions really can claim to be new: new in the process behind it, in the breadth of its ownership, in its style and in its emphasis. Some key features:

- in working up the plan, everyone at the AIHW had a good chance to make it *theirs* (see below)
- the resulting document is a clear change from the booklet form of previous years—it is now an attractive, concertina-style brochure that is handy and concise
- the AIHW mission stays the same, but said in fewer words
- our values are listed succinctly
- there are five main directions for 2007–2010, each with a background to explain it and a series of strategies to advance it.

In short, *Strategic directions* comes from the heart as well as the mind. At a glance, it says who we are at the AIHW, what we do and what we care about. Then it goes on to the special directions we plan to take over the next few years.

AIHW *mission*

Better information and statistics for better health and wellbeing

The five directions

Those directions are:

1. Strengthening our policy relevance
2. Capitalising on the new information environment
3. Enhancing data access, protecting privacy
4. Getting the messages out better
5. Our people—valued, expert and versatile

Does this mean these will be our *only* directions? Certainly not—much of our work will be important business as usual. But we'll make a particular effort in these few areas.

Policy relevance

We want our work to 'inform discussions and decisions on policy and services'. To keep improving in this area, we plan to stay strongly engaged with policy agendas around Australia, take more 'holistic' views of government programs and people's lives, and tailor our reports better to policy issues.

New information environment

Consider changes such as the impending electronic health record, the continuous client record for community services and a growing awareness that many data sources are being underused. We intend to capitalise on them, not just to react. We're aiming to stay closely in touch with key developments, build our technical and analytical capacity to take advantage of them, and play a leading role in helping others do the same.

Access and privacy

These two values of society are vital in their own right and for each other. The AIHW will be taking a strong stance in promoting our unique combination of privacy measures and the greater access this gives to health and welfare data sets brought under our protection. We will also play a leading national role in explaining that privacy and access are mutually beneficial.

The messages

Through our reports, if we want our messages to be policy relevant, we also want them to be as widely read and *used* as possible. So we will be making extra efforts to find out what our readers want, especially those who make policy and run programs. We will also consider the variety, style, detail and mode of delivery of our products, including how to distil our statistics into digestible key messages.

Our people

The AIHW has long valued its people and aims to reflect that through a fulfilling and nurturing work environment. To follow our other strategic directions, our strong statistical know-how remains vital but is only part of the story. We will be taking steps, in our training and recruitment, to ensure we are a versatile and adaptable team with the wide range of skills to meet the challenges ahead.

How did we get here and what's next?

Every step was taken to make this strategic plan come from the whole AIHW, not just from a few senior managers. Over many months, numerous open sessions were held to raise issues and discuss strategies. Drafts were run by the whole AIHW and every line in the initial drafts attracted five lines of good suggestions! The AIHW's Board saw two stages of draft as well and provided many astute comments that fed into the final version.

As to what's next, the big task is to flesh out the strategies into detailed plans with a 'who'll do it, how and by when'. Each strategic direction has a member of the AIHW's Executive team as a champion and a progress report will be given to the Board in June next year. ■

AIHW's new corporate plan *Strategic directions 2007–2010* can be viewed online at: www.aihw.gov.au/publications/index.cfm/title/10477

Policy relevance and getting the messages out better

Shedding some light

It's an old joke that statistics are like a drunk using a lamppost: more for support than illumination. But a renewed focus on the relevancy and communication of the AIHW's work is set to firmly contradict that witticism.

The AIHW's *Strategic directions 2007–2010* includes a focus on strengthening its relevance and getting its messages out better—both of which aim to ensure the use of the AIHW's vast bank of statistics will produce greater knowledge and wisdom.

According to the AIHW's Director, Dr Penny Allbon, the two issues go hand in hand.

Coming from a policy background, Dr Allbon has championed policy relevance as one of the AIHW's strategic directions and advocates the importance of ensuring that accurate and relevant information forms the basis of policy development. Policy relevance requires strong engagement with stakeholders to identify information needs and emerging issues.

According to Dr Allbon, primary health care is one of the big issues in the community, and among policy makers is an area that is demanding more attention and more information.

The current focus on chronic diseases, prevention and management, and coordinated care means more data are required on what is happening in terms of conditions and health services. At the same time, data gathering in primary care is more challenging due to the nature of services being delivered outside institutions such as hospitals.

Indigenous health is another area that continually demands greater efforts in terms of information gathering and linkage.

The new information environment offers many more opportunities to ask the right questions and gather information so that Australia can learn more about its current health and welfare status and how it is changing (see feature, page 9).

As a national leader in the development of health and welfare statistics, the AIHW's work can both drive and serve policy. But it must be partnered by good communication.

Clarity is the key

'No matter how good an analysis we have done, if the message doesn't get out there, then we are only doing half the job,' says Dr Allbon.

In his role to lead the implementation of the AIHW's 'messages' strategy, Medical Adviser, Dr Paul Magnus, firmly agrees.

'If we present our work badly, at best, all the analysis, the data and the work are just wasted. At worst, it can put the reader off the topic entirely.'

Implementing this improved communication strategy starts right at the beginning of the publication process. New style and reporting guides have been developed to direct the planning and development of publications—reviewing questions and focus, considering audience and reader needs, and bringing context to information and analysis.

One approach for publications is to make writing simpler and clearer, even if the topics aren't always simple (see box on Idiopathic thrombocytopenic purpura at the end of this article).

Putting facts into context

Another is to ensure that statistics and analyses are appropriately contextualised so that people understand what is important and how things compare.

'A number tells us nothing. On its own, that is,' Dr Magnus says.

There are a few figures that 'speak for themselves' because of the long-gained idea among people about their relevance and context. Interest rates or unemployment rates are examples where many people will know whether a figure is high or low.

'If someone is eight feet tall, we know that's tall.'

But with most of the statistics the AIHW produces, it has to put them in a wider context if they're to make sense, he says. 'Take a disease with an annual death rate of 200 per 100,000 population. On its own, that number will mean virtually nothing to the typical reader. But we can give it meaning and perspective by comparing it wherever we can—for example, with the situation last year or 10 years ago, with the lowest rates overseas, with some standard or with some goal set for 10 years hence, and so forth.'

For example, consider the following recently released statistics:

- There were 130 reported events which potentially or actually led to serious patient harm in Australian public hospitals in 2004–05 (*Sentinel events in Australian public hospitals 2004–05*).
- Over the past 5 years, the number of Australian children in out-of-home care has increased by 40%, with 25,454 children in out-of-home care and 27,188 on care and protection orders in 2006 (*Child protection Australia 2005–06*).

On their own, while interesting, these figures lack a frame of reference to make them meaningful to the average reader. However, using comparisons and examination of trends, a broader picture is revealed:

- The 130 hospital events analysed were reported from 759 public hospitals across Australia, which provided 4.3 million patient separations and 42.6 million occasions of service to non-admitted patients. Sentinel event reporting is in its 'infancy' and this was the first national report of its kind. As a 'reporting culture' grows, so too will national rates.

- The increase in child protection care and orders is due, in part, to a greater community awareness of child abuse and neglect and willingness to report to authorities, as well as to the cumulative effect of children entering the system at a young age and remaining on care and protection orders for longer periods.

And as the 'data in the bank' continue to grow, the opportunity to make the AIHW's work more sophisticated and practical is there.

Keeping 'on the pulse'

With a growing thirst for knowledge in the community and among policy makers, another equally important goal for the AIHW is to ensure the relevance of its work—in terms of both timeliness and content. 'There is quite a tension between being authoritative and being timely,' Dr Allbon says.

Cancer information is one such area where many stakeholders are anxious for the latest available data, to ensure their own work is based on the most up-to-date figures available.

'The line we walk is to ensure the data are substantive—if we don't, it would take us all backwards in terms of an issue as well as the AIHW's reputation—while also trying to improve the time taken to get information out there.'

To do this, the AIHW is looking at its information gathering and delivery processes.

For example, the AIHW is continually working to improve the systems by which it and others can gather and share information efficiently. It is also exploring a variety of delivery options for its reports that both improve timeliness and reader accessibility.

For the AIHW, it is a matter of taking a leading role in these areas and having more good ideas on how best to harness the potential of the information it gathers. ■

Idiopathic thrombocytopenic purpura

Like much medical terminology, such a term can seem dramatic or even fantastic to those who do not yet know its meaning.

Part of the AIHW's strategic direction to get its messages out better is to make all its information more accessible—and that includes using intelligible and uncomplicated language.

Idiopathic thrombocytopenic purpura, or ITP, refers to an autoimmune disease of unknown cause—idiopathic where *patho-* means disease or suffering and *idio-* means peculiar to the individual. It features low blood platelets—the cell-like particles called *thrombocytes* because they're involved in forming a clot/thrombus and *-penia* meaning deficiency. Finally, *purpura* refers to the purplish bruises that show up in the skin because the effect is a tendency to bleed easily. ITP is usually a temporary and mild disease affecting children.

So, if the AIHW had to discuss ITP, it would have to introduce the formal term first. Then it might describe the condition along the lines that it is 'a disease of unknown cause that usually affects children, where there are too few of the tiny clotting agents in the blood, known as platelets, and this leads to purplish bruises caused by bleeding in the skin'. It might go on to explain the medical words as above. We can see that the medical term is extremely efficient but it is also highly technical and requires a lot of plain words to explain it.

For the AIHW, it's about giving its people the licence to write simply, Dr Magnus says. 'These can be serious and complex topics but we aspire to use simple language and clear writing. There is no reason to not simplify the language wherever we can do that without simplifying the meaning.'

Pulmonary? Why not just say 'lung'.

Cardiac? What about 'heart'?

It's a simple but important strategy to skip the jargon and make the AIHW's information accessible to all. ■

The information environment and privacy issues

Photo: istockphoto.com

Balancing access with confidentiality

Privacy is a fundamental tenet of the AIHW and is at the heart of an incident that has become one of the AIHW's best-loved legends.

In October 1997, the Australian Federal Police arrived at the AIHW with a warrant to search records held by the AIHW in its homeless accommodation collection. After a stand-off to rival High Noon, the police ultimately withdrew, empty-handed.

Re-telling the story, current AIHW Director Dr Penny Allbon underscores how this spirit of rigorously defending privacy continues to prevail: 'Privacy is a fundamental for us. It's our core business. You don't get access to data without protecting the privacy of the source.'

This explains why privacy protection and enhancing data access form the basis of one of the AIHW's 2007–2010 strategic directions. They're not new issues, but data quality, privacy and accountability remain a crucial part of the AIHW's charter. And its privacy bona fides are particularly important for the AIHW in taking on other crucial responsibilities, such as promoting the benefits of enhancing and expanding access to more information.

Access to information is essential to good planning and knowledge, but must be balanced with privacy rights. The AIHW has a leading national role to take in explaining and demonstrating the mutually beneficial nature of both privacy and access.

This role is made even more important by the challenges and opportunities raised by the new information environment.

Incorporating new developments

The AIHW has identified in its strategic directions the need to capitalise on the potential of advances such as the electronic health (e-health) record, the continuous community services client record, and new informatics technologies that enhance information gathering and knowledge building.

Dr Allbon says there is 'enormous potential' to increase the level of information gathered and to link data for a 'whole-of-life approach'.

But she says there are also risks in terms of public confidence as well as technical issues.

As Deputy Director and Head of the Information and Strategy Group, Julie Roediger, explains, a strong goal of the AIHW is to preserve the trust people have in the confidentiality of their relationships with medical professionals and any other health or welfare service providers.

'Nothing we do to analyse data should ever compromise the confidence people have in accessing the services they need,' Ms Roediger says.

Public confidence in the privacy aspects of the new information environment is crucial. Whether it's a fear of any 'Big Brother' approach from governments or commercial entities, the community has its concerns.

For example, in 2001, there were major concerns raised by the health and consumer communities over moves by a commercial general practice software provider to gather data from electronic patient records and on-sell it in a de-identified form.

The episode ultimately highlighted the fact that electronic personal records could be more readily accessed and integrated than their paper-based predecessors and that there was an urgent need to balance the benefits of technology with individual privacy and consensual rights.

Dr Allbon emphasises the AIHW does not make a profit from data. 'We use the data for public good only, not for commercial gain.'

In terms of technical issues, Dr Allbon says the AIHW aims to be at the forefront of e-health and making sure data collection in the future is compatible with what information is held now.

For example, the AIHW is working with the information technology area in general practice to ensure standards are such that meaningful and integrated data can be gathered.

With about 20.3 million people visiting a general practitioner (GP) at least once in a year—and more than 90 million GP patient consultations annually—there is much to be learned about Australians' health and how it is managed in the health system.

The AIHW is already taking a key role in a new project that is leading developments in the balance between high security and the innovative use of information. The AIHW will provide a secure point for storage and provision of data as part of the Australian Government's Healthy for Life program, which aims to improve the health of Indigenous people, particularly in the areas of maternal and child health and chronic disease.

In addition to safely collecting data on health programs, this 'support, collection, analysis and reporting function' of Healthy for Life will allow for an analysis of people's health status and the activities of health service providers. This evaluation of health services will then be made available to providers and communities, allowing relevant people and practices to benchmark themselves against the performance of others and review what is working to improve outcomes.

'It is focused at the service provider level and on providing useful data,' says Dr Allbon.

The person-centred approach

The AIHW is also continuing with work that refines its approach further to give a person-centred perspective to information. This approach is 'very powerful', Ms Roediger says, as instead of looking at one program area, it allows for data linkage and analysis across multiple programs and of people's experiences and outcomes.

Ms Roediger emphasises that the person-centred approach does not mean an individual's identified case is being examined but rather the aggregated data of groups of people experiencing the same thing.

For example, a person-centred approach allows analysis of the experiences and needs of people who have a particular health issue, identifying any patterns in areas such as employment, welfare needs, or hospitalisation. Or it might show what percentage of people in juvenile detention might also have been in hospital, had particular health issues, or been homeless or had other welfare issues.

A major project for the AIHW this year is looking at older Australians and the passage of people from being healthy and at home, to perhaps being hospitalised or going into residential care.

'There is an opportunity to examine what services are available for people, what works, and what influences outcomes such as whether people can stay at home or go back home,' Ms Roediger says.

With so many opportunities raised by new technology, the AIHW has clearly staked a claim for a leading role in developments that will benefit policy makers and the

broader community. At the same time, its well-established commitment to protecting privacy could be the key to unlocking a safe and reliable path forward to greater information.

Expanding information environment

The ins and outs of maintaining information databases and infrastructure aren't issues that naturally make people sit up and listen. But consider the extraordinary growth in the AIHW's basic collections and the fundamental challenges such growth raises.

In 1996–1997, the combined size of the AIHW's basic data collections was 53 gigabytes. A decade later, it is now 60 times larger at 3.2 terabytes. The number of databases has grown from 61 to 374 over the same period.

According to AIHW Director, Dr Penny Allbon, the challenge for the AIHW is to appropriately manage that information, ensure its quality, and to keep receiving data while expanding the information that it makes available.

An additional challenge to this growing core workload is to balance it with the AIHW's aims of maintaining policy relevance and responsiveness.

Over the past 10 years, the AIHW has had a much heavier reliance on contract work, with two-thirds of its work now associated with stakeholder requests to examine specific issues and areas.

Having the ability to work on areas of current interest is a clear strength. However, the AIHW is keenly aware of the dangers of losing any of its capacity to respond to emerging areas that no-one is yet interested in, or to undertake the maintenance work that is not regarded as being as 'sexy' as other issues.

'Any limitations on our core work and we run the risk of not being able to keep up,' Dr Allbon says.

The AIHW faces a clear challenge of ensuring appropriate resourcing of these fundamental activities.

With the exponential growth in the AIHW's collections and the opportunities created by the new information environment, the AIHW has set a constant goal to maintain the infrastructure needed to manage the data.

According to Dr Allbon: 'It's why the AIHW was set up in the first place.' ■

AIHW's privacy regime

The AIHW has a unique and powerful combination of privacy measures, at the centre of which are the strict confidentiality provisions of the *Australian Institute of Health and Welfare Act 1987* (AIHW Act).

Under the Act:

- no information can be released which could identify an individual to anyone outside of the AIHW
- information is protected against being required to be divulged or communicated to a court, which means data cannot be subpoenaed
- it is prohibited to disclose even 'the whereabouts, existence or non-existence of a document concerning a person'
- severe penalties, including a $2,000 fine or 12-month imprisonment, or both, can be imposed on those who breach the confidentiality provisions of the Act.

As well as the AIHW's own legislative guards, personal information held by the AIHW is protected by the provisions of the Commonwealth *Privacy Act 1988* which, among other things:

- provides that all reasonable security measures are taken to protect personal information against loss or unauthorised access
- prohibits the use of personal information for other than the purpose for which it was collected unless consent has been given for broader use
- prohibits the disclosure of personal information to any other person, body or agency except in specified circumstances.

The AIHW also has a range of well-established policies, protocols and practices to support the management of data and collections.

A number of people at the AIHW can assist with any questions on these issues, including the Privacy Officer, Information Officer or any of the Custodians of AIHW data sets. ■

Our people
valued, expert and versatile

The AIHW is a special place to work. A great social club and weekly sporting activities coupled with an office bush setting with (ahem) free parking all make for a very attractive working environment.

It's not often that an organisation with just over 200 staff can also boast such an array of highly qualified staff from diverse backgrounds. This intellectual mix alongside AIHW's physical size allows strong collegiality to develop and gives staff an opportunity to really be involved in decision-making processes. This real connection with management allows staff to be integral to the overall strategic direction that the AIHW takes.

Supporting and maintaining valued, expert and versatile staff is one of the key strategic directions for the AIHW to focus on over the next 3 years.

People are the heart of our organisation. The AIHW strongly values its expert and dedicated individuals and teams and has long aimed to provide employment that is fulfilling, challenging and secure.

The AIHW recently asked some of our staff who had been employed as graduates to speak candidly about their professional background, experiences as an employee at the AIHW, and the sorts of opportunities that have been offered to them. This is what they had to say...

Back (l-r) Nick Mann, Andrew Powierski and Sergei Mitnik.
Front (l-r) Rebecca Bennetts, Bin Tong and Lynda Carney.

Our people

Graduate experiences

Nick Mann

4 years at the AIHW, currently working in the Expenditure and Economics Unit

My first career was in outdoor education in a boys' school. I was a stay-at-home dad after the birth of my first child while I gained qualifications as a massage therapist and then, just after the birth of our second child, I left the paid workforce to commence full-time studies in human biology at the University of Canberra. I never expected to work in an office, but while I was studying I'd heard about the AIHW's work so when I saw the advertisements for graduates I applied—and 4 years later, I'm really glad I did!

What do I like about working at the AIHW? Well, I enjoy the fact that I've worked in some quite different areas, starting in the Summary Measures Unit doing burden of disease work, then the Ageing and Aged Care Unit contributing to a report on dementia, followed by the Hospitals Unit where I worked in the team that produces the annual *Australian hospital statistics* report. I'm now with the Economics and Expenditure Unit. I really enjoy the people I work with at the AIHW, and have had opportunities for promotion: I started as a graduate at the APS4 level and am now working in an Executive Level 1 position.

There are plenty of opportunities to learn and it's okay to ask questions—about anything! As well as learning about the subject matter of my work areas, I've been able to improve my technical skills—I've so far had training in SAS programming language, writing and media skills. □

Graduate experiences

Rebecca Bennetts

3 ½ years at the AIHW, currently in the Expenditure and Economics Unit

I accepted a graduate position in the Expenditure Unit (now the Expenditure and Economics Unit) of the AIHW in January 2004, following the completion of a combined Bachelor of Actuarial Studies/Bachelor of Economics (Honours) degree at the Australian National University.

Initially I was attracted to a position at the AIHW because it offered me the opportunity to utilise the skills that I had learnt through my university studies and apply them in a field that was of interest to me. Having now worked at the AIHW for over 3 years, I can appreciate its reputation, the expertise of its staff, the work–life balance and the competitive salaries that it offers.

Within the Expenditure and Economics Unit, I have primarily worked in the field of health expenditure, preparing Australian health expenditure statistics and reports for national purposes, but also for the Organisation for Economic Co-operation and Development (OECD) and World Health Organization (WHO). In addition, I have had the opportunity to work on aligning national statistics on health expenditure with international reporting requirements and been given the chance to participate in and give presentations at meetings of Australian Government and state and territory health authorities.

There is a wide range of learning and development opportunities at the AIHW and I have attended courses in health economics and computer software applications as well as a residential course in leadership development. □

If you are interested in working at the AIHW, please visit the employment section on our website at <http://www.aihw.gov.au/employment/index.cfm>. All employment opportunities are advertised on our website, including graduate positions.

Graduate experiences

Lynda Carney

6 months at the AIHW, currently working in the Supported Accommodation and Crisis Services Unit

I finally realised my ambition to attend university in my late forties. I enrolled in an Arts degree at the Australian National University (ANU) in 2003, living with friends in Canberra and returning every weekend to my husband on our farm at Tuena—a tiny village in New South Wales situated between Goulburn and Bathurst.

At the ANU, I studied anthropology, political science and theatre studies—a very well rounded education! I then enrolled in a sociology unit on quantitative research methods, which has proven to be a most valuable preparation for work at the AIHW.

When I started work at the AIHW, a very charming and helpful young co-worker, a graduate from the previous year, was assigned to look after me and teach me my first job. The unit I work in collects data on homelessness, and I have been involved in writing training material for Indigenous service providers. I even wrote scenarios for a training DVD. My first trip away was to Brisbane and Cairns, where I met some wonderful Indigenous women from remote communities in Cape York. Assigned to a number of teams and attending numerous training courses, I am delighted with the new skills I have acquired in the 6 months since I arrived.

With the farm deeply affected by drought, this exciting new career has come at a very opportune time in my life—a time when many of my peers are ready to retire. Working flexible hours means I can comfortably drive home early Friday afternoon and back on Monday morning. Sometimes, back at the farm when I am out working with our sheep, I smile to think of the contrast to what I was doing at the AIHW the day before, and give thanks for this opportunity to walk in both worlds. □

Graduate experiences

Andrew Powierski

2 ½ years at the AIHW, currently working in the Labour Force Unit

Working at the AIHW appealed to me because I thought it would give me the chance to apply the statistical skills I had developed at university. After completing my undergraduate degree in 2002 at the University of Southern Queensland in Toowoomba, majoring in statistics and computing, I did my Honours in applied statistics.

Having worked at the AIHW for two-and-a-half years, I could come up with a plethora of reasons why working at the AIHW is gold—the major reasons being the diversity of work, general working atmosphere and daily sporting activities.

They say that variety is the spice of life, and variety is what I had in my graduate year at the AIHW. During this time, I travelled around Australia conducting data training courses; provided assistance to agencies on a national hotline; and applied my statistical computing skills to produce reports.

I have found the AIHW to be always very accepting of any proposed training courses that will help me with my work. When I started, I had not used the SAS programming language. SAS is commonly used here as a data administration, analysis and extraction tool. Three in-depth SAS training courses are run in-house ranging from beginner to intermediate to advanced (macro level). These courses provided me with the skills required to undertake my work.

At the AIHW, we take the health side of things literally. We have a daily sporting event at lunchtime which includes either hand tennis, Australian Rules football or soccer. There's also a choir and Pilates classes. These events are great icebreakers and help you to get to know people at the AIHW. □

Our people

Graduate experiences

Bin Tong

4 years at the AIHW, currently working in the Cardiovascular Disease and Diabetes Unit

I hold a medical degree and worked for 6 years as a medical practitioner in China before I came to Australia. I completed my Master of Public Health at the University of Melbourne 6 years ago, majoring in epidemiology and biostatistics, then worked at La Trobe University in Melbourne as a biostatistician. I commenced at the AIHW in 2003.

My main duties include data extraction, data analysis, interpretation and writing research reports. I have been working in several health-related areas, mainly cardiovascular disease, diabetes and chronic kidney disease. I was the major author of *Comorbidity of cardiovascular disease, diabetes and chronic kidney disease in Australia* and *Chronic kidney disease in Australia, 2005*. I am also writing for *Australia's health 2008*.

The AIHW is a great place to work. Firstly, it holds a huge amount of health and community services information resources. A lot of national databases that are critical to health and welfare monitoring and surveillance, such as the AIHW National Hospital Morbidity Database, the AIHW National Mortality Database, and the National Health Survey, are installed in the computer system and are available for research. The AIHW is 'heaven' for epidemiologists and biostatisticians.

Secondly, AIHW is a national statistical agency. A lot of colleagues are experts in their areas. In addition, our work is supported by varied national advisory committees and groups, which consist of top experts in different fields in Australia. Working here, you have the great advantage of receiving the best advice and learning from the top experts in your area. The knowledge that you gain here will provide a solid foundation for your further development.

Thirdly, AIHW has a very family-friendly working environment. Jobs are secure and working hours are very flexible. It is great for people who have young children. □

Graduate experiences

Sergei Mitnik

2 years at the AIHW, currently working in the National Data Development and Standards Unit

I'd been exposed to the AIHW's work through the population studies part of my degree (a combined Commerce/Law degree at Macquarie University) and I thought it would be an interesting place to work. I began here in January 2005.

Since I started, I've worked in three completely different units: the Labour Force Unit, the Supported Accommodation and Crisis Services (SACS) Unit, and the National Data Development and Standards Unit (NDDSU). This has given me invaluable experience in a wide array of duties from SAS programming work during my time in the Labour Force Unit, researching/editing reports and answering client queries during my time at SACS, to preparing various agenda items for national committee meetings during my time at NDDSU.

I have also had the privilege of travelling to all the eastern state capitals for various activities, from conducting training sessions to attending conferences. Thus I have been able to establish and maintain working relationships with various employees in other organisations around the country.

They treat you well at the AIHW—bosses are generally not too demanding, co-workers are friendly and the culture in general is happy but hard-working. The AIHW is also big on encouraging staff to attend relevant courses and workshops. In addition, it is generally quite flexible with work arrangements—for example, if you want to study, you are likely to be able to take some study leave.

There are plenty of opportunities to move to different sections of the AIHW to broaden your experience. If you are technically minded, can write effectively, and like statistics, the AIHW is a good place to work. □

twenty

Bennett House

Bennett House gardens

John Goss

1 July 1987

AIH set up as a Statutory Authority in response to the Kerr-White report, which recommended a new national emphasis on public health research and training. Its 50 staff occupied a prime waterfront position in Bennett House, Acton Peninsula—a former nurses' residence in the grounds of the now demolished Royal Canberra Hospital. A renovator's delight, each 'office' was equipped with a hand basin and mirror.

AIH releases 7 publications.

We enjoy our social activities and can't resist the chance to dress up.

Australia's welfare 1993

1993

First *Australia's welfare: services and assistance* published.

1996

AIHW website launched.

1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 19

1988

Three Collaborating Units join the Institute—National Perinatal Statistics Unit, National Injury Surveillance and Prevention Project and Dental Statistics and Research Unit.

First *Australia's health* published.

AIH Ethics Committee established—one of the first in a government agency.

1989

Purchase of a very advanced mainframe computer, delivered by crane to the upper level of the building—photographed by the local press!

1992

AIH expands under Health Minister Brian Howe to take on welfare functions, and becomes the AIHW.

Protocols established for release and publication of data.

1995

Move to Fernhill Park—all staff issued with a commemorative t-shirt for the event!

AIH Ethics Committee 1988

Australia's health 1988

Nigel Harding

Leaving Bennett House

years at the AIHW

Santa and his helper arrive at Bennett House

AIHW directors

1987–93
Dr Leonard R Smith

1993–94
Dr Tim Skinner

1994–96
Dr Bruce Armstrong

1996–2006
Dr Richard Madden

2006–
Dr Penny Allbon

Judith Abercromby, Richard Madden and Jan Reid demonstrate the AIHW website

2002

AIHW, as an Australian Collaborating Centre for the World Health Organization, hosts major international meeting on the Family of International Classifications.

Harmony Counts

97 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007

1997

First Memorandum of Understanding with the Department of Health and Family Services.

2000

AIHW boardroom named The Sidney Sax Room to honour the prominent public health expert and Institute supporter.

2001

First Memorandum of Understanding with the Department of Family and Community Services.

2005

METeOR (Metadata Online Registry) launched—an innovative tool developed by the AIHW to support the development of consistent metadata across the health and welfare fields.

AIHW Choir (Harmony Counts) performs at Australian National Eisteddfod and Floriade.

2007

Now with a staff of 200, AIHW releases a record 140 publications.

Richard Madden, Gwen Sax, Sidney Sax and Jan Reid in 2000

AIHW staff 2007, Fernhill Park

Working in partnership

AIHW and the Australian Commission on Safety and Quality in Health Care

Safety and quality in health care are of major importance to Australians and their representatives. All Australians will receive health care at some time in their lives. As our health improves, and knowledge about health and health care grows, there are increasing expectations that our health system will achieve better standards of safety and quality.

To help meet these expectations, Australian health ministers established the Australian Commission on Safety and Quality in Health Care (the Commission). The Commission's role is to lead, coordinate and monitor improvements in the safety and quality of patient care.

In September 2006, the Commission and the AIHW entered into a partnership with the intention of working together towards a more comprehensive and useful national information system for safety and quality in health care. This enhanced information will assist clinicians, health administrators and policy makers, as well as inform the wider public about the status and progress of safety and quality in health care.

The agreement recognises the unique roles of both organisations and the potential benefits of a fruitful collaboration to safety and quality in health care in Australia.

The Commission, as part of its role, will recommend national data sets for safety and quality and report publicly on safety and quality, including performance against national standards. The Commission will work in partnership with key national and state/territory bodies, and will consult broadly among stakeholders including health-care consumers, professionals, providers, funders and administrators.

The AIHW has developed a national leadership role within current multilateral governmental arrangements to undertake data development, collection, analysis and reporting in areas relevant to safety and quality in health care. It also has a reputation as a secure and respected data repository for a wide range of national data in the health, housing and community services fields.

With these shared and complementary roles, the two organisations are well placed to work together to enhance national information on safety and quality in health care.

The Commission has developed an information strategy and the AIHW, with its distinctive position in health information development and reporting, will be undertaking some projects within this strategy.

In particular, the AIHW and the Commission are currently finalising an agreement in relation to a specific project titled National Indicators: Review and Directions. As part of the work being undertaken to prepare for this project, the AIHW hosted a workshop in Canberra at which a comprehensive group of stakeholders was brought together to contribute to discussions regarding the development of health-care safety and quality indicators at a national level.

The workshop was attended by approximately 70 participants, with representatives from the states and

territories, several federal departments and health-related organisations, and numerous colleges and peak bodies from the medical sector, as well as academics working in the area of health-care safety and quality. The day included vigorous discussions on the need for, and shape of, national safety and quality indicators for health care. The information gathered at the workshop is helping to infrom the development of the national safety and quality indicators for health care.

The AIHW and the Commission have also recently published their first joint publication, *Sentinel events in Australian public hospitals 2004–05*. A profile of this publication is below. ■

Report profile

Sentinel events in Australian public hospitals 2004–05

Publication can be viewed online at: www.aihw.gov.au/publications/index.cfm/title/10353

Fast facts

In 2004–05, Australian public hospitals reported 130 'sentinel events'—a specific set of adverse events considered to be serious.

The most common sentinel events reported were procedures involving the wrong patient or body part.

The most common factors leading to these events were problems with rules, policies and procedures, or a breakdown within those rules, policies and procedures.

Summary

Studying sentinel events encourages learning from mistakes.

Sentinel events are relatively rare events which can potentially, or actually, contribute to patient harm. Ministers agreed on eight categories for national reporting, including:

- procedures involving the wrong patient or body part
- suicide of a patient in an inpatient unit
- retained instruments or other material after surgery requiring re-operation or further surgical procedure
- intravascular gas embolism resulting in death or neurological damage
- haemolytic blood transfusion reaction resulting from blood type incompatibility
- medication error leading to the death of patient reasonably believed to be due to incorrect administration of drugs
- maternal death or serious morbidity associated with labour or delivery
- infant discharged to wrong family.

A recent joint report by the AIHW and the Australian Commission on Safety and Quality in Health Care (the Commission) examined 130 such events that occurred in Australian public hospitals in 2004–05.

Jenny Hargreaves, who heads the AIHW's Economics and Health Services Group, said, 'The study of these events contributes to improving the public hospital system and making the complex world of hospital care safer for patients.'

'Of course we wish that these events didn't happen at all, but we all know that mistakes can happen. What we want is to minimise the harm that could occur.'

About the unit

The Health Care Safety and Quality Unit's main role is to develop and maintain a national system of information that provides an evidence base for enhancing safety and quality in the health sector. The unit is working in collaboration with the Commission. ■

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The people behind the stats:

Hospitals Unit

(l-r) Christina Barry, Laura Cleator, Katrina Burgess, Cid Riley, Alex Peng, Tony Mole and George Bodilsen

Photo: Irene Dowdy

Quenching the thirst for data

As head of the AIHW's Hospitals Unit, George Bodilsen says 'there is always a call for more data on hospitals.'

Hospitals attract a lot of attention as service providers and as recipients of substantial funding, 'and whilst we at the AIHW continue to do a lot of great work, there is always room for further data development.'

The AIHW's Hospitals Unit compiles and reports data on Australian public and private hospitals, including admitted patient activity, elective surgery waiting times, non-admitted patients in emergency departments, and outpatient activity.

The unit's major publication is the annual *Australian hospital statistics* report, now in its 13th edition, which is useful to many, including service planners and policy makers (see report profile, page 23).

Apart from its work in continually updating and developing this publication, the unit also produces a range of online data cubes. They cover the clinical information available in the admitted patient care collection, including principal diagnoses, procedures performed and diagnosis-related groups.

These cubes contain data for all Australian hospitals over a period of several years and can be used to produce reports on specific diagnoses or procedures by the sex and age group of the patient.

The unit also liaises with a range of clients to provide and assist in the use of hospital data.

'Most of the health-related units at the AIHW use hospital-based data at some point, and we work with them to provide data and assist in its use.'

'The AIHW collaborating units also incorporate our hospital data in reports on their specialties, such as injuries, vaccine-preventable diseases, asthma, mothers and babies, and public health issues,' says Mr Bodilsen.

'We also liaise with the Department of Health and Ageing to ensure that their annual hospital report (that uses the same hospital data) is consistent with ours, and the Productivity Commission uses our data in its annual report on government services.'

The Hospitals Unit also provides an 'ad hoc data request service' and has provided data to a variety of external users such as university researchers and students, market researchers for pharmaceutical or medical device companies, and representatives of private health associations.

Enhancing available information

The unit also spends a great deal of time on data evaluation and data development work.

'An important focus for us within the Hospitals Unit is encouraging development of data in a way that enhances its usefulness for reporting on hospital services,' says Mr Bodilsen.

With that focus in mind, the Hospitals Unit provides input into a number of national committees.

For example, unit representatives sit on the Coding Standards Advisory Committee (a national committee that sets standards for the coding of clinical data and advises the clinical coding workforce) to ensure that the needs of users of the data are considered when developing guidelines for the reporting of diagnoses and interventions. They also participate in the Health Data Standards Committee.

An area that the unit sees itself becoming more involved in over time is in relation to non-admitted patient data. While there is a lot of data available on admitted patients, data on non-admitted patients are much less developed.

'Our work with the Non-admitted Patient National Minimum Data Set Working Group involves liaising with the state and territory health authorities and other government departments to progress the development of useful non-admitted patient data elements to inform this under-reported segment of hospital activity.'

'At present, the extent of national data available for this activity consists of only aggregated counts of services provided within very broad "clinic types". There is a need for information on the specific types of health issues being dealt with in those clinics, and demographic information on the patients accessing those services,' says Mr Bodilsen.

The unit is also working with stakeholders to develop analyses of changes in admitted versus non-admitted activity over time. For example, there have been shifts over time in the provision of chemotherapy services in some states and territories, and changes like these in the delivery of services have not been thoroughly explored.

A diverse staff

As with many other areas within the AIHW, the staff that make up the Hospitals Unit come from varied and interesting backgrounds, with everyone bringing their own individual skills set to the team.

They can cook a banquet (including pickled herring), have a go at minor surgery (no anaesthetists though), decipher a doctor's handwriting, sing a traditional Tongan song, and conduct a soil analysis (by taste), in a few languages!

'I recently joined the AIHW from Calvary Hospital in the Australian Capital Territory,' says Mr Bodilsen 'and have reported on hospital costing and funding issues in a variety of settings in the past.'

'Katrina Burgess knows hospital data backwards, is extremely organised and is central to ensuring *Australian hospital statistics* is published on time. Cid Riley brings a broad range of data analysis experience from outside health and also has a wealth of knowledge in the area of publication development. Alex Peng has a medical background and very strong data analysis and IT skills.'

'In addition, Christina Barry and Laura Cleator are both health information managers and this gives them great insight into hospital data. Tony Mole is a demographer with lots of innovative ideas.'

This combination of skills and expertise means that the unit is well placed to expand on its work program and product lines over the coming year.

New ventures

'We have several projects in progress or about to start,' says Mr Bodilsen.

These include involvement in an audit of Indigenous data reported in admitted patient settings, with the aim of estimating the extent of under-reporting of Indigenous people in hospital data and to identify best practices in collecting Indigenous information.

'We are also involved in data developmental projects stemming from the evaluation of several of the national minimum data sets reporting hospital activity, including the admitted patient care data, the public hospital establishments data and the elective surgery waiting times data.'

The unit is also currently working to develop a new suite of information, including a new bulletin on hospital services and a new online data cube for public hospitals establishments data.

'It's a very exciting time for us here in the Hospitals Unit with new products and projects being developed.'

'AIHW is a friendly and supportive environment. The team works well together and we have interesting and challenging work to keep us very busy!' ■

People power

With around 200 staff, it is very much a case of 'people power' underpinning the AIHW's success and growth.

According to AIHW Director Dr Penny Allbon, the AIHW's staff is 'one of the most wonderful things about this place' and supporting a versatile and adaptable team is another of the AIHW's strategic goals.

'This is a highly qualified public service organisation, full of very capable and committed and passionate people.'

With a rich and committed workforce, it is important that staff dedication doesn't lead to people getting 'burnt out', according to Dr Allbon. 'We want workloads to be reasonable so people can deliver their best.'

The AIHW's staff strategy identifies the need to support staff and recognise their professional development and capabilities. It also includes publicising the broad range of staff expertise when recruiting.

'We want people to know what a good place this is to work,' Dr Allbon says. ■

Report profile

Publication can be viewed online at: www.aihw.gov.au/publications/index.cfm/title/10455

Fast facts

The report demonstrates that the growth in activity and expenditure within Australia's hospitals is continuing, with the strongest growth occurring within public acute hospitals.

Same-day admissions remain on the increase, with public hospitals picking up a large part of this. The length of stay for overnight cases remains fairly constant.

The rate of hospitalisation for Aboriginal and Torres Strait Islander peoples is double that for other persons.

The rate of hospitalisation for people who live in very remote areas of Australia is double that for people living in major cities.

The growing burden of disease attributable to chronic conditions is reflected in part by increased admission rates for selected chronic diseases.

Australian hospital statistics 2005–06

Summary

***Australian** hospital statistics 2005–06* is the 13th annual report on the characteristics and activity of Australia's hospitals. Hospitals covered in the report include public acute care and psychiatric hospitals, public non-acute hospitals, private free-standing day hospital facilities and other private hospitals.

The report describes aspects of Australia's hospital services, including admitted patient care, elective surgery waiting times, non-admitted emergency department care, outpatient care, and public hospital expenditure and resources.

Growth in activity continued, with 7.3 million public and private hospital admissions in 2005–06, compared to 7.0 million in 2004–05. While the proportion of separations that were same day has increased (from 45% in 1996–97 to 55% in 2005–06), the average length of overnight hospital stays has remained constant.

There were approximately 6.3 million accident and emergency occasions of service provided in Australia's public hospitals in 2005–06, an increase of 300,000 episodes over 2004–05. In the majority of emergency visits (69%), patients were seen on time, including 99% of those needing immediate care and 77% of those who required care within 10 minutes of arriving in the emergency department.

The rate of hospitalisation for Aboriginal and Torres Strait Islander peoples is double that for other persons. Similarly, the rate of hospitalisation for people who live in very remote areas of Australia is double that for people living in major cities.

The growing burden of disease attributable to chronic conditions is reflected in part by increased admission rates for selected chronic diseases. For example, the separation rate for complications of diabetes has increased by an average of 8.6% per year between 2001–02 and 2005–06.

Total recurrent expenditure on public acute and public psychiatric hospitals was $24 billion in 2005–06, 5.6% higher than expenditure in 2004–05 after adjusting for inflation.

About the unit

The Hospitals Unit undertakes work to develop, collate and report from the Institute's national hospitals databases, in consultation with national stakeholders. Key responsibilities of the unit are the production of the annual *Australian hospital statistics* report and accompanying internet-based electronic data resources; improving the quality and usefulness of Australia's hospitals data; and progressing data analysis and information dissemination to support community discussion and decision making. ■

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METeOR

two years on

The contribution that data standards make to the production of high-quality statistics can go unrecognised. However, without the use of consistent data standards, the resulting statistics are potentially meaningless, perhaps even misleading. The AIHW manages critical data standards for many of Australia's key health, community services and housing assistance data collections. For many years, the AIHW had used a data standard registry known as the Knowledge Base to store and manage these data standards. This registry was based on the first edition of the international metadata standard (ISO/IEC 11179).

With the arrival of a new, more sophisticated edition of the ISO/IEC 11179 standard, the AIHW decided it was time to replace the ageing Knowledge Base. The AIHW selected an XML-based content management system and customised it to serve as an innovative, online data standard registry. The new registry, known as the Metadata Online Registry, or METeOR, introduced a whole suite of new features not previously available in the Knowledge Base, including online data standard creation and automated dictionary extraction facilities. Extensive restructuring of our existing data standards was also undertaken to comply with the new edition ISO/IEC 11179 standard.

METeOR and the restructured data standards were released in May 2005 and was one of the few registries available at that time to be based on the new ISO/IEC 11179 standard. It was unique in its capacity to allow registration of data standards to more than one sector of government activity, thereby encouraging the re-use of data standards across service boundaries and silos. The official launch generated a great deal of interest, resulting in numerous invitations to demonstrate the system both locally and overseas (including a demonstration for the committee responsible for ISO/IEC 11179). The system went on to become a finalist for the 2006 *Excellence in e-Government Award*, an award for excellence and innovation in the electronic delivery of government services.

In the two-and-a-half years since its release, the fanfare has been followed by strong growth in system use to access data standards. The pattern of growth was quite pronounced during 2006–07, with almost 7 million hits received, double that achieved during the previous year. METeOR also enabled high levels of new data standard creation. Over 600 data elements were added to the system during 2006–07, giving a total of 2,700 data elements in the system—an increase of 30%. The number of data standard development workgroups operating within METeOR increased by 10% to 106.

While tremendous benefits were gained in terms of effective data standard management and re-usability, the move to the second edition of the ISO/IEC 11179 has introduced many new features and tools. To assist data standard users and authors make best use of these, a series of hands-on training workshops was delivered to over 400 staff across 30 government departments and non-government organisations. Over 150 staff members were trained during 2006–07 as the training program expanded to include visits to states and territories.

Not everything has proceeded according to plan. The higher-than-expected levels of user activity have meant our plans for upgrading the capacity of the system will be brought forward. The closure of our IT partners has meant our exciting plans to make the system a commercial product have had to be shelved at this stage.

two years on

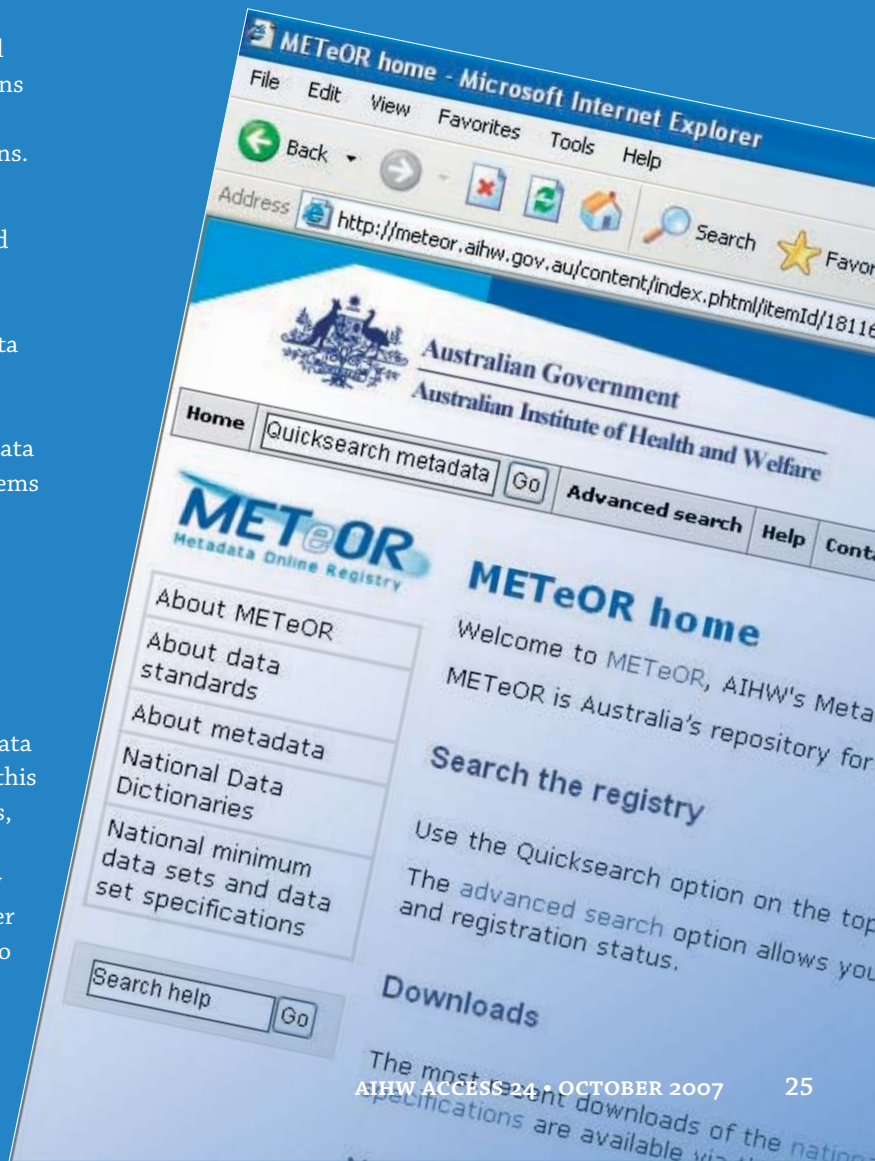
Ongoing improvements

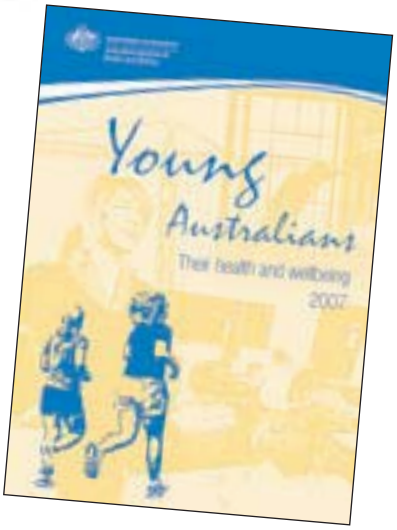
Since the launch of METeOR, the AIHW has been consulting with users about their experience of the system and what enhancements they would like to see. The aim of these efforts has been to identify priorities for system refinements and to ensure the system continues to evolve to meet changing user expectations. To date, enhancements have included the introduction of useful new tools such as glossary items, more download options for users including simple formats, refining the search interface, and adding new fields to data set specifications.

Perhaps the most exciting enhancement to date has been the implementation of an electronic data standard transmission tool. This tool allows external systems to extract data standards from METeOR and has the potential to revolutionise the way the AIHW and its data providers and data users work together. Traditionally, data standards have been disseminated using 'human-readable' documents, such as data dictionaries. These data standards are then manually transferred into data systems to support data collection, extraction and validation processes.

External systems can now extract data standards electronically from METeOR. This offers tremendous potential to boost data standard compliance and consistency and to reduce inefficiencies and duplicated effort in data-handling processes through automated data collection and validation. The AIHW has been trialling this new tool with a number of volunteer system developers, both internally and with some state and territory departments. The results to date have been particularly promising. The AIHW plans to provide support for other system developers during 2007–08 so that they can also utilise this tool. ■

For more information on any aspect of the METeOR system, please contact Robyn Kingham Edwards, National Data Development and Standards Unit on 02 6244 1088, or robyn.kinghamedwards@aihw.gov.au.





Young Australians: their health and wellbeing 2007

Summary

Youth is the period during which dependent children develop into independent adults. It is also a critical time for establishing and reinforcing good health and social behaviours. Young people who are unable to make the transition to adulthood smoothly can face significant difficulties and obstacles in both the short and long term.

Young Australians: their health and wellbeing 2007 is the third in a series of reports on young people (aged 12–24 years) and goes beyond traditional measures of health to include community and family, education and employment, socioeconomic status, social support and environmental factors in order to look at the health and wellbeing of Australia's young people against a broader social and environmental backdrop.

In general, young Australians are healthy and well, with over 90% of them rating their health as excellent, very good or good.

Some of the best news out of the report is that death rates among young people have halved over the last two decades. But significant improvements have been seen in other areas too—asthma prevalence has declined and melanoma incidence has dropped, although less for females than males.

Unfortunately, hospitalisation rates for some chronic conditions, such as diabetes and Crohn's disease are on the rise, and obesity and some mental health issues have also increased in recent years. Almost one-third of young people drank alcohol in amounts that put them at risk of alcohol-related harm and around 17% were current smokers.

Most Year 7 students met the national benchmarks for reading, writing and numeracy, and the proportion of high school students staying on at school until the end of Year 12 has more than doubled since 1980.

Fast facts

Death rates among young people aged 12–24 years halved between 1980 and 2004, largely due to decreases in deaths due to injury and suicide.

Large declines have been observed over the last decade for some communicable diseases including measles, rubella, and hepatitis A and B.

Increasing proportions of young people are staying in school to Year 12.

Less than half of young people met the recommended physical activity guidelines and only a minority met the daily vegetable consumption guidelines.

Almost one-third of young people drank alcohol in amounts that put them at risk of alcohol-related harm and around 17% were current smokers.

About the unit

The Children, Youth and Families Unit works on a range of statistical reporting, data collection and data development activities in relation to child and youth health and wellbeing and also the following areas of community services: children's services (child care and preschools); child protection services; adoptions; and family support services. ■

Publication can be viewed online at: www.aihw.gov.au/publications/index.cfm/title/10451

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The burden of disease and injury in Australia 2003

Publication can be viewed online at: www.aihw.gov.au/publications/index.cfm/title/10317

Fast facts

Cancer (19%) and cardiovascular disease (18%) were the two leading causes of burden of disease in 2003.

The five leading causes of non-fatal burden were anxiety and depression (14% of the non-fatal burden), type 2 diabetes (8%), dementia (5%), adult-onset hearing loss (5%) and asthma (4%).

Of the 14 preventable health risks examined, tobacco was responsible for the greatest burden (7.8% of the total burden) in Australia.

Summary

The burden of disease and injury in Australia 2003 examines levels of death and disability from a variety of diseases, injuries and health risks to determine the total 'burden of disease' in Australia.

It shows that cancer and cardiovascular disease were the two leading causes of the burden of disease in 2003. Cancer has now overtaken cardiovascular disease as the leading cause of burden, largely because of Australia's success in reducing the burden of cardiovascular disease.

The burden of disease analysis in this report goes beyond the mortality impact of a disease and also looks at the impact of illness and disability. This non-fatal burden (the amount of healthy life years lost due to disability from disease and injury) made up 51% of the total burden.

The five leading causes of non-fatal burden of disease were anxiety and depression (14% of the non-fatal burden), Type 2 diabetes (8%), dementia (5%), adult-onset hearing loss (5%) and asthma (4%).

For those 75 years and over, the leading causes of non-fatal burden were dementia (23%), ischemic heart disease (8%), Type 2 diabetes (7%) and adult-onset hearing loss (5%).

Of the 14 preventable health risks examined in the report, tobacco was responsible for the greatest burden (7.8% of the total burden) in Australia. Other leading risks in 2003 were high blood pressure (7.6% of the total burden), high body mass (7.5%), physical inactivity (6.6%) and high blood cholesterol (6.2%). Excessive alcohol consumption, low fruit and vegetable consumption, illicit drugs, occupational exposures and hazards, intimate partner violence, child sexual abuse, urban air pollution, unsafe sex and osteoporosis were also risk factors. These 14 risks together accounted for 32% of the total burden of disease and injury in 2003.

The report also showed that a strong upsurge in the number of people with diabetes is likely, mostly due to higher levels of obesity.

The report, prepared primarily by the University of Queensland with input from the AIHW, is the first complete assessment of the health of Australians to be released in the new millennium, and significantly expands the scope of the first burden of disease study released by the AIHW in 1999.

About the unit

The Expenditure and Economics Unit develops, collates and reports information on expenditure relating to the provision of specific types of health and welfare services, and expenditure by disease. The unit also undertakes economic analyses relevant to health and welfare. ■

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Australia's welfare 2007 conference

DISADVANTAGE AND DIVERSITY

PRESENTED BY THE **Australian Institute of Health and Welfare**

THURSDAY 6 DECEMBER 2007, THE MARQUE HOTEL, CANBERRA

'Disadvantage and Diversity', a one-day conference to be held in the nation's capital, will provide a forum for debate and discussion on some of the welfare issues facing Australia. Topics covered will include ageing and aged care, children, youth and families, expenditure, labour force, housing and homelessness. This conference will also include the launch of AIHW's flagship publication *Australia's welfare 2007,* the most comprehensive and authoritative source of national information on welfare services in Australia. Some of the material discussed during the day will centre around this publication.

How much is the conference?

The one-day conference registration fee is just $235 and includes lunch, morning and afternoon tea and a copy of AIHW's flagship publication ***Australia's welfare 2007***, the nation's most comprehensive and authoritative source of welfare information and statistics (valued at $60). Alternatively you can register for the conference alone for the price of $195.

How do you register?

For more information on our high profile speakers, the venue and accommodation and sponsorship opportunities, please visit our conference website at www.aihw.gov.au where you will also be able to download a registration form.

All conference inquiries can be directed to our conference coordinator Alison Diamond on 02 6244 1287 or email conference2007@aihw.gov.au

PROGRAM AT A GLANCE

Combining a mixture of plenary and parallel sessions, this conference has something for everyone. Some of the topics to be covered include:

Ageing and aged care

Disability and disability services

Children and family services

Housing

Homelessness

Welfare expenditure and labour force

SPEAKERS WILL INCLUDE:

Monsignor David Cappo
COMMISSIONER FOR SOCIAL INCLUSION SOUTH AUSTRALIA

Dr Ken Henry
SECRETARY TO THE TREASURY

and other notable speakers including
Prof. Ilan Katz, Dr Owen Donald, Prof. Helen Bartlett, Ms Jill Whitehorn, Dr Ken Baker, Prof. Peter Saunders, Dr Penny Allbon and Dr Diane Gibson

8.30 AM	**Registration, tea/coffee on arrival**	
9.00 AM	**Welcome to country**	
9.05 AM	**Welcome** and to introduce keynote speaker (and to chair opening session) **Dr Penny Allbon**, Director, AIHW	
9.10 AM	**Opening keynote speech** **Monsignor David Cappo**, Commissioner for Social Inclusion, South Australia	
9.50 AM	Break for arrival of Minister and media	
10.00 AM	**To introduce the Minister** **Hon Peter Collins AM, QC**, Chair of AIHW Board	
10.10 AM	**Address to launch *Australia's welfare 2007*—Minister (to be confirmed)**	
10.30 AM	Morning tea	
	Stream A	**Stream B**
11.00 AM	**Children, Youth and Families** **Ms Cynthia Kim** *Head, Children, Youth and Families Unit, AIHW* **Professor Ilan Katz** *Director, Social Policy Research Centre, UNSW* Chair: **Professor Alan Hayes** *Director, Australian Institute of Family Studies*	**Housing** **Ms Tracie Ennis** *Head, Housing Assistance Unit, AIHW* **Mr Owen Donald** *Former Director of Housing, Victoria* Chair: **Dr Peter Smith** *AIHW Board member*
12.10 PM	Lunch	
1.00 PM	**Ageing and Aged care** **Ms Ann Peut** *Head, Ageing and Aged Care Unit, AIHW* **Professor Helen Bartlett** *Foundation Director Australasian Centre on Ageing, University of Queensland* Chair: **Professor Heather Gardner** *Adjunct Associate Professor, School of Public Health, La Trobe University*	**Homelessness** **Ms Anne Giovanetti** *Head, Supported Accommodation and Crisis Services, AIHW* **Ms Jill Whitehorn** *Senior Adviser, Social Inclusion Board, South Australia* Chair: **tba** *ACT Government*
2.10 PM	**Disability and Disability Services** **Dr Chris Stevenson** *Head, Functioning and Disability Unit, AIHW* **Dr Ken Baker** *Chief Executive Officer, National Disability Services* Chair: **Mr Ian Spicer** *AIHW Board member*	**Resources** **Ms Jenny Hargreaves** *Group Head, Economics and Health Services Group, AIHW* **Professor Peter Saunders** *Australian Professorial Fellow, Social Policy Research Centre, UNSW* Chair: **Ms Robyn McKay** *Deputy Secretary, Department of Families, Community Services and Indigenous Affairs*
3.25 PM	Afternoon tea	
3.45 PM	**Closing keynote speech** **Dr Ken Henry**, Secretary to the Treasury	
4.20 PM	**Summary and closing remarks** **Dr Diane Gibson**, Head, Welfare and Housing Group, Australian Institute of Health and Welfare	
4.40 PM	**Conference close**	

Recent publications

August 2007

Alcohol and other drug treatment services State and Territory data briefings. FREE (INTERNET ONLY)

Comorbidity of cardiovascular disease, diabetes and chronic kidney disease in Australia. (Cardiovascular disease series no. 28). CAT. NO.CVD 37 • $ 26.00

Comparing name-based and event-based strategies for data linkage. (Data linkage series no. 3). CAT. NO.CSI 3 • $ 30.00

Juvenile justice in Australia 2005–06. (Juvenile justice series no. 3). CAT. NO.JUV 3 • $ 27.00

Ladder-related fall injuries. (NISU briefing no. 11). CAT. NO.INJ 105 • FREE (INTERNET ONLY)

Medical indemnity national data collection public sector 2005–06. (Safety and quality of health care no. 3). CAT. NO.HSE 52 • $ 26.00

National Diabetes Register: statistical profile 1999–2005. (Diabetes series no. 7). CAT. NO.CVD 39 • $ 26.00

National indicators for monitoring diabetes. (Diabetes series no. 6). CAT. NO.CVD 38 • $ 33.00

Older Australians in hospital. (AIHW bulletin no. 53). CAT. NO.AUS 92 • $ 10.00

September 2007

Hospitalised football injuries, 2004–05. (NISU briefing no. 10). CAT. NO.INJCAT 103 • FREE (INTERNET ONLY)

Impairments and disability associated with arthritis and osteoporosis. (Arthritis series no. 4). CAT. NO.PHE 90 • $ 21.00

National palliative care performance indicators: results of the 2006 performance indicator data collection. (AIHW bulletin no. 54). CAT. NO.AUS 94 • $ 10.00

October 2007

A picture of osteoarthritis in Australia. (Arthritis series no. 5). CAT. NO.PHE 93 • $ 18.00

Assisted reproduction technology in Australia and New Zealand 2005. (Assisted reproduction technology series no. 11). CAT. NO.PER 36 • $ 33.00

Breast cancer survival by size and nodal status in Australia. (Cancer series no. 39). CAT. NO.CAN 34 • $ 20.00

Congenital anomalies in Australia 1998–2001. (Birth anomalies series no. 2). CAT. NO.PER 37 • FREE (INTERNET ONLY)

News in brief

From leg-warmers to fire-fighters the AIHW's 20th birthday party had it all! Guests arrived in their finest 80s fashions, were evacuated (due to a fire alarm being set off) and arrived again for what was to be a memorable event.

A debate (which was better—the 80s or the 00s?) set the tone of the night, which continued on with 80's trivia, music and stories from the last 20 years retold in imaginative and amusing ways—definitely an evening that will be remembered for years to come. Many thanks to all those who made it such a special occasion.

(l-r) Diane Gibson, Jenny Hargreaves, Penny Allbon, Julie Roediger, Susan Killion and Andrew Kettle

ent publications

October 2007 (continued)

Disability support services 2005–06. (Disability series). CAT. NO.DIS 51 • FREE

Health expenditure Australia 2005–06. (Health and welfare expenditure series no. 30). CAT. NO.HWE 37 • $ 30.00

Indigenous housing indicators 2005–06. (Indigenous housing series no. 2). CAT. NO.HOU 168 • $ 29.00

Indigenous mothers and their babies, Australia 2001–2004. (Perinatal statistics series no. 19). CAT. NO.PER 38 • FREE

Nursing and midwifery labour force 2005. (National health labour force series no. 39). CAT. NO.HWL 40 • FREE

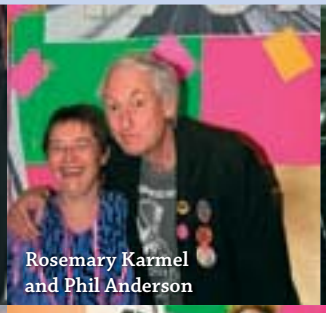
Serious injury due to land transport accidents, Australia 2003–04. (Injury research and statistics series no. 38). CAT. NO.INJCAT 107 • FREE (INTERNET ONLY)

Serious injury due to transport accidents involving a railway train, Australia 1999–00 to 2003–04. (Injury research and statistics series no. 37). CAT. NO.INJCAT 104 • FREE (INTERNET ONLY)

Serious injury due to transport accidents, Australia 2003–04. (Injury research and statistics series no. 35). CAT. NO.INJCAT 101 • FREE (INTERNET ONLY)

Use of multiple causes of death data for identifying and reporting injury mortality. (Injury technical paper series no. 9). CAT. NO.INJCAT 98 • FREE (INTERNET ONLY)

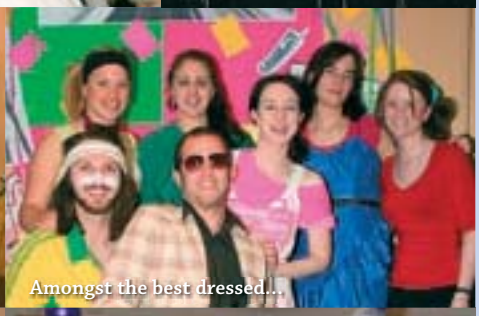

Penny Allbon and AIHW board member Heather Gardner


Rosemary Karmel and Phil Anderson


Ching Choi


MC for the night, Julian Emerson-Elliott


Media and publishing staff


Amongst the best dressed...


(l-r) Diane Gibson, Susan Killion, Richard Madden and Julian Emerson-Elliott


Members of the Housing and Homelessness cluster

Fast Facts

Focus on cancer

This statistical snapshot is taken from three of our recent cancer publications: *Cancer in Australia—an overview, 2006*, *BreastScreen Australia monitoring report 2003–2004* and *Cervical screening in Australia 2004–2005*. A more in-depth picture can be gained from reading the publications in their entirety, all of which can be accessed on our website at <http://www.aihw.gov.au/publications/index.cfm/criteria//subject/3>.

The general picture in 2006

- There were an estimated 106,000 new cases of cancer diagnosed in Australia in 2006 (a 34% increase in 10 years) and 39,200 deaths from cancer (12% increase in 10 years).

The incidence of cancer in 2003

- Apart from non-melanoma skin cancer, prostate cancer was the most common cancer diagnosed in Australia in 2003, followed by colorectal cancer, breast cancer, melanoma and lung cancer. The most common cancer diagnosed in males was prostate cancer and the most common cancer diagnosed in females was breast cancer.
- The most common cancer deaths in 2003 were from lung cancer followed by colorectal cancer. The most common cancer death in males was from lung cancer followed by prostate cancer. The most common cancer death in females was from breast cancer followed by lung cancer.
- The risk of cancer diagnosis for males is 1 in 3 before age 75, and 1 in 2 before age 85. The risk of cancer diagnosis for females is 1 in 4 before age 75, and 1 in 3 before age 85.
- There were an estimated 10,378 new cases of cancer and 7,727 deaths from cancer attributed to smoking and an estimated 2,844 new cases of cancer and 1,358 deaths from cancer attributed to excessive alcohol consumption.
- Although incidence of all cancers in 2001–2003 was about 10% lower in very remote areas than in major cities, mortality was about 10% higher. However, both lung cancer incidence and mortality were around 36% higher in very remote areas than in major cities.

Changes over time

- In the 10 years from 1993 to 2003, the cancers which increased the most in number were thyroid cancer (106%), myeloma (44%), melanoma (41%), kidney cancer (39%) and non-Hodgkin lymphoma (36%).
- In the 10 years from 1993 to 2003, the incidence of cervical cancer declined by 41% and lung cancer by 11%.

The impact on our hospitals

- In 2004–05, 10% of all hospital admissions in Australia were cancer-related and the numbers increased by 4.5% a year from 2000–01 to 2004–05.

BreastScreen Australia Program

- In the 2-year period 2003–2004, 1.6 million Australian women were screened by the BreastScreen Australia Program. For those women who are being screened, small breast cancer tumours are being found earlier, which means they can be treated more effectively.
- Breast cancer incidence has been rising, with the incidence rate for women in the 50–69 year age group increasing significantly from 280.5 per 100,000 women in 1994–1998 to 295.4 per 100,000 women in 1999–2003.
- Breast cancer was the most common cause of cancer-related deaths in women in Australia in 2004, with 2,641 deaths. Mortality from breast cancer declined by an average of 2% per annum between 1990 and 2004.

National Cervical Screening Program

- In the 2-year period 2004–2005, just under 3.5 million women underwent screening for cervical cancer as part of the National Cervical Screening Program, with approximately 31,000 abnormalities detected in 2005.
- The numbers of new cases of cervical cancer continue to decline, with 725 new cases detected in 2003 compared with 1,091 in 1991 before the start of the organised screening program.
- There was a decline in deaths from cervical cancer, with 212 deaths in 2004 compared with 329 deaths in 1991. ■