

## 'Powerhouse' launch of *Indigenous health and welfare report*

The ABS/AIHW report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* was launched on 30 August by the Director-General of NSW Health, Mick Reid, and National Aboriginal and Torres Strait Islander Health Council member Barbara Flick.

The launch, hosted by Acting Australian Statistician Rob Edwards and AIHW Director Richard Madden, was held at the Powerhouse Museum, Sydney.

The 2001 report is the third in a biennial series produced since 1997 by the Aboriginal and Torres Strait Islander Health and Welfare Information Unit (ATSIHWIU), a joint program of the Australian Bureau of Statistics (ABS) and the Institute. This Unit is located within the National Centre for Aboriginal and Torres Strait Islander Statistics, which is part of the ABS office in Darwin.

Principal authors were Dr Janis Shaw (Head of ATSIHWIU), Barbara Gray, Mary Beneforti, Michael Bourchier, Elena Mobilia and Sean Kavanagh.

Mick Reid, who is also Chair of the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data, explained that this year's edition of the report contains a special chapter on the serious impact of diabetes on the Indigenous population. Over the 1997-99 period there were 7-9 times more deaths of Indigenous people than expected from endocrine and metabolic diseases, with 88% of these attributable to diabetes.



*Mick Reid presenting The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2001 to Barbara Flick.*

Other major findings of the report outlined by Mr Reid included:

- Death rates among Aboriginal and Torres Strait Islander people were higher than those recorded in the general population for almost all causes of death and for every age group. In the age group 35-54 years, the Indigenous death rate was 5-6 times higher than for the total Australian population.
- Life expectancy at birth for an Indigenous male was 56 years for men and 63 years for women, compared with figures for the total Australian population of 76 years and 82 years.
- The main reason for hospitalisation of Aboriginal and Torres Strait Islander people in 1998-99 was for 'care involving dialysis'. It accounted for just over 26% of hospital stays for Indigenous people.

*Continued on page 4* ▶

### INSIDE

*Expenditures on health services for Indigenous people*

*Soapbox Prognostication: a necessary science*

*Spotlight on Robert Todd, AM*

# contents

## from the Director



### Cover story 1, 4

'Powerhouse' launch of Indigenous health and welfare report

### From the Director 2

### Project Reports 5

Expenditures on health services for Indigenous people

Projections of Older Immigrants

Labour Force and Rural Health Unit

### Soapbox 8

Prognostication: a necessary science

### Spotlight 10

on Robert Todd, AM

### The driving force 12

National Health Information Management Group (NHIMG)

National Community Services Information Management Group (NCSIMG)

National Housing Data Agreement Management Group (NHDAMG)

National Indigenous Housing Information Implementation Committee (NIHIC)

### From the inside 16

General Practice Statistics and Classification Unit (GPSCU)

### Data speak 19

The importance of documentation in data management

### Trust me 20

A moving dilemma: Part 2

### Recent releases 24

I am delighted to report another successful year for the AIHW. Eighty-two major reports were released and the pace continues unabated.

In 2000–01, our contract services exceeded \$10 million for the first time, 25% more than AIHW's appropriation. Reflecting this commercial reality, a business plan is now in place, with input from all sectors of the Institute.

The end of the 2000–01 financial year also meant the end of the term of office of our Board. It is with regret that we said goodbye to our long-serving Chair, Professor Janice Reid, who has been Chair of the Board since 1995.

Jan encouraged, reacted and defended as situations required and has been an outstanding ambassador for the Institute and deeply committed to it. The AIHW has gone from strength to strength under her leadership over the past six years. Because of the pressures of her role as Vice-Chancellor of the University of Western Sydney, Jan decided that she would not seek reappointment to the Board.

On behalf of all the Institute, my heartfelt thanks to Professor Reid for her valuable support and contribution to the Institute. We wish her the very best for the future.

I am pleased to announce that Dr Sandra Hacker is the new Chair of the AIHW Board. Sandra has been a member of the Board since 1998 and we look forward to her leadership of the Institute in the challenges ahead.

Also retiring at the end of 2000–01 was Dr Sid Sax, Chair of the Ethics Committee since 1995. Sadly, Sid passed away on 24 August 2001 after a short illness (see obituary on page 3). His funeral at University House, Australian National University, was a deeply moving occasion, made all the more poignant by the AIHW choir's renditions of a selection of African songs much loved by Sid.

We welcome Mr Robert Todd as the newly appointed Chair of the Ethics Committee. Robert has been a member of the Committee for some years now (see article on page 10). Two new members of the Ethics Committee are Prof. Tony Adams and Ms Marina Farnan.

The Institute's Act has now been amended so that the Institute can, subject to ethical clearance, make available identifiable welfare-related data for research purposes. To permit this change, the role of the Ethics Committee has been expanded to include both health and welfare information.

The AIHW is now leading Australian efforts in the area of summary measures of health system performance following the release of the World Health Report in June 2000. A new specific-purpose unit has been established to work closely with other units on cross-cutting interests. Long-time head of the AIHW's Health and Welfare Expenditure Unit, John Goss, will lead this new activity. A working paper on the Fairness of Financial Contributions has already been released.

Finally, on a lighter note, I had the pleasure of refereeing a friendly AIHW–NHMRC soccer match recently. The score was 4–3 in favour of NHMRC. We look forward to a rematch!

*Richard Madden, Director, AIHW*

## Vale Sidney Sax, CBE, MD, DPH, FRCP, FRACMA, FRACP

*Born 16 February 1920; died 24 August 2001*

Sid was a man combining many attributes that made him an exemplary person: great humanity, high intelligence and the amazing courage that led him out of South Africa to make such a notable and unforgettable contribution to Australia.

He was simply the outstanding leader in Australian health care policy development and public health research for 35 years, and an icon for those of us who work at the interface of health and welfare statistics.

Sid received his medical training at the University of Witwatersrand, and worked as a doctor and physician in South Africa, Rhodesia and Swaziland before emigrating to Australia in 1960.

Sid served as a physician and deputy medical superintendent at Garrawarra and Lidcombe hospitals before becoming Director of Geriatrics for New South Wales in 1964. Between 1970 and 1973 he was Director of Health Services Research and Planning in New South Wales, and then came to Canberra to become Chairman of the National Hospitals and Health Services Commission, where he stayed for five years. He then became Head of the Commonwealth's Social Policy and Welfare Secretariat between 1978 and 1983. He was awarded a CBE in 1982 for his services to health.

Sid was also closely involved in numerous reviews, councils, committees, boards and commissions in New South Wales and Canberra, including membership of the Medibank Review Committee and chairmanship of the NHMRC Public Health Research and Development Committee.

He wrote several books, including *Medical Care in the Melting Pot* (1972), *Medicine in the 80s: Can we Afford it?* (1980), *A Strife of Interests* (1984), *Health Care Choices and the Public Purse* (1990) and *Ageing and Public Policy in Australia* (1993).

He also published over 60 journal articles in the fields of epidemiology, chronic disease, geriatrics and health services administration.

Few people had as long an association with the purposes and ideals of the Australian Institute of Health and Welfare as Sidney Sax.

During the 1970s and early 1980s Sid was involved in many inquiries and committees that pointed to the lack of health services research and lack of national statistics on health services in Australia.

Out of one of these inquiries, the Kerr White review of 1985–1986, the Australian Institute of Health and Welfare, or Australian Institute of Health as it was then, was born.

Sid served briefly as an observer on the first AIH Board, which was a temporary Board until more permanent arrangements could be put in place.

He then took up the position of Visiting Fellow to the Institute in 1986, a year before the Institute was finally established as a statutory authority in 1987.

In his role as a Visiting Fellow, which he fulfilled until 1994, Sid engaged with everyone he met. He was a source of wise and experienced guidance and counsel on any matter across health, aged care and other topics. He became a social and intellectual nucleus, nurturing the Institute in its early days.

Sid was without peer in this regard. Not only was his advice invaluable, he was a heck of a nice guy too, one of humanity's true gentlemen.

In 1995, Sid became Chairman of our Ethics Committee, a position he relinquished only a few months ago. Again, he served with unparalleled distinction.

In this role he always encouraged soundly-based research, and strongly supported our values (which were really his own!). Values such as objectivity, independence, quality, respect, accessibility and client focus.

He had no time for pomposity and self-serving behaviour, and reacted forcefully to the few instances where such behaviour came before the Committee.

It was an honour for us last December to be permitted to name our Board Room the Sidney Sax Room.

Sid was an outstanding humanitarian, outstanding writer, chairman without peer, theatre patron extraordinaire, keen gardener, devoted husband, determined advocate, and a selfless campaigner for fairness and equality in all societies.

But above everything, to us at the AIHW he was a wonderful person and a dear friend. We are privileged to have had the benefit of his wisdom and friendship over the years.

Our deepest sympathies go to Gwen, Anne and all Sid's family.



# 'Powerhouse' launch of **Indigenous health and welfare report**

Continued from page 1

- Indigenous people were more likely than non-Indigenous people to smoke, consume alcohol at hazardous levels, be exposed to violence, and to be categorised as obese, all of which are significant health risk factors.
- In 1998–99, an estimated \$1,245 million was spent on health services for Aboriginal and Torres Strait Islander people. This figure represented 2.6% of health expenditure for all Australians.
- Greater amounts were spent on Indigenous people in relation to community and public health, patient transport, public hospital services, mental health institutions, and government administration and research.
- Lesser amounts were spent on Indigenous people with respect to Medicare, private hospitals, the Pharmaceutical Benefits Scheme and residential aged care.
- Overall, for each dollar spent on health services for non-Indigenous people, \$1.22 was spent on health services for Indigenous people.

Mr Reid said that the greater per person amount spent on health services for Indigenous people was 'plainly not enough' given their vastly inferior health status.

In her response to the report, Barbara Flick recounted her training as a nurse and working at the Royal Alexandra Hospital for Children, but being unable to forget or ignore some of the disparities faced by her people within the health system. At the local hospital at Collarenebri, where Barbara grew up, there were separate wards for white and black people. As a child she had wondered why every piece of cutlery her family used at the hospital had the letters 'ABO' engraved on it.

Barbara called for action on Indigenous health and welfare rather than words, but acknowledged the importance of Indigenous health and welfare statistics in decision making,



(L to R) Rob Edwards (Acting Australian Statistician), Barbara Flick (National Aboriginal and Torres Strait Islander Health Council), Richard Madden (AIHW Director), and Mick Reid (Director-General, NSW Health).

even if only to make decision-makers better realise the extent of the problems.

She lamented how Aboriginal people were deliberately excluded from official population figures until 1967.

'We want to be counted. So please, count us. Count us', she urged.

Describing the report as 'the most comprehensive, authoritative and up to date source of statistical and related information on this topic', Richard Madden paid tribute to the ABS's many recent initiatives to improve the quality and availability of data on the Aboriginal and Torres Strait Islander population.

As outlined by Rob Edwards, the initiatives include:

- high priority to improving the quality of Indigenous data from the Census and annual Indigenous population estimates
- a new six-yearly Indigenous Social Survey
- a new supplementary Indigenous sample in the 2001 National Health Survey, with a larger sample in 2004
- regular identification of Indigenous people in the Labour Force Survey
- conducting the 2001 Community Housing and Infrastructure Needs Survey on behalf of the Aboriginal and Torres Strait Islander Commission
- improved identification of Indigenous people in administrative data sets.

Following the launch, guests were taken on a conducted tour of the Powerhouse Museum's permanent Indigenous Communication Exhibition.

*The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2001* (212 pp., ABS Cat. No. 4704.0, AIHW Cat. No. IHW 6, \$44.00) is available from ABS bookshops (tel. 02 6252 6627) or AusInfo (freecall 132 447).



'Count us'. Barbara Flick at the launch.

## Expenditures on health services for Indigenous people

**Expenditures on the provision of health services to Aboriginal and Torres Strait Islander people for the 1998–99 financial year were examined in a recent report from the Australian Institute of Health and Welfare and the Department of Health and Aged Care. This was the second such report, the first having been published in 1998 and covering the 1995–96 financial year.**

The report confirmed the findings of the 1998 study that different life circumstances have a significant impact on the relative health status and consequent health care needs of Indigenous and non-Indigenous Australians.

Indigenous Australians typically have the poorest health status of all Australians. Average life expectancy at birth is 20 years less than for other Australians, and infant mortality rates are up to 3 times that of all Australian infants. The much lower average annual income of Indigenous Australians contributes to the poorer health of Aboriginal and Torres Strait Islander people.

The report showed that a much higher proportion (27.5%) of Aboriginal and Torres Strait Islander people live in remote areas, compared with non-Indigenous Australians (2.0%). This, combined with the higher average costs of providing health services in those remote areas, has contributed to differences in expenditure between Indigenous and non-Indigenous Australians.

However, despite their much poorer health status and the cost implications of remoteness that affect health services for Indigenous people to a greater extent than for non-Indigenous people, average expenditure on health services for Aboriginal and Torres Strait Islander people (\$3,065 per person) was not much higher than for the rest of the population (\$2,518)—a ratio of 1.2:1.

The report showed that Indigenous Australians have lower levels of access to Medicare-funded

medical services and pharmaceuticals than other Australians. This may indicate that they are not receiving the same levels of early intervention and appropriate specialist services as their non-Indigenous counterparts. This, in turn, could be a factor in the higher hospital admission rates resulting in higher average expenditure on admitted patient services for Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander people used, on average, more publicly funded health services than did non-Indigenous people. This was particularly the case in relation to services provided by State and Territory Governments, such as admitted patient services in hospitals and community health services. About 72% of expenditure on health services for Aboriginal and Torres Strait Islander people—\$2,205 per person—was for services provided by State and Territory Governments. This contrasts with 37% for non-Indigenous people.

Reflecting their significantly lower average income level, Indigenous people used fewer privately funded services such as doctors in private practice, private hospitals, dentists and other privately funded allied health professionals.

They incurred a much lower proportion of their total health expenditures through the major Commonwealth health financing programs—Medicare and the Pharmaceutical Benefits Scheme (PBS)—than did other Australians. For Aboriginal and Torres Strait Islander people, 7.3% of total expenditure was attributable to those programs, compared with 23.9% for other Australians. Indigenous peoples' usage of these types of services was much lower. On average, expenditure on an Indigenous person through these two programs was 37% of that for a non-Indigenous person.

Average expenditure on Indigenous Australians through all Commonwealth Government programs was \$691 per person. Of that, \$224 was provided through Medicare and the PBS, \$298 was provided through Indigenous-specific programs such as Aboriginal Community

*Continued on page 18* ►

## Projections of Older Immigrants

A new report entitled *Projections of Older Immigrants* has recently been completed by staff of the AIHW Aged Care Unit. It describes the results of projections (1996–2026) of the numbers of overseas-born older Australians from culturally and linguistically diverse backgrounds.

The projections were calculated at the national, State/Territory and statistical local area (SLA) level, and looked at country of birth, languages spoken and religion.

The report found that this overseas-born population (aged 65 and over) is expected to increase substantially by 2011, with a growth rate of 66% over the 15 years from 1996: from 392,800 to 653,000. By 2011, 23% of the Australian population aged 65 and over are projected to be immigrants from culturally and linguistically diverse backgrounds. Not only is this older overseas-born population growing more rapidly than the older Australian-born population, it is also ageing more rapidly. In 1996, 13% of people aged 80 and over were immigrants from culturally and linguistically diverse backgrounds. By 2011, this number is projected to be one in five, and by 2026, one in four.

Persons born in Italy were the largest group of these older immigrants living in Australia in 1996, and are expected to remain the largest group in the future. Other countries of birth with a large older population living in Australia include Poland, Germany, Greece and the Netherlands. Between 1996 and 2011, growth rates are projected to be particularly high among those aged 80 and over born in Italy, Greece, Germany and China. The number of older persons in the 80-and-over group born in China, for example, is projected to grow by 167% over the 15-year period.

Italian was by far the most commonly used language among these older immigrants, followed by Greek, German, Polish and Dutch. In 2011, Italian is projected to remain the most commonly used foreign language. Other commonly spoken languages are projected to be Cantonese and Croatian. Between 1996 and 2011, growth rates are projected to be particularly high in the Italian, Greek, Cantonese, Croatian, Arabic, Spanish, and Maltese-speaking populations of older immigrants.

Three-quarters of older immigrants from culturally and linguistically diverse backgrounds

espoused a Christian religion, followed by Judaism and Buddhism. Among Christian religions, Catholic affiliation was the most common, followed by Greek Orthodox, Lutheran and Anglican. In 2011, the majority of older immigrants are projected to belong to a Christian religion, followed by Buddhism and Islam.

An examination of State and Territory differences revealed that the Australian Capital Territory had the most diverse older population, with 25% of its older population being immigrants from culturally and linguistically diverse backgrounds. It was followed by Victoria, the Northern Territory and Western Australia, with higher than average proportions of people from diverse backgrounds. New South Wales and South Australia were similar to the national average, while Queensland and Tasmania had somewhat less diverse populations. In 2011 Victoria is projected to have the most diverse older population, with roughly one in three of that older population being immigrants from culturally and linguistically diverse backgrounds.

The report was prepared by Diane Gibson, Peter Braun, Christine Benham and Frieda Mason at the request of the Aged and Community Care Division of the Commonwealth Department of Health and Aged Care. The projections were undertaken by the Australian Bureau of Statistics.

For further information, contact Dr Diane Gibson, AIHW, ph. (02) 6244 1190 or e-mail: [diane.gibson@aihw.gov.au](mailto:diane.gibson@aihw.gov.au)



## Labour Force and Rural Health Unit

**In January 2001, a new Labour Force and Rural Health Unit was established at the AIHW. The objective of the new Unit is to integrate labour force and rural health data, with a view to linking health services provision, within the broader community services context, with the health status of the populations in various geographical areas.**

The focus of the Unit will move away from the existing style of publication in the Labour Force Series towards more issues-driven publications. These will use a wider range of data sources to inform current areas of concern.

As part of this process, the Unit will investigate alternative data dissemination strategies, specifically through the use of COGNOS cubes (interactive web-based data sets).

The above approach would allow us to make better use of existing community services data collections to complement analyses of the health professions labour force. The first Institute publication of detailed data for community service industries and occupations, using ABS 1996 Census data, was released recently by the Unit.

Other publications to be released shortly include *Physiotherapy Labour Force 1998*, *Occupational Therapy Labour Force 1998* and *Nursing Labour Force 1999*. In the pipeline for release later in 2001–02 are *Nursing Labour Force 2001*, *Medical Labour Force 1999*, *Podiatry Labour Force 1998* and *Pharmacy Labour Force 2000*.

The Unit provides statistical support to the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC).

Last year AMWAC published its advice to the Australian Health Ministers' Advisory Council on the supply of general practitioners, neurosurgeons, gastroenterologists, cardiothoracic surgeons and oncologists.

AHWAC is currently concentrating on the nursing specialties of midwifery and critical care nursing. A new project to profile the nursing labour force in Australia is in the planning stage, and it is expected that the AIHW will provide data from our nursing labour force collection for this project.

A workshop to discuss the data required for nursing workforce planning is scheduled for November. It will review the minimum data required for health workforce planning, as this has not occurred since the collection began in 1993. It will also seek to resolve issues of timeliness and response rates for the biennial nursing labour force survey.

Specific rural health projects are being developed under a contract signed with the Department of Health and Aged Care (DHAC) in May this year. These are to:

- develop a rural health information infrastructure, including a framework for rural health statistics, and formation of a Rural Health Information Advisory Committee;
- report against the indicators developed as part of the framework;
- report on rural health status using mortality and hospital morbidity data for both Indigenous and non-Indigenous people; and
- explore in detail regional variations for several health issues (e.g. suicide, motor vehicle accidents).

In conjunction with these activities, the Unit will:

- develop a rural health 'portal' for the AIHW website; and
- explore collaborative links with university departments of rural health. These links would aim to facilitate the use of AIHW data holdings for rural health research projects.

For further information, contact Glenice Taylor, AIHW, ph. 02 6244 1153 or e-mail [glenice.taylor@aihw.gov.au](mailto:glenice.taylor@aihw.gov.au)

# Prognostication: *a necessary science*



Andrew Tonkin,  
National Heart  
Foundation of Australia

Recently I had the opportunity to attend a small-group meeting during which, over a few hours, I listened to a series of focused expert presentations. Among other topics, these concerned:

- The Human Genome Project.
- Other scientific areas which are the subject of extraordinary advances: 'proteomics', and the pluripotentiality of embryonic stem cells, although application of the latter is still the subject of discussion in Australia.
- The tensions in health care delivery, concerning access and equality, for those who carry the major burden of disease, versus a 'user pays' approach.
- The spiralling costs of our health care system.

While at first glance these are seemingly unconnected, the plethora of exciting new therapeutic approaches which will flow from the remarkable basic science discoveries will only heighten the tensions surrounding health care delivery.

## How do we cope?

My personal opinion is that accurate prognostication—the risk for future events—will take a pivotal role as we seek to apportion resources in the most appropriate manner. This

will be driven by the awareness that not only will Australia best utilise the health benefits that should be anticipated from new discoveries by more precise risk stratification, but also that we will simply not be able to afford very liberal application of all newer but more costly therapies. Monitoring should be even more valued in this process, suggesting a pivotal role for a body such as the AIHW.

Taking cardiovascular disease as one example, what are some of the areas in which the AIHW could participate and collaborate? The following represents a personal short list.

- Development of risk equations which are contemporary and most relevant to the Australian context.

Traditionally, clinicians have tended to adopt a narrow approach to established cardiovascular risk factors such as cholesterol and blood pressure. These have often been seen in isolation, with a somewhat arbitrary definition of *hypercholesterolaemia* (and *normal* cholesterol) and *hypertension* (and *normal* blood pressure). However, the relationship between the intensity of these factors and the risk of future events is continuous. This speaks against these being seen, somewhat simplistically, as dichotomised variables. Indeed, the same principle may well apply to diabetes/impaired fasting glucose/impaired glucose tolerance. This has led to the development of absolute risk tools which generate 'scores' which measure the future risk of coronary events. These tools, which have been



introduced overseas, lack the simplicity which would facilitate their ready uptake by busy clinicians, although palm-held devices can help. However, they may also have other limitations: they do not include physical (in)activity and bodyweight, the two risk factors which in Australia particularly show unfavourable trends, and they take no account of other important non-biomedical risk factors such as socioeconomic status. Also, such absolute risk scores are often based on risk equations developed in the prolonged follow-up of the Framingham community in the United States.

In future, measures of risk and outcome would be applied to the assessment of risk in not only individuals but also in subgroups of the population. This could inform appropriate health policies. Very important subgroups in Australia are:

1. Aboriginal and Torres Strait Islander peoples, in whom rates of cardiovascular disease are alarming;
  2. the elderly. I believe it is essential that data monitoring include elderly Australians. Presently, coronary heart disease indicators for conditions such as myocardial infarction have an upper-age cut-off point of 69 years. However, the 12% of the population who are aged 65 years and over account for 60% of hospitalisation for cardiovascular disease, the major portion of direct health costs. Also, Australians aged 65 presently have a projected life expectancy of around 15–20 years;
  3. those living in rural and remote areas. The extent to which living in non-metropolitan regions imparts risk independent of that associated with Indigenous populations, continues to be debated. However, recent work shows a graded relationship between age-standardised coronary mortality and the ARIA index based on distance from large population centres. The need for data in this group will be accentuated, as ageing is impacting earlier in non-metropolitan regions.
- The value of projections.

It is laudable that all attempts are being made to ensure the accuracy of current statistics and data on trends to this time. However, despite

possible uncertainties related to assumptions to enable valid projections, these should be taken into account to direct the most strategic health planning. Otherwise it is tempting for resources to be allocated with a relatively short time frame in mind, when the medical and particularly preventive health 'half-lives' are much longer.

- Linkage between cardiovascular disease and diabetes.

Epidemiological transitions are occurring world-wide. The major burden of cardiovascular disease in developed countries such as Australia occurs particularly in those in lower socioeconomic groups. In developing countries the new epidemic particularly affects those in upper socioeconomic groups, partly associated with population migration from rural areas to large cities. One major link for both situations is the dramatic increase in rates of diabetes. In those with diabetes, cardiovascular disease is the cause of death in 85–90%.

In recent years, careful steps have been taken to promote linkage between cardiovascular disease and diabetes, both within the AIHW and more generally in Health Departments and non-government organisations. It is essential that collaboration between these two major health priorities be further promoted.

Common non-communicable diseases, such as coronary heart disease, result from the interaction between many genes and the environment. The Human Genome Project tells us that humans have fewer genes than we thought. I learnt at the recent meeting that we have about as many as a mustard seed and twice as many as a fruit fly! We are differentiated particularly by the greater number of proteins (and associated biological functions) which are influenced by these genes. Basic science is today taking giant steps and the challenges are to take an appropriately broad view of health determinants and, particularly, to establish how best to apply exciting new discoveries. My contention is that practicalities will dictate the need for robust epidemiological data and accurate prognostication—the estimation of risk—to also be given 'main billing'. We can lead in this as in basic science areas relating to cardiovascular disease.

# spotlight



# Robert

'I think that deciding to practise law came about through a process of exclusion', Robert said. 'I decided I couldn't do anything else.'

But as a keen reader of military history, Robert might also admit that retrospective analysis has a way of rewriting the facts. Either way, when he graduated in the late 1950s with law degrees from both the University of Melbourne and Oxford University, he began a career path that led him to his recent appointment as Chair of the Institute's Ethics Committee.

As a member of the Committee since August 1996, Robert has used his extensive background in administrative law in looking at whether research proposals brought before the committee are ethically acceptable. His interest in this kind of work stems from his time as a Senior Member and later a Deputy President of the Commonwealth Administrative Appeals Tribunal (AAT), and as President of the equivalent ACT Tribunal in the early 1990s.

'My work with the Tribunal, and later as President of the Legal Aid Commission (ACT), was the most satisfying for me because I really felt I was doing something for people. I particularly like the idea that citizens could challenge the decisions of government in the fullest way, which they hadn't been able to do before. Likewise, in my work on the Ethics Committee, I'm particularly interested in the way that the general public will be approached, and ultimately benefit by the projects that come before us.'

**True freedom is defined by some as the right to exercise options, to make choices, but Robert Todd—new Chair of the AIHW Health and Welfare Ethics Committee—suggests he had little choice when he embarked on a legal career over 40 years ago.**

# Todd, AM

Being a good lawyer in these areas, according to Robert, is as much about making people feel at ease as it is about knowing the law. He credits three great teachers, in his early days as a law student, with arousing his real interest in law: Professor of History, Kathleen Fitzpatrick, who lectured on the great constitutional clashes of the seventeenth century in Britain; Professor Zelman Cowen, Professor of Public Law; and Peter Balmford, his law tutor in his University College. 'They showed me that the law can be interesting, amusing, and relevant in historical terms.'

Robert has since established a long and distinguished career in administrative law. He practised at the Victorian Bar from 1958 to 1971, and was a member of the Taxation Board of Review before his career began at the AAT.

In later years, he took up the opportunity to follow one of his other passions—history. In particular, he has worked and lectured on the tangled story of 'Breaker' Morant.

As Vice-President of the Friends of the National Museum since 1995, Robert is proud to have been involved in pressing for the building of an institution that presents the icons of Australia's past and present in a style that represents a departure from the less adventurous architectural style and internal museum design of the nineteenth and twentieth centuries.

Another great interest is travel. In July this year, Robert and his wife visited the heartland of old imperial Russia and journeyed by train across

**Robert has used his extensive background in administrative law in looking at whether research proposals brought before the committee are ethically acceptable.**

the countries behind the former Iron Curtain. 'I'd also like to do some more travel in Australia', he said.

Robert travels for the pleasure of the journey and believes that getting there is as much fun as being there. Now, as newly appointed Chair of the Ethics Committee, he has embarked on another challenging and exciting journey.

'I feel I've got to do a bit of learning to get me there, and be more keenly focused. As Chair, you need an overall view but I know I'll be relying heavily on the knowledge, experience and judgment of the other members of the Committee.'



## National Health Information Management Group **(NHIMG)**

The National Health Information Management Group as the driving force towards consistent and reliable national health information has made several important steps in recent months.

The main role of the NHIMG is to manage the National Health Information Agreement (NHIA) and its related structures and processes. The NHIA aims to ensure that the collection, compilation and interpretation of nationally relevant health information are appropriate and carried out efficiently. This requires agreement on definitions, standards and rules of collection of information and on guidelines for the coordination of access, interpretation and publication of national health information. The NHIA aims to improve access to uniform health information by community groups, health professionals, and government and non-government organisations. The following paragraphs summarise some of the recent activities of the NHIMG to fulfil this role.

### **National Health Information Plan**

The National Health Information Plan sets the direction for nationally agreed priorities for health information development. The last plan was published in 1995 and in recent months the NHIMG has been developing a new plan for the next five years. A workshop held in November 2000 looked at progress made during the lifetime of the previous plan and at areas where further work is required and identified new priorities. Final drafting of the document is progressing and we can look forward to publication of the new plan in the third quarter of this year.

### **Business rules for linkage in statistical collections using unique patient identifiers**

Victoria has taken the lead in developing business rules for linkage in statistical collections using unique patient identifiers. This document was developed in the context of a number of national and jurisdictional activities directed towards the development of national privacy principles and electronic health record networks.

The business rules have been transmitted to the Australian Health Ministers' Advisory Council (AHMAC) for endorsement.

### **HealthWIZ**

HealthWIZ: Principles and Practices has been developed by the HealthWIZ Dataset Production Working Group and endorsed by the NHIMG. This document delivers principles and practices for governing the ongoing development and management of HealthWIZ and establishes standards and procedures for the publication data sets that are for public release through HealthWIZ. This document has been sent to the Commonwealth Department of Health and Aged Care.

### **Disease Registers**

The NHIMG has prepared minimum guidelines for health registers for statistical and research purposes. The paper provides guidance on the establishment, maintenance and coordination of health registers, and on their use for health information analysis and research. It will be useful for government and other bodies that may consider proposals to fund or to provide some other form of assistance to the establishment and or operation of a health register. It aims to document 'good practice' for the operation of a health register.

### National Health Data Committee

The National Health Data Committee, as a standing committee of NHIMG, continues its work on definitions for inclusion in the *National Health Data Dictionary*, ensuring that they comply with endorsed standards.

### Expert Group on Health Classifications

NHIMG has established an Expert Group on Health Classifications to act as a point of reference for harmonising existing and ongoing work on classifications. The objectives of the group are:

- to establish a sustainable process for the national maintenance of classifications and terminologies, and mechanisms to facilitate inter-operability through the use of a national reference terminology;
- to agree upon national classification systems for all sectors identified within the

framework (taking the WHO family of health classifications as a starting point); and

- to establish a national mechanism for the assessment and accreditation of interface terminologies in use in all health care settings.

The Expert Group has contributed to work that was presented at the World Health Organization Links with Other Classifications Committee meeting in Copenhagen in April.

NHIMG last met in Sydney on 2 August 2001.

For further information on any of these projects or on the NHIMG, contact Catherine Sykes, AIHW, ph. (02) 6244 1123 or e-mail: [catherine.sykes@aihw.gov.au](mailto:catherine.sykes@aihw.gov.au)

## National Community Services Information Management Group (NCSIMG)

Membership of the NCSIMG has been expanded. The Australasian Juvenile Justice Administrators (AJJA) have accepted the invitation from the Community Services Ministers' Advisory Council (CSMAC) to join the Information Management Group. The National Community Services Information Agreement covers data about juvenile justice, but juvenile justice administrators have not previously been directly represented on the NCSIMG. A Juvenile Justice Data Working Group will be established as a sub-group of NCSIMG.

The AJJA have agreed to fund continuation of the development of a national minimum data set (NMDS) on juvenile justice. Version 1 of the NMDS is expected to include nationally comparable unit record information on juveniles for whom relevant juvenile justice agencies have a supervisory role, as well as data on detention centre activity.

The NCSIMG is currently managing an active work program. Reports are due by the end of

the year on the review of the National Classifications of Community Services and on investigations regarding the development and usage of statistical linkage keys in community services data. The National Child Protection and Support Services Data Working Group is monitoring a number of projects. The CSMAC has granted funding for the current financial year towards the development of Version 3 of the *National Community Services Data Dictionary* and for implementation of recommendations in the report *Community Services Principles and Standards for Indigenous Client Data*.

For further information on any of these projects or on the NCSIMG, contact Margaret Fisher, AIHW, ph. (02) 6244 1033 or e-mail: [margaret.fisher@aihw.gov.au](mailto:margaret.fisher@aihw.gov.au)

## National Housing Data Agreement Management Group (NHDAMG)

The NHDAMG at its May 2001 meeting endorsed the 2001–2002 National Housing Data Agreement (NHDA) work program. This work consolidates the 2000–2001 work on national public housing data and undertakes further development of national data in the other priority areas for national data of private rental market assistance, community housing, and Indigenous housing. Indigenous housing priorities are being progressed jointly with the National Indigenous Housing Information Implementation Committee (NIHIC) which operates under the Agreement on National Indigenous Housing Information (ANIHI).

For 2001–2002 the work program aligns with the requirements of the 3 schedules of work contained in the NHDA:

- National Minimum Data Set (Schedule 1)—continue development of a national housing data repository to contain data for public, community and private rental housing assistance;
- National Performance Indicators (Schedule 2)—improve the quality and comparability of public rental housing indicator data, undertake the development and collection of Aboriginal Rental Housing Program (ARHP) data for the Report on Government Service Provision (RGSP), improve data collection for community housing and undertake development of relevant national performance information for the other areas of Commonwealth–State Housing Agreement activity; and

- National Data Definitions and Standards (Schedule 3)—develop policy relevant national standards across the Commonwealth–State Housing Agreement areas, improve financial and cost information in public and community housing and develop national standards that are compatible with IT developments as well as production of Version 2 of the *National Housing Assistance Data Dictionary*.

The National Housing Data Development Committee manages these projects and reports to the Management Group.

Due to changed work circumstances, Barbara Lypka, CEO Housing Tasmania, has had to resign from her position as the Chair of the NHDAMG. Bryan Walsh, from the Department of Housing and Works, Western Australia, is the interim Chair. At the May 2001 meeting, the members of the Management Group thanked Barbara for her leadership and guidance in the formative stage of the Management Group.



# National Indigenous Housing Information Implementation Committee (NIHIIC)

The Housing Ministers' Advisory Council (HMAC), at its March 2001 meeting endorsed the NIHIIC work program. The NIHIIC work program is an important first stage in developing national Indigenous housing administrative data and contains five projects for 2001–2002 that seek to:

- establish an Indigenous Housing Information Management Strategy;
- establish outcome measures through development of an Indigenous performance information framework;
- report on issues and improvements to data coverage and quality for targeted as well as mainstream assistance by reporting on community-managed housing and Indigenous access to government-managed assistance;
- continue development of national data standards through work on areas of high priority for Indigenous housing assistance for inclusion in the national housing data dictionary;
- bring together current data related initiatives across jurisdictions to feed into future national data development and data standards for asset management systems.

The commencement of work on the Indigenous Housing Information Management Strategy is timely given the recent endorsement by Housing Ministers of the Report of the Commonwealth State Working Group on Indigenous Housing and also a 10-year statement 'Building a better future: Indigenous

Housing to 2010'. These documents provide the national policy priorities and directions for the national data development work of NIHIIC to align with.

The ongoing strategic management of national Indigenous housing data development has also been facilitated by the recent formation of the Standing Committee on Indigenous Housing of HMAC. At its first meeting James Christian, CEO, NSW Aboriginal Housing Office and the Chair of NIHIIC was endorsed as Chair of the Standing Committee. To spread the workload more evenly across jurisdictions James has subsequently resigned as Chair of NIHIIC and the NIHIIC Deputy Chair, Jody Broun, Executive Director, Aboriginal Housing and Infrastructure Unit, Department of Housing and Works, Western Australia, was endorsed by the Steering Committee as the new NIHIIC Chair. NIHIIC members would like to thank James for his marvellous work as Chair in the establishment of NIHIIC and look forward to working with him in the future in his new role.

For more information on the NIHIIC, NHDAMG or other housing information issues, please contact David Wilson  
ph. (02) 6244 1202  
e-mail: david.wilson@aihw.gov.au

# from the Inside

## General Practice Statistics and

**The General Practice Statistics and Classification Unit (GPSCU) was established in 1998 as a collaboration between the AIHW and the Family Medicine Research Centre of the University of Sydney. Its work focuses on the collection, classification, analysis and dissemination of information about general practice activity in Australia. Until its formation, reports of the health of Australia largely ignored the 100 million GP consultations conducted across the country each year, because of the lack of data about this sector of the health care system.**

### **The GPSCU projects**

The Unit is responsible for the continuous national data collection program in general practice called BEACH (Bettering the Evaluation and Care of Health). However, data are only useful if appropriately classified. The Unit therefore also continues to develop and maintain classification systems for primary care. Its research and development activities currently centre on improving statistical methods for management of general practice data and the development and testing of data collection through electronic means.

### **The BEACH process**

BEACH is currently a paper-based data collection system involving 1,000 randomly selected GPs per year, each of whom completes details about 100 consecutive patient

encounters. They also provide information about themselves and their practice which allows research into practice patterns of specific groups of GPs. Randomly selected GPs are approached by letter, with telephone follow-up. From the completed encounter forms, data are coded, classified and entered into an ACCESS database by secondary coding staff. The database must deal with the many-to-many relationships between patient characteristics, multiple morbidity managed and multiple management types per problem. Each GP receives a report about their own results compared with those of nine other unidentified participants and against the national average.

The data are cleaned and distributed to participating organisations quarterly, and the annual data set is weighted to ensure representation of the 103 million GP consultations conducted nationally. The data are analysed in SAS (currently Version 6.2 but moving to Version 8.2). Sub-studies on population health risk factors, prevalence and management of selected disease are also undertaken throughout the year in the SAND (Supplementary Analysis of Nominated Data) section of the encounter forms.

### **The people**

There are 11 appointed staff in the Unit and about 10 casual employees. While each member of the Unit has specific responsibilities regarding the BEACH program, the Unit is a research team rather than simply a data provider.

Helena Britt heads the Unit and has been Director of the Family Medicine Research Centre since its inception. She is a clinical psychologist by training but her doctorate is in general practice. She started her career in market research and educational research but has been in general practice research and development for about 25 years. Her passion is data quality and this has led to an ongoing

# Classification Unit (GPSCU)

international involvement in the development of classifications for primary care and in methodological development.


Graeme Miller, Medical Director of the GPSCU, provides the clinical input to the team. He brings to the Unit about 25 years experience as a GP. His recent role as Director of Standards for the Royal Australian College of General Practitioners and as Chairman of the Standards Committee of the Australian Council on Healthcare Standards also provides valuable background for a Unit which concentrates on ongoing development of standards in a young field of research. Graeme is also involved in committees and working parties on classification, privacy and confidentiality, data model, codesets and measurement of quality.

Jan Charles, (BA, MScMed), leads the group responsible for ensuring successful GP recruitment through to data entry. Jan has been with the Centre since the late 1980s. She is also responsible for the ongoing development of the Coding Atlas of Pharmaceutical Substances (CAPS), a classification system applied to the recorded medications.

Joan Henderson (BAppSc [Health Information Management] Hons) is responsible for the development and ethics clearance for the SAND questions developed about every five weeks, for the GP database and for ensuring outflow of research packs and individual reports to the GPs. Joan undertook her Honours thesis with the Centre, measuring the long-term effects of educational interventions on GP practice.

Staff employed for GP recruitment and data entry have casual appointments and many of these are students of the Sydney University's Health Information Management undergraduate program.

**There are 11 appointed staff in the Unit and about 10 casual employees. While each member of the Unit has specific responsibilities regarding the BEACH program, the Unit is a research team rather than simply a data provider.**



The data management and analytical team is led by Stephanie Knox who has both Science and Arts (Psychology) degrees. She manages the ever-growing database and ensures the quality and timely delivery of the many analyses required by the Unit and by external bodies. Stephanie joined the Unit in 2000 after working in HIV research and is currently undertaking her MPH.

Lisa Valenti (BEc) is currently completing her Masters of Medical Statistics. She joined the Unit in 2000, after spending five years in London largely working on a European study of toxoplasmosis. She specialises in quality assurance and analysis of the BEACH data.

Ying Pan is medically qualified and has a MCH. She also joined the Unit in 2000 as an analyst, coming from the area of HIV research.

Zoe Kelly and Matt Hou have roles which cross all aspects of the program. Zoe (BAppSc [HIM] Hons) also completed her Honours thesis with the Centre. She assists in data management, data cleaning, development of quality assurance mechanisms, analysis and reporting. Matt Hou (BAppSc [HIM]) supports the team by ensuring reliability of the hardware and software systems and developing of the database for each new sub-study in SAND. He is also responsible for ensuring the ongoing development of the GP interface terminology called ICPC-2 PLUS, in response to GP user needs and those of the



# from the Inside

secondary coders from the BEACH program. Matt is studying for a Master of Health Science (Health Informatics).

Gervaise Woods and Dulcie Bucksath provide the Unit with strong administrative support.

## Publications

The flagship publications from the GPSCU are the AIHW General Practice Series (GEP). Since the BEACH program began in April 1998 the Unit has produced six major AIHW reports, has one in press and a further two under development.

The major difficulty faced by the team is finding time to write all the papers they would like to submit for publication, but currently four papers are in preparation.

## External services

Being centred within a university environment, the Unit also acts as a source of information to postgraduate students, academics and industry about the activities of general practitioners in Australia. While the BEACH program receives funding from the Commonwealth Department of Health and Aged Care and the pharmaceutical industry (including AstraZeneca, Roche Products, Aventis Pty Ltd and Janssen-Cilag), other organisations need to be able to access the data. The complexity of the database and the funding structure of the program mean that the Unit undertakes individual analyses for external bodies on specific areas of interest. The Unit also supports other collaborating units in providing them with data for their own reports, as well as assisting divisions within the AIHW by provision of data or reporting advice on the GP aspects of specific disease reports.

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## Expenditures on health services for Indigenous people

*Continued from page 5*

Controlled Health Services, and \$169 was provided through other programs. For non-Indigenous Australians, the average expenditure through Commonwealth Government programs was \$937 per person.

The report also examined variations in the patterns of expenditure between highly accessible and more remote areas based on the Accessibility/Remoteness Index of Australia scale (ARIA).

The analysis showed decreasing levels of access to Medicare-funded services and pharmaceutical benefits as remoteness increased. In contrast, there was an increase in admitted patient expenditure with increasing remoteness. Aboriginal and Torres Strait Islander people in the remote regions have rates of separation from hospitals more than twice that of Indigenous people in the highly accessible regions. This was reflected in patterns of expenditure by State. States with a large proportion of Indigenous people living in remote regions generally had higher average expenditures per Indigenous person on hospital services.

Expenditure on Aboriginal Community Controlled Health Services was highest in the remote regions. Expenditure on aged care facilities for Aboriginal and Torres Strait Islander people in the remote regions was also higher than in the more accessible regions.

It is difficult to directly compare the figures in this report with those of the first report on 1995–96 expenditure as there have been changes in both methodology and data availability. Nonetheless, after controlling for population growth and inflation, there are areas where it is possible to say with some confidence that there have been increases in funding and service provision. Overall, expenditure per Indigenous Australian increased between 1995–96 and 1998–99 by between 15% and 29% in real terms. This compares with a real increase in expenditure on health for non-Indigenous Australians of about 10% over that same period.

For further information contact Tony Hynes, AIHW, ph. 02 6244 1160 or e-mail [tony.hynes@aihw.gov.au](mailto:tony.hynes@aihw.gov.au)



## **The importance of documentation in the management of data**

**The Institute provides on-line information about health and welfare data through the Knowledgebase and Datahound.**

The Knowledgebase contains definitions and standards for Australian health, community services, housing and related data, including the National Health and Community Services Data Dictionaries.

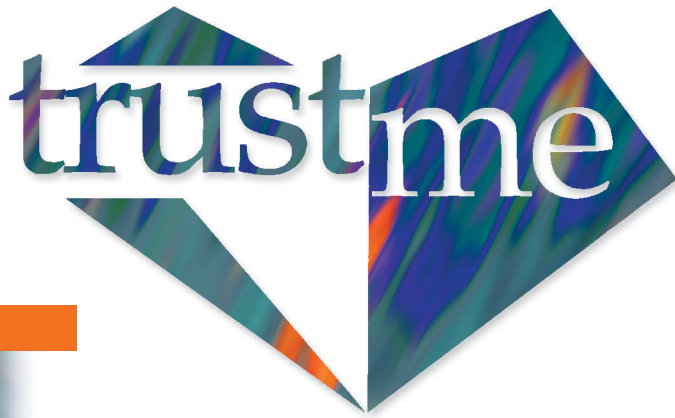
Datahound identifies all AIHW data collections, data custodians, data usage caveats, the location and accessibility of data, and related documentation.

Further on-line documentation provides guidelines for staff and researchers regarding the collection, use and storage of data collected under the AIHW Act.

This documentation, together with corporate data policies, data dictionaries, validation and processing rules, user guides, collectors manuals, and file and data transfer specifications is essential for the effective management and use of data at all stages, from definition of requirements, through collection, storage and processing, to analysis and dissemination. All elements play a major role in setting and maintaining data quality standards by ensuring consistent definitions, and collection and processing practices. They are also an integral part of the analytical and dissemination process, since they are vital to a proper understanding of the data.

Proper documentation provides the information someone unfamiliar with a collection needs in order to make use of it, just as it makes sure those involved in the collection and processing of the data do so in a consistent specified manner.

For further information, contact Mike McGrath, AIHW, ph. (02) 6244 1106 or e-mail [mike.mcgrath@aihw.gov.au](mailto:mike.mcgrath@aihw.gov.au)



# A moving

## *Fighting for a flabules future*

**Er, should I say I'm sorry? Someone may remember what I said the last time I wrote ('A Moving Dilemma', *Access*, December 2000). I speculated on the causes of Australia's galloping fatness and wagered that the main cause was not how much or what we eat. Instead, I plumped for physical inactivity, linked with mechanisation, as the prime culprit.**

I even hinted that Australia may be like Britain. Data on food and drink intake there suggested a fall in per capita energy intake between the 1980s and 1990s. This left an even bigger fall in physical energy expenditure as the only logical explanation for Britain's weight gain.

Now it seems I may have to eat my words. Writing about Australia's obesity problem in the 4 June issue of the *Medical Journal of Australia*, Anthea Magarey and colleagues pointed to recent trends in the dietary intakes of our children. From two national nutrition surveys, children aged 10–15 years were estimated to have taken in an average of 0.5–2.0 megajoules more per day in 1995 than their considerably lighter counterparts a decade ago. Likewise, children aged 4–8 years were found to be consuming 0.5–1.5 megajoules more than those in an Adelaide survey in the early 1980s.

So these worrying dietary trends will probably also be shown in adults. We patiently await more analysis of the national nutrition surveys to confirm that. But, even if we are eating more, that doesn't mean that physical inactivity isn't a major factor in the problem of overweight, making it even worse than it would otherwise be. And (trust me) it doesn't change the point I was going to make in today's column, which I promised would discuss issues in tackling our national waistline. Whatever the main cause of



# dilemma

## Part 2



Dr Paul Magnus  
AIHW Medical Advisor

that girth growth, if we're going to have any hope of a *solution*, it will have to come from both sides of the energy equation. We will have to cut the energy we take in through our diet *and* increase the energy we use up through physical activity. Simple, eh?

But before going into that, let's briefly repeat some of the background facts. As Richard Eckersley wrote in the same journal issue as Anthea Magarey, almost 6 in 10 Australian adults now have some degree of overweight. One in 5 of us qualifies as obese. Our typical adult today weighs about 5 kg more than their counterpart 20 years ago; rates of obesity have more than doubled. And it's part of a worldwide trend, where as many people are now said to be overweight as are underweight.

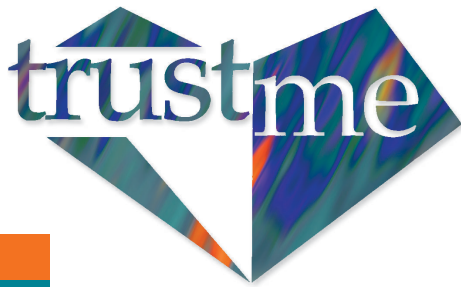
For the health implications of figures like this, the warning bells are everywhere: a resultant trebling of Type 2 diabetes in Australia over the past 20 years, as Eckersley reports (a ten-fold rise in the onset of this 'adult' form of diabetes among US children and adolescents just in the past decade). The fear is that, among other effects, this may soon start to reverse the good trends in heart attack and stroke, common complications of diabetes.

One could go on. From a health perspective it is very hard to exaggerate the problem. Something

simply must be done—and soon. But wouldn't you like a dollar for every time you've heard that said lately? Exactly what *are* we going to do, apart from uttering platitudes? Well, don't expect to hear anything better here, of course. But we can at least start by acknowledging just how immense and daunting the task would be to reverse our current energy imbalance. Would we be up to it even if we really tried? Especially when, if our actions were all we could judge by, we are already hell-bent on our present course of moving less and less and eating whatever and whenever we like.

Take diet in an affluent, mainly Western setting like ours. Before the last few decades or so, has there ever been a time when pretty well everyone had all they could eat and much more? Where entire societies had to face the prospect of wrestling with their appetite. Where there is an endless choice of rich fatty foods, so often strategically put in our face, often ready-cooked. And where, because we are always squeezing in other activities, we feel we have less and less time to prepare alternatives.

In response to this there are many programs and proposals to have healthier foods in school and workplace canteens; to educate Australians about a healthy diet and what they can do for themselves and their family; to provide low fat alternatives and better food labelling; to regulate



food advertising to children; and to impose price disincentives for 'unhealthy' foods and even to have warning labels on them. Much is going on in the health promotion field but clearly not enough yet to change the momentum.

Good public policy doesn't just encourage us to make healthy choices. It also tries to set up conditions that make it easier for us to be healthy, and sometimes without our having to make any conscious effort. Whatever the success of these measures, though, if we're going to turn the obesity problem around, there is no getting away from one uncomfortable implication. As individuals, most of us will still have to exercise some will-power and self-control in a way that previous generations never had to. Let's not pretend otherwise. Other public health challenges are pushovers compared with this. Consider the half-successful 'campaign' for Australia to stop smoking. We regard smoking as addictive for many. Yet you have to learn to like smoking and we don't *have* to smoke. Eating is naturally pleasurable and we do have to do it, fronting up to the pleasure several times each day.

Then there is the question of how much physical activity we will get in any given day. We're simply not going to give up labour-saving devices, deliberately engineer inefficiency back into our lives and embrace drudgery again. So, much of any increases in activity will have to be consciously taken as exercise. For most of us that will be outside working hours. During the week, that will be difficult for many, and maybe increasingly so if we keep expanding our working day. Would our bosses be happy to give us a two-hour lunch break so we can go to a gym, or a pool or for a walk? And would we guarantee to use the extra time that way anyhow? Not very likely at this stage.

One obvious prospect being explored is whether we can build surroundings that attract us to activities like walking or cycling: more bike paths, parks and walking trails; better security and lighting to overcome our fear of violence outside our homes. Peter Newman, Professor

**Good public policy doesn't just encourage us to make healthy choices. It also tries to set up conditions that make it easier for us to be healthy, and sometimes without our having to make any conscious effort.**

and Director of the Institute for Sustainability and Technology Policy at Murdoch University in Perth, describes small urban villages being built overseas in an effort to develop an environmentally friendly lifestyle and cut our reliance on the motor car. They are being built by private co-ops. The owners share cars and this markedly cuts the overall space they need while still freeing up more space for outdoor activities and walking. Will innovations like these ever become the norm or will they remain mere drops in the ocean? Newman also points out that those who use public transport for commuting end up walking a lot more than those who use cars. In Copenhagen they provide free use of bicycles in the city and car use has been held steady for 30 years, much against trends elsewhere. Along these lines, is it possible that developers could see it in their interest to design shopping complexes so that people enjoy walking around and end up covering a lot of ground without thinking too much about it? Or do the developers think they're doing this to the hilt anyway (to encourage more purchases) and are any benefits cancelled out by constant incitements to eat along the way?

Looking directly at obesity, however, there is some concrete source of hope. Two developed countries seem to have bucked the international trend. The first is Finland. Surveys there showed that the average weight of men in some major regions stabilised or even fell over the 5 years between 1987 and 1992. This was after rapid rises in the preceding 15 years. For women between 1987 and 1992 the average weight seemed to level out after a rise over the preceding 5 years. Better still, these changes in Finland coincided with what has been described as a broad-ranging national nutrition program, which cut average fat intake over a 20-year period. The turnaround is even said to have occurred *despite* accompanying falls in levels of physical activity. The second country is Singapore. A coordinated healthy lifestyle program there has been reported to have reduced obesity rates among primary, secondary and junior college students. So it seems it can be done, although overweight will still be a challenge for both countries and we need to see if the good trends have continued.

Despite these glimmers of hope, from here it still seems like an uphill task for Australia. As a society, are we really motivated enough? Some challenges are so great that they will only be met by a single-minded and concerted national resolve and effort. We often hear about Australian public health campaigns as if they were like this. (The war on cancer. The national such and such campaign.) In truth they are not, worthwhile though many of them are. Even the best of them are usually pushed by professionals and some dedicated advocates, with goodwill and mostly passive support from the public. Only true wars seem to get everyone pulling together. And if the overweight crisis really needs that kind of effort the prospects could be, well, slim. This is the pessimistic view. And it is not to mention Richard Eckersley's point that some of the proposals will raise the old debate about how far governments should intervene in people's daily lives.

But maybe a war isn't necessary. Maybe it can be just a matter of increments. A bit here, a bit there, multiplied by thousands. Piecemeal advances that add up until the tide begins to turn. And after all, along with reforms that may help them without any conscious effort on their part, people *can* exercise will-power and self-discipline. They do it in many parts of their lives, hour by hour and day by day. And many already do it with their diet and exercise habits. Not everyone who is normal weight is just lucky. Also, we need to understand that the problem of widespread energy imbalance has probably only been with the world for a few decades. A trend of this length does not have to be permanent, much as it may seem so at present. Perhaps it's a matter of learning to come to grips with something very new in history, which we can't do overnight. Maybe we just need to develop an entirely new discipline and to do this we may well need to understand much more about the psychology of eating and physical activity. It would be extremely difficult at first, but perhaps it could become routine for future generations. This is the optimistic view.

Of course, we shouldn't forget an entirely different option. That is to rationalise the whole situation. First, we could try to reassure ourselves about the rise in obesity-caused Type 2 diabetes. We haven't discerned any bad impact of this on cardiovascular figures—yet. Next we can do what many in the United States have done: adjusted their perceptions of overweight to suit their expanding waistlines. Even though average Americans rated themselves 4.5 kg heavier in 1999 than in a similar survey in 1990, they were *less* likely to see themselves as overweight. If you don't see the problem, maybe it isn't there. Going with the overflow, so to speak. And maybe the 'gorge and stay trim' pill really will arrive soon. These are all valid views so long as we are prepared to take the risk and pay the price.

**Somehow I don't think we are.**



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