Meeting the national needs for public health information

Report of a Consultancy to review statistical information needs and strategies of the Public Health Division of the Commonwealth Department of Health and Family Services

Australian Institute of Health and Welfare

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Report of a Consultancy to review statistical information needs and strategies of the Public Health Division of the Commonwealth Department of Health and Family Services

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Summary and recommendations

This report reviews the statistical information needs of the Public Health Division, recommends a coherent set of strategies for addressing its future information needs and makes specific recommendations for the future management of its current statistical activities (reviewed in Section 2). The report develops a coherent conceptual framework for national public health information, including a systematic approach to priority populations and equity issues (Section 3) and uses this to identify the information needs of the Public Health Division and gaps and deficiencies in existing national information (Section 4). The wider national health information environment and potential sources of national public health information are summarised in Section 5. Section 6 proposes a coherent set of strategies for addressing the Division's needs for public health information and makes specific recommendations listed below.

The report proposes that the Australian Institute of Health and Welfare (AIHW) be the lead agency for information infrastructure development under the proposed National Public Health Partnership, with its responsibilities including:

- the co-ordination and development of national health data collections to address the national needs for public health data under the Partnership;
- development and implementation of comprehensive national indicators for surveillance (*"warning and prioritising"*) and core national indicators for monitoring (*"how are we doing"*); and
- national reporting of these sets of indicators.

The Report also proposes that the Division reach agreement with AIHW to provide it with support for a number of existing statistical activities, for development activities, for general support in provision and analysis of health information, for online access to AIHW data collections, and for the provision of statistical and health information expertise to the Division in its areas of national public health priority. More detailed data for management, performance monitoring, and evaluation in these areas should remain the prime responsibility of the Division.

The report recommends a set of strategies for information planning and management by the Division, covering the information management role of Infrastructure Development Section, the outposting of several AIHW staff to coordinate and support information planning, the enhancement of online access to health data collections, a more strategic approach to addressing gaps in public health information, and the management of specific statistical activities. Specific recommendations follow.

Public Health Division statistical activities

Communicable diseases

It is recommended that:

- R1 the National Communicable Diseases Strategy be advanced under the auspices of the proposed National Public Health Partnership, and that the location of the proposed National Surveillance Centre be decided by the key stakeholders as set out in the draft Strategy report. In the interim all surveillance systems should remain together under the control of the Surveillance and Management Section of Public Health Division.
- R2 AIHW be given greater access to Divisional communicable disease surveillance data to enable it to enhance its monitoring and reporting of communicable disease indicators as part of its regular population health monitoring activities.
- R3 Public Health Division take active steps to secure the early release of data from the Childhood Immunization Register.
- R4 administration of the Creutzfeldt-Jakob Disease Patient Database and the Creutzfeldt-Jakob Disease Counselling Service Database continue to be maintained within Public Health Division until such time as the funding review. It is unlikely to be a continuing issue as the exposed group increasingly exceeds the time period for Creutzfeldt-Jakob Disease to appear.
- *R5* the Creutzfeldt-Jakob Disease Case Registry continue to be managed through the Centre for Disease Control and that any further funding be assessed in conjunction with other priorities.

HIV/AIDS and sexual risk behaviours

- R6 the Division take a lead role in reviewing the data requirements for evaluation of the National AIDS Strategy and for ongoing monitoring of sexual and other risk behaviours in the general populations and risk populations. This review should provide input to the development under the Partnership of a more coherent national set of survey vehicles for population risk factors, knowledge, attitudes and beliefs.
- R7 the Schools Survey (sexual risk behaviours and knowledge) be considered for consolidation with drugs and other youth health issues into a single schools survey to be conducted at regular intervals under the Partnership as a combined Commonwealth/State survey.

- R8 Project Male Call be reviewed and continued at appropriate intervals or replaced by a more systematic and time-comparable set of surveys of special risk populations to be conducted at regular intervals by the National Centres.
- R9 the usefulness of the Sydney Men and Sexual Health (SMASH) survey for routine monitoring of HIV risk behaviours be reviewed as part of the routinization of HIV/AIDS monitoring for the 3rd National AIDS Strategy.
- *R10* the Division continue to fund the National Centre to conduct this survey as part of the standard funding for HIV and Hepatitis C monitoring.

Cancer screening and control

It is recommended that:

- R11 the Division and the AIHW develop closer co-operation and co-ordination between the Cancer Control program's statistical activities and the Institute's cancer surveillance activities. In particular, the AIHW Disease Registers Unit should be consulted in the review of national reporting requirements for breast and cervical cancer screening and the development of national reports.
- R12 responsibility for the ongoing monitoring and reporting for the national breast and cancer screening programs be reviewed and the potential advantages and disadvantages of relocating to AIHW be considered, following the finalisation and implementation of national indicators and reports.

Population health strategies: men's and women's health

- R13 development of a minimum set of women's health indicators should be continued under the Partnership as part of the development of a core national set of public health indicators and that AIHW be funded to support the Public Health Division in the development and reporting of nationally monitored indicators for men's and women's health, including appropriate gender-specific indicators.
- R14 future collection of utilisation and other data for women's health services be addressed as part of the development of a national minimum dataset for monitoring women's health and build on the agreed minimum dataset for the national evaluation.
- *R15* the Public Health Division seek to achieve identification of age and sex in the Pharmaceutical Benefits Scheme database.

Population health strategies: child and youth health

It is recommended that:

- R16 the Public Health Division and AIHW be identified as the lead agencies, within the national health information structures and the Partnership to develop a comprehensive framework and indicators targeted at children and young people, 0-24 years of age.
- *R17* the \$63,000 provided by AHMAC in 1996 be used to develop a detailed proposal for a national minimum data set.
- R18 AIHW prepare bi-annual reports on child and youth health. Initially these reports would access available data from existing sources and as the recommended developmental processes proceed they would feed into the reports

Population health strategies: Aboriginal and Torres Strait Islander peoples

It is recommended that:

- R19 that the Division, in conjunction with OATSIS, continue efforts to ensure that major nationally relevant health related surveys and collections identify Aboriginal and Torres Strait Islander peoples and contain a sufficient sample size to provide, at minimum national estimates.
- R20 the Division take steps to ensure identification of Aboriginal and Torres Strait Islander peoples in all its own data collections, particularly in the communicable disease and cancer screening areas.

Reproductive health

- R21 summary annual reporting of the Family Planning Program be reviewed to develop a set of indicators that ensure family planning objectives continue to be addressed as a national priority.
- R22 key indicators of reproductive health and fertility management outcomes, risk behaviours, knowledge and service access be developed for inclusion in the broad national set of public health indicators to be monitored under the Partnership.

Enviromental Health

It is recommended that:

R23 AIHW be involved in the planned development by the Division and NCEPH of an information and monitoring strategy for environmental health through participation in an appropriate advisory forum and that appropriate national environmental health indicators be agreed for inclusion in AIHW reporting of national public health indicators under the Partnership.

Nutrition

It is recommended that:

- R24 AIHW be funded to review and implement a minimal national nutrition monitoring system under the National Public Health Partnership.
- R25 It is recommended that AIHW and ABS include the ANZFA in further discussion to review and agree on long term arrangements for the maintenance of the AIHW Apparent Consumption nutrient database and the publication of nutrient apparent consumption data.
- *R26 AIHW be funded to carry out additional analyses of the nutrition survey data as part of the proposed broader role in nutrition monitoring.*
- R27 a folate monitoring program be implemented as part of the general implementation of a national nutrition monitoring system.
- R28 the Division, Prometheus Ltd and ABS negotiate to develop summary datasets for both the Nutrition Survey and the National Health Survey to be installed on HealthWIZ.

Injury

It is recommended that:

R29 that the additional funding to NISU continue under the proposed single funding agreement between the Division and AIHW. This funding should be used to address the further development of the injury data collected by NISU, in particular the ISIS system, to facilitate its use as a population surveillance tool and to provide an increased level of analysis and interpretation to inform national injury control policy development and evaluation.

Tobacco, alcohol and illicit drugs

It is recommended that:

- R30 population data on tobacco, alcohol and drugs be addressed as part of a systematic enhancement of health risk behaviours, knowledge and attitudes collection under the Partnership.
- R31 AIHW and National Drug and Alcohol Research Centre co-ordinate the development of a minimum dataset for clients of drug treatment services under the National Health Information Agreement.
- R32 the Division transfer responsibility for the calculation of drug caused mortality and hospital admissions to AIHW.
- R33 the NDS Cost Shared Activity data collection be examined for pilot development of relevant performance indicators for the Commonwealth/State Agreements as part of broadbanded public health funding.
- R34 the Division ensure that the publication, "Statistics on drug abuse in Australia 1996" be completed before the end of 1996 as a matter of priority.
- R35 the Division resource AIHW to enhance its monitoring activity in relation to tobacco and alcohol and to provide an outposted officer to be located in the National Health Promotion and Protection Branch. The duties of this officer would be to:
 - co-ordinate the collection, analysis and reporting of drugs statistics;
 - prepare an annual report on drug use in Australia;
 - manage existing drugs datasets;
 - respond to requests for drug statistics; and
 - liaise with the Australian Institute of Criminology for the sharing and interchange of population data relating to public health aspects of drug use.
- R36 the needs for statistical information on population use of pharmaceutical drugs be addressed as part of the coordinated approach to drugs monitoring and surveillanceoutlined above.

Social Health Atlas

It is recommended that:

R37 that the Public Health Division proceed with funding the production of a second edition of a Social Health Atlas of Australia through the South Australian Health Commission and seek increased involvement of and collaboration with AIHW in the project..

Divisional information planning and management

It is recommended that the Infrastructure Development Section:

- R38 develop a Divisional Information Management Policy addressing the role of the Dataset Manager, a central register of data collections, standards for documentation and access, preferred software and hardware approaches, and data warehousing.
- R39 take responsibility for the ongoing management and support, development and promotion of HealthWIZ and HEAPS.
- *R40* take responsibility for the development and co-ordination of systematic electronic access within the Division to Divisional data collections through HealthWIZ.
- *R41* arrange secondment of an officer from the Institute to assist in the coordination of public health information activities between the Institute and the Public Health Division.
- R42 through its information management activities encourage the utilisation of the National Health Information Agreement's processes by the Division and facilitate the inclusion of Divisional projects in the National Health Information Work Program.
- *R43* that the Infrastructure Development Section and the AIHW play a lead role in the development of standards for public health information and their inclusion in the National Health Data Dictionary, in order to promote national consistency and comparability of population health data collections.
- R44 provide the central liaison point for the coordination of activities between the Division and the Institute and that arrangements be put in place to manage contractual arrangements between the two bodies as part of the larger Memorandum of Understanding between the Department and the Institute.
- R45 critically examine the Division's data needs, identify those that could be met through the Australian Bureau of Statistics household survey program and take appropriate steps to influence the content of the survey program.
- *R46* the Public Health Information Cross Divisional Coordination Group continue as part of the information development strategy for the Division.
- *R47* take formal steps to establish a cross-portfolio information group to meet monthly.

- *R48* prepare a Public Health Information Development Plan which reflects the priorities in information development within the Division and is consistent with the needs of the Partnership and the Institute's program for the development of national health information.
- *R49* explore options for training programs in population health statistics and the use of population information to address the needs of the Division.
- *R50* arrange for a consultant to develop a proposal for the implementation of an *Executive Information System for the Division.*

Development of national public health information

It is recommended that the AIHW play a lead role under the Partnership:

- *R51* in the development and implementation of core national indicators for monitoring the public health and comprehensive national indicators for surveillance of the public health.
- R52 to produce a regular national report on the state of the public health (based on the core national indicators) and also develop an appropriate mechanism for for the regular reporting and dissemination of the comprehensive national surveillance indicators.

It is recommended that the Division:

- *R53* should provide some funding to AIHW to support the implementation of the core national public health indicators and of comprehensive indicators for surveillance over the next three years.
- **R54** funding to enhance its statistical support to the Division in terms of public health information and data development, online and fast-turn-around access to statistics and value-added analysis and iterpretation. Such support could extend to the outposting or part outposting of an officer in the Population Health Strategies Section.

- R55 AIHW facilitate the ongoing provision of single sets of national data to HealthWIZ, for all major national health data collections held by AIHW.
- *R56 AIHW investigate the potential of HealthWIZ to provide a low cost and rapidly implementable solution to its need to develop appropriate general electronic access to its data collections.*

Filling gaps in public health information

It is recommended that:

R57 Public Health Division take a lead within the Department in identifying the public health importance of the continued population monitoring of dental health and support the resourcing of a national surveillance and monitoring system for dental health.

It is recommended that the Division and AIHW play a lead role under the Partnership in:

- *R58* the development of a co-ordinated national information collection strategy to address the need for population-based surveillance and monitoring of health risk factors, knowledge, attitudes and beliefs in adults.
- *R59* the development of a co-ordinated national information collection strategy to address the need for population-based surveillance and monitoring of health risk factors, knowledge, attitudes and beliefs in children and youth.
- *R60* the development of a broad-based survey of health risk factors, knowledge, attitudes and beliefs for Aboriginal and Torres Strait Islander people.
- *R61* assessing the need for a national blood survey as part of the national public health data collection system.

It is recommended that:

- *R62* the Population Health Strategies Section take responsibility for exploring collection strategies for primary care data in the context of the national public health needs and of the needs for service utilisation data for men and women.
- *R63* a program be instituted for the ongoing monitoring of public health expenditure and that it be coordinated with the AIHW health expenditure database.

AIHW Support for Public Health Division

It is recommended that:

R64 the Division negotiate an agreement with the AIHW for providing specific statistical support activities relating to public health information and that this Agreement be implemented as a component of the larger Memorandum of Understanding between the Department and the AIHW being developed by AIHW and Portfolio Strategies Group.

Recommendations above have addressed specific areas where it is proposed that AIHW provide support to the Division. These are summarised here again for convenience:

- continued additional funding to NISU for injury surveillance, analysis and interpretation (R29).
- funding to review and implement a minimal national nutrition monitoring system, including a folate monitoring program and long term responsibility for maintenance of the Apparent Consumption of Nutrients database, and additional analyses of the National Nutrition Survey to support nutrition monitoring and policy development (R24-27).
- funding to support the Public Health Division in the development and reporting of nationally monitored indicators for men's and women's health (R13).
- funding to assist the Division in the development of a comprehensive framework and indicators targeted at children and young people, and the preparation of biennial reports on child and youth health (R16-18).
- responsibility for monitoring drug caused mortality and hospital admissions (R32).
- resourcing to enhance monitoring activity in relation to tobacco and alcohol and to provide an outposted officer to the Division to co-ordinate the collection, analysis and reporting of drugs statistics, manage existing drugs datasets and respond to requests for drug statistics (R35).
- co-ordination with National Drug and Alcohol Research Centre of the development of a minimum dataset for clients of drug treatment services under the National Health Information Agreement (R31).
- an outposted officer to be located in the Infrastructure Development Section to assist the Division in the coordination of public health information activities between the AIHW and the Public Health Division (R41).
- funding to support the development and implementation of core national public health indicators and of comprehensive indicators for surveillance over the next three years (R53).
- funding to enhance its statistical support to the Division in terms of public health information and data development, online and fast-turn-around access to statistics and value-added analysis and iterpretation. Such support could extend to the outposting or part outposting of an officer in the Population Health Strategies Section (R54).

1. Introduction

1.1 Background

The Public Health Division (PHD) was created in 1995 to provide a more co-ordinated approach at the Commonwealth level, to national priorities for public health policy and action. The Division has been substantially restructured in 1996. Its new focus is one of leadership in the public health arena. A National Public Health Partnership is being forged and the broadbanding of existing specific purpose public health program funding to the States and Territories under Commonwealth/State Public Health Agreements has provided the catalyst for a stronger and more coordinated public health effort. Under these new initiatives, there will be increased emphasis on the use of population health information and scientific evidence to assist in identifying national priorities for public health, in planning public health strategies and in monitoring and evaluating the national public health action. The development of sound public health information will be essential to the management of the Partnership as it will provide a common understanding between the Commonwealth, States and Territories and define a national focus for public health.

The Public Health Division currently includes a number of areas with substantial statistical collection activity. For historical reasons, these collections have developed in different ways using a variety of methodologies, software and hardware. Major gaps exist in information required for the Division's future needs. Furthermore, the Division's use of external population health data, the national health infrastructure and co-ordination with the Australian Institute of Health (AIHW) population health data development and reporting activities has been limited and should be significantly improved to assist in addressing its future information requirements.

Public Health Division sought assistance from AIHW to document and review its statistical information activities and to advise on the Public Health Division's future information needs, and to commence an information management planning process. The Institute provided a consultant, Dr Colin Mathers, Principal Research Fellow in the Health Division, to spend 3 days a week for 3 months in the National Public Health Policy and Planning Branch to carry out these documentation and review tasks. The objectives of the consultancy are outlined below.

In addition, the Public Health Division had commenced a project to review the Division's approaches to planning and management of statistical information through Colleen Fogarty in the Evaluation Unit. Due to some overlap in the Terms of Reference for the consultancy and the project already commenced in the Evaluation Unit, it was agreed that Colleen Fogarty be reassigned to work jointly with Dr Mathers in reviewing statistical activities in the Division and in the preparation of this report.

1.2 Objectives of consultancy

The objectives of this consultancy were:

- To document and assess statistical information collected, analysed, held and disseminated by Public Health Division (describing the purposes for information collections and links to operational strategies and activities in the Division).
- To develop a proposal for consideration by the Public Health Division and AIHW in relation to the future location of existing collections.
- To assist in a review of the Division's operational and strategic information needs, taking into account the role and function of the Division and the emerging requirements of the National Public Health Partnership. Recommend strategies for meeting those needs, leading to the commencement of an information management planning process for the Public Health Division, with consideration of internal information management and relationships with external national information bodies such as AIHW and the Australian Bureau of Statistics.
- Through seminars, presentations and discussion, to increase the Division's understanding and awareness of AIHW collections and work program and the national health information sources and structures.

The outputs from the consultancy were specified as:

- a report which describes statistical information currently collected, analysed, held, or disseminated by Public Health Division, together with recommendations for the future management of these collections; and
- a report reviewing the Division's operational and strategic information needs, recommended strategies for meeting those needs, and recommendations for information management planning for the Public Health Division.

Because the future management of current collections intimately related to the strategies for meeting the Division's future information needs, it was decided that these two outputs should be combined in this one report. However, recommendations relating to these two areas are organised into clearly identified groups in the Summary at the beginning of the report.

1.3 Project methodology

Scope of consultancy

Statistical activities were considered within the scope of this review if they met the following criteria:

- They comprised statistical (quantitative) data. Text databases such as HEAPS were thus excluded from consideration here.
- The collection activity was either ongoing (either continuous or planned to be repeated) or there was an intention or perceived need to repeat it. Thus one-off collection

or there was an intention or perceived need to repeat it. Thus one-off collection activities carried out in the past were excluded from consideration.

- The collection activity was related to an entire population or public health service. Internal management information (eg. Divisional staffing/financial information) was excluded from consideration.
- The activity is either carried out within the Division (eg. communicable diseases surveillance) or under contract to the Division for the Division's use (eg. drugs surveys) or for the public good (eg. HealthWIZ), where the Division plays a major role in defining the activity. Other statistical activities carried out by bodies funded by the Division (eg. general statistical monitoring by a Division-funded research centre such as NDARC) were excluded from consideration.

As defined above, the scope of this review excluded research projects carried out by the Division or funded by the Division, unless such a project had a component comprising ongoing collection of population-level health information (eg. the Women's Longitudinal Study).

Cross Divisional Coordination Group

At the start of the consultancy, a Public Health Information Cross Divisional Coordination Group was established and included people representing all areas of the Division involved with statistical information. Its purpose was to provide a mechanism for discussion of information needs and availability within the Division, and to assist the authors in identifying the Division's future operational and strategic information needs and discussing strategies for addressing these. This Group met regularly through the period of the consultancy and it is recommended that it continue as part of the information development strategy for the Division (see Section 6).

Review of the Division's current statistical activities

This component of the project started with a review of recent reports relating to the Division's statistical activities. These included the DGR consultancy report, the survey of Departmental statistical collections carried out by the Portfolio Strategies Group and the draft report on the evaluation of Program 1.

Colin Mathers and Colleen Fogarty then held a series of meetings with staff in various areas of the Division to document statistical activities, to identify the purposes of the activities and issues related to their future management, and to identify any additional activities within scope. Discussions were also held with a number of people outside the Division, including Ali Nur (ABS National Centre for Aboriginal and Torres Strait Islander Statistics), AIHW management and staff, George Preston and Daryel Akerlind (Prometheus Ltd), John Glover (SAHC), Adam Graycar and David McDonald (AIC).

Future information needs and planning

This phase commenced with a review of documents outlining the Division's future core business and directions, and documents examining national information requirements for health promotion and public health. These included the Department's corporate plan, Divisional planning and restructure documents, discussions papers on the COAG reforms and proposed National Public Health Partnership, the Holman review of Public Health Division and international reports on public health information requirements.

The conceptual framework for public health information developed by AIHW for the Health Australia review of health promotion infrastructure was used as a starting point for the development of a framework for mapping the Division's information needs. This is discussed in Section 4. Future information needs and strategies were further identified and developed in a series of meetings with Divisional staff, AIHW staff, and other Divisions of the Department involved in public health information development, such as NHMRC, Portfolio Strategies Group and General Practice Branch.

Closer co-operation and mutual awareness of information activities between AIHW and PHD

A number of seminars were held for Divisional staff providing an overview of population health information in Australia, the national health information infrastructure, and techniques and issues involved in the measurement of population health status. Additionally, Colin Mathers interacted with and provided advice to staff involved in the development of the National Public Health Partnership, performance indicators for Commonwealth/State Public Health Agreements, and staff involved in the development of indicators and data relevant to public health priority areas. Papers canvassing approaches to the measurement of population health were also presented at the Health Outcomes Conference in Canberra (13-14 August) and the Public Health Association Conference in Perth (30 Sept-2 Oct).

We wish to thank all the staff of Public Health Division for their co-operation and willing assistance in this review.

2. Overview of current statistical activities

The Work Program for the consultancy included an audit of statistical information collected, analysed, held and disseminated by the Division, describing the purposes of the collections and recommending on their future management and location. As mentioned in Section 1, four criteria were used to define the scope of a current, divisional statistical activity. These were that the activity be:

- statistical (quantitative) in nature;
- ongoing or periodic;
- population or service related; and
- carried out within the Division or under contract to the Division.

The statistical activities were examined under seven broad headings, namely, communicable diseases, cancer control, population health strategies, healthy public policy, tobacco, alcohol and illicit drugs, sexual and injecting drug users risk behaviours and general. A list of the statistical activities identified are contained in Appendix A.

2.1 Estimated cost of statistical activities

Tables 1 and 2 show the order of magnitude of resources spent on statistical activities.

Subject area	Total FTE (years)	Information FTE (years)	Information FTE (percent)
Communicable diseases	20	5.56	28
HIV/AIDS	2	0.10	5
Drug use	17	4.10	24
Cancer control	12	1.13	9
Pituitary hormones	6	1.10	18
Nutrition	12	6.00	50
Injury	4	0.30	8
Other population health (a)	14	1.30	9
Total	87	19.59	23

Table 1: Divisional FTE Spent on Statistical Activities

(a) Includes Women's health, CPR education and Family Planning

The activities identified span the Division and do not necessarily align exactly with sections or branches within the Divisional management structure. Consequently, it is difficult to produce a reliable estimate of the proportion of resources spent on statistical and related activities. Furthermore, the variation in the type of activities undertaken, the periodicity of the activity, the nature of the funding arrangements and whether the activity is considered a core or supplementary function precludes direct comparisons of expenditure on statistical activities. Consequently, care should be exercised in interpreting or using the figures contained in Tables 1 and 2.

The figures in Table 1 do not represent the total FTE for the Division but attempt to show the FTE available in the subject groupings identified. The figures are based on current establishment numbers but again, due to the subject groupings used, may not reflect FTE on the ground. The Evaluation Unit has been allocated across four of the subject areas due to their involvement in the evaluation of national strategies. Some discrete sections have not been included. These include: the Business Unit, Migrant Medical Review, Strategies, Public Health Education, the environment area within Health Public Policy and the Public Health Policy and Planning Branch, excluding the Evaluation Unit. While the Infrastructure Development Section has not been included it is recognised that it will have a substantial role in information development in the future. The FTE for information activities shown against the subject groups have been drawn from the materials supplied by the subject areas. These figures are provided as a guide only and represent the estimated staff associated with the conduct of a range of statistical activities undertaken. It is likely, in some cases, that Divisional infrastructure and overheads have not been included in the estimates for specific statistical activities.

	Rui	nning costs		Program costs		Total costs			
Subject area	Total \$000	Inform \$000	%	Total \$000	Inform \$000	%	Total \$000	Inform \$000	%
Communicable diseases (a)	1,300	389	30	8,406	3,380	40	9,706	3,769	39
HIV/AIDS	130	12	9	21,539	665	3	21,669	677	3
Drug use	1,105	245	22	11,020	1,113	10	12,125	1,358	11
Cancer control	780	64	8	11,437	nil		12,217	64	-
Pituitary hormones	390	62	16	353	113	32	743	175	24
Nutrition	780	390	50	3,800	3,800	100	4,580	4,190	91
Injury	260	20	8	300	300	100	560	320	57
Other population health (b)	910	74	8	18,800	750	4	19,710	824	4
Total	5,655	1,256	22	75,655	10,121	13	81,310	11,377	14

Table 2: Expenditure on	Information	Activities b	y Subject Area
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(a) includes the Childhood Immunization Register

(b) includes Women's health, CPR education and Family Planning and other election commitments in diabetes and breast feeding

The figures shown in Table 2 have been drawn from the proposed outlays against specific

activities from the public health appropriation for 1996/97 which was signed by the Minister on 9 October 1996, except in the case of Nutrition. The Nutrition figures are an estimate of the cost of the National Nutrition Survey which was conducted during 1995/96. The costs for information activities shown against the subject groups have been drawn from the materials supplied by the subject areas. These figures are provided as a guide only and represent the estimated costs associated with the conduct of the range of statistical activities undertaken. Sometimes, these are ongoing (eg. communicable diseases monitoring) and in others these are periodic collections or surveys as identified by the relevant area (eg. the drug surveys). Running costs primarily includes staffing which has been estimated at \$65,000 per FTE. Again, these figures are presented as a guide only and care should be exercised in attempting to draw any conclusions from them.

Current statistical activity within the Division is undertaken as part of program management, including funding and quality assurance reporting surveillance, monitoring or evaluation. There is often considerable overlap between monitoring and evaluation activities whereby the same activity serves both purposes. For example, while the household drug surveys provide benchmark data for monitoring alcohol, drug and tobacco use the data is also used in evaluating the National Drug Strategy.

2.2 Information activities identified

Thirty-five primary statistical activities were identified within the scope defined above. A summary description of each of the collections identified is given in this section and Appendix A contains detailed information on each of the collections.

2.2.1 Communicable Diseases (Profiles 1-11)

1. National Notifiable Diseases Surveillance System

The National Notifiable Diseases Surveillance System (NNDSS) is the core national surveillance system providing information on 41 communicable diseases that are notified under State and Territory public health legislations. The diseases are notifiable because an immediate public health response may be required or trends in the disease need to be monitored for public health planning purposes. Case investigations occur at the local and/or state level. A minimum set of data is collated and analysed at the national level. The system provides important data on trends of disease and age, sex and geographic distribution of cases. The system can be used to generate hypotheses about the diseases but is not designed to provide information on emerging conditions or factors associated with transmission.

2. Hib Case Surveillance Scheme

The Hib Case Surveillance Scheme was created in 1993 to obtain information on cases of invasive Hib disease which is not available in the NNDSS, including type of illness, method of diagnosis and outcome. The scheme was also specifically created to obtain information on the immunisation status of cases and to record vaccine failures which occurred with these new vaccines. Case investigations occur at the local and/or State level and data is collated and analysed at the national level. The system provides important information on the effectiveness of the Hib immunisation program.

3. Virology and Serology Laboratory Reporting Scheme

The Virology and Serology Laboratory Reporting Scheme began operating in 1977. The scheme comprises 21 sentinel laboratories from all States and the Australian Capital Territory which contribute data on the laboratory identification of viruses and other organisms which are of national importance, such as influenza, rotavirus and RSV, and which are not included in NNDSS, all of which are significant causes of morbidity. Reports are collated, analysed and published each fortnight.

4. National Mycobacterial Surveillance System

The National Mycobacterial Surveillance system was established to strengthen monitoring of tuberculosis notification rates and contemporary risk factors such as HIV infection and birth in a country with a high prevalence of tuberculosis. Case investigations occur at the local and/or State level and data is collated and analysed at the national level. The data set includes the core data set in common with the NNDSS plus a supplementary data set comprising ethnicity, country of birth, length of residence in Australia, pathogen, principal site of disease, method of diagnosis, etc. The system provides important information on the changing overall epidemiology of the disease.

5. Communicable Diseases Intelligence

The Communicable Diseases Intelligence (CDI) bulletin includes reports from several national communicable diseases surveillance schemes on a regular basis. These surveillance systems are conducted to monitor the occurrence of communicable diseases in Australia, to detect trends and to highlight needs for further investigation or for the implementation or modification of control measures. Articles, editorials, outbreaks, case reports and notices regarding communicable diseases (incidence, epidemiology, public health issues, etc) are also published. The bulletin is one of the major methods for dissemination of communicable diseases data and updates on communicable disease outbreaks of national significance.

6. Surveillance of Serious Adverse Events Following Vaccination

The Serious Adverse Events Following Vaccination Surveillance Scheme is a national surveillance scheme initiated through the National Childhood Immunisation Committee. The scheme aims to identify and report in a timely fashion all serious adverse events which follow childhood vaccination. This permits (i) the identification of illnesses of infrequent occurrence that may be associated with vaccination, (ii) the estimation of rates of occurrence of events temporally associated with vaccination, (iii) monitoring for unusually high rates of adverse events, (iv) the provision of information to inform the debate on the risks and benefits of vaccines and (v) the identification of areas that require further research.

7. National Childhood Immunisation Register

The National Childhood Immunisation Register is a national register containing information on the immunisation status of children from birth to six years. The Register commenced on 1 January 1996 under the administration of the Health Insurance Commission on behalf of the National Childhood Immunisation Committee. It is expected that the Register will provide an effective management tool for monitoring immunisation coverage and service delivery. The data collected will also form the basis of an optional recall/reminder scheme which will have the ability to inform parents when their child's next vaccination is due or overdue.

8. HIV/AIDS National Register

National surveillance for HIV disease is coordinated by the National Centre in HIV Epidemiology and Clinical Research (NCHECR), in collaboration with State and Territory health authorities and the Commonwealth of Australia. Cases of HIV infection are notified to the National HIV Database on the first occasion of diagnosis in Australia and cases of AIDS are notified through the State and Territory health authorities to the National AIDS Registry. This system is internationally recognised as a model in surveillance and disease management and has been one of the cornerstones in the national response to the HIV/AIDS epidemic. The system provides important data on trends of the disease and age, sex and geographic distribution of cases and provides important data for examining the effectiveness of the HIV/AIDS Strategy.

9. Australian Human Pituitary Hormone Program - Patient Database

The Australian Human Pituitary Hormone Program Patient Database contains information relating to people who applied for or received treatment with human pituitary derived hormones under the Australian Human Pituitary Hormone Program. The database maintains up-to-date information on former recipients of human pituitary derived hormones so that they can be kept informed about the risk of Creutzfeldt-Jakob Disease, the need to exclude themselves from donation programs, the availability of assistance programs, such as the counselling program and any other information which may be of benefit. A quarterly HPH newsletter is sent to persons on this database.

10. Human Pituitary Derived Hormones Counselling Service Database

The Human Pituitary Derived Counselling Service was established in 1993 to provide special counselling and support services for people who received human pituitary derived hormones for infertility or short stature and who could, therefore be at risk of contracting Creutzfeldt-Jakob Disease. Counselling sessions are provided through Relationships Australia to recipients and their families who face personal and family difficulties as a result of the risk of contracting Creutzfeldt-Jakob Disease. The database provides up-to-date information on the utilisation of counselling services and assists in monitoring the cost effectiveness and appropriateness of the services.

11. Creutzfeldt-Jakob Disease Case Registry

The Creutzfeldt-Jakob Disease Case Registry was established in 1993 to collect information on and analyse all cases of Creutzfeldt-Jakob Disease in Australia. The Registry is based in the University of Melbourne's Department of Pathology and directed by the head of the department, Professor Colin Masters. The Creutzfeldt-Jakob Disease Case Registry collaborates with Creutzfeldt-Jakob Disease surveillance units in the United Kingdom and Europe to achieve an accurate assessment of the incidence rates of the disease and to identify any new developments for potential treatment strategies.

2.2.2 Cancer Control (Profiles 12-13)

12. BreastScreen Australia Performance Measures

BreastScreen Australia was established by the Commonwealth and the States and Territories in 1991 and is now one of the most comprehensive population-based screening programs in the world. Women are invited to have a screening mammogram every two years. Priority is given to women aged 50 to 69 years for whom research has demonstrated a benefit for mammography screening. In July 1996 there were 35 dedicated Screening and Assessment Services (SAS) in operation, providing screening units servicing over 400 locations. BreastScreen National Reports are performance information reports based on agreed definitions and can be generated from the nationally agreed Minimum Data Set that are routinely collected from each SAS. The reports monitor Program performance against accreditation standards, program objectives and national policies and will be used for a BreastScreen Australia Annual Statistical Report for monitoring and benchmarking purposes.

13. National Cervical Screening Program Performance Measures

The National Cervical Screening Program (NCSP) was introduced in 1991. The Programme aims to reduce morbidity and mortality from cancer of the cervix through a systematic approach to screening women aged 18 to 70. Cervical Cytology Registries are being established in all States and Territories to provide reliable data on cervical screening activity and outcomes. Agreement has been reached with the States and Territories on a minimum set of performance measures for the program but to date data has not been available at the national level.

2.2.3 Population Health Strategies (Profiles 14-18)

14. Australian Longitudinal Study on Women's Health

The Australian Longitudinal Study on Women's Health has been designed to follow a large group of women over a 25 year period to examine social, economic and environmental factors as well as physical and psychological factors that influence women's health and well-being. The study will explore how women's health is affected by what they do - the numerous functions they take on; their lifestyle choices and the key events in their lives.

15. National Women's Health Services - National Evaluation Dataset

The National Women's Health Dataset is a minimum dataset for women's primary health care services funded by the National Women's Health Program (NWHP). The first data has been collected in respect of 1995-96 and will be used in the evaluation of the NWHP. Information is collected at agency level by State and Territory health authorities and collated and analysed at the State level. The Dataset will provide important data on the utilisation of the specific health

care services.

16. Family Planning Program Annual Reporting

The Family Planning Program provides direct ongoing funding to selected non-government organisations to provide a comprehensive range of information, education, professional training, counselling and clinical services in sexual and reproductive health to the Australian community. Annual reports provide aggregated data on a subset of services provided by the family planning organisations. The data is not useful for monitoring sexual and reproductive health services utilisation at a population level but it is the only information available. Family planning clinics cannot meet all the community's needs for sexual and reproductive health services, the majority of such services being provided by general practitioners.

17. Cardiopulmonary Resuscitation (CPR) Training Evaluation

The Cardiopulmonary Resuscitation (CPR) Training Evaluation is being jointly conducted by the National Heart Foundation Heart Attack Committee and the New South Wales Ambulance Service. The study is examining all episodes of ventricular fibrillation treated by the NSW paramedics to determine the relationship between survival from out-of-hospital ventricular fibrillation and the type of training, if any, received by community members who initiated CPR. The study will provide quantitative data on the nature and quality of CPR training in the community.

18. The Teaching of Cardiopulmonary Resuscitation in Schools and Workplaces

The Teaching of Cardiopulmonary Resuscitation (CPR) in Schools and Workplaces Project was jointly conducted by the Australian Resuscitation Council and the Curtin University of Technology. The project conducted a national survey of organisations who teach Basic Life Support (BLS), health care facilities and secondary schools to determine the extent to which BLS is taught.

2.2.4 Healthy Public Policy (Profiles (19-20)

19. National Nutritional Survey

The National Nutrition Survey (NNS) was undertaken between February 1995 and April 1996 as a joint project of the Department of Health and Family Services and the Australian Bureau of Statistics (ABS). The survey will provide information on food and nutrient intakes, dietary habits and body measurements of a representative sample of Australians aged from 2 years. The survey data will be linked to that of the National Health Survey (NHS) which will provide information on socio-economic status, health status and health service utilisation. The first of a series of publications on the results of the survey will be available in late 1996.

The survey is the largest and most comprehensive food and nutrition survey of the Australian population ever undertaken. In addition to the Department and the ABS, many agencies and organisations have been involved in the development of the survey including State and Territory health authorities, AIHW, NHMRC, NFA and the Dietitians Association of Australia.

20. National Injury Surveillance Unit - Additional Funding

The National Injury Surveillance Unit (NISU) undertakes public health surveillance of injury at the national level to support injury prevention and control. It engages in all aspects of surveillance, and places special emphasis on analysis and dissemination of information, and on developing injury surveillance methods. It also provides a national contact point for liaison and information sharing on injury control.

NISU reports summary data on injury related deaths annually. Additional funding through the Public Health Division has assisted in advancing tighter and more detailed surveillance of injury through a variety of projects such as the development of National Data Standards for Injury Surveillance and studies into specific at risk populations, such as Aboriginals. Other projects include collaboration with coroners to develop improved data on injury deaths, development of a new approach to study emergency department injury attendances and development of a spinal cord injury register.

2.2.5 Tobacco, Alcohol and Illicit Drugs (Profiles 21-29)

21. National Drug Strategy Household Survey

The National Drug Strategy Household Survey has been conducted at 2 or 3 yearly intervals since 1985. The surveys have been undertaken to monitor and evaluate issues relevant to the National Drug Strategy (NDS). The survey methodology combines the personal interview and self completion techniques to obtain information on the four main areas of interest - drug use and exposure; knowledge, attitudes and policy preferences; law enforcement indicators and campaign awareness and impact. The surveys provide important data for monitoring emerging issues such as general health status and attitudes to marijuana, and the co-use of marijuana with other drugs.

22. National Drug Strategy Household Survey - Urban Aboriginal and Torres Strait Islander Peoples Supplement

The 1994 survey of drug use among Aboriginal and Torres Strait Islander (ATSI) peoples is part of the series of NDS household surveys. While ATSI peoples had been included in the 1993 NDS household survey, their low incidence in the general population (only 1.6%) was reflected in the sample, yielding insufficient sample to allow separate analysis. Thus this survey involved face-toface interviews with 2,993 ATSI peoples living in urban areas nationally, to supplement the information gathered in the 1993 survey, and more importantly, to provide reliable baseline data for this group.

23. National School Students Survey

The National School Students Survey is a collaborative effort involving the Commonwealth, each State and Territory health/education authority and the Centre for Behavioural Research in Cancer (CBRC). The survey was conducted during May - September 1996 and sought information on secondary school student alcohol, tobacco and illicit drug use. The core questions relating to alcohol and tobacco consumption are based on previous surveys conducted by the CBRC over the last fifteen years and for the first time, comparable national data for illicit drugs will be

derived. This is a major breakthrough and the survey will provide excellent baseline data among this age group.

24. Illicit Drug Reporting System

The Illicit Drug Reporting System (IDRS) - Pilot Survey was developed to trial a system to provide a co-ordinated approach to the monitoring of data associated with the use of opiates, cocaine, amphetamines and cannabis, and that the information act as an early warning indicator of the availability and use of the main drug categories. The National Drug and Alcohol Research Centre (NDARC) was commissioned to undertake this work. As part of a 12 month trial, NDARC conducted a quantitative survey of injecting drug users, supplemented with qualitative key informant interviews with professionals working in the drug field and illicit drug users. A further trial will be conducted over a 12 month period in Sydney, Melbourne and Adelaide commencing in October 1996.

25. Census of Clients of Treatment Service Agencies

The Census of Clients of Treatment Service Agencies (COTSA) has been conducted on three occasions since 1990. The Census identifies the characteristics of clients attending these services and compares the drug and alcohol problems being treated over the five years since the first census. The census provides important data on the extent to which people with a drug or alcohol related problems utilise treatment agencies.

26. Clients of Methadone Treatment Programs Register

The Clients of Methadone Treatment Programs Register was established in 1987 to identify the number of people registered in the methadone maintenance program and whether the clients attend public or private clinics.

27. Drug Caused Deaths

A detailed set of methods has been developed and applied to determine aetiologic fractions of deaths caused by alcohol, cigarette smoking and illicit drugs in Australia9Holman,English et al 1995). The methods relied on meta-analyses of published scientific literature on the adverse health effects (and in a small number of instances, the protective effects) of these substances on different diseases and injuries. The aetiologic fractions so derived are used to estimate deaths caused by alcohol, cigarette smoking and illicit drugs.

28. Cost Shared Program - Activity Indicators

The National Drug Strategy 'cost shared program' is a joint Commonwealth, State and Territory funding program which supports a range of drug and alcohol activities in areas such as treatment, prevention, supply, control, education and training. The activity indicators data collection provides information on services/projects funded wholly or partly under the cost shared program. The collection aims to assess the extent to which cost shared funded activities are consistent with the objectives and priorities of the National Drug Strategic Plan. Data is collected by regions and collated and reported at the national level annually.

29. Statistics on Drug Abuse in Australia

"Statistics on Drug Abuse in Australia" presents a composite picture of the drug situation in Australia. It draws together all the drug related data collections, particularly those funded under the National Drug Strategy. These collections are conducted to monitor drug use and measure attitudes and behaviour of the Australian population.

2.2.6 Sexual and IDU Risk Behaviours (Profiles 30-33)

30. Project Male-Call

Project Male-Call is a national telephone survey of men who have sex with men, the first of which was conducted in 1992. The survey's focus includes both gay men and men who live beyond the two main gay communities of Sydney and Melbourne. The major aims of the survey are: to describe homosexually active men's knowledge of HIV and AIDS and their sexual practice with special focus on the adoption of "safe" sexual strategies; and to examine the ways in which knowledge and safe sexual practice are related to a number of demographic and contextual variables.

31. Schools Survey

The Schools Survey is a HIV Risk and Sexual Behaviour Survey which was conducted in Australian schools for the first time in 1992. The survey gathered baseline data on the knowledge, attitudes and behaviour towards HIV/AIDS and other sexually transmitted diseases. The survey is an important component in the evaluation of the National HIV/AIDS Strategy and allows informed judgments about the success of school-based HIV/AIDS education. It is proposed to broaden the focus of the 1997 survey to maximise its utility and to enable the evaluation of a number of Commonwealth public health programs in the field of sexual health and communicable diseases.

32. Needle and Syringe Exchange Survey

The Needle and Syringe Exchange Survey commenced in 1995 to obtain information about the prevalence of HIV, Hepatitis B and Hepatitis C infection, and injecting and sexual practices among people attending selected needle and syringe exchange centres throughout Australia. Participating clients completed a self enumeration questionnaire and provided a finger prick blood spot specimen. Data is analysed and presented in the HIV Surveillance Report as well as information sources aimed at injecting drug users.

33. Sydney Men and Sexual Health Study

The Sydney Men and Sexual Health (SMASH) study is a longitudinal study of the sexual practices of gay and bisexual men. It has two study arms: a social-behavioural arm which focuses on the impact of HIV on the sexual and social lives of the men in the study; and a clinical arm which focuses on serological testing and assessments of disease progression. The study commenced in November 1992 and a second phase of recruitment was undertaken in 1994-1995. A number of reports relating to specific issues have been published from the first phase of the study and only

preliminary results from the second phase have been presented. The longitudinal data have not as yet been addressed.

2.2.7 General (Profiles 34-35)

34. HealthWIZ

HealthWIZ is the National Social Health Database containing datasets of health and population data collections. It is owned by the Department of Health and Family Services, and is developed and supported by Prometheus Ltd under contract to the Department. The project was established in 1991 and is acknowledged as a valuable information resource for public health planning both by Government and non-Government agencies. A major focus of HealthWIZ is to assist those working in public health to identify community and population subgroups with high rates of specific diseases and social disadvantage.

It is a high performance and user-friendly software interface with custom table making, viewing and analysis functions. The product runs on PCs under a Windows environment. HealthWIZ currently contains national datasets for population (1991 census), mortality (to 1993), hospital morbidity (to 1993/94), cancer (to 1994), Medicare (to 1995) and DSS recipients (1996).

35. Social Health Atlas of Australia (Profile 35)

The National Social Health Atlas of Australia was commissioned and funded by the Department through the National Better Health Program. The purpose of the Atlas is to describe the patterns of socioeconomic disadvantage and health status at the smallest spatial level possible and to thus draw attention to the associations which exist between these. It was produced by the South Australian Health Commission and the Australian Bureau of Statistics in 1992. There are two volumes of the Atlas - Volume One comprises 90 maps and deals mainly with demographic data and socioeconomic health status mapped by local government areas for capital cities, major urban areas and many towns and rural areas across Australia. Volume Two comprises 60 maps and illustrates data from two major Australian Bureau of Statistics population surveys - the 1989-90 National Health Survey and the Survey of Disabled and Aged Persons.

2.3 Other major sources of information used

A range of other statistical information activities are used and accessed by the Division. These are primarily in the surveillance of communicable diseases and are reported in the Communicable Diseases Intelligence bulletin on either a periodic or ad hoc basis. The main activities of this type are summarised below.

National Influenza Surveillance

Influenza surveillance in Australia is based on several schemes collecting a range of data which can be used to measure influenza activity. From autumn to spring, the results of each of the schemes are published in the Communicable Diseases Intelligence bulletin together as National Influenza Surveillance. These are: (i) absenteeism surveillance which encompasses reports for a selected day each week of the proportion of the 37,000 employees of Australia Post absent on sick leave; (ii) the Virology and Serology Reporting Scheme; and (iii) the WHO Collaborating Centre for Influenza Reference and Research at the Commonwealth Serum Laboratories, Melbourne which provides information on antigenic analysis of isolates received from Australia, New Zealand, other countries of the region and South Africa.

Laboratory Based Surveillance for Multi-Drug Resistant TB

The Australian Tuberculosis Laboratory Reporting Scheme is a joint project of the Special Interest Group in Mycobacteria of the Australian Society for Microbiology and the Department of Health and Family Services. Data are collected on organisms of the *Mycobacterium tuberculosis* complex (MTBC) including *M. bovis* and geographic variants such as *M. africanum*. Records include patient demographics, source of specimen, microscopy result, species isolated and results of drug susceptibility tests; HIV status is recorded if known.

Australian Sentinel Practice Research Network

The Research and Health Promotion Unit of the Royal Australian College of General Practitioners operates the Australian Sentinel Practice Research Network, a national network of general practices which report on a number of conditions each week. The Communicable Diseases Intelligence bulletin reports the communicable diseases under surveillance each fortnight. For each of the two reporting weeks reviewed, the number of cases of each listed disease encountered is tabulated and commented upon, together with the rate of reporting per 1000 consultations. Currently about 60 general practitioners from all States and Territories report on about 8000 consultations each week.

Sentinel Chicken Surveillance Programme

The Sentinel Chicken Surveillance Programme is coordinated by the Arbovirus Research Laboratory in the Department of Microbiology at the University of Western Australia. The programme provides an early warning of increased Australian encephalitis activity, by monitoring flavivirus seroconversions in chickens in sentinel flocks in Western Australia, the Northern Territory, Victoria, Queensland and New South Wales.

Australia Paediatric Surveillance Unit

The Australian Paediatric Surveillance Unit (APSU) was established in 1993 as a Unit of the Australian College of Paediatrics, with the objectives of monitoring trends in the occurrence of rare childhood disorders or conditions, or rare complications of common childhood conditions. The APSU conducts surveillance of conditions in collaboration with investigators who undertake more detailed follow-up of cases of individual conditions. On behalf of these investigators, APSU sends a monthly reply-paid card listing the conditions under surveillance to the participating clinicians, who include all members of the Australian College of Paediatrics, paediatricians listed by the Health Insurance Commission and the Royal Australasian College of Physicians, and members of paediatric sub-speciality organisations. The clinicians indicate whether they have seen any of the conditions during the last month and return the card even if they have a nil report.

APSU notifies the appropriate investigator of the cases reported, and the investigator then sends a simple questionnaire to the clinician to document the case. This is de-identified to maintain confidentiality, but sufficient data are obtained to detect duplicate reporting. Investigators present their findings in the Communicable Diseases Intelligence bulletin. Recent reports have included Congenital Rubella, HIV in Australian Children and Haemolytic Uraemic Syndrome.

National Neisseria Network

The National Neisseria Network is a national program for the examination of strains of *Neisseria meningitidis* from cases of invasive meningococcal disease. The program was commenced in 1994 with the cooperation and participation of reference laboratories in each State and Territory. This activity is designed to supplement data from existing notification schemes by adding information on the sero group of strains (and ultimately the serotype and subserotype) as well as antibiotic sensitivity data. For each isolate, data are collected on the State or Territory of the patient, age, sex, site of isolation, outcome, serogroup and sensitivities to a range of antibiotics.

Australian Gonococcal Surveillance Program

The Australian Gonococcal Surveillance Program is coordinated by the Prince of Wales Hospital in Sydney. The reference laboratories examine isolates of *Neisseria gonorrhoeae* for sensitivity to the penicillins and for susceptibility to ceftriaxone, ciprofloxacin and spectinomycin and for high level resistance to tetracycline. Data from this system are published quarterly in the Communicable Diseases Intelligence bulletin.

National Salmonella Surveillance Scheme

The National Salmonella Surveillance Scheme (NSSS) is a computer based data bank for the collection and analysis of information on salmonellas and other enteric pathogens in Australia. It is operated by the Microbiological Diagnostic Unit at the University of Melbourne. The system began in 1980 with the national collection of data on organisms isolated from humans. In 1983 it was expanded to include information on enteric pathogens from animals, food, water and environmental samples from throughout Australia. The database can be used to, search for information on outbreaks/suspected outbreaks in Australia, to look for unusual trends, etc. Quarterly and annual newsletters are produced by the Unit and are reproduced in the Communicable Diseases Intelligence bulletin each quarter.

National Antimicrobial Resistance Surveillance Program

The National Antimicrobial Resistance Surveillance Program (NARSP) commenced in June 1991 under the auspices of the Expert Panel on Antibiotics of the NHMRC. Twenty eight laboratories from throughout Australia currently participate. The system collates data on the resistance of common medical bacteria to antimicrobial drugs. These data are used in the development of guidelines to aid the rational and appropriate use of antimicrobials. Due to the ability of many bacteria of medical importance to rapidly develop resistance it is important that these data are kept up to date through an ongoing surveillance program. Data are published in the Communicable Diseases Intelligence bulletin.

Australian Malaria Register

The Australian Malaria Register (AMR) is currently maintained at the Australian Centre for International and Tropical Health and Nutrition (ACITHN) in Brisbane. The register was transferred from the School of public Health and Tropical Medicine, Sydney University in 1990. It provides comprehensive information on all cases of malaria notified in Australia. Data is collected by the States and Territories and forwarded to ACITHN. The AMR has published annual reports for 1990 and 1991. However, no AMR reports are available for subsequent years.

3. Conceptual framework for public health information

3.1 What is public health?

Public health is defined as the efforts organised by society to protect, promote and restore the public's health through collective or social actions (Health Advancement Standing Committee 1996). Public health is characterised by a focus on:

- the health of populations and groups within it, as opposed to the individual, as the starting point for planning and intervening;
- the determinants of health and causes of illness rather than symptoms;
- the promotion of health and prevention of illness rather than treatment; and
- the public as an active partner in public health than merely recipients of services.

Public health activities include the overlapping spheres of health promotion and community development, health protection, and preventive services, defined as follows:

Health promotion and community development

Communication activity aimed at promoting health through influencing the beliefs, attitudes, knowledge and behaviour of individuals and communities. This can be in relation to positive or negative aspects of individual lifestyle, to the uptake of preventive services, or in relation to community attitudes to the need for legislative or preventive programs. It is important that this communication be a two-way process, with public health practitioners working in partnership with:

- individuals, families and community organisations;
- the practitioners and institutions of the health care system; and
- the practitioners and stakeholders in other sectors such as transport, production, education, and town planning.

Preventive services

Primary prevention of disease onset through risk reduction and secondary prevention of disease through early detection and diagnosis of disease in order to improve the outcome of treatment. Preventive services include risk factor screening and modification programs as well as immunisation and population screening programs for asymptomatic disease.

Health protection

Legal or fiscal controls, other regulations and policies, and voluntary codes of practice,

aimed at the enhancement of positive health and the prevention of ill-health.

3.2 Monitoring, surveillance and evaluation

Although the terms 'monitoring' and 'surveillance' are often used interchangeably to refer to measurement of changes in trend or distribution in the population of relevant indicators, 'monitoring' is sometimes also used in relation to assessing the performance of a program, in a sense synonymous with 'evaluation'. These three terms will be used with specific meanings in this report as defined below.

Evaluation of a public health program involves assessing its success in achieving its aims. These may be defined in terms of activities (process evaluation) or in terms of short or long term effects (outcome evaluation). In relation to public health activities, outcomes may be defined in terms of entities such as knowledge or behaviour that the program is trying to influence, or in terms of health outcomes—the change in health resulting ultimately from the public health intervention. Evaluation is done both during the program implementation, to provide feedback about progress towards the program's aims, and afterwards, to assess how well the aims have been achieved.

Data for evaluation purposes must have the following characteristics:

- the data must relate specifically to the intervention population; and
- the proportion of the change in knowledge, behaviour or health status that is attributable to the intervention must be identifiable (and ideally quantifiable).

Thus data required for evaluation are usually fairly specific to the particular intervention, including data on factors in the causal chain between intervention and outcome, and often relate to a particular community or subpopulation.

The purposes of surveillance and monitoring at national, as well as State and Territory levels are different and result in different data requirements. The two major uses for population-level data collected at repeated time intervals are:

- As a general surveillance tool which will:
 - act as a 'warning system' for raising health issues which may need to be addressed by public health activities;
 - form a basis for setting priorities for public health activities; and
 - allow 'confirmatory analyses' to highlight changes in population health status or risk following public health activities.

Such data will primarily relate to health status and risk factors and should cover all aspects of risk and disease. This use we refer to as **surveillance**.

to provide indicators of progress towards a healthy society. Such data will primarily relate to the determinants of health and to process indicators summarising the 'health of structures', and should cover the current priority strategies for public health. However, the health status data will also provide relevant long-term indicators of progress. This use we refer to as **monitoring**.
3.3 Population-level data

A range of information is required for the planning, implementation, evaluation and monitoring of public health activities. As well as population-level data collected regularly over time, the scientific knowledge base on what protects and promotes health and causes disease and injury, the scientific knowledge base for public health practice, scientific knowledge about the efficacy or effectiveness of specific interventions, and community priorities and values are needed for informing the development, prioritising, planning, implementation and evaluation of public health activities (Figure 1). What distinguishes these latter classes of information from population data is that they do not need to be, nor is it often appropriate for them to be, collected repeatedly over time. For example, a well evaluated smoking intervention to identify the most cost-effective type of intervention need only be carried out in a representative sample population, and need not be carried out again, unless other elements of the scientific knowledge base suggest that the results may no longer be applicable.

Figure 1: Information Requirements for Public Health



The AIHW and AHMAC's National Health Information Development Plan (1995a) defined national health information as information which is either national in coverage or has relevance nationally and relates to:

- the health of the population;
- the determinants of the population's health, including those in the external environment (physical, biological, social, cultural and economic) and those internal to individuals (e.g. knowledge, behaviour, disease risk factors);
- health interventions or health services, including health interventions provided directly to individuals and those provided to communities, covering information on the nature of interventions, management, resourcing, accessibility, use and effectiveness; and
- the relationships among these elements.

National information does not necessarily mean large centralised data collections. The essential characteristics of national information are the nationwide comparability and national relevance of the information collected. In relation to national public health priorities, health information collected at State and Territory level clearly has national relevance. Information collected only for a subset of regions at sub-State level will probably usually not be of national significance, unless such regions can be taken as representative of broader populations.

3.4 Conceptual framework for public health

The World Health Organization defines health as:

'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO 1946).

This definition of health has the virtue of placing a strong emphasis on health as a positive experience, rather than the absence of negatives. However, it is so broad that it is difficult to operationalise in practical population measures, and is perhaps more readily treated as a notion of well-being, in which health is an important but not the only component.

Figure 2 presents a conceptual framework for population health data relevant to public health. This framework attempts to identify the major components of health and its determinants which are relevant to public health activities and to show their conceptual relationships with the three spheres of public health intervention described above. This framework is intended to assist in the identification and structuring of all the important kinds of information relevant to public health, to assist in the inventorying of existing data and the identification of data gaps and deficiencies. As such, its purposes are somewhat

different to those of an information model, but the major domains identified in it map to the National Health Information Model (AIHW 1995b), as discussed below.

One of the important dimensions of health status is functional ability, the ability to perform tasks of daily living and to carry out social roles. The terms impairment, disability and handicap are often erroneously used interchangeably, although the WHO's (1980) Classification of Impairments, Disabilities and Handicaps provides a conceptual framework and a consistent terminology. For the purposes of this framework, disease, injury, symptoms and impairments have been grouped together in a single box relating to 'within the skin' departures from good health, ie. 'ill-health'.





Disability is defined as a reduction or loss of functional capacity or activity resulting from impairment, which in turn may result from injury or ill-health. Disabilities are characterised by excesses or deficiencies of customarily expected behaviour or functions in relation to everyday activities. Handicap is defined as the social disadvantage resulting from an impairment and/or a disability, that is, a divergence between the individual's performance or status and that expected of him by his social group. Public health interventions are generally aimed at preventing disease. Some public health activities may aim to reduce the disabling consequences of disease through collective social action (eg. a public education campaign to improve management of diabetes and minimise disabling sequelae through early intervention). However, interventions which aim to reduce handicap without reducing disability are generally considered to be welfare interventions (e.g. provision of income support or carer services), so that handicap is excluded from the framework shown in Figure 2.

The determinants of health include individual characteristics such as genetic factors (inherited physiological and psychological traits as well as inherited risk of disease) and lifestyle and behavioural factors, as well as characteristics of the environment. In this context, environment includes many distinguishable components identified in the diagram under the following categories: physical (e.g. global climate change, air, water, radiation), chemical, biological (e.g. toxins, hazardous species), social, cultural and economic. Workplace hazards, the built environment and transport are relevant to the physical and the social environment.

These determinants also include risk factors which identify increased risk of disease in a reasonably clear manner as well as more complex determinants of health such as socioeconomic disadvantage, where causal links are not so well defined. There are many determinants of health, relevant to public health, where risk factors and risk markers may not have been well identified (e.g. social environment) and where it may not be important to do so.

Public health activities (shown in the shaded box in Figure 2) attempt to improve health and prevent disease either directly through preventive services or via a number of enabling factors:

- health knowledge, attitudes, beliefs and skills;
- health promotive environments; and
- policy, legislation and guidelines.

These factors are not, in themselves, determinants of health but rather the levers which public health interventions address in order to modify the determinants of health. All of these enabling factors can be addressed in a range of settings, shown at the bottom of Figure 2. Health promotive environments are aspects of the physical, social, cultural and economic environments that assist the adoption of practices and behaviours that are conducive to good health. They include smoke-free public places that discourage smoking and control passive exposure to tobacco smoke, traffic-calming devices designed to reduce

the rate of suburban road crashes, pricing policies to encourage use of lead-free fuel, staff training to reduce the sale of alcohol to intoxicated persons, no-hat-no-play sun protection programs in schools, healthy food choices in school canteens and provision of bike paths to promote exercise and reduce traffic injury.

A health promotive environment is one in which members of society and social and economic institutions work together to provide people with structures and environments which promote and protect their health. As well as changing individual knowledge and attitudes, and using legislation and policy, this includes direct and informal social activity to create healthy settings, products and services, to develop infrastructure that improves the sustainability of public health activities and builds capacity for addressing public health issues.

Nutbeam defines community development in health promotion as:

'...the process of involving a community in the identification and reinforcement of those aspects of everyday life, culture and political activity which are conducive to health. This might include support for political action to modify the total environment and strengthen resources for healthy living, as well as reinforcing social networks and social support within a community and developing the material resources available to the community. '(Nutbeam 1986).

Public health inputs are the resources—labour force, buildings, equipment, supplies, funds, knowledge and technology—which are put into a public health program. It is important to note that the information inputs include information on cost-effectiveness as an important input to priority setting and strategy development. These are shown in the box to the bottom right of Figure 2.

The process is the series of actions or events which use the inputs to produce outputs (or outcomes). The shaded box labelled 'Public Health' refers to public health interventions or processes. An output is a measure of the process. The dictionary definition of output and outcome are almost the same but output is now commonly used to refer to process outputs, or throughputs, such as the numbers of people exposed to a health education program or the numbers of screening tests performed.

The health outcome for an individual is defined as the change of health status that occurs as a result of any action that may influence health. This definition therefore includes changes in health status that occur because of actions outside the ambit of health authorities, even if a change in health status was not the intention of those actions. The term health outcome is often loosely but incorrectly used as a synonym for health status (after an intervention).

This framework is intended to provide a basis for identifying the basic categories of data required at the population level for public health. The information domains identified in Figure 2 provide one useful classificatory dimension for documenting public health population information requirements, quality and gaps and deficiencies:

Health

- Mortality
- Health and wellbeing
- Morbidity
- Disease and risk factor (cost, global measures)

Determinants of health

- Genetic contribution
- Lifestyle and behaviour
- Social and cultural environment
- Economic and political environment
- Physical, chemical and biological environment

Enabling factors

- Health knowledge, attitudes and beliefs
- Healthy public policy (legislation, policy, guidelines, etc)
 - Health-promotive environments (products, services, settings)

Public health interventions

- Preventive services (inputs, outputs)
- Health communication (inputs, outputs)
- Health protection (inputs, outputs)
- Community and organisational (inputs, outputs)

The AIHW has developed a National Health Information Model which provides a framework for the management of national health information. Currently at version one, the model identifies the basic categories of health information, and the key relationships between them. There is a need to develop the model in the areas of wellbeing and determinants of health. It is envisaged that the model will begin to be used to assist future information and data development work in health information systems and classification systems at Commonwealth, State and Territory levels. This process will both serve to further develop the model, but also to provide consistency, and therefore comparability, between information sources.

3.5 **Priority populations**

Equity objectives are integral to the national public health effort. In relation to health, inequity is a moral and ethical issue, and refers to differences which are unnecessary and avoidable, and also considered unfair and unjust. To describe a certain situation as inequitable, the cause has to be judged to be unfair in the context of what is going on in the rest of society.

The different population groups between which inequities may occur, can be characterised in terms of geographic location, health status, socioeconomic status, education, language spoken at home, etc. The equity policy objective is concerned with creating equal opportunities for health and with bringing inequitable health differentials down to the lowest level possible.

Priority populations are defined as identifiable populations with significant health disadvantage (eg. Aboriginal people and Torres Strait Islanders) or specific access problems, whether to knowledge or to services (e.g. people of non-English speaking background). For the purposes of the conceptual framework, populations defined by their health status (eg. people with disabilities, people with mental disorders) are not identified as priority populations, but are there to identify such groups, particularly in relation to public health intervention data in relation to equity of access.

Groups most commonly identified as disadvantaged in relation to public health include Aboriginal and Torres Strait Islanders and those who are socioeconomically disadvantaged. The Corporate Plan and Divisional strategic planning documents also identify several priority populations in relation to the reduction of inequities, including people with a disability, women, men, and children and youth. The 1996 Budget also identified the health of rural and remote people as a public health priority.

Population groups identified by age and/or sex are almost universally identified in health data collections (with the notable exception of some major collections such as the Pharmaceutical Benefits Scheme). Substantial efforts have been made to identify Aboriginal and Torres Strait Islander peoples in national health data collections, although the quality of much of this data is as yet inadequate to allow its use. However, it is not simple or straightforward to identify people with disabilities in health data collections. Pilot attempts by the Australian Bureau of Statistics to include a one to two questions identifying such people in the national census demonstrated that such data were of poor quality. Additionally, apart from data relating to access to health services, identification of disabled people in health data collections will be of limited use in addressing equity issues. For these reasons, disabled people have not been identified as a priority population group here.

Overseas-born Australians, particularly those of non-English-speaking background, are often included as a priority population, although their health is generally better than that of the Australian-born population. However, there are specific priority areas and aspects of lifestyle where there is a need to have information on Australians from particular ethnic backgrounds. In addition, there is additional concern about the access of Australians whose first language is not English to services and to health promotion information. For these reasons, ethnicity has been included in the following minimum list of priority populations:

- Aboriginal and Torres Strait Islander peoples;
- Overseas-born Australians;
- Socioeconomically disadvantaged Australians; and
- Geographic subgroups, particularly rural and remote populations.

Although the focus of this report is on national health information, the level of geographic

identification in data collections is relevant to assessing the usefulness of data to monitor socioeconomic disadvantage (for which small area may be the only feasible proxy) and regional differentials (rural and remote populations).

3.6 Public health information needs in the context of the framework

The health dimensions discussed above may be put together with the priority populations and a list of nationally identified priorities for public health action (eg. diabetes, HIV/AIDS etc) to form a comprehensive framework for discussion of data needs and gaps as shown in Figure 3. The priorities of the Public Health Division for national public health action are summarised in Section 4, which analyses the core business and information needs of the Division in terms of the framework developed here.





4. The information needs of Public Health Division

This Section examines the Division's future operational and strategic information needs starting from a review of the Program Budget Statements, the key result areas for Public Health Division outlined in the 1996 Corporate Plan, and Divisional strategic planning documents. The Division's information needs are summarised in terms of the conceptual framework outlined in Section 3 and existing statistical activities mapped against needs to identify gaps in information requirements.

4.1 Objectives of the Public Health Division

The Program Budget Statement identifies the objective and goals of Program 1.1 (Public Health Development and Programs) as:

Objective

Strong national public health capacity and effective national leadership in a more federal public health environment.

Goals

- Better health outcomes for population groups in agreed priority areas.
- Improved access to a range of preventive and primary health care services.
- A national and cooperative approach to public health effort in Australia.
- Strengthened infrastructure to support effective national public health action.
- Recognition of public health as an essential national activity integral to the best use of our wider health and community services system.
- Strong partnerships with other sectors which have an important public health contribution in priority areas, eg. transport, environment, employment and education, housing and primary industry.
- A population which is better informed about public health risks, disease prevention and management, and opportunities for better health throughout life.
- High quality advice to government on national needs and priorities, related action plans and on specific public health issues.

The key strategies for achieving these goals are listed below. Those with particular implications for the planning of information needs for the Division are italicised.

Strategies

- In partnership with the States, Territories and other stakeholders:
 - develop and implement a national public health framework for all health promotion, protection and disease prevention and control activities in Australia;
 - build and maintain a strong infrastructure to support national public action, including the health workforce, primary health care system, legislative framework, research and development, information base and continuous improvement programme; and
 - extend and apply a population health framework to the whole of health system planning and financing.
- Co-ordinate developing and implementing national public health strategies in agreed priority areas, and which involve other levels of government, non-government organisations, relevant sectors and industry, and consumer groups (as appropriate). Priority areas include:
 - diabetes;
 - AIDS and other communicable diseases;
 - women's health, including breast and cervical cancer;
 - nutrition;
 - injury prevention; and
 - drugs.
- Establish effective mechanisms to ensure intersectoral action in agreed priority areas at the national level.
- Build and maintain an evidence-based national public health policy and planning capacity to guide future investment in national interventions by Australian governments and other stakeholder groups.
- Involve the Australian community in planning, implementing, monitoring and reporting on national public health action.
- Together with States, Territories and other stakeholders, develop and implement effective strategies to increase public awareness of public health risks and the benefits of disease prevention and management to government and the community.
- Monitor and report to government and the community on progress of national public health strategies against key health outcome measures and performance indicators.
- Provide timely and accurate advice to government on public health issues, priorities, action and outcomes.

The Program Budget Statement identifies the following Performance Indicators and Targets for Program 1.1:

Performance Indicators and Targets

<u>Effectiveness</u>

• Incidence, prevalence and mortality rates attributable to specific diseases, injuries,

environmental hazards and licit and illicit drug use including a comparative analysis of specified target groups.

- Qualitative evidence from key stakeholders and the Australian community that major public health infrastructure initiatives:
 - meet the needs of key target groups; and
 - have a positive impact on improving public health planning, delivery and monitoring/reporting.
- Multi-lateral and bilateral National Public Health Agreements/Memoranda of Understanding negotiated and signed with all States and Territories.

Target: All states signed up to National Public Health agreements by scheduled dates.

- National public health strategies under way in agreed priority areas.
- Evaluative evidence of change in knowledge, attitudes, skills and behaviours of specific target groups as a consequence of health promotion and disease prevention strategies.
- The adaption and effective use of nationally recommended screening and immunisation policies, best practice guidelines and targets.

Target:

70 per cent participation among women aged 50 to 69 in breast screening, and 80 per cent participation among women aged 16 to 69 in cervical screening, by 1999.

<u>Efficiency</u>

- Per cent and number of activities/initiatives/milestones completed on time and within budget.
- Extent of savings to the Australian health system and Australian society attributable to nationally coordinated health promotion and prevention strategies as measured by case examples.

<u>Quality</u>

• Information from key stakeholders that the Commonwealth's inputs have been of high standard, timely, relevant and contributed to effective results and responses.

<u>Equity</u>

• Per cent and number of public health services and interventions accessed by specified target groups, including Aboriginal and Torres Strait Islanders, and people with a disability compared with the general population, adjusted for differences in need.

If these strategies and performance indicators are to be seriously addressed, they have a number of important implications for population information requirements. These are summarised in Section 4.4. We first examine the core business of the Division in order to

identify national priority areas for public health and to examine in more detail the types of statistical information required by the Division.

4.2 The core business of Public Health Division

The Mission of the Public Health Division is stated as:

"In partnership with stakeholders the Public Health Division will lead a national approach to public health effort aimed at improving and protecting Australia's health."

In carrying out this Mission, the Division is committed to the following core values:

- social justice and equity in public health outcomes;
- a population approach to health as a cost-effective means to achieve better health outcomes;
- the contribution of a range of disciplines to effective public health outcomes; and
- evidence-based approaches to interventions.

Under the Partnership, the Division has proposed that its core roles are to:

- facilitate the development of national public health policy in consultation with government, non-government, professional and community organisations;
- advocate at the national level for public health and build and strengthen a population health constituency with key players and with the public;
- facilitate ongoing negotiation and agreement between governments on national policy, planning, monitoring, reporting, programs, research, training and evaluation;
- facilitate the development of national consistency in areas where there is agreement that this is needed (eg. policy standards, legislation and regulation, workforce competencies, environmental protection, disease prevention and outbreak control methods);
- initiate and initially finance innovation in population health programs, in conjunction with states and territories;
- conduct national programs, in coordinated fashion with states and territories, where the need is agreed;
- monitor, evaluate and report on the performance of national public health strategies and programs, in collaboration with states and territories; and
- conduct, in consultation with other partners, Australia's international responsibilities and obligations in public health.

Following its restructuring in October 1996, the Public Health Division consists of three Branches and a Business Unit as shown in Figure 4. The core activities of the three Branches are outlined below.

4.2.1 National Centre for Disease Control (NCDC)

The core activities of this Branch relate to two main disease groupings - communicable/infectious and cancer. Major national strategies either in place or being developed by the National Centre for Disease Control include:

- Third National HIV/AIDS Strategy
- National Hepatitis C Action Plan
- National Childhood Immunization Program
- National Communicable Diseases Surveillance Strategy
- BreastScreen Australia
- National Cervical Screening Program.

Public Health Education Unit

Almost all major national strategies have an education component and so the Public Health Education Unit is located in the National Centre for Disease Control. The education component of national strategies for the Division is aimed at:

- priority population groups in the community; and
- health professionals.

Strategies Section

The Strategies Section is responsible for the development and management of national policies and programs for:

- HIV/AIDS
- Hepatitis C
- Immunization
- International activities
- Pituitary hormones.

National Cancer Prevention and Control Unit

The National Cancer Prevention and Control Unit is responsible for the:

- National coordination and monitoring of breast and cervical screening programs; and
- Development of National Cancer Control Plan

Surveillance and Management Section

The Surveillance and Management Section is responsible for:

- National communicable disease surveillance
- Epidemiology and technical support
- Publication of the Communicable Diseases Intelligence bulletin



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- Policy and management in response to communicable diseases of public health significance
- Communicable Diseases Network Australia and New Zealand coordination.

4.2.2 National Health Promotion and Protection Branch

The National Health Promotion and Protection Branch coordinates and monitors national public health strategies aimed at priority population groups, risk factors and specific diseases. Areas of activity include:

- Gender based and sexual health strategies
- Sexual and reproductive health
- Maternal and child health
- Tobacco, alcohol, illicit drugs.

Environmental health policy, injury and violence, and national food and nutrition policy, are also handled by the Branch.

Healthy Public Policy Unit

The Healthy Public Policy Unit focuses on policies and activities which target high risk conditions in such areas as the environment, housing, education and transport. The unit will focus on:

- National Environmental Health Strategy
- National Food and Nutrition Strategy
- National Injury Prevention Strategy
- Healthy public policy in national health priority areas, eg. violence, injury.

Public Health Litigation Section

The Public Health Litigation Section is responsible for the management of all major, active litigation arising in the Public Health Division.

Population Health Strategies Section

The Population Health Strategies Section is responsible for:

- Gender based population health strategies
- Sexual and reproductive health strategies
- Child and youth health strategies
- Migrant health
- Disease specific national health priorities such as diabetes

Tobacco and Alcohol Strategies Section

The Tobacco and Alcohol Strategies Section is responsible for:

- Administration of the Tobacco Advertising Prohibition Act 1992
- National Alcohol Strategic Plan
- Misuse of illicit drugs and steroids
- Aboriginal and Torres Strait Islander people substance abuse
- International drug policy activities.

Illicit Drug Strategies Section

The Illicit Drug Strategies Section is responsible for:

- Management of the Ministerial Council on Drug Strategy
- Implementation of the National Drud Strategy
- Policy advice on illicit drugs
- Administration of the National Drug Crime Prevention Fund (until transferred to Attorney General's Department).

4.2.3 National Public Health Policy and Planning Branch

The National Public Health Policy and Planning Branch is developing and coordinating a national public health policy and framework for Australia, in conjunction with the States and Territories and NGOs. Primary responsibilities include the development of the National Public Health Partnership and Agreements, and supporting a nationally agreed work programme to strengthen public health capacity in Australia. Areas of activity include:

- Research and development
- Quality and standards
- Public health information.

Public Health Policy and Planning Section

The Public Health Policy and Planning Section is responsible for:

- Public health partnership
- Public health agreements
- Broad banding
- COAG liaison
- Framework for agreement of national priorities, strategies and emerging issues
- Chief Health Officers' secretariat
- Funding mechanisms and resource allocation for public health
- Agreements funding formula development.

Infrastructure Development Section

The Infrastructure Development Section is responsible for:

- Workforce development
- Research and development
- Standard setting, Quality assurance and best practice
- Information development and systems
- Information reporting and analysis
- Divisional information warehouse
- Public health information tools and products.

Change Management Team

The Change Management Team is responsible for:

- Strategic direction, culture change and work practices for the Division
- Long-term divisional staffing strategy
- Staff training and development planning
- Documentation of division's core business and related processes.

Public Health Legal Policy Section

The Public Health Legal Policy Section is responsible for:

- Major review of public health law (modernisation and harmonisation)
- Legal training and Executive support.

Evaluation Unit

The Evaluation Unit is responsible for:

- Monitoring and reporting on the effectiveness of the national public health policy framework
- Performance measurement, indicator development and reporting
- Development of integrated evaluation framework for the division, linking evaluation activity with planning, program management and account ability functions
- National strategies and nation programme evaluations.

Aboriginal and Torres Strait Islander Task Force (from 20/11/96)

The Aboriginal and Torres Strait Islander Task Force will be responsible for:

- Development of the indigenous Sexual Health strategy
- Development of an effective and integrated approach to the public health response on ATSI issues across the Division.

4.2.4 National Public Health Priority areas

The Corporate Plan and Divisional strategic planning documents identify a number of national priorities for public health. Many of these areas have had National Strategies or Plans implemented or are under development. In addition, AHMAC has identified five National Health Priority Areas (NHPA), for which Public Health Division is the lead agency for three (asterisked) within the Department. Priority populations can also be seen as priority areas for public health. However, the approach taken by the conceptual framework for public health information is to treat priority populations as a separate dimension, in order to ensure that information requirements for priority populations are addressed in relation to all disease/risk factor based priority areas. It may be that, in practice, that national public health strategies are organised in relation to priority areas or priority populations. The identified priority populations for Public Health Division are also listed below.

Priority Areas

Disease/injury

- Communicable diseases (Draft National Strategy)
- HIV/AIDS (National Strategy)
- Cancers * (NHPA)
- Mental health (NHPA)
- Diabetes * (NHPA)
- Cardiovascular disease (NHPA)
- Maternal and infant health (several budget initiatives)
- Injury prevention and control * (NHPA)

• Determinants of health

- Tobacco (Health Australia priority)
- Alcohol (National Campaign)
- Illicit drugs (National Campaign)
- Nutrition (National Nutrition Policy)
- Physical activity and fitness (Proposed national strategy)
- Sexual and reproductive health
- Environmental health

• Public health interventions

- Childhood immunisation
- Breast and cervical cancer screening

Priority populations

- Aboriginal and Torres Strait Islander peoples
- Overseas-born Australians
- Socioeconomically disadvantaged Australians
- Geographic subgroups, particularly rural and remote populations
- Women
- Men
- Children and youth
- Disabled people

Aboriginal and Torres Strait Islander peoples, overseas-born Australians, and those who are socioeconomically disadvantaged are those most commonly identified as disadvantaged in relation to public health. In addition, the 1996 Budget identified the health of rural and remote people as a public health priority. The Corporate Plan and Divisional strategic planning documents also identify several priority populations in relation to the reduction of inequities, including people with a disability, women, men, and children and youth.

Other areas of national public health importance which may potentially become priority areas for the Public Health Division include dental health, asthma and osteoporosis.

Each priority area can be considered in relation to the data categories defined in the previous section and in relation to priority populations. Thus for example, in relation to tobacco smoking, there will be relevant data on health (tobacco-caused morbidity and mortality), behaviour (smoking prevalence etc.), enabling factors (knowledge of smoking risk, prevalence of smoke-free environments) and public health activities (e.g. expenditure on education about the adverse effects of smoking, smoking cessation programs).

As discussed in Section 3, statistical information relevant to the national public health effort involves the ongoing systematic collection, analysis and interpretation of national, or quasinational population-related data, which is collected repeatedly over time. The Division requires such statistical information for the following purposes:

- surveillance;
- monitoring and evaluation;
- performance indicators;
- program management and reporting;
- measuring health outcomes (attributable health gain); and
- input to priority setting processes.

Population information requirements of the Division are examined below in relation to each of these needs, with particular attention to the adequacy of currently available statistical information, and the important gaps and deficiencies that need to be addressed. The final part of this section examines the information requirements along the second dimension of the framework, in terms of priority populations.

4.3 Information needs for surveillance

Surveillance data are comprehensive health status and health determinants data used for monitoring trends or distributions as a 'warning system' for identifying emerging health issues which may need to be addressed by public health activities and as an input for setting priorities, strategies and interventions for public health activities. Surveillance indicators will tend to be fairly stable and reported over long-term periods.

To address these objectives, surveillance data must cover the whole spectrum of diseases and determinants of health in a systematic population health framework. Such data should include incidence, prevalence and mortality rates attributable to specific diseases, injuries, risk factors and other health determinants, and include the ability to compare rates across priority populations.

It is recommended in the following Section, that AIHW be commissioned by the Division to provide systematic surveillance of health status and the determinants of health in accordance with the framework shown in Figure 3. The existing mortality and cancer surveillance subprograms provide a starting point for this. It will be important to identify priority populations systematically in the surveillance data so that views of the data can be taken for surveillance of equity differentials without the need for one-off analyses requiring substantial extra resourcing.

Health status

The current Divisional activities addressing the surveillance of health status are:

- Communicable disease surveillance systems and reporting
- HIV/AIDS National Registry
- Creutzfeld-Jakob Disease Case Registry
- National Injury Surveillance Unit additional funding
- Drug caused deaths
- HealthWIZ
- National Social Health Atlas.

Other major sources of national health status data include legal/administrative data collections (deaths, perinatal data collections, hospital inpatient data), population surveys and disease registers.

The Australian Bureau of Statistics has taken steps to improve the timeliness of national mortality data, and this is now available for a registration year in October of the following year. However, this still means that surveillance reports based on registration year are not generally available until two years later. Steps are also being taken by coroners to develop a National Coronial Information System which will improve the timeliness of coronial information on cause of death, a current cause of considerable delay for injury deaths. However, consideration should be given to ways in which the timeliness of mortality data for broad population surveillance could be further improved, for example, by releasing a ten percent sample of death registrations within three months of the end of the calendar

year in which the deaths occurred.

Hospital inpatient episode data have been used as a proxy for the incidence of serious morbidity. These data have serious limitations relating to the current inability to identify multiple admissions for a single illness episode (this is being addressed in several States and Territories through the introduction of unique patient identifiers and record linkage) and to its sensitivity to the supply of inpatient services, to variations in the institutional arrangements for acute care and in admission policies.

While mortality and hospitalisation data provide useful information on aspects of many diseases, they are of little use in measuring the burden of chronic conditions with low fatality and comparatively infrequent need for hospitalisation but major impact on wellbeing. Examples of such conditions include asthma, diabetes, musculoskeletal conditions, dental conditions and hearing loss. There is currently little or no ongoing collection of data for surveillance of these and a number of other important chronic conditions.

The major national disease registers outside the Division cover cancer and congenital malformations. Each State and Territory has a register of all cancer cases which have been compiled into a national register by the Cancer Statistics Clearing House at the AIHW. This national register covers all cases diagnosed in Australia since 1982. There are considerable time lags for the compilation of national information from most disease registers. For example, the latest available published national cancer incidence data (at the time of writing in early November 1996) relates to 1992. It is essential that time lags be further reduced in the compilation of national data from disease registers.

The AIHW National Injury Surveillance Unit is responsible for collating information about injuries at a national level and the AIHW Dental Statistics and Research Unit is responsible for collating national dental health statistics. Funding for this survey was withdrawn following the cessation of the National Dental Health Program in the 1996 budget.

Cardiovascular disease remains the biggest killer of Australians and a major consumer of health resources. Although there have been some studies of incidence for specific populations (Boyle and Dobson 1995), the lack of national information on the incidence of cardiovascular disease limits Australia's capacity to make national decisions in relation to its prevention and treatment. AHMAC has endorsed the establishment of a national monitoring system as an urgent priority, and the Department of Human Services and Health has funded the AIHW to establish a National Centre for the Coordination of Cardiovascular Disease Monitoring. A major objective of this Centre will be to undertake cardiovascular disease monitoring, with specific attention to developing methods for the population surveillance of the incidence of myocardial infarction and stroke.

There are currently no national data on the incidence, prevalence and consequences of mental illness and outcomes of its care. The proposed National Mental Health Survey will provide baseline data on incidence and prevalence of mental illness. However, it is a one-off survey which will provide little information on outcomes of care and no continuing surveillance information. Apart from the national disease registers discussed above, there are few population level sources for disease incidence data. In particular, there are no incidence data for the surveillance of diabetes, the latest national health priority area.

Disease prevalence data are generally limited to that collected by self-report in population surveys. Such data are usually limited by the lack of information on severity and by its lack of relatability to clinical diagnosis categories, as well as by reporting biases. The inclusion of the SF-36 instrument in the 1995 National Health Survey is a step towards the collection of information on the severity and consequences of illness conditions in the population. The major surveys relevant for health surveillance are the Australian Bureau of Statistics' National Health surveys, and the ABS Survey of Disability, Ageing and Carers. The National Health Survey recurs every five years. This period is too long for their effective use for public health surveillance in many cases and it would be worth examining in conjunction with the Australian Bureau of Statistics and AIHW the pros and cons of different approaches to the collection of national health survey data. This is discussed further below.

Determinants of health

The current Divisional activities addressing the surveillance of health determinants are:

- National Nutrition Survey
- Drugs household survey series
- Illicit Drug Reporting System
- Project Male Call
- Schools Survey (Sexual risk behaviours)
- Needle and Syringe Exchange Survey
- Sydney Men and Sexual Health Survey
- HealthWIZ
- National Social Health Atlas.

Other major national data collections relating to surveillance of health determinants include the Australian Bureau of Statistics' National Health Survey, a number of surveys relating to smoking, the Australian Market Basket Survey conducted by the National Food Authority and the Australian Bureau of Statistics' social and economic indicator series.

Biological and nutritional risk factors

Ongoing national collections, such as the National Health Survey, do not cover all major risk factors (eg. blood pressure and blood cholesterol concentration are not measured). Moreover, few national collections are representative of the whole population; include sufficient numbers of people from priority populations (eg. Aboriginals and Torres Strait Islanders, people of non-English speaking background); use nationally agreed data collection instruments; include routine validation of subjects' self-reports; and include biological measurements where they are the most accurate and cost-effective measures. These are all important characteristics if the national data collected are to be accurate, comparable across time, and able to address major health policy needs.

Important biological and nutritional risk factors for surveillance include food, alcohol and tobacco consumption patterns, nutrient status, body weight and composition, exercise patterns, blood pressure and serum cholesterol. The National Heart Foundation surveys, which have measured some of these factors, did not include rural areas or cover risk factors in the young or elderly. That survey program does not have committed funding and a further survey is not planned at this stage.

Anthropometric measurements and blood pressure were collected as part of the nutrition component of the 1995 National Health and Nutrition Survey. Blood sampling was not included in this survey, which is unlikely to be repeated for at least ten years. It is recommended in Section 6.6.2 that national needs for population blood measurements be examined by AIHW.

It is impractical to collect nutrition intake data sufficiently often at sufficient detail for it to be the sole source basis of nutrition surveillance. Instead, food expenditure patterns may be used as a proxy for food intake under certain conditions and assumptions. However, more specific information on food expenditure is needed for it to be used in this way. Additionally, information on food expenditure is required to address issues of equity of access to healthy food.

Social and economic environmental risk factors

Better information on the relationships between socioeconomic status, health and use of health services, including public health interventions, will improve targeting of programs to reduce health inequalities and facilitate evaluation of their effects. Such information may not need to be collected at national or State or Territory level for monitoring or surveillance purposes. Further research is needed to identify whether there are key social and economic indicators for which it would be appropriate to conduct population surveillance as an early warning system for adverse trends. Candidates for such indicators could include family income, employment status, quality of housing, or presence and degree of overcrowding. Surveillance of some such indicators may be important for some priority populations, such as Aboriginal and Torres Strait Islander people, but not for the whole population.

If there are social indicators relevant to health that are identified as appropriate for monitoring and/or surveillance at population level, it would be desirable to have a nationally agreed minimum set of indicators, standards and instruments for use in administrative collections and population surveys relevant to health promotion monitoring and surveillance at the national and State or Territory level.

A key aspect of the economic environment is the workplace. Data collected by Worksafe Australia are mainly drawn from workers compensation statistics. These data provide little information about broader aspects of occupational health. In particular, they do not throw light on the gradients in health between different groups of workers. Data should be developed which allow examination of the social and cultural aspects of work experience, rather than just the injuries and illnesses which are directly attributable to occupational exposures and workplace settings. The development of such data could be linked to more general public health strategies, such as those relating to women's and men's health.

Physical environment

There are no direct measures of the physical environment such as air and water quality. Such measures are commonly recorded by State and Territory or local government authorities but are not collected in a standardised fashion nor aggregated nationally to produce relevant national surveillance indicators. There are environmental measures which relate to specific settings such as radiation exposure in the workplace and the home. Needs for environmental health surveillance and monitoring data are discussed below.

The physical environment has been largely neglected in the development of national health information. With global population growth and increasing industrialisation, the risks to population health of environmental change will grow. It is important that national summary information be developed on aspects of the environment relevant to health both for surveillance and monitoring purposes as part of the core and detailed sets of public health indicators which should be developed and monitored under the National Public Health Partnership.

Public health issues relating to global environmental change include:

effects of log-term climatic change in Australia; skin and eye damage from increased ultraviolet radiation exposure; increased incidence of some respiratory diseases; vector-borne and water born diseases; and, the social and physical effects of natural hazards and social and economic restructuring.

Other public health issues associated with radiation include:

Australian UVR climatology and its change with global environmental change; extremely low frequency electromagnetic fields and their health consequences; background levels of ionising radiation and the additional potential for environmental exposure resulting from mining and industrial activity.

There is evidence of significant links between poor air quality and illness in cities. National information on air quality is needed to guide policy on control measures to improve air quality. Public health issues relating to air quality include:

indoor air pollution with tobacco smoke, its extent and control in public places and contribution to ill health; radon concentrations in indoor air and their contribution, if any, to lung cancer rates; exposure to spike levels of NO_2 in Australian children from gas appliances in classrooms and homes and their consequences for respiratory health; and, chemical pollution of outdoor air, as with nitrogen dioxide, sulphur dioxide, polycyclic hydrocarbons, benzene, ozone, particulates (including asbestos fibres), and its contributions to disease.

The evidence for links between water quality and health in Australia is less clear. However, many Australian water supplies do not meet the World Health Organization drinking water quality guidelines and there are concerns that the massive expenditures required to meet these guidelines may not be justified by any resulting benefits to health. National information

on water quality is required to study associations between it and disease in Australia and to provide information to assist in decisions about the need for additional water treatment. Public health issues relating to water quality include:

the quality of Aboriginal water supplies; diseases caused by blue-green algae; the association between disinfection by-products and bladder and bower cancer; the role of salinity, water hardness, and magnesium on the development of cardiovascular disease; aluminium in water and Alzheimer's disease; pollution around ocean beaches and respiratory, ear, and eye symptoms; means of disposal of sewage and their contribution to microbial pollution of water; the contribution of low-level microbial pollution of water supplies (for example, with Cryptosporidium and Giardia) to gastro-intestinal illness in the community; and the balance of costs and benefits in implementing stricter water quality guidelines.

The safety of the food supply is an issue of great public importance, as has been highlighted by recent cases of microbiological and chemical contamination of meat. National monitoring of food composition and contamination will enable the ongoing effectiveness of food safety measures to be assessed and where necessary improved. It will also provide important exposure information for assessing the health consequences of food contamination and other compositional changes arising in the course of production and processing. National monitoring of food composition and contamination, and overall coordination of food safety measures are the responsibility of the National Food Authority. It would be useful, however, to identify some key national indicators for monitoring progress towards a safe food supply and to report on these as part of the national nutrition monitoring system (see recommendations in Section 6).

Research and development are needed to identify priority issues in the relationship between the physical and chemical environment and health, to identify a minimum set of key indicators which should be monitored at the national level. This is discussed further in Section 6.1.13.

4.4 Information needs for monitoring/evaluation

Monitoring data relate to health, its determinants and to process measures which together provide a set of indicators summarising progress towards the building of a healthy society in relation to areas addressed by public health strategies.

Data relevant for monitoring and evaluation will include health data and data on the determinants of health, though in many cases the timelags between public health interventions and ultimate health gains will be too long for the latter data to be useful indicators of progress. More importantly, such data will also include process indicators for public health activities which provide summary measures of progress towards a healthier society. Such indicators will relate to determinants of health and to health literacy and skills and healthy environments. They will relate closely to broad national public health priorities and strategies and need to be reviewed as strategies reach plateau levels of success and new strategies are developed. Thus indicators for monitoring and evaluation will not span all

aspects of health, but will be focused on the national public health priority areas and populations.

An indicator used for monitoring must be a statistic which is directly related to, and which facilitates concise, comprehensive and balanced judgments about, the condition of a major aspect of health, the determinants of health, or progress towards a healthy society. It should in all cases be subject to the interpretation that, if it changes in the 'right' direction, while other things remain equal, things have improved, or people are 'better off'. Thus indicators of health status are always useable as monitoring indicators, whereas input and output indicators should only be used as monitoring indicators if there is also a body of knowledge (the scientific bases of public health practice) that identifies a clear link between the input or output indicator and improvements in outcomes.

Health Status and Health Determinants

Monitoring data should include key health outcome measures (both for health status and health determinants) and provide a basis for 'confirmatory analyses' to highlight changes in population health status or risk following public health promotion interventions. They should enable the measurement of health gain and, to address the Program performance indicators, to identify attributable savings to the health system and society (at least on a case example basis). Global measures of health gain are discussed in more detail in Section 4.6.

The current Divisional activities addressing monitoring of health knowledge, attitude and beliefs are:

- Communicable disease surveillance systems and reporting
- HIV/AIDS National Registry
- Creutzfeld Jakob Disease Case Registry
- National Injury Surveillance Unit additional funding
- Drug caused deaths
- National Nutrition Survey
- Drugs household survey series
- Illicit drug reporting system
- Project Male Call
- Schools Surveys (Drugs and Sexual risk behaviours)
- Needle and Syringe Exchange Survey
- Sydney Men and Sexual Health Survey.

The areas best covered by current national data collections are health and determinants of health. These collections focus on ill-health (rather than health and wellbeing) and are mainly concerned with disease and risk factor measures which are well understood and easily measured. There has been increasing recent use of health and wellbeing measures such as the SF36 questionnaire, so future health data collections should have better coverage of this area.

The significant gaps and deficiencies in monitoring/evaluation data relating to health status and health determinants have been reviewed in the previous Section in relation to surveillance. The major gaps in monitoring data for the Division relate to data on health knowledge and beliefs, health-promotive environments, and the impact of public health interventions.

Health knowledge, attitudes and beliefs

The Program Performance indicators include evaluative indicators of change in the knowledge, attitudes and beliefs of specific target groups and indicators of achievement of best practice guidelines and targets for public health priorities.

The current Divisional activities addressing monitoring of health knowledge, attitudes and beliefs are:

- Drugs household survey series
- Project Male Call
- Schools Surveys (Drugs and Sexual risk behaviours)
- Sydney Men and Sexual Health Survey.

Though there are many aspects of health knowledge, attitudes and beliefs for which research is important to assist in developing public health interventions and improving their effectiveness, little work has been done to identify key aspects of health knowledge, attitudes and beliefs which could be used as indicators for monitoring progress at the population level. Nutbeam et al (1993) suggested a number of such indicators but further research is needed to validate such indicators as measuring key attributes causally associated with behaviour change and health gain, so that they may be used as valid process indicators of progress towards a healthier society.

Health-promotive environments

Monitoring is of particular importance for healthy public policy and health promotive environments, since they are not under the full control of the health sector and can show quite adverse trends that may demand a corrective 'lobbying' response from the public health sector. No current Divisional activities address monitoring of health-promotive environments.

Health promotive environments are at the forefront of public health practice (Health Advancement Standing Committee 1996); a concerted effort is required to measure the extent of their establishment and maintenance in Australia. To this end, work is needed to identify a key minimum set of indicators for monitoring at population level, which provide a measure of progress towards health promotive environments.

Healthy public policy

Influencing public policy is a key strategy for health control and promotion. The National Health Information Development Plan recommended the establishment of an ongoing inventory of public policy, regulations and legislation aimed at creating environments that are conducive to the improvement and maintenance of health and the extent of

implementation of such policies, including policies in relation to catastrophes, disasters, road crashes, etc. From such an inventory, it would be useful to identify a key minimum set of indicators for monitoring progress towards healthy public policy at a population level under the Partnership. Some of these indicators may also be relevant performance indicators for the bilateral agreements.

No current Divisional activities address monitoring of healthy public policy, although some Divisional strategies address this area (notably in the tobacco, alcohol and illicit drugs area) and it is intended that healthy public policy will be a focus of national strategies relating to nutrition, injury and environmental health.

Public health interventions

There is very little information available at the national level on public health programs which are not nationally co-ordinated and delivered. The development of a nationally agreed classification of public health programs will be a critical first step towards the development and collection of standardised information on the provision and use of health promotion services by the general population and priority populations.

The current Divisional activities addressing monitoring of public health interventions:

- National Childhood Immunization Register
- Human Pituitary Hormone Patient Database
- Human Pituitary Hormone Counselling Service Database
- Breastscreen Australia Performance Measures
- National Cervical Screening Program Performance Measures
- Women's health services national evaluation data
- Family Planning Program Annual Reporting
- Cardiopulmonary Resuscitation surveys
- Census of clients of drug treatment services
- Clients of Methadone treatment Programs Register
- NDS Cost Shared Program activity Indicators.

Data on expenditure on public health programs are needed at two levels. First, any evaluation of a public health program must collect expenditure data as an important component of the costs of the program. Evaluation requires comparison of the costs of a program with the benefits. Evaluations which show a positive ratio of benefits to costs can be used to argue for greater funding for such programs. These data are fairly easily collected and are required by standard protocols for evaluation.

Second, information on total monetary expenditure in the public health area is needed in evaluating whether the macro priorities for health expenditure are appropriate. These data are more difficult to collect because of disagreement as to what constitutes public health and because of the difficulty of attributing expenditure in health programs that deliver public health services as part of a wider range of services (eg. primary health care providers).

Work is being done under the National Health Information Agreement to standardise

definitions for health expenditure. As part of this National Health Information Agreement project a new category of 'Public Health Services' has been included in the Australian Bureau of Statistics Government purpose classification for Government finance statistics. This category covers designated public health programs but does not cover public health activity in other programs such as community health. Health authorities are required to comply with these definitions under Treasury guidelines. It is expected that reasonably accurate information will be supplied under this definition from financial year 1996-97. Additionally, a consultancy has beeb let to obtain a more detailed analysis of expenditure on public health activities by program area for Australia. The AIHW is collaborating with the National Centre for Health Program Evaluation in Melbourne in carrying out this consultancy.

Some states have indicated that they want the detailed methodology and definitions that are being produced by the National Centre for Health Program Evaluation consultancy included in the National Health Data Dictionary, so that there can be an on-going standardised collection of health information on public health activity expenditure.

Survey collection of monitoring and surveillance data

Information on health and health determinants for the population needs to be updated at regular intervals for monitoring and surveillance purposes. The conduct of periodic, large and complex surveys may not be the most effective approach for a number of reasons:

- Major periodic surveys are not usually able to cover adequately all topics of interest.
 A continuous program of data collection enables better coverage of specific topics while maintaining respondent burden at an acceptable level.
- Specific information needs change over time. A continuous data collection schedule increases the ability to respond to changing needs in an appropriate and timely manner while maintaining comparability of core data items.
- A single nationally representative survey sample is usually unable to provide data on most priority population sub-groups. A continuous program of data collection enables specific population sub-groups to be targeted until an adequate sample had been achieved while ensuring comparability of survey procedures between groups.
- In order to monitor trends over time, eg. progress towards national health goals and targets, it is important that the information collected is comparable over time. A continuous program of data collection facilitates this comparability.
- A considerable amount of time and effort is needed to set up the basic infrastructure required for carrying out health and risk factor surveys. A continuous program of data collection would minimise start-up and development costs, and maximise the retention of expertise and consistency of data quality.

A program of continuous data collection, with the possibility of a longitudinal component, has been adopted in some countries and it may be time to examine the efficacy of such an approach in the Australian context to address the national surveillance and monitoring needs of the Public Health Division and the National Public Health Partnership. The benefits of establishing a continuous national health and risk factor surveillance system should be weighed against potential disadvantages.

Disadvantages include the need to aggregate samples over longer periods of time for priority populations and State or Territory populations. This means that data would represent a recent years average rather than a point in time snapshot and there would be increased potential for comparisons between States, for example, to be confounded by regional interventions over an extended data collection period.

Other sources of data besides health surveys should also be explored for the collection of health and risk factor data such as, for example, sentinel practice networks and the routine collection of data during consultations with general practitioners or other health professionals.

4.5 Performance indicators and program management information needs

Performance indicators are a particular class of monitoring/evaluation data required for monitoring of public health activity under the bilateral Commonwealth-State public health agreements. Such indicators will need to rapidly reflect activities occurring on a short time scale of one to two years and hence will tend to be predominantly process indicators, with perhaps some enabling factors and health determinants, but generally less likely to include health status indicators.

Performance indicators will include process measures relating to former Special Purpose Payments, and could include needs adjusted public health service utilisation measures as proposed in the Program Budget Statement. Issues relating to process indicators for public health have been discussed above in Section 4.4 in relation to monitoring and evaluation.

Where the Division has responsibility for managing national public health programs, it will require program management, performance and quality control information. Such information will include dollars spent, outputs delivered, and in some cases outcome or quality control information, and will be used for program management, monitoring of contractual obligations, and annual reporting.

In implementing national public health programs, the Division will be following an evidencebased process to identify best public health practice in order to ensure that programs are cost-effective and result in health gain. In many areas of public health, evidence of effectiveness and cost-effectiveness has not been well documented or involves assumptions that results achieved in a specific population transfer to other populations. It will be important to systematically gather knowledge about what works in practice through the specification of appropriate and purposeful performance indicators for national public health programs which will assist in a continuing evaluation cycle.

4.6 Information needs for measuring health outcomes

Health outcomes are defined as the health gain that is attributable to the health intervention of interest. In order to measure changes in health status in a way that enables us to monitor health gain, to compare health outcomes for different priority areas or to compare outcomes for priority populations, we require population health measures which combine the contribution to overall health gain from mortality and non-fatal ill-health states using a single metric. Ultimately, it is necessary to be able to define and measure progress, as a nation, toward the achievement of improvements in the health of the population.

Combining a set of health scores on a number of dimensions into a single health index presents considerable methodological problems. Recent attempts to develop population indicators which combine mortality and morbidity components of the health of a population into a single measure include various indicators which use the quality adjusted life year (QALY) as a metric for health states. The quality adjusted life year (QALY) attempts to provide a measure of an individual's health status, relative to being in a state of excellent health.

For example, people asked to value health states have put the same value on being blind for one year as living 38% of a year in excellent health (Murray and Lopez 1996). A year of blindness has therefore a value of about 0.38 Quality Adjusted Life Years (QALYs). A public health program which prevents blindness therefore adds 0.62 QALYs per person per year.

There are a number ways of ascertaining from people the value weights for different illness conditions, and there is much debate about the appropriate methodology to do this. However the QALY methodologies are simply a way of converting the multidimensional data that come from measuring all aspects of health status to a one-dimensional number. Some people confuse QALYs with the non-medical dimensions of health status, others with specific health outcome indicators or population health indicators. The QALY is a timebased measure of health status which can be used for measuring health outcomes in clinical trials, or as a metric for indicators of population health. These latter include health-adjusted life expectancies and burden of disease indicators (eg. disability-adjusted life years)

Another possible single metric is the dollar, and economic approaches to measuring the burden of disease have attempted to place dollar values on premature mortality and morbidity resulting from disease.

At the most sophisticated end of population indicators of disease impact is the Disability Adjusted life Year (DALY), which was developed for the 1993 World Development Report on health (World Bank 1993) by Murray and Lopez to provide an assessment of disease burden by global region (Murray and Lopez 1994, Murray and Lopez 1996). The DALY is an extension of the concept of potential years of life lost due to premature death (PYLL) to include years of "healthy" life lost by virtue of being in states of ill-health due to disease or injury. Many diseases are not fatal, but lead to significant loss of healthy life: for example chronic depression and long-term disability arising from musculoskeletal disease or injury. For the loss of healthy life due to non-fatal health conditions, the incidence of the health condition in the specified time period is estimated; for each new case, the number of years of healthy life lost is obtained by multiplying the average duration of the condition (to remission or death) by a severity weight that measures the loss of healthy life in comparison with total loss of life.

4.7 Information needs for priority setting

The Division has identified a need to move to a more systematic approach to determine national priorities for public health policy, interventions and research which draws appropriately on scientific evidence and population information.

The public health knowledge base

The public health knowledge base as defined in Section 3.3 (see Figure 1) falls outside the scope of this review. It must be emphasised that such information is an important input to priority setting along with population-based statistical information. In many areas of public health priority, there is inadequate scientific evidence on health determinants and on the efficacy or effectiveness of interventions in the actual population. To the extent that the knowledge base relies on expert consensus or opinion (or even on non-consensus), it is important that the collection of data be built into public health programs to enable the evaluation of the programs to feed into and improve the public health knowledge base. In addition, such routinely collected data will assist in monitoring adherence to best practice in public health.

The size of health problems (disease and risk factor impact)

Measuring the size of health problems in populations allows us to measure the potential for population health gain (outcomes) in relation to a particular problem area and to measure the actual health gain or health outcomes at population level for a problem area. The size of health problems is also an input (together with information on the cost-effectiveness of potential interventions) to assist in setting priorities for health service programs, public health programs and for research and development.

Measures of disease impact (such as numbers of deaths, potential years of life lost, cost of illness) have been proposed for use in setting priorities for health services or health research. However, the size of the problem per se does not necessarily bear any relation to our ability to do something about it. To properly set health priorities, disease impact information must be combined with information or estimates of the potential for achieving health outcomes, that is, on the cost-effectiveness of potential interventions. The correct decision rule would then relate to maximising health gain per dollar investment at the margin.

An evidence-based approach to setting health intervention priorities on the basis of the additional health gain that could potentially be achieved from implementing a set of "best

buys" for public health activities at the margin would be as follows:

- Identify potentially cost-effective public health interventions at the margin for the public health areas of interest and review the evidence (or expert opinion) to identify the set of evidence-based best buys for each area.
- Measure the total impact of the relevant health problems on the health of the population. Such a measure of disease (or risk factor) impact must capture the impact of fatal and non-fatal consequences consequences (long-term and short-term disability, pain etc) in a single indicator which enables impact to be assessed across all areas of interest in a consistent manner.
- Information from the above steps are then combined to give estimates of health gain achievable from the identified cost-effective interventions at the margin.
- In prioritising these interventions, a number of other considerations such as equity issues may need to be taken into account. Disease impact analysis clearly has the potential to quantify the differential burden of sociodemographic subgroups within populations and hence to assist in examining the equity impact of potential interventions.

Other factors which may need to be considered in making the final choice of public health priorities include the sustainability of the proposed interventions (over time or politically), and the perceived public support/pressure for interventions (some highly cost effective interventions may not be publicly acceptable on non-health related grounds).

As a by-product of this process, the list of health areas for which there is a considerable health impact, but for which evidence-based cost-effective interventions could not be found, would form the basis (together with assessments of the promise of research and development and the adequacy of the existing research and development effort) for a process to set priorities for health research and development.

4.8 Information needs for priority populations

Aboriginal and Torres Strait Islander peoples

Funding provided by the Commonwealth Department of Human Services and Health and the Aboriginal and Torres Strait Islander Commission has enabled the Australian Institute of Health and Welfare and the Australian Bureau of Statistics to establish a National Aboriginal and Torres Strait Islander Health and Welfare Information Unit within the National Centre for Aboriginal and Torres Strait Islander Statistics in Darwin for a two year period. This period of time will not be sufficient to make substantial progress on all the aspects of improving indigenous health information. There will be a need to ensure continued funding for a national centre to coordinate the improvement and reporting of national information for indigenous people.

Following a recommendation of the National Health Information Development Plan (1995), AHMAC has provided additional funding to the Darwin Unit to develop a national plan to improve information about indigenous health and health services, in consultation with Aboriginal and Torres Strait Islander people.

The 1994 National Aboriginal and Torres Strait Islander Survey is an important advance in collection of information about Aboriginal and Torres Strait Islander people and should be repeated at regular intervals in order to address the need for specific information on their disability, health status, risk factors and other determinants of health.

However, there is also a need for more detailed and ongoing survey collection of data relating to key health determinants, health-promoting environments and health-related knowledge, attitudes and behaviour for Aboriginal and Torres Strait Islander people. The Division currently has one statistical activity in this area, the Urban ATSI Supplement to the Drugs Household Survey. Consideration should be given under the Partnership to the development of a broader survey in this area, which from time to time could address specific issues including drugs and sexual health.

The completeness and quality of identification of Aboriginal and Torres Strait Islander status in Commonwealth, State and Territory health data collections is variable and often poor. In particular, identification in mortality data collections and hospital inpatient data collections is inadequate in most States and Territories. Other health collections such as cancer registry data and notifiable disease data need to be examined to determine the completeness of identification and steps taken to address problems identified. Improvements in identification would greatly improve the quality and usefulness of data already collected.

Efforts to ensure the accurate and complete identification of Aboriginal and Torres Strait Islander peoples in all health information systems and vital statistics collections is being addressed by the AIHW/ABS Unit in Darwin, but the Public Health Division should pay particular attention to this issue in relation to its own data collections and also in lending its weight to national efforts to increase the priority for addressing this issue in other data collections.

While the National Aboriginal and Torres Strait Islander Survey is an important source of information on the health of indigenous Australians, its unique methods mean that this information cannot be readily compared with that available for other Australians. General population health surveys usually include few Aboriginal and Torres Strait Islander people and also may not identify them. In addition, incomplete and unreliable identification of Aboriginal and Torres Strait Islander status in health and vital statistics collections have also limited the capacity to report on their health.

With over-sampling of Aboriginal and Torres Strait Islander people in population health surveys, agreement on the definition of Aboriginal and Torres Strait Islander status for health data collection purposes, and its universal recording in surveys and vital statistics collections, reporting of results specific to Aboriginal and Torres Strait Islander people is becoming increasingly practicable. The reporting of those specific results should become routine for health related surveys and collections. The level of disaggregation and quality of the data used in this process should be scientifically defensible. For example, if numbers are low, reporting may only be appropriate at a State or national level.

People of non-English speaking background

Country of birth is a common but not universally accepted indicator of language background. On its own, however, it cannot identify those resident in Australia who do not share the majority Australian culture, or who may have language access barriers to health promotion programs. This would require at least the recording of language spoken at home or preferred language. These more direct measures of language and culture are rarely included in national or State or Territory health data collections (Australian Institute of Health and Welfare 1996c) and it is probably adequate for the Division's purposes to ensure that surveillance and monitoring information can be disaggregated by broad country of birth groups.

Socioeconomically disadvantaged people

Population surveys such as the ABS National Health Survey generally include a comprehensive range of socioeconomic information, including education level, income, employment status and occupation. Administrative collections rarely include any of these indicators of socioeconomic disadvantage. The vital statistics collections include occupation, but this is not collected in a form that provides data of sufficient accuracy or reliability for use in identifying socioeconomic disadvantage. Disease registers generally collect only limited information on socioeconomic status.

It would be highly desirable to have one or two nationally agreed identifiers of socioeconomic disadvantage for use in administrative collections and population surveys. Among these, family income adjusted for family composition is probably the best single indicator of socioeconomic status, but is rarely included in administrative collections. Employment status (whether a person is employed or not) and occupation are important indicators of socioeconomic status and important determinants of health in their own right, but are only applicable to working age adults, and need to be interpreted with care for women.

Less directly, but also less invasively, location of residence when classified at the level of Statistical Local Area, or more preferably at Census Collectors' District level, and combined with social indicators measured at the Census can be very useful as a socioeconomic indicator (Mathers 1994). For its usefulness to be realised for monitoring and surveillance purposes, however, a stable national classification of small areas, supported by appropriate national computer software development, would be necessary and locational data consistent with this classification would have to be included consistently in health data collections.

There is an urgent need to develop agreed national means of identifying broad population groups in terms of socioeconomic disadvantage using simple and readily collected data items, and to implement these in national surveillance and monitoring for public health under the Partnership.

Geographically defined subpopulations

National or State and Territory level surveillance and monitoring data should be collected in such a way that it is also useful for local area health promotion activity. Often this will take the form of benchmark information for comparison with locally collected data. However, large scale surveys and other large scale data collections such as disease registers should routinely include geographical identification so that data for local areas can be extracted. This can take the form of broad geographic classifications (such as urban, rural and remote areas) or local areas such as those defined by local councils or area health services.

The Australian Standard Geographic Classification (ASGC) maintained by ABS is the most widely used geographic classification in national health data collections, followed by postcode. Substantial efforts are required to monitor boundary changes and map areas into stable entities in order to use either of these classifications for surveillance and monitoring over time. Prometheus Pty Ltd has done a substantial amount of work in this area in order to produce stable geographical classifications for HealthWIZ and further work will be carried out in the implementation of a mapping function for HealthWIZ and the production of the 2nd edition of the National Social Health Atlas.

The Division should promote and support longer term efforts to develop a stable, mappable small area classification system for ongoing use in public health monitoring and surveillance. Ideally such a system would be based on absolute geographical references to maximise its comparability with other systems and to enable the aggregation of the basic geographical units into any specified regions. The Environmental Monitoring System developed in the United Kingdom for OPCS provides a model of this type of system. The use of highly specific postcodes (smaller than an Australian census collector district) in all major national health databases, together with an absolute geographic areas (for example, cancer incidence in concentric one kilometre circles around a high temperature waste incinerator).
5. The Larger Public Health Information Environment

5.1 National Public Health Partnership

The proposal for a National Public Health Partnership (NPHP) is part of the Government's commitment to strengthen national leadership and direction setting in public health and to enhance the national effort so that the health of Australians is protected and improved. A National Public Health Partnership will provide the broad multilateral, intergovernmental framework to build a cooperative approach to public health. It is a substantial departure from the current Commonwealth/State/Territory arrangements for management of selected programs towards a more systematic approach for addressing public health priorities. It will also provide a vehicle through which major initiatives, new directions, and best practice can be assessed and implemented.

The broad objectives of the Partnership are proposed to be:

- improved collaboration in the national public health effort;
- better coordination and sustainability of public health strategies; and
- strengthening of public health infrastructure and capacity.

The availability of national public health information is fundamental to the success of the Partnership. Effective efforts to improve health and to reduce inequalities depends on having good information on community knowledge, attitudes and behaviours as well as mortality and morbidity statistics. The Partnership will take a more evidence-based approach to identifying national public health priorities, strategies and interventions and there will be increased emphasis on monitoring and evaluation, with reporting focused more strongly on outputs and outcomes.

While substantial progress has been made in the provision of data to monitor the health of Australians, it is recognised that much work needs to be done to provide health planners with information which is timely, accurate and complete. The Partnership, as endorsed by AHMAC, identifies public health information requirements as a key issue and one on which urgent action is needed at the national level. It is essential that data collected by the different health agencies be consistent, employing uniform definitions, guidelines and standards.

An information system to enable more effective monitoring of the Australian population has been put in place through the 1993 National Health Information Agreement and its associated development and work plans. These will provide the basic framework and infrastructure for the development of public health focused agreements, work plans and priorities. The National Public Health Partnership provides a unique opportunity for Australia to develop a more coherent and cohesive approach to national public health information.

5.2 Council of Australian Governments (COAG)

Within the context of the Partnership, bilateral Public Health Outcome Funding Agreements are being explored as part of the COAG process for the reform of Health and Community Services. A single Agreement with each State and Territory, to replace the current individual agreements, covering sub-programme elements, is proposed. It is the intention that these new arrangements be simpler to administer, allowing more flexibility in the delivery of public health and deliver better outcomes to the Australian community.

The purpose of these agreements will be to focus the health system on the provision of high quality, cost-effective care which would meet people's needs better and to eliminate cost shifting between the different levels of government. A nationally consistent information system will be essential to monitoring the overall quality of care provided against the agreed outcome measures and performance standards. The proposals to strongly link these public health program funds to such outcomes, targets and performance indicators will require a variety of health data for their effective measurement. In addition, the ability to translate systematically collected data into meaningful indicators will be an important component of data availability and accessibility.

In assessing the need for sound statistical data recognition is made of the Australian Health Ministers' recommendation that public health should be a future area for indicator and benchmark development. To date, public health indicator development has occurred around particular public health issues rather than across the public health system as a whole. Abundant data exists on risk factors such as prevalence of alcohol, smoking, illicit drug use and practices relating to the transmission of HIV/AIDS. In addition, program indicators for such things as breast and cervical cancers have been well developed.

In terms of the broader public health, indicator and benchmark development is not well advanced. Such development will occur in the context of the Partnership and the proposed public health outcome funding agreements described above. A high priority will need to be placed on improving information systems and commissioning new data collections to meet requirements in the development of appropriate public health benchmarks and indicators. Work should be progressed to formally link the work of the Australian Health Ministers' Benchmarking Working Group with the new processes being established under the Partnership.

5.3 National Health Priority Areas

The National Health Priority Areas (NHPA) program is Australia's articulation of its commitment to the World Health Organisation's Health for All Charter. The objectives of the program are to achieve real gain in the overall health of Australians and to reduce inequalities in their health.

The National Health Priority Areas program is a re-focusing of the former National Health Goals and Targets program and is attempting to develop nationally agreed strategies designed to realise health gain in the chosen priority areas. In July 1996, Health Ministers agreed to a reporting approach which included:

- bi-annual reporting of each priority area;
- reporting on a limited number of priority indicators in each area;
- State and territories to develop their own targets and indicators to be consistent with national priorities.

An integral aspect of the National Health Priority Areas process will continue to be the preventive strategies/activities relating to each priority area. Accordingly, close links with the work of the National Public Health Partnership will be required. Strategies employed in pursuit of National Health Priority Areas objectives are to be "evidence based", to maximise health outcomes at the population level. Specific interventions by governments could involve the application of additional resources, the redirecting of existing resources, improved co-ordination of existing activities/systems, or the replacement of current activities with more cost-effective "best practice" activities. Resource constraints dictate that national health information needed for public health activities in Australia should be as consistent as possible with that needed for reporting on the National Health Priority Areas process.

5.4 National Health and Medical Research Council

The Corporate Plan targeted information and research management as one of the key result areas forming "the basis for achieving the Government's objectives of a financially sustainable health and family services system that is efficient and of world class effectiveness". The Office of the National Health and Medical Research Council (NHMRC) will be responsible for cross department coordination of information and research so that the necessary capability in these areas can be developed, thereby ensuring that the Commonwealth meet its responsibilities for national leadership in health and family services.

The Office of NHMRC will support the following activities:

- the establishment of an Information Planning Committee;
- the development and implementation of an Information Plan identifying information and research needs, key communication flows and strategies; and
- improvement in statistical analysis and information management through building and linking centres of excellence.

It is proposed that the Information Plan be finalised by February 1997. It will be essential for the Public Health Division to link its work and strategies in information development with that of the Plan. In particular, there is considerable common ground in the Division's need for evidence-based priority setting processes for national public health action and the NHMRC's need for evidence based processes for identifying priorities for strategic research.

5.5 Other information activities within the department

The Portfolio Strategies Group has responsibility for the co-ordination of information management in the Department, the provision of central statistical and information services and the co-ordination of national data and payments systems under the COAG reform process. Among the strategies being pursued by Portfolios Strategies Group to improve Departmental management of information are:

- a project to map all DFS data holdings onto the AIHW's Information Model and the National Data Dictionary to produce a Departmental data dictionary and improve the consistency and standardisation of Departmental data;
- a pilot implementation of the Intranet for providing improved access to information within the Department; and
- modelling of Medicare data to estimate the prevalence of specific health conditions in the population.

Portfolios Strategies Group also has responsibility for ORPHEUS, the Departments regional health database. This is a CDROM product containing summary tabulations (SLA-based) for Commonwealth health regions of Departmental and Social Security data (including Family Services, Childcare, Aged Care and Disabilities). ORPHEUS is used significantly in regional offices but only marginally in Canberra.

Portfolios Strategies Group has also been facilitating the inclusion of Departmental data collections into HealthWIZ and this offers a potentially more attractive solution than ORPHEUS to the need for regional health data.

The General Practice Branch is developing process and outcome indicators for Divisions of General Practice that may involve the collection of some data from general practitioners via the Divisions. Many of these indicators will be of potential relevance to the needs for public health information and the Division should liaise with General Practice Branch to ensure that information development is co-ordinated.

The Office of Aboriginal and Torres Strait Islander Health is responsible for raising the health status of Aboriginal and Torres Strait Islander peoples by improving access to culturally appropriate high quality health care. Longer term strategies include providing uniform access to comprehensive primary health care services founded on population based health measures. Such strategies will require coordinated planning and improvements in data systems. The Public Health Division will need to work closely with the Office in ensuring that all relevant health data collections adequately identify Aboriginal and Torres Strait Islander peoples. The Office is also co-ordinating the development of a national minimum data collection of Aboriginal health services.

The Therapeutic Goods Administration Branch is responsible for the safety, quality and efficacy of therapeutic goods available in Australia. In the management of more cohesive and strategic health regulation the Branch will continue to focus on the development of a common international approach to regulatory requirements with regulatory agencies in countries which have comparable standards in therapeutic goods, chemicals and food. The work undertaken in relation to the regulation of drugs and poisons may be of relevance to the Public Health Division. Apart from the adverse drug reaction reporting system, most of the data collections of the Therapeutic Goods Administration are product-based rather than population-based and hence of limited useful for monitoring and surveillance in relation to public health.

The Health Care and Access Program comprises the major Medicare components (Medicare Benefits, Pharmaceutical Benefits, hospital agreements with the States and Territories) as well as a range of other activities including private health insurance policy, mental health support, workforce measures and ancillary services. Several activities in this area hold potential data sources of relevance to the Public Health Division. Of particular importance is the Medicare Benefits Schedule and the Pharmaceutical Benefits Schedule, which could potentially provide useful insight into such things as the use/overuse of prescription drugs, the prevalence of over prescribing, the prevalence of "doctor shopping" for prescription drugs, etc.

The Drug Utilisation Subcommittee of the Pharmaceutical Benefits Advisory Committee maintains a drug utilisation database and publishes an annual statistical report Australian Statistics on Medicines. This database combines information on prescriptions for which the PBS provides copayments with estimates of the numbers of prescriptions for other drugs (unsubsidised PBS drugs and non-PBS drugs) derived from data supplied by 300 pharmacies. Estimated cost information is available for PBS drugs but not for other drugs. This database provides aggregate per capita estimates of consumption by drug type (prescriptions per capita and defined daily dose (DDD) per 1000 people per day) but does not include age and sex, so specific population groups cannot be examined. Additionally, information on over-the-counter drugs is not collected, apart from Schedule 3 recordable drugs (eg. ventolin in some States). This is not standardised across States at present.

For this information to be really useful to Public Health Division, it will be important to work towards the inclusion of age and sex in the database. The "easiest" way to achieve this is probably via inclusion of the Medicare number in the PBS database and then linkage with the Medicare database. Medicare number is already included in the PBS for Safety Net, but the Safety Net scheme is family-based rather than individual. Considerable work will need to be done to enable inclusion of age and sex in the Drug Utilisation Subcommittee database.

Other potential sources of information on pharmaceutical drug use include market research data and population health surveys. Although commercial sources of information are expensive and sometimes difficult to get access to, there are increasing links between industry and government in this area. The major marker research company conducts a rolling GP survey which enables analysis of patterns of drug prescription for a given diagnosis, and patterns of diagnoses for which a particular drug is prescribed. The 1995 ABS National Health Survey will also include useful information on prescription and over-the-counter drug use, and has substantially improved its collection and coding of data in this area compared to previous surveys. The collection of data on primary health services is another potential avenue for collection of pharmaceutical drug use data (see Section 6.6.3).

As part of the Health Care and Access Program, the Health Services Division's Mental Health Branch is responsible for the development and conduct by the Australian Bureau of Statistics of a National Mental Health Survey in late 1997. This survey will collect population-based information on mental health and mental health risk factors of relevance to Public Health Division.

5.6 States and territories

A number of States and Territories have developed population data collections of considerable relevance to national public health needs, including linked health service data collections, population health and risk factor surveys and health promotion surveys. There is considerable potential for the development of common national standards for data collection instruments and definitions to enable the wider use of State and Territory data collections for producing quasinational public health data. This should be advanced as part of the information development work program under the Partnership and using the National Health Information Agreement infrastructure (5.9 below).

While no consistent surveillance system exists nationally to provide information on community knowledge, attitudes and behaviours, South Australia has a Behavioural Risk Factor Surveillance System which could provide the basis for the development of a national system. Queensland also conducts regular health surveys using Computer Aided Telephone Interviewing (CATI) technology. New South Wales has recently conducted a comprehensive health promotion survey addressing determinants of health and knowledge and attitudes. Western Australia has made considerable progress in the linking of health administrative datasets and registration data to provide true population-based longitudinal information. Tasmania operates a Health and Wellbeing Indicators Project which could serve as the basis for national development and the translation of systematically collected data into meaningful indicators.

5.7 National Research Centres funded by Public Health Division

The Public Health Division provides funding to a range of national centres, either through specific funding from national strategies or through the Public Health Education and Research Programme. The main centres are associated with the work of the National HIV/AIDS Strategy or the National Drugs Strategy. These are:

- National Centre for Research into the Prevention of Drug Abuse;
- National Drug and Alcohol Research Centre;
- National Centre for HIV social Research;
- National Centre in HIV Virology;
- National Centre in HIV Epidemiology and Clinical Research; and
- The National Reference Laboratory.

The continued funding of these centres is considered integral to achieving the priorities of the two strategies. Greater use could possibly be made of resources at these centres as the Public Health Division strives to meet the greater need for information under the Partnership.

The Public Health Education and Research Program funded centres were primarily established to build public health capacity through education and training. These centres undertake research as part of their education function. There is little capacity in these centres to obtain assistance in the provision of population level information.

The National Injury Surveillance Unit also receives some funding from Public Health Division. These funds are primarily used in the enhancement of national data and has assisted in advancing tighter and more detailed surveillance of injury through a variety of projects such as the development of National Data Standards for Injury Surveillance and studies into specific at risk populations, such as Aboriginals.

5.8 Australia New Zealand Food Authority

The Australia New Zealand Food Authority is an independent expert body which makes recommendations on the development, variation and review of food standards. The Authority's main functions are to deal with applications to develop or vary food standards, to review standards, to prepare proposals to develop or vary standards, to prepare draft standards or variations to standards and to make recommendations to the Australia New Zealand Food Standards Council. In addition, the Authority has other functions such as coordinating food surveillance activities, developing food safety education initiatives, coordinating food recalls and developing assessment policies for imported foods.

Of specific relevance to the Public Health Division is the Authority's role in food surveillance activities, particularly in relation to food safety and food-borne disease, and its conduct of the National Food Composition Program. In addition, technological and regulatory changes in the composition of the food supply may have implications on the nutritional and health wellbeing of the Australian population and therefore have important implications on health policy and health services and social welfare programs. It will be essential that the Public Health Division and the AIHW work closely with the Australia New Zealand Food Authority and the AIHW in the implementation of the Nutrition Monitoring Plan.

5.9 National Health Information Infrastructure

The national health information infrastructure involves a number of key organisations at both the Commonwealth and State and Territory level. The AIHW has primary responsibility for the coordination, development, analysis and dissemination of national information on the health status of Australians. It is assisted in part by close working relationships with the Commonwealth, State and Territory health authorities as well as the Health Insurance Commission, the Office of the National Health and Medical Research Council, AHMAC and the Australian Bureau of Statistics.

The AIHW is an independent statutory authority and operates under the Australian Institute of Health and Welfare Act 1987. The Act delineates its health and welfare functions, of which leadership in the development and provision of health information is of high priority. The Institute has addressed its leadership role by, inter alia, promoting and facilitating national consensus on health information matters. It has developed and maintained an effective national infrastructure

for health information development and management, and brokered a critical agreement among the Commonwealth, State and Territory health authorities and the major Australian health statistical agencies on these matters. This agreement, the National Health Information Agreement came into effect on 1 June 1993. Appendix B summarises the 1996-97 work program of the AIHW as it relates to health information and health information infrastructure.

The National Health Information Agreement, which operates under the auspices of AHMAC, establishes cooperative processes and structures to facilitate and coordinate activities to improve, maintain and share national health information. The Agreement signifies a public commitment to a national approach to improve Australia's health information.

The National Health Information Management Group manages the Agreement and coordinates the National Health Information Work Program, a rolling triennial program of health information development activities that meet agreed national priorities. The data development is, in the main carried out by a supporting committee - the National Health Data Committee. The national coordination role of the Management Group is highly respected by all stakeholders as it provides a well proven executive level communication forum for policy analysis and the pursuit of consensus in national health information matters.

While the National Health Information Agreement is the foundation stone of the national health infrastructure, other important elements have been developed to support the continuing quest for better national health information. These elements are the National Health Information Work Program, the National Health Data Dictionary, the National Health Information Development Plan and the National Health Information Model. The National Health Information Model and the National Health Data Dictionary are currently being integrated to provide a framework for future information standards and development.

Significant contribution to national health information development is also made through the regular conduct of a National Health Information Forum. The 1994 Forum was attended by approximately 130 people from Australian health authorities, non-government health organisations, health consumer organisations, the private health industry sector and academic and research organisations. From this Forum emerged the major themes for national action on health information which are reflected in the National Health Information Development Plan.

The Australian Bureau of Statistics is also an important player in furthering national health information through the conduct of large-scale population surveys of health and health services and of disability and ageing every five years as well as other special surveys (eg. Mental Health Survey in 1997) from time to time.

Appendix C contains a more detailed description of the national health information infrastructure and each of its elements.

6.Strategies and recommendations

6.1 National public health priorities

6.1.1 Disease control: Communicable diseases surveillance

Communicable diseases control is the legislative responsibility of the States and Territories. However, the National Centre for Disease Control has responsibility for a number of aspects of communicable diseases surveillance and management. These are:

- Management of human quarantine;
- International liaison;
- Coordination of national surveillance and control;
- Secretariat for the Communicable Diseases Standing Committee of the NHMRC and the Communicable Diseases Network Australia-New Zealand; and
- Production of the *Communicable Diseases Intelligence* bulletin.

The Communicable Diseases Standing Committee of the NHMRC produces recommendations on best practice for communicable disease management, though funding for this work is limited and the source insecure. The Communicable Diseases Network Australia-New Zealand provides a mechanism for the coordination of some surveillance activities and coordinates outbreak responses. Laboratories throughout the country also make a significant contribution to the surveillance and control of communicable diseases through collaboration and partnership with epidemiologists, public health practitioners and others at the local national and international level. The *Communicable Diseases Intelligence* bulletin reports the core national surveillance system, that is the National Notifiable Diseases Surveillance System each fortnight. This system provides information on 41 communicable diseases that are notified under the State and Territory health legislations. A further twelve systems are maintained and reported on a regular or ad hoc basis in the bulletin.

The draft National Communicable Diseases Strategy (HFS 1996) recognises the limited resources in the National Centre for Disease Control to undertake the full range of surveillance activities, the limited capacity of the NHMRC to develop policies in a timely manner, the variation in infrastructure for communicable disease surveillance in the States and Territories, and the current ad hoc laboratory based surveillance. In view of these issues and the need to strengthen the coordination and planning of surveillance activities at the national level, and to develop a strategic plan for responding to new or emerging infections, the Strategy recommends the establishment of a National Surveillance Centre and that Surveillance Units be established to produce health intelligence and advise on specific disease or groups of diseases.

The National Surveillance Centre could continue to be located in PHD or established elsewhere, for example AIHW, and the Surveillance Units could be tendered by individuals, agencies or academic institutions. The draft Strategy recommends that these decisions should be made by the key stakeholders as the Strategy is adopted.

Establishment of the National Surveillance Centre at AIHW could offer some advantages in locating communicable disease surveillance more closely to broader monitoring of population health through mortality, hospital morbidity and other national data collections and in access to statistical and health information infrastructure expertise. One gap identified in current surveillance activities is the production of a comprehensive report summarising longer term trends in the infectious disease area, drawing on annual reports published from time to time in the *Communicable Diseases Intelligence* bulletin, and on other national data collections. Such a report could be produced by the AIHW as part of its national reporting in relation to public health under the Partnership, whether or not communicable disease surveillance is transferred outside the Division.

On the other hand, moving the National Surveillance Centre outside the Division would require substantial duplication of expertise and networking unless the control function was also moved. Other countries such as the UK and USA where communicable disease surveillance is located outside national government health departments have also located the control function outside health departments. Splitting the national surveillance and disease control functions in Australia would almost certainly require additional resources to duplicate expertise and communication network and ensure co-ordination of surveillance and control activities.

It is recommended that the National Communicable Diseases Strategy be advanced under the auspices of the proposed National Public Health Partnership, and that the location of the proposed National Surveillance Centre be decided by the key stakeholders as set out in the draft Strategy report. In the interim all surveillance systems should remain together under the control of the Surveillance and Management Section of Public Health Division.

It is recommended that AIHW be given greater access to Divisional communicable disease surveillance data to enable it to enhance its monitoring and reporting of communicable disease indicators as part of its regular population health monitoring activities.

6.1.2 Disease control: Childhood immunization

Strategic Human Capital have recently been contracted to evaluate the National Childhood Immunization Register. The evaluation process has commenced and is due to be finalised by the end of the year. In the medium term all processing and report generation will remain with the Health Insurance Commission. However, the Terms of Reference of the current evaluation includes a requirement to recommend on the appropriateness of the Commission to undertake the data analysis and output requirements of the Register. As the Register nears the end of its first year of operation concerted effort should be made to ensure the early release of data from the Register. It is recommended that Public Health Division take active steps to secure the early release of data from the Childhood Immunization Register.

6.1.3 Disease control: Pituitary hormones

Australian Human Pituitary Hormone Program - Patient Database Human Pituitary Derived Hormones Counselling Service Database

The Human Pituitary program operated between 1967 and 1985. The program supplied cadaver derived pituitary hormones to Australians as treatment for infertility and short stature. Other special projects associated with metabolic and growth problems and IVF programs between 1972 and 1978 also treated people with pituitary derived hormones. The total number of cases known to be treated are 2,129. The program ceased in May 1985 following overseas reports of deaths from Creutzfeldt-Jakob Disease (CJD) in people who had received human growth hormone treatment. This iatrogenic form of Creutzfeldt-Jakob Disease but with a shorter symptom free incubation period, from 18 months to 21 years and with an average of 15 years.

Following an independent inquiry into the use of pituitary derived hormones in Australia during 1993/94, a range of initiatives to address the ongoing needs of the human pituitary hormone recipients was introduced. These included the establishment of a \$5 million Trust Fund to cover ongoing counselling and support services and medical and other costs should further recipients contract Creutzfeldt-Jakob Disease. The Trust has been calculated to provide an ongoing commitment to fund counselling services until at least 2002-03 and to fund State based support groups until at least 2010. Ongoing funding requirements are due to be evaluated in 1997-98.

It is recommended that the administration of the Patient Database and the Counselling Service Database continue to be maintained within Public Health Division until such time as the funding review. It is unlikely to be a continuing issue as the exposed group increasingly exceeds the time period for Creutzfeldt-Jakob Disease to appear.

Creutzfeldt-Jakob Disease Case Registry

The Creutzfeldt-Jakob Disease Case Registry was established in 1993 and is supervised by Professor Colin Masters at Melbourne University. The Registry monitors and investigates known and suspected Creutzfeldt-Jakob Disease cases in Australia. In November 1994 the Government announced the provision of \$300,000 per year over the next four years to extend the period of retrospective analysis of the Registry to 1974 and to extend the period of prospective analysis to 2010.

It is recommended that the Creutzfeldt-Jakob Disease Case Registry continue to be managed through the Centre for Disease Control and that any further funding be assessed in conjunction with other priorities.

6.1.4 Disease control: HIV/AIDS and sexual risk behaviours

National surveillance for HIV disease is coordinated by the National Centre in HIV Epidemiology and Clinical Research (NCHECR), in collaboration with State and Territory health authorities and the Commonwealth of Australia. The National Centre is funded out of the research component of the National AIDS Strategy.

The Department has funded a number of surveys of sexual risk behaviours, knowledge, attitudes and beliefs over the last few years, mainly to address ongoing needs for monitoring and evaluation of the National AIDS Strategies. These have focused on homosexually active men, intravenous drug users and schoolchildren. National evaluation and monitoring of the response to HIV/AIDS will continue to be a major ongoing Commonwealth responsibility. There is a need to review the requirements for detailed evaluation data at periodic intervals as well as more regular monitoring of a smaller core set of risk behaviour indicators in the general population and high risk populations. High risk populations not currently addressed include Aboriginal and Torres Strait Islander people, homeless youth and prisoners. General population information on sexual risk behaviours should be collected as part of a systematic enhancement of health risk behaviours, knowledge and attitudes population data collection under the Partnership.

It is recommended that the Division take a lead role in reviewing the data requirements for evaluation of the National AIDS Strategy and for ongoing monitoring of sexual and other risk behaviours in the general populations and risk populations. This review should provide input to the development under the Partnership of a more coherent national set of survey vehicles for population risk factors, knowledge, attitudes and beliefs.

Schools Survey

This survey requires sensitive liaison with State and Territory Education Authorities. The Schools Survey should be considered for consolidation with drugs and other youth health issues into a single schools survey to be conducted under the Partnership as a combined Commonwealth/State survey at regular intervals. The current survey sample size is not large enough to analyse trends at the State level. Addressing this topic as part of a larger survey may allow a sufficient sample size for this purpose, albeit, at the expense of a likely reduction in the topics that could be included.

It is recommended that the Schools Survey (sexual risk behaviours and knowledge) be considered for consolidation with drugs and other youth health issues into a single schools survey to be conducted at regular intervals under the Partnership as a combined Commonwealth/State survey.

Project Male Call

This survey of HIV, Hepatitis and STD risk behaviours among a nationwide sample of homosexually active men was carried out in 1992 and 1996. It is a unique data collection because of its national focus and focus on both gay and non-gay community attached men. The primary focus of all other data collections for this group is one particular city and

principally gay community attached men. The survey allows for international comparisons as New Zealand and the United Kingdom have conducted similar surveys based on this one.

A decision to repeat this in 4 to 5 years time will depend on the priorities of the day. There are serious questions about comparability of these data over time due to the volunteer nature of the sample. There may also be a need to review and identify the types of risk behaviour/knowledge data needed (in light of changing social behaviour, improved treatment of the epidemic, and the need to target health education messages) and the most cost-effective vehicle for doing this.

It is recommended that Project Male Call should be reviewed and continued at appropriate intervals or replaced by a more systematic and time-comparable set of surveys of special risk populations to be conducted at regular intervals by the National Centres.

Sydney Men and Sexual Health (SMASH)

This cohort study has proved useful in looking at changes in social practices through the epidemic and for looking at the characteristics of newly infected men. Its usefulness for routine monitoring of HIV risk behaviours needs to be reviewed as part of the routinization of HIV/AIDS monitoring for the 3rd National AIDS Strategy under the Partnership. Two other similar surveys were conducted in Melbourne (MASH) and Brisbane (BASH) in 1995, primarily to compare the populations in these cities with their Sydney counterparts.

It is recommended that the usefulness of the Sydney Men and Sexual Health (SMASH) survey for routine monitoring of HIV risk behaviours be reviewed as part of the routinization of HIV/AIDS monitoring for the 3rd National AIDS Strategy.

Needle and Syringe Exchange Survey

The Needle and Syringe Exchange Survey provides a good model of the more strategic approach to monitoring key public health indicators - it is cheap to run, and provides timely national data for a very specific small set of indicators. This survey needs to become a routine part of the AIDS-related monitoring activities. It was funded the first time from the HIV/AIDS Strategy, and the second time from the Hepatitis C Action Plan.

General surveillance of incident cases of blood-borne infections is extremely resource intensive and this type of survey provides a reasonably efficient mechanism for the monitoring of Hepatitis C, at least in injecting drug users on a routine basis. The proposed National Communicable Diseases Surveillance Strategy has addressed the issue of general surveillance of blood borne infections and recommends that innovative surveillance strategies be planned and implemented for diseases of public health importance and for which no current national surveillance is in place.

It is recommended that the Division continue to fund the National Centre to conduct this survey as part of the standard funding for HIV and Hepatitis C monitoring.

6.1.5 Disease control: Cancer

The National Centre for Disease Control has responsibility for the development of a National Cancer Control Strategy as well as for national coordination and monitoring of national breast and cervical screening programs. The statistical information needs to underpin the development of a national cancer control strategy should be addressed by developing a closer working relationship with the cancer surveillance subprogram of the AIHW.

BreastScreen Australia Performance Measures National Cervical Screening Program Performance Measures

National minimum datasets and reporting mechanisms for these two programs have been agreed. The implementation phase for the breast screening program is almost complete and the detailed quarterly and 6 monthly reports to the Division from all Screening and Assessment Services are now being replaced by a single annual report at the State and Territory level. The Division will produce an annual report for Australia concentrating on broad national indicators relating to effectiveness, efficiency, quality of screening and outcomes. Over the next year, it is intended to review and revise the national minimum dataset in conjunction with accreditation requirements for breast screening services and the Commonwealth requirements for national data will be specifically addressed in conjunction with this process.

Cervical Cytology Registries are being established in all States and Territories to provide reliable data on cervical screening activity and outcomes for the National Cervical Screening Program. Agreement has been reached on a minimum set of performance measures for the program but to date data has not been available at the national level.

It is recommended that the Division and the AIHW develop closer co-operation and coordination between the Cancer Control program's statistical activities and the Institute's cancer surveillance activities. In particular, the AIHW Disease Registers Unit should be consulted in the review of national reporting requirements for breast and cervical cancer screening and the development of national reports.

While national performance and outcome information is essential to the ongoing national coordination, overall quality assurance and policy development, the actual collation and reporting of this data does not need to be carried out within the Division in the long term, as long as the Division has full and immediate access to the data. Following the review and finalisation of national reporting requirements for the screening programs, and the development of national reports, there may be benefits in locating the ongoing national monitoring and reporting with the AIHW cancer surveillance subprogram.

It is recommended that responsibility for the ongoing monitoring and reporting for the national breast and cancer screening programs be reviewed and the potential advantages and disadvantages of relocating to AIHW be considered, following the finalisation and implementation of national indicators and reports.

6.1.6 Population health strategies: men's and women's health

The Population Health Strategies Section has responsibility for advancing the NHMRC Women's Health Strategy and managing the National Women's Health Program. There will be a need for ongoing monitoring and surveillance of both women's and men's health and health services. This should be undertaken by AIHW.

Women's Health Longitudinal Survey

The University of Newcastle is currently funded for 3 years to conduct this survey. It will provide important information on the determinants of women's health and their access to and use of services and should be continued. However, data from this survey will be of more limited relevance for population monitoring and surveillance of women's health issues due to the longitudinal nature of the study and the limited age ranges included. Results from the survey will be very important in identifying appropriate indicators for health determinants and enabling factors that should be monitored at the national level for women.

Women's health services - national evaluation data

The Division has invested substantial effort in the development and specification of nationally consistent data for the evaluation of women's health services. This data will be collected for three one month time periods in all women's health services and sent to the Division via the State/Territory health authorities. State compliance with the minimum dataset and collection strategy has been variable and three States, at the time of writing, have not agreed to ongoing provision of this data. These service provision data for women should be further developed and supplemented by consistent service provision data for mainstream health care services. Work being undertaken for the development of a national minimum dataset for primary community health services for the National Health Data Dictionary will also assist here.

It is recommended that future collection of utilisation and other data for women's health services be addressed as part of the development of a national minimum dataset for monitoring women's health (see below) and build on the agreed minimum dataset for the national evaluation.

Female Genital Mutilation Program

This 5 year program has a need for measurement of the incidence and prevalence of female genital mutilation and of attitudes within specific ethnic groups. While attitudinal data may be collectable in broader population health surveys, the specificity of this issue to certain ethnic groups may require more innovative approaches to monitoring and evaluation. The use of key informants, both health professionals and representatives of ethnic communities, may provide a potential approach. The Illicit Drug Reporting System being piloted by the National Drug and Alcohol Research Centre provides an example of this type of approach.

Gender-specific population monitoring and surveillance

Gender-specificity should be a minimum requirement for all national health data collections. The Pharmaceutical Benefits Scheme is the only major national collection where it is not possible to identify age or sex.

It is recommended that the Public Health Division seek to achieve identification of age and sex in the Pharmaceutical Benefits Scheme database.

The Division has appointed consultants, including the Head of the AIHW's Health Outcomes Unit, to advise it on the development of a national minimum dataset for women's health. The proposed set of indicators is broadly consistent with the conceptual framework outlined in this report and should be implemented by AIHW as a systematic part of the development of a national set of public health indicators under the Partnership. Relevant process and access indicators for women's use of health services (see above) should be included in the national public health indicator set.

Men's health indicators should similarly be addressed for national monitoring and reporting under the Partnership. For both men and women, relevant gender-specific indicators need to be identified for monitoring and surveillance. In relation to monitoring, it will be important to identify a small core set of gender-specific indicators which are policy-relevant and normative (ie. movements in such indicators must be interpretable in terms of population health gain).

It is recommended that development of a minimum set of women's health indicators should be continued under the Partnership as part of the development of a core national set of public health indicators and that AIHW be funded to support the Public Health Division in the development and reporting of nationally monitored indicators for men's and women's health, including appropriate gender-specific indicators.

6.1.7 Population health strategies: child and youth health

The Australian Health Ministers endorsed a National Health Plan for Young Australians in June 1966. The Plan identifies the collaborative strategies needed to underpin the roles and responsibilities of individual jurisdictions in promoting and maintaining the health of children and young people. An information framework needed to move towards an evidence based approach to both monitoring the health of children and young people and the planning, delivery and assessment of effective and efficient health care for them is foremost among these strategies.

Particular emphasis on identifying and responding to the health needs of children and young people with, or at risk of developing, serious health problems is necessary. These include those who are living in poverty, in dysfunctional families, are homeless, or are located in rural or remote areas as well as those with disabilities, mental health problems or chronic illness. Particular attention should also be paid to Aboriginal and Torres Strait Islander young Australians.

NSW is in the process of developing a "Common Data Set for Community Child, Youth and Family Health". This appears to be closely related to the Primary and Community Health National Information Management project also being undertaken by NSW for development of a national minimum dataset for community health services for inclusion in the National Health Data Dictionary. There are several major deficiencies in the way this work has been developed that render it inappropriate for the basis of a nationally agreed data set. These are:

- the current focus is on episodes of care for younger children in community health services;
- the private sector, rather than the community sector, is the major health care service provider for both children and young people; and
- the proposal contains mainly process measures, with a limited number of service outcome measures, such as immunization.

Consequently, further work is needed to develop population monitoring and surveillance indicators for children and youth addressing population health status, health determinants, health outcomes and system performance indicators at state and national levels. A new framework, including a national minimum data set complemented by data dictionary definitions, is therefore needed to support a nationally consistent approach to the measurement of health indicators for children and young people. It is essential that consistent, comparable data be available to support evidence based health care planning and delivery, monitor performance and respond to emerging needs. It is likely that the indicators needed for children and for adolescents (or youth) will be quite different, and an early task will be to identify and define the key age ranges for which indicators should be developed.

AHMAC is currently considering the provision of \$63,000 for data development activities, including the possible development of a national report on the health of young Australians. At this stage, it may be more beneficial to use these funds for the early advancement of the review and development of a national minimum data set. Such activity should occur within the framework of the NHIA and National Health Data Dictionary (see Section 6.2).

It is recommended that the Public Health Division, jointly with AIHW, be identified as the lead agencies, within the national health information structures and the Partnership to develop a comprehensive framework and indicators targeted at children and young people, 0-24 years of age. The \$63,000 provided by AHMAC in 1996 should be used to develop a detailed proposal for a national minimum data set.

The Division currently co-ordinates the collection of survey data from school children (Years 10-12) in relation to tobacco, alcohol and illicit drugs and also sexual risk behaviours, attitudes and knowledge. It is recommended in Section 6.6.1, that the Division and AIHW, as lead agencies under the Partnership, consider the advantages of establishing a more broadly based survey program addressing child and youth health status, behaviours, knowledge and beliefs as part of a systematic enhancement of national public health data collection under the Partnership.

It is recommended that AIHW prepare bi-annual reports on child and youth health. Initially these reports would access available data from existing sources and as the recommended developmental processes proceed they would feed into the reports.

6.1.8 Population health strategies: Aboriginal and Torres Strait Islander peoples

As discussed in Section 4.8, the 1994 National Aboriginal and Torres Strait Islander Survey is an important advance in the collection of information about Aboriginal and Torres Strait Islander people and the Division should support its continuation at regular intervals. In addition, it is recommended in Section 6.6.1 that the Division also play a lead role in reviewing the need for broad-based and regular population monitoring of Aboriginal and Torres Strait Islander peoples in relation to behavioural risk factors, knowledge, attitudes and beliefs.

As discussed in Section 4.8, it is important to be able to provide estimates for Aboriginal and Torres Strait Islander peoples of the core national set of indicators for monitoring and surveillance. This requires increased attention to the completeness of identification of Aboriginal and Torres Strait Islander peoples in registration data and health services data and also to ensuring that adequate samples of Aboriginal and Torres Strait Islander peoples are included in national and quasi-national population surveys.

It is recommended that the Public Health Division, in conjunction with OATSIS, continue efforts to ensure that major nationally relevant health related surveys and collections identify Aboriginal and Torres Strait Islander peoples and contain a sufficient sample size to provide, at minimum national estimates.

The completeness and quality of identification of Aboriginal and Torres Strait Islander status in Commonwealth, State and Territory health data collections is variable and often poor. In particular, identification in mortality data collections and hospital inpatient data collections is inadequate in most States and Territories. Other health collections such as cancer registry data and notifiable disease data need to be examined to determine the completeness of identification and steps taken to address problems identified. Improvements in identification would greatly improve the quality and usefulness of data already collected.

It is recommended that the Public Health Division take steps to ensure identification of Aboriginal and Torres Strait Islander peoples in all its own data collections, particularly in the communicable disease and cancer screening areas.

6.1.9 Reproductive health

Reproductive and infant health issues such as folate and breast feeding are covered in relation to nutrition monitoring (see Section 6.1.14). The Family Planning Program and Alternative Birthing Services Program also involve management and evaluation information. The latter requires information for an evaluation and consumer profile - it is intended that this will be addressed via the AIHW's National Perinatal Statistics Unit which

will collect information through State health authorities.

Family Planning Program Annual Reporting

This summary management information should be reviewed with a view to implementing a set of indicators that ensure that family planning objectives continue to be met under the broad-banded funding arrangements, particularly in relation to training of health professionals and provision of community education to priority populations.

As part of the development of a broad national set of public health indicators under the Partnership, attention should be given to developing key indicators of reproductive health and fertility management outcomes (eg. unwanted pregnancy), reproductive risk behaviour and knowledge and indicators of access to reproductive health and fertility management services (both special purpose and mainstream primary care).

It is recommended that summary annual reporting of the Family Planning Program be reviewed to develop a set of indicators that ensure family planning objectives continue to be addressed as a national priority.

It is recommended that key indicators of reproductive health and fertility management outcomes, risk behaviours, knowledge and service access be developed for inclusion in the broad national set of public health indicators to be monitored under the Partnership.

6.1.10 National Health Priority: Diabetes

The development of indicators and required population data collection development are being addressed by AIHW in collaboration with the Department in relation to the development of a monitoring and reporting strategy for the National Health Priority Area. Diabetes monitoring is an additional responsibility of the Cardiovascular Disease Monitoring Unit at AIHW, along with nutrition monitoring.

6.1.11 Other National Health Priorities

The Public Health Division is the lead agency within the Department for three of the National Health Priority Areas: injury, cancer and diabetes. The other two priority areas, cardiovascular disease and mental health, are significant priorities for national public health action, and in both areas, there are identified risk factors amenable to population-based strategies.

Levels of overweight and obesity are increasing in Australia and this is a major public health issue in relation to cardiovascular disease, diabetes and other health problems. National strategies for addressing this issue are under development by NHMRC. Monitoring and surveillance in relation to this is being addressed by AIHW as part of its cardiovascular monitoring work.

Blood lipids are another important cardiovascular risk factor. While these were measured

in the three National Heart Foundation Risk Factor surveys, blood lipid measurement was not included as part of the 1995 National Nutrition Survey due to lack of funding. This is an important data gap which the AIHW is proposing to address through conduct of a national blood survey. This is discussed in Section 6.6.2.

Cardiopulmonary Resuscitation

Two surveys currently funded by the Division are collecting population-based information on schools training in Cardiopulmonary Resuscitation and on the types of Cardiopulmonary Resuscitation and outcomes of Cardiopulmonary Resuscitation used by members of the public in ambulance-attended emergencies. These data should be examined by AIHW for their usefulness in providing monitoring data for the cardiovascular disease National Health Priority Area.

6.1.12 Asthma, exercise and other population health strategies

There is a need for population data to assist in the prioritising of potential additional population health strategies to support policy development and to support the development of core national indicators for public health monitoring and surveillance. The Division should provide some funding to AIHW to enhance its ability to support the Division across the spectrum of potential public health priorities in the areas of data development, analysis and statistical support. See Section 6.7.

Dental health is a public health issue in its own right and particularly in relation to equity issues. Dental health is a particularly important issue for priority disadvantaged populations including Aboriginal and Torres Strait Islander people, socioeconomically disadvantaged people and institutionalised older people. Dental health is also an important enabling factor in relation to nutrition and cardiovascular, cancer and diabetes risk factors. Funding of the national dental health survey carried out by the AIHW Dental Statistics Unit ceased with the termination of the National Dental Health Program in this year's budget and the continued resourcing of data collection in relation to population dental health needs to be addressed. This provides an opportunity to develop a national surveillance and monitoring system for adult dental health which addresses relevant priority populations.

It is recommended that Public Health Division take a lead within the Department in identifying the public health importance of the continued population monitoring of dental health and support the resourcing of a national surveillance and monitoring system for dental health.

6.1.13 Healthy public policy: environment

Neither the Public Health Division nor the AIHW currently collect or monitor data in the area of environmental health. The Australian Bureau of Statistics produces regular environmental statistics and the Department of Environment Sport and Territories has recently facilitated the production of The State of the Environment Report 1996. Neither of these environmental reporting activities focuses specifically on indicators relevant to environmental determinants of health. The Healthy Public Policy Unit of the Division plans

to develop a national environmental health policy and has funded a conjoint appointment with the NCEPH to recruit an environmental health expert to assist the Division with the development of an information and monitoring strategy for environmental health.

It is recommended that AIHW be involved in the planned development by the Division and NCEPH of an information and monitoring strategy for environmental health through participation in an appropriate advisory forum and that appropriate national environmental health indicators be agreed for inclusion in AIHW reporting of national public health indicators under the Partnership.

6.1.14 Healthy public policy: Nutrition

Over the period 1993–1996, substantial National Better Health Program and National Health Advancement Program funds were provided by the Department to AIHW to implement the nutrition monitoring priority objective of the National Food and Nutrition Policy. The first phase of implementing the policy monitoring objective was to describe the existing food and nutrition system in Australia (Lester 1994) and to plan a program based on the development of key indicators to monitor implementation of the Policy. This phase of the monitoring objective was completed successfully by AIHW early in 1996 (Rutishauser et al 1995). With the end of the National Health Advancement Program at June 1996, Department funding to AIHW for nutrition monitoring ceased.

Over the same period, the Department provided substantial funding for the conduct of the 1995 National Nutrition Survey conducted by ABS in conjunction with the 1995 National Health Survey. The Department, supported by both the ABS and AIHW, played a lead role in the development, conduct and analysis of the 1995 Nutrition Survey.

An independent evaluation of the Policy implementation in 1995 led to the engagement of a team of consultants led by a group at Deakin University to re-develop an implementation plan for the National Food and Nutrition Policy. As one of the four priority objectives of the Policy, it will be important to ensure the continuation of a monitoring program for the policy implementation. As indicated in the AIHW report "Plan for a national food and nutrition monitoring program", key indicators for monitoring should include strategic tracking (process) indicators as well as longer term nutritional status and health indicators. It is also likely that analysis of the National Nutrition Survey will influence priorities for policy implementation and thus for monitoring.

The AIHW report specifies all the elements of a comprehensive nutrition monitoring system. It was recognised, however, that full implementation would require substantial resources, and the report was structured in such a way that monitoring of the National Nutrition Policy could proceed in a more limited way, by selecting an appropriate range of indicators in each of the priority areas for policy implementation. Having done this groundwork, AIHW is in a position to concentrate on putting a core monitoring program into place sooner rather than later. A key point of the initial plan, moreover, was to utilise existing mechanisms, outlining enhancements where appropriate, as a means to limit the need for resources. The AIHW report also lists relevant agencies together with their current (Novemner 1995) and projected responsibilities in a nutrition monitoring system. This

should be the starting point for implementing minimal monitoring, and AIHW is a highly appropriate body to coordinate.

It is recommended in the current circumstances that a core minimal monitoring approach is taken through the use of approximately 1.0-1.5 FTE to provide coordination of relevant stakeholders and agencies and to collate information on agreed indicators. This could be implemented immediately by AIHW, starting with a critical review of the key indicators detailed in the initial plan to align more closely with the implementation plan of the National Nutrition Policy and to identify a core minimum set for early implementation. It will also be important for AIHW to integrate nutrition monitoring closely with the monitoring of national core public health indicators under the Public Health Partnership.

It is recommended that AIHW be funded to review and implement a minimal mational nutrition monitoring program under the National Public Health Partnership.

As part of the Institute's previously funded nutrition monitoring work, responsibility for estimating, analysing and interpreting nutrient data for the ABS annual series Apparent Consumption of Foodstuffs and Nutrients (ABS 4306.0) was transferred from the Department to AIHW. With the cessation of Departmental funding, this work is now resourced by AIHW on an ad hoc basis, and discussion is in progress between ABS and AIHW on the long term future of the arrangement. It should be noted that the two requirements for this information are a suitable nutrient data base and a suitable food supply database. The existing nutrient database maintained by AIHW is developed from the Australian Nutrient Data Bank (administered by the ANZFA) and the food data base-a secondary ABS data collection. Whichever body carries out the analysis and interpretation of the nutrient data and the nutritional implications of food data trends needs to be familiar with the uses to which the end-result is put, and to the importance of the Apparent Consumption data as the only long term trend data available to describe food and nutrition in Australia. The resources required are for technical support for data analysis and table production (currently, Excel is used), and supervision and interpretation by an experienced nutritionist. End-stage nutrition data analysis of this kind would appear to fit comfortably with the proposed role of AIHW in nutrition monitoring under the Public Health Partnership.

It is recommended that AIHW and ABS include the ANZFA in further discussion to review and agree on long term arrangements for the maintenance of the AIHW Apparent Consumption nutrient database and the publication of nutrient apparent consumption data.

National Nutrition Survey

Current coding and analysis activities for the National Nutrition Survey are planned to finish this financial year. Although these activities could run over the end of the financial year, they could be prepaid from this year's budget. There will be an ongoing need within the Division for analyses of the nutrition survey data relating to policy questions, as well as in relation to providing indicator estimates for nutrition monitoring. The AIHW will be carrying out analyses of the National Nutrition Survey as part of its cardiovascular risk factors monitoring work and, rather than duplicating expertise and analyses, the AIHW could be funded to carry out analyses for the Division.

It is recommended that AIHW be funded to carry out additional analyses of the nutrition survey data as part of the proposed broader role in nutrition monitoring.

Previous nutrition surveys funded by the Department in 1983 and 1985 were significantly underutilised and it is important that the substantial investment made by the Department in funding the 1995 National Nutrition Survey be fully realised by ensuring that the survey data are appropriately used to inform national nutrition policy development and monitoring and are disseminated as widely as possible. All funders of the survey (Commonwealth, States/Territories, National Food Authority, AIHW) will receive a free package of tabulations to the value of \$5000, a unit record tape and publications. Although a unit record tape will be publicly available, this will be a very complex dataset due to the complexity of the survey design and the linkage with the National Health Survey. Access to the survey data should be maximised.

It is recommended that the Division, Prometheus Ltd and the Australian Bureau of Statistics negotiate to develop summary datasets for both the Nutrition Survey and the National Health Survey to be installed on HealthWIZ.

Folate Monitoring

The 1996 Budget provided funding for an education program to encourage women of child bearing age to increase their intake of dietary folate. A folate monitoring plan has been developed involving monitoring of the incidence of neural tube defects (terminations and births), analysis of folate in the Apparent Consumption of Foodstuffs and Nutrients series, monitoring of folate levels in foods, monitoring of fortification of foods, analysis of blood folate levels, and encouragement of routine antenatal screening of folate levels. The Division has approached the AIHW to co-ordinate and analyse the results of folate monitoring activities to allow for the evaluation of the folate program, with proposed resourcing for 0.5 FTE at ASO6 level.

It is recommended that the Division fund AIHW to implement a folate monitoring program as part of the general implementation of a national nutrition monitoring system.

6.1.15 Healthy public policy: injury and violence

The Australian Institute of Health and Welfare's National Injury Surveillance Unit (NISU) undertakes public health surveillance of injury at the national level to support injury prevention and control. It engages in all aspects of surveillance, and places special emphasis on analysis and dissemination of information, and on developing injury surveillance methods. It also provides a national contact point for liaison and information sharing on injury control. Many aspects of injury monitoring and control require more detailed, timely and reliable data than can be provided under NISU's core funding. Information is required to assist in the identification of hazards and solutions, enable target setting, identify and monitor new/unusual injury events and to investigate particular classes

of injury events at a fine level of detail to increase understanding of risk factors and enable research and evaluation.

NISU is addressing the surveillance and monitoring of violence and intentional injury as part of its broader injury surveillance work. The Australian Institute of Criminology is also addressing the monitoring of violence in the Australian population and is currently about to release a report on *Violent Deaths and Firearms*. It has established a homicide monitoring database and is attempting to develop population statistics relating to domestic violence. Information on alcohol-related violence is relevant to injury control, criminal justice and drugs policy making and the Division should ensure that there is appropriate coordination of information deriving from injury surveillance, criminological monitoring and the drugs statistical work.

The additional funding provided to NISU by the Public Health Division (see Appendix A, Profile 20) has assisted in advancing tighter and more detailed surveillance of injury through a variety of projects. The 1996-97 Budget provided \$300,000 for a continuation of these types of projects.

It is recommended that this additional funding to NISU continue under the proposed single funding agreement between the Division and AIHW. This funding should be used to address the further development of the injury data collected by NISU, in particular the ISIS system, to facilitate its use as a population surveillance tool and to provide an increased level of analysis and interpretation to inform national injury control policy development and evaluation.

6.1.16 Tobacco, alcohol and illicit drugs

The restructuring of the Public Health Division has led to the separation of responsibility for tobacco and alcohol in one section and illicit drugs in another. Neither of these areas has taken responsibility for the management of existing data collections, co-ordination of drug statistics or servicing of information requests. There is an urgent need to resolve the management and user support of existing data collections.

National Drug Strategy Household Survey

National Drug Strategy Household Survey - Urban Aboriginal and Torres Strait Islander Supplement

The Department has funded AGB McNair Anderson to carry out household surveys of drug use patterns, attitudes and behaviour. Because of the limited sample size, these essentially provide drug use data only for tobacco, alcohol and cannabis, the most widely used illicit drug. For these reasons, it would be feasible to address these issues as part of a broader survey program for adult and Aboriginal and Torres Strait Islander people behavioural risk factors, knowledge and beliefs (see Section 6.6.1). A number of national surveys, including the National Health Survey, collect data related to tobacco and alcohol use and there is probably scope for rationalisation of these data through the development of agreed national definitions and survey instruments under the National Health Information Agreement for inclusion in the National Health Data Dictionary.

These data provide a unique source of information on long-term trends and the collection should be repeated, though it could move to a longer time interval such as three years.

Previous surveys on drug use among people of non-English-speaking background (funded for the past 4 years) have come to an end.

It is recommended that population data on tobacco, alcohol and drugs be addressed as part of a systematic enhancement of health risk behaviours, knowledge and attitudes collection under the Partnership.

National School Students Survey

The Commonwealth provided \$76,000 towards the 1996 survey and provided national coordination to ensure that schools were not approached by States/Territories and other stakeholders to run surveys that overlapped in content. This approach should continue and could provide a useful model for development of a single broad national survey of school students health risk behaviours, knowledge and beliefs. Such a survey could be run annually and address a number of topics in depth from time to time, including tobacco, alcohol and illicit drugs.

Illicit Drug Reporting System

This system aims to provide a qualitative picture of trends in the use and availability of illicit drugs. The National Drug and Alcohol Research Centre (NDARC) conducted a 12 month pilot study of this system in Sydney and the Ministerial Council on Drug Strategy has agreed that NDARC should proceed with the trial's second stage. NDARC will report to the Ministerial Council on the trial's progress during 1997, and assuming that outcomes are satisfactory, national implementation of the Illicit Drug Reporting System should commence in 1998.

The Illicit Drug Reporting System addresses a need for monitoring data in an area that cannot be addressed using usual population health data collection methods. The current trial should lead to the establishment of an ongoing system as other drug-related data collections do not adequately provide information on the use of specific illicit drugs such as heroin. Steroid use is not included in the Illicit Drug Reporting System as it is prevalent among a different population sub-group. There is a need to develop methods to monitor the use of such drugs, and also the recreational use of licit drugs (eg. through analysis of drug prescribing patterns as discussed below).

Census of Clients of Treatment Services Clients of Methadone Treatment Programs Register

The National Drug and Alcohol Research Centre (NDARC) should continue to collect these data. Co-ordination and reporting should be carried out by the proposed AIHW-outposted officer (see below). These datasets consist essentially of head counts. There is a perceived need for more detailed data (eg. by age, sex, length of treatment). Some States have larger collections.

It is recommended that AIHW and National Drug and Alcohol Research Centre coordinate the development of a minimum dataset for clients of drug treatment services under the National Health Information Agreement.

Drug Caused Deaths

Calculation of drug caused deaths using Holman and English aetiological fractions is carried out currently in the Division and also by AIHW for its population health indicators program. Responsibility for this should transfer immediately to AIHW to be carried out as part of routine mortality surveillance. Relevant indicators should be added to all routine monitoring reports. Future responsibility for updating of aetiological fractions could also transfer to AIHW as PHD has split responsibility for drugs across two sections. This could appropriately continue as an external consultancy at five year intervals. The cost of the last consultancy was \$240,000 in 1995. These will need updating within a year or so.

The calculation of drug caused hospital admissions has not been attempted by the Department. This should also be addressed by AIHW as part of its routine monitoring work. The additional resources required by AIHW for this work would be minimal, but the Division would need to provide resources if AIHW was also to take on responsibility for updating aetiological fractions.

It is recommended that the Division transfer responsibility for the calculation of drug caused mortality and hospital admissions to AIHW.

National Drug Strategy Cost Shared Program Activity Indicators

305 services receive funding under the National Drug Strategy Cost Shared Program and each of these completes an annual 10 page questionnaire. Little use is made of this information.

It is recommended that the NDS Cost Shared Activity data collection be examined for pilot development of relevant performance indicators for the Commonwealth/State Agreements as part of broadbanded public health funding.

Use and Misuse of Pharmaceutical Drugs

The use and misuse of pharmaceutical drugs is an important public health issue, both in relation to overprescribing, polypharmacy and inappropriate prescribing, and also in relation to the illicit use of pharmaceutical drugs. This issue does not fall within the responsibility of either the Tobacco and Alcohol Strategies Section or the Illicit Drug Strategies Section. It may be a concern for the Population Health Strategies Section in relation to particular priority populations. However, there is no current focus for statistical data relating to this area. There is a need to examine the usefulness of TGA data collections and the Drug Utilisation Subcommittee database for population monitoring, surveillance and analysis in this area (see Section 5.5). If age and sex can be linked with the Drug Utilisation Subcommittee database, this could become an extremely useful source for monitoring the use of pharmaceutical drugs by particular population groups. Population surveys such as

the National Health Survey may provide another potential avenue for collecting this type of data, as may primary health service data collection (see Section 6.6.3).

It is recommended that the needs for statistical information on population use of pharmaceutical drugs be addressed as part of the coordinated approach to drugs monitoring and surveillance recommended below.

"Statistics on drug abuse in Australia 1996"

The current publication is very close to completion. It is estimated that there is approximately one person-week of work required to complete this publication to a stage ready for desktopping. Responsibility for co-ordination and preparation of future publications in this series should be taken by the AIHW outposted officer (see below) and the reports should be published jointly by AIHW and the Department.

It is recommended that the Division ensure that the publication, "Statistics on drug abuse in Australia 1996" be completed before the end of 1996 as a matter of priority.

Future responsibility for drug statistics

The Division does not currently have the capability to manage existing statistical collections, deal with drugs statistics requests or co-ordinate future data collection, analysis or reporting. The AIHW currently monitors tobacco and alcohol consumption in relation to cardiovascular disease and cancer risk using the Australian Bureau of Statistics National Health Survey, and in 1994-95, the Australian Bureau of Statistics Population Survey Monitor with funding from the Department.

An efficient way for the Division to address its needs for statistical support in relation to tobacco and alcohol statistics would be to fund the AIHW to enhance its monitoring and surveillance work in this area and provide statistical support to the Division. The National Drug and Alcohol Research Centre (NDARC) in Sydney should continue to play a lead role in the collection of data in relation to illicit drugs and drug treatment services. Co-ordination and reporting across all these areas should be carried out by the proposed AIHW-outposted officer (see Recommendation below).

The Australian Institute of Criminology is developing a criminal justice data warehouse which includes statistical information on drug usage, arrest and expitation patterns. There would be advantages to both the AIHW and to the Division in appropriate data sharing to enhance the statistical information on drugs for both organisations.

It is recommended that the Division resource AIHW to enhance its monitoring activity in relation to tobacco and alcohol and to provide an outposted officer to be located in the National Health Promotion and Protection Branch. The duties of this officer would be to:

- co-ordinate the collection, analysis and reporting of drugs statistics;
- prepare an annual report on drug use in Australia;
- manage existing drugs datasets;

- respond to requests for drug statistics; and
- liaise with the Australian Institute of Criminology for the sharing and interchange of population data relating to public health aspects of drug use.

6.1.17 National Social Health Atlas

The National Social Health Atlas of Australia was evaluated in 1995 and the evaluation report was reviewed by a Forum in Canberra on 21 November 1995. The evaluation and Forum strongly supported a second atlas based around the 1996 census as part of a larger strategy for improving spatially referenced social health information and establishing a geographically referenced social health dataset accessible in electronic form.

A proposal for the production of a second edition of *A Social Health Atlas of Australia*, *1996* based around the 1966 Population Census results is currently with the Division. The main changes from the first edition relate to the proposal to produce a separate atlas for each State and Territory, the method of producing the data and maps and the possibility of including a range of new, derived data items, such as health expectancy measures and an index of poor social health.

It is proposed to use the Department's national social health database, HealthWIZ, and its developers, Prometheus Ltd, as a main agent for this project. A mapping function is currently being added to HealthWIZ, based on EasyMap. The maps for the hardcopy atlas will be produced via HealthWIZ, which will be used to produce final output for production of film. The HealthWIZ package will allow PC users to reproduce atlas maps on the screen, for inclusion in their own reports, and also to produce custom maps and maps of other HealthWIZ data. This approach is likely to be the only one which could achieve the desired outputs in the timeframe of 18 months.

It is proposed that the SAHC be responsible for overall project management. There would be a technical reference group (to meet about twice) including 2 representatives from HFS, 2 State/Territory health agency representatives and 1 representative of AIHW. The Institute would also be involved in advising on the production of synthetic estimates, construction of health indicators from the NHS and health expectancies.

This report proposes a systematic approach to public health surveillance and monitoring. The National Social Health Atlas fits extremely well with this framework extending it from the National, State/Territory and broad regional (urban/rural/remote) perspective to enable information to be used at local level. There would be considerable gains in efficiency in coordinating these activities, for example through co-ordinated development of indicators, and in the longer term, bringing them together under the management of AIHW as part of the systematic monitoring and reporting of public health indicators.

It would thus be highly appropriate for the Division to seek closer involvement of the AIHW in the production of the second atlas. This would fit well with a closer working relationship between AIHW and Prometheus Ltd in the provision of national data for HealthWIZ and also with a closer partnership between AIHW and the Public Health Division in addressing national needs for public health information.

Issues which will need to be addressed by the Atlas project in developing summary measures of health expectancy and social health at small area level will also need to be addressed in terms of the development of core national indicators for public health monitoring. It would be worth considering a collaborative project between the Atlas team and AIHW to develop these during 1997.

It is recommended that the Public Health Division proceed with funding the production of a second edition of a Social Health Atlas of Australia through the South Australian Health Commission and seek increased involvement of and collaboration with AIHW in the project.

6.2 Information planning and management for the Division

There is currently no centralised policy or management for data collected by or for the Division. Data collections are held in subject matter branches or by agencies on behalf of these branches. This is an appropriate approach but there is a need for a Division-wide dataset management policy and cross-Divisional co-ordination to promote common standards, software and hardware approaches and to facilitate access and use within the Division. A dataset management policy should include the following elements:

- Central register of data collections this should be maintained by the Section with a requirement for dataset managers to review and update entries regularly. The documentation included in Appendix A of this report could provide a starting point for such a register.
- Dataset manager's role defined every data activity should have an identified data manager who has responsibility for managing the data activity, documenting it and regulating access by other users in accordance with any confidentiality or other constraints.
- Appropriate use of National Health Information Agreement infrastructure and conformance with national data standards and definitions.
- Software and hardware policy on preferred approaches to electronic data management within the Division.
- Data warehousing policy on Divisional standards and requirements for data warehousing once a data activity is no longer current. At present, some collections are warehoused within the Division and others in Research Centres or the ANU Social Science Data Archives. The Section or the Institute could provide a standard approach.

It is recommended that the Infrastructure Development Section develop a Divisional Information Management Policy addressing the role of the Dataset Manager, a central register of data collections, standards for documentation and access, preferred software and hardware approaches, and data warehousing.

The need for electronic access to population health data collections by the Division is discussed in Section 6.5 below. The Infrastructure Development Section will need to play

a lead role in ensuring that this need is addressed and satisfactorily implemented and that Divisional and other important health data collections are included in the system implemented. In particular, the Section should take responsibility for coordinating the provision of relevant Divisional datasets for inclusion in HealthWIZ.

It is recommended that the Infrastructure Development Section take responsibility for the development and co-ordination of systematic electronic access within the Division to Divisional data collections through HealthWIZ.

HealthWIZ comprises a large and expanding set of health and population data collections, together with a high performance and user-friendly software interface with custom table making, viewing and analysis functions. The product runs on personal computers under a Windows environment and the database can also be installed on a central server. The database will be made available on a CD-ROM later this year.

A major focus of HealthWIZ is to assist those working in public health to identify community and population subgroups with high rates of specific diseases and social disadvantage. This is one of the Division's strategies for addressing its key objective in relation to reduction of inequalities in health. For this reason, the product is priced so as to be affordable to organisations like community health centres and non-government and local groups involved in public health. Additionally, it is intended that the Partnership and the Commonwealth/State Agreements will provide incentives and conditions to promote a standardised approach to public health planning and monitoring and HealthWIZ provides a potentially valuable tool to assist in this.

A related Departmental product, also supported by Prometheus Ltd, is the HEAPS text database of primary health care and health promotion projects. While this lies outside the scope of this consultancy, it should be noted that HEAPS provides the potential for promoting evidence-based public health practice nationally and for dissemination of research in public health. HEAPS main limitation is its uneven coverage and incompleteness. Steps should be taken by the Section to ensure that, if HEAPS is to continue to be supported by the Division, that it becomes a requirement of grants and funding agreements that summary data be submitted to HEAPS.

It is recommended that the Infrastructure Development Section take responsibility for the ongoing management and support, development and promotion of HealthWIZ and HEAPS.

Both the Public Health Division and the AIHW have responsibilities in improving and promoting health and health awareness of the people of Australia. Consequently, there is a strong relationship between the work of the Institute and that of the Public Health Division. The information activities of the Institute are essential to the Division in meeting its responsibilities in the development of public health policy and in providing appropriate leadership and direction in strategies of national priority. Under the Partnership the Institute will continue to work closely with the Public Health Division and with the other partners, to collect public health data, set standards for data quality, produce public health policy

and practice.

The coordination of activities between the Public Health Division and AIHW will be essential to the successful management of the Partnership. The possibility of one or more officers from AIHW being out posted to the Division would provide diverse and far reaching advantages in the promotion and mutual awareness of each others information activities.

It is recommended that an officer from the Institute be seconded to the Infrastructure Development Section to assist in the coordination of public health information activities between the Institute and the Public Health Division. Note that this officer is in addition to that recommended in 6.1.16 regarding the future of drug statistics.

The National Health Information Agreement provides the processes and structures needed for the implementation of agreed definitions, standards and guidelines. Projects identified for development under the National Health Information Agreement are subject to the conditions specified in the National Health Information Agreement Procedure Manual. The responsibilities include: addressing the issues from a national rather than a Commonwealth, State or Territory perspective; consulting broadly; reporting to the NHIMG; and using agreed national data definitions and standards as defined in the National Health Data Dictionary.

Current developments in forging a National Public Health Partnership include plans to develop areas of the National Health Information Agreement workprogram relating to public health information. There are also plans to enhance the National Health Information Model and National Health Data Dictionary to address public health information. Information development within Public Health Division should use the existing structures to both enhance existing information and datasets and develop new ones. Work undertaken within the structures of the National Health Information Agreement culminates in its inclusion in the National Health Data Dictionary.

The National Health Data Dictionary was developed initially in the area of hospital administrative data collection, and to date, the Information Model and Dictionary have focussed largely on institutional data collections. With the increased focus on public health information by the Division, the proposed Partnership, and the increased focus on public health information in the Institute recommended by this Report, the time is ripe to develop and expand the Information Model and Dictionary to address population health data. A starting point for such activity could be the review and inclusion of relevant ABS standards for demographic data items (such as age, sex, country of birth, Aboriginal and Torres Strait Islander status). The Division could also play a lead role in the development of standards and definitions for the collection of population behavioural risk factor data such as tobacco smoking and alcohol consumption as part of its efforts to promote a coordinated approach to the collection of such data.

The development of standards and definitions for data relating to population health, health determinants and enabling factors is also a key strategy to increase the potential usefulness of State and Territory-based data collections for the compilation of national or quasi-

national public health information (see Section 6.6).

The expansion of the National Health Information Model to address population health information, determinants of health and enabling factors should be based on the conceptual model outlined and developed in Sections 3 and 4 of this report. The development of entries in the National Health Data Dictionary for such information should include not only definitions of classificatory data items (such as smoker), but also recommended survey instruments for the collection of such data. Data collected from respondents or proxies in self-completion or interview surveys is generally highly sensitive to the specific and detailed wording of questions, and it would greatly assist the standardisation of health data collection to have not only standard definitions but also standard preferred instruments for use in data collection.

Additionally, it would be useful to include in the Dictionary standards for nomenclature for defining and labelling priority populations (eg. youth, young people, adolescents) and for reporting public health information (eg. preferred age ranges). Standards for population health indicators would also be useful. An example of such a standard would be the preferred population for direct age standardisation of rates. AIHW and ABS have recently agreed on a common approach to this for national data, and it would be useful to include such standards in the National Health Data Dictionary.

It is recommended that the Infrastructure Development Section through its information management activities encourage the utilisation of the National Health Information Agreement's processes by the Division and facilitate the inclusion of Divisional projects in the National Health Information Work Program.

It is recommended that the Infrastructure Development Section and the AIHW play a lead role in the development of standards for public health information and their inclusion in the National Health Data Dictionary, in order to promote national consistency and comparability of population health data collections.

The Department currently contracts the AIHW under several separate agreements to provide a variety of statistical services to the value of \$3 million. Proposals to combine many of the ongoing agreements between the Department and the Institute into a single agreement are under discussion. As the demand for further services increases through the Public Health Division's work program it will be necessary that the Division appropriately manage contractual arrangements with the Institute and that the drafting of briefs which clearly specify requirements from both parties are properly controlled.

It is recommended that the Infrastructure Development Section provide the central liaison point for the coordination of activities between the Division and the Institute and that arrangements be put in place to manage contractual arrangements between the two bodies as part of the larger Memorandum of Understanding between the Department and the Institute.

The Australian Bureau of Statistics is Australia's national statistical agency and operates under a three year forward work program. The household survey program is designed in consultation with users under the auspices of the Population Survey Planning Committee. The Bureau's 1997-2000 forward program for their Special Household Surveys currently includes a Mental Health and Well-being Survey in 1997, a Disability and Ageing Survey in 1998 and a National Health Survey in 2000. The Infrastructure Development Section should ensure that the Division's needs are properly canvassed, that a more strategic approach is taken in identifying survey requirements and lobby for their inclusion in the Australian Bureau of Statistics survey program.

It is recommended that the Infrastructure Development Section critically examine the Division's data needs, identify those that could be met through the Australian Bureau of Statistics household survey program and take appropriate steps to influence the content of the survey program.

A Public Health Information Cross Divisional Coordination Group was established at the beginning of this consultancy to provide a mechanism for discussion of information needs and availability within the Division. All areas of the Division involved with statistical information were represented. This Group provides a useful forum for information exchange and strategy development.

It is recommended that the Public Health Information Cross Divisional Coordination Group continue as part of the information development strategy for the Division.

In Portfolio Strategies Group's rationalisation of statistical collections exercise, it was noted that the Department spends some \$8 million per annum on statistical functions. Obviously, there are many areas outside the Public Health Division contributing to this expenditure. Work needs to be put into identifying appropriate links with those areas throughout the department that are working on health and statistical issues so that information and experience can be shared. Furthermore, current technology provides an easy and relatively cost effective vehicle for information sharing so consideration should be given to preparing a short monthly "Public Health Newsletter" for electronic distribution. Good communication and information sharing arrangements should be established and maintained with the Portfolio Strategies Group, NHMRC, National Health Priority Areas and the National Health Information Management Group and other areas identified in Section 5 above.

It is recommended that the Infrastructure Development Section take formal steps to establish a cross-portfolio information group to meet monthly.

A public health information development plan should be prepared to guide the work of the Division within the context of the Partnership and its core activities in developing public health policy and promoting the health of Australians. This report and the recommendations contained therein would provide the starting point and a sound basis for a Public Health Information Development Plan. The Plan would require ongoing review and updating to reflect emerging priorities for the Division and the Partnership. The NHMRC's triennial work program and research priorities, and those of the AIHW and the National Health Information Management Group would need to be addressed in coordinating the Plan. The objectives of the Plan could be:

- to document the priorities and strategies in information development within the Public Health Division;
- to promote the development of high priority public health information;
- to improve collaboration in the development of public health information; and
- to increase the cost-effectiveness of Australia's public health information system.

The basic principles of timeliness, reliability, consistency, relevancy and accessibility are fundamental to the development of quality public health information. The Plan should address priority populations, diseases and intervention strategies as well as development of a public health information model which will provide the framework for all other developments. Such a model will be vital to the development of public health information to support both the Partnership and the proposed reforms in the financing and delivery of health and community services in Australia.

It is recommended that Infrastructure Development Section under the guidance of the Cross Divisional Coordination Group prepare a Public Health Information Development Plan which reflects the priorities in information development within the Division and is consistent with the needs of the Partnership and the Institute's program for the development of national health information.

As the Division moves into an era where greater demands are being placed on performance information, both in terms of monitoring the efficiency and effectiveness of individual programs as well as policy and management initiatives, there will be a need to increase the skill base in the Division. Consideration should be given to ensuring that relevant staff have the opportunity to develop skills in statistical methods, data management, use and analysis of statistics, and in the use of statistical and data base software packages. Elements of such training could be provided by the ABS, AIHW and NCEPH, either informally through seminars or more formally through the conduct of short training courses. More formal academically accredited training courses could potentially be provided by PHERP-funded university departments.

It is recommended that Infrastructure Development Section explore options for training programs that will meet the needs of the Division.

6.3 Public health indicator development strategy

Section 4 of this report outlined an integrated framework for the development of population indicators for national monitoring and surveillance relating to public health and identified the types of information needed for (a) monitoring, (b) surveillance and (c) evaluation and program management. Recommendations have been made throughout this Section for the development of indicators for specific areas of national public health priority. Three levels of indicators are proposed:

- core national indicators for monitoring the public health;
- comprehensive national indicators for surveillance of the public health; and
- performance indicators for national public health priority areas.

The core national indicators for monitoring the public health should consist of a relatively small number of indicators for monitoring improvements in the public health and the key determinants of the public health in order to report on progress in achieving national goals for improved population health. These indicators would include global measures of health gain (or disease impact) and cost savings, a single global indicator of health inequity for each priority population, as well as health indicators for major areas of national public health priority and normative indicators for key health determinants. Trends in these indicators would be reported on regularly at national and State/Territory level under the National Public Health Partnership.

It is very important to ensure that a hardnosed approach is taken to ensuring that the core national monitoring indicators are tightly focused and normative, so that trends in each such indicator are clearly and directly interpretable in terms of ultimate health gain. Where the links between public health interventions and health outcomes are not well understood, there is a need for further research and evaluation to examine the evidence base for the link between (1) interventions and outcomes and (2) indicators and the interventions they measure.

A comprehensive set of national indicators for surveillance of the public health would include comprehensive indicators covering all diseases, injury and known major determinants of health within the framework developed in Section 3. These indicators would provide a surveillance tool for identifying emerging issues and assist in developing national public health priorities under the Partnership.

Performance indicators for national public health priority areas would comprise predominantly process indicators and indicators of access for priority populations. These indicators would be used for evaluation of national public health programs, specifying performance in Commonwealth/State Agreements and for management, reporting and quality assurance. Agencies responsible for the co-ordination and management of public health programs should take responsibility for the development of appropriate performance indicators.

The AIHW is ideally placed to play a lead role under the Partnership in development of the first two of these sets of indicators. Such development should use the conceptual framework outlined in Section 3 to ensure that national indicators can be reported consistently for all priority populations.

It is recommended that the AIHW play a lead role under the Partnership in the development and implementation of core national indicators for monitoring the public health and comprehensive national indicators for surveillance of the public health.

It is recommended that the Division should provide some funding to AIHW to support the implementation of the core national public health indicators and of comprehensive indicators for surveillance over the next three years.

6.4 National reporting

The AIHW currently reports biennially on the health status of Australians as part of its biennial report to Parliament as required by its Act. AIHW has also taken responsibility for reporting to AHMAC annually on progress towards goals and targets for the National Health Priority Areas. Additionally, AIHW produces regular publications for surveillance and monitoring of mortality, cardiovascular disease, cancer, injury, congenital malformations and Aboriginal and Torres Strait Islander health (see Appendix B).

Recently, as part of the evaluation of Program 1, the AIHW was commissioned by the Division to produce a "state of the nation" report summarising trends in key population health status and health determinants and comparing Australia with seven comparable OECD countries (AIHW 1996b). There is an expressed need in the Division for a report of this type, although it inevitably cannot provide depth of analysis and detail in relation to specific areas of particular priority for the Division. Sections within the Division also identified the need for more detailed regular reports, with added-value analysis and commentary, in relation to public health areas of priority to the Division. These include child and youth health, rural and remote health, women's health, alcohol and drugs and areas of priority for healthy public policy.

It will be crucial to rationalise and address the various needs for reporting in a coherent way to ensure that the important needs are met without duplication or inefficiency. This will require that the needs for national reporting under the Partnership (where it is expected that AIHW would take a lead role), the needs for reporting to AHMAC on National Health Priority Areas, the national needs for regular statistical reports in areas of public health priority and for priority populations, and the Division's needs for statistical analysis and support all be addressed coherently by AIHW in developing its publication program in the health area.

In the course of this consultancy, it became apparent that there were a variety of perceived needs for national reporting of public health indicators and that these were not consistent. Some staff perceived a need for a state of the public health report placing Australia in international context, others for a more detailed reporting of a common set of public health indicators for the whole of Australia and for States/Territories, and in some cases, going down to regional and local level, others for a report focused more on performance indicators. There were also a variety of views on the format of reporting, ranging from straight statistical tabulations (perhaps in electronic format) to reports with considerable analysis and interpretation identifying key issues for policy development and evaluating the success of public health interventions.

It is recommended that AIHW produce a regular national report for the Partnership on the state of the public health (based on the core national indicators) and also develop an appropriate mechanism for the regular reporting and dissemination of the comprehensive national surveillance indicators.
6.5 Online access to public health information

Staff of the Public Health Division need access to up-to-date public health information in a way that enables them to explore the information beyond the level of predefined tabulations. As well as reports and ad hoc data tabulations, there is a clearly felt need for electronic access to population health data sets in a form that allows staff to define and revise tabulation requests, to construct particular views of data and to tabulate statistical indicators. In particular, if the Division is to fund AIHW to provide information support, there will be a need for AIHW to provide staff of the Division with appropriate electronic access to its major health data collections.

AIHW do not at present supply data online or provide electronic versions of their data collections for general external use, although it is currently developing a home page on the Internet and it is intended that text documents such as Australia's Health and static tabulations from their publications will be available there.

HealthWIZ has been funded by the Division to provide this type of functionality to all public health workers, but to date there has been limited access within the Division to HealthWIZ and even less use. HealthWIZ is owned by the Department of Health and Family Services, and is developed and supported by Prometheus Ltd under contract to the Department. The project was established in 1991 and is acknowledged as a valuable information resource for public health planning both by Government and non-Government agencies. The Department has made a substantial investment over 5 years in the development of HealthWIZ and plans to enhance and further promote its use. Work needs to be undertaken to pilot a project within the Division (or HFS more broadly) to ensure that HealthWIZ is available on the Department's computer system in a form that is readily accessible by PHD staff at their desks. This was discussed in Section 6.2.

The Department has invested considerable funding to develop a high performance database and software interface that substantially outperforms other statistical packages of this type in functionality, storage and memory requirements and speed. A mapping module is currently being added to HealthWIZ and the Department is considering a proposal to produce the second edition of the Australian Social Health Atlas using HealthWIZ as a primary tool for the production of the maps.

HealthWIZ currently contains national datasets for population (1991 census), mortality (to 1993), hospital morbidity (to 1993/94), cancer (to 1994), Medicare (to 1995) and DSS recipients (1996). Most of these datasets are also held by AIHW and there is currently a duplication of effort by AIHW and Prometheus Ltd in obtaining datasets from data providers, particularly State and Territory health authorities. For HealthWIZ to meet the Department's objectives and to be widely useful, it is important that it contain comprehensive and up-to-date health information.

There is considerable potential for addressing this need while minimising data provider burden, through the AIHW facilitating the provision of single sets of national data to HealthWIZ, both for existing datasets included in HealthWIZ and for additional major national health data collections. This will also provide a solution to the Division's need for online interrogation of AIHW data collections.

It is recommended that AIHW facilitate the ongoing provision of single sets of national data to HealthWIZ, for all major national health data collections held by AIHW.

The enhancement of HealthWIZ to include up-to-date datasets drawn from the major AIHW health data collections may also offer an attractive and cost-effective solution to some of AIHW's requirements for providing general electronic access to its data collections in a way that safeguards the databases and the confidentiality of data.

It is recommended that AIHW investigate the potential of HealthWIZ to provide a low cost and rapidly implementable solution to its need to develop appropriate general electronic access to its data collections.

It is recommended that the Division provide funding to AIHW to enhance its statistical support to the Division in terms of public health information and data development, online and fast-turn-around access to statistics and value-added analysis and iterpretation. Such support could extend to the outposting or part outposting of an officer in the Population Health Strategies Section.

The evaluation of Program 1 identified a concern within the Division and by its stakeholders that cost recovery policies introduced by Australian Bureau of Statistics had led to loss of access to public health data and a consequent reduction in the use of information in developing and evaluating public health policy. It will be important to ensure that moves to cost recovery by health statistical agencies are genuinely restricted to covering the marginal cost of information delivery and that public health information itself does not come to be seen as a business product. HealthWIZ has been developed by the Department to improve public access to national health information at low cost. As well as providing a potential solution to AIHW's need to provide online access to its national data collections, HealthWIZ could offer an attractive starting point for the development of a National Public Health Information System under the Partnership.

The Division has identified the need for an improved Division-wide information system, providing access not only to key health indicators, but also to program and budgetary performance information. Such an Executive Information System could also integrate access to key text databases. A pilot project should be undertaken to establish an on-line, user friendly public health data and information system for staff in the Division. The population statistics part of this could be based on HealthWIZ. The executive information (budgets, staffing, performance indicators) should be developed on contract. PSG currently provides spreadsheet-based up-to-date monthly performance information to the Secretary and this could be used as a model for the development of a Division Executive Information System. Alternately, HealthWIZ could be expanded to provide a platform for this information. A third option would be to develop a system using the Intranet, currently being piloted in several Divisions within the Department.

It is recommended that the Division contract a consultant to develop a proposal for the implementation of an Executive Information System for the Division.

6.6 Addressing gaps in public health data

The National Public Health Partnership, the National Health Information Agreement and the proposed closer collaboration between the Division and AIHW in developing national public health information collectively provide a valuable opportunity for systematically reviewing the collection of national health information in Australia and for addressing some of the data gaps and deficiencies identified in Section 4 and above in this Section.

New methods of data collection should be examined by the Division and the AIHW under the Partnership to support national public health surveillance and monitoring. These include:

- Sentinel surveillance networks. Sentinel surveillance networks are currently mainly used for identifying outbreaks of infectious diseases. Work should be done on exploring their use for other aspects of public health including determinants of health and public health service provision in primary care.
- Data collection through institutional settings. Data could be collected through institutional settings such as schools or workplaces. Issues to be explored here include whether such data should be incorporated into routine administrative collections or collected on the basis of a sample survey.
- Use of modern technologies for data capture (eg. CATI surveys).
- Rolling health and risk factor surveys.
- Collection of common modules of information in State-based surveys and aggregation to national level.

The National Health Information Agreement has initiated a process of national development of data items and definitions, and many groups are developing indicators and minimum data sets. These efforts have been largely confined to treatment services and institutional health care and the time is now right to extend them to address health status, the determinants of health, and public health inputs and processes.

If we are serious about monitoring progress in public health nationally, we need far more deliberate and conscious coordination of State and Territory health data collections, together with agreement on the basic indicators that should be monitored. This will provide the potential for production of national monitoring, surveillance and evaluation information without the necessity to mount expensive large national survey programs.

6.6.1 Surveillance of health risk factors, knowledge and beliefs

The rationalisation of some of the current statistical activities of the Division provides an opportunity to address the more systematic collection of population information relating to health determinants and enabling factors, especially knowledge, attitudes and beliefs. The Division should take a lead role in reviewing the data requirements for evaluation of the National AIDS Strategy and for ongoing monitoring of sexual and other risk behaviours in the general populations and risk populations. This review should provide input to the development under the Partnership of a more coherent national set of survey vehicles for population risk factors, knowledge, attitudes and beliefs.

It is recommended that the Division and AIHW play a lead role under the Partnership in the development of an information collection strategy to address the need for populationbased surveillance and monitoring of health risk factors, knowledge, attitudes and beliefs in adults.

The Division's success in co-ordinating a national approach to the collection of information on drugs from school children should provide a model for the development of a broader national survey vehicle for collecting health information for children and youth.

It is recommended that the Division and AIHW play a lead role under the Partnership in the development of a co-ordinated national information collection strategy to address the need for population-based surveillance and monitoring of health risk factors, knowledge, attitudes and beliefs in children and youth.

The National Aboriginal and Torres Strait Islander Survey covers a limited set of health issues as part of a wider survey covering the full range of issues. There is a need for a more focused survey that would address key risk factors, determinants of health, knowledge attitudes and beliefs for Aboriginal and Torres Strait Islander people. The drug survey could be widened to cover other areas of knowledge, attitudes and beliefs, but priority topics for coverage in such a survey would continue to be tobacco, alcohol, illicit drugs and sexual risk behaviours. It would be important to ensure that the content of such a survey is closely linked to agreed core public health indicators, that issues of comparability with non-Aboriginal population data are properly addressed, and that the survey is developed in consultation with Aboriginal and Torres Strait Islander people.

It is recommended that the Division and AIHW play a lead role under the Partnership in developing a broad-based survey of health risk factors, knowledge, attitudes and beliefs for Aboriginal and Torres Strait Islander people.

6.6.2 A national blood survey

The AIHW is currently investigating the perceived needs for a national blood survey to address an identified gap in Australia's health statistics in relation to monitoring of blood lipids and other biochemical risk markers. Such a survey would also be of potential relevance to the National Diabetes Action Plan, the National Childhood Immunisation Program as well as for National Health Priority Area monitoring of cardiovascular and cancer risk factors.

The AIHW has now had experience in the collection of population samples of blood in the National Survey of Lead Levels in Children. Potential stakeholders include the Division (in relation to national nutrition issues, diabetes and cardiovascular risk factors), other Federal government departments, industry and consumer organisations, NHMRC and health researchers, State and Territory health authorities and the National Food Authority. As part of the development of the 1995 National Nutrition Survey, an expert technical working group recommended the following priorities for biochemical tests of blood collected in a national survey. Priority One tests were recommended for collection from all participants aged 16 years and over. Priority Two tests were recommended for blood collected in

metropolitan areas only. The priority of measuring insulin level should also be considered now that diabetes has been identified as a national health priority area.

Priority One Ferritin Complete blood count Folate Red cell distribution width Haemoglobin Iron and total iron binding capacity Cholesterol (total and HDL) Albumin Glucose

Priority Two Retinol Vitamin E Carotenoids Triglycerides

The forthcoming 1996-97 New Zealand Health Survey and National Nutrition Survey will collect blood samples from a random population sample of 8,500 people aged 15 years and over. Blood measurements will be made for cholesterol, iron, folate, vitamin A and dioxins.

It is recommended that the Division and AIHW play a lead role under the Partnership in assessing the need for a national blood survey as part of the national public health data collection system.

6.6.3 Primary health services

As discussed in Section 4, the lack of population-based information on symptoms, diseases and injuries for which people seek primary health care and on the provision of public health interventions by primary health care providers is a major gap in the national health information.

The Department funded a national survey of general practitioners in 1990 which collected information on the reasons for encounter, diagnoses, treatments, prescriptions and referrals for over 100,000 general practitioner encounters (Bridges-Webb et al 1992). This survey has provided an invaluable source of information which is becoming increasingly dated. The Family Medicine Research Unit at Westmead has continued to collect similar data from a voluntary sample of general practitioners who earn accreditation points under the Family Medicine Program. This sample is much smaller than that of the 1990 survey and is likely to be skewed towards younger general practitioners.

A number of potential strategies could be used to address the needs for such data:

- Repetition of a survey along the lines of the Bridges-Webb survey of 1990. This has the disadvantage of being an expensive one-off data collection exercise but the advantage sufficient sample size for analysis of less common problems and interventions.
- Sentinel surveillance networks.
- Data collection from service providers. Collection of practice data from GPs could be co-ordinated through Divisions of General Practice and incentives provided in terms of accreditation points.

It is recommended that the Population Health Strategies Section take responsibility for exploring collection strategies for primary care data in the context of the national public health needs and of the needs for service utilisation data for men and women.

6.6.4 Expenditure on public health

A valuable addition to the collection of data on enabling factors, health determinants and health status would be appropriate reporting on the total monetary expenditure in the public health area by program area of expenditure, and perhaps in the longer term, by priority population. Such information would provide a vehicle for evaluating the macro priorities for health expenditure, the equity of current resourcing patterns, and additional analyses could also identify "value for money" public health programs (see Section 4.4).

Current developments in the COAG negotiations suggest that it may become increasingly difficult for the Commonwealth to obtain information on public health processes, inputs and outputs at State and Territory level. Consequently, it is important to ensure that appropriate public health financial reporting is in place, perhaps one stage removed from the source of funding, and therefore, that the work currently being developed by AIHW and the National Centre for Health Program Evaluation be continued.

It is recommended that a program be instituted for the ongoing monitoring of public health expenditure and that it be coordinated with the AIHW health expenditure database.

6.7 Proposed AIHW support for the Division

Under the Public Health Partnership, it is assumed that AIHW will be the lead agency for information infrastructure development, including:

- the co-ordination and development of national health data collections to address the national needs for public health data under the Partnership;
- development and implementation of a core national indicators for monitoring and comprehensive national indicators for surveillance; and
- national reporting of these sets of indicators.

Current core work program activities of the AIHW relevant to the Public Health Division include mortality surveillance, cancer surveillance, cardiovascular disease monitoring, injury surveillance, national perinatal statistics, Aboriginal and Torres Strait Islander statistics, health expenditure, monitoring of indicators for the National Health Priority Areas and monitoring of general population health indicators.

Recommendations have been made that the Division reach agreement with AIHW to provide it with support for a number of existing statistical activities, for development activities, for general support in provision and analysis of health information, for online access to AIHW data collections, and for the provision of statistical and health information expertise to the Division. Staff of the Division raised a number of concerns about a proposed arrangement under which AIHW provided enhanced support to Public Health Division. Some of these are also discussed in the Evaluation Report for Program 1. They included:

- insufficient agreement on and common understanding of objectives and outputs;
- lack of common understanding of the relationship between AIHW and Department;
- lack of confidence in AIHW expertise in interpretation and analysis in specific areas;
- lack of access to AIHW data; and
- concern about cost recovery becoming a barrier to access.

In relation to the first of these points, it is important to clarify the exact standing of the AIHW in relation to work for the Department - whether the relationship is purchasercontractor or partnership within the Portfolio. The proposed outposting arrangement will assist in improving mutual understanding on these issues, as will a closer working arrangement between the AIHW and the Division.

The Table on the following page summarises the proposed areas of AIHW support for the Division and provides estimates of either the annual funding in dollars or the estimated annual FTE required for each activity. Those estimates asterisked are total rather than annual estimates. The FTE estimates are very indicative and these activities will need to be properly costed, including non-staffing costs, in developing the proposed agreement.

These proposed activities should be consolidated into a single agreement between the Division and the AIHW and implemented as a part of the head Memorandum of Understanding being developed by AIHW and Portfolio Strategies Group.

It is recommended that the Division negotiate an agreement with the AIHW for providing specific statistical support activities relating to public health information and that this Agreement be implemented as a component of the larger Memorandum of Understanding between the Department and the AIHW being developed by AIHW and Portfolio Strategies Group.

Activity	FTE	Cost
Injury surveillance Additional funding to NISU		300,000
Nutrition monitoring Implementation of nutrition monitoring Further analysis of Nutrition Survey Folate monitoring	1.5 0.5* 0.5	
Men's and women's health Support for development and reporting of national monitored indicators	0.4	
Child and youth health Development of national minimum dataset Biennial reporting on child and youth health	0.3	63,000
Tobacco, alcohol and drugs Minimum dataset for clients of drug treatment services Monitoring of drug-caused mortality and morbidity Coordination and statistical support for tobacco, alcohol and drugs statistics - AIHW officer outposted to PHD Enhanced monitoring of tobacco and alcohol	0.1* - 1.0 0.2	
Development of national public health indicators Development and implementation Reporting	0.5	
Public health information support AIHW outposted officer for public health information support Population health strategies - statistical support and data development Online support (HFS access to AIHW data) Value-added analysis and interpretation	1.0 1.0(a) - 0.5	
Data warehousing		
Total - AIHW based - Seconded to Division	4.5 3.0	363,000

Table 3: Proposed Areas of AIHW Support to Public Health Division

(a) Level of support determined by the Division's requirements. An AIHW officer could be seconded or part-seconded to the Population Health Strategies Section.

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APPENDIX A

Public Health Division Statistical Activities

Communicable Diseases (Profiles 1-11)

- Communicable disease surveillance systems and reporting
- National Childhood Immunization Register
- HIV/AIDS National Registry
- Human Pituitary Hormone Patient Database
- Human Pituitary Hormone Counselling Service Database
- Creutzfeld-Jakob Disease Case Registry

Cancer Control (Profiles 12-13)

- Breastscreen Australia Performance Measures
- National Cervical Screening Program Performance Measures

Population Health Strategies (Profiles 14-18)

- Australian Longitudinal Study on Women's Health
- National Women's Health Services National Evaluation Dataset
- Family Planning Program Annual Reporting
- Cardiopulmonary Rescuscitation (CPR)

Healthy Public Policy (Profiles 19-20)

- National Nutrition Survey
- NISU Additional Funding

Tobacco, Alcohol and Illicit Drugs (Profiles21-29)

- National Drug Strategy Household Survey
- NDS Household Survey Urban ATSI Supplement
- National School Students Survey
- Illicit Drug Reporting System
- Census of clients of treatment services
- Clients of Methadone Treatment Programs Register
- Drug Caused Deaths
- NDS Cost Shared Program Activity Indicators
- Statistics on drug abuse in Australia 1996

Sexual and IDU Risk Behaviours (Profiles 30-33)

- Project Male Call
- Schools Survey
- Needle and Syringe Exchange Survey
- Sydney Men and Sexual Health (SMASH, MASH and BASH)

General

- HealthWIZ
- Social Health Atlas of Australia

1: NATIONAL NOTIFIABLE DISEASES SURVEILLANCE SYSTEM

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Brief description:	The NNDSS coordinates the surveillance of communicable diseases that are notifiable under State and Territory public health legislation. The list of nationally notifiable diseases is recommended by the National Health and Medical Research Council.
PHD Branch:	National Centre for Disease Control
Purposes:	 Monitor the occurrence of communicable diseases in Australia Identify trends in the incidence of notifiable diseases, including outbreaks Provide data for the efficient planning of prevention and control measures (policy development)
Frequency/timing:	Fortnightly, Annual report
Target population:	All Australians
Scope and coverage:	National
Collection methodology/ Data sources:	Case reports from each State and Territory health authority
Collection/management agency:	State and Territory health authorities
Ownership/Access:	State and Territory health authorities provide computerised, de-identified unit records of notifications to the Department of Health and Family Services for collation, analysis and publication. The Communicable Diseases Network Australia- New Zealand 'owns' the data.
Unit of enumeration:	Episodes of specified disease/disease group
Size of collection:	Approximately 300,000 records
Data content:	State Disease name Date of onset Date of notification to the relevant health authority Demographic information (age, sex, postcode) Unique identifying number
Aboriginal identification:	Yes
Geographic levels:	Postcode
Identifiability:	No
Output:	Communicable Diseases Intelligence Department of Health and Family Services (Fortnightly); Annual Report; Presentations at scientific meetings.
Storage:	Electronic (EpiInfo)

Appendix A Communicable Diseases

Special technical requirements:	Expertise in epidemiology, communicable diseases and public health
PHD Staffing:	1.8 FTE per annum
Cost:	1. Running costs \$117,000 2. Program costs \$Nil
Funding sources:	Ongoing surveillance program funds
Review/evaluation:	Current case definitions were developed in 1993. A further review is planned for 1997. The list of notifiable diseases is also to be reviewed.
Comments:	The draft National Communicable Diseases Strategy (HFS 1996) recognises the limited resources in the National Centre for Disease Control to undertake the full range of surveillance activities, the limited capacity of the NHMRC to develop policies in a timely manner, the variation in infrastructure for communicable disease surveillance in the States and Territories, and the current ad hoc laboratory based surveillance. In view of these issues and the need to strengthen the coordination and planning of surveillance activities at the national level, and to develop a strategic plan for responding to new or emerging infections, the Strategy recommends the establishment of a National Surveillance Centre and that Surveillance Units be established to produce health intelligence and advise on specific disease or groups of diseases.
Data Manager/Contact:	Graeme Oliver 06 289 7217 Margaret Curran 06 289 7416

2: HIB CASE SURVEILLANCE SCHEME

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Brief description:	A national surveillance scheme which provides information on cases of invasive Hib disease, including type of illness, method of diagnosis and outcome.
PHD Branch:	National Centre for Disease Control
Purposes:	 Monitor trends in Haemophilias influenzae type b (Hib) Measure the effectiveness of the Hib immunisation program
Frequency/timing:	Ongoing surveillance
Target population:	All Australians
Scope and coverage:	National
Collection methodology/ Data sources:	Case reports from State and Territory health authorities
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	Communicable Diseases Network Australia - New Zealand owns the data. The Department has unlimited access.
Unit of enumeration:	Person
Size of collection:	Approximately 400 records
Data content:	Age Sex Date of birth Postcode Date of onset of illness Type of illness Method of diagnosis Outcome and immunisation status
Aboriginal identification:	Yes
Geographic levels:	Postcode
Identifiability:	Yes
Output:	Communicable Discases Intelligence Department of Health and Family Services (Annual)
Storage:	Electronic
Special technical requirements:	Knowledge of issues relating to public health, especially immunisation and vaccine efficacy
PHD Staffing:	0.06 FTE per annum

Appendix A Communicable Diseases

Cost:	1. Running costs \$4,000 2. Program costs \$Nil
Funding sources:	Ongoing surveillance funds
Review/evaluation:	
Comments:	The system may be able to be discontinued within the next few years assuming case reports continue to decrease at the present rate
Data Manager/Contact:	Ana Herceg 06 289 8638

3: VIROLOGY AND SEROLOGY LABORATORY REPORTING SCHEME

Brief description:	The Virology and Serology Reporting Scheme began operating in 1977. At present the scheme comprises 21 sentinel laboratories from all States and the ACT which contribute data on the laboratory identification of viruses and other organisms.
PHD Branch:	National Centre for Disease Control
Purposes:	Monitor trends in viral pathogens eg influenza
Frequency/timing:	Fortnightly
Target population:	All Australians
Scope and coverage:	National
Collection methodology/ Data sources:	21 laboratories from around Australia forward reports to the Department of Health and Family Services
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	Department of Health and Family Services is the custodian of the data. Contributing laboratories own the data.
Unit of enumeration:	Person
Size of collection:	Approximately 500,000 records
Data content:	Mandatory: Laboratory Specimen Collection date Patient identifier code Specimen source Agent detected Method of diagnosis Optional: Specimen code Sex Date of birth or age Postcode of residence Clinical diagnosis Risk factors Comments
Aboriginal identification:	No
Geographic levels:	Postcode
Identifiability:	No

Appendix A Communicable Diseases

Output:	Communicable Diseases Intelligence Department of Health and Family Services (Fortnightly); Annual Report; Presentations at national and international meetings.
Storage:	Mainframe
Special technical requirements:	Knowledge of diagnostic virology/microbiology, epidemiology and public health
PHD Staffing:	0.5 FTE per annum
Cost:	1. Running costs \$32,500 2. Program costs \$Nil
Funding sources:	Ongoing surveillance program funds
Review/evaluation:	The system was evaluated in 1995 and many of the recommendations have been implemented
Comments:	The information is required on a regular basis by public health officials. The system could be managed externally without significant impact provided the Department had access to the database as required
Data Manager/Contact:	Ross Andrews 06 289 7475 Margaret Curran 06 289 7416

4: NATIONAL MYCOBACTERIAL SURVEILLANCE SYSTEM

Brief description:	The National Mycobacterial Surveillance System was instituted in 1991 to strengthen monitoring of tuberculosis notification rates and contemporary risk factors such as HIV infection and birth in a country with a high prevalence of tuberculosis.
PHD Branch:	National Centre for Disease Control
Purposes:	 Monitor trends in tuberculosis Provide data for policy development
Frequency/timing:	Annual
Target population:	All Australians
Scope and coverage:	National
Collection methodology/ Data sources:	Reports from State and Territory health authorities
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	State and Territory health authorities
Unit of enumeration:	Person
Size of collection:	Department of Health and Family Services
Data content:	Person
Aboriginal identification:	Yes
Geographic levels:	States and Territories
Identifiability:	No
Output:	Communicable Diseases Intelligence Department of Health and Family Services (Fortnightly)
Storage:	Electronic
Special technical requirements:	Expertise in epidemiology, communicable diseases and public health
PHD Staffing:	0.2 FTE per annum
Cost:	1. Running costs \$13,000 2. Program costs \$Nil
Funding sources:	Ongoing surveillance program funds

Appendix A Communicable Diseases

Review/evaluation:	The system was reviewed in August 1996 in the context of the recommendations of the NHMRC TB Working Party
Comments:	
Data Manager/Contact:	Graeme Oliver 06 289 7217

5: COMMUNICABLE DISEASES INTELLIGENCE

Brief description:	Communicable Diseases Intelligence (CDI) publishes reports from several national communicable diseases surveillance schemes on a regular basis. These surveillance systems are conducted to monitor the occurrence of communicable diseases in Australia, to detect trends and to highlight needs for further investigation or for the implementation or modification of control measures. Articles, editorials, outbreaks, case reports and notices regarding communicable diseases (incidence, epidemiology, public health issues, etc) are also published in the CDI.
PHD Branch:	National Centre for Disease Control
Purposes:	 Provide information on communicable diseases Inform and assist those involved in the management of communicable diseases
Frequency/timing:	Fortnightly
Target population:	All Australians
Scope and coverage:	National
Collection methodology/ Data sources:	See individual surveillance systems included in the bulletin; Articles are also submitted by independent authors
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	Communicable Diseases Network Australia - New Zealand
Unit of enumeration:	Person
Size of collection:	Refer to individual surveillance systems
Data content:	Refer to individual surveillance systems
Aboriginal identification:	No
Geographic levels:	National
Identifiability:	No
Output:	Fortnightly publication
Storage:	PC / Hard copy / Internet
Special technical requirements:	Knowledge of epidemiology, public health surveillance, communicable diseases and editing
PHD Staffing:	2.0 FTE per annum
Cost:	1. Running costs \$130,000 2. Program costs \$200,000

Appendix A Communicable Discases

Funding sources:	Ongoing surveillance program funds
Review/evaluation:	The publication has recently been reviewed by a consultancy team from the Medical Journal of Australia plus a readership survey (1995). An Editorial Advisory Board also oversee the process.
Comments:	The publication is part of the core function of the Surveillance and Management Section to disseminate significant summary information of all national surveillance and updates on communicable disease outbreaks of national significance
Data Manager/Contact:	Ana Herceg 06 289 8638

6: SURVEILLANCE OF SERIOUS ADVERSE EVENTS FOLLOWING VACCINATION

Brief description:	A national surveillance scheme initiated through the National Childhood Immunisation Committee
PHD Branch:	National Centre for Disease Control
Purposes:	 Identify serious adverse events which follow childhood vaccination Monitor trends and risk factors in serious adverse events following childhood vaccination Provide information to inform the debate on the risks and benefits of vaccination Identify areas that require further research
Frequency/timing:	Ongoing surveillance
Target population:	All children
Scope and coverage:	National
Collection methodology/ Data sources:	Case reports from State and Territory health authorities
Collection/management agency:	State and Territory health authorities
Ownership/Access:	State and Territory health authorities provide unit records of notifications to the Department of Health and Family Services for collation, analysis and publication. The Communicable Diseases Network Australia - New Zealand 'owns' the data.
Unit of enumeration:	Person
Size of collection:	180 records
Data content:	Vaccine(s) temporally associated with the event Possible risk factors in the child's medical history Details about the nature, timing and outcome of the event Demographic information (name, date of birth, postcode)
Aboriginal identification:	No
Geographic levels:	Postcode
Identifiability:	Yes
Output:	Communicable Diseases Intelligence Department of Health and Family Services (Quarterly)
Storage:	Electronic
Special technical requirements:	Knowledge of immunisation procedures and epidemiology and public health

Appendix A Communicable Diseases

PHD Staffing:	0.09 FTE per annum
Cost:	1. Running costs \$6,000 2. Program costs \$Nil
Funding sources:	Ongoing surveillance program funds
Review/evaluation:	The system will need to be revised within the next year
Comments:	The information collected is also provided to ADRAC. While there is some overlap in the data collected, this system collects much more detailed information.
Data Manager/Contact:	Ana Herceg 06 289 8638

7: NATIONAL CHILDHOOD IMMUNISATION REGISTER

Brief description:	A national register containing information on the immunisation status of children from birth to six years of age.
PHD Branch:	National Centre for Disease Control
Purposes:	 Provide a measure of immunisation coverage data at national, State, Territory and local level. Provide an effective management tool for monitoring immunisation coverage to improve service delivery. Identify areas at high risk because of large numbers of unimmunised children. Enable immunisation providers and parents to check on the immunisation status of an individual child, regardless of where in Australia the child was immunised. Form the basis of an optional recall/reminder scheme which will inform parents when their child's next vaccination is due or overdue.
Frequency/timing:	Ongoing
Target population:	All children under 7 years of age
Scope and coverage:	National
Collection methodology/ Data sources:	 The registration of immunisation providers is self initiated. The registration of children is primarily based on Medicare registrations. However, other registrations occur as a result of an encounter with a registered provider. Immunisation notifications are provided through the state health authority in each of Queensland, Northern Territory, and the ACT. In other states the notifications are made direct to the HIC by the registered provider.
Collection/management agency:	Health Insurance Commission (HIC)
Ownership/Access:	"Nominally" ownership of the data is currently vested in the National Childhood Immunisation Committee (NCIC). This issue of ownership needs to be resolved. Departmental access as determined by the HIC
Unit of enumeration:	Person/Vaccine
Size of collection:	1.85 million children at 30 June 1996
Data content:	Children: Medicare No. Demographics Vaccine Provider: Identifying no. Agency or GP name BSB/account details

Appendix A Communicable Diseases

Aboriginal identification:	Optional
Geographic levels:	Postcodes
Identifiability:	Yes, but access may be denied
Output:	Regular reporting unavailable. This is issue under discussion.
Storage:	HIC mainframe
Special technical requirements:	Knowledge of NMHRC and childhood immunisation vaccines
PHD Staffing:	0.3 FTE per annum
Cost:	 Running costs \$20,000 Program costs \$3.18 million plus \$5.24 million in SPP's as the Commonwealth's share of the immunisation rebate.
Funding sources:	Special appropriation
Review/evaluation:	 HIC commissioned a study into barriers to provider participation - completed by Frank Small & Associates in August 1996. A 10% sample of GP's were surveyed regarding participation - Paper to be submitted to AMJ in September 1996. Rural providers were surveyed on participation and views on the Register May - July 1996. Preliminary results available. An operational evaluation by Strategic Human Capital is due in November 1996. Other small studies through academic institutions are in progress.
Comments:	August 1996 Budget committed funds for another 2 years from 1997/98. Strategic Human Capital have recently been contracted to evaluate the National Childhood Immunization Register. The evaluation process has commenced and is due to be finalised by the end of the year. In the medium term all processing and report generation will remain with the Health Insurance Commission. However, the Terms of Reference of the current evaluation includes a requirement to recommend on the appropriateness of the Commission to undertake the data analysis and output requirements of the Register. As the Register nears the end of its first year of operation concerted effort should be made to ensure the early release of data from the Register.
Data Manager/Contact:	Paul Williams 06 289 6851 - Public Health Division Leonic Balclock 06 2036456 - HIC

8: HIV/AIDS NATIONAL REGISTRY

Brief description:	National surveillance for HIV disease is coordinated by the National Centre in HIV Epidemiology and Clinical Research (NCHECR), in collaboration with State and Territory health authorities and the Commonwealth of Australia. Cases of HIV infection are notified to the National HIV Database on the first occasion of diagnosis in Australia and cases of AIDS are notified through the State and Territory health authorities to the National AIDS Registry.
PHD Branch:	National Centre for Disease Control
Purposes:	Monitoring of HIV/AIDS epidemic: incidence, transmission modes, etc
Frequency/timing:	Continuous notification and monitoring
Target population:	All Australians
Scope and coverage:	National
Collection methodology/ Data sources:	Continuous collection of notifications forwarded by medical practitioners to State/Territory health authorities who then forward the notifications to the NCHECR.
Collection/management agency:	National Centre in HIV Epidemiology and Clinical Research (NCHECR)
Ownership/Access:	State/Territory Health Authorities. Minimum dataset released publicly. Other data requests require individual approval.
Unit of enumeration:	Person
Size of collection:	19,661 (at 31 March 1996)
Data content:	State/Territory of diagnosis Name code Sex Date of birth Country of birth (for AIDS diagnosis only) Ddate of AIDS diagnosis AIDS-defining illnesses Source of exposure to HIV Date of HIV Whether new infection Other laboratory information - CD4 at HIV or AIDS diagnosis Date and cause of death (if applicable)
Aboriginal identification:	Yes
Geographic levels:	State/Territory; postcode when available
Identifiability:	No

Appendix A Communicable Diseases

Output:	Australian HIV Surveillance Report (quarterly)
Storage:	NCHECR
Special technical requirements:	Subject matter expertise. National HIV Centre is nationally and internationally recognised for its work in this area.
PHD Staffing:	Nil
Cost:	 Running costs \$Nil Program costs - The Centre is fully funded. Apportionment of monies to the maintainance of the Registry is not practicable at this stage.
Funding source:	HIV/AIDS Strategy research funds (COPO)
Review/evaluation:	The Centre is subject to regular NHMRC evaluation procedures. The Registry proper is verified through a variety of methodologies on an ongoing but ad hoc basis.
Comments:	The three national HIV/AIDS centres are funded out of the research component of the National AIDS Strategy. Under the 3rd National Strategy, it is likely that funding for the clinical/epidemiological national centre (with its monitoring and case registration function) would remain with the PHD.
Data Manager/Contact:	Professor John Kaldor 02 9332 4648 Jan Wiebe 06 289 4147 (Centre administration)

<u>9: AUSTRALIAN HUMAN PITUITARY HORMONES PROGRAM</u> <u>PATIENT DATABASE</u>

.

Brief description:	Australian Human Pituitary Hormones Program - Patient Database holds data relating to people who applied for or received treatment with human pituitary derived hormones
PHD Branch:	National Centre for Disease Control
Purposes:	Maintain up-to-date information of former recipients of human pituitary derived hormones including address, treatment details, doctor details and information supplied as part of the Pituitary Hormone Recipient Survey conducted in 1995
Frequency/timing:	Ongoing
Target population:	Former recipients of human pituitary derived hormones and their families
Scope and coverage:	National
Collection methodology/ Data sources:	Information supplied by original treating doctors, current doctors and recipients
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Person
Unit of enumeration: Size of collection:	Person Approximately 3000
Unit of enumeration: Size of collection: Data content:	Person Approximately 3000 File numbers Recipients names Treatment type Sex Date of Birth Details on whether application for participation in the AHPHP received, approved, treated, traced or counselled Treatment details Current postal and residential addresses Children details Doctor details - address, whether original, current or nominated doctor Ethnic Background Willingness to share information with other recipients Willingness to participate in research studies or an epidemiological study
Unit of enumeration: Size of collection: Data content: Aboriginal identification:	Person Approximately 3000 File numbers Recipients names Treatment type Sex Date of Birth Details on whether application for participation in the AHPHP received, approved, treated, traced or counselled Treatment details Current postal and residential addresses Children details Doctor details - address, whether original, current or nominated doctor Ethnic Background Willingness to share information with other recipients Willingness to participate in research studies or an epidemiological study Yes
Unit of enumeration: Size of collection: Data content: Aboriginal identification: Geographic levels:	Person Approximately 3000 File numbers Recipients names Treatment type Sex Date of Birth Details on whether application for participation in the AHPHP received, approved, treated, traced or counselled Treatment details Current postal and residential addresses Children details Doctor details - address, whether original, current or nominated doctor Ethnic Background Willingness to share information with other recipients Willingness to participate in research studies or an epidemiological study Yes Postcode

Appendix A Communicable Diseases

Output:	Aggregated statistics for inclusion in briefs and publications; List of names for Blood Banks and Tissue/Organ donation agencies
Storage:	Electronic/PC
Special technical requirements:	Nil
PHD Staffing:	0.3 FTE per annum
Cost:	1. Running costs \$18,000 2. Program costs \$ Nil
Funding sources:	
Review/evaluation:	N/A
Comments:	Following an independent inquiry into the use of pituitary derived hormones in Australia during 1993/94, a range of initiatives to address the ongoing needs of the human pituitary hormone recipients was introduced. These included the establishment of a \$5 million Trust Fund to cover ongoing counselling and support services and medical and other costs should further recipients contract Creutzfeldt-Jakob Disease. The Trust has been calculated to provide an ongoing commitment to fund counselling services until at least 2002-03 and to fund State based support groups until at least 2010. Ongoing funding requirements are due to be evaluated in 1997-98.
Data Manager/Contact:	Stephen Kirby 06 289 7376

10: HUMAN PITUITARY DERIVED HORMONES COUNSELLING SERVICE DATABASE

Brief description:	Database recording details of each counselling session provided by Relationships Australia to former recipients of human derived pituitary hormones and their families
PHD Branch:	National Centre for Disease Control
Purposes:	 Maintain up-to-date information on the utilisation of counselling services by pituitary hormone recipients and their families. Monitor the cost effectiveness and appropriateness of the services.
Frequency/timing:	Ongoing
Target population:	Former recipients of human pituitary derived hormones and their families that utilise human pituitary hormone counselling services.
Scope and coverage:	National
Collection methodology/ Data sources:	Information supplied by counsellors.
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Counselling session
Size of collection:	Approximately 1000 records
Data content:	State Type of session Recipient/family member Type of hormone Gender Place of residence Mode of contact Where contact took place Individual/family/group session Duration of contact Trigger to contact counselling unit Referrals
Aboriginal identification:	No
Geographic levels:	State
Identifiability:	Yes
Output:	Aggregated statistics for performance monitoring, briefs and inclusion in publications.
Storage:	Electronic/PC and hardcopy

Appendix A Communicable Diseases

Special technical requirements:	Nil
PHD Staffing:	0.6 FTE per annum
Cost:	 Running costs \$ 31,000 Program costs \$Nil
Funding sources:	
Review/evaluation:	Part of Grant Agreement with Relationships Australia - for tracking of payments and review of services provided
Comments:	Following an independent inquiry into the use of pituitary derived hormones in Australia during 1993/94, a range of initiatives to address the ongoing needs of the human pituitary hormone recipients was introduced. These included the establishment of a \$5 million Trust Fund to cover ongoing counselling and support services and medical and other costs should further recipients contract Creutzfeldt-Jakob Disease. The Trust has been calculated to provide an ongoing commitment to fund counselling services until at least 2002-03 and to fund State based support groups until at least 2010. Ongoing funding requirements are due to be evaluated in 1997-98.
Data Manager/Contact:	Letresha Martin 06 289 8517

11: CREUTZFELDT-JAKOB DISEASE (CJD) CASE REGISTRY

Brief description:	Registry of CJD cases reported in Australia since 1970
PHD Branch:	National Centre for Disease Control
Purposes:	 Obtain a better understanding of the risk factors and demographic trends associated with the occurrence of CJD in Australia and New Zealand. Provide recommendations to the Australian Government on the best way to manage the problem of CJD and related prion diseases. Monitor and review the scientific and Medical developments which relate to CJD and related subjects. Improve awareness of the disease in the medical and general communities to prevent future iatrogenic transmission occurring.
Frequency/timing:	Ongoing
Target population:	All Australians
Scope and coverage:	National
Collection methodology/ Data sources:	Information is obtained from the National Death Index, Death Certificates, medical practitioners, hospital records, commonwealth and State health authorities and the CJD Counselling Service.
Collection/management agency:	Department of Pathology, University of Melbourne
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Cases of CJD
Size of collection:	294
Data content:	Age Gender Classification of CJD at onset of illness and death Duration of illness Lifetime occupation Country of birth Location Travel details
Aboriginal identification:	No
Geographic levels:	State
Identifiability:	Identifying information held by Case Registry
Output:	Quarterly Reports to the Department of Health and Family Services
Storage:	Electronic.

Appendix A Communicable Diseases

Special technical requirements:	N/A
PHD Staffing:	0.2 FTE per annum
Cost:	1. Running costs \$13,000 2. Program costs \$Nil
Funding sources:	Funded by the Department of Health and Family Services under a Grant Agreement. 1996/97 - \$113,500.
Review/evaluation:	Annual review through re-negotiation of the Grant Agreement.
Comments:	The Creutzfeldt-Jakob Disease Case Registry was established in 1993 and is supervised by Professor Colin Masters at Melbourne University. The Registry monitors and investigates known and suspected Creutzfeldt-Jakob Disease cases in Australia. In November 1994 the Government announced the provision of \$300,000 per year over the next four years to extend the period of retrospective analysis of the Registry to 1974 and to extend the period of prospective analysis to 2010.
Data Manager/Contact:	Simon Douglas 06 289 7513

12: BREASTSCREEN AUSTRALIA PERFORMANCE MEASURES

Brief description:	Annual program performance measures for BreastScreen Australia
PHD Branch:	National Centre for Disease Control
Purposes:	 Management information to monitor policy implementation. Monitoring and reporting of screening processes and outcomes to ensure high program quality, effectiveness and efficiency. Resource allocation - funding to States and Territories
Frequency/timing:	Six-monthly (no. of women screened by age group), annual (all else)
Target population:	Women aged 40 years and over
Scope and coverage:	National
Collection methodology/ Data sources:	Screening and assessment services reports generated from 35 services who maintain their own data bases based on clinical records. Data is aggregated by State Coordination Units to State/Territory level as required, and summary data submitted to the Commonwealth.
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	Aggregate data owned by Commonwealth. Unit record data is confidential. Nationally agreed data will be published and will be available for policy makers, researchers, etc.
Unit of enumeration:	5-year age group by State/Territory
Size of collection:	1760 cells (20 data items x 11 age groups x 8 States)
Data content:	By 5 year age groups and by prevalent and incident screens: Women screened: no., no. ATSI, NESB and rural/remote No. women assessed No. open biopsies No. benign biopsies No. cancers detected No. small cancers detected No. DCIS detected No. cancers detected by histological type, nodal status and grade No. mastectomics Interval cancer rate for 50-69 year old women
Aboriginal identification:	Yes.
Geographic levels:	State/Territory
Identifiability:	No.
Output:	BreastScreen Australia annual statistical report. Ad-hoc analysis and interrogation for Parliamentary questions, briefings etc

Appendix A Cancer Control

Storage:	Spreadsheet, PHD
Special technical requirements:	Knowledge breast cancer screening pathway and coding and terminology; knowledge of program policies and emerging issues.
PHD Staffing:	0.63 FTE per annum
Cost:	 Running costs \$33,000 Program costs - Part of BreastScreen program (Approx. \$44m p.a.)
Funding sources:	Costs associated with BreastScreen Australia service delivery and data collection and capture will be incorporated in the new broad banded public health agreements.
Review/evaluation:	Performance measures and specifications are still under development. The National Minimum Data Set and the National Monitoring Reports are to be revised in the near future in conjunction with revision of the National Accreditation Requirements.
Comments:	Effective monitoring and evaluation of screening program performance is considered important to ensure that benefits are maximised and adverse effects minimised at an acceptable cost. Financial arrangements with States/Territories will need to include incentives for reaching targets in key areas (e.g. rural/remote, ATSI) and maintaining service quality. The implementation phase for the breast screening program is almost complete and the detailed quarterly and 6 monthly reports to the Division from all Screening and Assessment Services are now being replaced by a single annual report at the State and Territory level. The Division will produce an annual report for Australia concentrating on broad national indicators relating to effectiveness, efficiency, quality of screening and outcomes. Over the next year, it is intended to review and revise the national minimum dataset in conjunction with accreditation requirements for breast screening services and the Commonwealth requirements for national data
	will be specifically addressed in conjunction with this process.
Data Manager/Contact:	Joy Eshpeter 06 289 7481
13: NATIONAL CERVICAL SCREENING PROGRAM PERFORMANCE MEASURES

Brief description:	Annual program performance measures for the National Cervical Screening Program
PHD Branch:	National Centre for Disease Control
Purposes:	 Management information to monitor policy implementation and potentially, savings to Medicare. Monitoring and reporting of screening processes and outcomes to ensure high program quality, effectiveness and efficiency.
Frequency/timing:	Annual
Target population:	Women aged 20-69
Scope and coverage:	National
Collection methodology/ Data sources:	Summary information for 11 performance measures provided annually by States and Territories to the Commonwealth. Information is derived from State/Territory Cervical Cytology Registry (5 operational by end 1996) in conjunction with the State Cancer Registry.
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	Aggregate data owned by Commonwealth Unit record data is confidential. Nationally agreed data will be published and will be available for policy makers, researchers, etc.
Unit of enumeration:	5-year age group within State/Territory
Size of collection:	1600 cells (20 data items x 10 age groups x 8 States/Territories)
Data content:	Screening participation rates for target population Number of women rescreened within a 2-year interval Frequency of retesting during a 2-year period Profile of first cytology reports Proportion of technically satisfactory smears with endocervical component Proportion of cytology reports recommending colposcopy/ specialist opinion Number of women lost to follow-up Interval cancer rates among women with negative cytology report Incidence rates of cervical cancer Death rates from cervical cancer
Aboriginal identification:	No
Geographic levels:	State/Territory
Identifiability:	No

Appendix A Cancer Control

Output:	Published report. Ad-hoc analysis and interrogation for Pqs, briefings etc
Storage:	Spreadsheet, PHD
Special technical requirements:	Knowledge of cervical screening path way and cytology coding and terminology; knowledge of program policies and emerging issues.
PHD Staffing:	0.5 FTE per annum
Cost:	 Running costs \$31,000 Program costs Part of National Cervical Screening Program
Funding sources:	Payments to States and Territories associated with the National Cervical Screening Program will be incorporated into the new broad banded public health agreements.
Review/evaluation:	Performance measures and specifications are still under development.
Comments:	Effective monitoring and evaluation of screening program performance is considered important to ensure that benefits are maximised and adverse effects minimised and to ensure a cost effective program. Financial arrangements with States/Territories will need to include incentives for reaching targets in key areas (e.g. older women and compliance with screening interval).
	Cervical Cytology Registries are being established in all States and Territories to provide reliable data on cervical screening activity and outcomes for the National Cervical Screening Program. Agreement has been reached on a minimum set of performance measures for the program but to date data has not been available at the national level.
Data Manager/Contact:	Joy Eshpeter 06 289 7481

14: AUSTRALIAN LONGITUDINAL STUDY ON WOMEN'S HEALTH

Brief description:	Longitudinal study of the health of Australian women over 25 year period	
PHD Branch:	National Health Planning Branch	
Purposes:	 Data collection system to enable monitoring of women's health issues over time in Australia Research to identify determinants and important dimensions of women's health 	
Frequency/timing:	Baseline survey 1996, follow up pilot in 1998 Dependant upon continued funding.	then 5 yearly to 2020.
Target population:	Australian women aged 18-22 years, 45-49 years and 70-74 years. Additional samples for priority populations (Aboriginal, Torres Strait Islander, migrants from Phillippines and Balkan Peninsular). Different age groups may be used for these priority populations.	
Scope and coverage:	National sample of women in the three age cohorts from urban, rural and remote areas with over sampling of rural and remote areas and priority populations	
Collection methodology/ Data sources:	Voluntary sample of women recruited using Medicare claims database. Mailed self-completion questionnaire(with telephone query support). Survey data linked to Medicare usage data for subset and potentially (in future) to National Death Index, cancer registration data, perinatal data.	
Collection/management agency:	University of Newcastle & University of Queensland (ATSI and Ethnic Special Studies)	
Ownership/Access:	University of Newcastle	
Unit of enumeration:	Person	
Size of collection:	12,000 women for each of 3 age cohorts 300 women in each of 4 special cohorts. (Now unspecified. Adjustments to be made with experience throughout the survey)	
Data content:	Socio-demographic General health and SF-36 Use of and satisfaction with health services Procedures, medications No. pregnancies and children Common health conditions Stress Tobacco and alcohol use Weight and shape Exercise Work and time use Family and social support	This is a complete list of topics but not all will be included from the start. Much of this plus other more sensitive data will come from nested sub- studies.
Aboriginal identification:	Yes	

Appendix A Population Health Strategies

Geographic levels:	Postcode
Identifiability:	Yes
Output:	To be published. It will be cleared by Department of Health and Family Services
Storage:	University of Newcastle and University of Queensland
Special technical requirements:	Expertise in women's health and in the conduct of longitudinal epidemiological studies
Staffing:	1.0 FTE over the life of the survey (1994-1998)
Cost:	Running Costs \$0.2 million (1994-1998) Program costs \$3.5 million (1994-1998)
Funding source:	National Women's Health Program Funds
Review/evaluation:	Not planned other than subject to publication in peer reviewed national and international journals and conference presentations
Comments:	The University of Newcastle is currently funded for 3 years to conduct this survey. It will provide important information on the determinants of women's health and their access to and use of services and should be continued. However, data from this survey will be of more limited relevance for population monitoring and surveillance of women's health issues due to the longitudinal nature of the study and the limited age ranges included. Results from the survey will be very important in identifying appropriate indicators for health determinants and enabling factors that should be monitored at the national level for women.
Data Manager/Contact:	Manoa Renwick 06 289 6832 Phoebe Bissett, University of Newcastle - Project Administration Dr Wendy Brown, University of Newcastle - Project Manager

15: NATIONAL WOMEN'S HEALTH SERVICES NATIONAL EVALUATION DATASET

Brief description:	Minimum Data Set (MDS) for women's primary health care services funded by the National Women's Health Program (NWHP)
PHD Branch:	National Public Health Planning Branch
Purposes:	 To describe service inputs and outputs for evaluation of NWHP To form the basis of national MDS for all community - based health care for women
Frequency/timing:	Ad hoc collections
Target population:	All women in Australia, but especially those targeted by the NWHP - ie women disadvantaged by race, ethnicity, socioeconomic status, age, geographic isolation, etc
Scope and coverage:	National
Collection methodology/ Data sources:	For direct services, unit record data completed by service providers at agencies during 3 x one month collections in 1995-96 specifically for the national evaluation; For indirect services, selected best practice activities collected once; Both sets processed at State level and compiled nationally by the Department of Health and Family Services.
Collection/management agency:	State Health Authorities/Department of Health and Family Services
Ownership/Access:	State Health Authorities/Department of Health and Family Services
Unit of enumeration:	Person or health promotion group
Size of collection:	Approximately 200 agencies
Data content:	Four datasets for services delivered directly to women: enquiries; client registrations; client contacts; health promotion group registrations. One dataset for 'indirect' activities (ie research, planning, community development, coordination, etc).
Aboriginal identification:	Yes
Geographic levels:	postcode and agency are collected but aggregated to State level
Identifiability:	No
Output:	Summaries following each data collection period; compiled for national evaluation October 1996
Storage:	State Health Authorities/ summary hardcopy data held in Department of Health and Family Services

Appendix A Population Health Strategies

Special technical requirements:	None
PHD Staffing:	0.1 FTE per annum
Cost:	1. Running costs \$6,000 2. Program costs \$Nil
Funding sources:	The NWHP costs approximately \$63m
Review/evaluation:	Awaiting consideration following completion of the NWHP evaluation
Comments:	The Division has invested substantial effort in the development and specification of nationally consistent data for the evaluation of women's health services. This data will be collected for three one month time periods in all women's health services and sent to the Division via the State/Territory health authorities.NWHP is implemented variously across States so State-level compilations are the most practical aggregation; and three States, at the time of writing, have not agreed to ongoing provision of this data.
Data Manager/Contact:	Manoa Renwick 06 289 6832

Appendix A Population Health Strategies

Summary annual data on services provided by Family Planning Associations **Brief description:** funded under the Family Planning Program National Health Promotion and Protection Branch **PHD Branch**: 1. Management information **Purposes:** 2. Annual reporting Annual Frequency/timing: Recipients of sexual and reproductive health services provided by family **Target population:** planning organisations Family Planning Associations funded under the Family Planning Program Scope and coverage: Summary statistical information for specified performance indicators Collection methodology/ Data sources: reported annually in hardcopy form by funded agencies National Health Promotion and Protection Branch **Collection/management** agency: Department of Health and Family Services **Ownership/Access:** Organisation Unit of enumeration: 11 - 8FPOs, WCH (Vic), FPA Inc and ACSWC Size of collection: Number of client visits by type of client (NESB, ATSI, HCC holder, etc) **Data content:** Number of services delivered by type of service (fertility control, etc) No. participants in community education, by type of course Natural family planning outcomes (%achieve pregnancy, %avoid pregnancy) Yes Aboriginal identification: National **Geographic levels:** No **Identifiability:** Program annual reporting **Output:** Hard copy Storage: **Special technical** None requirements: 0.1 FTE per annum **PHD Staffing:** 1. Running costs \$6,000 Cost: 2. Program costs \$Nil (Grants to the organisations total approx \$14 m per annum)

16: FAMILY PLANNING PROGRAM ANNUAL REPORTING

Appendix A Population Health Strategies

Funding source:	
Review/evaluation:	Review of the Family Planning organisations and Family Planning Australia Inc was completed August 1995. This recommended a move to new contractual arrangement with agreed outcomes, which would require more comprehensive data collection.
Comments:	This is very aggregated data on a subset of sexual and reproductive health services provided by dedicated family planning organisations which receive funding from PHD. Such data is not useful for monitoring sexual and reproductive health services utilisation at a population level, but it is the only information available. It should be noted that logistically, family planning clinics cannot meet all the community's need for sexual and reproductive health services, the majority of such services being provided by general practitioners.
Data Manager/Contact:	Suzy Saw 06 289 8297

17: CARDIOPULMONARY RESUSITATION TRAINING EVALUATION

Brief description:	The Cardiopulmonary Resusitation (CPR) Training Evaluation Project is examining all episodes of ventricular fibrillation treated by ambulance paramedics in NSW
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Determine the relationship between survival from out-of-hospital ventricular fibrillation and the type of training, if any, received by community members who initiated CPR. Provide quantitative data on the nature and quality of CPR training in the community.
Frequency/timing:	Ongoing (May 1995 - May 1997)
Target population:	Persons performing CPR
Scope and coverage:	NSW
Collection methodology/ Data sources:	Paramedics attending relevant episodes will hand out a survey card to the main person at the scene performing CPR. The person will be requested to call a designated number to provide the information or to mail the card to the study officer at the NSW Ambulance Service. A second contact will be made following the receipt of the card. Attending paramedics will be interviewed regarding the efficacy of CPR. The patient will also be followed up to determine outcome of the episode.
Collection/management agency:	NSW Ambulance Service and the National Heart Foundation Heart Attack Committee
Ownership/Access:	National Heart Foundation. Results and copy of reports made available to the Department of Health and Family Services as part of Grant conditions.
Unit of enumeration:	Person
Size of collection:	Approximately 2,000
Data content:	Name of person who initiated CPR Contact details of person who initiated CPR How long the CPR lasted before the ambulance officers took over Whether the person had received CPR training Type of CPR training Time from onset of unconsciousness to defibrillation Efficacy of CPR as assessed by the paramedics Whether patient left hospital alive Subsequent outcome Age, sex and medical history of patient
Aboriginal identification:	No
Geographic levels:	State

Appendix A Population Health Strategies

Identifiability:	Yes
Output:	Report at conclusion of data collection and analysis (Release expected end 1997)
Storage:	Electronic
Special technical requirements:	Nil
PHD Staffing:	0.05 FTE per annum
Cost:	Running costs \$5,000 Program costs \$100,000
Funding sources:	National Health Advancement Program
Review/evaluation:	No
Comments:	This project does not appear to have been well coordinated within the National Heart Foundation and between the NSW Ambulance. It is unclear whether any data has emerged and whether the response rate is acceptable. Data on level of CPR training and number trained should be made available from the study to provide information on population health skills and training.
Data Manager/Contact:	Penny Graham 06 289 7939

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18: THE TEACHING OF CARDIOPULMONARY RESUSCITATION IN SCHOOLS AND WORKPLACES

Brief description:	The Teaching of Cardiopulmonary Resuscitation (CPR) in Schools and Workplaces Project surveyed organisations teaching Basic Life Support (BLS), Health Care Facilities and Schools to determine the extent to which BLS is taught.
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Determine the extent to which BLS skills are being taugh in high schools, workplaces and health care facilities. Develop strategies to encourage and enhance the teaching of BLS skills.
Frequency/timing:	1995/96
Target population:	Teaching organisations, health care facilities, high schools
Scope and coverage:	National
Collection methodology/ Data sources:	Postal survey of identified institutions
Collection/management agency:	Australian Resuscitation Council and Curtin University of Technology
Ownership/Access:	Australian Resuscitation Council and Curtin University of Technology. Results and copy of reports made available to the Department of Health and Family Services as part of Grant conditions.
Unit of enumeration:	Institution
Size of collection:	Approximately 4,100

Data content:	Teaching organisation Type of operation Location of services Number of teachers of BLS Number of people taught Length of instruction Cost of instruction Courses offered Health care facility Type of institution Location of services Number of staff Number of patients BLS training Staff assessment in BLS Duration of course Schools Type of school Location BLS training Attitude to BLS training
Aboriginal identification:	No
Geographic levels:	Metropolitan/Extra-metropolitan
Identifiability:	No
Output:	Development of Strategies to Encourage the Teaching of Cardiopulmonary Resuscitation in Schools and Workplaces Jacobs and Kroll, The School of Public Health Curtin University of Technology Perth WA (Draft)
Storage:	Electronic
Special technical requirements:	Nil
PHD Staffing:	0.05 FTE per annum
Cost:	Running costs \$5,000 Program costs \$86,950
Funding sources:	National Health Promotion Grant
Review/evaluation:	Nil
Comments:	The report should be finalised by end 1996 and should provide data on level of BLS training and number trained
Data Manager/Contact:	Penny Graham 06 289 7939

19: NATIONAL NUTRITION SURVEY 1995

Brief description:	National food and nutrition survey conducted by the Australian Bureau of Statistics (ABS) on behalf of the Department of Health and Family Services
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Provide baseline and monitoring population data on food and nutrient intakes, dietary habits and body measurements Provide data which is linked to the National Health Survey (NHS)
Frequency/timing:	1995-96
Target population:	Australians aged 2 years and over
Scope and coverage:	Persons living in private dwellings - all States, rural and urban
Collection methodology/ Data sources:	Cross-sectional survey undertaken on a sub-sample of respondents in 1995 ABS NHS. Personal interview collection in the home of 24 hour dietary recall data, physical measurements and related questions and self- administered food frequency questionnaire (for respondents aged 12 yearsand over)
Collection/management agency:	Data collected by the ABS as a voluntary survey under the Census and Statistics legislation
Ownership/Access:	ABS. Access subject to privacy and confidentiality provisions of the Census and Statistics Act. An unidentified unit record tape and three publications are planned for release.
Unit of enumeration:	Person
Size of collection:	13,800
Data content:	Sociodemographic information Food and nutrient intakes Dietary habits Dietary attitudes Food security Weight, height, waist and abdominal measurements Blood pressure (16 years and older) Health status and risk factor information (from NHS) health service utilisation (from the National Health Survey)
Aboriginal identification:	Yes. Aboriginality will not be released by ABS for analysis due to limitations of sample size
Geographic levels:	Metropolitan, extra-metropolitan within some States/Territory
Identifiability:	No
Output:	ABS publications and release of unit record file

Appendix A Healthy Public Policy

Storage:	ABS mainframe
Special technical requirements:	Subject matter expertise, statistical analysis and data retrieval skills
Staffing:	6.0 FTE for survey
Cost:	Running costs \$400,000 approximately Program costs \$3,800,000 approximately. The total cost of the survey is estimated to be approximately \$4m.
Funding source:	
Review/evaluation:	No firm plans for funding or undertaking further National Nutrition Surveys, though it is proposed that such surveys be carried out every 10 years.
Comments:	Current coding and analysis activities for the National Nutrition Survey are planned to finish this financial year. Although these activities could run over the end of the financial year, they could be prepaid from this year's budget. There will be an ongoing need within the Division for analyses of the nutrition survey data relating to policy questions, as well as in relation to providing indicator estimates for nutrition monitoring. The AIHW will be carrying out analyses of the National Nutrition Survey as part of its cardiovascular risk factors monitoring work and, rather than duplicating expertise and analyses, the AIHW could be funded to carry out analyses for the Division.
Data Manager/Contact:	Barbara Brown 06 289 8087

Appendix A Healthy Public Policy

20: NATIONAL INJURY SURVEILLANCE UNIT ADDITIONAL FUNDING

The National Injury Surveillance Unit (NISU) undertakes public health surveillance of injury at the e national level to support injury prevention and control. It engages in all aspects of surveillance, and places special emphasis on analysis and dissemination of information, and on developing injury surveillance methods. It also provides a national contact point for liaison and information sharing on injury control.

NISU reports summary data on injury related deaths annually. Despite the volume of this data, it is only suitable for basic, routine public health surveillance and can only be used for broad policy development. Many aspects of injury monitoring and control require more detailed, timely and reliable data. Information is required to assist in the identification of hazards and solutions, enable target setting, identify and monitor new/unusual injury events and to investigate particular classes of injury events at a fine level of detail to increase understanding of risk factors and enable research and evaluation.

In recognition of these needs the Client Liaison and Development and the Road Injury Information programs within NISU are primarily funded by the Department. This funding has assisted in advancing tighter and more detailed surveillance of injury through a variety of projects such as the development of National Data Standards for Injury Surveillance and studies into specific at risk populations, such as Aboriginals. Other projects include collaboration with coroners to develop improved data on injury deaths, development of a new approach to study emergency department injury attendances and development of a spinal cord injury register.

In addition theses funds assist NISU in the provision of key research studies and other statistical activities such as routine road injury reporting which are heavily used by specific user groups in the transport sector. NISU also undertakes a key role in liaison and distribution of information concerning events in injury prevention and research. The "Injury Issues Monitor" is the only comprehensive information source on injury issues that is routinely distributed across a variety of sectors in Australia. In the past the Monitor has been fully funded from Departmental monies.

The 1996-97 Budget provided \$300,000 for a continuation of these types of projects. continued funding to NISU.

21: NATIONAL DRUG STRATEGY HOUSEHOLD SURVEY

Brief description:	Household survey of drug use and exposure, knowledge and attitude to drugs, exposure to and participation in alcohol related crime and recognition and reaction to drug/alcohol awareness campaigns
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Provide benchmark data for monitoring and evaluating the National Drug Strategy (NDS) Measure the drug using patterns, attitudes and behaviour of the Australian population Policy development
Frequency/timing:	1985, 1988, 1991, 1993, 1995
Target population:	All persons aged 14 years and over
Scope and coverage:	National
Collection methodology/ Data sources:	Personal interview combined with self enumeration for the more sensitive questions, such as drug use and exposure to crime. The self enumerated questionnaires were returned to the interviewer in a scaled envelope.
Collection/management agency:	AGB McNair (1995)
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Person
Size of collection:	3850 (1995)
Data content:	Perceptions about drugs including health risks Access to information about drugs General health Regulations relating to cannabis use (1995) Policy support to assist in the control of alcohol, drug and cigarette use Awareness of drug campaign Demographics Drug use and exposure to crime (self enumeration)
Aboriginal identification:	Yes
Geographic levels:	State/Territory Metropolitan/Ex-metropolitan
Identifiability:	No

Appendix A Tobacco, Alcohol and Illicit Drugs

Output:	Commonwealth Department of Health and Family Services - National Drug Strategy, Household Survey, Survey Report 1995 Makkai Tony 1994 Patterns of Drug Use: Australia and the United States Commonwealth Department of Health and Family Services - Statistics on Drug Abuse in Australia 1994
Storage:	Mainframe/PC
Special technical requirements:	Subject matter expertise
PHD Staffing:	1.12 FTE per survey
Cost:	1. Running costs \$80,000 per survey 2. Program costs \$275,000 (1995)
Funding sources:	NDS monies - Information and monitoring funds - Commonwealth
Review/evaluation:	Part of survey planning
Comments:	The Department has funded AGB McNair Anderson to carry out household surveys of drug use patterns, attitudes and behaviour. Because of the limited sample size, these essentially provide drug use data only for tobacco, alcohol and cannabis, the most widely used illicit drug. For these reasons, it would be feasible to address these issues as part of a broader survey program for adult and Aboriginal and Torres Strait Islander people behavioural risk factors, knowledge and beliefs
Data Manager/Contact:	Peter Vuksa 06 289 8666

22: NATIONAL DRUG STRATEGY HOUSEHOLD SURVEY

URBAN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES SUPPLEMENT

Brief description:	Household survey of drug use and exposure, knowledge and attitude to drugs, exposure to and participation in alcohol related crime and recognition and reaction to drug/alcohol awareness campaigns among urban Aboriginal and Torres Strait Islander Peoples.
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Provide baseline data on drug use, exposure, etc by Aboriginal and Torres Strait Islander Peoples Monitor and evaluate National Drug Strategy (NDS) issues Identify needs and strategies to address drug related problems in Aboriginal and Torres Strait Islander Peoples
Frequency/timing:	1994, proposal to repeat in 1997
Target population:	Aboriginal and Torres Strait Islander Peoples
Scope and coverage:	National/urban/persons 14 years and over
Collection methodology/ Data sources:	Personal interview combined with self enumeration for the more sensitive questions, such as drug use and exposure to crime. The self enumerated questionnaires were returned to the interviewer in a sealed envelope
Collection/management agency:	AGB McNair
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Person
Size of collection:	3000
Data content:	Perceptions about drugs/alcohol including health risks Access to information about drugs Policy support to assist in the control of alcohol, drug and cigarette use Awareness of drug campaign Demographics Drug use and exposure to crime (self enumeration)
Aboriginal identification:	Yes
Geographic levels:	State/Territory Metropolitan/urban
Identifiability:	No
Output:	Commonwealth Department of Health and Family Services - National Drug Strategy, Household Survey, Urban Aboriginal and Torres Strait Islander Peoples Supplement, 1994

Appendix A Tobacco, Alcohol and Illicit Drugs

Storage:	Mainframe/PC
Special technical requirements:	Subject matter expertise
PHD Staffing:	1.5 FTE per survey
Cost:	1. Running costs \$98,000 2. Program costs \$492,000
Funding sources:	NDS monies - Information and monitoring funds - Commonwealth
Review/evaluation:	Part of survey planning
Comments:	The possibility of extending the survey to cover a range of public health issues should be investigated
Data Manager/Contact:	Peter Vuksa 06 289 8666

23: NATIONAL SCHOOL STUDENTS SURVEY 1996

Brief description:	National Survey of school students re knowledge, attitudes, practices and behaviour related to drug use
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 To provide baseline data on drug use, exposure, etc. To monitor and evaluate National Drug Strategy (NDS) issues To develop drug related trend data To identify needs and strategies to address drug related problems
Frequency/timing:	1996
Target population:	School students
Scope and coverage:	School students in Years 7 to 11 of study. State variations in Year levels will be acknowledged.
Collection methodology/ Data sources:	Self enumeration
Collection/management agency:	Centre for Behavioural Research in Cancer (CBRC) - Anti Cancer Council of Victoria
Ownership/Access:	State/Territory; Commonwealth access through the provision of national "uninterpreted" unit record data
Unit of enumeration:	Person
Size of collection:	Approximately 25,500
Data content:	Incidence and prevalence of licit and illicit drug use Sun exposure Demographics
Aboriginal identification:	Ycs
Geographic levels:	State/ Territory
Identifiability:	No
Output:	To be determined
Storage:	Mainframe
Special technical requirements:	Expertise in survey design and drug issues
PHD Staffing:	0.1 FTE per survey
Cost:	 Running costs \$6,000 Program costs \$76,000 (Commonwealth contribution)

Appendix A Tobacco, Alcohol and Illicit Drugs

Funding sources:	NDS; CBRC; State/Territory governments
Review/evaluation:	
Comments:	The Commonwealth provided \$76,000 towards the 1996 survey and provided national co-ordination to ensure that schools were not approached by States/Territories and other stakeholders to run surveys that overlapped in content.
Data Manager/Contact:	Mal Gibson 06 289 8364

24: ILLICIT DRUG REPORTING SYSTEM

<u> Pilot Survey - Sydney</u>

Brief description:	Revision of the Illicit Drug Reporting System (IDRS) to provide a coordinated approach to the monitoring of data associated with the use of opiates, cocaine, amphetamines and cannabis.
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Monitor trends in illicit drug use from an early warning perspective Identify strategically important trends in the use of heroin, amphetamines, cocaine and cannabis that require further investigation
Frequency/timing:	Trial for development of ongoing IDRS
Target population:	Drug users; Professional informants with intimate knowledge of drug trends
Scope and coverage:	Sydney
Collection methodology/ Data sources:	Personal interview; group discussions
Collection/management agency:	National Drug and Alcohol Research Centre
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Person
Size of collection:	Approximately 200
Data content:	Demographics Drug usage Drug choice Cost and purity of drug choice (opinion) Availability of drug
Aboriginal identification:	No
Geographic levels:	Inner city; south west city
Identifiability:	No
Output:	O'Brien et al Drug Trends: Findings from the Illicit Drug Reporting System (IDRS) NDARC 1996
Storage:	Hard copy
Special technical requirements:	Subject matter expertise

Appendix A Tobacco, Alcohol and Illicit Drugs

PHD Staffing:	0.5 FTE (1996)
Cost:	1. Running costs \$32,000 2. Program costs \$170,000
Funding sources:	NDS monies - Information and monitoring fund (Commonwealth)
Review/evaluation:	See Comments.
Comments:	This system aims to provide a qualitative picture of trends in the use and availability of illicit drugs. The National Drug and Alcohol Research Centre (NDARC) conducted a 12 month pilot study of this system in Sydney and the Ministerial Council on Drug Strategy has agreed that NDARC should proceed with the trial's second stage. NDARC will report to the Ministerial Council on the trial's progress during 1997, and assuming that outcomes are satisfactory, national implementation of the Illicit Drug Reporting System should commence in 1998.
Data Manager/Contact:	Peter Vuksa 06 289 8666

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25: CENSUS OF CLIENTS OF TREATMENT SERVICE AGENCIES

Brief description:	National Census of clients of treatment service agencies
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Identify the characteristics of clients attending drug treatment services Monitor and evaluate National Drug Strategy (NDS) issues Develop drug related trend data To identify needs and strategies to address drug related problems
Frequency/timing:	1990, 1992, 1995
Target population:	Users of drug and alcohol treatment services
Scope and coverage:	National
Collection methodology/ Data sources:	Information recorded by agencies providing face-to-face specialist treatment for alcohol and other drugs in respect of all clients treated in the 24 hours of 29 March 1995 in all states; in SA information was recorded in respect of all clients treated in the 24 hours of 22 March 1995.
Collection/management agency:	National Drug and Alcohol Research Centre (NDARC)
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Treatment agency
Size of collection:	498
Data content:	Client status Demographics Language Employment status Service provided Drug problem Injection of illicit drugs
Aboriginal identification:	Yes
Geographic levels:	Australia
Identifiability:	No
Output:	Torres et al 1995. Clients of Treatment Service Agencies March 1995 Census Findings
Storage:	Electronic
Special technical requirements:	Subject matter expertise
PHD Staffing:	0.11 FTE per annum

Appendix A Tobacco, Alcohol and Illicit Drugs

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Cost:	1. Running costs \$7,000 2. Program costs \$70,000 (1995)
Funding sources:	NDS monies - Information and monitoring funds - Commonwealth
Review/evaluation:	Part of Census planning
Comments:	These datasets consist essentially of head counts. There is a perceived need for more detailed data (eg. by age, sex, length of treatment). Some States have larger collections.
Data Manager/Contact:	Peter Vuksa 06 289 8666

26: CLIENTS OF METHADONE TREATMENT PROGRAMS

Brief description:	Register of clients of methadone programs in Australia
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Identify the characteristics of clients attending methadone programs Monitor and evaluate National Drug Strategy (NDS) issues Develop drug related trend data Identify needs and strategies to address drug related problems
Frequency/timing:	Quarterly
Target population:	Users of methadone programs
Scope and coverage:	National (Methadone maintenance for opioid dependance unavailable in NT)
Collection methodology/ Data sources:	Data provided by jurisdictions on a quarterly basis
Collection/management agency:	Collected by jurisdictions / coordinated by Department of Health and Family Services
Ownership/Access:	State and Territory health authorities
Unit of enumeration:	Methadone clients
Size of collection:	Approximately 17,000 March 1995
Data content:	Clients Type of clinic
Aboriginal identification:	No
Geographic levels:	State/Territory
Identifiability:	No
Output:	Assorted drug abuse publications
Storage:	Electronic/ hard copy
Special technical requirements:	Subject matter expertise
PHD Staffing:	Approx 6 days per annum
Cost:	1. Running costs \$Negligible 2. Program costs \$Nil
Funding sources:	NDS monies - Information and monitoring fund (Commonwealth)
Review/evaluation:	

Appendix A Tobacco, Alcohol and Illicit Drugs

Comments:	These datasets consist essentially of head counts. There is a perceived need for more detailed data (eg. by age, sex, length of treatment). Some States have larger collections
Data Manager/Contact:	Peter Vuksa 06 289 8666

27: DRUG CAUSED DEATHS

Brief description:	Estimation of drug caused deaths by applying aetiological fractions to ABS "Cause of Death" data
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 To monitor and evaluate National Drug Strategy (NDS) issues To develop drug related trend data To identify needs and strategies to address drug related problems
Frequency/timing:	Annual
Target population:	Total population
Scope and coverage:	All deaths
Collection methodology/ Data sources:	Application of revised aetiological fractions to latest available cause of death data
Collection/management agency:	Australian Bureau of Statistics / Department of Health and Family Services
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Person
Size of collection:	Approximately 25,000
Data content:	Cause of drug related death
Aboriginal identification:	No
Geographic levels:	Australia
Identifiability:	No
Output:	English et al The quantification of drug caused morbidity and mortality in Australia 1995 Commonwealth Department of Human Services and Health, Canberra 1995; Statistics on Drug Abuse in Australia (Annual)
Storage:	Hard copy, PC floppy
Special technical requirements:	Subject matter expertise
PHD Staffing:	0.23 FTE per annum
Cost:	 Running costs \$34,000 Program costs \$240,000 (to revise actiological fraction methodology in 1995)
Funding sources:	NDS monies - Information and monitoring fund (Commonwealth)

Appendix A Tobacco, Alcohol and Illicit Drugs

Review/evaluation:	Aetiological fraction methodology (developed in 1988) revised in 1995 for application to current data.
Comments:	Calculation of drug caused deaths using Holman and English aetiological fractions is carried out currently in the Division and also by AIHW for its population health indicators program. Responsibility for this should transfer immediately to AIHW to be carried out as part of routine mortality surveillance. Future responsibility for updating of aetiological fractions should also be addressed. This could appropriately continue as an external consultancy at five year intervals. The cost of the last consultancy was \$240,000 in 1995. These will need updating within a year or so. The calculation of drug caused hospital admissions has not been attempted by the Department and should also be addressed by AIHW as part of its routine monitoring work.
Data Manager/Contact:	Peter Vuksa 06 289 8666

28: COST SHARED PROGRAM - ACTIVITY INDICATORS

Brief description:	The National Drug Strategy "cost shared program" is a joint Commonwealth, State and Territory funding program which supports a range of drug and alcohol activities in areas such as treatment, prevention, supply, control, education and training
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Assess the extent to which cost shared funded activities are consistent with the objectives and priorities of the National Drug Strategic Plan Comply with administrative arrangements such as audit requirements
Frequency/timing:	Annual
Target population:	Services/projects funded wholly or partly under the cost shared program
Scope and coverage:	National
Collection methodology/ Data sources:	A report form is completed in respect of each Service/project. The report forms were coordinated by health jurisdictions in each State and Territory and forwarded to the Department of Health and Family Services for analysis.
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Service/project
Size of collection:	Approximately 300
Data content:	Expenditure - Commonwealth allocation and matched funds No. of services/projects Major focus of services/projects Types of organisations involved in services/projects Time spent on activities Population groups targeted by services/projects Client population numbers Drug types targeted by services/projects
Aboriginal identification:	Yes
Geographic levels:	State and Territories
Identifiability:	No
Output:	Summary Report on National Drug Strategy Cost Shared Program Department of Health and Family Services Annual

Appendix A Tobacco, Alcohol and Illicit Drugs

Storage:	Electronic
Special technical requirements:	Subject matter expertise
PHD Staffing:	0.1 FTE per annum
Cost:	 Running costs \$6,000 Program costs \$Nil (In 1993-94 the Commonwealth allocation to the cost shared services/projects was \$19.5m, matched by \$20.5m from the States and Territories)
Funding sources:	NDS monies - Information and monitoring fund (Commonwealth)
Review/evaluation:	The questionnaire and guidelines were developed in early 1993 by an Activity Indicators Working Group, a sub-committee of the National Drug Strategy Committee. Following the 1993-94 reporting it was considered that the questionnaire was not particularly efficient and that it should be reviewed prior to the 1994-95 collection. In the absence of this review jurisdictions have commenced using the same reporting form as was used for 1994-95.
Comments:	The cost shared program will be broad banded in the future and a few sensible indicators will need to be developed to report against
Data Manager/Contact:	Mal Gibson 06 289 8364

29: STATISTICS ON DRUG ABUSE IN AUSTRALIA

Brief description:	Statistics on Drug Abuse in Australia presents a composite picture of the drug situation in Australia. It draws together all the related data collections, particularly those funded through the National Drug Strategy.
PHD Branch:	National Health Promotion and Protection Branch
Purposes:	 Provide information on drugs, alcohol and tobacco Inform and assist those involved in the management of relevant programs Identify needs and strategies to address drug related problems
Frequency/timing:	Bi-annual
Target population:	All Australians
Scope and coverage:	National
Collection methodology/ Data sources:	See individual collection reports
Collection/management agency:	Department of Health and Family Services
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Refer to individual collection
Size of collection:	Refer to individual collection
Data content:	Refer to individual collection
Aboriginal identification:	Refer to individual collection
Geographic levels:	National
Identifiability:	No
Output:	Bi-annual publication
Storage:	Electronic
Special technical requirements:	Subject matter knowledge
PHD Staffing:	0.3 FTE per annum
Cost:	Running Costs \$20,000 Program Costs \$30,000
Funding sources:	NDS monies
Review/evaluation:	Routinely as publication produced

Appendix A Tobacco, Alcohol and Illicit Drugs

Comments:	The publication in its revised format will provide a useful source of information on drugs, alcohol and tobacco, particularly the casual user
Data Manager/Contact:	Peter Vuksa 06 289 8666

30: PROJECT MALE-CALL

Brief description:	Survey of HIV, Hepatitis and STD risk behaviours among a nationwide sample of homosexually active men.
PHD Branch:	National Public Health Planning Branch
Purposes:	 Monitoring of risk factors - comparison to 1992 baseline data Evaluation of effectiveness of National HIV/AIDS Strategy
Frequency/timing:	1992, 1996 (Male Call 2)
Target population:	Homosexually active men.
Scope and coverage:	National
Collection methodology/ Data sources:	Cross-sectional telephone interview survey of self-selected sample of homosexually active men recruited through advertising, posters, media etc.
Collection/management agency:	HIV Social Research Centre, Macquarie University
Ownership/Access:	HIV Social Research Centre. Copy of dataset to SSDA at ANU in 1997.
Unit of enumeration:	Person
Size of collection:	2583 (1992); The 1996 survey is programmed to run October - December
Data content:	Demographic Contextual Sexual practices HIV - related knowledge Service usage Drug use HIV positive Knowledge of hepatitis, STDs
Aboriginal identification:	Yes
Geographic levels:	State/Territory ; postcode sought but not compulsory
Identifiability:	No
Output:	Kippax et al 1994. Report on Project Male Call: national telephone survey of men who have sex with men. AGPS Canberra. Crawford et al 1996. An analysis of trends over time in social and behavioural factors related to the transmission of HIV in men who have sex with men.
Storage:	Mainframe, Macquarie University.

Special technical requirements:	Subject matter expertise. National HIV Social Research Centre is nationally and internationally recognised for its work in this area.
PHD Staffing:	0.1 FTE per survey
Cost:	1. Running costs \$6,200 2. Program costs \$300,000 (1996)
Funding source:	HIV/AIDS Strategy evaluation funds (PHD)
Review/evaluation:	Male Call 2 will be evaluated after its completion to assess when and whether it is desirable to repeat it.
Comments:	Questions about comparability over time due to volunteer nature of sample. May need to review and identify the types of risk behaviour/knowledge data needed (in light of changing social behaviour, improved treatment of epidemic, need to target health education message) and the most cost- effective vehicle for doing this. It is a unique data collection because of its national focus and focus on both gay and non-gay community attached men. The primary focus of all other data collections for this group is one particular city and principally gay community attached men. The survey allows for international comparisons as New Zealand and the United Kingdom have copied male call and conducted similar surveys. The National Centre is funded under a contract to deliver a product defined by PHD. The Centre and the PHD work closely together and there are strong links between data collection and the use of this data for program management and policy development.
Data Manager/Contact:	Frances Byers 06 289 8123

31: SCHOOLS SURVEY

Brief description:	Survey of high school students
PHD Branch:	National Public Health Planning Branch
Purposes:	 Monitoring of knowledge, attitudes, beliefs and risk behaviours relating to sexual health - comparison to 1992 baseline data Evaluation of effectiveness of National HIV/AIDS Strategy
Frequency/timing:	1992, 1997
Target population:	High school students aged 13-19 (1992), students in Grades 10 and 12 (1997)
Scope and coverage:	Government schools, national sample (except NSW in 1992); the 1997 survey is expected to include all states
Collection methodology/ Data sources:	Cross-sectional 2-stage stratified sample, self completed questionnaire
Collection/management agency:	HIV Social Research Centre, La Trobe University
Ownership/Access:	HIV Social Research Centre, La Trobe University. Copy of dataset to be sent to SSDA at ANU in 1997
Unit of enumeration:	Person
Size of collection:	4589 (1992), to be determined (1997)
Data content:	Knowledge, attitude and behaviour related to transmission of HIV, STDs and hepatitis Demographics
Aboriginal identification:	Yes
Geographic levels:	State and Territory
Identifiability:	No
Output:	Dunne et al 1993. 1992 HIV Risk and Sexual Behaviour Survey in Australian Secondary Schools. AGPS Canberra
Storage:	Mainframe, La Trobe University
Special technical requirements:	Subject matter expertise. National Hiv Social Research Centre is nationally and internationally recognised for its work in this area
PHD Staffing:	0.1 FTE per survey
Cost:	1. Running costs \$6,000 2. Program costs \$320,000 (1996)
Appendix A Sexual and IDU Risk Behaviours

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Funding sources:	HIV/AIDS Strategy evaluation funds (PHD)
Review/evaluation:	The survey will be evaluated after its completion to assess when and whether it is desirable to repeat
Comments:	The Centre and the PHD work closely together and there are strong links between data collection and the use of this data for program management and policy development. Running the survey also requires careful liaison between HFS and State and Territory Education Departments.
Data Manager/Contact:	Frances Byers 06 289 8123

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Brief description:	Survey of HIV, Hepatitis B and Hepatitis C among intravenous drug users

32: NEEDLE AND SYRINGE EXCHANGE SURVEY

PHD Branch:	National Public Health Planning Branch
Purposes:	 Monitor prevalence of HIV, Hepatitis B and Hepatitis C infection Obtain information on injecting and sexual practices Evaluation of effectiveness of National HIV/AIDS Strategy
Frequency/timing:	1995, 1996
Target population:	Attendees at selected needle and sytinge exchange centres throughout Australia
Scope and coverage:	National
Collection methodology/ Data sources:	Self selected sample completed self enumeration questionnaire and provided a finger prick blood spot specimen
Collection/management agency:	National Centre in HIV Epidemiology and Clinical Research University of New South Wales, Sydney
Ownership/Access:	National Centre in HIV Epidemiology and Clinical Research University of New South Wales, Sydney
Unit of enumeration:	Person
Size of collection:	979 (1995), approx1300 (1996)
Data content:	Age Age at first injection event Drug injected Frequency of injections Frequency of use of the same needle No of people who used the same needle Receipt of drug treatment Sexual behaviour HIV and hepatitis C testing Hepatitis B infection and vaccination Demographics
Aboriginal identification:	Yes
Geographic levels:	States and Territories
Identifiability:	No
Output:	Australian HIV Surveillance Report plus peer reviewed journals and information sources aimed at IDU's
Storage:	

Appendix A Sexual and IDU Risk Behaviours

Special technical: requirements:	Subject matter expertise. National Centre in HIV Epidemiology and Clinical Research is nationally and internationally recognised for its work in this area
PHD Staffing:	Nil
Cost:	1. Running costs \$Nil 2. Program costs \$70,000 (1995), \$25,000 (1996)
Funding sources:	HIV/AIDS Strategy evaluation funds (PHD), Hepatitis C Epidemiology funds
Review/evaluation:	The survey will be evaluated after its completion to assess when and whether it is desirable to repeat
Comments:	This type of survey is the easiest way to monitor Hepatitis C in IDUs on a routine basis. The Centre and the PHD work closely together and there are strong links between data collection and the use of this data for program management and policy development.
Data Manager/Contact:	Frances Byers 06 289 8123

33: SYDNEY MEN AND SEXUAL HEALTH (SMASH) STUDY

Brief description:	SMASH is an on-going, longitudinal study of a cohort of approximately 1000 gay and homosexually active men
PHD Branch:	National Public Health Planning Branch
Purposes:	 Provide comprehensive baseline data for future comparisons Examine the impact of HIV on the sexual and social lives of the men in the study Provide serological testing and assessments of disease progression
Frequency/timing:	Commenced late 1992
Target population:	Sydney gay men
Scope and coverage:	 Sydney gay men: Priori criteria for entry into the study were: 1. having had sexual contact with another man during the five years prior to recruitment 2. living within the one hour commuting zone of, or participating regularly in, the Sydney gay scene
Collection methodology/ Data sources:	The sample was recruited through the following sources: Gay press, organisations, dance parties, sex venues community events, other research studies, doctors/clinics, and others. Initial interviews were conducted and follow up interviews arranged with those willing to continue in the study. Participants are interviewed every six to 12 months and those participants included in the clinical arm of the study are asked to have their medical practitioners report on specified serological tests and, if relevant, their HIV-related disease progression. The clinical reports are requested every six to 12 months to coincide with the socio-behavioural interviews.
Collection/management agency:	National Centre in HIV Social Research, Macquarie University, Sydney N.S.W.
Ownership/Access:	Jointly: National Centre in HIV Epidemiology and Clinical Research (University of New South Wales), National Centre in HIV Social Research, Macquarie University and the Aids Council of New South Wales
Unit of enumeration:	Person
Size of collection:	Initial cohort sample 903. It is estimated that 20 to 25 percent would fail to complete their follow-up interviews each year. The second and subsequent recruitment phases are expected to replace the losses. The second recruitment phase (1994-1995) provided another 135 to the sample.

Data content:	Demographics Sources of HIV information Sexuality and sexual identity Sexual relationships and sexual practices with men Sexual relationships and sexual practices with women Involvement with the gay community Knowledge of HIV transmission and changes of behaviour Health practices and management, drug usage and relationship to people with aids Attitudes to issues relating to sexuality
Aboriginal identification:	Yes
Geographic levels:	Sydney
Identifiability:	No
Output:	Sydney Gay Community Surveillance Report Bi-annual
Storage:	Electronic
Special technical: requirements:	Subject matter expertise. National Centre in HIV Epidemiology and Clinical Research is nationally and internationally recognised for its work in this area
PHD Staffing:	Nil
Cost:	 Running costs \$Nil Program costs - funded through the general funding of the National Centres in HIV Social Research
Funding sources:	HIV/AIDS Strategy research funds (COPO)
Review/evaluation:	
Comments:	Surveys were also conducted in Melbourne (MASH) and Brisbane (BASH) during 1995. The methodology used was the same as the SMASH study. It is hoped that these surveys may be continued at a later date but funds are currently unavailable and unlikely to be endorsed. The primary purpose of these two surveys was to compare the populations of these cities with their Sydney counterparts. The Centre and the PHD work closely together and there are strong links between data collection and the use of this data for program management and policy development.
Data Manager/Contact:	Frances Byers 06 289 8123

34: HEALTHWIZ

Brief description:	HealthWIZ is the National Social Health Database containing datasets on the Population Census, Mortality, Hospital Morbidity, Cancer Incidence and Mortality and a range of other health and demographic statistical collections
PHD Branch:	National Public Health Planning Branch
Purposes:	 Raise awareness and increase the utility of data collections which may otherwise be unnecessarily restricted. Assist health education and promotion workers in identifying community and population sub-groups with high rates of specific diseases or health problems. Provide a single respository of health and population information.
Frequency/timing:	Ongoing
Target population:	Health workers and general public
Scope and coverage:	Population and health databases
Collection methodology/ Data sources:	Databases bought from relevant owners - Australian Bureau of Statistics, State health authorities, private organisations
Collection/management agency:	Prometheus Information under contract to the Commonwealth Department of Health and Family Services
Ownership/Access:	Prometheus Information
Unit of enumeration:	Data collections
Size of collection:	Approximately 20 collections
Data content:	As per individual collections
Aboriginal identification:	Yes
Geographic levels:	Local area
Identifiability:	No
Output:	As required
Storage:	Electronic
Special technical requirements:	
PHD Staffing:	0.1 FTE per annum

Appendix A General

Cost:	Running costs \$6,000 Program costs \$5,800 plus maintenance costs of \$2,500 per month
Funding sources:	Contractual agreement
Review/evaluation:	
Comments:	HealthWIZ comprises a large and expanding set of health and population data collections, together with a high performance and user-friendly software interface with custom table making, viewing and analysis functions. The product runs on personal computers under a Windows environment and the database can also be installed on a central server. The database will be made available on a CD-ROM later this year.
	A major focus of HealthWIZ is to assist those working in public health to identify community and population subgroups with high rates of specific diseases and social disadvantage. This is one of the Division's strategies for addressing its key objective in relation to reduction of inequalities in health. For this reason, the product is priced so as to be affordable to organisations like community health centres and non-government and local groups involved in public health. Additionally, it is intended that the Partnership and the Commonwealth/State Agreements will provide incentives and conditions to promote a standardised approach to public health planning and monitoring and HealthWIZ provides a potentially valuable tool to assist in this.
	A related Departmental product, also supported by Prometheus Ltd, is the HEAPS text database of primary health care and health promotion projects. While this lies outside the scope of this consultancy, it should be noted that HEAPS provides the potential for promoting evidence-based public health practice nationally and for dissemination of research in public health. HEAPS main limitation is its uneven coverage and incompleteness.
Data Manager/Contact:	Chris Roberts 06 289 8064

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35: SOCIAL HEALTH ATLAS OF AUSTRALIA

Brief description:	The Social Health Atlas of Australia is a two volume atlas which maps the patterns of socio-economic disadvantage, health status and use of health services at the small area level and for different population groups.
PHD Branch:	Public Health Policy and Planning Branch
Purposes:	 Provides information for needs based policy development Provides data for local area planning Monitoring and evaluation of health services
Frequency/timing:	First edition 1992
Target population:	All Australians
Scope and coverage:	National
Collection methodology/ Data sources:	Data bought from relevant Australian Bureau of Statistics
Collection/management agency:	Developed by the South Australian Health Commission under contract to the Department of Health and Family Services
Ownership/Access:	Department of Health and Family Services
Unit of enumeration:	Person
Size of collection:	150 maps from a range of data collections
Data content:	Demographic and socio-economic status Families Labour force Schooling Language Income Health status Mortality Health service utilization
Aboriginal identification:	Yes
Geographic levels:	Statistical local area
Identifiability:	No
Output:	"A Social Health Atlas of Australia" 1992
Storage:	Hardcopy/electronic

Appendix A General

Special technical requirements:	Data analysis and writing skills
PHD Staffing:	Nil
Cost:	Running costsNil Program costs \$Approximately \$400,000
Funding sources:	Contractual agreement
Review/evaluation:	The Atlas was evaluated in 1995 by the Department of Geography University of Adelaide and the the Community Planning and Urban Design Branch of the Planning Division of the South Australian Department of Housing and Urban Development. The main recommendations from the Evaluation were: the Atlas should become a regularly updated publication; the second edition should be a joint activity of the Department and the ABS; Its production should become part of a larger national strategy which addresses a review of data collections, identification of key health variablesand the setting up of a geographically referenced social health dataset; the production of separate atlases for eachState and Territory; and the development of a comprehensive launching and publicity strategy for its release.
Comments:	The second edition of the Atlas is currently under negotiation between the Department and the South Australian Health Commission
Data Manager/Contact:	Chris Roberts 06 289 8064

Appendix A General

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APPENDIX B

AIHW HEALTH WORKPROGRAM 1996-97

This Appendix summarises the elements of the AIHW 1996-97 work program relevant to national public health information. Planned publications are listed under each subprogram in italics.

Health Program

Disease registers subprogram

National Cancer Statistics Clearinghouse Cancer in Australia 1991-1993

> Breast Cancer in Australia 1982-1992 Cancer mortality in migrants to Australia by period of residence 1918-1995

National Death Index Mortality data Mortality surveillance Australia 1984-1995

Cardiovascular Disease Monitoring Subprogram

Cardiovascular disease Mortality surveillance for CVD 1983-1994 CVD Medical Care report CVD conditions and functional status report Position papers on outcomes and data collection Diabetes monitoring Risk factors Food and nutrition

Population Health Subprogram

Monitoring national health priorities National Health Priorities report Public health Public health indicators report Australian health trends 1997 Health of young Australians Health differentials Trends in mortality differentials in Australia Health in rural and remote Australia International health Data to WHO and OECD Australia's health: international comparisons Health, disability and burden of disease Costs of diseases in Australia 1993-94 Costs of cardiovascular disease in Australia 1993-94 Costs of cancer in Australia 1993-94 Monitoring asthma and musculoskeletal diseases Population data co-ordination

Health Outcomes Subprogram

Australian Health Outcomes Clearinghouse Health Outcomes Bulletins no.s 8 and 9 Integrating Health outcomes into Routine Care Conference Proceedings

Welfare Program

Health and Welfare Expenditure Statistics Subprogram

Health Expenditure data Health Expenditure Bulletin 1994-95 Health Satellite National Accounts Discussion Paper

Information Management and Business Services Program

National Information Infrastructure Subprogram

National standards, definitions and classifications National Health Data Dictionary Version 6

Communication and Public Affairs Subprogram

Publications AIHW Internet Home Page

Executive Program

National Information Development subprogram National Health Information Agreement National Health Information Work Program 1996-97 NHWI News

Extramural Program

Aboriginal and Torres Strait Islander Health and Welfare Information subprogram

National Aboriginal and Torres Strait Islander Survey: Health National Aboriginal and Torres Strait Islander Survey: Housing characteristics and conditions Mortality of indigenous Australians The Health of indigenous Australians

Dental Health Statistics subprogram

Child Dental Health Survey 1994 National report Child Dental Health Survey 1995 State and Territory reports Adult Dental Program Survey 1996 report National Dental telephone Interview Survey 1996 report Satisfaction with Dental Care 1996 report Attitudes to Dental Care 1996 report Adult Dental Progress Survey 1996 prospective report Commonwealth Dental Health Program 1996 evaluation report AIHW Dental Statistics and Research Unit newsletter

Injury Information and Statistics subprogram

Injury surveillance strategy and standards Emergency department injury surveillance development report National Injury Surveillance Data Standards National datasets and routine reports Injury surveillance Data Reports: Morbidity 1993-94 : Mortality 1994 and 1995 Spinal injury register quarterly reports Injury in the Elderly: preliminary report on falls Information service Australian Injury Prevention Bulletin NISU Directory of Products Research and development Aboriginal injury surveillance report Spinal injury register development report

Perinatal Information and Statistics subprogram

National perinatal data Perinatal newsletter and bulletins Australia's mothers and babies 1995 Congenital malformations incidence monitoring Congenital Malformations Australia 1995 Register of assisted conception Assisted conception, Australia and New Zealand 1996 Neonatal intensive care units Australian and New Zealand Neonatal Network 1995

Classification in Health subprogram

Implementation of ICD-10 in the health sector Development of ICD-10-AM (Australian modification) Clearinghouse for information on health classification Promote national standards on health classification and coding WHO Collaborating Centre for the Classification of Diseases

Appendix C

NATIONAL HEALTH INFORMATION INFRASTRUCTURE

1. INTRODUCTION

Government agencies routinely collect and analyse data produced in the course of managing their programs. Selected information of this kind is incorporated into national data sets and used to prepare reports on the health of Australians and on their health services. The main agencies involved in such data collection and analysis are the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW).

2. THE ROLE OF THE ABS

The ABS is Australia's national statistical agency. Its responsibilities include: providing a statistical service to Australian governments and the community generally; coordinating the statistical activities of other agencies; and promoting the use of statistical standards. As part of its statistical service, the ABS conducts large-scale population surveys of health and health services every five years, a national survey of disability and ageing every five years, and many of its other surveys provide health-related data. The ABS also conducts national surveys on health subjects from time to time under its own work program, as well as with funding from stakeholders. The Division is a major funder of the recently conducted National Nutrition Survey and will be a major funder of the National Mental Health Survey to be conducted in 1997.

3. THE ROLE OF AIHW

The AIHW was established in 1985 to fill a long recognised gap in Australia's national public health infrastructure. The Institute's mission, backed by its legislative mandate, is to inform community discussion and decision making through national leadership in the development and provision of authoritative and timely information and analysis on the health and welfare of Australians. The Institute is also responsible for conducting and promoting research into the health of Australians and their health services, and for undertaking studies into the provision and effectiveness of health services and technologies.

The Institute has addressed its leadership role by, inter alia, promoting and facilitating national consensus on health information matters. One of the most significant developments of health information in Australia has been the signing of the National Health Information Agreement by the Commonwealth, State and Territory health and statistical authorities in 1993.

4. NATIONAL HEALTH INFORMATION AGREEMENT

In recognition of the need for national, coordinated information about health, health services and

consumers, and about environmental and human factors that may affect health, the Commonwealth, State and Territory health authorities, the Australian Bureau of Statistics and the Australian Institute of Health and Welfare, signed an agreement to improve the quality of and cooperation in the development of national health information. This Agreement, the National Health Information Agreement, came into effect on 1 June 1993 and is for an initial period of five years (1993-1998).

The Agreement seeks to ensure that the collection, analysis and dissemination of national health information is undertaken appropriately and efficiently. This can only be achieved through the use of agreed uniform definitions, standards and rules of data collection and guidelines for co-ordination of access, interpretation and publication of national health information. The National Health Information Agreement Procedure Manual states that:

"The aim of the Agreement is to improve access to uniform health information by community groups, health professionals, government and non-government organisations".

The objectives of the Agreement have been listed in the Agreement itself. These are:

- to promote the collection, compilation, analysis and dissemination of relevant, timely, accurate and reliable health information concerned with the full range of health services and of a range of population parameters (including health status and risks), in accordance with nationally agreed protocols and standards;
- to develop and agree on projects to improve, maintain and share national health information;
- to cooperate in the provision of resources necessary to address national health information development priorities efficiently and effectively;
- to provide the information required to research, monitor and improve health and the delivery of health services;
- to provide the information required to facilitate nationally agreed projects which promote the development and reform of the health care system in accordance with the priorities of the Australian Health Ministers' Advisory Council; and
- to promote the extension of the range of national health information and encourage other groups and individuals in government and non-government sectors to participate by making available information that they hold.

The National Health Information Agreement provides the processes and structures needed for the implementation of the agreed definitions, standards and guidelines. The Agreement is managed by the National Health Information Management Group (NHIMG), comprised of senior representatives of the signatories to the Agreement.

5. NATIONAL HEALTH INFORMATION MANAGEMENT GROUP

The Agreement mandates the operations of the National Health Information Management Group, a now well proven executive level communication forum for policy analysis and the pursuit of consensus in national health information matters. This group and a subordinate committee structure provide the essential decision-making infrastructure for establishing priorities, roles and responsibilities of the various stakeholders in high quality health information in Australia.

Specifically, the National Health Information Management Group is responsible for:

- overseeing the direction, development, review and implementation of the National Health Information Agreement and the agreed national priorities;
- coordinating the National Health Information Work Program;
- making recommendations to AHMAC on national health information priorities, work programs, funding implications and other policy issues;
- negotiating with other groups and individuals for the collection and dissemination of information which will enhance the provision of health care;
- overseeing the role and function of the National Health Data Committee; and
- overseeing the review and maintenance of the National Health Data Dictionary.

The Management Group usually meets twice yearly, approximately six weeks before scheduled AHMAC meetings in April and November.

6. NATIONAL HEALTH INFORMATION WORK PROGRAM

The National Health Information Work Program is a rolling triennial work program of national health information projects, agreed to by the National Health Information Management Group and endorsed by AHMAC. The work program includes those health information activities that both meet agreed national priorities and have either a national focus or national implications. These activities include development work on standard charts of hospital accounts, health outcome measures and new data collections such as mental health. They also cover work on improved definitions and enhancement of existing collections such as vital statistics and hospital morbidity.

Responsibility for each project in the work program is allocated to a signatory to the National Health Information Agreement. Agreed roles and responsibilities for these signatories have been developed and are spelt out in the National Health Information Agreement Procedure Manual. The responsibilities include: addressing the issues from a national rather than a Commonwealth, State or Territory perspective; consulting broadly; reporting to the National Health Information Management Group; and using agreed national data definitions and standards as defined in the National Health Data Dictionary.

The complete triennial work program is published and is also provided to participating agencies. It is revised with new inclusions each financial year. A summary work program listing the projects for the current year, major outputs, and responsible agencies is published annually.

7. NATIONAL HEALTH DATA DICTIONARY

The National Health Data Dictionary (NHDD) is a set of data items and definitions. It is intended to facilitate the collection of uniform data to more accurately describe and compare health services throughout Australia. The National Health Data Dictionary, introduced in 1991-92 and originally targeting definitions for institutional health care only, has progressively been expanded and now provides broad coverage of the health sector. The National Health Data Dictionary incorporates established national and international data definitions as well as a growing range of new definitions. Widespread commitment to the Dictionary has resulted in significant improvement in the comparability and quality of health care data in Australia.

The recommended format for the National Health Data Dictionary definitions is included in detail in the National Health Information Agreement Procedure Manual. Developments and revisions to the dictionary are the responsibility of the National Health Data Committee (NHDC).

8. NATIONAL HEALTH DATA COMMITTEE

The functions of the National Health Data Committee have been identified in the National Health Information Agreement Procedure Manual. These include:

- maintain the development and revision of the National Health Data Dictionary and national minimum
- data sets in all areas of health, including institutional health care;
- receive, consider and comment on all draft National Health Data Dictionary input;
- take a pro-active role in national definition development;
- ensure that draft inputs have been subjected to sufficient national consultation;
- make recommendations regarding inputs to the National Health Data Dictionary for endorsement by the National Health Information Management Group, and
- consult on and determine the expansion of the National Health Data Dictionary to other areas of health.

The membership of the National Health Data Committee comprises representatives of each signatory to the Agreement, the Australian Private Hospitals Association, the Department of Veterans Affairs, and others designated by the National Health Information Management Group. The National Health Data Committee operates a review, development and publication cycle based on the calendar year.

9. NATIONAL HEALTH INFORMATION FORUM

The AIHW has developed a national leadership role in promoting the development of national health statistics. As part of this role the Institute promotes community discussion and supports public policy-making through the conduct of regular national health information forums. The 1994 National Health Information Forum was attended by approximately 130 people from Australian health authorities, non-government health organisations, health consumer organisations, the private health industry sector and academic and research organisations.

Six major themes for national action on health information emerged from the Forum. They were identified "... as the needs to:

- improve information on the health of Aboriginal and Torres Strait Islander peoples and other priority populations;
- increase consumer and provider involvement in national health information development and use;
- address deficiencies in, and improve the quality of, existing data collections;
- improve access to, and dissemination of, information;
- develop appropriate linkage of individual records; and
- develop and implement health information standards, including standard classifications and indicators."

These themes are reflected in the information development directions proposed in the National Health Information Development Plan (NHIDP).

10. NATIONAL HEALTH INFORMATION DEVELOPMENT PLAN

The National Health Information Development Plan was prepared in recognition of the need for nationally agreed priorities for national health information. While the Plan primarily guides the work of the AIHW, it also provides a development program for national health information to improve the quality of decision making by health care providers, consumers and governments.

The basic principles of timeliness, reliability, consistency, relevancy and accessibility, combined with efficient collection, analysis and collation, are fundamental to the development of quality national health information. Consistent with the purpose of the National Health Information Agreement, it is intended that the Plan should influence the work programs of State, Territory and Commonwealth health authorities, the Australian Bureau of Statistics, and other bodies involved in the collection and production of health related information and statistics in Australia.

The Plan builds on the National Health Information Agreement and its structures and processes to provide a new set of national health information development priorities. The Plan document specifies that "the objectives of the Plan are:

- to promote the development of high priority health information;
- to increase the cost-effectiveness of Australia's health information system; and
- to contribute to increases in the cost effectiveness and equity of Australian health services and thereby the well-being of Australians."

In developing the plan, the AIHW invited submissions from interested parties and undertook a series of consultation workshops. These, in conjunction with the National Health Information Forum identified priorities for the development of health information at the national level. While some of the priority areas relate to specific populations or specific illness or disease, the underlying theme is the need for a well developed and widely accepted national health information model to provide the framework for all other developments. It is considered that such a model

will be vital to the development of information to support the proposed major reforms in the financing and delivery of health and community services in Australia.

11. NATIONAL HEALTH INFORMATION MODEL

Information modelling is "the process of determining what information is important, associated definitions, classifications and interrelationships, and how that information is to be organised." The result of this process is physically represented by an information model. The National Health Information Model (NHIM) uses entity relationship diagrams (E-R diagrams) to depict information. The basis of the E-R technique is the identification of entities and relationships. An entity is the thing that we need to know information or hold data about - that is people, places, objects, events or concepts. The information required about an entity is referred to as attributes or data items.

The National Health Information Model (Version 1) was published in November 1995. It was developed through collaboration between the AIHW, NSW Health, and Victorian Health and Community Services. Contributions were also received from participants at model development workshops. The National Health Information Model offers a highly visible and logically ordered basis for organising information, data definitions, classifications and data relationships. By developing a model that aims to represent the kinds of information needed within all health and health related activities in Australia, it becomes possible to highlight the areas of overlap where identical data items would serve multiple purposes.

The National Health Information Model provides the fundamental framework for Australia's future data collection/standards development work. Features of the model are:

- the inclusion of a person's or group's state of wellbeing, existing independently of a health or welfare system;
- the depiction of events which occur and which may influence a state of wellbeing;
- the inclusion of health and welfare events and services, the resources they use, and the policy and planning elements which may affect them;
- the incorporation of a date and time element, allowing the representation of situations and events occurring over time; and
- the inclusion of classification systems for each of the major parts of the model.

Current developments in forging National Public Health Partnership include plans to expand the National Health Information Model's coverage of public health information. Furthermore, over the next few years, the National Health Information Model will be refined and enhanced to encompass national welfare information and will then enable the ongoing development of information standards that usually bridge the health and welfare sectors. It will provide a basis for management of aspects of the COAG agenda which are aimed at coordination of service delivery across health and community services fields.

During 1996-97, the AIHW will release a comprehensive electronic version of its national information products as an integrated and cross-referenced metadata source. This new edition

will draw together the National Health Information Model, the National Health Data Dictionary and the National Directory of Data Collections in Health, Welfare and Housing.

13. NATIONAL DIRECTORY OF DATA COLLECTIONS IN HEALTH, WELFARE AND HOUSING

The need for an authoritative list of available data collections in health, welfare and housing was identified in the National Health Information Development Plan. The AIHW released the National Directory of Data Collections in Health, Welfare and Housing in August 1996. The directory is a major revision of "Inventory of Australian Health Data Collections", published by the AIHW and the ABS in 1991.

The directory is based on information from continuous, periodic and terminated collections from 1985 onwards, or collections of particular significance. The criteria for collections to be included in the Directory was that they are national in coverage or have potential to provide a national picture or guidance for national health, welfare and housing assistance policy.

The directory provides invaluable assistance to those interested in identifying the availability of health data and how that data fits within their specific subject of interest.

14. SUMMARY

Australia's national health information products have been developed and progressively refined since the National Health Information Agreement was signed in 1993. Backed by well-established policies and procedures, development activities have targeted nationally consistent data within a system of agreed priorities and in support of the administrative and policy needs of a range of institutional settings. The essential process in developing uniform national data has been one of broad consultation and consensus involving Commonwealth, State and Territory health authorities as well as service providers, private sector representatives and information management specialists. Financial constraints on the health system and the cost of information have prompted recognition of the advantages of adopting a rationalised, national approach to information development rather than a piecemeal State-by-State approach.

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