Australian Government
Australian Institute of Health and Welfare

access

Issue 23 • May 2007

Feature articles on:

Australia's future generations

Inside this issue...

Contents

AIHW Access

A complete list of the Institute's publications is available from the Institute's website <www.aihw.gov.au>.

ISSN 1442-4908
Catalogue No. HWI 96

Australian Institute of Health and Welfare

Board Chair
Hon. Peter Collins, AM, QC

Director
Penny Allbon

Any enquiries about or comments on this publication should be directed to:
Janine Martin, Business Promotion and Media Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601
Phone: (02) 6244 1012
Email: Janine.martin@aihw.gov.au

Published by the Australian Institute of Health and Welfare
Printed by
Cover photo: Getty Images

Print post approved pp 255003/04169

Dear readers

Welcome to our new-look *Access* magazine. As in all we do at the Institute, we aim to make *Access* as informative and relevant as possible.


Photo: Irene Dowdy

Penny Allbon

In this edition we feature several articles on the important work the AIHW is doing, in collaboration with its partners, on the health and wellbeing of Australia's children.

My first 12 months at the Institute have seen both stability and change. Our flagship publication, *Australia's health 2006*, was launched last June and both the book and the associated conference were very well received. Our regular publications have grown and some interesting new ones have been delivered—such as the analysis of coronary heart disease in Aboriginal and Torres Strait Islander people, or the paper tackling the challenge of avoiding multiple data entry and reporting by service providers (a report profile of *Cutting the red tape* appears on page 28). Other important reports published in the last year include: *Breast cancer in Australia, an overview 2006*; *Australia's mothers and babies 2004*; and *Dementia in Australia*.

Our senior team has lost a few valued faces and gained a few new ones—you can catch up on the latest in this issue.

We've been exploring how we want the AIHW to develop into the future through our corporate planning process. The Board, many of our policy partners and our staff have used this planning as an opportunity to shake ourselves a little and decide on our key strategic directions for the next few years.

Our consultations have convinced us that one of our key directions will be to strengthen our policy relevance. Statistics are, after all, a servant to policy. The information needs of policy makers can often be specific, urgent and sophisticated. In response, we need to be sure we tailor our information products to those needs.

This strategic direction does not take us away from delivering many of the reliable products that we have in the past. But it may add new kinds of products and different analyses, to ensure we keep up with our customers, ranging from government through to the general community.

Another key direction will be to make sure we capitalise on the major changes in the information scene: the impending electronic record for clinical medicine and the continuous client record for community services; emerging terminologies in health informatics; and a growing awareness that data linkage can deliver much more sophisticated analyses of what is happening in our society.

Some of these changes could pose hazards to traditional systems of governing, gathering and analysing information. Equally, they offer opportunities for filling information gaps and for faster and more responsive systems. At the Institute we are well placed to lead the thinking about how Australia's health and welfare statistical system can rise to the occasion.

I look forward to a year of challenges and opportunities and I welcome your feedback and insights into how we might continue to improve our business. ■

Dr Penny Allbon
Director

The early years

WHAT WILL BE THE LONG-TERM HEALTH IMPACT OF RISING CAESAREAN RATES?

WHY HAS THE RATE OF LOW BIRTHWEIGHT BABIES FAILED TO DROP OVER THE PAST DECADE?

HOW MANY ABORTIONS ARE PERFORMED IN AUSTRALIA?

HOW HAVE THE OUTCOMES FROM ASSISTED REPRODUCTIVE TECHNOLOGY TREATMENTS CHANGED?

Photo: istockphoto.com

The AIHW National Perinatal Statistics Unit's large and consistent collection on mothers, babies and reproductive health is providing an enormous opportunity to put flesh on the bones of the complex contemporary issues related to modern pregnancy and childbirth in Australia.

The data collections

Much of the strength and capacity of the AIHW's collection stem from its age, size and unique profile.

Since 1991 the National Perinatal Statistics Unit (NPSU) has compiled national information on the characteristics and outcomes of pregnancy, childbirth and reproductive health in Australia. The set of information collected is large and quite stable—steady at about 260,000 records each year.

It's also unique compared to many other health data collections in that the cohort is generally of good health rather than being unwell and much of its information relates to key indicators of people's future health and wellbeing.

The NPSU's Dr Elizabeth Sullivan says the nature of the data collection provides a strong national profile.

The recently released *Australia's mothers and babies 2004*, the 14th annual report, shows 257,205 babies were born in 2004. It found that the average age of first-time mums was 28 years, 20% of women who gave birth were over 35, about 6% of live-born babies were of low birthweight, and that 30% of all mothers had caesareans.

Another recent release, *Assisted reproduction technology in Australia and New Zealand 2004*, shows that 7,029 of the live births in Australia in 2004 were the result of nearly 39,000 ART cycles.

Maternal deaths in Australia 2000–2002 shows there were 84 deaths related directly or indirectly to pregnancy and birth during that period, most commonly due to amniotic fluid embolism, haemorrhage, infection and cardiac disease.

Adoptions Australia 2005–06, published by the AIHW's Children, Youth and Families Unit, reveals there were 576 adoptions in Australia, 73% of which were of children from overseas.

Identifying changes and trends

These figures represent a minute sampling of information reported by the Institute and through the NPSU.

However, they illustrate another of the collections' strengths—that is, their ability to identify the changes and trends that reflect and influence individual choices, clinical practice, social views and policy making.

For example, the number of babies has been pretty stable for the past 15 years, with a similar number of babies born in 1991 (256,634 births) to those born in 2004. However, the 28-year-old first-time mothers in 2004 were two years older than their 1994 counterparts, the proportion of low birthweight babies has not changed since 1991, and caesarean rates have increased from 18% in 1991.

The plateau in the rate of low birthweight babies is an issue that stands out to the statistical experts.

Low birthweight is a major indicator of a child's long-term health, and both medical and population health initiatives have been focused on improving risk factors such as tobacco smoking and nutrition in pregnancy.

'But with all these improvements, we are not seeing a corresponding improvement in birthweights', Dr Sullivan says. 'This is also being seen internationally, but we don't know why.'

'It is a big question, can we do anything else [to improve it]?'

Big questions are also raised by the increase in the rate of caesareans, which is likely to continue, according to Dr Sullivan, with the majority of women who have had a previous caesarean section having another in the subsequent pregnancy.

Filling the gaps

Because of the nature of its work, the NPSU is in a prime position to respond to community and government needs in filling important data gaps, as has been highlighted by the recent debate on abortion.

Abortion issues have again risen to the forefront of public debate following a number of developments including government-funded pregnancy counselling services and the availability of the drug RU486.

It's a sensitive and emotive issue on many fronts and the debate has been complicated by ongoing questions over the actual rates of abortion.

In its role as an important source of health data, the AIHW NPSU included estimates on induced abortions and patient characteristics in its recent *Mothers and babies in Australia 2004* report.

Using hospital and Medicare data, the report estimates the number of induced abortions in 2004 was 83,210. Seventy-six per cent were for women who lived in major cities and the highest number was in the 20–24 years age group (21,504 or 25.8%).

With the AIHW NPSU national figures now reported, the community can continue its current debate better informed, as well as benefit in the future from the latest statistics and their insights into changes and activity.

Highlighting improvements

Meanwhile, the AIHW NPSU's data on assisted reproduction technology (ART) provide an example of how ongoing collections can provide evidence of improved health trends, which in this case are benefiting clinicians and patients on the ground.

Live births from ART have increased significantly since 1991, and the data also show the proportion of deliveries of one baby rose, reflecting improvements in ART processes as well as the chance of better health outcomes for singleton babies.

'That's good news for couples who utilise fertility services', Dr Sullivan says.

The influence of medical, social and legal factors at work are also evidenced in the AIHW reports on adoptions and maternal deaths.

The availability of and changes in birth control, family planning centres and sex education classes, individual preferences and social trends regarding child raising, as well as a drop in Australian children available for adoption, were all shown to contribute to the 17-fold decrease in adoption numbers since the 1970s.

Improved reporting and changes in some classifications have resulted in the number of deaths indirectly related to pregnancy—caused by conditions such as cardiac disease, infection and psychiatric causes—rising from 30 in 1997–99 to 52 in the latest report on maternal deaths.

While at first glance the higher numbers raise major concerns, the report explains that some of the reported changes actually reflect advances in the knowledge of the etiology of some conditions in relation to pregnancy.

The report found that incidental maternal deaths, such as those due to a road accident, have fallen. And although overall maternal death rates remained fairly stable, potentially preventable deaths due to suicide and

Photo: istockphoto.com

unintentional injury continue to factor among the leading causes of death. The report concluded that better inquiries into maternal deaths must still be made, particularly with figures showing a persisting higher rate of mortality among Indigenous mothers, which is 4.5 times that of non-Indigenous mothers.

Maternal mortality, like many of the issues relating to pregnancy and birth, is often used as a measure of a country's overall health and development status.

The NPSU's unique collection of data on pregnancy, childbirth and reproductive health is providing a robust and detailed insight into how Australia is faring and what it might face in the future. ■

Data at work

An important by-product of the NPSU's comprehensive collections is its ability to prompt questions about why and how issues change, and stay the same, which in turn instigate further investigation and discovery.

'It's hypothesis-forming data', Dr Sullivan says.

'When we present our data to a wide audience we hope it raises questions about why...that it will stimulate research and thinking and hopefully get answers to the questions our data might raise.'

The NPSU hopes that the data—such as the figures on prevailing low birthweight and rising caesarean rates—will spark new ideas, research and debate by population health and clinical researchers, obstetricians, midwives, public health professionals and the community.

Feedback and inquiries also help the Unit to improve the range and quality of its own data gathering and analysis and bring opportunities for collaboration between experts.

The NPSU's technical expertise and data have been put to work in the Core Maternity Indicator Project, which was tasked with developing a set of national indicators that can be used to improve maternal outcomes.

A national set of maternity indicators was recommended by the Douglas Inquiry into adverse obstetric patient outcomes at King Edward Memorial Hospital, Western Australia, in 1999 to 2000.

As a member of the project's expert working group, the NPSU has provided technical advice and data on the indicators that aim to enable comparative analysis and benchmarks for clinical practice and maternal outcomes across Australia.

At the same time, the work of the Unit can also help the individual, with health information not just reaching doctors but the patients in their rooms, such as the woman over 35 having her first child or the couple considering ART.

About NPSU

The NPSU was the AIHW's first collaborating unit. Contracted through the University of Sydney in 1985, the NPSU has been part of the University of New South Wales in the School of Women and Children's Health since 1997.

Its location at the Sydney Children's Hospital allows the Unit to work closely with practising clinicians, public health specialists and data users, and means that NPSU can provide both practitioner and end user perspective in its reports.

Location

Level 2 McNevin Dickson Building, Sydney Children's Hospital, Randwick Hospital Campus, Randwick NSW 2031
Phone: (02) 9382 1014 • Fax: (02) 9382 1025 • Web: www.npsu.unsw.edu.au

Primary contact

Director, Elizabeth Sullivan
Phone: (02) 9382 1014 • Fax: (02) 9382 1025 • Email: npsu@unsw.edu.au

Childrens' health

On a fact-finding mission

Photo: istockphoto.com

If, as William Wordsworth wrote, 'the child is father of the man' then the more we know about Australia's future fathers and mothers now, the better insight we will have into the issues they will face and the factors that will affect their lifelong health and wellbeing.

Obesity, diabetes, smoking, alcohol and drug use, services for people with disabilities, the state of Indigenous health—these are contemporary matters, facing Australians of every age, that are sensitive, complex and sometimes contentious. As such, the availability of information that is both accurate and robust is crucial to a rational debate and response to these issues from governments, health and welfare groups, and the public.

But when they relate to children—a vulnerable group in society—the stakes are even higher and often the relevant information is not always easy to come by.

Fact finders

In the AIHW's Population Health Unit, Mark Cooper-Stanbury says it can be challenging to collect and analyse relevant national data on issues related to children, and childhood obesity is a case in point.

Australia's health 2006 includes the best available statistics on overweight/obesity rates among children, and it shows that rates have risen from 20% in 1997 to 25% in 2004.

Mr Cooper-Stanbury acknowledges it is a problem but that the issue of childhood obesity also needs to be kept in perspective.

'The rates are not going down but it is not out of control either. It is still only one in four compared to an adult rate of 60%', he says.

While the report provides an insight into an important aspect of children's health, meaningful analysis and responses are inhibited by the fact that the data are based on the results of a New South Wales only study and an Australian Bureau of Statistics 1995 national survey.

He says it is important to shift the focus to a national level and on to the mental and social health aspects of obesity, so more can be learnt about fundamental behavioural issues such as diet and activity.

'What we don't know is almost everything about those topics!'

The good news is that the data problem is about to improve with a $3 million national study—funded by two Australian Government Departments and the Food and Grocery Council of Australia, and conducted by the CSIRO and the University of South Australia—due to begin in early 2007.

'That will fill a whole lot of gaps. At the moment the debate is active, but without enough good information. The Population Health Unit will take all the new information when it becomes available to update its reports and push those results so the debate is better informed—that's our role.'

Good data can be used to energise and invigorate health messages, he says, and the successful use of population health research is well illustrated by the issue of passive smoking.

In 1995, an Institute analysis showed children were exposed to tobacco smoke inside the home in 31% of Australian households.

In real life

It's a hard task for a body like the AIHW to reach into the lives of individual children.

But it can, and does.

Mark Cooper-Stanbury says that a presentation to his son's school by a drug and alcohol expert last year included Institute statistics which show 95% of 12–15 year olds have *not* tried cannabis or ecstasy.

'We can contribute to some rationality and learning…There was debate and discussion in the classroom, fuelled by statistics, and that's something that's good. It's a powerful message to kids—because of the small percentage actively experimenting in drugs, peer pressure is not a significant factor.'

Meanwhile, when the Institute's report on children with disabilities was released, Louise York says she received calls from many parents who found it useful in their own lives.

One Queensland woman got in touch because she wanted to distribute relevant information across the education sector in her state.

The AIHW report had confirmed that 97% of children with a disability attended school—89% in mainstream schools—but some people still didn't think this was the case.

Helping people access information was even more rewarding in light of what the Institute's own report showed about the 40-plus hours per week many carers spent directly caring for their children, according to Ms York.

'When you hear about the hours carers are putting in, you wonder how do they stay active in lobbying and advocacy to improve their children's lives?'

The latest figures published in *Australia's health 2006* now show how the passive smoking public health messages based on those initial reports helped reduce that proportion to 12% in 2004.

Positive measures

A better understanding of the social influences on health is also fundamental to improvements in Indigenous health.

Fadwa Al-Yaman from the Institute's Aboriginal and Torres Strait Islander Unit says that understanding the social causes of good outcomes is crucial to bettering all children's health and welfare, but it is particularly important for Indigenous children who suffer from a number of common diseases at significantly higher rates than other Australian children.

'We want to find what are the protective factors in Indigenous communities…assess the lives of children and see what protects them and helps them succeed.'

A nine-year longitudinal study of Australian children is currently underway to help improve knowledge of children's lives and needs. This study is being conducted by the Australian Institute of Family Studies and is funded through the Australian Government Department of Family, Community Services and Indigenous Affairs (FaCSIA).

The study has also provided a template for the development of a separate longitudinal study of Indigenous children, for which the Australian Government has funded consultation and development.

Dr Al-Yaman says this study of Indigenous children, many of whom have life experiences and health outcomes that are different from non-Indigenous children, will be invaluable.

For example, a recent AIHW report showed that 50% of Indigenous women smoked while pregnant. Smoking during pregnancy is strongly linked to low birthweight babies and low birthweight babies potentially could have long-term health problems that will last well into their adult lives.

'We know that babies born to Indigenous women are twice as likely to have a low birthweight, but we don't know what happens to a low birthweight baby later in life. Do children recover or continue with setbacks?

'If you gather information of positive outcomes in childhood you can find out what works', she says. The 'ultimate aim' is to improve health and wellbeing through the use of better information.

The longitudinal study will add another dimension to existing information on Indigenous children which is only collected when they have trouble in their lives, such as hospitalisation, or being in the child protection or juvenile justice system.

'This information only tells us why Indigenous children get into trouble, not how they stay out of trouble. Many Indigenous children live normal and successful lives, and we want to know what helps them to do this,' says Dr Al-Yaman.

'If we follow a cohort of children throughout their life we will not just see those who fall through the cracks, but those who do not, and what helped them to succeed.'

The invisible issues

And while the Institute's ongoing work continues to inform topical debates about child health, it is also serving to shed some light on another particularly vulnerable group of children; those with disabilities.

It was a challenging task given that until the last half of the 20th century, children with disabilities were largely an 'invisible population'.

Louise York from the Functioning and Disability Unit, says 'it was harder than we would have hoped to compile the information about children with disabilities and their families'.

But the result of the Institute's work—the *Children with disabilities in Australia 2004* report and 2006 update—provided a national snapshot of these children and their needs.

Importantly, they found that one in 12 children have a disability and half of those have a severe or profound disability meaning they need help with basic daily activities.

'That's quite a lot of kids who need additional assistance', Ms York says.

The report also showed that 97% of children attended school, with 89% attending a mainstream school, and that more boys (10%) than girls (6.5%) have a disability.

Photo: iStockphot.com

Snapshot

- In 2004 there were approximately 4 million children under 15 years of age in Australia.
- In 2001 there were about 179,000 Indigenous Australian children.
- Infant and child mortality rates, dental health, and tobacco use and exposure are changing for the better.
- There is no comparable trend data on child mental health, children with severe/profound activity restrictions, or alcohol misuse.
- Babies of Indigenous mothers are twice as likely as babies born to non-Indigenous mothers to have a low birthweight.
- The perinatal mortality rate of babies of Indigenous mothers is twice that of babies born to non-Indigenous mothers.
- Infant mortality rates for Aboriginal and Torres Strait Islander babies are almost three times the rate of non-Indigenous infants.
- The death rate of Indigenous children aged 1–14 years is twice that of non-Indigenous children

'The vast majority of care comes from families and mostly mothers [91%], with 59% spending 40 hours or more directly caring for their children.'

These statistics raise additional questions about women's participation in the workforce, family incomes and poverty, and the need for support.

The lack of standard data across Australia and the historical silos of research, practice and policy mean 'you're often comparing apples with oranges' when trying to progress these issues, Ms York says.

However, the Institute and other bodies are putting a lot of effort into improving the consistent collection of information about people with disabilities.

'Good information can be used to assist people', she says.

Helping people through the provision of better information also underpins the Institute's efforts to improve data collection related to Indigenous health, particularly regarding the current under-identification of Indigenous peoples.

Importantly, this statistical problem also means that the disparity between Indigenous and non-Indigenous health outcomes (see snapshot box) is likely to be worse than estimated, Dr Al-Yaman says.

One project is focused on overcoming these problems through the development of best practice guidelines for identification of Indigenous people.

Another project is designed to get a more accurate picture of Indigenous people from current data through the development of a methodology that estimates the level of current under-identification.

Identification of people, including children, is not purely a statistical exercise, Dr Al-Yaman says, but the results can ensure people access and receive services designed to help improve their health and wellbeing. ■

The people behind the stats:

Children, Youth and Families Unit

(l-r) Indrani Pieris-Caldwell, Cathy Hotstone, Kristy Raithel, Deanna Eldridge, Cynthia Kim, Sushma Mathur (with Sarah and Zach), Deidre Penhaligon and Nicole Hunter

It's a great feeling coming to work each day knowing that I am contributing to the health and wellbeing of children and young people in Australia

Photo: Irene Dowdy

The AIHW has played a leading role in the monitoring and reporting of children's health and wellbeing since 1996, and the lion's share of this work is undertaken by the Children, Youth and Families Unit (CYF).

'I am fascinated by the subject matter that my team works on', says Cynthia Kim, joint head of the Unit.

'Because ours is a cross-cutting unit, we get exposed to all issues relevant to children, young people and families and there is never a dull moment.

'Yes, the workload is demanding at times but it's also very rewarding when I see our statistics being quoted and used by people who work hard to improve our community.

'As a mother, it's a great feeling coming to work each day knowing that I am contributing to the health and wellbeing of children and young people in Australia.'

The CYF regularly reports on children and youth health and wellbeing, child protection and adoption. It is also involved in the development of national minimum datasets and is probably involved in more national committees than any other area of the Institute.

'We are very proud of our most prominent publications, *A picture of Australia's children* and *Young Australians: their health and wellbeing*', says Sushma Mathur, the other joint head of the Unit.

Both publications are in their third edition and each is produced under the guidance of a broad-based advisory group, chaired by a senior academic to ensure that policy-relevant and up-to-date information is included.

Early childhood development and whole of government (life course) approach to information are highly topical issues at present

The Unit also produces two other yearly reports: *Child protection, Australia* and *Adoptions, Australia*.

'Both are the only national statistical reports in their field, and as such are the only national 'official' statistics. The publications are used by governments, academics and NGOs alike', says Ms Mathur.

Early childhood development, early intervention and whole of government (life course) approach to information are highly topical issues at present.

'This stems from recognition that children are the future of the country. It also reflects evidence about the importance of the early years of life for laying the foundation for future success and wellbeing', notes Ms Mathur.

As such, all levels of government are highly interested in identifying and monitoring the risk and protective factors that influence children's development, health and wellbeing.

The Unit works closely with the Australian Government Department of Health and Ageing, the Australian Government Department of Family and Community Services and Indigenous Affairs, the Australian Bureau of Statistics and the Australian Institute of Family Studies, as well as all the Community Services departments in the states and territories. The AIHW is also a member of the Australian Research Alliance for Children and Youth (ARACY) network.

Reports have become more indicators-based rather than lengthy analysis

Internally, because of the cross-cutting nature of its work, CYF works regularly with most units across the Institute as well as some of the AIHW's interstate collaborating units.

Ms Kim says that although the overall direction of the work the Unit handles hasn't changed significantly in the last five years, things have certainly changed at the lower level, with methods of reporting continually developing.

'For example, the style of the latest children and youth health and wellbeing reports have become more indicator-based rather than lengthy analysis.'

A total of 44 key indicators were identified in the last edition of *A picture of Australia's children* and 88 key indicators will be included in the soon to be released *Young Australians: their health and wellbeing* (due to be published in May 2007).

'In the area of child protection, we are piloting a unit record level collection to replace our current aggregate level (spreadsheet style) collection, and in relation to children's services, we have completed the development of the children's services national minimum dataset and are now involved in examining the options for its implementation.'

The Unit has also undertaken a number of other interesting projects recently, such as a bulletin looking at changes in the affordability of child care between

1991 and 2004; an evaluation of the childhood obesity projects funded by the Telstra Foundation; a scoping study looking at the feasibility of collecting national data on foster carers to complement the information the Unit already collects on children in out-of-home care; and a groundbreaking data linkage pilot study looking at the educational outcomes of children on guardianship and custody orders.

'This pilot study has involved the community services and education departments in the states and territories, and our early thinking for the project proper is that it may involve other collaborating partners such as the Australian Institute of Family Studies and other notable academics and experts in the field of child protection.'

A potential new area of work is in supporting a set of headline indicators across 19 priority areas to be reported on biennially.

'State health and community and disability services ministers have asked us to develop a business plan for the Children's Health and Wellbeing Headline Indicators Project. It is a recognition of the excellent work we have done in this area for over a decade', says Ms Kim.

The seven members of staff working in the Unit are more than capable of dealing with the variety of work thrown their way, and with two staff members as substantive part-time unit heads, job-sharing on an ongoing basis, the managerial support is doubly strong.

The AIHW is an organisation serious about assisting staff to achieve work–life balance

Unit staff come from a range of backgrounds, such as demography, psychology, public health, all with very good writing, analytical and liaison skills.

Cynthia Kim has a background in econometrics and public policy and is particularly skilled in strategic planning, project management, liaison with committees and writing briefing notes, while Sushma Mathur has a background in statistics and is a very strong analyst and project manager.

'Sushma and I have different skills and expertise so having the two of us on deck widens the skills base at the unit head level and also for the Unit as a whole.

'There is added efficiency when we divide up the work based on our skills and expertise. We also bounce ideas off each other, learning from each other's strengths, and the decisions we make are perhaps better considered.'

This arrangement is a demonstration that the AIHW is an organisation serious about assisting staff to achieve work–life balance and that 'job sharing' can work even at higher levels.

'I think this sends a very positive message to the staff in the Unit and across the organisation. All the more fitting that it should happen in the Children, Youth and Families Unit!'

And what about future directions for their work program?

'To date, we have had somewhat limited dealings with the education departments both at the national and sub-national level, even though education is a critical aspect for children and young people. This is something that we are working on improving over the next few years.

'We are also trying to build a closer working relationship with the experts and academics in the field of child protection', says Ms Kim.

The AIHW is one of the leaders in data linkage

'Of course, AIHW is one of the leaders in data linkage which is basically the way of the future. The next step in this area for CYF is to examine the possibility of further data linkage, either between AIHW datasets or with other external datasets to further improve our evidence base to inform policy.

And in an ideal world where CYF had access to unlimited funds 'we would want to produce two distinctively different types of reports', says Ms Mathur.

'Short fact sheets on particular topics that people can easily carry with them and use as reference, and in-depth policy-relevant analysis on particular topics or issues of interest which were akin to academic journal style publications or something that could be easily converted to an academic journal article.

We already have a long list of topics that would lend themselves to these two types of report.'■

Families and communities

Photo: istockphoto.com

The context in which Australian children are growing up

This paper was presented by Nicole Hunter, Children, Youth and Families Unit, at the 13th Biennial Conference, Australian Population Association, 5–8 December 2006, Adelaide, Australia.

Australian families have changed considerably over the last 30 years largely due to changes in social attitudes towards marriage, cohabitation and fertility choices. As a result, Australian children are growing up in a diverse range of family types, which has implications for family functioning and ultimately for the health and wellbeing of children.

Family functioning can be affected by internal stressors, such as parental illness or disability, or external stressors, such as economic security. There is also growing evidence suggesting that neighbourhood influences, including social capital, can impact on children's physical and social development. These contexts set foundations for learning, behaviour and health over the course of their lives.

This paper is based on Part III of the AIHW publication *A picture of Australia's children* (2005), and the original data were sourced from various Australian Bureau of Statistics (ABS) surveys and the Household, Income and Labour Dynamics in Australia (HILDA) survey. It provides national data on the family and community contexts in which Australian children aged 0–14 years are growing up and, where possible, describes how these may influence their health and wellbeing.

Family structure

In 2003, most children aged 0–14 years (72%) lived in intact families—where the child is the biological, adopted or foster child of both members of the couple (see Figure 1). Nearly one in five children (19%) lived in lone-parent families—of these children, 88% lived with lone mothers. A small proportion of children (less than 1%) lived with grandparents, and almost half of these (47%) were lone-grandparent families (ABS 2003a).

Although the dominant type of family in Australia is still the couple family, lone-parent families are becoming increasingly common. Between 1992 and 2003, the proportion of single-parent families increased from 14% to 19% of all family types (ABS 2003a).

In 2001, in households with Indigenous people, the proportion of children living in one-parent families (44%) was twice the proportion of other children in one-parent households (20%). It was also found that, in households with Indigenous people, the proportion of children living in multi-family or group households (6%) was higher compared to children in other households (2%) (ABS 2003b).

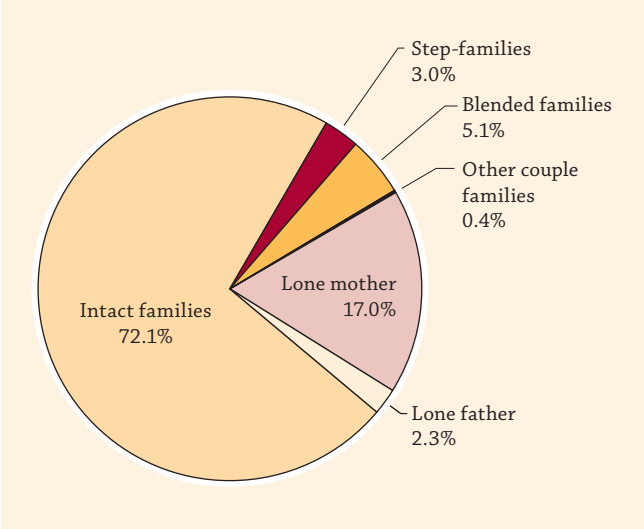


Figure 1: Children aged 0–14 years, by family structure, 2003

Note: Intact families are where the child is the biological, adopted or foster child of both members of the couple; blended families are where at least one child is the biological child of the couple and at least one child is the stepchild of either member of the couple; and stepfamilies are where at least one child is the stepchild of either member of the couple and none of the children is the natural or foster child of both members of the couple.

Family functioning

Family functioning is an important aspect of the family environment that influences child health and wellbeing. In general terms, family functioning is about how families relate, communicate, make decisions, solve problems and maintain relationships.

The relationships that children maintain with their family, particularly their parents, are among the most important influences on healthy child development and psychological wellbeing (Shonkoff & Phillips 2000). In Australia, family discord has been found to be a significant risk factor for children's poor mental health (Silburn et al. 1996). Research studies in other countries have also shown links between parental conflict and children's wellbeing and behaviour (Grych & Fincham 1990).

The majority of Australian families reported high levels of family cohesion in 1998. However, the proportion of families reporting good to excellent family cohesion was higher among intact families (93%), compared with lone parent (87%) and other family types (88%). It was also more common for families with lower weekly household incomes to report 'poor to fair' family cohesion than high income families (12% compared to 5%) (ABS 1998).

Economic security

Children living in families without economic security are at a greater risk of poor outcomes both in the short and longer term. The immediate impact of economic hardship is evident. Living in a family with low income can affect a child's nutrition, their access to medical care, the safety of their environment, the level of stress in the home, and the quality and stability of their care (Shore 1997). In addition, research confirms that for a number of health and social outcomes, including socio-emotional functioning, mental health, physical health, educational attainment and later employment prospects, children in the lowest income groups are at a higher risk of disadvantage than other children (Bradbury 2003; Mayer 2002).

In 2002–03, 22% of Australian children aged 0–14 years lived in low income households. When comparing equivalised incomes (which allows for differences in household size and composition), the proportion of children in one-parent households with incomes in the lowest income quintile was more than twice that of children in couple households (43% compared with 17%) (ABS 2003c).

Overall, the proportions of children living in families where no parent is employed remained fairly steady between 1994 and 2004 for all family types (see Figure 2). However, the proportion of children with no parent employed was considerably higher for those in one-parent families than in couple families over this period. This is hardly surprising, given that single parents have no co-resident parent available to care for their children while they work. In 2004, 7% of children in couple families had no parent employed, compared to 57% of children in one-parent families (ABS various years).

The proportion of households experiencing financial stress varied markedly by family type. In 2002, among lone-parent families, 10% reported going without meals in the past year because of cash flow problems, compared to only 1% of couple families. In addition, the proportion of single-parent households who said they would be unable to raise $2,000 within a week for something important was more than three times that of couple families (48% compared to 15%) (ABS 2002).

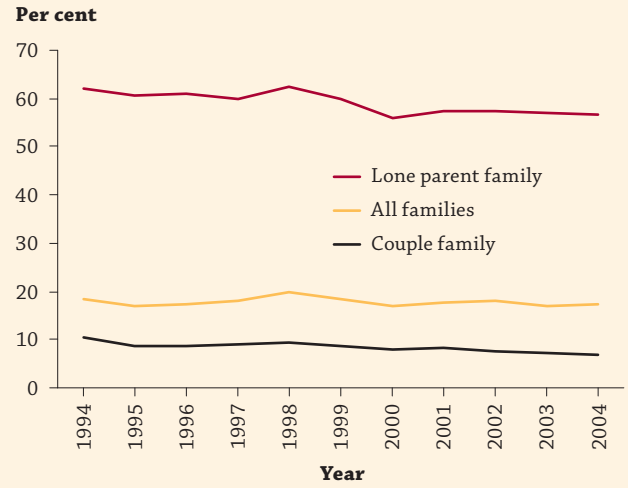


Figure 2: Children aged 0–14 years living in families where no parent is employed, June 1994 to June 2004

Parents with a disability or chronic illness

Children who live with a parent with a disability or a chronic illness are sometimes involved in caring for that parent. Depending on the severity, the wellbeing of children of parents with a disability or mental illness may be affected by such factors as family discord, discontinuity of care, poor general parental skills, social isolation and poverty arising from the parental health status (ABS 1999; AICAFMHA 2001). Children whose parents have a mental illness are likely to be genetically predisposed to mental illness, and are more likely to suffer major depression, have emotional and behavioural problems, to perform poorly academically, and be susceptible to substance abuse (Farrell et al. 1999; Lancaster 1999; Kowalenko et al. 2000).

In general, most Australian children live with parents who are in good health. In 2004, 20% of children lived in families where at least one parent reported to be in fair or poor health (HILDA 2004).

In 2003, 15% of children aged 0–14 years lived with a parent who had a disability. Of these children, approximately 85% lived with a parent whose main disabling condition was a physical condition and about 17% with a parent whose main condition was a mental or behavioural disorder. Most children (71%) lived with a parent whose disability was moderate or mild, but almost one-third (29%) lived with a parent with a profound or severe limitation (ABS 2003d).

Neighbourhood safety

While family characteristics are generally considered more important influences on children's overall health and wellbeing, there is growing evidence that neighbourhood influences can impact on children's physical and social development (Putnam 2000; Vinson 2004).

Fear of crime and concerns about neighbourhood safety can impact on children's health in several ways. There is evidence that increased parental or child anxiety about neighbourhood safety is significantly associated with decreased children's physical activity (Gomez et al. 2004; Weir et al. 2006). It has also been found that living with stress and anxiety associated with concerns about neighbourhood safety may directly impact on children's health (Ross & Mirowsky 2001).

Most Australian children are growing up in families that feel safe in their neighbourhood. In 2002, 90% of Australian householders said they always felt safe in their home. While people living in major cities were least likely to report always feeling safe in their home (90%), there was very little difference when compared to those living in inner regional (92%) and outer regional and remote areas (91%) (ABS 2002).

The proportion of people who never felt safe in their home was highest for those in the lowest socioeconomic group (5%) and lowest for people in the highest socioeconomic group (1%). By contrast, the proportion of people who always felt safe was highest for people in the highest socioeconomic group (95%) and lowest for people in the lowest socioeconomic group (83%) (ABS 2002).

Research has also found that features of the physical and social environment which indicate disorder or incivility will increase people's fear of crime (AIC: Grabosky 1995). In 2004, many signs of disorder and incivility, such as disrepair, rubbish, vandalism, gatherings of teenagers and hostile behaviour, were found to be most common in the neighbourhoods of people with the lowest socioeconomic status (HILDA 2004).

Social capital

Research indicates that child development is powerfully shaped by social capital. Trust, social networks, and norms of reciprocity within a child's family, school, peer group and larger community have far-reaching effects on their opportunities and choices, and therefore on their behaviour and development (Putnam 2000).

Access to social support is suggested to have a positive impact on health (Baum et al. 2000) and to buffer stress (Cassel 1976). Findings by Vinson (2004) and Putnam (2000) also indicate that people living in disadvantaged areas where social cohesion is high cope better than those from equivalent areas where social cohesion is lower.

In 2002, most Australian families with children had good family and social support networks, and were able to get support in time of crisis, could ask for small favours and had regular contact with family and friends (ABS 2002).

Couple families were slightly more likely to be able to ask for small favours than lone-parent families (95% compared to 91%), while those living in major cities were slightly less likely to be able to ask for small favours than those living in 'outer regional and remote' areas (94% compared to 97%) (ABS 2002).

Those families with at least one parent employed were more able to get support during a crisis and were in a better position to ask for small favours (96%), compared to those families with no parent employed (91%) (ABS 2002).

With the available data, it is possible to examine national statistics about the family and community context in which children are currently living, but it is much more difficult to show how these contexts have influenced short- and long-term outcomes for children. Questions such as how physical and mental health status, opportunities for learning and education, and access to health services and leisure and recreational activities are influenced by family and community factors, are best answered by multivariate and longitudinal research. However, at present, the majority of this type of research has been conducted on a small scale, rather than at a national level.

Full references for this paper can be found on our website at http://www.aihw.gov.au/publications/index.cfm/10127

Photo: Getty Images

Working in partnership:

Australian Institute of Family Studies

Professor Alan Hayes

A great partnership begins

The Australian Institute of Family Studies (AIFS) values the opportunity for greater collaboration with the AIHW. AIFS is a national and international leader in identifying, developing and providing timely and reliable information on issues affecting families in Australia. Its work falls within the Australian Government's National Research Priority Area, 'Promoting good health and wellbeing for all Australians'. We seek to contribute to family wellbeing by undertaking high-quality research that informs the Australian Government and the community and that influences policy, services and support for families. An independent statutory authority established under the *Australian Family Law Act (1975)*, AIFS is located within the Families, Community Services and Indigenous Affairs portfolio.

Developed following extensive formal consultations and informal discussions with a wide range of key stakeholders, the Institute's current Research Plan (2006–2008), *Families Through Life*, provides a focus on transitions and changes experienced by families. Examples include relationship formation and dissolution, moves into or from paid work, retirement decisions and changes in parental responsibilities. The Research Plan 2006–2008 is available from www.aifs.gov.au

While some of AIFS's research is Institute-initiated, much is commissioned or contracted. Our work involves both the development of new datasets, and further analyses of those that already exist, including those of the AIHW.

An important development in family research in Australia has been the establishment of large-scale longitudinal surveys. AIFS is at the forefront of this advance, being responsible for the development and management of Growing up in Australia: The Longitudinal Study of Australian Children. We are one of three partners in the consortium conducting the Household, Income, and Labour Dynamics in Australia (HILDA) survey. We are also responsible for the Australian Temperament Project, a longitudinal survey of Victorian children now in its 22nd year.

The AIFS's research program focuses on the following themes: family relationships; children, youth and patterns of care; families and work; and families and communities. All themes relate in some way to the primary functions of families: (a) providing for the health and wellbeing of all family members; and (b) raising children to be healthy, well-adjusted and productive members of society.

In addition to its research projects addressing the above themes, AIFS has four clearing houses that play an important role in identifying, gathering, synthesising and publishing information that is relevant to the development of policy and useful for practitioners. The clearing houses are the Australian Centre for the Study of Sexual Assault, the Communities and Families Clearinghouse Australia, the National Child Protection Clearinghouse, and the Australian Family Relationships Clearinghouse.

Continued overleaf

Working in partnership (continued)

In December 2006, I signed a Memorandum of Understanding (MoU) to facilitate an active collaborative relationship with the AIHW. The MoU encourages opportunities for bringing together our relevant expertise and developing new approaches to understanding topics related to children and families.

Under the MoU, the AIHW and AIFS will draw upon their respective expertise in the areas of policy and research related to children and families, the development and collection of longitudinal datasets and the provision of statistical advice and services to contribute to the overall success of each agency's activities. To progress the collaboration, we maintain regular communication.

The MoU is already bearing fruit. Staff of both Institutes recently worked together to prepare an ARACY ARC/NHMRC Future Generation Research Network seeding grant application. The application seeks funds to foster a new collaboration focused on researching educational outcomes of children on guardianship/custody orders. I am delighted that the proposal includes an opportunity for staff exchange.

With staff of AIFS, I welcome this opportunity to build strong collaborative links with the AIHW, in areas where our interests so clearly intersect. This is a very positive development. ■

Professor Alan Hayes
Director
Australian Institute of Family Studies
February 2007

Thinking globally

The AIHW has an important international role to play in the collection and reporting of health and welfare statistics. The exchange of information with international counterparts allows the AIHW to increase its awareness of international perspectives, keeping abreast of the latest ideas as well as contributing to international development.

Below is a brief overview of some of the activities the AIHW has been involved in over the last year. Further information can be found on our website and with the relevant staff members.

INTERNATIONAL GROUP FOR INDIGENOUS HEALTH MEASUREMENT

A three-day meeting, hosted in Canberra in November 2006 by the AIHW in partnership with the National Advisory Group Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID), focused on understanding the differences in health status between Indigenous and non-Indigenous populations.

Representatives from New Zealand, Canada, the United States and Australia came together as the International Group for Indigenous Health Measurement to exchange experiences and work towards improving data and shared projects, such as a common set of indicators, to highlight progress.

Speakers included Australia's Minister for Health and Ageing, the Hon. Tony Abbott, the Associate Minister for Health in New Zealand, the Hon. Mita Ririnui, Chief Tom Bressette, Chairman of the First Nations Statistical Institute Advisory Panel, Canada, Leo Nolan, from the Office of the Director of the Indian Health Service in the United States and Dea Delaney-Thiele, Chief Executive Officer of the National Aboriginal Community Controlled Health Organisation in Australia.

The Canberra meeting, organised by Fadwa Al-Yaman, Head of AIHW's Aboriginal and Torres Strait Islander Health and Welfare Unit, was the second meeting of the International Group for Indigenous Health Measurement following the first in Vancouver in 2005.

www.aihw.gov.au/indigenous/index.cfm

International Group for Indigenous Health Measurement, November 2006. Front (l-r) Chief Tom Bressette, Chairman, First Nations Statistics Advisory Panel, Canada; Dea Delaney Thiele, CEO, NACCHO, Australia; Hon Mita Ririnui, Associate Minister of Health, New Zealand. Back (l-r) Leo Nolan, Senior Policy Analyst, Indian Health Service, USA; Penny Allbon, Director, AIHW.

Poverty statistics

The AIHW was represented at the Expert (Rio) Group on Poverty Statistics meeting in Rio de Janeiro earlier last year. This meeting coincided with the launch of the *Compendium on Best Practices in Poverty Measurement*, which members of the Rio Group had been working on for a number of years. Justin Griffin, Head of the AIHW's Housing and Homelessness Cluster, gave a presentation on the most recent developments in the use of administrative data collected from government programs aimed at reducing disadvantage in Australia.

The AIHW is a member of and has contributed to almost all of the eight meetings of the Rio Group, in its role as an internationally recognised expert in welfare and housing data analysis and management. The AIHW, in so doing, contributes to the improvement of the quality of the evidence base on which policy and planning decisions are made by governments to reduce poverty and social exclusion.

www.aihw.gov.au/housing/index.cfm

Health Metrics Network

Together with the Brisbane-based arm of the AIHW's collaborating unit, the National Centre for Classifications in Health (NCCH), the AIHW has been increasing its interest in assisting Australia's close neighbours in the Asia/Pacific region to build better information for policy. The AIHW has developed linkages with the Health Metrics Network, an international organisation funded by the Bill and Melinda Gates Foundation, which aims to address the 'information paradox' (those countries who can least afford it are the ones that most need health information to guide policy and funding decisions).

Last year AIHW attended a meeting convened by the WHO Health Metrics Network—Workshop for Pacific Island Countries. The workshop was held to assess national health information systems, and to define areas for future investment or technical assistance. Ken Tallis, Deputy Director represented the AIHW as a technical advisor and panel session member and Gary Waller from NCCH in Brisbane also presented to the Forum.

The AIHW and its partners look forward to further work with the Health Metrics Network.

www.aihw.gov.au/international/index.cfm

OECD

In his capacity as Australian Health Data Correspondent, the AIHW's Michael de Looper keeps Australian health data feeding into the Organisation of Economic Cooperation and Development (OECD). Mr De Looper's role gives AIHW responsibility for the annual supply of Australian health and related data, along with information about sources and methods, for inclusion in *OECD Health Data*. (This publication is one of the most authoritative sources for international comparisons of health status, services and expenditure. It has over 1,500 variables with health data from OECD's 30 member countries, with many time series going back to 1960.)

www.aihw.gov.au/international/oecd/oecdhd06.cfm

The International Society for the Prevention of Child Abuse and Neglect (ISPCAN)

The ISPCAN is the only multidisciplinary international organisation that brings together a worldwide cross-section of committed professionals to work towards the prevention and treatment of child abuse, neglect and exploitation globally.

In 2006, an official data working group, known as the ISPCAN Working Group on Child Maltreatment Data,

was formed. The first meeting of this group was held on 3 September 2006 at the ISPCAN 16th International Congress in York, England. Following the official meeting, experts from several countries including Australia (represented by the AIHW) hosted a workshop on planning and establishing national child maltreatment data programs. The Children, Youth and Families Unit contributed a paper to this workshop, presented on our behalf by our Canadian colleagues.

www.aihw.gov.au/childyouth/index.cfm

WHO-FIC network

The AIHW has been the Australian Collaborating Centre for the WHO Family of International Classifications (FIC) Network since 1991. As head of the Australian Centre, the Director of AIHW acts as leader and coordinator for a range of activity within Australia which contributes to the WHO work on developing classifications. The classifications cover morbidity and mortality (ICD), functioning, disability and health (ICF), health interventions (ICHI), external causes of injury (ICECI) and primary care (ICPC), as well as drugs (ATC), technical aids for people with disabilities (ISO 9999), numerous related and derived classifications and (potentially) traditional medicine.

Led by the head of the Australian Centre, Penny Allbon, a delegation from the National Centre for Classifications in Health (NCCH) and AIHW attended the 2006 network meeting in Tunisia (co-hosted by the French Collaborating Centre).

Australian delegates play a key role in many aspects of the WHO-FIC work program, with Professor Richard Madden (NCCH) heading the Family Development Committee and the Morbidity Reference Group (MbRG) and Ros Madden (now with the Australian Commission for Safety and Quality in Health Care) heading the Functioning and Disability Reference Group, ably assisted by Catherine Sykes from the AIHW.

The AIHW will be hosting a national workshop later this year to ensure coordination of the various contributions it makes to the international and national development of the Family of International Classifications.

More information: Barbara.Levings@aihw.gov.au

The AIHW's international reputation in relation to the ICF extends to Greece, with the recent invitation for Chrysanthe Psychogios from the AIHW's Functioning and Disability Unit to attend the Hellenic ICF Conference in Athens, Greece. The AIHW was invited to attend the conference by the Greek Ministry of Health and was asked to make a presentation on the international classification of functioning, disability and health in Australia.

More information:
www.aihw.gov.au/disability/icf/index.cfm

Connections with New Zealand

The AIHW Director, Penny Allbon visited the New Zealand Ministry of Health in 2006 to explore potential links and collaborative work with the New Zealand Health Information Service and the Public Health Intelligence Unit. As a result, delegates from the New Zealand Health Information Service recently visited the Institute in March and a return visit to New Zealand is planned for later in the year. The AIHW Board is keen to extend these cross-country links into other aspects of the Institute's work, such as housing and community services.

Connections with Canada

The Canadian Institute of Health Information (CIHI) parallels the AIHW in many ways, so the AIHW Director was pleased to accept an invitation to Ottawa in early March 2007 to address the CIHI Board and to spend two days talking with senior staff at CIHI. A return visit from the CIHI President and CEO, Glenda Yeates is planned and the AIHW also hopes to explore the potential for exchange placements between Canberra and Ottawa.

Hosting of international visitors

The AIHW regularly hosts delegations or individuals from overseas health systems who want to understand how Australia keeps track of its health and welfare information. Over the last year, for example, the AIHW has participated in visits from the Republic of Korea and China. ■

Our new-look team

With over 200 staff, the AIHW continues to develop. There have been many new arrivals, and a few sad farewells. The leadership of the Institute too has changed over the past year. The new Director, Dr Penny Allbon, joined the Institute in February 2006 and has in place a strong team of senior managers — some new to the Institute, some with long experience. The most notable change is the creation of the new position of Deputy Director, which was initially filled by Ken Tallis. Ken has been a real force for intellectual rigour and simple sanity within the AIHW and his departure is a very sad occasion. With Ken's departure to Cambridge, England, we welcome Julie Roediger to the Institute as Deputy Director. See over for brief profiles of the executive team that supports Penny Allbon.

Photo: Irene Dowdy

AIHW staff members, Canberra, 2007

DEPUTY DIRECTOR, AND HEAD OF INFORMATION AND STRATEGY GROUP

Julie Roediger

Julie Roediger joins AIHW from the Australian Government Department of Health and Ageing, where she previously headed the Economic and Statistical Analysis Branch and most recently has been managing the budget function.

Ms Roediger's earlier experience was as an intelligence analyst in Defence, in capability analysis and as Director General of Communication Systems. Her work has involved the conduct and management of many statistical analyses as well as the management of billion-dollar projects.

The task of providing evidentiary support for health policy is by no means new to Ms Roediger as she has been involved in the national information management infrastructure, including data standards and linkage.

With a strong reputation for probity and professionalism and an excellent people manager, Ms Roediger has strong technical and management experience across all areas of the position. As well as supporting the Director, Ms Roediger will look after the information and strategy group which includes data information and technology, METeOR management, national data development and standards, and Aboriginal and Torres Strait Islander health and welfare.

HEAD OF BUSINESS GROUP

Andrew Kettle

Andrew Kettle has excellent financial and strategic budget experience, with over 10 years experience as the most senior financial officer in two Australian Government agencies, and also has experience at the SES level as General Manager of Corporate Services.

He has relevant experience in a small agency under a Board, having been at the Australian Fisheries Management Authority (AFMA) for the last eight years and was instrumental in the expansion of AFMA's budget.

Mr Kettle has previously worked in Canada and England for major firms of chartered accountants.

As Business Manager, Andrew heads up AIHW's business functions including human resources, finance and commercial services, information services and publishing, and business promotion and media.

HEAD OF HEALTH AND FUNCTIONING GROUP

Susan Killion

Susan Killion has been a leader and manager at the senior executive level for the past six years with extensive experience in service delivery, management, planning, research and analysis.

She initially worked in the health sector as a clinical nurse with the US Army Nurse Corps and this was followed by work as a clinical nurse in both the USA and Australia.

Ms Killion then moved into policy and education roles through a position with the US Embassy in Canberra and then as a Lecturer with the University of Canberra.

She joined the ACT public service, filling senior management roles in Health Services Policy and Planning within ACT Health. Susan also worked as a senior executive in the ACT Chief Minister's Department before taking up her previous role at Calvary Health Care where she was Executive Director of Performance and Information Technology.

As head of the Health and Functioning Group, Ms Killion is responsible for managing functioning and disability, health registers and cancer, population health, cardiovascular diseases, and asthma, arthritis and environmental health.

HEAD OF WELFARE AND HOUSING GROUP

Dr Diane Gibson

Dr Diane Gibson joined the Institute as the founding Head of the Ageing and Aged Care Unit in 1993. She was responsible for the development of an extensive statistical reporting and research program relating to aged care at the AIHW, and in national data development work relating to both community care and aged care assessment. In 2002 she was promoted to the position of Head of the Welfare Division.

As Head of the Welfare and Housing Group, Dr Gibson has responsibility for AIHW work on children, youth and families, ageing, homelessness and housing. She also manages the Community Services Integration and Linkage Unit, which undertakes an array of data linkage and analysis projects in addition to developing and applying innovative data linkage strategies to administrative by-product data.

Dr Gibson is a Fellow of the Academy of Social Sciences, a founding member of both the Ageing Well Ageing Productively ARC/NH&MRC Network and the Future Generations ARC/NH&MRC Network, and a former Editor-in-Chief of the Australasian Journal on Ageing. Her previous appointments included research and teaching positions at the Australian National University, Griffith University and the University of Queensland. She is an experienced statistical analyst who has worked with both quantitative and qualitative methods and in recent years has focused on innovative developments in linking administrative by-product data.

Head of Economics and Health Services Group

Jenny Hargreaves

Jenny Hargreaves joined the AIHW in 1996, when she began leading the Institute's work to develop, collate, analyse and disseminate statistical information on Australia's hospitals. Since 2001, she has been responsible for the AIHW's mental health services work program. This has included the development of a major data collection on the resources and expenditure of specialised public mental health services, and of data collections on residential and community mental health care.

Ms Hargreaves currently leads the AIHW's Economics and Health Services Group, responsible for developing, compiling and disseminating statistical information on Australia's health and community services expenditure, hospitals, mental health services, the safety and quality of health care, summary measures of health and health care services, and the health and community services workforces.

Medical adviser

Dr Paul Magnus

Dr Paul Magnus has been Medical Adviser at the AIHW for nine years. His main interest is in public health and epidemiology and his special background has been in cardiovascular health.

Dr Magnus graduated in medicine from the University of Western Australia in 1976, worked as a hospital doctor and later on an epidemiological project until 1980, then spent another two years in the USA as a postdoctoral fellow. In 1982 he joined the National Heart Foundation of Australia as Medical Associate to the Director and was later the Foundation's Medical Director and deputy national CEO from 1990 to 1997.

Dr Magnus has variously been involved as an executive, a scientific administrator, a public spokesman, a health editor and a medical writer for both general and professional readers. He has authored and co-authored a range of peer-reviewed publications for overseas and Australian health journals.

Photo: Irene Dowdy

The AIHW executive, March 2007. Front (l-r) Andrew Kettle, Penny Allbon, Ken Tallis. Back (l-r) Susan Killion, Paul Magnus, Diane Gibson, Jenny Hargreaves

AIHW Board

The AIHW is an independent statutory authority which is under the direction of a governing Board. Among other things the Board sets the strategic directions for the Institute, approves its work program and budget and oversights its operations and finances.

The composition of the Board is designed to ensure that the members collectively have the knowledge and expertise to provide AIHW with the guidance it requires in fulfilling its national mission in relation to health and welfare information. The membership currently comprises the Board Chair, four independent members nominated by the Minister for Health and Ageing for their relevant expertise, the Secretary of the Australian Government Department of Health and Ageing, the Australian Statistician, an independent member with public health research expertise, and representatives of each of the Ministerial Advisory Councils for health, housing and community services. The Director of the AIHW is also a member of the Board, and the Secretary of the Department of Families, Community Services and Indigenous Affairs and the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) are observers.

The Chair of the Board, the Hon Peter Collins, AM, QC, welcomed two new independent Board members during 2006: Professor Sandra Eades, who was appointed to the Board as an expert in public health research, and Dr Greg Stewart, an independent member nominated by the Minister.

The new Board members bring a broad range of expertise and skills.

Professor Eades is a medical epidemiologist with a special interest in paediatrics, and is the first Aboriginal medical doctor to be awarded a PhD. She is a Senior Research Fellow in Aboriginal Health at the Institute for Health Research in Sydney and is a Professor in the Faculty of Public Health at Newcastle University. As a mark of her achievements, leadership and commitment in the field of health and medical research, particularly in relation to Aboriginal health, she was honoured as New South Wales Woman of the Year in 2006.

Professor Eades's expertise will be very valuable in providing guidance to the AIHW's growing body of work in relation to public health in general and the health and wellbeing of Aboriginal and Torres Strait Islander people.

Dr Stewart is a public health physician and is currently the Director of Population Health, Planning and Performance at Sydney South West Area Health Service. He graduated MBBS in 1979 and MPH in 1991 (both from Sydney University). In 1988, he was awarded a Fellowship of the Royal Australasian College of Medical Administrators and, in 1990, a Foundation Fellowship of the Australasian Faculty of Public Health Medicine. His previous experience includes appointments as Director of South Western Sydney Area Health Services Public Health Unit (1990–96), Director of Health Services in Central Sydney Area Health Service (1996–2000) and Chief Executive Officer of Wentworth Area Health Service (2000–01).

Dr Stewart brings a strong background in health services administration to the AIHW Board.

Other members will be profiled in coming issues of *Access*.

Gone but definitely not forgotten...

Although AIHW has said goodbye to a number of key staff over the last year, we are proud to say that some strong working relationships remain...

Former AIHW Director, **Professor Richard Madden**, now heads up AIHW's collaborating unit, the National Centre for Classification in Health.

Dr Ching Choi, the former head of the Health Division, is currently carrying out research at the ANU's Research School of Social Sciences. Dr Choi has recently been appointed to the AIHW's Ethics Committee.

Ros Madden, who used to head up the Functioning and Disability Unit here at AIHW, is now the National Data Manager at the Australian Commission on Safety and Quality in Healthcare. The AIHW has recently signed a Memorandum of Understanding with the Australian Commission on Safety and Quality in Healthcare and Ms Madden is currently working closely with AIHW on a couple of projects.

The former head of the Business Promotion and Media Unit, **Nigel Harding**, maintains close working ties with many AIHW staff in his new role as Director of Communications at the National Health and Medical Research Council.

News in brief

New look for AIHW reports

After many years of faithful service, the Institute's standard cover design has been updated. Composed of arcs, gradients and the familiar diamonds, the design is fresh but familiar.

Developed in-house, the new cover includes elements that can be used across all AIHW print publications. The arc at the top of the cover is one of these special elements, and is used on all book covers, bulletins, brochures and even this edition of *Access*. By using common elements on all Institute publications, a distinct and recognisable AIHW brand emerges.

Already, several reports have been published using the new design, including *Dementia in Australia: national data analysis and development*; *Report on the evaluation of the National Minimum Data Set for Public Hospital Establishments*; *Data sources for monitoring arthritis and musculoskeletal conditions*; and *Homeless SAAP clients with mental health and substance use problems 2004–05*.

AIHW in the media

Doing the research and publishing accurate and meaningful statistics is only part of the Institute's job. Of equal importance is letting people know via the media that those statistics are out there and available.

In the first three months of 2007, the AIHW issued a number of media releases on a variety of report topics ranging from hospitalisations and deaths from injuries, public health expenditure, child protection, dementia and asthma.

Child protection was a hot topic, with the Institute's report *Child protection Australia 2005–06* generating nearly a dozen press articles and garnering 50 radio mentions, particularly because the report drew attention to a 40% increase in the number of children under protections orders—an increase due in part, the report said, to a greater community awareness of child abuse and neglect.

The AIHW reports *Dementia in Australia* and *Statistical snapshots of people with asthma in Australia 2001* also received a lot of news coverage, with 21 radio mentions and nine print articles for the dementia report, and 13 radio mentions and four print articles for the asthma report. ■

Mark your diaries

Australia's welfare Conference 2007

THURSDAY 6 DECEMBER

The Marque Hotel (formerly the Chifley on Northbourne), Canberra

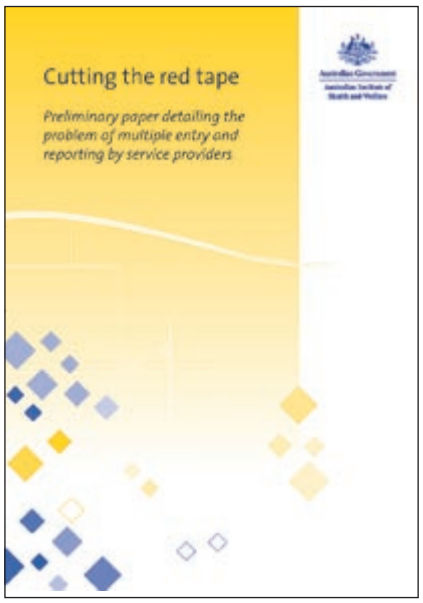
This one-day conference will incorporate the launch of Australia's premier welfare publication, ***Australia's welfare 2007***, and presentations from renowned welfare and community services professionals.

To register your interest please contact Joanna Wilson:
Phone: 02 6244 1032
Email: joanna.wilson@aihw.gov.au

Report profile

Cutting the red tape

Preliminary paper detailing the problem of multiple entry and reporting by service providers



AIHW cat. no. HWI 92

Fast facts

Current methods of data collection do not support the ideal of 'create once, use often'.

Without the use of common data standards, information requirements and communication technology cannot be integrated to work together.

Primary contact

Tanya Wordsworth, National Data Development and Standards Unit
Phone: 02 6244 1054
Fax: 02 6244 1069
Email:
tanya.wordsworth@aihw.gov.au

Project scope

The aim of this study was to convey a better understanding of the day-to-day experiences of clients and service providers in relation to multiple data collection and reporting.

Summary

Many community service agencies deliver multiple programs and are funded through a variety of sources (local, state, Australian Government and private funding). There is considerable anecdotal evidence that these multi-funded services have an increased administrative and reporting burden placed on them, as they are required to collect and report on the same or similar data multiple times.

This project examines the problems of multiple data collection and reporting from the perspective of service providers who have multiple reporting responsibilities at a national level.

The principal underlying assumption is that service providers who are required to report to more than one national data collection are often reporting on the same client concurrently. Of particular interest are service providers who help clients with complex needs ranging across the health, welfare and housing assistance continuum.

The project looked at agencies that were required to report to at least two national collections, including the Alcohol and Other Drug Treatment Services National Minimum Dataset, and the Supported Accommodation Assistance Program (SAAP) data collections.

The research found that service providers can end up having to enter data about the same client (such as a client's name, date of birth, address, etc.) many times—up to 14 times in one case study.

This happens, in part, because of the requirement that service providers use separate forms and/or software for each different service program, which results in the client providing, and the service provider recording and reporting, the same information on the same client on multiple occasions.

Another factor is the lack of electronic data capture, storage and reporting systems in the community services sector, which would give providers the capacity to record data once, from which multiple reporting could occur.

Three case studies in this report clearly illustrate the issues of multiple data collection and reporting.

Outcomes

The project made several recommendations regarding the multiple reporting problems and identified a suitable information model to support client-centred data collection (that is, reflects the person as a whole, over and above organisational or program-based agendas).

A number of agencies across Australia have expressed interest in working with AIHW to develop a practical way forward and the Institute hopes to convene a workshop of interested parties in the next few months.

About the Unit:

The National Data Development and Standards Unit aims to improve the comparability, consistency, relevance and availability of national health and community services information. The Unit manages Australia's national health and community services data definitions and standards, which provide the national infrastructure for the gathering and analysis of information in these areas.

Partner organisations

National Community Services Data Committee:
www.aihw.gov.au/committees/ncsdc/index.cfm

Related reading

National community services data dictionary version 4. AIHW cat. no. HWI 91.
www.aihw.gov.au/publications/index.cfm/title/10243

National health data dictionary version 13. AIHW cat. no. HWI 88.
www.aihw.gov.au/publications/index.cfm/title/10326

Related areas

METeOR is AIHW's Metadata Online Registry. It is Australia's repository for national data standards for the health, community services and housing assistance sectors.
meteor.aihw.gov.au/content/index.phtml/itemId/181414

Web links

www.aihw.gov.au/datadevelopment/index.cfm ■

Recent releases

January 2007

Child protection Australia 2005–06
CWS 28 • $25.00

Community housing 2005–06
HOU 152 • $26.00

Dementia in Australia
AGE 53 • $37.00

Developing a nationally consistent data set for needle and syringe programs
HWI 90 • $27.00

General practice activity in Australia 2005–06
GEP 19 • $28.00

Hospital separations due to injury and poisoning, Australia 2003–04
INJCAT 88 • $30.00

Injury deaths, Australia 2003–04
INJCAT 89 • $30.00

National public health expenditure report 2004–05
HWE 36 • $30.00

February 2007

A guide to data development
HWI 94 • $27.00

Australian diet quality index project
PHE 85 • INTERNET ONLY

Community Housing Data Collection, 2004–05
WELFARE WORKING PAPER NO. 55 • INTERNET ONLY

Final report on the development of the Children's Services National Minimum Data Set
CFS 6 • $28.00

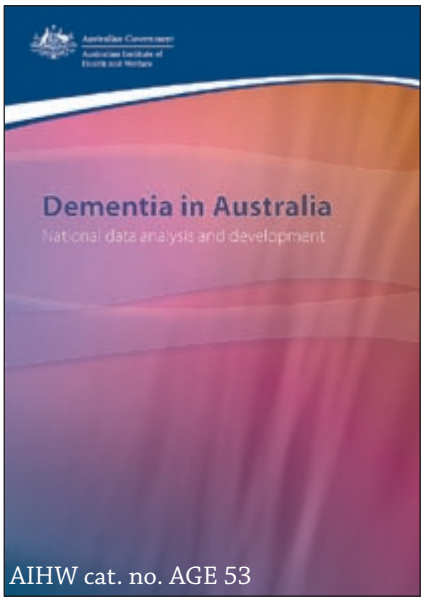
Report on the evaluation of the National Minimum Data Set for Public Hospital Establishments
HSE 45 • $32.00

Statistical snapshots of people with asthma in Australia 2001
ACM 8 • $23.00

Continued on page 31

Report profile

Dementia in Australia



Fast facts

In 2003, there were around 175,000 people with dementia in Australia and this number is expected to grow to almost 465,000 by 2031.

Eighty-one per cent of people with dementia were aged 75 or older in 2003 and 22% of people aged 85 and over have dementia.

Studies show that around 65% of primary carers who live with the person they care for spend 40 or more hours each week actively caring or supervising that person.

Primary contact

Ann Peut, Ageing and Aged Care Unit
Phone: 02 6244 1108
Fax: 02 6244 1199
Email: ann.peut@aihw.gov.au

Project scope

Drawing from a wide range of data sources, *Dementia in Australia* presents a profile of Australians with dementia and those who care for them. It investigates the prevalence and incidence of dementia, describes the characteristics and circumstances of people with dementia and their carers, and examines their use of health and aged care services.

Summary

Dementia is an extremely disabling health condition for many Australians.

In 2003, there were around 175,000 people with dementia in Australia, and that number could grow to almost 465,000 by 2031 as the Australian population grows and ages.

Ann Peut who heads the Institute's Ageing and Aged Care Unit, says that while dementia is not a natural part of ageing, most people with dementia are older and the prevalence rate rises with age.

'In 2003, 81% of people with dementia were aged 75 or older, and of people aged 85 and over, 22% have dementia.'

The recently released report, *Dementia in Australia: national data analysis and development,* shows that people with dementia use a substantial amount of health and aged care services, and require a significant amount of time and help from their carers.

Both monetary expenditure and emotional toll can be difficult to measure. But a new approach to estimating expenditure in this report takes account of other health conditions a person with dementia may have, resulting in estimates that can be specifically attributed to the dementia condition.

'We know that many carers experience distress associated with the behavioural and psychological symptoms of dementia, and that is also addressed in the report', Ms Peut said.

There is always scope for improved consistency between data sources in terms of identification of people with dementia and cognitive impairment. For this report, the AIHW worked closely with a group of dementia experts to put forward a menu of data elements which could be drawn on to improve the collection of dementia data.

'The goal is always improved data', Ms Peut said, 'with the long-term goal being better and earlier diagnosis of dementia'.

About the Unit

The Ageing and Aged Care Unit engages in a variety of statistical reporting, research, evaluation and data development projects in relation to the wellbeing, health and patterns of service use of older Australians.

Partner organisations

The AIHW is a participating member of the Primary Dementia Collaborative Research Centre which is working to build a sound evidence base to support policy initiatives to improve the quality of life for people with dementia and their carers.

More information

www.aihw.gov.au/agedcare/specialgps/dementia.cfm

On the horizon

In partnership with Dementia Collaborative Research Centres, AIHW is working to undertake a systematic review of evidence about transition in care for people with dementia.

In a project funded by the National Health and Medical Research Council, AIHW is exploring care pathways for older people with dementia, arthritis, and cardiovascular disease. Professor Steven Duckett and Dr Yvonne Wells at La Trobe University are partners in this exciting project.

Web links

The impact of dementia on the health and aged care systems:
www.aihw.gov.au/publications/index.cfm/title/10011

National evaluation of the Aged Care Innovative Pool Dementia Pilot: final report:
www.aihw.gov.au/publications/index.cfm/title/10288 ■

Recent releases (continued)

March 2007

Alcohol and other drug treatment services NMDS specifications 2007–08
HSE 46 • INTERNET ONLY

Australia's dental generations
DEN 165 • $40

Data sources for monitoring arthritis and musculoskeletal conditions
PHE 84 • $26.00

Homeless SAAP clients with mental health and substance use problems 2004–05
AUS 89 • $10

Juvenile justice in Australia 2004–05
JUV 2 • $26

Public and state owned and managed Indigenous housing 2005–06
HOU 154 • $26.00

Quality of Aboriginal and Torres Strait Islander identification in community services data collections
HWI 79 • INTERNET ONLY

April 2007

Statistics on drug use in Australia 2006

Mental health services 2004–05

All AIHW publications are available for purchase or download from <www.aihw.gov.au/publications>. All prices include GST. ■

Fast Facts

Australia's health 2006

We want to provide you with some of the key FACTS from our publications, and what better place to start than with *Australia's health 2006*.

How long are we living?

- Australians continue to live longer. Babies born today can expect to live for over 80 years on average. For females, life expectancy at birth in 2002–04 was 83 years and for males, 78 years.

What about our major killers?

- Death rates for cardiovascular disease continue to decline, including heart attack and stroke.
- Australia's overall cancer death rates declined by about 14% between 1986 and 2004 and these rates are low when compared with other Western countries.
- Despite improvements, cancer is now Australia's leading cause of death among 45–64 year olds and causes more premature deaths and overall disease burden than cardiovascular disease.

What about the money?

- Health continues to grow in importance as a sector of the Australian economy—national expenditure on health was 9.7% of gross domestic product in 2003–04.
- Average per person expenditure for Aboriginal and Torres Strait Islander peoples was 18% higher than for other Australians although the general health status of Indigenous peoples was considerably poorer.

Mixed news on risks

- Smoking rates continue to fall, with one in six Australians aged 14 years or over smoking tobacco daily in 2004, compared with seven in 10 men and three in 10 women in the 1950s.
- In 2004, about five in six Australians aged 14 years or over had drunk alcohol in the previous 12 months. About one in 12 had drunk at levels that risked harm in both the short and long term.

Matters for concern

- About 70% of Indigenous Australians die before reaching 65 years of age, compared with a little over 20% for other Australians.
- Death rates of Indigenous infants and children (under 15 years) generally remain about three times those of other Australian infants and children.
- Mental ill health is the leading cause of the non-fatal burden of disease and injury in Australia. Also, it is estimated to have caused about one-eighth of the total Australian disease burden in 2003, exceeded only by cancer and cardiovascular disease.
- Dementia is the greatest single contributor to the burden of disease due to disability at older ages, as well as the greatest single contributor to the cost of care in residential aged care. It is estimated that in 2004 about 171,000 people aged 65 years or over had dementia.
- The proportion of children under 15 years who are overweight or obese continues to rise, according to state-level data.
- The prevalence of self-reported diabetes more than doubled between 1989–90 and 2004–05. However, between 1997 and 2004, death rates from diabetes were stable for males and fell slightly for females. ■

Australia's health 2006 **(**AUS 73 • $60.00) is available from www.aihw.gov.au/publications for purchase or download.