For health and welfare statistics and information

Merry Christmas and Happy New Year

Australia's Welfare 1999 Conference and Launch
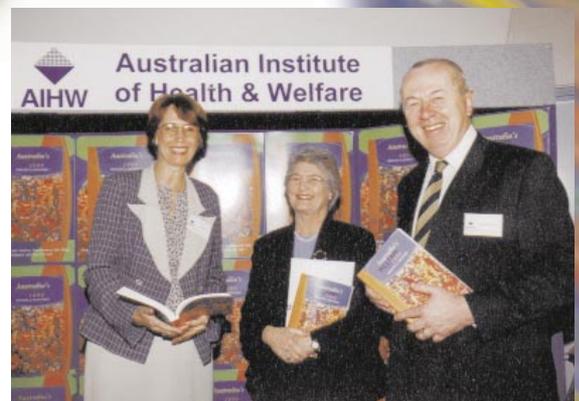
The Australia's Welfare 1999 Conference and launch on 25 November at the Manning Clark Theatre Centre, Australian National University, capped an extraordinarily busy period for the Institute in the last quarter of the calendar year.

The *Australia's Welfare 1999* report was launched by the Minister for Family and Community Services, Senator Jocelyn Newman. It is the fourth biennial report on welfare services by the AIHW, and is a legislative requirement. This year it contains a special chapter on changing work patterns and the community services workforce, by Professor Peter Saunders, Director of the Social Policy Research Centre at the University of New South Wales.

Senator Newman said *Australia's Welfare 1999* was 'an invaluable resource for anyone interested in the welfare sector—particularly

because it goes beyond the dollars spent and looks at other ways we support Australians in need…and certainly, this report represents the most up-to-date, comprehensive and authoritative source of national information, so far, on welfare support across Australia'.

The Minister also spoke of the relevance of the report in that it would provide key data for the government's National Families Strategy and Stronger Communities Strategy, and its forthcoming Green Paper on welfare dependency.

Senator Newman said that the Green Paper 'will take a fresh look at our system to see what more can be done to prevent (the) social and economic exclusion that dependency brings'. (An interim report is due early in 2000, with the final Green Paper due by 30 June 2000).

from the Director

CONTENTS

Although the Institute's main trade is in numbers, one debate we won't be entering is whether the new millennium starts in 2000 or 2001. However, as we approach the end of the year it is a good time to reflect on achievements and plan for the upcoming year.

Over the last few months the Institute has been involved in reviewing and redeveloping the Corporate Plan for the next three years (there was an article on this in an earlier *Access*). We are building on a successful three years since the Plan was last reviewed, with much improved timeliness for key collections and a wide range of new work.

We are re-emphasising our two flagship publications, *Australia's Health and Australia's Welfare*. The Institute's Act requires that these be produced every two years and be tabled in Parliament. This is both a responsibility and a challenge: to summarise the current state of Australia's health and community services systems, and inevitably to focus debate on key issues. The two books are now widely sold and used, and are available free on the Institute's web site (www.aihw.gov.au).

New challenges have come from the creation of the Department of Health and Aged Care (DHAC) and the Department of Family and Community Services (FaCS) after the 1998 Commonwealth election. The Institute is providing a wide range of excellent statistics and information services for both agencies from its own resources and through contract work. It will continue to collaborate closely with these departments in forming its work program.

State and Territory information needs continue to be most important for the Institute. The National Health Information Management Group is now seven years old. During the term of the last Corporate Plan, the National Community Services Information Agreement was put in place and has led to important initiatives, including the National Community Services Data Dictionary and the National Community Services Information Development Plan. Broadbased data development groups now exist for aged care, disability, child protection and child care data, as well as the longer established SAAP committee.

Our people remain a top priority. At 30 June the Institute had 164 staff, and around 70 more work in collaborating units across Australia. We are committed to providing interesting and challenging work in a friendly environment. We, by necessity, have many contract staff, reflecting the volume of our contract work, although permanent staff have now risen to 90. Turnover of these staff is low, reflecting, I think, the general satisfaction with the work environment in AIHW. A demonstration of our collaborative working environment was the development of our Certified Agreement, with 94% of staff supporting it.

Another initiative from the last Corporate Plan has been the conferences held in conjunction with the launches of *Australia's Health* and *Australia's Welfare*. I urge you to read the report on the *Australia's Welfare 1999* launch and conference which is in this edition of *Access*.

The past year has also seen a review of the internal structure of AIHW. From early 2000 the Institute will have three divisions: Health

Division, Welfare Division and Economics and Business Division. The new year will also see the appointment of a new Division Head for the Economics and Business Division. I look forward to announcing who it is in the next edition of *Access*. An outcome of the review is that a new function has been added to the Institute through the newly created Business Development Unit. This Unit will develop relationships, promote AIHW capability, contract liaison and involvement in collaboration and contracting arrangements with other organisations.

I'm pleased to welcome Linda Apelt, David Butt, Ian Procter, Libby Davies and (staff member) Lyn Elliott to the AIHW Board. We are looking forward to our continued good relationship with the Board. The guidance from the Board enables us to maintain the high standard of work we set for ourselves at the Institute, as well as bringing new strategies to fruition. As I write, I have just attended the last Board meeting of the year at which a number of strategic directions for the Institute were discussed. There was a lot of active participation of Board members which has given us a good grounding to progress these strategies in the new year.

On a final note, I wish all our readers a happy and safe festive season and a prosperous 2000. So, good-bye for 1999 and remember, don't let the Y2K bug bite!

Tell us what you think!

A web site is always a 'work in progress'! The Institute is keenly aware of the importance of the Internet in getting its message out to clients. For many people, the site is their only direct contact with us. That's why we've decided to allocate more resources to the site. We aim to make it more user friendly and client-focused, to re-package and exploit existing information better and to expand the range and format of material included—in short, to give our clients what they want! Full-text online versions of our publications have been the cornerstone of our web site until now. We've been told by many clients that this is useful—is it what you want? What other types and formats of information would YOU like to see on the site?

Please help us to help you—this is a great time to have your say in the redevelopment happening over the next few months. Included with this issue of *Access* is a feedback form for your comments. The form can be faxed back to us on the number at the top. The form is also on our web site where, if you prefer, you can fill it in online and send it to us over the Internet.

As an incentive we're offering a pack of AIHW publications to 10 people who complete the form and return it to us. The pack will contain hard copies of *Australia's Health 1998*, *Australia's Welfare 1999* and a new edition of our very popular *Older Australia at a Glance*—due out this month. Winners will be drawn out of a hat at the end of February, and notified by e-mail.

Australia's Welfare 1999 Conference and launch

'**It is an opportunity to present a comprehensive view**

– as comprehensive as possible –

of welfare services in Australia'.

Senator Newman then drew attention to a number of specific projects and issues covered in the report, while also acknowledging that it was not possible to cover everything in the short time available to her.

The Minister spoke of the $60 million Youth Homeless Early Intervention Plan (recently renamed *Reconnect)*, and the five-year Youth Pathways Action Plan for vulnerable young adolescents. Also mentioned was the unmet demand for disability services and the Commonwealth's recent $150 million offer to the States and Territories for urgent in-home respite care services for people with a disability who have ageing carers.

The Commonwealth–State Housing Agreement was highlighted in that, for the first time, there would be separate bilateral agreements with each State that take account of the variety of housing circumstances in different parts of Australia.

In the Aged Care field the Minister drew attention to multi-million dollar extra funding for community respite services and Aged Care Minister Bronwyn Bishop's recently-announced increase in the number of community care packages (over 4,000), and 3,000 extra residential care places, especially in rural and regional areas.

Senator Newman also indicated her interest in the special chapter in Australia's Welfare (by Professor Peter Saunders) on changing work patterns and the community services workforce. She paid tribute to the 320,000-strong community services sector employees, the 240,000 volunteers, and the 'many hundreds of thousands of primary carers, many looking after elderly and disabled people in their own homes'.

At the launch AIHW Board Chair Professor Janice Reid remarked on the decreasing gaps between major launches or announcements by the AIHW:

'It seems like only last week, but was, in fact, just on three months ago, that I was involved in launching *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*.

And there have been a number of releases since then that I haven't been involved with—in the fields of cancer, breast cancer, the burden of disease, disability services, general practice, neonatal births, the medical labour force, open employment for people with a disability, the National Drug Strategy Household Survey, and child protection.'

Jan said that the Board saw the report as 'an opportunity' rather than as a legal requirement.

'It is an opportunity to present a comprehensive view—as comprehensive as possible—of welfare services in Australia.

'It is also an opportunity to present that view to as many people as we can, from the Minister to administrators, to academics and students, from service providers to clients to interested citizens.'

Professor Reid paid tribute to the *Australia's Welfare* authors, its editorial committee headed by AIHW Welfare Division Head Dr Ching Choi, and the Institute's Communication and Public Affairs Unit, which produced the report and organised the conference and launch.

Keynote speakers at the conference were Community Services Commissioner and former ACOSS President, Robert Fitzgerald, and Professor Peter Saunders.

Robert Fitzgerald provoked conference delegates with his address, entitled 'Community services: for sale to the highest bidder?' He lamented that a more accurate title for his presentation, in some cases, might have been 'Community services: for sale to the lowest bidder'. He said, however, that recent trends to competitive tendering for community services should not be rejected out
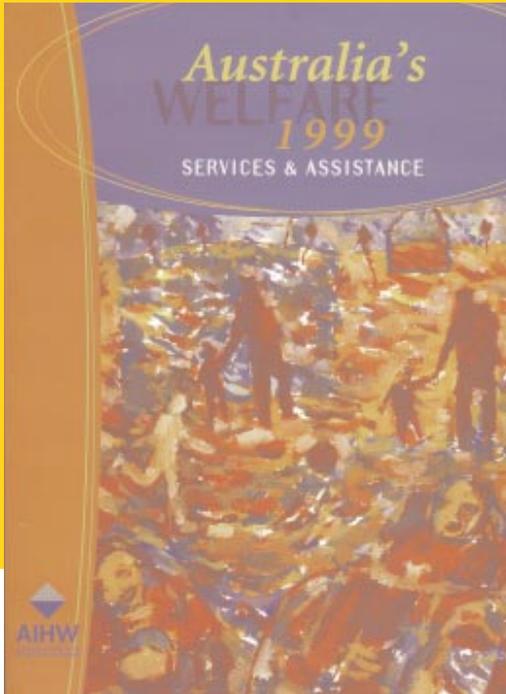
of hand—they had been partly responsible for a shift in focus to outcomes for clients, whereas previously, in his opinion, the community services sector had been more service-provider-driven. The 'trade-off', said Robert, had been 'a loss of innovation, a growing conservatism in the boards of management of non-government organisations' (see page 20 for an edited version of Robert Fitzgerald's presentation).

In his presentation entitled 'The community services workforce—who are they?í Professor Saunders outlined some of the major factors considered in his special chapter. These included:

- employment shifts to the service sector relative to manufacturing (the service sector now employs nearly three-quarters of all workers
- ageing of population combined with increased longevity
- increased prevalence of disability in the population
- the specialised nature of the community services workforce, where almost half are employed part-time and around 80% are women. Corresponding figures for the

labour force as a whole are one-quarter part-time, and less than half being women.

- employment is becoming more of a key to personal dignity and self-respect, even among older workers
- much-increased labour force participation of married women and mothers
- government role in community services has expanded, but most care and support is still provided in the family
- large contributions are made by unpaid volunteer workers.

All these factors have had an effect not only on demand for community services workers, but also the supply of suitable and available paid workers and volunteers (see chapter 3 of *Australia's Welfare 1999* for more details).

Australia's Welfare authors presented concurrent sessions on their areas of expertise in the early afternoon, and the conference concluded with a panel discussion, 'Welfare services: a new partnership between government, the community and business'. Panel members were Jeff Whalan, Deputy Secretary, Department of Family and Community Services; Libby Davies, National Director, Uniting Community Services Australia; and Sylvia Geddes, Manager, Charitable Services, ANZ Bank.

Australia's Welfare 1999 (400 pp) is on sale for $35 in Government Info Shops and ABS bookshops, and through AusInfo mail order sales (phone 132 447).

The report and conference presentations are available at the AIHW web site (www.aihw.gov.au).

Australia's Welfare 1999 **is the most comprehensive and authoritative source of national information on welfare services in Australia.**

Topics include welfare services expenditure, children's and family services, child protection, housing assistance, crisis accommodation and support services, aged care services and disability services.

Australia's Welfare 1999 **features a special chapter on the interactions between changing work patterns and the demand for, and supply of, welfare services. Both formal and informal care services are explored, as well as changes in the nature of the welfare labour force.**

project reports

Project 1 ►

National Community Housing Mapping Project

The Institute recently completed the first national data collection on the community housing sector. Community housing is an important area of housing assistance as it provides a range of housing choices that may not be available from public or private housing markets. This is particularly relevant to households that may require supported accommodation services with the links to aged, disabled and health services.

This collection was part of the Community Housing Mapping Project undertaken by the National Community Housing Forum (NCHF). The aim of the project was to overcome the lack of information on the number of organisations managing community housing and how they operate. The project aims to identify and 'map' by region all non-profit non-government-managed rental housing in Australia, including housing financed outside the Commonwealth–State Housing Agreement (CSHA).

Over 39,600 households were identified as residing in community housing at 30 June 1998, occupying around 38,000 dwellings. Around 23,600 units of community housing were administered by State housing administrations through the CSHA. Over one in every five dwellings (23%) were specifically modified or purpose-built for use by people with disabilities or the frail aged of which the majority were non-CSHA funded. The majority of organisations have polices to specifically target housing services. The main target groups identified were 'aged' (36%), 'low income' (31%) and 'people with disabilities' (28%).

The data collection identified a number of data quality issues that will need to be tackled. The major factors influencing the collection of consistent and reliable data were lack of standard terminology in describing activities and the complexity in the provision of services across a diverse sector.

The Community Housing Mapping Project was one of three initiatives funded by the Commonwealth Department of Family and Community Services to improve information on the community housing sector. The two areas not covered by this project were CSHA crisis accommodation and Indigenous community housing, which were covered by two additional projects. The Institute served on the steering committees of both these projects and ensured overlap and duplication of data were minimised. The major information issue identified in all projects was a need to move to a standard language, terminology and classification both within and between the parts of the community housing sector

For further information, contact Tanya Wordsworth, Housing Assistance Unit, ph. (02) 6244 1119, e-mail tanya.wordsworth@aihw.gov.au

Project 2

Meeting of the Heads of ICD Centres

Richard Madden attended the annual meeting of Heads of WHO Collaborating Centres for the Classification of Diseases, held in Cardiff, Wales, 17–22 October 1999. The Institute is the WHO Collaborating Centre for the Classification of Diseases for the Western Pacific region. The AIHW role covers both the ICD and ICIDH. This meeting was largely restricted to ICD issues, but WHO was keen to shift the focus to the broader Family of (Health) Classifications centred around ICD and ICIDH.

Key outcomes of the meeting were:

- the acceptance of the concepts of the WHO Family of Health Classifications (WHOFIC) based around ICD (diseases) and ICIDH (disabilities);
- agreement to a WHO proposal for an efficient management structure for WHOFIC, including ICD and ICIDH Heads of Collaborating Centres; and
- agreement to four ICD Centre Heads Sub committees:
  – Implementation
  – Update (Rosemary Roberts, National Centre for Classification in Health, to chair)
  – Linkages with Other Classifications (Richard Madden to chair)
  – Electronic tools.

Linkages with Other Classifications Committee

The Linkages Committee has been established by ICD Centre Heads with responsibilities covering several classification domains: interventions, injury and primary care. The meeting concluded that:

- there should be a Family of Health Classifications;
- WHO should be the 'proprietor' of the Family;
- the Family should be comprehensive and willing to admit classifications developed elsewhere; and
- WHO and Centre Heads should seek to ensure that the Family is available for, and used in, the construction of electronic health records.

In summary, concerted actions in recent years by Centre Heads to develop an active management structure for ICD, combined with management changes at WHO associated with the new leadership, have now resulted in a coherent strategy and management structure for ICD.

Project 3

Mindshop Excellence

The Institute hosted six year 10 students from Canberra's Campbell High School as part of the Mindshop Excellence Program sponsored by the Commonwealth Bank. The students spent a week as 'consultants' at the Institute — studying a live issue and their visit culminating in a presentation of their findings. The task we set them was to examine our web site (www.aihw.gov.au), from the perspective of usability, aesthetics and content. The students worked hard, interacted with

Institute staff and learnt some new skills which they demonstrated in their presentation to staff, teachers and parents. They left us with some fresh, constructive ideas and some food for thought.

For further information, contact Judith Abercromby, AIHW, ph. (02) 6244 1004 or e-mail: judith.abercromby@aihw.gov.au

Community Care Data Development Project

In June 1999, the Department of Health and Aged Care and the AIHW signed a Memorandum of Understanding for the development of community care data. The project is designed to improve the coordination of national community care data development activities, with the aim of moving towards nationally consistent and meaningful community care information and indicators that can be used for planning, reporting and policy development purposes. The memorandum also includes the establishment by the AIHW of a data repository for the pilot test of the HACC Minimum Data Set (see below).

The AIHW's work on the Community Care Data Development Project includes:

• developing an overall framework for community care data that identifies the information needed to support performance measurement and planning at a national level across all community care programs managed (or jointly managed) by the Community Care Branch of the Department of Health and Aged Care;

• developing Version 2 of the Aged Care Assessment Program Minimum Data Set; and

• identifying and defining data required for the Community Aged Care Package Program.

A major aim of the project is to ensure consistency of data definitions with endorsed national standards in the National Community Services Data Dictionary and to contribute to the development of such standards across the broader health and community services sectors.

However, the first step is to work towards consistency across the main programs managed by the Community Care Branch — the Home and Community Care Program, the Aged Care Assessment Program, the Community Aged Care Package Program and the National Respite for Carers Program.

The project is due for completion in July 2000.

For further information contact,
Trish Ryan, AIHW, ph. (02) 6244 1054
or e-mail: trish.ryan@aihw.gov.au

National Public Health Indicators discussion paper

Australia currently lacks an agreed set of national public health indicators. The Australian Institute of Health and Welfare, in consultation with the National Public Health Information Working Group, has produced a paper that discusses the issues involved in developing such a set of national indicators. The purpose of the National Public Health Indicators project is to provide a set of summary indicators for surveillance and monitoring, enabling reporting on Australia's public health via key health domains with a national focus. Indicators provide a summary method of describing the public health problems that affect a population.

The discussion paper sets out the development, so far, in the process to formulate and adopt measures that will indicate the level of achievement in public health in Australia. In doing so, the paper seeks views and input from the public health community to assist in the further development of an agreed set of national public health indicators.

Copies of the paper are available from
Gerard Fitzsimmons by calling (02) 6244
1105 or e-mail a request to
gerard.fitzsimmons@aihw.gov.au

Developing quality measures for Home and Community Care: hearing the voice of the consumer

Including consumer views in the assessment of service quality in Home and Community Care (HACC) is the subject of the Consumer Appraisal Project, currently being undertaken by the AIHW Aged Care Unit. Consumers from more than 50 HACC funded agencies across Australia are currently participating in surveys about the services they receive. Telephone interviews, focus groups and mail surveys are among the methods trialled in this project which aims to investigate the best methods for obtaining service appraisal information from consumers.

The Consumer Appraisal Project is the second project undertaken by the Aged Care Unit that addresses methods for implementing quality assurance initiatives in the Home and Community Care Program. Previously, the Institute assisted in the development and refinement of the HACC National Service Standards Instrument, which is designed to measure agency compliance with the standards. This instrument examines service provision practices as they are reported by the agency and is currently being implemented by State and Territory governments.

One of the principal goals of the Consumer Appraisal Project is to establish a survey tool and method that will be useful to those assessing HACC agencies using the HACC National Service Standards Instrument. Issues such as acceptability to clients, usefulness to service providers, cost, timeliness and practicality will be considered, as will the capacity of the tool to stand alone as an accurate indicator of agency service quality.

The first stage of this project involved reporting on existing research and practice in the area. A review of relevant literature was conducted, including library based literature searches and consultation with prominent practitioners and researchers in the field. The review canvassed consumer involvement in the appraisal of a range of health and welfare services. The findings of this review have been incorporated into the fieldwork, in this way improving results by sharpening its direct relevance and appropriateness to the HACC Program. A copy of the literature review (entitled 'Obtaining consumer feedback from clients of home based care services') can be obtained by contacting the Institute's Aged Care Unit on (02) 6244 1173.

The fieldwork, currently in progress, is canvassing agencies providing a wide range of HACC funded services, including transport, meals, home maintenance and modification, respite, personal care and home help. Focus group discussions are yielding a wealth of qualitative information about consumer views of service quality and are providing insight into factors that facilitate or impede effective collection of consumer opinion of service quality. Focus groups are being conducted with consumers using a range of HACC services, with members of non-English speaking background groups, and with Aboriginal and Torres Strait Islander people in urban, rural and remote locations. When telephone interview data and mail survey data collection is complete, a comprehensive report will be prepared. The report will examine the question of best practice in obtaining and using consumer feedback for HACC service quality assessment. This report is expected to be available early in 2000.

For further information, contact Dr Anne Jenkins, AIHW, ph. (02) 6244-1173, e-mail: anne.jenkins@aihw.gov.au

project reports

Survival and Hospitalisation of Infants with Birth Defects

The National Perinatal Statistics Unit (NPSU) was awarded a grant from the Sydney Children's Hospital Foundation to examine the outcomes of infants born with surgically correctable malformations. Birth defects diagnosed prenatally or soon after birth account for many admissions of infants to children's hospitals in Australia each year. The National Hospital Morbidity Database contains summary records collected in Australia of all hospital admissions and was used to select infants born with heart defects, bowel, diaphragm and abdominal wall defects and spina bifida. We have followed these infants in their first year of life. Linking this database with the Congenital Malformations Database and ABS Annual Perinatal Deaths unit record data has facilitated and enhanced this research.

The research has found that most of the infants have three visits to hospital and stay for an average of 12 days. Ninety-two per cent were either transferred to another hospital or went home; 7% died in hospital. Infants with congenital heart defects have more visits and length of stay that infants born with spina bifida or intestinal defects. We are continuing to examine the major medical complications these infants have, taking into account their gestational age and birthweight. Each of these factors may be important determinants of the infant's ultimate outcome.

Two journal articles, concurrently being prepared for publication, will outline the finding of the research.

For more information contact: Emma Slaytor, Senior Research Assistant, National Perinatal Statistics Unit, Sydney Children's Hospital, Randwick NSW 2031, ph: (02) 9382 1136

Data repository for the HACC Minimum Data Set pilot

In August 1999, the AIHW commenced work on establishing a data repository for the pilot of the Home and Community Care Program Minimum Data Set (HACC MDS). The pilot test, under the management of the Department of Health and Aged Care, is an important step in the implementation of the HACC MDS which will provide a better understanding of the characteristics of HACC clients and of the services they receive.

This project uses a combination of resources supplied by the Department of Health and Aged Care and the AIHW under the Community Care Data Development Schedule. The AIHW is mainly responsible for the establishment of the database and data transmission standards, collection and compilation of the pilot data, review of the validation rules on the pilot data, and test analyses of the pilot data.

The pilot was run for two data collection periods: 13 September to 2 October 1999 and 3 October to 22 October 1999. About 90 HACC agencies across Australia participated. The project is progressing well, and is expected to be completed late in 1999.

For further information, contact Zhibin Liu, AIHW ph (02) 6244-1174, e-mail: zhibin.liu@aihw.gov.au

Project 9

AIHW Ethics Committee— Guidelines for the preparation of submissions for ethical clearance

The AIHW Ethics Committee endorsed the revised Guidelines for the Preparation of Submissions for Ethical Clearance during its meeting on 17 August 1999. The guidelines were developed after considerable consultation with staff, Ethics Committee members and the Institute's Board. They provide a guide to all individuals, institutions and organisations seeking to access AIHW data.

The guidelines set out the functions of the AIHW Health and Welfare Ethics Committees. The guidelines explain the criteria used for ethical evaluation and the process involved: the submission (there is a set format for submissions), assurances, complaints, monitoring, charging policy and disposal/storage or return of data. Attached to the guidelines are the Information Privacy Principles, an information sheet on how to prepare the submission, a submission form and a monitoring form.

The AIHW is keen to assist research and analysis of the data it collects. It recognises that an unduly restrictive data release policy is contrary to the public interest. On the other hand, the AIHW is also aware of its legislative responsibility to protect the confidentiality of the information it receives, to respect the privacy and sensitivity of those to whom it relates, to maintain high-level data security procedures and, where appropriate, to incorporate the requirements of its information providers in those procedures. Therefore, all research activities with which the AIHW is involved must be ethically acceptable.

Copies of the guidelines are available from the Institute's Intranet and from the Institute's web site.

For further information, contact Marina Alvarenga, AIHW, ph. (02) 6244 1158, e-mail: marina.alvarenga@aihw.gov.au

the drivingforce »

National Community Services Information Management Group (NCSIMG)

This article provides a description of the four subcommittees which operate under the auspices of the National Community Services Information Management Group (NCSIMG). The subcommittees enhance information development initiatives in Australia in the community services sector.

The National Community Services Data Committee

The NCSDC was established on 1 March 1997. It has a very broad coverage with representatives from Commonwealth, State and Territory jurisdictions with responsibility for community services matters, the ABS, the Commonwealth Grants Commission, the Productivity Commission, the Institute, the Australian Catholic Social Welfare Commission, the Brotherhood of St Laurence and the Wesley Mission. Dr Ching Choi, Head of the AIHW Welfare Division, is Chair of the committee. The committee is responsible for the development and maintenance of the *National Community Services Data Dictionary.*

The National Child Protection and Support Services Data Working Group

This working group was established in November 1997, and has members from Commonwealth, State and Territory departments with responsibility for children's services. John Prent from the Department of Human Services, Victoria, is Chair of the group. Recent work by this group has been to assist the Productivity Commission in the preparation of the 'Protection and support services' chapter of the *Report on Government Services*, a project on the comparability of data for key output categories for child protection, and on new outcome indicators for child protection and supported placements.

The Children's Services Data Working Group

This working group was established in April 1998. Membership consists of senior staff of the relevant Commonwealth, State and Territory departments. The objectives of the group are:

- to foster cooperation between the Commonwealth and the States and Territories on the collection of children's services data

- to contribute to strategic monitoring of data development activity within the children's services sector

- to provide advice to NCSIMG on national children's services information priorities.

The Chair of the group is Judy Raymond from the Commonwealth Department of Family and Community Services. That department also provides the secretariat for the group. The group is developing a national minimum data set for children's services, including child care and preschools.

Community Services Ministers' Conference

Standing Committee of Community Service and Income Security Administrators

National Community Services Information Management Group

National Health Information Management Group

National Community Services Data Committee

National Child Protection and Support Services Data Working Group

Aged Care Data Advisory Group

Children's Services Data Working Group

Disability Data Reference and Advisory

The Disability Data Reference Group

The Disability Data Reference Group, established by the Institute in February 1996, is not formally a subcommittee of the NCSIMG, but reports regularly to the Management Group meetings on its work program activities.

Members have been chosen for their expert knowledge in the field of disability. They represent community groups including disability consumer groups, non-government providers, Aboriginal and Torres Strait Islander peoples, State and Commonwealth governments, and people with expert knowledge, as researchers, statisticians and clinicians. Major current work of the DDRAG includes the development of disability data elements for the *National Community Services Data Dictionary*, and work in conjunction with the Institute on the revision of the International Classification of Impairments, Disabilities and Handicaps (ICIDH).

The Aged Care Data Advisory Group

The first meeting of this advisory group was held on 3 August 1999. Its terms of reference are to:

- review aged and community care data collections and data development needs and identify gaps in data development
- ensure consistency across aged and community care data development and with the *National Community Services Data Dictionary*
- develop a data dictionary subset for aged and community care
- provide advice to the NCSIMG on aged and community care data issues.

The Commonwealth Department of Health and Aged Care provides both the Chair (Warwick Bruen, Assistant Secretary, Community Care Branch), and secretariat for the group.

For further information on any of these groups or other NCSIMG issues, contact Margaret Fisher, AIHW, ph. (02) 6244 1033, or e-mail: margaret.fisher@aihw.gov.au

National Health Information Management Group

At the all-important two-day NHIMG meeting held on 11 and 12 November, a number of items were approved for admission into the Data Dictionary and/or National Minimum Data Sets. These items were a mixture of new elements and revised data elements. Elements were approved for:

Hospital admitted patients and non-admitted patients

Contracted hospital care

Urgency of admission

Mode of separation

Public patient status, Medicare eligibility, billing or compensable status

External cause of injury data elements

Estimated date flag

Perinatal NMDS

Alcohol and other drug treatment services NMDS

Mental health care NMDS

Palliative care NMDS

The NHIMG was also pleased to have Dr Jeff Harmer, Managing Director of the Health Insurance Commission, speak to the meeting. The HIC has recently become a signatory to the National Health Information Agreement, and now has a representative at NHIMG. Dr Harmer spoke of the new strategic direction of the HIC and how that fits in with the aims of the NHIA.

For further information, contact Michele Flint, AIHW, ph. (02) 6244 1123 or e-mail: michele.flint@aihw.gov.au

spotlight

on Justin Griffin

As Head of the Institute's Supported Accommodation and Crisis Services Unit, Justin believes that collecting data is his chance to make a difference.

'I like the culture here at the Institute—partly because it's a small organisation and partly because you're constantly in contact with the users of the data. This contact with users provides evidence that you're really contributing to the outside world', he said.

'The public consultation side is one of the Institute's strengths.'

Indeed, since the Supported Accommodation and Crisis Services Unit began managing the Supported Accommodation Assistance Program (SAAP) National Data Collection more than 3 years ago, key stakeholders have recognised the enormous achievement of establishing the collection, and the Unit's role in developing a national and comprehensive data collection on SAAP clients and the services they receive or needs that can't be met. The national data collection has now been consolidated and eight individual State reports and a national overview are published annually.

Following this success, Justin believes the Unit faces new challenges in the year 2000 and beyond, both in its role within the Data Collection Agency and in the Institute itself.

'SAAP in many ways has been a maverick within the Institute and it's important to bring it into the Institute's culture. I think the program's wider statistical ambitions have been avoided until now, and it's important that we become involved in other areas—such as the national community services data development, for example.

'We now have 2 years' worth of information in the collection and there's been a lot of effort made in getting the program off the ground, but we're looking at more innovative ways of producing that information so it's more manageable—and giving the data a higher profile than it's had previously.

'The real challenge now that we have this data is to provide more analysis and to look at the broader issue of homelessness and crisis services.'

It is Justin's unconventional upbringing, not just statistics, however, that has influenced his view of the world. His father was a teacher at a Catholic school in Melbourne, and an amateur opera singer. Born in Turkey, Justin's mother is of Austrian–German descent and, after being forcibly transported from her home in Iran, found herself in an internment camp in Northern Victoria. Born in Melbourne and raised in Papua New Guinea, Justin and his five siblings were exposed to a variety of different cultures at an early age.

'I wouldn't swap that time in Papua New Guinea for anything. I think I formed a lot of ideas about the world in my time there; you become less provincial, less parochial. But by the time I reached my final year of high school I convinced my parents that I was having too much of a good time, so I was sent to Melbourne to complete my studies.'

Sharing his father's passion for music, Justin said that as a teenager he wanted to be a rock journalist. Today, however, Justin joins a long

line of staff at the Institute who have a history working as statisticians. Following a burning desire to 'serve the public', Justin moved to Canberra in 1979 to begin an 18-year stint with the Australian Bureau of Statistics. During this time he worked in a number of divisions, including foreign trade and population census, and on economic and household surveys. Yet it was his interest in the health and welfare of Australians that brought him to the Institute in October 1997.

When it comes to life outside work, Justin admits that as a Melburnian he 'had been brainwashed' as a young lad when his father introduced him to the world of Aussie Rules and the Hawthorn Football Club. Justin himself played 'z-grade' Aussie Rules and, although retired, is still involved in junior footy in Canberra, and enjoys 'a game of touch football or a jog at lunchtime every now and

then'. He also has a diverse interest in music, art and movies and is 'obsessive' when it comes to current affairs.

Life as a single parent of two children doesn't leave him much time to consider what is in store for him in the future, but he believes there's more to it than a bunch of statistics; there's the bigger picture.

'Ultimately, providing a stable family life for my children and being happy are very important', he said.

'At work, I have a similar aim to most people at the Institute, which is to provide a quality service to our clients and to the public.'

Justin Griffin,
Head of the AIHW's Supported
Accomodation and Crisis Services Unit

'The real challenge now that we have this data is to provide more analysis and to look at the broader issue of homelessness and crisis services.'

The process of gathering statistical information on services for Australia's homeless is more than a matter of number crunching for the Institute's Justin Griffin.
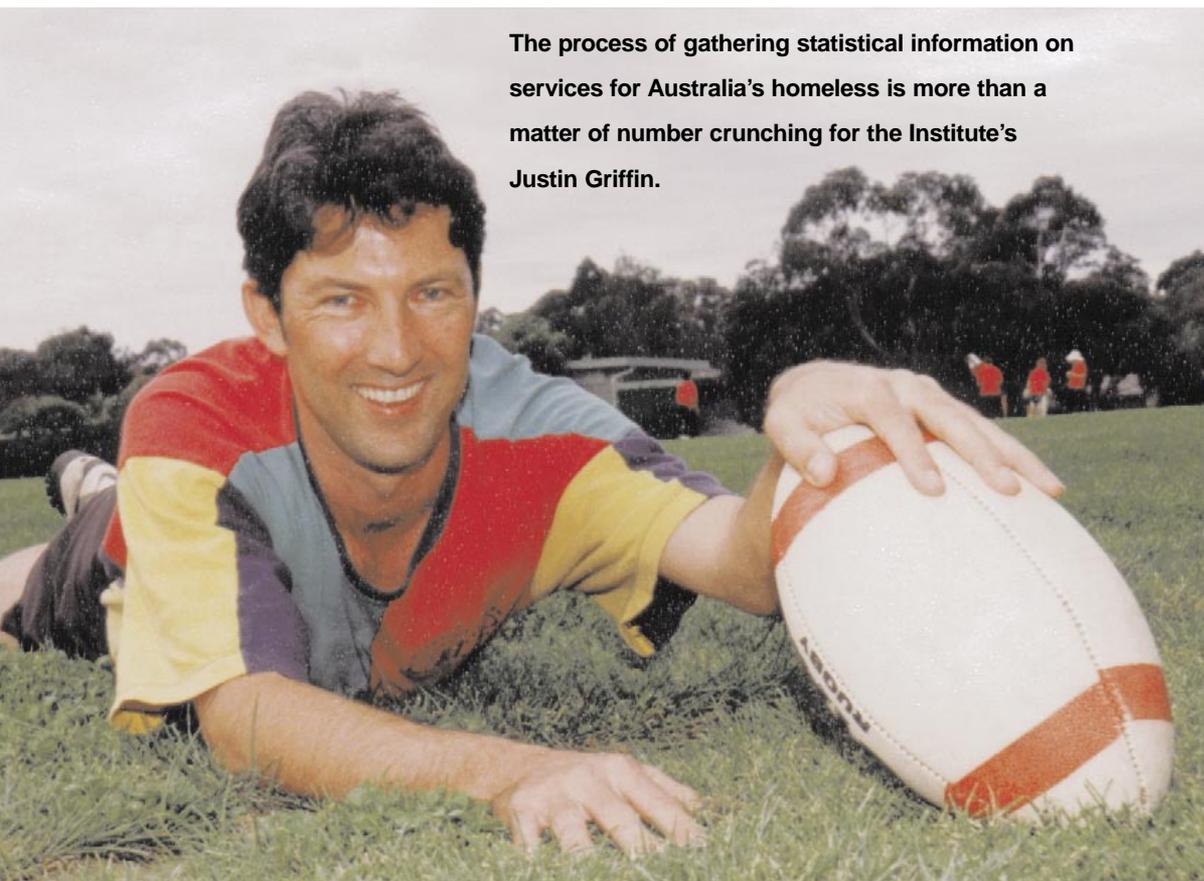
from the Inside

The melting

The Population Health Unit develops and provides information on the health of the Australian population and various sub-populations. The Unit does this by examining issues that include health/disease trends, quality of life related to various diseases, health-related risk factors and demographic issues that affect health so as to objectively inform community discussion.

The Unit's work in population health has become increasingly diverse and collaborative. To cope with the diversifying work program, the Unit has enlisted expertise from around Australia. The Unit staff come from a variety of backgrounds and their eclectic set of skills is the real strength of the Unit. This article hopes to showcase the broad range of projects currently being undertaken in the Unit and to highlight the depth of skills and knowledge that Unit staff possess to enable them to undertake these projects.

The triumvirate

The Population Health Unit is fortunate to have not just one but three managers. This again is a reflection of the variety of work undertaken in the Unit as each manager contributes a unique set of skills to his particular area.

Kuldeep Bhatia is an anthropologist by profession. Nowadays, he devotes the majority of his time to managing the Institute's contributions to the National Health Priority Areas (NHPA) of cardiovascular health, injury prevention and control, mental health, cancer control, diabetes mellitus and the recently introduced priority of asthma. A key focus of his strategic plan relies on a consultative process with various stakeholders. Manisha Njihawan, Andrew Smith and Marijke Van Ommeron work tirelessly helping Kuldeep to report on these issues.

Tony Greville, a recent import to the Population Health Unit, joined the Institute in 1988 after negotiating the transfer of nurse education from hospitals to universities and earlier work in New Guinea in health and district administration. Tony has the challenging task of managing the National Public Health Information Development Plan. The Plan was released in August 1999 and identifies the action needed to improve national public health information by recommending high-priority strategies and initiatives.

Noted scholar and former theoretical physicist Colin Mathers is leading the Australian Burden of Disease study (also known as AusBOD). An article describing this project in more detail appeared in the previous *Access* issue. Colin started with the Institute in 1986 and his latest work, AusBOD, began in mid-1998, when the Institute began a national burden of disease study. The study uses the disability-adjusted life year (or DALY) to estimate the combined burden of fatal and non-fatal health outcomes for over 175 disease and injury categories for Australia in 1996. Colin's team includes Chris Stevenson and James Morris.

Other key projects

The Population Health Unit, via Michael de Looper, recently published *International Health—How Australia Compares*. The health report examines Australia's international standing for approximately 70 different health and health-related issues. Areas examined include population, fertility, causes of ill-health, mortality, health services, and health determinants. This publication arose out of the Unit's obligation to provide data annually to international organisations, such as the Organisation for Economic Co-operation & Development (OECD) and the World Health Organization (WHO).

The Population Health Unit triumvirate (from left to right): Kuldeep Bhatia, Colin Mathers and Tony Greville

pot of population health

The Unit's next report, *Australian Health Trends 1999*, is due soon. The report is a follow-up to the successful 1995 edition. Eighty health indicators will be included in the report, which aims to bring together up-to-date information on health status, determinants of health, health service use and health resources, along with an analysis of trends for each indicator.

Health of people living in rural and remote Australia

If you intend to report on the health of people living in rural and remote Australia, then it is a great advantage to have the project managed by a person with a rural or remote background. Andrew Phillips recently joined the Institute after stints as an epidemiologist in western New South Wales and leading the development of National Guidelines for Health Impact Assessment work in Tasmania.

National Health Priority Area: diabetes

Indrani Pieris-Caldwell is responsible for the NHPA diabetes project. Since joining the Institute in January 1998, Indrani has participated in the production of the first NHPA diabetes report to Australia's Health Ministers, which was released on 4 August 1999. Currently she is undertaking two projects: developing operational definitions for national diabetes indicators and preparing a national data development plan for diabetes mellitus.

Drugs and alcohol

Drug-caused mortality and hospitalisation has been managed by the Population Health Unit's Bruno Ridolfo. Before returning to Perth, Bruno revised the aetiological fraction estimates of the mortality and hospital admissions resulting from tobacco, alcohol and illicit drug use. Up-to-date estimates of aetiological fractions will be generated using the revised relative risk estimates and exposure prevalence. A report on the estimates covering deaths registered in 1998 and hospital separations during 1997–98 will be published.

Child and youth health monitoring

The Population Health Unit is charged with monitoring and reporting on the health and wellbeing of Australia's children and youth. The major report from the project so far was the publication, late last year, of *Australia's Children: Their Health and Wellbeing 1998,* covering children aged 0 to 14. The next report, *Australia's Young People: Their Health and Wellbeing 1999* will be published later this year. The team working on the youth health report is Lynelle Moon, Jacki Grau, Paul Meyer and Lorraine Taylor. Their report will document the major health concerns for this population group, such as injuries, suicide, mental health problems, substance use, and reproductive and sexual health problems. They are also analysing some of the key determinants of health for this age group: physical activity, diet, weight, and social factors such as relationships, education and employment.

National public health indicators

Work continues on a project to develop a set of indicators that report on public health at a national level. Gerard Fitzsimmons leads this project. Gerard has focused his efforts on managing the consultations with Chairs of National Public Health Strategies, Chief Health Officers of State and Territory Health Departments and the National Public Health Information Working Group on draft indicators, which commenced in December 1998. The progress of the project is being coordinated with the development of national population health indicators under the National Public Health Information Development Work Program. The team is working towards finalising a list of indicators by the end of 1999, and a report based on these indicators will be published in late 2000.

> The Population Health Unit's biggest challenge remains the vast changes and blurring of the previous long-established boundaries of public health as we adopt a more contemporary view of population health. The complex problems that we face are more likely to be resolved using our eclectic and multidisciplinary approach. Fortunately, we have a diverse and talented group of people capable of meeting this challenge.

Still pur

My fictitious friend Larry led us into the last 'Trust Me' column. He took us into some points about how we judge causation in health (see box on right).

In response, I suggested how we could begin to tackle issues like these a little more calmly and systematically than Larry does. In this follow-up column I'll mention a few other things that affect how we look at the question of whether suspect A might be a cause of health problem B. Then I'll discuss how we might bring many of these points together to help us analyse what we read about possible causes.

Let's begin with a few myths and problems:

- one study that proves it all
- epidemiology deals only with associations
- naive or mischievous associations.

The first problem is when scientists—or do we blame the media?—seem to hang their hat on one study alone. The fact is that a single health study—regardless of how large or how well done—rarely if ever 'proves' anything, let alone something as important as a cause. It always stands on the shoulders of all previous research. It may seem to be the final piece in the jigsaw puzzle. It may carry us over the line into a state of certainty. But if we claim it 'proves' a case, at best we are factoring in what we already know from earlier studies. Also, conditions can change dramatically over time and that is a big reason for being vigilant and periodically revisiting what we 'know' through further studies.

Another problem is the criticism often made of epidemiological work, namely that it deals only with 'associations', in contrast with laboratory studies. At heart, this is a nonsensical distinction. They are *all* associations. It's only the *nature* of those associations that differs between the two kinds of work.

In the laboratory the associations can be utterly convincing. They are repeatable and often easily tested, the various factors can be much better known and controlled, and the result often comes very quickly. But from the very process of observing, we are still basically dealing with associations. We must still put our faith in the associations represented by the readings on instruments, often many readings over many steps.

In population studies the time gaps are so much longer, the 'noise' of other possible explanatory factors is much greater and we have little or no scope to manipulate the conditions. For these reasons we seek to corroborate the associations by considering them along with other kinds of research, including experimental work where that is fair and feasible. But we should not forget that epidemiology can often build up a formidable pattern of associations that point to a cause, and often in a much wider context than laboratory research alone.

And finally there is the mischievous or naive use of associations that can give research into causes a bad name it doesn't deserve. Imagine a study found that Britons wearing monocles in the early part of the century were three times as likely to get heart disease as others at the time. Would someone reading this really jump to the conclusion that monocles cause heart attacks? Would the monocle market plummet even further? The reader would do better to ask whether this made biological sense and whether monocles go with something else that can reasonably be linked to heart troubles. On reflection, our reader would notice that monocles were confined to aristocratic types. And in the United Kingdom back then, contrary to these days, it was the men in toffier classes that had more heart attacks. They probably ate more animal fats, set the fatal fashion of cigarette smoking and got little exercise beyond the odd childhood spot of rugger.

suing a cause

So this column and the last have touched on how we may start to pursue the question of a cause. I've had to ignore the issue of how we judge the quality of individual studies, only partly out of cowardice and mainly because the area is so huge and usually well covered elsewhere. I've ducked the vexed concepts of multiple causation and how the impact of a cause can be large on an individual but not on a population, or vice versa. I've not gone into the matter of who is doing the research and possible ulterior motives in how and when they present it. (Such factors amount to a different kind of 'evidence' and, at any rate, they should mainly be cancelled out if causal criteria and other rules of approach are applied dispassionately.) And I've not tried to deal with the selective use of evidence, which can be even harder for us to detect if we are not experts.

Well, now that I have tried to show how hard it is to judge causes, where does this leave us if we're only enthusiastic amateurs? Let me suggest a compromise. Read a report that claims to be a review of a possible causal link. Begin by asking whether the reviewers have outlined a systematic approach to their inquiry. In particular, have they followed a checklist for causation along the lines of the criteria given in my previous column? (Represented here in the box on the right.) Second, do the learned reviewers seem to have taken account of the full range and depth of the research that can be brought to bear on the question at hand—animal, human, laboratory, clinical, group, population and so forth? You cannot be certain that they have been thorough. But they can at least give clues by referring to the various areas of research, summarising what other reviews of those areas have done and concluded, and supplying references.

If you did this exercise, you may be surprised at the quality of some reviews. If the reviewers haven't met the two broad questions above, you might be less confident that they have done a good job—even if this would make no difference to the conclusion. If they produce a 'yes' for each question, you might be inclined to agree with them. Either way, if you do gain a working knowledge of the principles of causation—crude guide though they are—this is one area where you'll actually be ahead of many scientists, who keep showing that they have no system for looking at the bigger picture.

And if you really want to go through the research in detail yourself, good luck. I'd offer you some spinach to help you along, but…

Dr Paul Magnus,
AIHW Medical Advisor

Some questions to ask when suspect A seems to be causully linked to B:

Does the link seem biologically reasonable?

Could there be alternative explanations for the link?

Have other possible explanations been fully taken into account?

How strong is the association?

Does the suspected cause come before the 'effect'?

Does the amount of the suspect relate to the size of the 'effect'?

Does the 'effect' occur and increase as the factor is added; or reduce or stop if the factor is removed?

Has the research been truly extensive and on large enough numbers to allow good statistical analysis?

Does the work range across epidemiological, animal, clinical and other studies?

Have results been confirmed using the same methods applied by various study groups, and by variations on those methods?

Considering all the pieces above, do they tend to hang together, to converge, to point in the same direction, to tell a story…?

soap box

Robert Fitzgerald
Community services:- for sale

The main future agenda for the community services sector has to be capacity-building—capacity-building in individuals, communities and organisations. Coupled with a new notion of shared responsibility, and the building of new coalitions with common goals and a common purpose, capacity-building is a key ingredient in redressing social exclusion, inequality and vulnerability in our community.

The 'capacity' of agencies, communities, families and individuals has suffered dramatically over the last decade. To take one example, the catchcry of rural communities is that they have less capacity to deal with the modern challenges and needs than ever before. I've just finished 11 regional forums, in rural communities as well as in metropolitan areas, and the message from all of those agencies represented is that they are less able to cope today than they were 10 or 20 years ago. Less certain, less secure and less robust in their ability to deal with an increasing level of need of those excluded from the benefits of economic growth.

Part of that situation has been due to government policies, where in certain States there has been a determined strategy to undermine small community based service organisations in favour of large welfare organisations and a preoccupation with market processes, rather than sustainable quality outcomes.

But the issue is much broader than that.

It's actually about a failure to build capacity in many parts of our sector over time, which we now must remedy.

We have to build better capacity within our staff and volunteers. We must significantly increase the entry-level skills of workers coming into the sector. The consumers of community services do not need people that do not have the skills to meet their demands. And they do not need a stressed-out workforce that, frankly, should be seeking counselling to a greater extent than their clients. Consumers deserve something considerably better. And it is at the entry point that we have to start the work. Improved skills, improved training and improved peer support is a start. Improved and continued evaluation of performance, and improved pay and conditions, over term, in the sector are also needed. If we do not improve the capacity of our employees (and most of these issues apply to volunteers as well) in terms of training and ongoing support, then we will continue to be weakened as a sector and less able to deliver decent outcomes.

We must develop the capacity of organisations through new funding arrangements with governments. Some improved arrangements were outlined five years ago by the Industry Commission in its report on charitable organisations. What are they? They are contracts that recognise sustainability of organisations and build in resources to achieve this. There needs to be full cost recovery—so that training, evaluation and management efforts are actually costed into

to the highest bidder?

the contracts. The contracts need to be recurrent and longer term, subject to regular evaluation. There needs to be special funding to allow innovation and risk-taking to trial new programs. Above all we need objective and thorough evaluations of programs in order to guide the way ahead.

The tragedy is that in many parts of Australia most of what I have called for is not a reality. In fact, the reverse is true. Short-term contracts, underfunded contracts, contracts that do not provide for objective evaluation, increased costs of managing contracts without compensation and contracts that are at the pleasure of government rather than a genuine agreement between equal partners.

Another area of capacity-building is the capacity-building of communities. In the 1970s we would have called it community development. Today, we see a whole range of terms for it: place management, community management, community empowerment, and so on. But at the heart of this is building stronger and sustainable communities. It needs to be different from the 1970s—a way that does require the collaboration of governments, and is not purely seen as a grass roots movement. It is a way that allows communities—both rural and metropolitan—to take greater control and ownership of the issues that confront those communities, with the support and strength of central agencies.

The third area is building the capacity of individuals and families, placing their needs and aspirations at the centre of a capacity-building agenda.

The sector has moved away from what I believe was 'consumer control' by the service provider. We have become more consumer focused—some by choice, others because they were forced to.

This is good, but in the drive to being more consumer-focused I don't think we have really thought enough about how we build capacity for and within individuals and families. Take for example the area of people with disabilities. In a sense, what we've done in some areas of disability services is remove all the natural support structures that normally support a person and replace them with artificial paid structures. We've put the person with the disability at the centre but we've then taken away all the natural support that exists—family, friends, workplace and community. Now what surrounds many are doctors, nurses, social workers, and other professionals. Now is that a criticism of the paid professions? No, it's not. But it is time to reflect about what we mean by adding capacity and support to individuals. It is not about replacing natural supporting arrangements with artificially constructed arrangements. Rather, it is supporting those natural arrangements in different and better ways. It is about allowing people to exercise life choices and take life's chances by giving them the skills, resources, and confidence to do so, within a system of support and encouragement. They must be active participants in all decisions that affect them.

In concert with capacity-building, the second major element in a new agenda for community services has to be "shared responsibility"—shared responsibility among

soap box

Robert Fitzgerald – Community services: for sale to the highest bidder?

governments, business, community and individuals. Shared responsibility is not 'mutual obligation' in the way that we've now come to know it—you give me this and in return I'll give you that. It is about recognising that we each share equally in the task of our own wellbeing and we each share equally in the responsibility for our community as a whole. How we share or balance the burden of that sharing will be contestable. However, when you look at the statistics about families in crisis, children in the care and protection system, the unmet need for people with disabilities, and the unmet need for homeless people, you start to understand that we as a community are not fairly sharing that responsibility. Too many are left struggling, bearing too much of that responsibility.

The third major element in a new agenda for community services is the development of new coalitions with common goals and common purpose. This is not about philanthropy alone, although increased philanthropy will be welcome in this sector, just as the notion of corporate giving is very important to increasing the capacity of the community sector. But more important are coalitions where we actually work together— not just in relation to how we raise money— but about important issues such as reshaping economic policies so that they are socially responsible. We should no longer just talk about safety nets, assuming that it's okay to allow people to fall through the cracks and then rescue them when they've fallen. We should work together to design systems that produce fairer, more equitable and socially responsible outcomes, outcomes that strengthen people's ability to manage.

We need to work together to reshape the agenda so dominated by purest market principles to an agenda that is designed around producing quality outcomes in an efficient manner, rather than being obsessed with process.

Whilst competition principles can be beneficial in designing a service system, they are only a means to an end. The sector is not for sale to the highest, or should I say, the lowest bidder. A notion that is emerging from the United Kingdom is 'best value'. ACOSS talks about 'best practice, best value, best outcomes'. Best value is a term that now replaces the notion of competitive tendering as being an end in itself; rather it tries to incorporate notions of quality and value as being dominant in designing service arrangements. We should develop a human service system that is capable of delivering 'best value' outcomes for all involved.

Let me conclude by asserting that the community services sector is about more than service provision. We are, in the way of the new language, about trying to develop social capital. It is important that we do try to work together with government, non-government agencies, the community at large, and business, in a way that delivers quality, sustainable outcomes for those most vulnerable in our community by strengthening communities, individuals and organisations. I, frankly, believe that we have the wisdom to do it. But we can only do it if we are prepared to embrace a new agenda. A positive, capacity-building agenda that takes us and those who are most vulnerable into a stronger position in the years ahead.

By all means, as the Australian Institute of Health and Welfare is doing, let us continue to measure what is taking place in the sector. But more importantly, let us continue to value what we are doing, be clear about why we are doing it and respect, empower and engage those for whom and with whom we are doing it.

AIHW Publications

## Burden of Disease and Injury in Australia

The *Burden of Disease and Injury in Australia* provides a comprehensive assessment of the health status of Australians. The report measures mortality, disability, impairment, illness and injury arising from 176 diseases, injuries and risk factors using a common metric, the disability-adjusted life year or DALY, and methods developed by the Global Burden of Disease Study.

Burden of disease analysis gives a unique perspective on health. Fatal and non-fatal outcomes are integrated, but can be examined separately as well. This report provides detailed estimates of the burden of mortality and disability for each disease and injury category by sex and age. It also assesses the burden attributable to each of ten major risk factors and inequalities in the disease burden associated with socioeconomic disadvantage.

The *Burden of Disease and Injury in Australia* (273 pp.) is available from AusInfo at a cost of $25 (AIHW cat. no. PHE 17).

A Summary Report is also available. *The Burden of Disease and Injury in Australia: Summary Report* (39 pp.) is available from AusInfo at a cost of $10.00 (AIHW cat. no. PHE 18).

A special package including the full report and the summary report is available from AusInfo at a cost of $30.
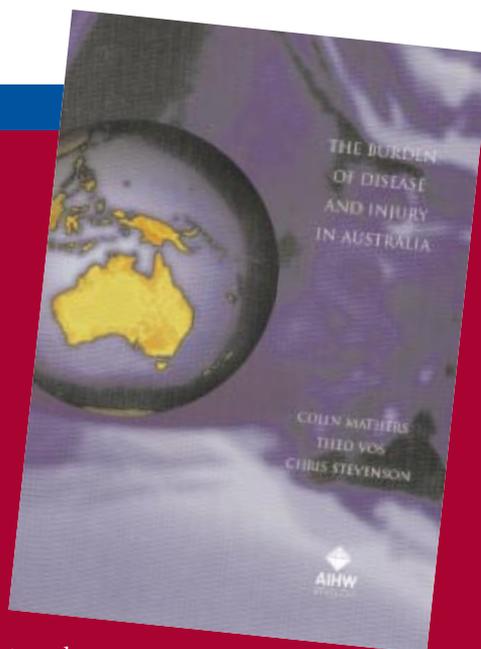
The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 1999

The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 1999 (222 pp.) is available from the Australian Bureau of Statistics at a cost of $41.00.
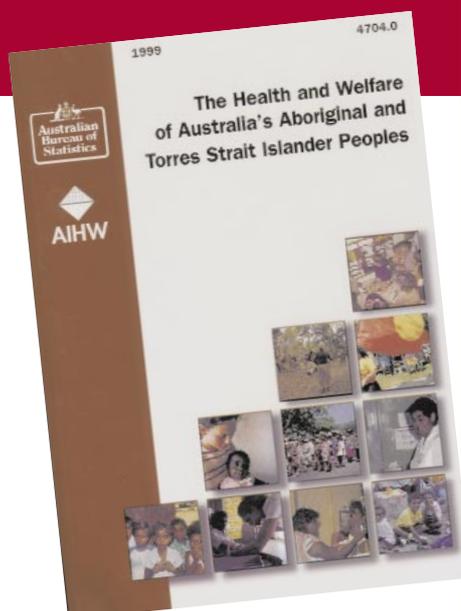
Recent releases

AUGUST

Breast Cancer in Australian Women 1982–1996	(Cat. no. CAN 6)	Free*
Child Protection Australia 1997–98	(Cat. no. CWS 8)	$15.00
Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 1999, The	(Cat. no. IHW 3)	$41.00*
Indigenous Mothers and their Babies Australia 1994–1996	(Cat. no. PER 9)	$19.95
1998 National Drug Strategy Household Survey: First Results	(Cat. no. PHE 15)	Free*
NHPA Report on Diabetes Mellitus 1998	(Cat. no. PHE 10)	$19.95
NHPA Report on Diabetes Mellitus 1998 Summary	(Cat. No. PHE 13)	$10.00
NHPA Report on Mental Health 1998: A Report Focusing on Depression)	(Cat. no. PHE 11)	$19.95
NHPA Report on Mental Health 1998 Summary	(Cat. no. PHE 14)	$10.00
NHPA Report on Cardiovascular Healt 1998: A Report on Heat, Stroke and Vascular Disease	(Cat. no. PHE 9)	$19.95
NHPA Report on Cardiovascular Health 1998 Summary	(Cat. no. PHE 12)	$10.00
National Public Health Information Development Plan	(Cat. no. HWI 22)	Free*

SEPTEMBER

Assisted Conception Australia and New Zealand 1997	(PER 10)	$19.95*
National Minimum Data Set for Home and Community Care, A	(Cat. no. AGE 13)	$15.00
Nursing Labour Force 1998	(HWL 14)	$25.00
Open Employment Services for People with Disabilities 1997–98	(DIS 14)	$15.00

OCTOBER

AIHW Annual Report 1998–99	(Cat. No. AUS 15)	Free
Australian and New Zealand Neonatal Network 1996–1997	(Cat. No. PER 11)	$15.00
Disability support services provided under the Commonwealth/State Disability Agreement: national data 1998	(Cat. No. DIS 16)	$15.00
General Practice Activity in Australia 1998–99	(Cat. no. GEP 2)	$25.00
Medical Labour Force 1997	(Cat. no. HWL 13)	$20.00

NOVEMBER

Australia's Welfare 1999: Services and Assistance	(Cat. No. AUS 16)	$35.00
Burden of Disease and Injury in Australia, The	(Cat. No. PHE 17)	$25.00
Burden of Disease and Injury in Australia: Summary Report, The	(Cat. No. PHE 18)	$10.00
Cancer in Australia 1996	(Cat. No. CAN 7)	$22.00
Morbidity of Vietnam Veterans: A Study of the Health of Australia's Vietnam Veteran Community	(PHE 20)	$15.00
SAAP National Data Collection: Adjustment methods for incomplete coverage	(Cat. No. HOU 37)	$15.00

DECEMBER

Cardiac Surgery in Australia 1995	(Cat. No. CVD 8)	$10.00
Coronary Angioplasty in Australia 1996	(Cat. No. CVD 9)	$10.00

Where to get AIHW publications

All AIHW publications are available from Government Info Shops in each capital city or from AusInfo (formerly AGPS) mail order sales

Phone toll free 132 447