Fearless curiosity, and light in dark places

Such was the catch cry of AIHW Board Chair Dr Sandra Hacker at the AIHW's off-site workshop for its Unit Heads and Executive Committee, held at Batemans Bay, NSW, in March 2002.

Sandra canvassed the views of her fellow Board members before addressing the AIHW's management team. She wanted a collective view rather than purely the view from the 'clinicians' coalface'—a reference to her own work as a practising clinical psychiatrist.

Sandra warned, however, that the AIHW had to be mindful where it directed its curiosity.

'We need to be sensible. We should go where *we* want to go, provided that there is reciprocity attached. We must have a sense of where others in the community are up to. We must have the skills to do the job well, but we must also have a demonstrable capacity to be critically aware, and to know when to desist.'

Dr Hacker cited the *National Health Data Dictionary* and the *National Community Services Data Dictionary* as examples of two areas where the AIHW had been brave enough to go, and had done the job well.

Another theme of Sandra's was 'analytic integrity', which, among many things, meant asking questions such as 'How much of this data do people truly want? When? How?'.

'The AIHW is at the crossroads of intersectoral demands versus subject matter 'silos' versus resources needed to make health, community services and housing data more useful.

'I think we should focus on the edge, the new—we should not be fearful of challenging the paradigms that underpin what we do.'

The final plea from the Board Chair was a plea for 'nous', something 'notoriously difficult to define, but which has a lot to do with understanding one's audience'.

'Are we speaking to the right communities at the right time in the right way?'

Not an easy one to answer.

Sandra's next question was no easier: 'When are the data good enough [to release]?'

Dr Hacker drew the parallel of the case of a mother demanding to know 'right now' if her child had a schizophrenic illness, when most psychiatrists would consider that a proper diagnosis of schizophrenia is not possible in under six months of psychiatric ill health.

The Secretary of the Department of Health and Ageing, Jane Halton, and Family and Community Services Department Secretary, Mark Sullivan, also spoke to the gathering.

Ms Halton recounted how nearly four years in the Department of Prime Minister and Cabinet had enabled her to look at the Department of Health and Ageing from a distance. She emphasised the importance of being able to stand back from statistics and research to take in other perspectives.

'In focusing in and down, we don't look out to see how the world sees what we do. We can get too focused on the micro, and too busy on what *we* see as the critical issues. There's a danger that we don't connect to the rest of government, and to how the community sees us.

Dr Sandra Hacker,
AIHW Board Chair

Contents

from the Director

Since the beginning of the year, the AIHW has undergone significant staffing changes at the Divisional Head level. Mr Geoff Sims, former Head of the Health Division, left in February to pursue a career path out of the public arena. Dr Ching Choi now heads up this division and Dr Diane Gibson, the Welfare Division.

The promotion of Dr Diane Gibson as Head of the Welfare Division was announced on 26 February 2002. Diane has been with the AIHW since 1993 as Head of the Aged Care Unit. She looks forward to the challenge of building on her specialist background in social policy in working more broadly across the Welfare Division.

Following portfolio and staffing changes made in 2001, I am pleased to welcome the following members to the AIHW Board: Ms Jane Halton, Secretary, Department of Health and Ageing; Mr Dennis Trewin, Australian Statistician; and Mr Mark Sullivan, Secretary, Department of Family and Community Services.

In March, Ms Halton and Mr Sullivan joined the Board Chair, Dr Sandra Hacker, and ongoing Board member, Ms Libby Davies, as participants in an off-site workshop held by the AIHW for its Executive Committee, and Unit and Collaborating Unit Heads. The principal focus of the workshop was to examine the current AIHW Corporate Plan, which runs until the end of 2002. Observers from the National Centre for Classification in Health and the Public Health Information Development Unit also attended at the invitation of the AIHW.

Workshop deliberations were guided by Professor Geoff Eagleson, a statistician and Professor of Quality Management at the Australian Graduate School of Management. Professor Eagleson played a similar role in developing our current Corporate Plan.

Against the backdrop of the lively discussion generated by the agenda, we considered afresh our Mission, our values and our overall objectives. The outcome is a strong platform of shared views on which to build and develop the *AIHW Corporate Plan 2003–2006*. As was the case for our current Corporate Plan, the process will involve a high level of consultation with our stakeholders. I welcome any contribution *Access* readers might choose to make to the development of this vital document.

On 3 May 2002, the National Health and National Community Services Information Management groups will participate in their first joint meeting. This collaboration offers the potential for more efficient service delivery through improved collection and dissemination of information, new information links to reduce service redundancy or duplication, and enhanced information comparability across jurisdictions and services.

Richard Madden, Director, AIHW

project reports

Health update on Australia's children

In May 2002 the AIHW released *Australia's Children 2002: Their Health and Wellbeing*. This publication updates the popular *Australia's Children 1998*. It reports on child health and wellbeing indicators nationally, and on indicators for Aboriginal and Torres Strait Islander children and children living in rural and remote areas.

It includes information on various aspects of children's health, including risk and protective factors for child health and wellbeing (such as nutrition and vaccination coverage, infant and child mortality, hospitalisations, disability, burden of disease, chronic diseases, injuries and communicable diseases).

The report is an outcome of an AIHW monitoring program that involves developing indicators of child and youth health and wellbeing, and reporting on these nationally. The program is assisted with funding from the Commonwealth Department of Health and Ageing.

For further information, contact Helen Moyle, AIHW, ph. 02 6244 1188 or e-mail helen.moyle@aihw.gov.au

Australian Centre for Asthma Monitoring
A collaborating unit of the AIHW

The Australian Centre for Asthma Monitoring (the Centre), the newest AIHW collaborating unit, became operational on 4 February 2002. The Centre is located at the Institute of Respiratory Medicine in Sydney. Dr Guy Marks is the founding director of the Centre. A management committee and a technical advisory committee will support the activities of the Centre.

Australian Health Ministers declared asthma as a National Health Priority Area in August 1999 in recognition of the significant health, social, economic and emotional burden that this disease places on the Australian community.

The prevalence of asthma in Australia is one of the highest in the world; some estimates suggest more than 2 million Australians are affected by it. Asthma is a major reason for health care visits and lost productivity, and although there have been fewer deaths over the past decade, the death rate remains unacceptably high, particularly among older people.

The Australian Asthma Monitoring System for Asthma, with the Australian Centre for Asthma Monitoring as one of its major components, was established shortly after asthma was included in the NHPA program.

The initial focus of the Centre will be:

- monitoring and reporting on disease levels, burden, trends and differentials associated with asthma;
- overseeing the systematic development of national asthma data sets; and
- developing and managing special projects and collaborations for the integration and enhancement of asthma-related information.

Issues in asthma monitoring and surveillance

Surveillance and monitoring of asthma is complex. In particular, identification and enumeration of cases of asthma can be a difficult task, as there are many ways in which asthma can be operationally defined. Definitions include diagnosis by a doctor or at a hospital; self-reported symptoms such as a wheeze, chest tightness, shortness of breath, cough, 'attack' with or without timing of symptoms (e.g. night, early morning, triggered by an external stimuli); and objective physiological measures such as airway hyper-responsiveness. In the absence of a 'gold standard' definition none of these can be regarded as the best or correct measure.

Therefore, a decision must be made early as to what constitutes a diagnosis of asthma. The definition of an asthma case must be suitable for use in monitoring the prevalence of asthma in the population, but sensitive enough to changes over time. If it is to be symptom-based, which symptoms should be used? What measure— cumulative, 'ever had' asthma, or current asthma? If we use current asthma, what do we define as current? When identifying available data sources do we use data with nationwide coverage, or opt for comprehensive reporting of data that are available at a local level?

The analysis and interpretation of asthma mortality data is similarly complex. Most asthma deaths occur in people aged over 55 years, but the distinction between asthma and chronic obstructive pulmonary disease (COPD), a common alternative form of airway disease, is difficult in this age range. Attribution of deaths to asthma in the age range 5 to 34 years is more likely to be accurate, and this age range is commonly used for purposes of regional and international comparisons. Changes in ICD coding over the years have also affected recorded mortality rates. Changes in mortality may be attributable to changes in prevalence, disease severity, management and treatment, and even diagnostic fashion.

Similar issues arise in the analysis and interpretation of hospitalisation data for asthma.

So where to from here?

The work program of the new centre will initially consist of three broad phases and their associated tasks:

- establishing operational definitions of indicators and identifying data sources for asthma;
- reporting on Asthma Indicators; and
- preparation of an Asthma Data Development Plan.

During 2000–2001, in consultation with consumers and representatives from clinical, academic, statistical, policy, and prevention backgrounds, a set of 23 indicators were developed in order to monitor asthma. These indicators are integral to the monitoring and surveillance activities that the Centre will undertake. They cover the areas of prevalence; health care utilisation; comorbidities; impact (quality of life, disability, disease severity and mortality); risk factors; and management practices.

Identifying data sources and deciding on their suitability for asthma monitoring are the main tasks for this phase of the work program. Once a data source is identified, it will be aligned with the indicator(s) it may be able to monitor.

There are two stages to this process—data description (see Table 1), and data source assessment (see Table 2).

TABLE 1: PRELIMINARY CRITERIA FOR DATA DESCRIPTION

Criteria	Description
Asthma definition	Factors used to determine an asthma case
Coverage	Is data available for Local Area, State, nationally
Sampling method	Method for selecting population
Population	Target population for the study
Sample size	Size of the study sample
Frequency/year of study/survey /time series available	When the study was conducted and how often, to indicate availability of time series data
Completeness of data	Response rate
Disaggregation	Age, sex, Aboriginal and Torres Strait Islander status, ethnicity, socio-economic status, geographic area

Note: Based on criteria developed by Public Health Information Development Unit for the Nationwide Chronic Disease and Associated Risk Factor Information and Monitoring System.

TABLE 2: PRELIMINARY CRITERIA FOR DATA SOURCE ASSESSMENT

Criteria	Description
Acceptability	Willingness of data source custodians to participate in a monitoring system for asthma
Completeness of data	Proportion of all people with asthma who are identified by the data source
Sensitivity to changes over time	Ability of the data source to pick up changes over time
Predictive value positive	Proportion of persons identified as cases who actually have asthma
Representativeness	Whether the persons with asthma in the data source are representative of people with asthma in the population
Timeliness	Time taken from data collection to data availability and the availability of time series data for trends

Note: Based on monitoring criteria developed by Klaucke, DN, for evaluating public health surveillance.

Reporting on asthma indicators will involve the negotiation of access to data, followed by description and analysis of data.

The main task involved in developing an Asthma Data Development Plan will be to identify deficiencies in existing data, and develop a consensus-based proposal for addressing these. Deficiencies will be identified via a lack of available data for the indicator, poor reliability and validity of existing data, and data heterogeneity. Options for improvement will be explored by examining existing Australian and overseas models, and through discussion with key personnel.

In order to improve asthma monitoring and provide information that will improve outcomes for people with asthma, the Centre has a big task ahead over the next 18 months. The subject area is complex and the project is multi-dimensional. There are a vast array of data available for some indicators, and little or none for others. A major challenge will be to identify the best data to use in a systematic and critical manner, and to determine what additional data are needed. The objective is to produce an end result that makes a significant contribution to the systematic development of asthma data nationwide.

For further information, contact Guy Marks, the Australian Centre for Asthma Monitoring, ph. 02 9515 8631 or Deborah Baker, the Australian Centre for Asthma Monitoring, ph. 02 9515 5164.

New data on waiting times for elective surgery

The AIHW's report *Waiting Times for Elective Surgery in Australia, 1999–00* was published on 30 January. It presents summary data on waiting times for elective surgery, collected by State and Territory health authorities and provided to the National Elective Surgery Waiting Times Data Collection at the AIHW.

New measures of elective surgery waiting times in Australian hospitals were introduced for this report. These will aid understanding of the data and improve comparability of data provided by the States and Territories. The data are now mainly presented as the number of days waited by which time 50% (the median waiting time) and 90% of patients had been admitted.

This new approach considers all patients together, rather than in categories for different clinical urgencies, which had been the basis for previous reports. This enables comparative data to be presented, despite apparent variation in urgency categorisation among the States and Territories. The new approach has been developed in cooperation with the States and Territories through the Australian Health Ministers' Advisory Council (AHMAC) and the National Health Information Management Group (NHIMG) and with advice from the AIHW Board.

A standardised method for estimating the proportion of elective surgery admissions covered by the collection was also developed for this report. It showed that, overall, coverage of the collection (excluding the Australian Capital Territory, for which data were not available) was about 85%. The estimates used are only indicative, so further work to develop actual measures of coverage will be undertaken in the future in consultation with the States and Territories.

The report shows that in 1999–00, nationally, the median waiting time was 27 days. It ranged from 22 days in Queensland to 36 days in Tasmania. Overall, 90% of patients were admitted within 175 days. The proportion of patients admitted after waiting more than 12 months was 3.1%.

Data are presented for the first time for different hospital peer groups. In principal-referral and specialist women's and children's hospitals, the median waiting time was 24 days. It was 31 days in other large hospitals, and 28 days in medium hospitals. The 65 principal-referral and women's and children's hospitals accounted for about 66% of all admissions from waiting lists in the collection, with the 95 other large and medium hospitals accounting for another 32% between them.

Data are also presented for a range of surgical specialties and for 15 different high-volume 'indicator' procedures. Cardio-thoracic surgery was the surgical specialty with the shortest median waiting time (11 days). Orthopaedic surgery and ophthalmology had the longest median waiting times at

53 and 54 days respectively (see figure below). Coronary artery bypass graft was the procedure with the lowest median waiting time (15 days), while total knee replacement had the highest median waiting time at 112 days.

Data on elective surgery waiting times will be included in *Australian Hospital Statistics* for data from 2000–01. This will allow it to be presented with a range of other performance indicator information relating to public hospitals. Details of how these data will be included in

Australian Hospital Statistics were finalised with the AIHW's Australian Hospital Statistics Advisory Committee when it met in April.

For further information, contact Jenny Hargreaves, AIHW, ph. 02 6244 1121 or e-mail jenny.hargreaves@aihw.com.au

MEDIAN TIME WAITED BY PATIENTS ADMITTED FOR ELECTIVE SURGERY, BY SURGICAL SPECIALTY, 1999–00
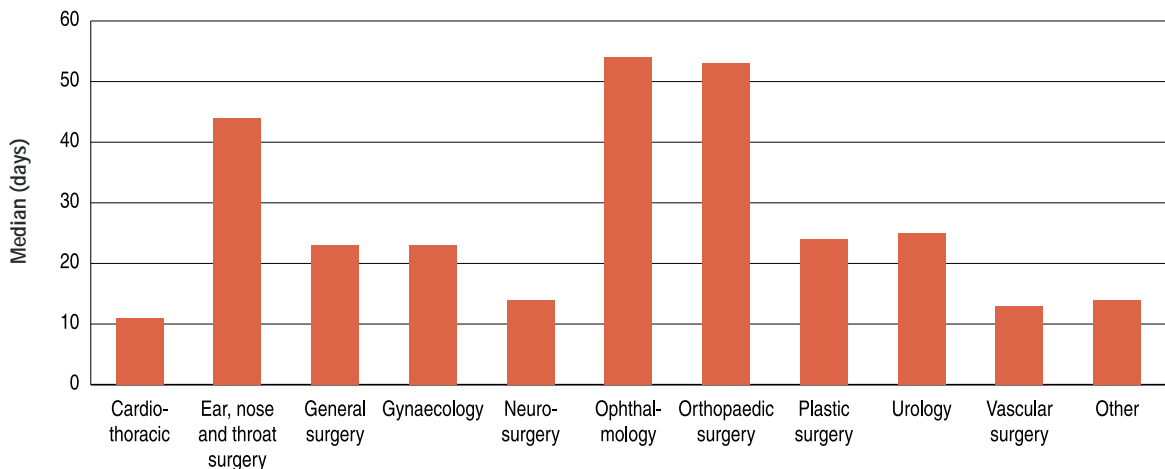
Project 4

Unmet need study for disability services

The National Disability Administrators has commissioned the AIHW to undertake a study on the effectiveness of 'unmet need' funding for disability services and to identify any remaining unmet need, the outcome of which will contribute to discussions and negotiations for the third Commonwealth/State Disability Agreement (CSDA).

The study has a dual purpose. Firstly, it will examine the degree to which objectives for CSDA funding of unmet need have been met. The additional services provided by the funding, and the impact of these services on people receiving support, will be described and quantified. Secondly, the study will explore those areas in disability accommodation, in-home support, day programs, respite

services and disability employment services where need remains unmet in order to reveal current service shortfalls.

A range of sources will be used both to ensure that all available information is brought to bear on this project, and also to seek opportunities for confirming findings using data from different sources. Sources will include State/Territory databases, national data sets, literature review and peak body discussions.

For further information, see the disability portal on the Institute's web site: www.aihw.gov.au/disability

ICD-10-AM released

On 18 March 2002 the National Centre for Classification in Health released the latest Australian version of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision—known as ICD-10-AM. This classification, the third edition of the Australian modification of the World Health Organization's ICD-10, will be implemented in all Australian acute care hospitals from 1 July 2002.

ICD-10-AM classifies, and standardises the representation of, all possible diseases, symptoms, signs, causes of injury, types of neoplasm, surgical procedures and other medical and allied health interventions. This allows collation of accurate de-identified data about health care in Australia from records, as well as statistical and other interpretation of these data. When attached to an inpatient episode of care ICD-10-AM codes can be used to describe a hospital's casemix for clinical management and funding purposes.

This important, but largely invisible, part of the health care system is critical in maintaining accurate information about the health care of Australians as it provides a common language of health used by all Australia's health care services.

The terms used are revised constantly, and informed through a continuing dialogue with health services providers. This means that the classification is a valid representation of the language of health being used today.

ICD-10-AM is produced by Australia's National Centre for Classification in Health and is endorsed by the National Health Information Management Group.

For further information, contact Associate Professor Rosemary Roberts, Director, National Centre for Classification in Health, ph. 02 9351 9461.

Fearless curiosity, and light in dark places

'We need to create a constituency for what we do and manage. Otherwise we can come up with a gorgeous policy solution but no constituency for the problem.'

Mark Sullivan says the first thing that struck him when he walked into the Department of Family and Community Services (FaCS) was the scale of its operations: in financial terms, $54 billion.

'FaCS has to pull it all together, from early childhood to retirement. Our reach is enormous.'

Mr Sullivan said that while his Department prided itself on internal excellence, and it did have good external relationships, it could perhaps do more to 'really engage' with the external world. This was part of the challenge of a 'whole of government' approach to issues.

'The 'best' policy', he said, 'is the best you can do in the time government can give, rather than the perfect policy in your own time.

'Policy must still, of course, be evidence-based. But the evidence has got to be there quickly.'

AIHW Director Dr Richard Madden convened the off-site workshop to kick off the AIHW's 2002–2005 corporate planning process.

'I want us to challenge ourselves, to celebrate our achievements, and to take stock of where we are and what are our circumstances', he said.

'Our balance sheet is respectable, our infrastructure is in good shape, and our people are a strong, energetic and well-respected team.

'But nothing remains the same. We have new Ministers, new portfolio Secretaries, and a new Board Chair…As well, many of us are hardly fresh faces…So are we at risk of accepting our success and slipping into a comfort zone mentality?'

from the Inside

Hospitals and Mental Health Services Unit

If use of computer capacity is a measure of worth, the Hospitals and Mental Health Services Unit must be one of the AIHW's most worthy units!

Of the five AIHW databases for which the Unit is responsible, the National Hospital Morbidity Database is by far the largest. With its 43 million records of hospitalisations in Australia since 1993–94, it comprises 65% of the data in the Institute's major databases. For the more technically minded, this translates to about 26 gigabytes of the 40 gigabyte total. The Unit's other long-established major database is the National Public Hospital Establishments Database.

This year major databases are being established for the AIHW's National Elective Surgery Waiting Times Data Collection (with about one million records for the last two years), and, most recently, for the National Community Mental Health Morbidity Database (with three to four million records for this, its first year). The Unit's 'midget' database, the National Community Mental Health Establishments Database (with about 600 records on public community mental health services) is also being added to the major database list.

All five databases are compiled from data provided to the AIHW by the States and Territories under the National Health Information Agreement. The Unit maintains close links with States and Territories to ensure databases are compiled and interpreted accurately. It also maintains close links with these and other stakeholders in its annual use of the databases to produce the publications *Australian Hospital Statistics* and *Mental Health Services in Australia*.

The Unit also busies itself with data development for each of its databases, so that they continue to reflect national priorities for mental health and hospital statistics. Major emphases in recent times have been on mental health establishments, elective surgery waiting times and adverse events.

Providing data services is another important part of our work. We provide extracts of the National Hospital Morbidity Database to several of the AIHW's Collaborating Units, and assist users of our databases throughout the Institute. We also provide data (mainly from the National Hospital Morbidity Database) in response to several hundred ad hoc requests each year from government agencies, non-government organisations, universities, private sector organisations and community individuals.

Anyway, so much for the report on our recent activities! Let's look briefly at who makes up our team.

- Alannah Smith, a Unit member for three years, is the longest serving Institute employee. She joined the AIHW in 1990. She is a whiz with publication formatting, and provides administrative support for most of the Unit's work areas.

- Ruth Penm is another long-serving Institute staff member. She began working for the AIHW in 1993, and with the Unit in 1997. She is our 'backbone' when it comes to doing clever things to prepare data for loading into databases, and to generate hospital morbidity tables for *Australian Hospital Statistics*.

- Jenny Hargreaves joined both the AIHW and the Unit in 1996. As our Unit Head, she is naturally across all areas of our work.

Hospitals and Mental Health Services Unit (left to right):
David Braddock, Jenny Hargreaves (front), Jenny Kok,
Alannah Smith, Lucianne Lewin (front), Narelle Greyson (back),
Bree Cook, Ruth Penm, Katrina Burgess, Ian Titulaer.

the drivingforce »»

National Health Information Management Group and National Community Services Information Management Group

Accurate, reliable and timely information in the health system and community services sector requires a coordinated approach and agreed rules to facilitate jurisdictional cooperation and efficient use of resources. The National Health and National Community Services Information Agreements provide a framework for the collection, compilation and interpretation of information on a nationally consistent basis. Desired economies may be achieved by rationalising information development activities and reducing duplication of effort between agencies and across service areas.

Increasingly, program initiatives of Commonwealth, State and Territory governments are focusing on provision of multi-service indexes and directories of both private and public sector services. To build on these initiatives and maximise their benefit across the human services sectors, the first joint meeting of the National Health Information Management Group and the National Community Services Information Management Group was held on 3 May. The National Housing Data Development Committee and the Indigenous Housing Data Committee accepted an invitation to participate in the meeting.

The meeting was co-chaired by Patricia Faulkner, Chair of the National Health Information Management Group, and Jim Davidson, the recently appointed Chair of the National Community Services Information Management Group. Jim Davidson is Executive Director, Policy and Strategic Projects at the Department of Human Services, Victoria.

Discussion at the joint meeting was lively, with members agreeing that projects currently being managed by each of the Groups would benefit from closer cooperation. Key projects are on the topics:

• Indigenous information

• data linkage; and

• privacy.

Each Group agreed to consider at future meetings a report on the activities of the other Group, and that there is potential for a further joint meeting on an annual basis. The importance of inclusion of housing data was acknowledged, with a representative of the Housing Groups to be invited to future joint meetings.

Management Group publications

CSMAC recently endorsed for publication a report on statistical data linkage in community services data collections. The project was managed by a steering group led by the Aged and Community Care Division of the Commonwealth Department of Health and Ageing. The report acknowledges the significant potential policy pay-off from using linked data. It will be disseminated widely and will shortly be available on the AIHW web site to ensure broad engagement and discussion.

The report of a project to develop guidelines for the appropriate interpretation of performance indicators for child protection and out-of-home care, as reported in the *Report on Government Services*, is also available on the AIHW web site. The project was managed by the National Child Protection and Support Services Data Working Group (a working group of the NCSIMG), in conjunction with the AIHW. The project report is based on consultation with all jurisdictions and follows a detailed review of the international child protection literature.

Publications of the Management Groups are available on the Australian Institute of Health and Welfare web site: www.aihw.gov.au.

For further information on the management groups or their projects, contact Margaret Fisher at the AIHW, ph. 02 6244 1033 or e-mail margaret.fisher@aihw.gov.au

soap box

Improved housing: vital for a better future for Indigenous Australians

'Across Australia, Indigenous housing is now being viewed as more than just bricks and mortar or a roof over our heads' is the message emphasised by James Christian, CEO of the NSW Aboriginal Housing Office. As the Chair of the newly formed Standing Committee on Indigenous Housing of the Housing Ministers' Advisory Council, James is responsible for progressing reforms designed to improve housing outcomes for Indigenous Australians.

Australian Housing Ministers recently released a 10-year statement of New Directions for Indigenous Housing titled *Building a Better Future: Indigenous Housing to 2010*. They charged the Standing Committee with the task of leading the reform process.

The reforms aim to address many of the current inequities and shortfalls in housing, and recognise the importance of housing in the economic and social development of Indigenous communities. There is a range of problems to be addressed—from providing reliable water and power to houses in rural locations to overcoming the discrimination and affordability barriers very often associated with access to private rental markets by Indigenous people. There is also a major challenge of ensuring that mainstream public housing more responsively and appropriately assists Indigenous people meet their housing needs and aspirations.

This will be a complex task. However, James believes his experience in establishing the NSW Aboriginal Housing Office from a piece of legislation in 1998 to the fully operational organisation it is today demonstrates how governments are responding to this pressing issue. It also demonstrates the potential there is for change that will deliver long-lasting improvements.

'In New South Wales', James says, 'we have adopted a structure that not only delivers better housing assistance to Aboriginal people, including the provision of much needed training for Aboriginal community housing organisations, but also accords very much with the principles and values of self-determination'.

James notes that NSW is not alone in this transformation of the way government thinks about and provides housing for Indigenous people. He points out that governments across the country are, in consultation with Indigenous people, devising more effective ways of addressing housing need. This work will now be better supported and coordinated at the national level through the work of the Standing Committee.
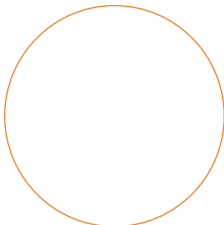
'In New South Wales we have transformed the delivery and operation of Indigenous housing to a stage where there is improved coordination and cooperation at all levels. The Board of the AHO in NSW comprises representatives from Aboriginal communities across the State. This greatly assists the strategic and policy work of the AHO. While we have achieved many milestones in NSW, we also experience setbacks which I think portray the range of complex and sensitive issues we are trying to address.

'The task before us is enormous. Some may view our journey over the last few years with some pride. It is my concern, though, that we have not really left the parking lot—it is a very long journey. We still have a long way to go to address one of the most appalling housing situations in Australia—the housing of Indigenous communities and their people.

'We are only now trying to bring together the different circumstances facing communities and State and Territory governments. We are only now beginning to work together to alleviate the problems and build the capacity of Indigenous communities and their housing organisations to be better able to meet the needs of the people.'

James sees the task of the Standing Committee as the most challenging and interesting area of housing reform.

'In communities, good housing is essential for health and wellbeing, but adequate funding is essential if we are to make a real difference in this area. For every dollar spent on building or buying homes, at least another two or three dollars is needed to bring existing homes up to standard

and ensure that Aboriginal people are trained and supported in the management of housing. It is simply not an option to do nothing about the backlog of repairs and maintenance to community assets. Long-term net gain will be reduced as properties fall down or are sold off through forced liquidations [because of inadequate management] quicker than we can build or buy new homes.
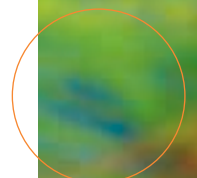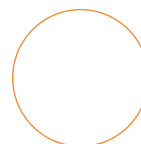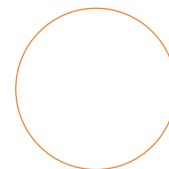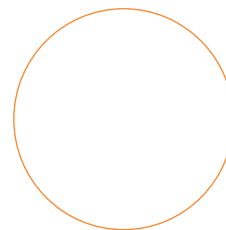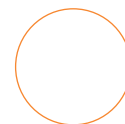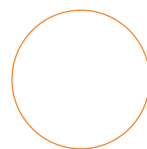
'The benefits gained from a well-managed, robust Aboriginal community housing sector should never be underestimated. The indirect benefits have, nevertheless, not always been a factor weighted into the development of past policies and funding considerations. By having Aboriginal housing programs that are planned, delivered and managed "by Aboriginal people for Aboriginal people", we are ensuring the fulfilment of broader social outcomes for Indigenous people, not to mention the economic stimulation needed for new and existing Aboriginal community building ventures and so on. I would also suggest that young Indigenous people look up to Indigenous people working in their community organisations as role models. The long-term social impact of this is incalculable.

'Despite this potential benefit, the relatively high proportions of Indigenous people still in public and community housing and the low rates of Indigenous home ownership continue to indicate social and economic disadvantage.

'As the Chair, I hope the work of this Standing Committee will succeed in an area vital to the health, wellbeing and future of Indigenous Australians.'

James Christian,
NSW Aboriginal
Housing Office

spotlight

He came to Canberra on a scholarship to pursue his interest in demography. He studied at the Australian National University, which at that time was the only university in the world to offer demography studies.

After obtaining his doctorate at the ANU, Ching returned to Hong Kong to lecture in sociology and demography at the Chinese University of Hong Kong, where he stayed for five years.

Australia, however, offered green pastures for demographers. Dr Choi joined the then Commonwealth Department of Environment, Housing and Community Development to study the demographic impact of decentralisation. This included some work on the impact on the distribution of Sydney's population of building a second major airport.

In the early 1980s Ching joined the Australian Bureau of Statistics (ABS) to start a project on social indicators. He later became Head of the Demography Section.

'At the ABS I worked on some most interesting issues, including a project to rebase population estimates—to compile them on a "usual residence" basis rather than a "defacto basis"', he recalls. 'It was also a fascinating time to do research in routine population projections, because of the quickly declining birth and death rates in Australia.'

In May 1992 Ching joined the AIHW as Head of the newly established Welfare Division. 'I was attracted to the opportunity to develop new data in the new and complex welfare field, with a lot of players in both the Commonwealth and the State and Territory governments.

'I was immediately presented with my first challenge— preparing the Institute's first biennial report to Parliament on the welfare of Australians (the first issue of *Australia's Welfare*).

'We managed to do it with only 10 staff in the Division in 1993. The work leading up to the release of the report had a double benefit. As well as enabling us to come up with a comprehensive report, it also allowed us to survey the welfare field and set directions for the future of the Division.

'A highlight of my term as Head of the Welfare Division was our role in establishing a National Community Services Information Agreement in 1997. The National Housing Information Agreement followed in 1999, signed by all States

Dr Ching Choi is the new Head of the AIHW's Health Division following the departure of Geoff Sims to the world of private consulting. Dr Choi is no stranger to the Institute, having headed the AIHW's Welfare Division for 9 years since its inception in 1992.

So, why the switch?

Dr Choi says that he has always had an interest in health matters, having worked on demographic, aged care and disability issues in the past. The switch gives him an excellent opportunity to look at health and welfare fields in a more integrated way.

'This is a logical thing to do because health and welfare services, often provided by separate departments, essentially respond to the same human needs.'

Dr Choi's career has been truly international. Born in China, he went to school in Hong Kong, before heading to Tokyo, where he obtained a degree in social science from the International Christian University.

and Territories. These agreements made it possible to establish various national minimum data sets, including a repository of national housing data now held at the Institute.

'Another important outcome was the fact that this process generated a cooperative atmosphere for other data sets, such as the Supported Accommodation Assistance Program and Disability Services data sets, which provide information for monitoring very important community services fields in the country.'

Dr Choi saw his welfare team grow from 10 to 70 staff in nine years, and admits that he leaves with some regrets.

'I am sorry not to be able to do more analytical work on welfare data that now exist. However I do have a lot to look forward to in the Health Division—there are a great deal of excellent and established data and great

opportunities for data analysis, and I can't wait to get my teeth into it. I am especially interested in improving and adding value to existing data, and perhaps coming back to analysis of mortality and fertility, which is related to some of the work I started at the ABS.'

Dr Choi is excited about working with the Health Division staff, who he says, 'have such a high reputation in the health statistics field that it is with some trepidation that I join them'.

Realising that his new job will require a lot of energy and stamina, Dr Choi is looking to improve his own personal fitness through activities which supplement his long-standing interest in badminton.

'My family bought me a bicycle for Christmas. I am still open to suggestions, since my other interests—bridge and mah jong [a Chinese board game]—do not help me to keep fit!'

from the Inside

Hospitals and Mental Health Services Unit

- Ian Titulaer joined the Institute the same year as Jenny. The following year he became part of the Australian hospital statistics project. He is the 'glue' for the National Public Hospital Establishments Database and our local statistical analysis and programming guru.

- The 'glue' for the National Hospital Morbidity Database is Narelle Grayson, who joined the AIHW and the Unit in 1999. Development and reporting of national data on elective surgery waiting times also help to keep her busy.

- Maryellen Moore has been with the AIHW's mental health project since 1999. She works with national hospital morbidity data related to mental health, and collates the national data on community mental health establishments.

- David Braddock also works on the mental health project, having been there since 2000. He busies himself with preparation of *Mental Health Services in Australia* and is steering the Unit through mental health data developments.

- Bree Cook has worked for the AIHW since 1999, and been with the Unit since 2000. She created our hospital morbidity Internet data cubes and is currently working to describe de-institutionalisation in hospitals.

- Lucianne Lewin, a previous Unit employee (in 1999–00), returned to us in January 2000. She makes her mark by dealing with the myriad of ad hoc requests — and does her best to keep those who make them happy!

- Jenny Kok also joined the Unit in January this year. She took on the task of compiling the National Community Mental Health Morbidity Database in its first year, and has fearlessly coped with anything else thrown at her.

- Katrina Burgess is the Unit's most recent recruit (joining us in February this year). She has begun the task of documenting links between the Unit's five databases, and is rapidly proving to be a database preparation specialist.

Exposing a myth of the heart

Part 1: Introducing coronary heart disease and a not-so-romantic myth

Have you ever stopped to think twice about some major, long-known fact—one of those important things we all 'just know' because we've heard it so often and from sources of authority?

That's what a colleague and I did not so long ago, when we decided to thoroughly check out a time-honoured claim. It led us down an intriguing path that I want to trace in this article. I hope you'll see that one of the main morals of this exercise is one you'd have thought we all knew well, especially if we profess to be in science: don't blindly accept what you read or hear, even from credible sources. And always check out the references in detail if you want to be sure.

The 'fact' in question concerns a claim that is ultimately about how much we might be able to prevent coronary heart disease (CHD). In particular, it's about how much we can prevent CHD by acting on its so-called risk factors. These are the factors that increase the CHD risk for individuals and contribute to population levels of CHD. If you work in public health, you've probably heard the claim. It goes that the well-known coronary risk factors— such as high blood cholesterol, cigarette smoking and high blood pressure—explain only about half of CHD at most.

I'll talk more about this 'only 50%' claim and its implications later. But let me say first what my colleague and I found. As best as we could tell, the claim is a complete and utter myth. It's not just a miscalculation. It's not even an underestimate. It's simply an assertion, and one with no basis. On the other hand, using the actual evidence, we concluded that the risk factors explain at least 75% of the occurrence of CHD within populations.

To see just how much is at stake here, let's detour for a while into CHD. With heart attack as its most dramatic feature, CHD was by far the greatest epidemic of affluent countries in the twentieth century. It remains the leading cause of premature death and disability among developed nations today. This is despite impressive falls in coronary death rates in many of those countries, including Australia, over the past 30-odd years. Ominously, the epidemic is now spreading so strongly to the developing world that it is projected to become the leading cause of death there, too, by 2020.

Over the past five decades there have been dozens of candidates for what we call coronary risk factors—things that increase the risk of heart attack, especially those we

can prevent. Clearly the biggest proven risk factor is age, but that's hardly preventable unless we prefer to die of something else earlier!

However, it is well accepted that much preventive scope is suggested by just a few key risk factors—high blood cholesterol, high blood pressure and cigarette smoking. Unlike nearly all the remaining candidates, these are true risk factors in both the scientific and public health sense. They are causal, they are common and they are controllable. (In fact they already have been partly controlled in some countries, with immense benefit. I'll discuss that at a later date.)

These three risk factors meet the criteria of causation in having a strong, dose-related, independent relationship with CHD, with plausible mechanisms to explain their effect. This has been shown in many follow-up studies of populations around the world; through supportive evidence from animal, autopsy and laboratory research; and, for cholesterol and blood pressure, through clinical trials of the benefits of lowering the factors. There is great coherence in this decades-long body of evidence. It produces the same conclusions time and again through different studies done in slightly different ways in different places.

Because they're so long established, these risk factors are often known as the 'classical', 'major established' or just 'major' coronary risk factors. Virtually no one disputes that they're important. Also, from complementary evidence, most experts would add physical inactivity to the list of major factors. Many would also include obesity.

We can think of the CHD epidemics like this. First—and essentially—a country widely adopts a 'rich' diet, one that has a high proportion of saturated (harder-type) fat and is low in antioxidants. This has become known as the 'Western' style diet, as compared with the Mediterranean or Asian diets. It tends to raise people's cholesterol levels and cause related disturbances, setting the population up for widespread atherosclerosis—the artery-blocking process that leads to heart attacks.

To this key underlying injury from mass cholesterol-raising, other major insults may then be added as features of twentieth century society. Cigarette smoking, physical inactivity and other inappropriate aspects of diet, with the latter two interacting to produce excess weight and high levels of blood pressure. In one sense it all boils down to what we put in our mouths and how much we move our bodies around! Other possible risk factors may add further

to these problems, such as widespread alcohol abuse in high-CHD Russia. But we have a firm handle on practically none of those other factors, despite many ideas.

Of course this simple summary can't remotely account for *all* cases of CHD. There will always be some 'natural' background level of CHD, as we may find in low-CHD countries such as Japan. But in my view it does basically explain the *epidemic* levels of CHD found in Australia and similar nations.

Needless to say, social and economic factors are clearly involved in all of this as well. First there are the general cultural preferences, farming and agricultural factors, and of course, levels of income. They determine whether many people in a country obtain access to rich food, cigarettes and ways of avoiding physical activity. Then there are special socioeconomic factors that decide which social groups are most affected at various stages of the epidemic.

It seems that, as a country develops, CHD first strikes the better-off groups but later becomes most common among those with lower incomes. This fits the idea that wealthier people are the first to be able to indulge in a Western diet, the first to take up the smoking habit in large numbers, but also the first to quit smoking in droves while other groups are still 'catching up'.

Despite this, it should be noted that the risk factors are prevalent in both the developed and developing areas of the world, among all social classes and are of similar public health significance in all countries regardless of a their level of development. Also, in theory and practice, each factor can be controlled at both the personal and population level.

This all suggests immense scope for further reducing CHD in developed countries and for curbing the emerging epidemic in poorer nations. A huge task but an equally great prospect if we really want to apply what we know.

But now we come back to our claim. Go to any sizeable meeting about heart disease and you will hear someone say: 'Of course, we all know that the classical risk factors only explain half of CHD at most'. This will be said with total confidence as an unarguable fact. Heads around the room will nod wisely. Over the years, the claim has been made in many scientific articles as well, as we shall see. It seems to be widely accepted as fact and appears in review articles presented as state of the art.

You might ask what's wrong with that. Don't we all know that we can never expect to explain most of anything? For a start, there's the well-known issue of measurement errors and other difficulties in estimating how much is explained.

Explaining half with the established risk factors alone could be seen as pretty good going in itself, as close to a full explanation as one could usually expect.

But that is not how the 'only-50%' claim is used. It is used to imply that, even if we could fully control the major CHD risk factors, we could reduce CHD by half at most. It's further implied that there is another unexplained 50% or more to discover—one researcher even refers to 'the other 60%'! Given this huge deficit, it follows that high priority must be given to research on 'new' or 'emerging' CHD risk factors. After all, aren't there all those other risk factors we keep hearing about, besides the tired old classical ones? And aren't the classical ones too much part of a blinkered 'medical model' view of health, ignoring social causes and other ways of looking at the issue? Can't we just move on with the times?

The 'only-50%' claim has persisted over decades. It is used by researchers from all areas of cardiovascular research, be it laboratory, clinical, social or population. For a long time, though, I had been puzzled, curious and somewhat irritated by it. What was its basis? It was way out of line with some important studies of which I was aware. I also vaguely remembered checking up on a reference given with the claim, which did not seem to support it at all. What was going on here?

Someone who shared my doubts and desire to look get to the bottom of the matter is Robert Beaglehole. Robert is Professor of Community Health at the University of Auckland and a well-known figure on the international cardiovascular scene. (He was the Institute's keynote speaker for the launch of *Australia's Health 1998*.)

I have told you the basic conclusions we reached after looking carefully into the matter. For us, the 'only-50%' claim is one of the most serious myths in public health.

I'll back this up in a following issue of *Access*.

Dr Paul Magnus,
AIHW Medical Adviser

Readers wanting to find out more at this stage can refer to the December 10/21 2001 issue of the Archives of Internal Medicine, *Magnus P, Beaglehole R. The Real Contribution of the Major Risk Factors to the Coronary Epidemics, pages 2657 to 2660. (www.archinternmed.com) "Copyrighted 2001, American Medical Association."*

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