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Australian Institute of
Health and Welfare

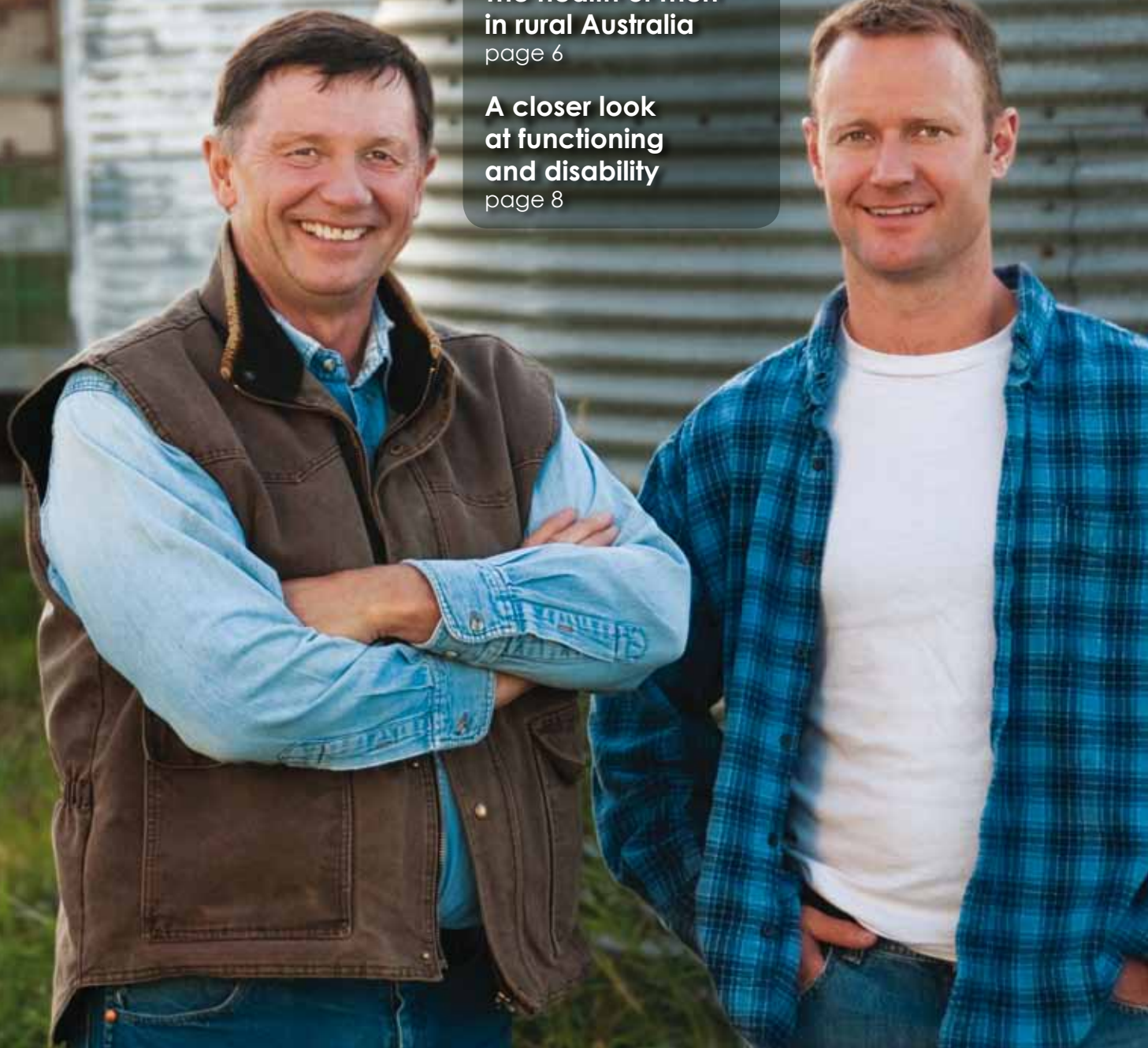
access

issue no. 28 2010

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Dear reader

a message from **Dr Penny Allbon**, Director, AIHW



Welcome to the spring issue. The blossoms are out, the weather is slowly warming up and there are signs of growth everywhere. Here at the AIHW, demand for the data and information we supply has also continued to grow.

The number of staff has also grown—from 270 to 372. This has been possible due to the solid infrastructure, corporate expertise, effective processes and collaborative relationships that provide a good foundation for growth.

We are continuing our work on the performance indicators in the four Council of the Australian Governments (COAG) National Agreement areas—healthcare and hospitals, housing and homelessness, disability services and Indigenous reform. The Institute has also played a significant role in developing better data on cancer, child protection services, Indigenous primary care services, juvenile justice, the health of prisoners and the health professional workforces.

As mentioned in the last issue, the work on the new Specialist Homelessness Services Collection and its associated new client management tool has been a major undertaking and I am pleased to report that work is on track for delivery of the new system by 1 July 2011.

As well, a new data receipting and validation system for hospitals data has been developed and is now being implemented under the name VALIDATA. We are also looking to extend the use of VALIDATA to other collections across the AIHW.

Some of our best-known publications have been revamped to make them more accessible, with short publications produced to highlight the key messages. *Australia's health 2010* had a very successful accompanying short publication,

Australia's health 2010: in brief. Both publications were launched at the *Australia's health 2010* 'beach-themed' conference in June, which is featured on pages 4–5. Another revamped publication was the *Australian Hospital Statistics 2008-09*, with the accompanying *Australia's hospitals 2008-09 at a glance*.

In accordance with COAG's National Indigenous Reform Agreement, the AIHW produced the publication *National best practice guidelines for collecting Indigenous status in health data sets*. The guidelines stress the need to ask the question, 'Are you of Aboriginal or Torres Strait Islander origin?' irrespective of appearance, country of birth or whether the staff know of the client or their family background. The answers provided will help in the design, delivery and evaluation of services to Indigenous Australians. More information can be found on page 10.

The scope of our work has also led to some very exciting 'firsts'. *The health of Australia's prisoners 2009* was the first report to make use of the National Prisoner Health Indicators, developed to help monitor the health of prisoners and assist in creating and implementing prisoner health services. You can read about the 'breakthrough' report on page 13. Another first was *A snapshot of men's health in regional and remote Australia*, offering a unique perspective on longstanding health issues faced in regional and remote Australia (pages 6–7).

In other exciting news, we have commenced a complete redevelopment of our website, together with the installation of a new content management system. The new site will feature significantly enhanced functionality and other technologies in line with Gov 2.0 strategic directions. At the same time, we are redeveloping our intranet to improve internal communication, collaboration and knowledge sharing across the Institute.

On the international front, the Institute has developed stronger relations with both the Canadian Institute of Health Information (CIHI) and the United States National Center for Health Statistics. In fact, three CIHI staff will commence work with AIHW in 2010–11, whilst the United States have agreed to the exchange of

information, statistics and expertise focusing on Indigenous populations.

As I put the finishing touches to the AIHW's 2009–10 annual report (due out in late October), some interesting facts about our staff come to light. Over 21% of staff currently work part-time hours, taking advantage of the Institute's renowned work-life balance conditions; 21 new graduates were employed in the 2009–10 intake, 10 of whom relocated from interstate, and of the 12 graduates who commenced in the 2007-08 intake, 8 were still at the Institute by the end of 2009–10. This is a credit to the Institute in continuing to offer challenging and fulfilling work, competitive salaries, good work-life balance and a great work environment.

Before closing, I would like to pay tribute to Dr Ken Tallis, who recently retired from the Institute after filling many roles, including that of Acting Director whilst I was on extended leave earlier this year.

Over a career of nearly 40 years in the Australian Public Service, Ken has made an outstanding and highly innovative contribution to the development of methodology for a wide range of Australia's socioeconomic statistics. Within the AIHW he has advanced our thinking around the way in which e-health can be harnessed for statistical purposes. He has made a significant contribution to every aspect of statistical work across the AIHW, and has been a major influence on both our culture and reputation. We all wish him well in his future endeavours.

This will be my last edition of Access magazine as I will be leaving the Institute at the end of November. I came to an organisation with a high reputation for quality and collaboration and a great workplace culture. I am proud that the Institute has grown in resources and in reputation over the past 5 years and that the culture is still cooperative, professional and warm. It has been a pleasure to lead the AIHW and I look forward to watching its continuing contribution to policy-making and to community debate in Australia.

A handwritten signature in black ink, appearing to read 'Penny Allbon'.

Dr Penny Allbon

Australia's health 2010

wrap up

The latest national report on Australia's health was launched in June at the Australia's health 2010 conference by Minister for Health and Ageing, Nicola Roxon MP.

The nation's report card on health

Every two years, the AIHW publishes a comprehensive report on the health of the nation. This report contains information on a wide range of health related topics, including diseases, injury, health services, expenditure and the health workforce.



Minister for Health and Ageing, Nicola Roxon MP

The AIHW held a national conference to coincide with the launch of the report on 23 June. At the conference dinner, 2010 Australian of the Year, Professor Patrick McGorry described his work in the field of mental health, and in particular the prevalence of mental illness among young people.

Prominent medical journalist Melissa Sweet also spoke at the dinner on how social media helps create transparency within the healthcare system. Much of her talk was based upon suggestions from her Croakey blog contributors, whom she'd asked prior to the conference to define equity and why it matters.

Speakers at the conference and launch included the Deputy Privacy Commissioner, Timothy Pilgrim, who spoke about the challenges surrounding privacy, research and e-health. Geoff Simmons, co-author of the book *Health Cheque: the truth we should all know about New Zealand's public health system*, described various expectations of the health system and how we can realistically meet this demand.

Launching the report, Minister Roxon said *Australia's Health 2010* was 'a very valuable analysis of where we are as a nation, what we're doing well, where we need to pick up our game and the trends showing us the risks on the horizons that of course any smart government will plan for.'

What the report shows

Australia is one of the healthiest nations in the world—our health is improving on many fronts and compares well with other countries in a lot of ways.

'The bottom line from this report is that our nation's health is by and large good,' Minister Roxon said.

Compared with other OECD countries, for 31 comparable indicators of health, we are in the top third for most and amongst the very best for life expectancy.

Death rates continue to fall for many of our major health problems, such as cancer, cardiovascular disease, chronic lung disease, asthma and injuries.

But while the report shows that Australians generally enjoy good health, it also indicates that there is room for improvement and there are some serious areas of concern.

It is plain to see that some population groups do worse than others—in some cases much worse—and there are also many diseases that continue to place a major burden on individuals and the community.

With rising rates of obesity and diabetes, an ageing population and a continuing gap between the health of Indigenous and non-Indigenous Australians, it is clear that while we are doing well in some areas, many challenges lie ahead.

Heavier and heavier

One of the strongest trends for Australians in recent decades has been the distinct and steady increase in body weight. In 2007-08, 3 in 5 adults and 1 in 4 children were either overweight or obese, putting Australia's obesity level squarely among the 'worst' third of OECD countries.

As a known health risk factor, many experts are concerned about the effect our increasing body weight will have on rates of diabetes, heart disease, and perhaps even life expectancy.

The report shows that there is great scope for health improvements through tackling rates of overweight and obesity and other so-called 'lifestyle' health risk factors, such as smoking, high blood pressure, physical inactivity, high blood cholesterol and excessive alcohol consumption.

The prevalence of diabetes, which is strongly related to these risk factors, has trebled over the last two decades. Over 800,000 Australians are now diagnosed with the disease and Type 2 diabetes is projected to become the leading cause of disease burden by 2023.

Burden on young minds

Many Australians experience mental illness—around 1 in 5 Australians aged 16-85 years has a mental disorder at some time in a 12-month period.

However, recent surveys show that many of the people who experience mental health disorders are young people. An estimated 1 in 4 young people had experienced a mental health disorder in the 12 months before the survey—a higher proportion than any other age group. And in the estimates of disease burden for 2010, mental disorders account for about half of the burden in young people.

In 2007, women aged 16 to 24 were more likely to have experienced a mental health disorder than men of the same age.

The most commonly reported mental health disorders among young people were anxiety disorders, substance use disorders and affective disorders.

Cancer on the rise, but survival improving

The report shows new cases of cancer are set to increase by 10% in 2010 compared to 2006, with the number of people diagnosed with the disease predicted to rise to around 115,000. However, most of the projected increase is because of growth in the population aged 60 years and over.

Cancer now causes Australia's biggest burden of disease, having replaced cardiovascular disease around the turn of the century.

By the age of 75, 1 in 3 Australian men and 1 in 4 women will have been diagnosed with cancer at some stage in their life.

In 2006, prostate cancer was the most common type of newly diagnosed cancer among men, with 17,444 cases diagnosed that year. Among women, breast cancer was the most registered cancer, with 12,614 new cases in 2006.

Lung cancer was by far the most common cause of cancer death for both men and women in 2007 (7,626 deaths).

However, while new cases of cancer are projected to increase, over recent decades there has been progressively better cancer survival, and cancer death rates have fallen. From the latest estimates, the overall 5-year survival rate of people with cancer was 61% compared with 47% in the early 1980s.

And between 1987 and 2007, the overall cancer death rate fell by 16%.

Dementia set to grow

As more Australians reach advanced old age, the number of people with dementia is projected to increase significantly. Over 200,000 Australians are estimated to have dementia in 2010, with the number projected to more than double over the next 20 years.

Among those aged 75 years and over, dementia is estimated to be the leading cause of the burden of disease among both men and women in 2010. Across all ages, it is the fifth highest specific cause of disease burden, accounting for 4% of the total disease burden in Australia.

Some doing worse than others

Indigenous Australians, people of low socioeconomic status, people living in rural and remote areas, people with disability, the unemployed and prisoners are all groups who are disadvantaged in their health to varying degrees.

For example, while death rates vary a lot across different groups, the death rate for Indigenous Australians is almost twice the rate for other Australians. Accordingly, the estimated life expectancy for Indigenous men is about 12 years less than for non-Indigenous men. For Indigenous women the corresponding gap is 10 years.

For people living in rural and remote areas, health outcomes also tend to be worse than for urban dwellers, with higher levels of disease risk factors and illness.

Did you know that in a single day in Australia...

806 babies are born;
27 of these were conceived using **assisted reproduction technology**

330 women (28 years of age on average) become a mum for the **first time**

More than **287,000** people **consult a GP**

Over **687,000** prescription pharmacy **medicines are dispensed**

144 people have a **hip or knee replacement** to relieve severe arthritis

Ambulance services attend almost **8,000** incidents

135 people aged 40–90 years have a heart attack; **50** of them die

378 people die, including **109** from various types of **cancer**



L-R 2010 Geoff Simmons, consumer advocate Anne Cahill Lambert and CEO of Public Health Association of Australia Michael Moore



Rural men face more health risks

The image of men living in rural Australia as 'indestructible' and 'tough as nails' has been around for decades, but a new report has revealed that these men are at greater risk from many health issues than their city counterparts.

Why rural men?

There is the potential for a double disadvantage for men living in regional and remote Australia. This is because of the higher proportion of socioeconomic disadvantage in rural areas and the generally poorer health status of men compared to women.

In most areas of health, men have worse outcomes than women. Men's death rates are higher; men experience a higher burden of disease and they are more likely to have health risk factors, such as high blood pressure, misuse of alcohol and low consumption of fruit and vegetables.

For men living in the country, these health issues can be even more pronounced, because of location, work and lifestyle. They may also be compounded by specific barriers to accessing health services, including lack of services, long work hours and lower levels of health literacy.

Another influencing factor is the strong correlation between poor health and socioeconomic disadvantage. Over half of outer regional, remote and very remote residents live in areas of socioeconomic disadvantage, compared to about one quarter in major cities. Aboriginal and Torres Strait Islander people, who make up a greater proportion of remote populations, are also socioeconomically disadvantaged compared to other Australians.

A new approach

The health challenges facing men were recently highlighted in the Australian Government's development of a National Men's Health Policy, which recognised men in regional and remote areas as a group with distinct health needs and issues.

The AIHW report, *A snapshot of men's health in regional and remote Australia*, outlines these issues. In a first for the Institute, the report brings together research on the health differentials between men and women and the impact of remoteness on health. It compares illness and mortality in men in rural and urban areas. The report is a useful starting point for monitoring future changes to the health status of men throughout the course of the National Men's Health Policy.

While the focus of the report is men in rural Australia, the AIHW acknowledges that rural women also have particular health needs, and we will be pursuing opportunities to do more research in this area.

What were the report's findings?

One of the report's authors, Sally Bullock, says one of the most startling findings in the report concerned death rates, which generally increased with remoteness. 'Compared to men in major cities, death rates were 8% higher in inner regional areas and up to 80% higher in very remote areas,' she said.

'While this can be explained partly by the greater proportion of Indigenous people living in more remote areas, even if you remove Indigenous deaths, the death rate for men outside major cities is still about 20% higher.'

Cardiovascular disease is responsible for nearly a third of the elevated male death rates outside the city, while deaths from diabetes were 1.3 times as high in inner regional areas and 3.7 times as high in very remote areas. Male death rates due to poisoning and injury also increased with remoteness. Specifically, deaths from traffic accidents, chronic obstructive pulmonary disease, prostate cancer, suicide and diseases of the liver were also more common in men living outside major cities.

Ms Bullock said some of the things we already know about men may help explain the reasons for the increased death rates.

'Men often have smaller social networks than women and can be less inclined to use health services. Cultural norms and values may influence the way men think about their health and seek help for physical and mental problems.'

'Men often have smaller social networks than women and can be less inclined to use health services'

Injury, illness and risk factors

Rates of injury and poisoning for men living in very remote areas are over three times higher than for men living in major cities. Similarly, men living outside major cities were 15% more likely to report a recent injury.

Ms Bullock said men living outside major cities were also more likely to have health risk factors such as daily smoking and risky or high risk alcohol use.

Men in these areas were also more likely to have experienced



a substance use related mental disorder throughout their lifetime.

'While there can be distinct health benefits gained from living away from major cities, the physical nature of some occupations in these regions can be detrimental, for example jobs may involve heavy machinery and chemicals, long shifts and isolation,' Ms Bullock said.

'There is also an increased risk on country roads for drivers and passengers as they often travel longer distances than people living in cities.'

Ms Bullock said simply being located far away from medical services could have an impact, with longer travel times for ambulances and fewer health professionals close by.

Health literacy

There is evidence that poorer health status can be associated with lower levels of health literacy—the ability to understand health information and use that information to make good decisions about personal health and medical care.

In 2006, men living in inner regional, outer regional and remote areas were 22% less likely than men in major cities to possess an adequate level of health literacy.

Ms Bullock said that lower levels of health literacy may have an impact on health, for example in self-management of disease.

'It may come down to something as simple as being able to understand medicine labels and information sheets,' she said.

'Understanding medicine labels and information sheets'

Where to from here?

In 2006, about a third of all Australian men lived outside major cities, in what can loosely be referred to as regional and remote (or rural) areas. *A snapshot of men's health in regional and remote Australia* is a sobering analysis which for the first time drills down into some of the health issues affecting rural men.

Ms Bullock said while some of the findings in the report are concerning, there are many things men living in these areas can do.

'We know from the report that there are higher health risk factors for these men and behavioural changes, such as not smoking, reducing alcohol consumption, getting sufficient physical exercise and eating properly can help reduce some of these risks.'

'Continued monitoring of these issues can also show us the areas where more work is needed.'

Work is currently underway at the AIHW, in conjunction with the Department of Health and Ageing, to produce a further set of bulletins on men's health.

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Disability on the rise

The number of Australians with disability has increased significantly over the past two decades and will continue to escalate in coming years. Between 1981 and 2003, the number of Australians with disability doubled to an estimated 3.9 million, or 1 in 5 Australians. To better meet the needs of these Australians there have been calls to set-up a Medicare-type disability levy.

Where are we headed?

It is estimated that by the year 2030, the number of Australians with severe disability will increase to 2.3 million due to population growth and ageing. These Australians will almost certainly require some help with everyday activities such as self care, mobility and communication. The Productivity Commission is currently holding an inquiry into a National Disability Long-Term Care and Support Scheme. This inquiry will look at a range of approaches for providing long-term care and support to people with disability and it is expected that the findings will be available by July 2011.

The role of the AIHW

The Functioning and Disability Unit at the AIHW develops, collates and reports on data relating to functioning and disability in Australia.

The unit currently manages two national data collections on government-funded disability services—the Disability Services National Minimum Data Set and the Younger People with Disability in Residential Aged Care Program Minimum Data Set. Considerable input is provided to the Council of Australian Governments (COAG) performance reporting processes based on these data. The Unit also provides national leadership in the analysis and reporting of disability statistics collected by the Australian Bureau of Statistics, while maintaining a watching brief on international developments in the field.

Sean Ackland, who heads the Unit, says, 'The role of the Unit has diversified in recent years reflecting the changing focus of governments onto evidence-based policy and practice, and the need to provide statistical analysis and commentary that informs these processes.'

What is functioning and disability?

Disability is something that is likely to affect most people at some stage in their life. In the past, the medical model of disability focused on diagnosis of dysfunction and its causes, while the social model of disability focussed on the disabling nature of social environments. In introducing the International Classification of Functioning, Disability and Health (ICF 2001), the World Health Organization observed that 'Disability is always an interaction between features of the person and features of the overall context in which the person lives but some aspects of disability are almost entirely internal to the person while another aspect is almost entirely external.'

Sean Ackland, Unit Head, says, 'Disability is not an individual's intrinsic feature, but the result of the interaction between his or her health condition and the environmental and personal context in which he or she lives.'

Disability is often described in terms of the individual's ability to perform Activities of Daily Living (ADLs). ADLs depict ordinary tasks

a person would usually undertake such as feeding themselves, bathing, grooming, learning and going to work. Disability can be measured along a continuum which could vary from 'hearing loss which requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision' (2003 ABS Disability Ageing and Carers: Summary of Findings, Australia 4430.0).

Younger people with disability

One of the Unit's main responsibilities is to maintain the Younger People with Disability in Residential Aged Care (YPIRAC) Program Minimum Data Set.

The YPIRAC program is a 5-year program agreed on by COAG, which aims to reduce the number of people with disability aged less than 65 who live in residential aged care.

Earlier this year, the AIHW released a report on the YPIRAC program, which showed that over the first three years of the program, over 90 people moved out of residential aged care into more age-appropriate supported disability accommodation.

'In the same period, more than 300 people were provided with enhanced services within a residential aged care setting and almost 150 were diverted from inappropriate admission to residential aged care,' said the report's author, Anne Aisbett, of the Functioning and Disability Unit.

'150 people diverted from inappropriate admission to residential aged care'

It also showed that in 2008–09, a total of 817 people received services funded by the YPIRAC program.

'Nearly half of these service users had a primary disability relating to acquired brain injury, and almost 30% had a neurological primary disability,' Ms Aisbett said.

Autism Spectrum Disorders Register

At the moment, the Functioning and Disability Unit are working with the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) to explore the feasibility of developing an Autism Spectrum Disorders (ASD) Register. This register would record the diagnosis of people with ASD, and would include sufficient diagnostic and treatment detail to inform policy and to support the development of future research.

'ASD is a neurodevelopmental disorder that involves impaired social and communication behaviours, as well as repetitious or ritualistic behaviours,' said Merryl Uebel-Yan of the Functioning and Disability Unit.

'The disorder is present in infancy and early childhood but may not be diagnosed until school age or later.'

Dr Uebel-Yan said there are fluctuating rates of ASD reported across the world, although all agree there has been an increase in the number of children diagnosed with autism internationally, including in Australia.

'Rates have been reported as low as 2 to 5 per 10,000 or as prevalent as 100 in 10,000,' Dr Uebel-Yan said,

depending on which disorders on the spectrum are included in the rate and the age under consideration.

Australian rates are suggested as averaging 46 in 10,000 among 0 to 6 year olds and 77 in 10,000 for children aged 3 to 5 years.

'Governments around the world have responded to increasing rates of diagnosis of ASD by implementing programs to support newly diagnosed children and their families.'

'Overall international increase in the number of children diagnosed with autism'

'There has also been a burgeoning interest in research to discover the cause or causes of ASD and to ascertain if there is a real increase in prevalence or whether improvements in diagnosis account for what appears to be a dramatic rise in numbers.'

The Autism Spectrum Disorders Register would cover Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Delay-Not Otherwise Specified, Childhood Disintegrative Disorder and Rett's Syndrome.

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ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER ORIGIN?



All Australians should soon become accustomed to being asked 'Are you of Aboriginal or Torres Strait Islander origin?' when they visit a health service.

The AIHW's *National best practice guidelines for collecting Indigenous status in health data sets* stress that the question, 'Are you of Aboriginal or Torres Strait Islander origin?' should be asked of all clients irrespective of appearance, country of birth or whether the staff know of the client or their family background.

All states and territories have agreed to adopt the guidelines and have them in systematic use by December 2012.

'We know that the question on Aboriginal or Torres Strait Islander origin is not always asked of every client, because staff may not realise the question is important, or they are concerned that this question is sensitive or even discriminatory', said Kerryn Pholi of the AIHW's National Indigenous Data Improvement Support Centre.

'Asking the question helps the design, delivery and evaluation of services to Indigenous Australians.

'It also assists researchers, policy makers and community organisations who rely on the data to understand and improve the health of Aboriginal and Torres Strait Islander people', Ms Pholi said.

'Far from being discriminatory, the reverse may be true. It may be discriminatory if service providers choose not to ask some people, because everyone should have the right to answer the question for themselves', she said.

The report includes recommendations for putting the guidelines into practice, providing useful advice for dealing with common scenarios such as when the client is too ill to be asked, does not speak English, or when Indigenous status has to be established for a deceased person.

Also included are practical and easy guidelines for staff who might be reluctant to ask the question, and examples of clear concise responses if the client wants to know why they are being asked.

Asking the question

The question should be asked of all patients, regardless of appearance, country of birth, or whether they are personally known to the health service.

Patients may be asked the question in person, over the phone or in a form, but it is important that the question is asked exactly as it is worded.

If a patient objects to the question or says they don't want to answer, they should be assured that their standard of care will not be affected if they choose not to answer.

Patients may not always realise that the Indigenous status question applies to everybody. Sometimes

patients may skip this question simply because they think it doesn't apply to them. If the question has not been completed on a returned form, this should be followed up and confirmed with the patient.

Why is it important?

Reliable data on the health of Indigenous Australians is essential for measuring how effective health services are in meeting the needs of Aboriginal and Torres Strait Islander people and to improve service delivery.

Aboriginal and Torres Strait Islander patients should be provided with the option of accessing information and services specifically designed to meet their needs, and this can only be ensured if all clients are given the opportunity to respond to the Indigenous status question.

Advice and assistance

For advice and assistance for service providers and data managers on how to implement the best Practice Guidelines, please contact the AIHW's National Indigenous Data Improvement Support Centre Helpdesk on **1800 223 919** or email **NIDISC@aihw.gov.au**

National Best Practice Guidelines for collecting Indigenous status in health data sets is available free online at **www.aihw.gov.au**

To order printed copies, call (02) 6244 1032 or email **pubs@aihw.gov.au**



Think **twice** about prevalence

We're measuring progress with a health problem and we find its prevalence has risen quite a lot. That's a worry, isn't it? Well, the answer is 'usually yes but not always'. It depends on the problem in question. Compared with its partner in crime, incidence, prevalence is usually much easier to measure—but there are more traps in interpreting it. This discussion aims to show why.

By Paul Magnus

What is prevalence?

To do that, let's begin by saying what prevalence means when used as a public health term. Prevalence is the number (of cases, instances and so forth) present in the population at a given time. It helps to show the extent and importance of a problem, such as the load it may place on the health system. Take a rising prevalence of Type 2 diabetes, for example. This would mean there will be more people around that need to be treated for it; and we'd worry about all the complications they might get, such as heart disease or blindness. The same worries would go with a rising prevalence of the human immunodeficiency (HIV) virus or many other chronic and serious problems.

And just as we do when we're looking at the incidence (onset) of something, if we want a sense of proportion with prevalence we need to describe it in relation to the size of the population. Hence the *prevalence rate*, typically measured as the number of cases per 100,000 population.

Not always a worry

Now back to the question of whether we should always worry about a rising prevalence. First we need to remember what can lead to that rise. Say there's a highly contagious disease going around. Cases will occur frequently and the prevalence will tend to rise. In other words, prevalence depends partly on the

incidence—and a rising incidence, if it's not just due to better detection, can never be a good thing.

But say that particular contagious disease is highly fatal as well. Then the prevalence may stay relatively low and even steady because the victims die quickly and are removed from the calculations. So the point is that prevalence depends on how many people get a problem over a given period *and* how long it lasts for each person, including whether it is fatal or not. And in this example, therefore, prevalence is a poor guide to the seriousness of a problem and the incidence and mortality figures are much better.

There could also be the factor of how many people immigrate to or emigrate from the population, but that is probably not important very often.

To illustrate this another way, take another highly fatal disease, lung cancer. If its incidence remained steady and we found a dramatically effective way of treating it, the prevalence could rise apace because we're keeping more of the people alive at any one time. Assuming those people can also be kept feeling well, the rising prevalence can only be a good thing, although not as good as if we could then go on to cut the incidence sharply too.

There's another perspective too. Say we had a million cases of high blood cholesterol, defined here as having a blood cholesterol level of 5.5 mmol/L, and their average level is 6.2 mmol/L. The use of cholesterol-lowering drugs in many of these cases may lower the average level to 5.9 mmol/L. But with new cases arising the overall prevalence is unchanged.

In other words, the same number of people may 'have' high cholesterol but not to the same degree as before, so the overall community risk is lower. This could be applied to numerous other risk factors that

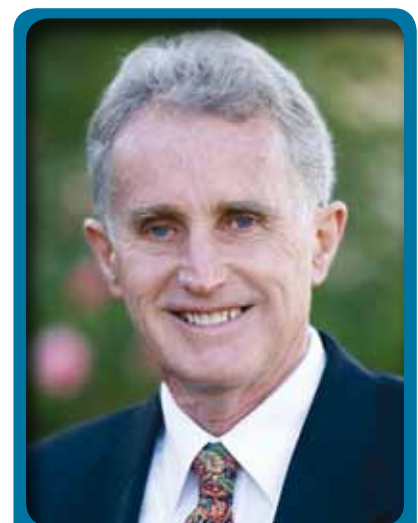
are defined by the blunt measure of a cut-off level, such as high blood pressure, overweight and obesity, and so forth.

And consider the situation with smoking. Its prevalence has fallen but also today's average smokers smoke fewer cigarettes than those of past years—so again, the prevalence alone is only a partial measure of progress.

Consider other things too

In summary, we may often need to look beyond prevalence and ask more questions about it. For risk factors (those defined by cut-off levels), which are not usually fatal in themselves, a rising prevalence is usually a concern but a steady one may not necessarily be. For often-fatal diseases a rising prevalence may be a welcome change providing it is due to falling deaths and not to a rising incidence.

The other moral of this story is that it can be all too easy to fall into reflex reactions about what's good or bad. It never hurts to stop and think twice.



Dr Paul Magnus retired from the AIHW Medical Adviser position in June 2010

The people behind the stats:

Mental Health Services Unit



The Mental Health Services Unit team

community health services, Medicare subsidies, prescriptions, and residential care facilities.

Not surprisingly then, MHSU finds itself frequently involved with government departments—DoHA and FaHCSIA mostly—and organisations such as the Australian Health Ministers' Advisory Council, the Mental Health Council of Australia, the Private Mental Health Alliance and the Productivity Commission, among others.

There is, too, a great deal of overlap and collaboration with other Units within the Institute.

'Mental health data informs such a lot of areas, and is relevant to so many issues,' says Mr Hanson, naming homelessness, drug use, and Indigenous welfare as a few of the major areas where cross-overs are seen.

Fittingly, the Unit's staff are as varied and diverse as their work, with backgrounds that span clinical psychiatry, defence, immigration, Medicare, nursing, and nuclear medicine.

Mr Hanson himself is a registered psychologist whose experience in the military and later in the public service enables him to take a multidimensional approach to his Unit's work.

Gary suggests data collection relating to carers is an area we don't have much information on and one where there is scope for expansion.

AIHW's Mental Health Services Unit (MHSU) has its work cut out for it.

Gary Hanson, head of the Unit for the last three years, is very aware that mental health is a big issue in Australia at the moment – politically, socially and academically.

'For a leading example we need look no further than Professor Patrick McGorry, whose extensive research work on youth mental health issues won him the Australian of the Year Award in 2010. 'Clearly research in this area is seen as particularly valuable to Australia and worthy of public and media attention.'

The main function of MHSU is to compile, produce and manage three National Minimum Data Sets: Community Mental Health Care, Residential Mental Health Care and Mental Health Care Establishments.

The Unit undertakes additional work concerning Mental Health

Intervention Classifications (MHIC), which serve to clarify, as well as classify, what actually takes place at interventions. 'This is the area that probably has the most potential to make a difference,' says Mr Hanson, 'as it enables the interaction between clinician and client to be more fully understood and described.'

The Unit is also involved with the Mental Health Non-Government Organisation Scoping Project, which seeks to improve information on services provided by NGOs.

'NGOs are characterised by diversity and innovation... [therefore] it's difficult to describe and classify the sorts of work they do. But without this kind of information it is near-impossible to gain a holistic understanding of mental health services in this country.'

Mental health care spans a number of areas, involving GPs, hospital emergency departments,

Report profiles

Women and heart disease: cardiovascular profile of women in Australia

Fast facts

- Cardiovascular diseases (CVDs)—a highly preventable and treatable group of diseases—are a major threat to the health of Australian women. But there is a lack of awareness of this threat.
- More than one in three women who died in 2006 did so as a result of a cardiovascular disease.
- Coronary heart disease (CHD), stroke and other heart diseases (including heart failure) are the three leading causes of death among women.
- About two million women (one in five) have cardiovascular disease. About 226,000 of these women have CHD, 168,000 have had a stroke and 176,000 have heart failure.
- CHD and stroke are in the top 10 causes of poor health and disability among Australian women.
- Most women (91%) have at least one modifiable risk factor for cardiovascular disease, and half of all women have two or three.

- Most of the risk factors for cardiovascular disease are known, and many of them can be changed. For example, smoking, poor diet, physical inactivity and high blood pressure can be modified and their burden reduced.
- Many of these risk factors are already common among young females—from as young as 35–44 years, it is more common for females to be overweight or obese than to have a healthy weight; and one in five of those aged 20–29 years smoke daily.
- CVDs are the second most expensive diseases in terms of health system expenditure on women, with \$2,682.8 million spent treating CVD in women in Australia in 2004–05.

Summary

Cardiovascular disease is Australia's biggest killer. This report focuses on its impact on the health of Australian women—a group who may not be aware of how significant a threat

this disease is to them. The report presents the latest data on prevalence, deaths, disability, hospitalisations, services, treatments, risk factors and expenditure, as well as comparisons to other important diseases among women. The report provides both the evidence that CVDs are an important health issue for Australian women, and the baseline picture against which future monitoring can be compared.

Further information

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*Women and heart disease:
cardiovascular profile of women in
Australia*
[www.aihw.gov.au/publications/
index.cfm/title/10748](http://www.aihw.gov.au/publications/index.cfm/title/10748)



The health of Australia's Prisoners 2009

Fast facts

- Among prisoners, rates of chronic conditions such as asthma, cardiovascular disease, diabetes and communicable diseases such as hepatitis B and C are higher than the general population.
- Health risk factors such as smoking, consumption of alcohol at risky levels and use of illicit drugs are also more prevalent among prison entrants.
- A history of head injury leading to a loss of consciousness is common, as are a range of mental health issues and high levels of psychological distress.

A week-long snapshot of prison entrants in Australia during 2009 showed:

- 25% had a chronic condition (asthma, cardiovascular disease, diabetes, arthritis or cancer).
- 35% had tested positive for hepatitis C.
- 81% were smokers.
- 52% consumed alcohol at risky levels.
- 71% had used illicit drugs during the previous 12 months.
- 31% were referred to prison mental health services.
- 37% had been diagnosed with a mental health condition at some time.
- 18% were taking medication for a mental-health related condition.

Summary

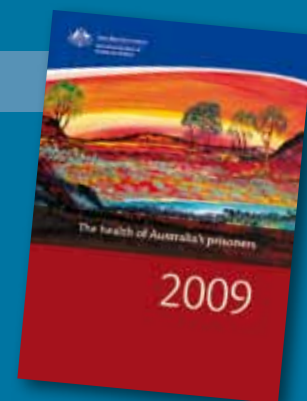
The health of Australia's prisoners 2009 is the culmination of several years' development of national indicators in relation to prisoner health in Australia. Prison populations are known to have some of the poorest health in the community. Despite this, little information on prisoner health has been available until now. The report presents, for the first time, national information on

this group. It compares the health of prisoners with the general community, and provides valuable information on chronic conditions, communicable diseases, deaths in custody and the use of prison health services.

Further information

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The health of Australia's prisoners 2009
[www.aihw.gov.au/publications/
index.cfm/title/11012](http://www.aihw.gov.au/publications/index.cfm/title/11012)





In the pipeline...

Projects

- Australian National Infant Feeding Survey
- 2010 National Social Housing Survey of public rental housing and community housing (KM)
- Development of Specialist Homelessness Services National Minimum Dataset
- Expansion of the child health indicators to include wellbeing indicators
- Redevelopment of AIHW website
- Hospital data validation project
- Feasibility study for the development of an Autism Spectrum Disorders register

Events

- **October 2010**
Community and Disability Services Ministers' Advisory Council meeting
Housing Ministers' Advisory Committee
Australian Health Ministers' Advisory Council
- **November 2010**
AIHW Ethics meeting
National Community Services Information Management Group meeting
- **December 2010**
Review of Government Service Provision meeting
AIHW board meeting

Publications

- Cancer in Australia: an overview 2010
- Australia's food and nutrition
- A profile of social housing in Australia
- A snapshot of arthritis 2010
- Outcomes of diabetes in pregnancy for Australian women and their babies

Homelessness collection— the path for a clearer picture

The new Specialist Homelessness Services (SHS) data collection will replace the current Supported Accommodation Assistance Program (SAAP) collection and will 'go live' on 1 July 2011.

The new SHS collection will help paint a clearer picture of homelessness and the issues faced by people who are searching for somewhere decent to live.

Information will be collected to indicate whether a client has a diagnosed mental illness or is undergoing treatment for mental health issues. Also, children will be recorded individually. The information will be continuously collected enabling the AIHW to provide quicker reports and more up-to-date information on any new trends.

Contact: National Data Collection Agency
Hotline number 1800 627 191
ndca@aihw.gov.au

A profile of social housing in Australia

This publication provides an overview of the different social housing programs that have been provided under the 2003 Community Social Housing Agreement, including public rental housing, state owned and managed Indigenous housing, community housing, and Indigenous community housing... **Published 23 September 2010**

When musculoskeletal conditions and mental disorders occur together

This bulletin outlines the relationship between disability and chronic pain due to many musculoskeletal conditions and the development or exacerbation of a variety of mental disorders... **Published 20 September 2010**

Assisted reproductive technology in Australia and New Zealand 2008

The 2008 report provides data on the assisted reproductive technology treatment cycles undertaken in Australia and New Zealand. In 2008, there were 61,929 cycles. Of these cycles, 17.2% resulted in a live delivery (the birth of at least one liveborn baby)... **Published 17 September 2010**

National Bowel Cancer Screening Program: annual monitoring report 2009 data supplement 2010

The National Bowel Cancer Screening Program annual monitoring report 2009 presented estimated national statistics on key program activity, performance and outcome indicators for people invited to screen in 2008... **Published 15 September 2010**

Hospital separations due to injury and poisoning, Australia 2005–06

This publication uses data for hospital separations due to injury and poisoning that occurred in Australia during 2005–06 to describe the occurrence of hospitalised injury in Australia... **Published 14 September 2010**

Aboriginal and Torres Strait Islander Health Services Report, 2008-09: OATSIH Services Reporting—Key Results

The findings from this report provides information on the activities, clients, provision of care and staffing of Australian Government funded Aboriginal and Torres Strait Islander primary health-care, substance use, and Bringing Them Home and Link Up counselling services... **Published 13 September 2010**

2010 Pandemic Vaccination Survey: summary results

This report presents results from the 2010 Pandemic Vaccination Survey conducted in January and February 2010 by the Australian Institute of Health and Welfare. The report provides estimates of swine flu vaccination uptake by Australians, along with the motivation for, and barriers to, vaccination... **Published 10 September 2010**

National Community Services data dictionary, version 6

The purpose of the community services dictionary is to provide national standards on the community services reporting framework for both statistical and clinical analysis... **Published 23 August 2010**

Chronic kidney disease hospitalisations in Australia 2000–01 to 2007–08

People with chronic kidney disease require extensive hospital services, particularly those patients with end-stage kidney disease who require kidney replacement therapy to survive. This report examines hospital usage for the treatment of chronic kidney disease, and how this varies with different population groups... **Published 18 August 2010**

Australia's health 2010

The nation's premier source of statistics and informed commentary on: determinants of health and keys to prevention; diseases and injury; how health varies across population groups; health across the life stages; health services, expenditure and workforce; the health sector's performance... **Published 23 June 2010**



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