AIHW
AUSTRALIAN INSTITUTE OF HEALTH & WELFARE

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Issue 14 September 2003

INSIDE

Spotlight on Fadwa Al-Yaman

Double – jeopardy in childhood disabilities

Australian of the year launches Indigenous health and welfare report

'Let's give a big tick to governments as employers of Aboriginal and Torres Strait Islander people. Let's give some encouragement here. They've led the way, and there are certainly some good news stories in employment.'

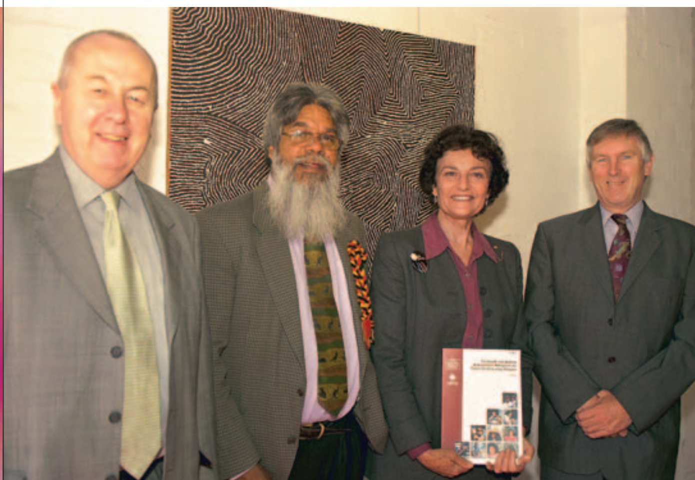
'But in housing, and education, and in general infrastructure, it's harder to find good news.'

'We have 320 environmental health workers, but we need five times that number.'

'In health services, we have a higher level of expenditure [on Indigenous Australians], but not commensurate with their level of illness.'

Professor Fiona Stanley, AC, Director of the Telethon Institute for Child Health Research, 2003 Australian of the Year, and as forthright as ever, was launching the fourth edition of the biennial ABS–AIHW report *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*.

The report was launched in Perth on 29 August at Indigenart—The Mossenson Gallery of Authentic Aboriginal Art, Subiaco.



(L to R) Dr Richard Madden (AIHW Director), Assoc. Professor Ted Wilkes (Senior Research Fellow with Centre for Developmental Health, Curtin University), Professor Fiona Stanley (2003 Australian of the Year) and Mr Dennis Trewin (Australian Statistician, ABS)

Describing the report as 'a magnificent publication', 'an unbiased assessment', and 'yet another wake-up call', Fiona acknowledged how far Aboriginal health and welfare data had come in the last few years, but there were still some gaps. She took some State jurisdictions to task for lagging on Indigenous identification in basic data, asking 'Don't they want to count deaths properly?'

Fiona also acknowledged that, as expected, much of the news in the report was still 'depressing and terrible', and that many people, both Indigenous and non-Indigenous, 'must get sick of it'.

But she was also keen to highlight the positives, and paid tribute to the many information boxes in the report describing worthwhile health and welfare projects that were already making a significant difference to the lives of Indigenous Australians.

'These are fantastic snapshots, the stories behind the facts, and they really are positive.'

Professor Stanley said it was lifestyle, environment and health services together that would make the difference: 'The message is not getting through—joined-up solutions are what we need'.

Professor Stanley concluded by saying that the energy that went into the report should be reflected by governments and the community 'to turn this around'.

'If they put in the same energy there wouldn't be a problem.'

A response on behalf of Aboriginal and Torres Strait Islander peoples was given by Associate Professor Ted Wilkes, a Nyungar

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Recent releases 20

At the end of a highly successful financial year the Institute has released a record amount of publications. The total number of reports produced during the financial year was 115, a 62% increase on the previous year and a 44% increase on the previous record annual output. A noteworthy addition to the output was the series of six Commonwealth–State Housing Agreement National Data Reports published in May. Thank you to all staff for the hard work required to make this happen.

A new Institute structure has been implemented to address the growth of the Institute over the past few years. The Resources Division is now operational and is directly responsible for some Units that previously existed within other Divisions, along with responsibility for the recently established Aboriginal and Torres Strait Islander Health and Welfare Unit. I am delighted to welcome Mr Ken Tallis as the recently appointed head of the Division. Ken has had a distinguished career in the Australian Bureau of Statistics and we are pleased that he has joined the Institute.

The structure of the Dental Statistics Research Unit has been reconfigured under the umbrella of the Australian Research Centre for Population Oral Health (ARCPOH), a research centre formed within the University of Adelaide in 2002. Professor John Spencer who had been DSRU's leader since its inception in 1988 is now Director of ARCPOH, and hence continues to be actively involved in all aspects of population oral health and dental labour force surveillance and research conducted by DSRU.

John was instrumental in building up the Unit to its current high standing. I am confident that the Unit will continue to grow in strength under the directorship of the new head, Professor Gary Slade. The DSRU features in this edition in 'From the Inside'.

There is notable new work being undertaken covering a broad spectrum of the health and welfare sphere:

- Recently, the AIHW participated in a bowel cancer screening pilot and has now started work on full bowel cancer screening monitoring. This work follows on from successful monitoring of cervical and breast screening.
- And, of course, there is the recently-released 2003 Biennial Report: *The Health and Welfare of Australia's Aboriginal and Torres Strait Islanders*, prepared in conjunction with the Australian Bureau of Statistics. You will read more about that publication in this edition of Access.

Finally, we were sad to lose Helen Moyle who has led AIHW's work on children, youth and families for the past eight years. Helen has joined the Department of Family and Community Services, and we look forward to continuing to work with her there.

Australian of the year launches Indigenous health and welfare report

Continued from page 1

man and Senior Research Fellow at the Centre for Developmental Health, Curtin University. Professor Wilkes was Director of the Perth Aboriginal Medical Service (now known as the Derbarl Yerrigan Health Service) for 16 years.

He said that working and walking alongside Fiona was an experience—'She's a fast mover I can tell you'.

Ted said that while it was good to hear about the positives from Fiona, from the Aboriginal perspective 'the mere fact that a group is different in health is little to enthuse about'.

'The indicators for positive change are hard to see, and some jurisdictions are not putting in with respect to Aboriginal data.'

'Our mortality rates are shocking. If Australia is so good on the world health stage, why are things so bad for Aboriginal and Torres Strait Islander people?'

Ted said that in his view the standardised mortality ratio was the best measure of how Aboriginal and Torres Strait Islander health was progressing. Currently it was 'unacceptable that death rates were three times that of non-Indigenous Australians'.

Professor Wilkes believes that diabetes needs to be better understood among Indigenous Australians, with more materials made available 'in friendly English'.

One area where Indigenous Australians were 'doing well' according to Ted was in fertility, with Indigenous mothers having on average 2.14 babies compared with 1.73 for all Australians

While he appreciated the genuine efforts being made in Indigenous health and welfare, Professor Wilkes thought it was not good enough.

'There's been no improvement in the gap in life expectancy between Indigenous people and all Australians. What is it telling us? If this gap doesn't close it's no use telling Indigenous people that things are getting better.'

The launch of *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2003* was hosted by the Australian Statistician, Dennis Trewin, and the Director of the Australian Institute of Health and Welfare, Richard Madden. Both spoke at the launch.

Dr Madden acknowledged calls from both Indigenous and non-Indigenous Australians for action rather than statistical facts.

'But it's a fact of life these days that if you want changes in policy and resourcing decisions it is essential to have good statistical information', Dr Madden said.

Printed copies of the 300-page report (ABS Catalogue no. 4704.0, AIHW Catalogue no. IHW 11) are available from either the ABS or the AIHW (price $60), or the report can be accessed free of charge on the AIHW web site (www.aihw.gov.au).

Mr Dan Black (Director of NCATSIS), Mr Dennis Trewin (ABS), Dr Richard Madden (AIHW), Dr Fadwa Al-Yaman (AIHW) and Mr Geoff Sims.

project reports

Project 1

Australian Hospital Statistics 2001–02

There were 6,394,498 separations from Australian hospitals during 2001–02, involving 23,223,762 patient days. Of these separations nearly 38% were from private hospitals and over 52% were same day. There was $16.8 billion dollars spent on public acute and psychiatric hospitals and the average cost of providing care for an admitted patient was $3,017.

These and countless other fascinating statistics can be found in *Australian Hospital Statistics 2001–02*. Produced by the Hospitals and Mental Health Services Unit (HMHSU), it is the AIHW's ninth annual report on Australia's hospitals and was compiled using data from the Institute's National Hospital Morbidity Database, the National Public Hospital Establishments Database and the National Elective Surgery Waiting Times Data Collection.

Regular readers of this report will discover several new sections, as well as enhancements to some old favourites. The most striking change is to the Highlights chapter, which is now called Hospitals at a glance. This section provides information on the number, activity and performance of Australian hospitals, including time series information from 1993–94 to 2001–02, illustrating the changing nature of Australia's hospitals over the past eight years. For example, did you know that there was an 85% increase in the number of private hospital separations from 1993–94 to 2001–02 compared with a 20% increase in the number of public acute hospital separations? Or that there has been a 45% increase in the number of full-time equivalent salaried medical officers and a 6% increase in the number of nurses?

The proportion of same day separations increased from 37% in 1993–94 to over 52% in 2001–02. To reflect the increasing volume of this type of hospitalisation, a number of tables have been added that summarise separately the most common diagnoses and procedures for same day and overnight patients. In public hospitals the most common diagnosis for overnight patients was Angina pectoris, while the most common for same day patients was Care involving dialysis.

Another addition is the reporting of potentially preventable hospitalisation data. These refer to hospital admissions that may have been preventable with adequate and timely non-hospital care, and include conditions such as asthma, hypertension, dental conditions and vaccine-preventable conditions. There were over 600,000 of these separations in Australia in 2001–02, with increasing numbers of admissions per 1,000 population and increasing remoteness of area of usual residence.

So whether you need to include information on hospital separations in a report, provide background on hospital expenditure in a presentation or simply impress your friends with your vast knowledge of Australia's hospitals, check out *Australian Hospital Statistics 2001–02*.

Project 2

Youth health report 2003

The AIHW receives funding from the Commonwealth Department of Health and Ageing to monitor child and youth health and wellbeing. This work involves developing indicators of child and youth health and wellbeing and reporting on these indicators nationally. In late 1998, the Institute released a report on children's health and in early 2000 a report on youth health. A report on *Australia's Children: Their Health and Wellbeing 2002* was released in May 2002. A companion report Australia's *Young People: Their Health and Wellbeing 2003* will be released towards the end of this year. This publication reports on health and wellbeing indicators for young people aged 12–24 years. It includes information on various aspects of young people's health and wellbeing, such as risk and protective factors (including diet and nutrition and sexual behaviour), general health and wellbeing, injury (including transport accidents), mental health problems and disorders, substance misuse and disorders, intentional self-harm and suicide, reproductive and sexual health, chronic diseases and communicable diseases. Some indicators of young people's social, cultural and economic environment are also included in the report covering the areas of the family environment, relationships and social participation, education, employment and income, crime and justice and housing and homelessness.

Project 3

Institute tackles 'big' issue

Many things are getting better about Australia's health in recent times, as we all know. But one thing certainly isn't. And it's finally receiving some of the attention it deserves. It's of course our epidemic of overweight and obesity.

It's not just Australia's epidemic either. Information from the past couple of decades shows that we are caught up in the rapid worldwide trend of becoming fatter and fatter. It's a problem affecting Australians of all ages, from very young to very old. The latest figures show that one in six carry so much weight that they're obese and about half of our adults weigh too much. Among Australian children and adolescents, up to a quarter are now too heavy and the proportion rated as obese more than tripled between the mid-1980s and the mid-1990s.

Given this picture, urgent public health action is needed. And to support that action we need information as always. That is where the AIHW comes in.

The action front includes summits held by several state governments over the past year or so. It has also led to the National Obesity Taskforce being set up (see box). On the information front, the AIHW can continue to play a vital national role. It is doing this in numerous areas and across two of its Divisions.

Take obesity among older Australians, for example. While there are very good reasons to focus on prevention among the young (as the National Obesity Task Force is doing), we also need to keep a weather eye on the weight of people at the other end of the life course. There's a strong link between excess weight and a range of chronic health problems that continue into older age—diabetes and joint problems being just two examples. We have a potentially serious problem when we combine this fact with the unprecedented ageing of the population that will continue for decades. The Institute's Ageing and Aged Care Unit plans to issue two reports that examine obesity trends in this context and also the likely health, economic and social consequences.

At the same time, the Cardiovascular Disease, Diabetes and Risk Factor Monitoring Unit is working to answer equally important questions across a wider range of adult and younger Australians. For example, just how widespread and how fast and how continuing is this overweight trend in Australia? If it affects virtually everyone this reinforces the need for broad preventive measures along with any special targets. If some groups are markedly more affected than others they may need to be the subject of a special focus. And how do the bodyweight trends relate to trends in physical activity and the amount and types of food we're eating? Are there any groups who are not getting fat and what might we learn from knowing this? Over the coming year, the unit is producing several bulletins and fact sheets on topics such as these.

A lot of activity for a 'large' issue!

National Obesity Task Force

The problem of obesity has been recognised at a high policy level—late in 2002, the Australian Health Ministers' Conference agreed that obesity is a significant public health problem in Australia which could jeopardise the health gains made over the last century. Hence the National Obesity Task Force, set up under the Australian Health Ministers' Advisory Council. Its brief is to produce a national action plan for tackling overweight and obesity, with a final report due at the end of 2003.

The main aim is prevention, so the Task Force has decided to focus on obesity in children. Faced with such a huge task it aims to work with key partners across the many sectors of society that can help shape how much energy we use up each day and how much we take in through our food.

project reports

Project 4

Commonwealth–State Housing Agreement national reports

Reports covering all six program areas of the Commonwealth–State Housing Agreement (CSHA) for 2001–02 were recently released by the National Housing Data Agreement Management Group (NHDAMG) and the AIHW. Programs funded under the CSHA are designed to help people whose needs for appropriate housing cannot be met by the private market alone. The reports cover government assistance provided under the CSHA to low-income households and include data for all household tenure types.

The reports show that public and community housing are being increasingly targeted to low-income households that have additional needs that cannot be met by the private rental market. At least 354,400 households received assistance through mainstream public housing and Aboriginal Rental Housing Program state and territory owned and managed Indigenous housing during 2001–02, representing 6% of all households. In addition, CSHA community housing assisted about 29,000 households with rental housing.

The number of community houses in Australia is small—representing less than half of 1% of all housing tenures.

The CSHA also provided 3,258 dwellings for emergency accommodation at 30 June 2002 under its Crisis Accommodation Program (CAP), while spending $41 million on additional dwellings or new constructions. Governments, churches and other welfare organisations use CAP-funded dwellings to assist people in situations of actual or impending crisis or homelessness. Support services to these households are provided directly by health and community services organisations, and the national Supported Accommodation Assistance Program.

Almost 37,000 households were newly allocated public housing during 2001–02. Of these 44% were to households who had 'special needs'. These are often people who have difficulty accessing appropriate accommodation in the private rental market because of discrimination or in the case of people with disabilities, lack of appropriate housing to suit their needs.

Of the new households allocated public rental housing in Australia from 1 July 2001 to 30 June 2002, 3,500 allocations were made to Indigenous households, representing 9.5% of all new allocations. Similarly, 3,000 of the 20,600 new households provided with community housing under the CSHA during 2001–02 were to Indigenous households, representing 15% of all new households assisted. More than 1,700 Indigenous households were newly allocated housing under Aboriginal Rental Housing Program state and territory owned and managed Indigenous housing in 2001–02.

In the private housing market, the related data reports show that approximately 202,000 Australian households received assistance during 2001–02 with home purchase or private renting through the CSHA. Over $600 million was provided for home purchase assistance, while $80 million was spent on private rent assistance. Home purchase assistance is usually provided as a loan, not a grant.

Home purchase assistance provided by the states and territories under the agreement included $586 million in direct lending, $1.8 million in deposit assistance, $10.5 million in interest rate assistance, and $1 million in mortgage relief.

Of the $80 million spent on private rent assistance for 153,000 households across Australia, $46 million was in the form of loans for rental bonds, while $28 million was for rental assistance. In addition, over $1.8 billion was provided by the Commonwealth through Centrelink in Commonwealth Rent Assistance payments.

Copies of the CSHA reports are available from the AIHW web site: www.aihw.gov.au

For more information on the CSHA reports or other housing information issues, please contact David Wilson, ph. (02) 6244 1202 or e-mail david.wilson@aihw.gov.au

data speak

GRIM Books

Ever wanted to access mortality information for a specific cause of death? Now you can, using the GRIM Books (General Record of Incidence of Mortality).

The GRIM Books are a collection of dynamic and interactive workbooks comprising cause-specific Australian mortality information for the most recent years (to 2001) and historically to 1907 for many causes of death. For over 150 causes, features added functionality and an interactive mechanism, enabling the user to set limits on the data (for example by age groups and years) for analysis. Each workbook contains comprehensive user information and notes on data source and methods.

GRIM Books present mortality data indexed by year, sex and five-year age groups for a specific cause, or a combination of causes mapped to the International Classification of Diseases Version 10 (ICD10). The workbooks, built in Excel, contain deaths and population data, which allow the user to manipulate the data in many ways. Graphs and tables are available and can easily be copied into documents. Data are included subject to availability, with some workbooks beginning in 1907. The workbooks are updated annually upon the release of mortality data from the ABS.

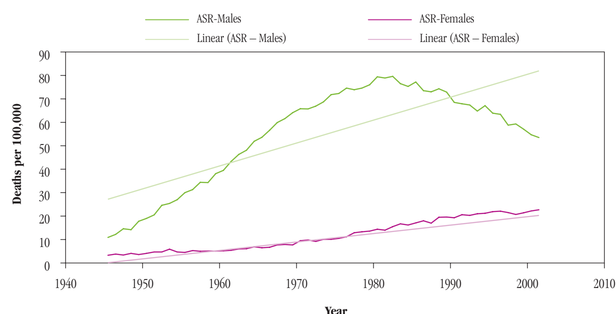
Cause-specific mortality information is presented in multiple ways: deaths (total deaths, median age at death, percent of all causes, percent of ICD10 chapter causes and PYLL — potential years of life lost) and death rates (age-specific and age-standardised, male:female ratio and lifetime risk of dying). GRIM Books also turn the data around and examine mortality by five- and ten-year birth cohorts. The workbooks include graphs featuring cause-specific trends in death rates (comparing the pattern against all causes of death), number of deaths and age-specific rates and deaths and death rates for five- and ten-year birth cohorts.

A new addition to the GRIM Books is an interactive feature, enabling the user to generate summary tables. Version 6 comprises five tables — summary measures (for example mean age at death, and lifetime risk of dying), average annual rates of change, aggregated age-specific rates, risk of dying and PYLL. Users drive the tables by specifying the year(s), age group(s) and a population standard to their requirements.

Other features include colour coding according to ICD version, notes relating to classification, and where applicable, a comparability factor to facilitate comparison of ICD9 (1979–96) and ICD10 (1997 onwards) data.

GRIM Books are available, for a small charge, for over 150 specific causes and combinations of causes of death. Two examples (All causes combined, and Lung cancer (see illustration) are available free of charge on the AIHW web site (www.aihw.gov.au/mortality under 'What's new and interesting'). A list of available diseases can also be found on the web site. To order GRIM Books, or for technical information, please contact mortality_info@aihw.gov.au.

GRIM Books are a useful data resource to get some summary information quickly, but should be used with the notes about the ICD versions, and generally with the attention to some of the detailed data available. For example, 'lung cancer deaths between 1950 and 2000 for males increased' is a conclusion that can come from the summary data, if you don't look at the graph or the spreadsheet with all the data.



Summary measures of mortality

1. Select a year

(Data available for 1945 to 2001)

1995
1996
1997
1998
1999
2000
2001

Total deaths, ASR, Male:female ratio, Mean age at death, % ICD10 Chapter Causes, % All Causes, PYLL(75), PYLL (75) rate, % Total PYLL and Lifetime risk for Lung cancer (ICD-10 C33, C34) in Australia, 2001.

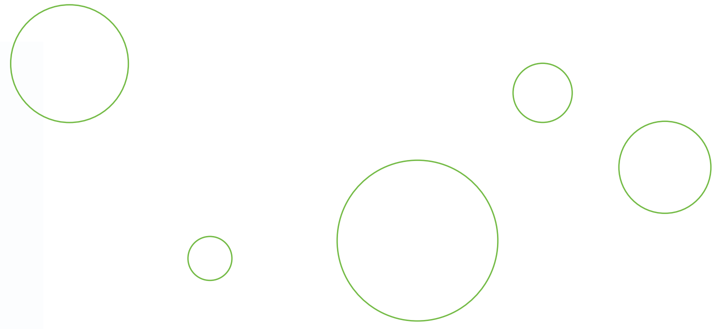
	Total Deaths	ASR [1]	Male: Female Ratio	Mean Age at Death	% ICD10 Chapter Causes	% All Causes	PYLL (75)[2]	PYLL (75) Rate [3]	% All Causes PYLL	Lifetime Risk of dying [4]
Males	4,642	53.5	2.4	71.1	22.0%	6.9%	28,848	3.1	< 0.1%	1 in 27
Females	2,396	22.7		70.8	14.6%	3.9%	16,203	1.8	< 0.1%	1 in 57
Persons	7,038	36.2		71.0	18.8%	5.5%	45,050	2.5	< 0.1%	1 in 37

Notes

Please refer to the User information page for notes on the methods used.

1. ASR is the age-standardised mortality rate per 100,000 population using the Australian Standard Population 2001.
2. The PYLL measure used here uses an arbitrary limit to life of 75 years.
3. The PYLL Rate is expressed as the years of life lost per 1,000 population.
4. The lifetime risk of dying is calculated here for ages 0 to 74.

.. Not applicable



Double-Jeopardy in childhood disabilities

DENNIS HOGAN, BROWN UNIVERSITY

All studies of children, youth and families would benefit from the inclusion of information on disability. This recommendation was the focus of a discussion on the survey measurement of childhood disability by Dennis Hogan, in a May 2003 meeting at AIHW. Hogan, the Robert E. Turner Distinguished Professor of Population Studies at Brown University, has been developing methods for the survey measurement of disability in children.

Hogan was in Australia to work with his colleague Peter Brandon, a Visiting Fellow in Demography at the Australian National University. The meeting at AIHW was the first of what we hope will be many meetings to exchange ideas, compare data and methods, and to compare findings. We hope that these contacts and exchanges may ultimately lead to the development of collaborative work.

Hogan has worked with an interdisciplinary team of collaborators (sociologists, economists, medical doctors and demographers) over the past ten years to develop a comprehensive population-based portrait of children with disability. This research has used the new World Health Organisation's International Classification of Functioning, Disability and Health (ICFDH) to capture the various aspects of disability in children. In the ICFDH, health condition is an umbrella term for disease (acute or chronic), disorder, injury or trauma. Disability is an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environment and personal factors). Most large government-sponsored surveys of health have historically concentrated on the measurement of illness and disease (impairments), access and use of medical services, and unmet needs for medical care. Limitations in activity and participation are dimensions of disability for which demographic data collection and analysis of population surveys are particularly appropriate. There is a long tradition of measuring limitations in activities of daily living among the elderly; Hogan shows that it is equally important to measure limitations in activities and participation to understand disability among children, and to assess its implications for successful child development.

Hogan reported on new population-based survey methodologies for the measurement of disabilities among children, with regard to mobility, self-care, communication, and learning and behaviour, during his visit to AIHW. An important component of this research is the finding that only a handful of questions is adequate to measure these dimensions of disability. More specifically, he recommends for use in general population surveys a concise set of survey questions worded similarly to the following:

- Does R have any trouble seeing, even when wearing glasses or contact lenses?
- Does R have any trouble hearing what is said in normal conversation, even when wearing a hearing aid?
- Does R have difficulty communicating so that people outside the family understand?
- Is R limited in his/her ability to walk, run or play?
- Does R have difficulty learning how to do things that most people of the same age are able to learn?
- Does R have significant problems at school with paying attention in class?

Recent work using these survey-based methods has focused on the use of medical care and rehabilitation among children with impairments and limitations in activities. The occurrence and severity of disabilities vary systematically according to social and demographic characteristics of families (especially race and ethnicity, and migration status). Families with children with disabilities report a variety of types of distress—sleep deprivation, changes in work to meet specialised child care needs, and major financial loss. Yet most families are fairly resilient, adaptating to the challenges posed by a child with a disability. In the United States, these problems are more severe than in Australia because of its limited provision for childcare for children with disabilities and the expectation that mothers (including single mothers) will work to support their families. Parents in America face the need for intensive time-use to mobilise a fractured system of medical, rehabilitation and social services. Hogan has shown that well children who have a sibling with a disability are considerably less likely to receive routine medical, dental and vision care.

Disabilities in childhood create a double jeopardy to successful youth development that is linked to the disability itself and to the less advantageous family and socioeconomic resources of households containing a child with a disability. Young persons with disabilities face a variety of challenges in becoming fully participating members of adult society. In the United States, the school-to-work transition and obtaining a place of independent residence are particularly difficult. Hogan and colleague Brandon suspect that the situation in Australia is somewhat different because of its well-established post-secondary vocational education and training system.

Hogan reported, 'I greatly enjoyed my visit to AIHW. The exciting and diverse research activities, and the friendly and knowledgeable staff, made my meeting especially interesting and productive. I hope that we can continue to meet and exchange ideas, and that members of AIHW will be able to visit Brown University in the not too distant future'.

Dennis Hogan,
Brown University

web insite

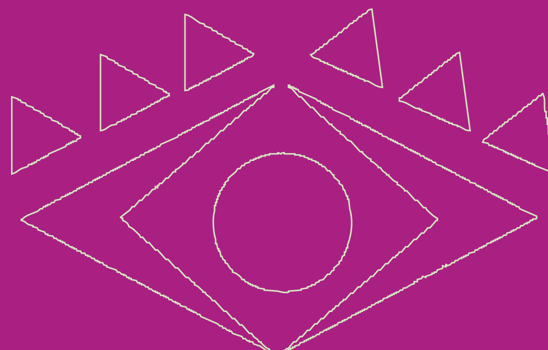
Our cubes are multiplying!

For those not familiar with the cubes on our web site — these are multidimensional representations of data which let you drill down to the statistics YOU want without having to download large publications from our website. All you need to use our cubes is your web browser (Internet Explorer or Netscape Navigator) — no extra software is required.

The addition of several new expenditure cubes (http://www.aihw.gov.au/expenditure/datacubes/index.html) has brought to approximately 40 the total number of data cubes on our website. The new cubes cover welfare services expenditure by state and national government and by non-government community services organisations.

Also new in our Data Online portal are three cubes containing data from the Alcohol and Other Drug Treatment Services National Minimum Data Set (http://www.aihw.gov.au/drugs/datacubes/index.html) — these provide statistics on treatment services and client demographics.

HINT:
For regular users of our data cubes — please do not bookmark a specific cube page in your browser, as we refresh the cubes as new data come to hand. To ensure you always find your way to our latest data, bookmark the Data Online page (http://www.aihw.gov.au/dataonline/index.html) and navigate to your cube of choice from there!



the driving force

National Community Services Information Management Group (NCSIMG)

The National Community Services Information Management Group (NCSIMG) has embarked on a new phase of its life, holding its first meeting with Dr David Filby as Chair. The meeting, held over two days in July, covered both retrospective as well as prospective aspects of the work of the Group.

Leaders of NCSIMG work program project teams reported to Group members about the status of those projects. Those projects are:

- a final report on Statistical Data Linkage in Community Services Data Collections. The original report was endorsed by the Community Services Ministers' Advisory Council in March 2002 and was distributed for consultation and comment. NCSIMG endorsed the updated report, which incorporates comments received, including those from the Office of the Federal Privacy Commissioner, for publication and distribution as a resource to inform consideration of data linkage in the sector. Please contact the Secretary, NCSIMG if you want a copy of the final report;
- an extensive program of work of the National Community Services Data Committee, including preparation of Version 3 of the National Community Services Data Dictionary;
- projects relating to the development of national minimum data sets for juvenile justice and for children's services;
- an extensive program of work of the National Child Protection and Support Services Data Working Group;
- projects to support Aboriginal reconciliation;
- a draft report, prepared by the AIHW, on the data quality of Indigenous identification in seven community services data collections;
- development of a website-based resource providing information on ways of improving the identification of Aboriginal and Torres Strait Islander people in administrative datasets;
- scoping work regarding the development of national outcome indicators for community services.

The NCSIMG has now completed the priority tasks identified in its National Community Services Information Development Plan (available on the NCSIMG web page at: http://www.aihw.gov.au/committees/welfare/ncsimg/publications/ncsidp.pdf). Group members suggested projects for inclusion in a future work program; comments on the draft work program will be sought in a range of consultations with interested parties. It was particularly valuable to have David Filby lead that exercise. David was inaugural Chair of the National Health Information Management Group and strongly supports current processes to more closely link the work of the two Groups.

David, who, at the request of the Community Services Ministers' Advisory Council (CSMAC), is reviewing the National Community Services Information Agreement, also led a healthy discussion and debate among management group members regarding the scope and shape of a future Agreement. David has already consulted with representatives of CSMAC and will hold further consultative meetings to inform the report he is preparing on the review.

For further information contact Margaret Fisher, Secretary, NCSIMG (margaret.fisher@aihw.gov.au).

force

National Housing Data Agreement Management Group (NHDAMG)

In June 2003 the Commonwealth and the states and territories signed the new five-year Commonwealth–State Housing Agreement (CSHA). The new Agreement is designed to provide strategic directions and funding certainty for the provision of housing assistance across Australia in the five years from 1 July 2003. The new CSHA consists of a multilateral agreement accompanied by bilateral agreements between the Commonwealth and each state and territory. The bilateral agreements allow each jurisdiction more flexibility in delivering housing assistance according to priorities and circumstances.

The multilateral agreement specifies the guiding principles, funding arrangements and operating procedures. It also specifies an outcome measurement framework based on bilateral information and a core set of nationally consistent indicators and data. Like the previous CSHA signed in 1999, the new Agreement includes the National Housing Data Agreement (NHDA) as a subsidiary agreement to the CSHA. Under the NHDA, the Commonwealth and states and territories will provide data as specified under the Data Agreement, according to agreed standards, and will provide funding for data management and other purposes

The new CSHA includes Indigenous housing in a broader way than previous Agreements and should facilitate a closer alignment between mainstream and targeted housing assistance data requirements.

This work on national housing data development, management and reporting is coordinated by the National Housing Data Advisory Management Group (NHDAMG). The Institute is the secretariat for the NHDAMG, the National Housing Data Committee and the National Indigenous Housing Information reports.

Under the new CSHA the NHDAMG will work more closely with national policy and research groups to ensure expertise and skills are effectively utilised. The development of common approaches across the CSHA and related programs to defining and measuring need, alignment of national reporting requirements and the use of common standards will continue.

For more information on the NHDAMG or other housing information issues, please contact the head of the Housing Assistance Unit at the AIHW, David Wilson, ph. (02) 6244 1202 or e-mail david.wilson@aihw.gov.au

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Dental Statistics and Research Unit

There are about 446 million teeth in Australia, an average of more than 20 for each man, woman and child in the nation. Based on those numbers, you might think that quantifying the country's state of dental health would call for at least 20 organisations equivalent in size to the Australian Institute of Health and Welfare. Miraculously, the task is achieved by a dedicated group of 11 people who work in AIHW's collaborating unit, the Dental Statistics and Research Unit (DSRU).

Established in 1988, DSRU is housed in South Australia at The University of Adelaide. DSRU aims to improve the oral health of Australians through the collection, analysis and reporting of information on oral health and access to dental care, the practice of dentistry and the dental labour force in Australia. There are numerous features of population oral health and dental care that challenge the dedicated crew at DSRU. Following are three examples of the spirited conversations going on around the corridors in Adelaide. (To learn more, check out DSRU's publications at http://www.arcpoh.adelaide.edu.au)

Conversation stopper no. 1
Dental enamel is the hardest tissue in the human body, but it can be destroyed within a matter of months by decay.

To keep track of this destructive process, DSRU manages the Child Dental Health Survey which collects information about decayed, missing and filled teeth among 80,000 school children annually. Data have been collected annually since 1977 during which time children's decay rates have halved in the deciduous dentition ('baby teeth') and reduced by 80% in permanent teeth.

Conversation stopper no. 2
So you need a dental visit?

Dentistry has never been included in Medicare. Consequently, more than 60% of the $2.6 billion spent annually on dental care is paid out of pocket and 16% is funded by governments, predominantly the states and territories. About 60% of Australians visit a dentist for a check-up; the remaining 40% go only when they have symptoms. State/territory public dental programs for adults limit eligibility to those who have a health care card or pensioner health care card and have lengthy waiting lists. In South Australia, for example, it takes three years to get an examination for general dental care. Forty-one per cent of adults who attend public clinics with symptoms receive an extraction, compared with 5% of adults who attend a private dentist for a check-up. The problems are worsening, in part because of a growing shortage of dentists in both the private and public sector. Within the capital cities, there are nearly 60 practising dentists per 100,000 population; outside capital cities, the ratio is almost halved.

DSRU has tracked trends in the practice of dentistry, especially productivity and service-mix in private general practice, for 15 years. These data, along with registration data on dental providers, inform projection models on dentistry's capacity to supply services to the Australian population in an effective and efficient manner. DSRU monitors dental visits through its biennial National Dental Telephone Interview Survey. Since 1994, five surveys of approximately 6,000 people per survey have been conducted from DSRU's Computer Assisted Telephone Interview laboratory at The University of Adelaide.

Conversation stopper no. 3
Water fluoridation is one of the five greatest public health achievements of the 20th century.

This year celebrates the 50th anniversary of Australia's first venture into community water fluoridation in Beaconsfield, Tasmania. Today, two-thirds of the Australian population lives in communities served by fluoridated water. DSRU has been at the forefront, internationally, of studies evaluating the effects of fluoridation nowadays in child populations where decay rates are dramatically lower than the levels found half a century ago. In a 1992–93 study of 20,000 children in Queensland and South Australia, DSRU researchers demonstrated clear benefits of community water fluoridation in reducing levels of decay and in reducing socioeconomic inequalities in dental decay. A new study is now underway to update those findings, and will involve 50,000 children in Victoria, Queensland, South Australia and Tasmania.

Aside from these research interests, DSRU conversations have been buzzing with a new acronym: ARCPOH. The Australian Research Centre for Population Oral Health

(ARCPOH) is a research centre formed within the University of Adelaide in 2002. ARCPOH is an umbrella for four main research endeavours, the most prominent of which is DSRU. Alongside DSRU are two academic areas (Oral Epidemiology and Social and Preventive Dentistry) and the Dental Practice Education Research Unit. This administrative arrangement creates new opportunities for collaboration (for example, by offering a broader range of research participation in surveillance activities) while also permitting differentiation between DSRU reporting activities and broader policy analyses that fall outside the DSRU workplan.

The Dental Statistics and Research Unit (L to R)
Loc Do, Kaye Roberts-Thomson, David Brennan, Lorna Lucas, Dana Teusner, Gary Slade, Anne Sanders, John Spencer, Jane Harford, Judy Stewart (absent), Jason Armfield (absent)

Who's who at DSRU

In 2003, Gary Slade became head of DSRU. He has returned to Adelaide as Professor of Oral Epidemiology following eight years at the University of North Carolina in the United States, prior to which he was consultant oral epidemiologist to DSRU from 1988–94. Gary undertook dental training at The University of Melbourne and completed a postgraduate Diploma in Dental Public Health at The University of Toronto, Canada. He obtained a PhD in dentistry at The University of Adelaide studying oral health related quality of life among elderly South Australians. Gary teaches oral epidemiology and dental public health in undergraduate courses and he supervises graduate students in Master of Public Health (MPH) and PhD programs at the university. He provides dental treatment to patients in the South Australian Dental Service.

John Spencer is the Professor of Social and Preventive Dentistry at The University of Adelaide and Director of ARCPOH. John established DSRU in 1988, at which time it comprised two staff. In the following 15 years it grew to become a leader among the handful of dental statistics units around the world. John trained in dentistry at The University of Melbourne and completed a Master of Public Health degree at the University of Michigan, USA. He obtained a PhD from The University of Melbourne, studying contribution of fluorides to dental health in the Australian population. He is Associate Editor of Community Dentistry Oral Epidemiology, International Adviser to Community Dental Health and on the Editorial Advisory Board of the Australian Dental Journal. John teaches dental public health and dental health services research in undergraduate courses, and supervises graduate students in MPH and PhD programs at the university.

David Brennan, who joined DSRU in 1988, has worked on a range of projects involving both cross-sectional and longitudinal analysis of dental service provision such as the Longitudinal Study of Dentists' Practice Activity. Trained as a biologist, his PhD research involved investigating the influence of provider, practice and patient factors on variation in rates of service provision. More recently he has been investigating burden of disease estimates in dentistry, and trends in oral health among adult public dental patients.

Judy Stewart has worked with DSRU since 1991 on issues involved with access to dental care among special target groups compared with the general population. She has been closely involved in the National Dental Telephone Interview Surveys and the Dental Satisfaction Surveys. Her research interests are oral health and access to dental services of young adults, rural and remote dwellers and migrants.

Lorna Lucas provides administrative support to the research and academic staff of DSRU where she has worked since 1992. She is involved in the production of reports and in maintaining DSRU and ARCPOH projects. Lorna has the most prominent face and voice in DSRU, serving as first point of contact for all DSRU and ARCPOH enquiries.

Since 1997, Jason Armfield has been responsible for the analysis and reporting of the Child Dental Health Survey. He has also been involved in the Child Fluoride Study, a large multi-site study into the effectiveness of fluoridated water consumption in reducing dental caries in children. Jason has an undergraduate degree in psychology and currently he is undertaking a PhD investigating the aetiology of dental fear.

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spotlight

on Fadwa Al-Yaman

A love of challenges and intellectual 'restlessness' have driven Fadwa Al-Yaman's career since her graduation from Kuwait University. These qualities have also helped her gather first-hand experience in an extensive number of fields—an excellent foundation for her recent appointment as Head of the AIHW's new Aboriginal and Torres Strait Islander Health and Welfare Unit.

Born in East Jerusalem in Palestine, Fadwa did her schooling in Kuwait. After graduating with a BSc in zoology from Kuwait University, then a new institution with many American and British lecturers, she was encouraged by her teachers and her father to apply for overseas scholarships.

'My father was my biggest mentor, always encouraging me to do further studies. There is a big emphasis on education among Palestinian people who cannot return to the country they were born in.'

An Australian National University scholarship brought Fadwa to far-away Australia, to do a PhD in immunology, a particular interest of hers, at the John Curtin School of Medical Research. Fadwa's work focused on skin cancer in sheep. It is not well known that large numbers of Australian sheep suffer from skin cancer on the face and on more delicate parts of their bodies. Fadwa's research was to try to find if sheeps' immune systems can respond by producing antibodies. When offered the opportunity to work on sheep, Fadwa was unaware that it involved wrestling with large merino wethers that were about a metre tall at the shoulder — she regularly had crushed toes as she struggled with the sheep to gain control!

With her PhD completed, Fadwa took up a position as a lecturer in Yarmouk University near the Syrian border. A number of fascinating projects followed, including research on the immunological aspects of hydatids that involved spells of fieldwork in Kenya and a visit to the Tropen Institute in Hamburg, and the development of an anti venom to stonefish venom in the Gulf of Aqaba.

Unable to continue her work on cancer in Jordan, Fadwa won a fellowship to work in the UK, where she again worked on cancer and carcinogenesis at Patterson Laboratories, Christie Hospital, in Manchester. She returned to Jordan for further lecturing, the establishment of an immunology laboratory and a Masters program.

Conscious that she had to get experience in the rapidly developing field of molecular biology, Fadwa travelled to the USA on a one-year Fulbright scholarship to work on bovine cysticercosis (a type of parasitic worm infection), where a team at the US Department of Agriculture in Maryland developed diagnostic tests using recombinant DNA technology.

'We actually applied for a patent, but I'm not sure if it was ever given because I can't find it on the US Patent Office's web site. For a while I thought I might make my fortune, but no such luck.'

At the end of the Fulbright scholarship an excellent opportunity presented itself. This was to work on a malaria vaccine in Papua New Guinea—the PNG Institute of Medical research had received a US$7 million grant to set up a site for testing a malaria vaccine for children, with 10,000 local residents in a survey population. Fadwa established a field laboratory in Maprik and was involved in large sero-epidemiological surveys among children and adults in villages in the heavily populated Wosera area, where malaria was endemic. She and other team members carried out the safety and immunogenicity work that had to be done on adults, before the vaccine could be trialled on young children.

Fadwa stayed in PNG for four years.

'It was a life-changing experience I would recommend to anyone. Working with people who have so little in terms of material possessions, and yet are so happy with their lives, certainly made me reconsider my life values.'

'It was a very exciting time dodging hold-ups on the main road, and putting four-wheel-drives through bridges or into bogs along the village tracks.'

'There was also the opportunity to work with scientists from the Swiss Tropical Institute, the Walter and Eliza Hall Institute of Medical Research and the Queensland Institute

of Medical Research. The first vaccine was going to be an American one, but in the end we trialled an Australian vaccine for children, rather than one for American soldiers.'

While in PNG, Fadwa met her Australian husband, who was doing fieldwork for the ANU and came to the Institute at Madang to present a seminar. Fadwa was running the seminar program at the time. After some time commuting in both directions, and two children later, Fadwa came to Australia in 1995 and applied for an NHMRC grant to continue work on the PNG material.

'I did that for three years, but the best work on malaria in Australia was not being done in Canberra, and to get further grants I needed to be in Melbourne or Brisbane. I made several return visits to PNG during the vaccine trial on the children, including one visit that the whole family went on for three months, to complete the last stage of the trial in 1998. So I decided to change direction and enrolled in a Masters in Demography at the ANU.'

Shortly after graduating, Fadwa joined the Population Health Unit at the AIHW. 'I was familiar with the work of the Institute before I came to work here, and I always thought that the AIHW was making a difference in a variety of health and welfare fields, so I was excited about the opportunity to participate in its work. I felt that my medical background, infectious disease and epidemiological experience, statistical skills, and the demography course, would help me in doing that.'

Fadwa worked briefly on diabetes before moving to the then Children and Families Unit. Her first project there was to develop a questionnaire to collect data on childcare and preschool services for the National Minimum Data Set. When the Unit acquired responsibility for youth health, Fadwa concentrated on child and youth health indicators and produced two AIHW reports on child and youth health and welfare.

'After working on these projects for two-and-a-half years, I was ready for a new challenge. I am full of enthusiasm about heading the new Unit, because so much needs to be done in the Indigenous health and welfare areas.'

'The goal is to improve the health and welfare of Aboriginal and Torres Strait Islander peoples. To this end we need to engage both Indigenous and non-Indigenous Australians in an effort to improve the quality of data on the health and welfare of Indigenous Australians and use best practice from other areas.'

'Accurate and timely data can provide the evidence to inform policy and can be an advocacy tool for Indigenous people to influence and shape policy outcomes. The AIHW can play a central role in this process and can become a clearing house for Indigenous data, providing advice on the data and its usage, and identifying trends.'

'One of our immediate priorities, however, is to establish and maintain relationships with our major stakeholders, including the National Aboriginal Community Controlled Health Organisations, the Aboriginal and Torres Strait Islander Commission, the Australian Institute of Aboriginal and Torres Strait Islander Studies, and the Office of Aboriginal and Torres Strait Islander Health in the Department of Health and Ageing. There are also the state and territory governments, the Commonwealth Department of Family and Community Services, the Australian Bureau of Statistics, and many research and academic groups.'

The Unit will also play a central role in coordinating the Indigenous work across the AIHW and its collaborating units. Regular reports are planned, including bulletins on selected topics, and the 29 August launch, with the ABS, of the latest biennial reports on the health and welfare of Aboriginal and Torres Strait Islander peoples (see article on page 1).

Fadwa says it is clear to her that the loss of land and livelihood that Aboriginal people have suffered in the past are important determinants of their health status today.

'I have personally experienced loss of my home and my country, and I know how frustrating and angry that situation can make you. I was lucky to get a good education and to get out, but many Palestinians remain trapped in the refugee camps in Lebanon and Jordan, with serious implications for their physical and mental health, and their wellbeing.'

'My new position has a very steep learning curve. It involves working with the many existing interest groups at the national and state and territory levels, as well as with the bodies that represent Aboriginal and Torres Strait Islander people.'

'Meetings are held all over Australia so I have the opportunity to read as much as I can on the long plane journeys. I've started with Stuart Harris's little book on an Aboriginal treaty that I found in a second-hand bookshop at Belconnen. It was written in 1979!'

'We have a way to go yet. I hope I can help to move things along a bit.'

Here's to your (version of) good health

Who's healthy?

A picture of health, is Darryl. He radiates fitness. Decked out in the latest Lycra suit, astride his bike, drink bottle to mouth. If that were Gatorade he was drinking, they could put him in an ad for the stuff.

Darryl is the bike club's best rider at 40. He has never smoked and is only a light drinker. He keeps to a varied and low fat diet and always checks out perfectly with his regular health screening as prescribed to guard against what we call risk factors--high levels of blood pressure, blood cholesterol, body weight etc. Not to mention his full sun protection measures and safe driving practices. With his amount of physical activity, he's a rare egg. Close to 60% of Australian adults don't even have enough to get a health benefit from it.

The picture gets better. Darryl has never missed a day's work in the high powered job that he thrives on. Illnesses bounce off him and if he ever starts to get a cold, which is once every few years, he shakes it off within a day. And he is mentally strong. Even when his sister died in a freak accident he grieved, he wept, but he didn't stop. He coped so well that the rest of his family felt they could turn to him when it got too much for them.

And the story goes even further. Darryl comes from a very long living line. His mother's parents are still alive in their 90s and his father's dad died recently aged 91, leaving a widow of the same age.

But healthy is not how Darryl sees himself. At least not at this moment on his bike. 'I've been a bit off the pace lately'.

'Off the pace?'

'Yeah, I'm way below my PB for the 40k ride. My pulse rate's up a bit to 50 and my recovery rate's poor. Checked out my Vo2max the other day and it was below par. Think I might be coming down with something.'

So that's Darryl's version of truly good health. Could it be that he's read the World Health Organization's definition of health as 'a state of complete physical, mental and social well being and not merely the absence of disease or infirmity'? The cynical reader may assume that's the kind of state we can only think we're reaching at Nimbin. Others may feel it's the only test we can stand by.

This raises questions about what we mean by the term healthy, how we measure good health and the standards we set for it.

So who's truly healthy?

To explore this more, let's look at some of Darryl's friends.

First there's Craig, aged 55 and a fellow club member. He's not a star like Darryl but he looks after himself pretty well. He doesn't get sick very often and he too comes from a healthy line of people. He's slightly on the heavy side but then about 60% of adults weigh too much, with over 20% being obese. Craig's real worry is that his cholesterol has been up for a year or so. Very up, actually, and though he chose to start on a healthy diet and stuck to it he'll probably have to go on to tablets now as well. (You might say he's in good company because about 50% of Australian men and women have cholesterol levels that can be regarded as high and at least in need of a better diet.)

Is Craig healthy, then? Although he feels and functions fine like Darryl, he has a problem that just might be blocking up his arteries badly.

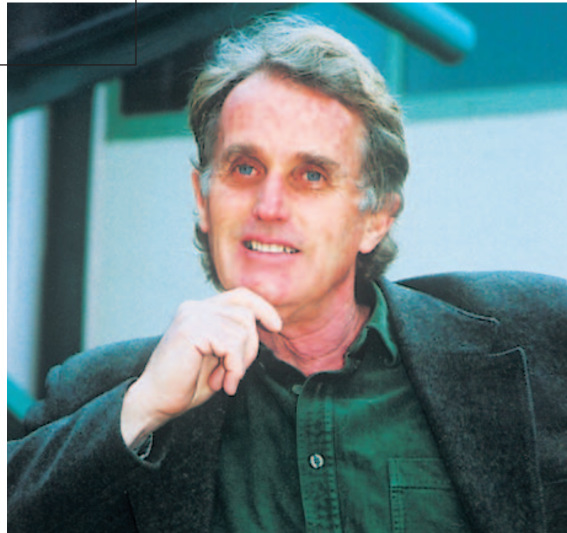
Darryl's old classmate Sally-Anne is another story. She's not into bike riding like the other two and admits she's not as fit as they are. For her, life is short for all of us no matter how you look at it. She likes to party and doesn't believe in taking herself too seriously: 'I don't like to stress or obsess too much.' But she walks for an hour every day, doesn't have a bad diet, almost always feels healthy and passes her health checks with what she calls flying colours. And she really does seem happy.

Pity she smokes. Like close to 20% of adults and almost a quarter of other women in their twenties.

Can we say Sally-Anne is healthy? Unlike with Craig, basic checks don't show that her system has a problem yet. She may be one of those rare smokers that seem to have no symptoms. But it depends on how closely we can look. Some tests like that for blood cholesterol can be done with little fuss. The picture may look very different if we viewed the insidious damage being done by what's in the cigarette smoke to Sally-Anne's mouth, gullet, lungs, her arteries everywhere and the organs they supply.

Then there's Darryl's partner Joelene. She's been a gold medal

Dr Paul Magnus,
AIHW Medical Adviser



winner in swimming and has a similar healthy profile to Darryl. She also has two above-knee artificial legs as a result of a traffic accident when she was ten. But Joelene's so-called problem isn't a problem if you ask her. If told she might be counted in the disability part of a report on the national burden of disease and injury, she would be outraged. So would many of her friends with various disabilities, some with disabilities more marked than her own and who may or may not choose to play sport. Joelene does not have a disease. And although she's had what can be termed a loss of body structure, she lives independently with no help and is able to participate in the full range of areas of life. For her, her problem was a once-only period. History. She has fully compensated for it. She will live to be 100 and feel good with it. In what sense is she unhealthy? Because she doesn't have 'complete' physical functioning in the sense that it would have been better if she had kept her legs? But then if she had, she may well be in worse health now. She might not have become so health and fitness conscious, might she?

And last there is the disturbing case of Kath, who reached only 64. She came through on every score and was renowned for her fitness. She emerged from her last check-up saying her doctor told her she was in top form and would live forever. She played her regular game of squash the next day and dropped dead. An autopsy showed one of her heart's main arteries had been critically blocked. The blocked area had thrown a big clot and her heart couldn't survive the massive and sudden cut to its blood supply.

This tragic story is mercifully rare — especially for a woman her age. But we all know it happens. Kath had never had a symptom, at least not one that anyone knew of. The day before her death, was she healthy when her artery surely wasn't?

So let's summarise the notions of good health embodied in the profiles given here. Except maybe for Darryl himself, most of us would agree that none of our cast is healthier than him in conventional terms. He has no symptoms, good test results and no known behaviours or features that put him at special risk of future illness. If we could check out all his organs and systems we'd find them in top order, with plenty of reserve. He is resilient in body and mind. In short, he *feels and functions well and is in condition to keep doing so for a long time.*

We may not be so sure about cholesterol Craig and smoking Sally-Anne. They aren't necessarily in condition to stay well for so long. There is also a question arising from the case of Joelene with her artificial legs–the notion of 'compensated' good health. And would this extend to someone who takes a medication to replace a deficiency? And further to people taking drugs like blood pressure lowering tablets that don't in any simple way replace a deficiency and can have strong side effects? But in any case, many would argue that Joelene's just as healthy as Darryl.

Finally, how far do we take our concept of what it is to be healthy? What if Darryl and the rest lived in a country that was about to be overthrown and plunged into totalitarian rule? Where they could be shot for saying the wrong thing or merely forced into crowded refugee camps without sewerage or running water. Or what if they all worked in the same company and stood in acute fear of losing their jobs soon in a country that would allow huge inequalities in both wealth and opportunities for education and employment?

Before we can be called truly healthy, do we have to be in an *environment* that's healthy and in a condition to remain so?

A need for personal balance?

Having said all this, are some of us in danger of getting it all out of balance? (Here I'm not talking about the obvious needs of people around the world who are disadvantaged, below par or seriously sick. I probably mean the 'worried well' who tend to write and read pieces like this one.)

It can be a little demanding, can't it? Are we going to make it so hard for anyone to be rated healthy that the word loses its meaning? As technology, other medical science and especially genetics advance, we'll be able to probe more and more secrets of the body and the personal and social factors that affect it. Fascinating stuff for the medical profession. More and more risks will be put in our faces and they'll far outpace the solutions. Still, more and more 'interventions' will present themselves.

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We'll be able to invoke against every risk and screen for every this and that at every age. Maybe we'll be able to calculate that our usual route A to work carries twice the accident risk of route B, even when both risks are actually very small. You could really start to worry about that.

We may well keep living longer and livelier. Few would argue against that hope. But will we also keep raising the bar and worrying? Perhaps you can't be healthy unless you're within a couple of standard deviations of organ and performance PBs every week. Plus, you may need a PELE (**p**ersonal **e**stimated **l**ife **e**xpectancy, given to our parents when we're born) close to that of the highest socioeconomic group, or to our parents or grandparents—whichever is the best. And you may also need a good health EXPLORE score: the **e**xtended **p**ersonal **l**ist **o**f **r**isk **e**stimates, a thousand of them. What a present for our parents on the day we're born!

Is Darryl genuinely healthy in his obsession? Does he have something to learn from the more easy-going Sally-Anne (apart from her smoking habit)? Are some of us using the pursuit of perfect health as a proxy for the order, control and meaning that we feel we need more of in our lives? And even for judging others so we feel superior?

Is it human nature to never be satisfied or is this just another twentieth and twenty-first century epidemic we need to conquer?

A hierarchy of 'healthiness' that we can measure?

To measure 'healthiness' we could first ask ourselves whether good health is:

1. The absence of physical and mental symptoms? This would apply to our entire cast.
2. As for (1) but also the presence of physical and mental vigour? The whole cast again.
3. As for (2) but also with no detected risk factors? Only Darryl, Joelene and Kath, not Craig and Sally-Anne.
4. As for (3) but also with evidence of healthy underlying organs and body systems? Kath and Sally-Anne may not have passed.
5. As for (4) but also living in a 'healthy' and 'health promoting' physical and social environment? Looking good so far for Darryl and Joelene.

If we took something along these lines as a rough guide to the healthy side of health, could we measure the elements to get population levels? That would be very difficult to do fully. Of course the idea of risk and protective factors, known as determinants when applied to populations, has long been used. It is presented in frameworks used by the AIHW and the National Health Performance Committee (NHPC), among many others. And the International Classification of Functioning, Disability and Health (ICF) deals with the concepts relating to people like Joelene, among many others. In other words the ICF can be used as a framework to think about health in terms of structural and functional impairments, activity limitations and/or restrictions on participation. (The International Classification of Diseases (ICD), true to its name, focuses on ill-health rather than on degrees of good health.)

We can regularly measure levels of factors, such as smoking and physical activity, that are covered by self-reports through major national survey programs like the National Health Survey series run by the ABS. But it seems to be another thing to get a similar program going for physical measures, especially blood samples for factors such as cholesterol and glucose. In principle we could obtain physical information that acts as a guide to the health of our lungs, kidneys and liver, for example, with relatively simple breathing, urine and blood tests. But other tests, for example to look at the inner linings of our lungs and arteries, would be unacceptably invasive.

There's also a problem with how we could combine the information about self-reported health and risk factors in a way that is meaningful and not misleading about an individual and hence about populations. For example heart disease risk factors like 'high blood pressure' and 'high blood glucose' are fairly arbitrarily defined by cut-off points. The effect is that such factors do not necessarily carry an equal risk of developing heart disease. It follows that different combinations of risk factors can carry different levels of total heart risk. We are able to say, for example, that in 1995 over 80% of Australian adults had at least one of the cardiovascular risk factors of smoking, high blood pressure, physical inactivity, and excess weight. This gives a very crude guide to the size of the problem for health promotion purposes. But even when we become a little more precise by 'stratifying' the population according to any two risk factors, any three, and so forth, the guide remains crude.

from the Inside

Dental Statistics and Research Unit

Continued from page 13

Kaye Roberts-Thomson has been a member of the DSRU since 1998. She works on oral health of Aboriginal and Torres Strait Islanders, oral health and access to dental care of young adults and oral health indicators. Kaye graduated in dentistry from The University of Melbourne, and received her Master of Public Health from The University of Adelaide.

Dana Teusner has been with the DSRU since 1999 and has worked principally on dental labour force research projects, collections, and publications.

Loc Do, a recent member, is a dentist trained in Vietnam. Loc undertook the analysis of the East Timor National Oral Health Survey 2001, a contracted project supported by AusAID. He also conducted two consecutive Dental Satisfaction Surveys (2001 and 2002) among Hospital Contribution Funds Limited members.

Anne Sanders joined the DSRU in 2002. Her educational background is in adult education and the health and social sciences. Prior to commencing a research degree on the topic 'social determinants of oral health', she worked as a dental therapist with the South Australian Dental Service for nine years. Her current research projects include explaining social inequality in population oral health, and examining the effectiveness of a preschool enrolment program on reducing the prevalence of untreated caries in children commencing school.

Jane Harford is the DSRU's newest recruit. She has a background in public health, health policy and health economics. Jane is working on a series of discussion papers on topics that include strengthening a public health/primary care approach to oral health; the impact of various funding arrangements, including government subsidies on oral health service delivery and oral health status; and access to and priority setting in oral health care services.

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