

Appendix 1

Quality of evidence ratings

These ratings have been adapted from the *Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions* (United States Preventive Services Task Force 1989).

- I Evidence obtained from a systematic review of all relevant randomised controlled trials.
- II Evidence obtained from at least one properly designed randomised controlled trial.
- III-1 Evidence obtained from well-designed controlled trials without randomisation.
- III-2 Evidence obtained from well-designed cohort or case-control analytic studies preferably from more than one centre or research group.
- III-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.
- IV Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Source: NHMRC Quality of Care and Health Outcomes Committee (1995) *Guidelines for the Development and Implementation of Clinical Practice Guidelines*. AGPS, Canberra.

Appendix 2

Data and statistical issues

Data issues concerning specific cancers have been discussed in relevant sections of the report. However, there are several issues involved in the NHPA monitoring that are common to one or more of the priority areas. These include not only the demographic and statistical techniques used for determining trends, but also those that pertain to age standardisation and establishment of baselines. Comparability of data sources, data availability and use of common terminology are other relevant issues. This appendix provides information to assist in the interpretation of data and statistical techniques used in the report.

Sources of national data

Major databases accessed for preparing this report were:

National Cancer Statistics Clearing House database

The registration of cancer cases is required by law in each of the States and Territories, where the data are collected by cancer registries. The registries collect clinical and demographic information about people with newly diagnosed cancer. This information is obtained from hospitals, pathologists, radiation oncologists, cancer treatment centres and nursing homes. Information related to deaths is collected by the Registrars of Births, Deaths and Marriages.

By combining information from these sources, the State and Territory cancer registries produce statistics of cancer incidence and mortality. A national collection of cancer data is maintained by the National Cancer Statistics Clearing House at the AIHW.

National mortality database

Registration of deaths in Australia is the responsibility of the State and Territory Registrars of Births, Deaths and Marriages. Information on the cause of death is supplied by the medical practitioner certifying the death or by a coroner. Other information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official institution where the death occurred. Registration of death is a legal requirement in Australia and compliance is virtually complete.

Information on deaths is provided by the Registrars to the Australian Bureau of Statistics (ABS) for coding of information and compilation into national statistics. AIHW maintains these data without personal identifiers in a national database which currently includes data to 1996.

Data deficiencies

For a general discussion of gaps and deficiencies in Australian health statistics, see *Australia's Health 1998* (AIHW 1998).

Mortality data remain the most comprehensively collected national data pertaining to health. However, problems relating to coding of all conditions listed on death certificates and poor identification of priority populations (eg Indigenous peoples) remain. Proposed changes to death registration, and the introduction of automatic multiple cause of death coding, will allow study of all conditions on death certificates.

Cancer incidence data are currently available to 1994 for all States and Territories, except Queensland for which data are available to 1990. However, incidence rates at the national level include pro-rated estimates for Queensland to 1994.

No new data on the incidence of treated non-melanocytic skin cancer have been published since the release of the *First Report on NHPA*, which included incidence rates for 1985 and 1990.

International data have been included in this report and are for the following countries and time periods.

Country	Years	
	Incidence	Mortality
Canada	1983- 87	1993
Finland	1995	1993
New Zealand	1993	1993
United Kingdom & Wales	1983- 87	1993
United States of America	1983- 87	1993

Sources: Mortality — World Health Organization 1996.
Incidence — Canada, UK & Wales, and USA from Parkin et al 1992; Finland from Finnish Cancer Registry 1997; and New Zealand from New Zealand Ministry of Health 1997.

Incidence and death rates for these countries were age-standardised to the total estimated resident population of Australia as at 30 June 1991 (see below). Despite this, care should be taken in interpreting international differences in incidence because data for Canada, the United Kingdom and Wales, and the United States are old. Therefore, recent changes in incidence trends such as that observed in the past few years for prostate cancer are not shown for these countries. This is because current incidence data at the level required for age standardisation were not readily available for countries other than New Zealand and Finland.

International data on melanoma deaths have not been included, as these data were not readily available.

Priority indicators reported against in the *First Report on National Health Priority Areas 1996* (AIHW & DHFS 1997) and updated for this report are listed in Chapter 1. For a number of other priority indicators, there is incomplete information. These are:

- Five-year survival for melanoma of the skin
- Five-year survival rate for cancer of the cervix
- Five-year survival rate for breast cancer
- Five-year survival rate for colorectal cancer
- Five-year survival rate for prostate cancer
- Patient satisfaction for treatment for cancer of the cervix
- Patient satisfaction for treatment for breast cancer
- Patient satisfaction for treatment for prostate cancer
- Improved access to quality support services for all cancer patients, their families and carers
- Establishment of hospital-based cancer registries

Data developments

In 1998, the AIHW in conjunction with State and Territory cancer registries will begin the process of standardising data items collected by cancer registries. For data items already included in the National Health Data Dictionary (NHDD), the process will involve ensuring that cancer registries are using definitions consistent with those in the dictionary. For data items not included in the NHDD, the process will involve developing standard definitions under the guidelines set by the National Health Data Committee. This development work will concentrate on a limited number of key items and occur in a way that maximises the value of existing databases, some of which have operated for decades. It is intended that this process will improve the collection of data items such as country of birth and Indigenous status by drawing attention to their current inadequacies and by implementing corrective action. The end result of this process will be a data set that is nationally consistent internally and with other health and demographic data collections.

Targets for cancer indicators, when originally decided in 1992, were only set for a few of the cancer-specific indicators. This was due to either a lack of appropriate information, some rapidly changing cancer incidence patterns, the likelihood of changing patterns due to the impact of screening or the recognition that the cancer is not amenable to significant change in the near future given current detection and treatment practices. As we move towards the date of original target, Year 2000, this situation poses a challenge to the NHPA program when it next considers a target setting process for the future. This challenge should be assisted though by an improving health information system which is able to deliver more timely information on the cancer priority indicators and some recent changes in screening practices and a stabilisation of cancer incidence rates in some cancers.

Statistical methods

State and Territory data

Unlike the national data, the data presented for each State and Territory are averaged annual rates over four years for incidence and over six years for mortality. By presenting data in this manner, natural statistical variation due to small numbers of cases within each State and Territory are averaged across the period, providing a more stable representation of the annual rates. To take account of the latest data available, mortality data were averaged for the years 1991–96, while cancer incidence data were for the years 1991–94.

Age standardisation

To control for any effects of differing age structures, direct age standardisation was applied to death rates and incidence rates for both Australian and international data. The standard population used in age standardisation was the total estimated resident population of Australia at 30 June 1991 (Table A2.1).

Table A2.1 Age composition of the Australian population by sex, 30 June 1991

Age group	Males	Females	Total
0-4	652,302	619,401	1,271,703
5-9	652,418	619,790	1,272,208
10-14	638,311	603,308	1,241,619
15-19	698,773	665,301	1,364,074
20-24	707,124	689,640	1,396,764
25-29	702,728	696,935	1,399,663
30-34	713,784	711,951	1,425,735
35-39	664,228	664,159	1,328,387
40-44	655,138	639,133	1,294,271
45-49	526,498	502,647	1,029,145
50-54	433,762	413,172	846,934
55-59	367,302	358,648	725,950
60-64	366,779	370,089	736,868
65-69	320,142	351,248	671,390
70-74	228,494	282,261	510,755
75-79	158,993	225,502	384,495
80-84	84,413	145,415	229,828
85 and over	44,220	110,027	154,247
Total	8,615,409	8,668,627	17,284,036

Source: Australian Bureau of Statistics.

The usual convention of using age-specific rates for five-year age groups, as shown in Table A2.1, was followed using the following formula:

$$SR = \frac{\sum \{R_i \times P_i\}}{\sum P_i}$$

where SR = the age-standardised rate

R_i = the age-specific rate for age group i , and

P_i = the standard population in age group i .

It should be noted that age-standardised rates estimated using this standard population may differ from those obtained using another standard population (eg the World Standard Population).

Rural, remote and metropolitan areas classification

To compare the death rate ratio for cancer among people living in rural and remote areas of Australia and the general population, the deaths data were cross-categorised using the Rural, Remote and Metropolitan Areas (RRMA) classification. The classification has been developed by the Commonwealth Departments of Primary Industries and Energy and Human Services and Health, based primarily on population numbers and an index of remoteness. The RRMA categories show a natural hierarchy, providing a model for incremental health disadvantage with rurality and remoteness as risk factors. Based on population density, the following three zones and seven area categories are recognised.

Zone	Category
Metropolitan zone	Capital cities Other metropolitan centres (urban centres population \geq 100,000)
Rural zone (index of remoteness < 10.5)	Large rural centres (urban centres population 25,000-99,000) Small rural centres (urban centres population 10,000-24,999) Other rural areas (urban centres population < 10,000)
Remote zone (index of remoteness > 10.5)	Remote centres (urban centres population \geq 5,000) Other remote areas (urban centres population < 5,000)

Acronyms and abbreviations

AAHPC	Australian Association of Hospice and Palliative Care
ABS	Australian Bureau of Statistics
AHMAC	Australian Health Ministers' Advisory Council
AHTAC	Australian Health Technology Advisory Committee
AIHW	Australian Institute of Health and Welfare
DCBE	double-contrast barium enema
DHFS	Commonwealth Department of Health and Family Services
DHSH	Commonwealth Department of Human Services and Health
DRE	digital rectal examination
FAP	familial adenomatous polyposis
FOBT	faecal occult blood test
HPV	human papilloma virus
NCCI	National Cancer Control Initiative
NHDD	National Health Data Dictionary
NHMRC	National Health and Medical Research Council
NHPA	National Health Priority Areas
NHPC	National Health Priority Committee
NRT	nicotine replacement therapy
NSCLC	non-small-cell lung cancer
Pap	Papanicolaou test
PSA	prostate-specific antigen
RRMA	Rural, Remote and Metropolitan Areas
SCLC	small-cell lung cancer
UV	ultraviolet
WHO	World Health Organization

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