



Australian Government

Australian Institute of Health and Welfare

I N S I D E

From the inside—
NPSU

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access

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Complexities of health to the fore at Aus Health 2004 launch and conference

'When I was Workplace Relations Minister I thought I was as busy as a person could possibly be. But then I came to Health and Ageing ...'

Federal Health and Ageing Minister Tony Abbott was reflecting on the complexities of his current portfolio as he launched *Australia's Health 2004*, the AIHW's ninth biennial health report to the nation.

The launch was held on 22 June 2004 at the National Library of Australia.

Mr Abbott was also opening *Vital Statistics, Vital Signs*, the Institute's first two-day national conference on health information and our health and health system. He emphasised that despite the complexities and ongoing debates in health, there was much to be happy about.

'Australia's health system is among the best in the world. This report refutes claims by some that Australia's health system is in crisis', Mr Abbott said.

'We do have problems and challenges but the Commonwealth Government, working with the state and territory governments and health professionals, is continuing to address these.'

The Minister said that *Australia's Health 2004*, the nation's health 'report card', showed that Australians are living longer, surviving cancer better, are less likely to die from heart disease, and less inclined to smoke. Childhood vaccination rates are up considerably, and dental health is improving.

'Our cancer survival statistics are among the best in the world and suicide rates are gradually falling, with the rate for young men the lowest in 20 years. The report also shows that Australia's health workforce has increased by 12 per cent between 1996 and 2001.'

Mr Abbott said that he saw Indigenous health as his 'greatest challenge', but also singled out diabetes and obesity.

'Diabetes is a national health priority. The government spends more than \$300 million a year treating diabetes, but collectively we need to do more to prevent the onset of diabetes.'

'The government has a range of programs to tackle obesity and will be announcing further programs shortly.' (One week after the conference the Prime Minister launched the \$116 million *Building a Healthy, Active Australia* initiative).

In introducing the Minister, AIHW Board Chair Dr Sandra Hacker compared *Australia's Health 2004* with the first edition of the report, *Australia's Health 1988*.

'... *Australia's Health 1988* had 230 pages and 23 statistical tables... by a strange numerological twist, *Australia's Health 2004* has 530 pages and 223 tables. And 111 charts and diagrams', Dr Hacker said.

Continued on page 3 ►



(Left to right): Dr Ching Choi (Head, Health Division, AIHW), Hon. Tony Abbott (Minister for Health and Ageing), Dr Sandra Hacker (AIHW Board Chair), Dr Richard Madden (AIHW Director).

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I shall limit myself in this edition to three key events for AIHW.

First, this edition of Access is devoted to describing the amazing array of interesting and challenging material presented at our conference in June, *Vital Statistics, Vital Signs*. The conference was held simultaneously with the launch of *Australia's Health 2004*. I hope all readers find something to interest them in this rich well of material.

Second, Dr Sandra Hacker's term as AIHW Board Chair has come to an end. As her last official responsibility Sandra addressed all staff and her fellow Board members at the Institute's 17th birthday party in June. She pointed out what an exceptional year the Institute has had, and encouraged staff to continue to produce quality publications, positioning the Institute among the world leaders in providing health and welfare statistics.

As Chairperson, Sandra led the Institute from strength to strength. Under her wise guidance, the Institute released each year a record number of publications to inform policy debate; and grew in size in response to an increasing number of external contracts. The Institute hosted a dinner for past and present Board members and senior staff to celebrate Sandra's achievements and to thank her for her leadership and friendship.

Third, the Hon. Peter Collins AM QC has been appointed Board Chair. Peter chairs his first Board meeting on 30 September, and we look forward to welcoming him and working with him in the coming years. Peter is a previous Minister for Health in NSW, so he is well aware of the need for good quality information to make sense of Australia's complex health, community services and housing systems.

Richard Madden, Director, AIHW.

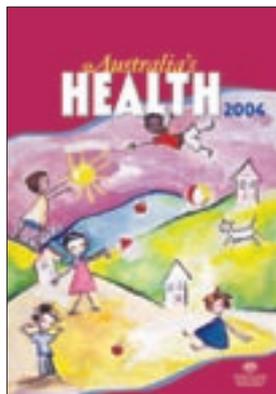
Complexities of health to the fore at Aus Health 2004 launch and conference

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Health and Ageing Minister Tony Abbott launching Australia's Health 2004.

'That doesn't mean that with the passing years we have become experts in waffling. It means that there is a great deal more to write about in health, because a great deal more statistics are now available.



Australia's Health 2004, AIHW catalogue no. AUS 44, available over the counter at AIHW (\$10 discount applies) or from CanPrint (Ph: 1300 889 873); \$55.00.

'In short, things are a whole lot bigger and better now on the national health statistics front than they were 16 years ago.'

Sandra also alluded to the complexities in health: '... health continues to be a growing and increasingly complex field of competing priorities—from the individual

to governments, business, the health professions and the health services system'.

'From our vantage point at the Institute, against this background of complexity, health statistics and related information are fundamental to developing effective health policies and programs.'

'Or, to use the theme of the conference, from our perspective statistics give some **vital signs**. They are **vital** in:

- assessing the level and distribution of the health of populations;
- measuring the level, distribution and influence of determinants;
- monitoring and appraising health interventions;
- quantifying the inputs to the health system;
- furthering knowledge through research and statistics;
- evaluating the performance of the health system; and last but not least
- understanding the relationships among all of the above.'

'All a piece of cake really...'

Sandra also said that it was particularly heartening to her, as Board Chair, to see AIHW work informing policy and enhancing the level of debate on various health and welfare issues.

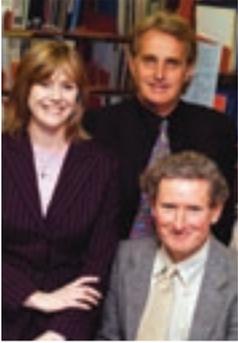
'For example it was the AIHW that was the first to bring out statistics showing the enormous burden of depression in our society, and the first to show how high it was on the list of problems managed by GPs. This has led to a whole range of mental health initiatives at both federal and state and territory levels, and has influenced general practitioner training programs as well.'

'It was the AIHW that first showed, through some innovative analysis just a few months ago, that contrary to popular belief, Australians in their fifties are continuing to gain weight as they gain years, at least into their mid-seventies.'



AIHW Board Chair
Dr Sandra Hacker.

Three key staff in the *Australia's Health 2004* team, left to right: Media and Marketing Manager Janine Martin, Editor Dr Paul Magnus, and Health Division Coordinator John Harding.



'Our current obesity epidemic has outstripped any natural tendency for older people to lose weight as they age. And this brings a number of potential challenges for older people in their daily functioning, social lives, mental health and personal health care costs. It has implications for health and aged care services. For nurses and others involved in the care of obese older Australians, there could well be occupational health and safety concerns.'

Sandra went on to say that this was just one example of how the ageing of the population is shifting the dynamics of the health landscape, and that other examples were on offer in the 'Health of Older Australians' special chapter in *Australia's Health 2004*.

The launch of *Australia's Health 2004* received excellent media coverage across major metropolitan newspapers, radio and television.

Australia's Health 2004 (RRP \$55.00) is available over the counter at AIHW (\$10 discount applies), through online purchase at www.aihw.gov.au, or via telephone order from Canprint (freecall 1300 889 873).

A special deal of \$70 for *Australia's Health 2004* combined with *Australia's Welfare 2003* is also available.

From the conference—Day 1

Ed Sondik gives insight into US vision for health stats

After the official opening by Hon. Tony Abbott, the AIHW's *Vital Statistics Vital Signs* conference kicked off in international style with our international guest, Dr Ed Sondik, who gave a very informative presentation on *Monitoring Health in the United States—Now and the Future*.

Ed is Director of the US National Center for Health Statistics (see the 'Spotlight on...' feature article elsewhere in this issue of *AIHW Access* for more details).

In describing the 'now' of US health monitoring stats, Ed concentrated on:

- the **National Vital Statistics System** (covering all births, deaths, marriages, and divorces)
- the **National Health Interview Survey (NHIS)** involving personal interviews in 41,000 households annually (110,000 people), with deliberate oversampling of African Americans and Hispanics

- the **National Health Care Survey (NHCS)**, a monster collection of surveys sampling thousands of health care settings of every kind, from hospitals to nursing homes, surgery centres, hospices and general practitioners. Data is collected on many topics, including diagnosis and treatment, trends in service use, patient characteristics, patterns of disease, use of technology, and medications.
- the **National Health and Nutrition Examination Survey (NHANES)**, a mobile survey covering a representative sample of 5,000 people each year, involving a 1.5 hour interview, a 3.5 hour medical examination, and a follow-up second diet recall survey. The survey yields useful statistics on a host of items, including disease prevalence, risk factors, nutrition, anthropometry, and growth and development.

Of all the surveys mentioned, the one that boggled most minds was NHANES, and its four monstrous pantechnicon mobile exam centres. Ed regaled us with photos of these behemoths being lifted by giant crane onto a ship in New York harbour.

One interesting 'turn of events' yielded by NHANES was a rise in the prevalence of hypertension in the USA from about 1988 onwards, after some prior dramatic falls from the mid-1970s. A portent of things to come in Australia perhaps?

Another interesting graph from the 1999–2000 NHANES showed the association of blood mercury levels with increasing consumption of shellfish, fish or a combination of the two. The Environmental Protection Authority reference dose was exceeded at around the 80th percentile when a combination of fish and shellfish were eaten.

Ed also spoke about disparities in US health, principally elevated death rates and infant mortality rates for blacks compared with whites, and finished with the US vision for health statistics, encapsulated in his organisation's report, *Shaping a Health Statistics Vision for the 21st Century*.

The four core values of the US vision were familiar territory for observers and developers of Australian health stats, namely:

- confidentiality and security of identifiable health information
- scientific integrity acknowledging contexts (*an acknowledgment that the development and production of health stats, while retaining scientific integrity, also had to take account of the natural environment, cultural contexts and political contexts*)
- optimising accountability to data users to ensure availability of critical data
- ensuring accountability to data suppliers.

(Left to right): AIHW National Health Priorities and Environmental Health Unit Head Dr Kuldeep Bhatia, Libby Davies from the Institute's Board, Director of the US National Centre for Health Statistics Dr Ed Sondik, and AIHW Medical Adviser Dr Paul Magnus.



Ed's view of the current key issues for health statistics in the USA also had a familiar ring that was echoed in Richard Madden's subsequent presentation on the Australian situation. It was strangely reassuring that such problems seem to have some universality!

The key US issues were:

- State and local health data needs
- dissemination vs confidentiality
- longitudinal data—health state transition probabilities
- coordination across sources
- independence
- reengineering/informatics
- training [*of health statisticians*].

AIHW Director speaks on reality and potential of health stats in Australia

AIHW Director Dr Richard Madden opened his address by describing Australia's health statistics as a 'treasure trove' and offered the following activities as evidence:

- **State and Territory collections collated into national datasets by AIHW**
 - hospital activity, waiting times, health labour force, perinatal, cancer, alcohol and other drug treatment services, dental health, disability services, etc.
- **Australian Government collections**
 - Medicare, pharmaceutical benefits, immunisation, National Diabetes Services Scheme data collection, communicable diseases, screening programs, aged care
- **ABS national census and surveys**
 - population census; health survey disability; ageing and carers survey; health industries
- **ABS and AIHW vital statistics databases**
- **Other national surveys**
 - GP utilisation (by the AIHW General Practice Statistics and Classification Unit at the University of Sydney), drug use, physical activity
- **State and Territory health surveys (generally telephone-based)**
- **National health expenditure database**
 - compiled by AIHW from many sources, to OECD standards.

Other data registers and collections mentioned by Richard included the WA Aboriginal Child Health Survey, AusDiab, the Women's Longitudinal Health survey, the End Stage Renal Disease register, and the HIV/AIDS register.

While conceding that the treasure trove yields a 'wealth of published material' from the AIHW among many others, Richard also said the treasure was underutilised in terms of its potential to inform health services planning and clinical treatment planning: 'Much more could be done, both in digging deeper into the statistics we publish, and in "value-added" statistical analysis using data from a variety of sources.'

Richard cited the AIHW's Bulletin series as an example of a series of short documents pulling together data from all relevant sources.

As examples of value-added analysis he pointed to the AIHW's work on cancer survival rates, and on analysing unmet need for disability services.

He said that the cancer survival work had 'shown the generally improving survival rates across various cancers, and well-demonstrated the impact of the national breast and cervical cancer screening programs'.

Richard said that the problem with 'digging deeper' was 'of course, resources: both money and the skilled people to do the work.'

'But even then, analysis is difficult. For example, we want to answer the simple question:

'Is Aboriginal and Torres Strait Islander health getting better, worse or staying the same?'

'Both mortality statistics and population data are difficult to interpret and subject to substantial variation in identification over time. Answering this question is most definitely a work in progress!'

Richard also spoke on the integration of health statistics with recent moves to reform health information and communications technology (ICT).



Director Dr Richard Madden and guest speaker Dr Rosemary Stanton.

‘...Health statistics has had a sound record of progress, with strong governance from AHMAC, for more than a decade. On the other hand, there has been far too little agreement on standards for health ICT systems, and no adequate governance arrangement.’

‘The establishment of the National Health Information Group in 2003 subsumed the former governing body established under the National Health Information Agreement. The focus under the new body has, quite sensibly, been on the need for national coordination in ICT. The danger is that health statistics could be overlooked in this process, or lose resources.’

‘So far, this has not happened...but there must be close cooperation in setting standards for ICT and for statistical purposes. For example, statisticians use classifications for cause of death, disease and disability. ICT systems demand structured health language, or terminologies. Each has to be compatible with the other.’

The potential for statistical data linkage in health, such as has already occurred to some extent in Western Australia, was highlighted.

‘In WA this has opened the way to study who gets what treatment for what condition (and who doesn’t), how often, and when’, Dr Madden said.

‘At the national level, AIHW routinely links the National Death Index to researchers’ data sets, to enable researchers

to determine who has died, and cause of death. With appropriate permissions and consents, national cancer statistics can also be linked to other data sets.’

‘But nationally there are still key gaps. No arrangements exist for linkage of hospital separations with other collections, although progress is being made in some jurisdictions.’

‘At present, the ABS does not link census and survey data with other data sets. Other countries, notably England, have been able to do this for many years. I am glad that the ABS is now reviewing the potential for such linkage. No identifiable data will be released outside the legislative protection of the AIHW and the ABS.’

‘Electronic health records provide a great opportunity for the statistician as far as data linkage goes. A person’s electronic health record links information on services in different settings...Such comprehensive records obviously offer major research opportunities as well as facilitating “joined up” health care services. But these outcomes depend on high participation in the EHR system.’

‘Also, as with health information and communications technology systems, the standards used in the EHRs need to tie in with statistical data standards. “Semantic inter-operability” is a term that does not flow easily off the tongue, but common standards across sectors are essential not just for clinical care, but also if statistical value is to be obtained from EHRs.’

Richard concluded his address by pointing to some of the current gaps in national health statistics, all of which are detailed in *Australia’s Health 2004*. These include:

- **reliable Aboriginal and Torres Strait Islander health statistics**
- **an Australian health measurement survey**, focusing on direct measurement of biomedical risk factors, such as blood cholesterol, blood pressure, and even height and weight.
- **nutrition and diet survey**. There has been no national survey since 1995, despite the high level of interest in obesity and the need for reliable nutrition data to back the setting of food standards.
- **mental health survey**. None has been done since 1997, and none are planned despite mental health being a National Health Priority Area and a major contributor to the national burden of disease.
- **safety in health care**. No national framework is in place for reporting on health care safety and adverse events.
- **small area health statistics**. Canada reports health performance at sub-provincial level. The Australian states and



Lindy Ingham and Tony Hynes from the AIHW Health and Welfare Expenditure Unit.

territories have not supported any move in this direction in Australia, and a national approach is yet to be developed.

- **measuring work-related physical activity.** Current Australian surveys only enquire about leisure time physical activity.

Day 1 parallel sessions

Parallel sessions on Day 1 covered health expenditure, Indigenous health, obesity and lifestyle, hospitals, maternal and infant health, and asthma.

Brief summaries of each session are presented below (please note that opinions expressed were the views of participants, and do not necessarily reflect the views of the AIHW).

Health expenditure: viewed through the microscope

Presenters: **Ms Lindy Ingham**, AIHW; **Prof. Jane Hall**, Centre for Health Economics and Research and Evaluation, UTS

Chair: Mr John Goss, AIHW

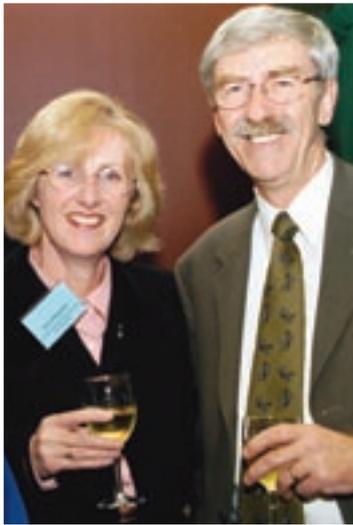
- Health expenditure in Australia represented 9.3% of GDP in 2001–02, compared with 8.7% in 1998–99 and 8.1% in the early 1990s.
- In 2001–02, \$66.6 billion was spent on health services in Australia. About 69% was funded by governments—46% by the Australian Government, and 23% by state, territory and local governments.
- Spending on health by Australians from their own pockets has grown at a greater rate (7.7%) than funding by governments (5.7%) over the period 1997–98 to 2001–02.
- Expenditure on pharmaceuticals grew, in real terms, at an average of 12.3% per year between 1997–98 and 2001–02.
- Average spending on health services for Aboriginal and Torres Strait Islander people in 1998–99 (\$3,065 per person) was 22% higher than for other Australians. The next study on this topic, covering 2001–02, is due for release later in 2004.
- Total expenditure on public health in Australia was \$987 million in 2000–01 (1.7% of recurrent health expenditure)

Indigenous health: is the imbalance improving?

Presenters: **Dr Fadwa Al-Yaman**, AIHW; **Prof. Ted Wilkes**, Curtin University and Telethon Institute for Child Health Research

Chair: Dr Kuldeep Bhatia, AIHW

- The session focused on the continuing poor state of the health of Indigenous Australians and our inability, so far, to tackle the issue.
- Dr Al-Yaman outlined the unacceptable imbalance between the health of Indigenous and non-Indigenous Australians. She said that almost all of the early deaths of Indigenous Australians are avoidable and could be reduced if high risk behaviours such as smoking and obesity were reduced.
- But there is mounting evidence that past traumas (dispossession of land, loss of livelihood, removal of children) are fundamental causes of high risk behaviours and poor health among many Indigenous Australians and their children.
- Is there any evidence for changes in the health for Indigenous people? In some aspects there is evidence of improvements, e.g. infant mortality (65 deaths per 1,000 births in 1970, 14 per 1,000 in 2001). But the life expectancy estimates available (1981–2001) do not show any improvement over this period. Either there has been no improvement, or the available data do not adequately portray the improvement.
- The uncertainty in the numerators and denominator in all Indigenous health rate calculations makes answering the original question anything but straightforward
- Problems exist with counting the total number of Indigenous Australians. For example the number of Indigenous Australians counted fluctuates significantly between censuses. One argument is that the fluctuations are the result of changes in propensity to identify as Indigenous, depending on the social and political climate of the time.
- Whether or not the health of Indigenous people has improved, the quality of Indigenous health remains unacceptably poor compared to the non-Indigenous population and in absolute terms.
- Professor Wilkes emphasised the need to generate good quality Indigenous health information to redress the imbalance and to get the point across to policy makers and the general public.



AIHW Hospitals and Mental Health Services Unit Head Jenny Hargreaves with her husband John Hargreaves MLA.

Obesity and lifestyle: weighing up the risks

Presenters: **Ms Bonnie Field**, AIHW; **Dr Anthony Rogers**, Clinical Trials Research Unit, University of Auckland; Dr Karen Cashel, University of Canberra

Chair: Ms Judith Abercromby, AIHW

- Since 1980, the prevalence of overweight and obesity among adults increased more rapidly than the prevalence of other major risk factors. Most notably, trends in smoking and high blood pressure decreased markedly over this period of time and cholesterol levels remained relatively stable.
- By 2000, 66% of males and 47% of females aged 25–64 years were overweight or obese compared with 47% and 27%, respectively, in 1980. Similar increases have occurred throughout the adult population irrespective of age, educational level, employment status or Indigenous status.
- Between 1985 and 1995, the prevalence of overweight and obesity among children aged 7–15 years increased from 11% to 20% among boys and from 12% to 22% among girls. More recent national data are not available for children but regional analyses indicate that this upward trend has been continuing.
- Traditional ‘cutpoints’ for risk factors—high blood pressure, high cholesterol and obesity—should be monitored but not treated as absolutes. ANY reduction in an individual’s risk factors is useful in prevention.
- Talking about the cardiovascular risk factors, as they’re currently defined, is really talking about the tip of the iceberg
- ‘Cut-points’ have traditionally been used to define the risk factors, such as ‘high cholesterol’ being marked by a level of 5.5 mmol/L or more in a person. But because cut-points like this are usually far above an ideal level for the individual, the potential for prevention is greatly underestimated when they are used.
- The combined effects of obesity and lifestyle risk factors are much greater than commonly realised.
- The vast majority of cardiovascular disease can be accounted for by just six major risk factors: high blood pressure, high cholesterol, low fruit and vegetable intake, BMI greater than 21, smoking, inactivity.
- Priorities for prevention efforts should be guided by prevention potential, attributable DALYs (Disability Adjusted Life Years) and potential cost savings, rather than by the risk levels themselves.

Hospitals: changing roles

Presenters: **Ms Jenny Hargreaves**, AIHW; **Dr Charles Maskell-Knight**, Australian Government Department of Health and Ageing; **Ms Maxine Drake**, Health Consumers Council of WA; **Prof. Jim Pearse**, Centre for Health Service Development, University of Wollongong

Chair: Mr Ken Tallis, AIHW

- During the past decade, there has been a fall in the average length of time that patients have stayed in hospital. In the main, this has reflected an increasing proportion of same-day patients; there has also been some fall in average length of stay for other (overnight) patients.
- There was debate among session participants on differences in ways of treating same-day patients in different countries’ hospital statistics, and whether the apparently faster fall in Australia might be a statistical artefact. There was also debate about the implications of falling length of stay for the quality of service in hospitals.
- During the past decade, private hospitals have accounted for an increasing share of total hospital separations, and public hospitals for a decreasing share. Some participants attributed this to greater affordability and take-up of private health insurance. And some asserted that the private sector has been absorbing a large part of the increased demand for hospital services, and thereby taking some pressure off public hospitals.
- But some conference participants believed that the public hospital sector is in crisis, and suggested that thorough going reform was needed. Suggested reforms included better integration of patient care across sectors (say, across primary care and hospitals, or across aged care and hospitals) and an overhaul of the multilevel funding arrangements for Australia’s public hospitals.
- There was a lively discussion on the quality and safety of hospital care in Australia. The evidence is patchy, although improving. There has been some debate in Australia about the interpretation of the evidence—for example, some studies have indicated a much higher overall rate of adverse events than others. But analyses of anaesthesia-related deaths and maternal mortality suggest that, in these areas at least, quality and safety have been improving.
- Discussants put forward a menu of suggestions for improving our understanding of quality and safety issues, such as: introducing new codes for adverse events (such

as pressure ulcers); linking data (for example, to capture deaths after discharge from hospital, or to analyse patients rather than episodes); and undertaking patient surveys and chart reviews.

Maternal and infant health: from little acorns...

Presenters: **Ms Sally Tracy**, AIHW; **Prof. David Ellwood**, Australian National University

Chair: Dr Kerry Carrington, AIHW

- The most significant features of the current scene are: increasing maternal age, low total fertility rate, continued rise in caesarean sections, and higher rates of multiple births.
- Consequences of increasing maternal age include: a higher rate of infertility treatments amongst first time mothers; many women in their first pregnancy will have significant co-morbidities (diabetes, hypertension, renal); and higher demand for prenatal diagnosis. Postnatal recovery and return to work may also be affected. There is an increased risk of having a baby with Down Syndrome.
- The low fertility rate means that nearly half of all babies are now born to 'first-time' mothers and there are lower rates of 'low-risk' births. Smaller maternity units are becoming marginal in terms of birth numbers and there may need to be some rationalisation of metropolitan maternity sites.
- The rise in the number of caesarean sections has resource implications. Some of the rise is due to elective caesarean sections. There is a reduction in morbidity if the caesarean section procedure is replacing an emergency caesarean section. There are increased risks of thrombo-embolic disease and surgical complications (placenta accreta) with caesarean sections.
- Nearly 2% of all pregnancies are multiples (mainly twins). This is an effect of both increasing maternal age and assisted reproduction technology. This leads to much higher rates of complications, including preterm delivery and low birthweight, which in turn has a significant impact on neonatal intensive care unit resources.
- The trends in perinatal statistics show no real sign of changing, hence maternity services must realign themselves to deal with older mothers with higher rates of complications. Will obstetricians of the future simply be caesarean section technicians?



AIHW National Health Priorities and Environmental Health Unit Head Dr Kuldeep Bhatia.

Asthma: are we breathing easier?

Presenters: **Dr Guy Marks**, Australian Centre for Asthma Monitoring (AIHW);

Dr Anne-Louise Ponsonby, National Centre for Epidemiology and Population Health, ANU

Chair: Dr Kuldeep Bhatia

- There is a myriad of definitions used for determining the prevalence of asthma, and the lack of standard definitions clouds the message.
- Asthma prevalence among Australian children has reached a plateau lately.
- Prevalence in adults is 10–12%; in children 14–16%.
- Prevalence was increasing until the 1980s/early 1990s; it is possibly stable now.
- There is little regional variation, but prevalence is higher in older Indigenous persons.
- Asthma has a measurable impact on quality of life at a population level.
- Asthma mortality mainly affects the elderly, and is decreasing in all ages.
- Hospitalisations for asthma mainly affects the very young and is decreasing, but only in this age group. There are higher hospitalisation rates in older Indigenous people.
- There is under-use of action plans and preventer medication—especially in young adults. There has been little change in medication use over the last six years apart from an increase in use of long-acting beta agonists and combined medications.
- Dr Ponsonby raised the possibility of a future decline in childhood asthma in Australia. The possible turnaround in asthma incidence and the factors contributing to this change were discussed.

From the conference—Day 2

Prominent health academics speak out on health statistics and policy

Day 2 of the Vital Statistics Vital Signs conference kicked off with a bang with lively presentations from three very prominent Australian health academics:

- **Prof. Kerin O’Dea**, AO, Director of the Menzies School of Health Research
- **Prof. Tony McMichael**, Director of the National Centre for Epidemiology and Population Health, Australian National University
- **Prof. Gavin Andrews**, Policy and Epidemiology Group (Mental Health), University of New South Wales

Kerin got the ball rolling by drawing attention to the critical role of population-based data in revealing undiagnosed burdens of disease, in eliciting predictors of disease and associated conditions (e.g. obesity, sedentariness, overconsumption of energy-dense foods) and in enabling identification of trends (such as the recent sharp increase in obesity in children).

Kerin also drew attention to the population-based AusDiab study, which had revealed (among many other findings of course) a stronger likelihood of abnormal glucose metabolism the less people exercised and the more they watched television.

The presentation then moved into the realms of the Aboriginal and Torres Strait Islander health, work for which Kerin is recognised internationally. She warned against treating Indigenous people as a single population. Among the convincing examples that she gave was the much higher age-specific prevalence of diabetes and obesity among Torres Strait Islanders compared with Aboriginal people. She also pointed to end stage renal disease (ESRD), where cases per million per year in 1993–1996 were five times higher in the Tiwi Islands (for example) than in East Arnhem land—and rates of ESRD among Indigenous Australians varied 36-fold across different ATSIC regions.

Kerin said that Australia’s accelerating diabetes epidemic called for regular monitoring (along the lines of the AusDiab study) rather than one-off studies, longitudinal data to follow trends in incidence and progression of complications, and routine data collection that would shed more light in the areas of gestational diabetes and trends in childhood and adolescent obesity.

Returning to data on the health of Indigenous Australian populations, she pondered how the differences among

the populations could be better documented, and drew attention to the lack of population-based data on urban Indigenous communities. She urged consideration of sentinel sites for 5-yearly monitoring of chronic diseases and their risk factors. Such a scheme would cover urban, rural and remote communities, and yield biomedical as well as social demographic data.

And, as if that wasn’t quite enough in the way of recommendations for the future, Kerin finished by championing the case for a regular biomedical risk factor survey in Australia. She said that we should not be too ambitious in what is measured, and that a nutrition component should be included. If practical, the survey should be linked to the ABS’s National Health Survey. An alternative was to set up a cooperative research centre, a broad partnership of researchers and the public and private sectors, to run the survey. A minimally invasive survey of Australia’s children should be part of the project, possibly involving urine analysis and anthropometric and blood pressure measurements.

Tony McMichael opened his presentation with a call to consider a longer ‘causal chain’ than usual in the area of health risk factors, and to collect data on what he called ‘upstream’ risk indicators. For example, in the field of overweight and obesity, in addition to collecting time trends in body mass index by age and sex, and time trends in self-reported dietary and physical activity habits, could we not also consider time trends in:

- national food production and marketing
- school canteens and play facilities
- school transport trends
- bicycle use
- suburban layout (incl. retail shopping)
- energy expenditure at work
- TV viewing?

In other words, avoid being constrained by conventional ‘individual-level risk factor’ models of disease causation.

Professor McMichael then moved to the topic of hospital morbidity data and the increasing tension between confidentiality legislation and the need for data disaggregation to reveal policy-relevant patterns – e.g. small-area comparisons of SES-based regions, air-sheds, and water catchments.

He lamented the delays, costs and frustrations of seeking approval for use of de-identified individual-level data from state

health departments, which he said differed from the situation with national individual-level mortality data, which was available from the ABS (the custodian) to licensed end-users.

Tony wondered whether state health departments might authorise AIHW to grant access to individual-level data, within agreed guidelines, possibly as part of the National Health Information Agreement.

The third pillar of Tony's presentation was a call for standardisation of geo-coding for health research. He said that we need a consistent, time-stable spatial coding/referencing system for Australia's health and related statistics to enable a broader range of community-level studies on diverse health topics.

To date geocoding has centred on Statistical Local Areas (SLAs), one of the planks in the hierarchy that comprises the Australian Standard Geographic Classification System used by the ABS. But Tony saw several problems with SLAs, principally:

- they are not demographically standardised (areas can range from a fraction of a square kilometre to over 670,000 km², populations from 0 to 190,000, some are based on suburbs, others on local government areas)
- boundaries change over time
- codes change over time
- numerator–denominator mismatches can occur as a result
- some health databases use non-SLA units.

Other methods of health data geo-referencing also have problems, e.g. postcodes, which change repeatedly, and do not map to census collector districts (CCDs).

Tony saw that the way forward was to develop a set of standard national geographic areas for health information collections that could build on initiatives such as ABS's review of the Australian Standard Geographical Classification. He believed the AIHW should have a key role in this process, which would involve a reference group to take the project forward, some funding, and extensive consultation.

Gavin Andrews' take on the topic of health statistics and policy was to report on a study that he and his colleagues had undertaken, 'Best buys in mental health'. Available epidemiological statistics were used to determine how to get best value out of scarce resources in mental health. It was a brave path to tread, with the current efficiency of psychiatric treatment and potential for improvement being among the topics covered. Gavin said that the way health services function now, only about one-fifth of the current burden

of mental disorders was curable. You can read all about this and more on the 'Soapbox' page of this issue of *AIHW Access*, which Prof. Andrews kindly agreed to write for us.

Lively and varied debate followed the presentations. There were three strong threads to the discussion:

- Health statistics are increasingly unearthing hitherto unknown facts and associations, and increasingly informing policy.
- This phenomenon is increasing the thirst for more and better statistics.
- In particular there is rising demand for:
 - biomedical surveys
 - linking of health-related data (i.e. 'joined-up stats')
 - small area/small community analysis and comparisons
 - stats that help provide the 'evidence' for evidence-based medicine.

Day 2 parallel sessions

Parallel sessions on Day 2 covered the health labour force, the health of older Australians, cancer statistics, dental labour force and oral health, national population and state/territory health surveys, cardiovascular disease, health expenditure on diseases, children's health and mental disorders.

Brief summaries of each session are presented below (and please note that, as with the Day 1 summaries, opinions expressed were the views of participants, and do not necessarily reflect the views of the AIHW).

Labour force: who is looking after your health

Presenters: **Ms Glenice Taylor**, AIHW; **Mr Paul Gavel**, Australian Medical Workforce Advisory Committee and NSW Health Department

Chair: Mr Tony Hynes, AIHW

- The medical workforce is growing in all areas except enrolled nurses (but there is a shift between enrolled nurses and nursing carers).
- Female participation and part-time hours are key features of this workforce, but this varies among the different occupations.
- Maldistribution between areas is still an issue, especially rural/remote.
- Medical and nursing workforces are ageing and the number of hours worked per person is declining,



(Left to right): AIHW Labour Force and Rural Health Unit Head Glenice Taylor, Board Chair Dr Sandra Hacker, and Graham Rogers, President of the Institute of Actuaries of Australia.

influenced by work-life balance changes, increasing female participation (in medicine), demands on practitioners' time.

- The number of nurses completing undergraduate courses fell between 1997 and 2000 before rising slightly in 2001.
- Demand in the health labour force is expected to keep growing, influenced by empowered consumers, ageing population and technology.
- Will there ever be enough practitioners in rural areas? Urban growth areas are also not favoured. Perhaps it is time for disincentives to work in favoured areas.
- Health must be a priority in a tightening labour market. We need to be able to attract, recruit and retain.
- One view put forward (and disputed) was that nurse training should never have been taken out of the hospitals.

Health of older Australians: living older and healthier?

Presenters: **Dr Ching Choi**, AIHW; **Ms Ros Madden**, AIHW, **Prof. Anthony Jorm**, Centre for Mental Health Research, ANU

Chair: Ms Ann Peut, AIHW

- Proportion of people in Australia aged 65+ years is 13%; proportion 80+ is 3.2%.
- Comparable rates for Japan 18% and 4%; Sweden 17% and 5%.
- Growth rate in the last 5 years for 65+ years is 11%; for 80+ years it is 27%, compared with all ages 6%.
- Baby boomers are yet to reach these age brackets.
- Mortality is decreasing across all major diseases.
- Incidence for many diseases has declined, but not all, e.g. type 2 diabetes, many cancers.

- Self-rated health status as 'good' or better is 69% for males aged 65–74, and 72% for females aged 65–74. For those aged 85+ the figures are 22% (males) and 31% (females). Very few self-rated their health as 'poor'.
- Most older people live in private dwellings:
 - Males: aged 85–94, 81%; aged 95+, 68%
 - Females: aged 85–94, 68%, aged 95+, 41%.
- Few older people live in cared accommodation (including hospitals and residential aged care)
 - Males: aged 65+, 3.7%
 - Females: aged 65+, 7.8%.
- Whether Australians are living older and healthier is unclear when taking disability into account. There is mixed evidence from other OECD countries.
- Reported rates of 'severe disability' increased from the 1993 to 1998 ABS Disability Survey, although previously stable. Possible reasons:
 - survey methodology
 - population ageing
 - possible increase in prevalence in oldest groups.
- However, new information may soon clarify trends—the 2003 ABS disability survey has maintained 1998 methods.

Cancer statistics: winning the battle?

Presenters: **Mr John Harding**, AIHW; **Prof. Freddie Sitas**, NSW Cancer Council

Chair: Dr Paul Magnus, AIHW

- 1 in 3 men and 1 in 4 women in Australia can expect to be diagnosed with a malignant cancer by age 75.
- With ageing of the population, and the median age of first diagnosis 69 for men and 65 for women, there is a strong growth in demand for cancer services: 2 million GP patient encounters per year and hospital admissions increasing at 4.7% per year.
- Good news includes falling mortality rates and improving relative survival, largely driven by improvements in earlier detection and treatment, and a reduction in smoking prevalence by men.
- Tobacco consumption, both directly and passively, remains a major preventable cause of premature death and there are substantial reductions in risk in stopping smoking, even at age 50 for lifelong smokers.
- Australian Government funding of anti-tobacco consumption is less than it is for public health campaigns

for suicide, illicit drugs and AIDS, all associated with much lower numbers of deaths per year.

- Tobacco-attributed mortality estimation in Australia could be greatly improved by inclusion of smoking on death certificates, as this has been done very successfully in South Africa. This may be used to calibrate the well-developed indirect methods used in Australia and internationally.
- There are still a number of unknown causes of certain cancers, requiring continuing research, and known causes need to be better quantified in Australia instead of relying on overseas-derived research.

Dental labour force and oral health: brushing up on where we're at...



AIHW Media and Marketing Manager Janine Martin and Health Registers and Cancer Monitoring Unit Head John Harding.

Presenters: **Prof. John Spencer**, University of Adelaide;
Prof. Gary Slade, AIHW Dental Statistics and Research Unit

Chair: Mr John Harding, AIHW

- During the last 25 years there has been substantial change in the dentate status of the population, with a large fall in the proportion who have no remaining natural teeth.
- This has contributed to a significant increase in per capita dentate demand and dental visits in all age groups, except the 25–34 year age group. There is strong growth in projected demand to 2010, mainly in the diagnostic, preventive and restorative fields of dental practice.
- Projections of the dental labour force indicate modest growth to 2010, below projected growth in demand for visits to dentists.
- The decline in children's decay rates has stalled in permanent teeth and reversed in deciduous teeth.
- Adult edentulism continues to decline as the effect of the tooth loss epidemic of the mid 20th century recedes.
- Greater tooth retention has created an unprecedented need for maintenance of teeth that previously have been restored.
- No group before or since today's 40–69 yr old 'amalgam generation' has experienced a similar burden of dental decay.
- Health card holders are falling behind in this struggle to maintain oral health.
- Positive dimensions of oral health are strongly influenced by age and income.

National population and state/territory health surveys

Presenters: **Mr Mark Cooper-Stanbury**, AIHW; **Ms Sally Goodspeed**, Australian Bureau of Statistics

Chair: Mr Robert Van der Hoek, AIHW

- Australia has very rich health data sources and associated infrastructure.
- The Australian Bureau of Statistics is a substantial contributor to this position through
 - the National Health Survey, now planned on a 3-year cycle, and its Aboriginal and Torres Strait Islander cousin;
 - a range of other surveys with health content;
 - the development of survey module manuals to document best practice in chronic disease and associated risk factors surveillance.
- The AIHW complements this work with two national surveys in the areas of drug use, and influenza vaccination.
- Important contributions are also made by all of the states and territories, a number of which conduct ongoing surveillance using Computer Assisted Telephone Interviewing (CATI) and other methods.
- Critical gaps exist in the current suite of surveillance activities, notably in the areas of physical measurements, biochemical measurements, nutrition, and mental health.



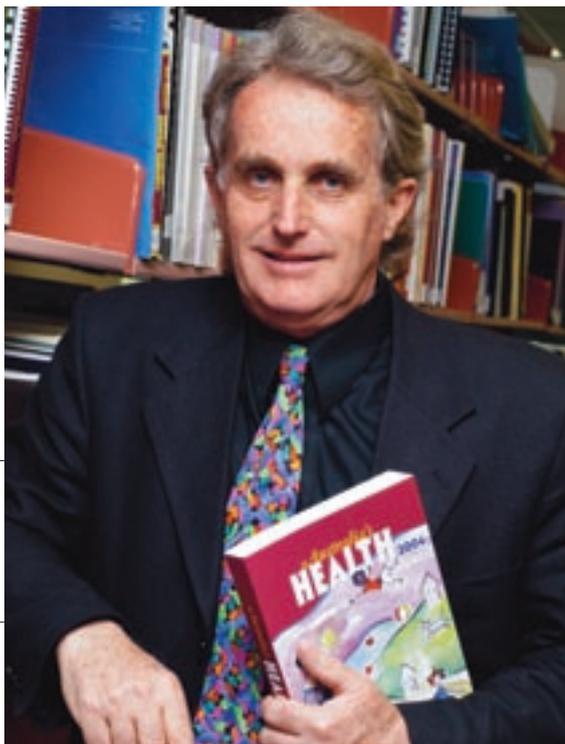
(Left to right): Amber Summerill and Mark Cooper-Stanbury from the AIHW Population Health Data Information Services Unit, and Library and Information Services Unit Head Judith Abercromby.

Cardiovascular diseases and diabetes: concerns and considerations

Presenters: Ms Lynelle Moon, AIHW; Prof. Annette Dobson, University of Queensland; Prof. Paul Zimmet, International Diabetes Institute

Chair: Dr Paul Magnus, AIHW

- The AIHW's National Centre for Monitoring Cardiovascular Disease provides an effective and very cost efficient way of monitoring some of the major causes of mortality, morbidity and health care costs in Australia.
- From data readily available from AIHW's website, one can obtain an up-to-date picture of the changing



Australia's Health 2004 Editor, Dr Paul Magnus.

epidemiology of CVD which is now dominated by conditions, especially heart failure, in the elderly.

- The important work could be further enhanced by: more secure funding for the Centre; a national risk factor survey including physical measurements and blood analysis; and national strategies to enhance record linkage of health data from different sources.

Trends

- Cardiovascular disease (CVD) deaths are declining, but CVD remains the largest killer.
- Diabetes prevalence is increasing dramatically.
- The main risk factors for CVD and diabetes have mixed trends, e.g. blood pressure improving, but obesity getting worse.
- Both CVD and diabetes remain major health problems in Australia today.

Inequalities

- Inequalities in CVD and diabetes remain and are large.
- CVD and diabetes account for a large proportion of total health inequality.

Combined impact of CVD and diabetes

- CVD and diabetes share a number of risk factors.
- They have a large combined impact: around a quarter of adults have one or both of these conditions; they are involved in around one-fifth of all hospitalisations and over 60% of all deaths.
- They occur together reasonably often.
- But they have different characteristics, e.g. most of the disease burden for CVD comes from deaths, while for diabetes most of the burden comes from the disability associated with having the disease.

'Fat and flabby' to 'fit and fabulous'

- The health and wellbeing of Australia's children and adolescents, now and in the future, is under threat. Our children are getting fatter, and it could be killing them.
- Overweight and obesity affect about 23 per cent of Australian children and adolescents, with 6 per cent being obese. Over the previous decade, the prevalence of overweight children almost doubled, and the prevalence of obese children more than tripled.
- The Australian Government has taken a significant decision and has identified the key areas that need to be addressed to

help Australians lose weight and avoid diabetes: increased activity both during and after school (less time in front of television and computers); early training in healthy (and tasty) eating; and education of Australians (parents and non-parents) to have a healthy diet.

- Obesity carries with it more than the health consequences of high blood pressure, heart disease, asthma, sleep problems and diabetes – being severely overweight is a greater stigma in children than any physical disability. Being unable to play sport, looking different to your peers and suffering the social isolation of obesity all affect a child's social and psychological wellbeing.
- Government policy once changed us from 'bronzed Aussies' to 'SunSmart'. This latest policy has the potential to turn us from 'fat and flabby' to 'fit and fabulous'.

Diseases and dollars

Presenters: **Mr John Goss**, AIHW; **Prof. Robert Carter**, Melbourne University

Chair: Dr Richard Madden, AIHW

- More money per person is spent on the health of females than males over the lifespan, even when maternal factors are taken into account.
- Cardiovascular conditions, musculoskeletal conditions and injuries are the top three National Health Priority Area diseases in terms of costs.
- Over the 1993–94 to 2000–01 period the two burden of disease chapters showing the highest inflation-adjusted rises in health system costs were diabetes and diseases of the nervous system.
- Average real per person health expenditure growth from 1976 to 2001 was around 2.4%. The component due to ageing of the population fluctuated around the 0.5% mark.
- Some interesting patterns emerge in rises in the per capita cost of prescribed pharmaceuticals between 1993–94 and 2000–01, by disease group. Nervous system pharmaceuticals have shown a marked rise in the 65+ age groups, mental health pharmaceuticals have risen in the 75+ age groups, and musculoskeletal pharmaceuticals have shown rises in the 15–24 and 65+ age groups.

(Left to right): **Dr Sue Page, Dr Graeme Miller, Lieutenant Colonel Victoria Ross and Brian Curren** enjoying dinner at the National Press Club.

Children's health: strong foundations for the future?

Presenters: **Dr Sharon Goldfeld**, Royal Children's Hospital, Melbourne; **Dr Kerry Carrington**, AIHW

Chair: Ms Ros Madden, AIHW

- With child health there is great value in early intervention. The 'early years' study from Canada is a case in point. Information from the field of neurobiology matches findings from social research; in a nutshell 'from neurons to neighbourhoods'. The brain is immature at birth; life experience changes and develops its structure and function.
- Many societies put their intervention dollars at the end of life. If more were done at the start of life there may be fewer of the sorts of health problems described elsewhere in the conference, e.g. obesity.
- Research is available showing good long-term outcomes of early intervention; data is 'central' to policy.
- We have a unique policy window open in Australia to instigate positive change for children and young people. While the focus is currently on young children, effort is also required to leverage activity towards older children and young people.
- The real challenge lies in maintaining the policy window in order to make a real difference to outcomes for children; to improve their health and wellbeing and to minimise the inequalities already apparent when children are young.
- A policy shift is required that changes concerns from service delivery outputs to a focus on outcomes that encompass the issues of social determinants, inequalities





(Left to right): Rob Carter from Melbourne University, AIHW Resources Division Head Ken Tallis, and Prof Gavin Andrews in a lively discussion of mental health issues.

and system performance. If we fail to build capacity in our information systems the policy window will close, as the 'problem' will no longer be visible and the political and policy imperative will be lost.

- Infant mortality has halved in the last two decades, largely as a result of a 74% fall in SIDS deaths between 1982 and 2002. However, SIDS still remains the single most important leading cause of death in the post-neonatal period, i.e. deaths between 28 days and under 12 months of age.
- A similar decline in mortality is also observed among children aged 1–14 years of age. Between 1982 and 2002, mortality in this age group fell by 51% for boys and by 50% for girls. This decline was, in large part, a result of the decreased deaths from injury, which nevertheless remains the leading cause of death for children.
- Despite the low level of child mortality overall, Indigenous Australian babies are 2.2 times more likely to die in infancy than non-Indigenous babies and Indigenous children aged 1–14 years are 2.7 times more likely to experience death in childhood than their non-Indigenous counterparts. These facts are reinforced by the very high deaths rates prevalent in remote and very remote areas of Australia, where most Indigenous children live.

Mental disorders: what about the stats?

Presenters: **Mr Ken Tallis**, AIHW; **Dr Grant Sara**, NSW Health

Chair: Ms Glenice Taylor, AIHW

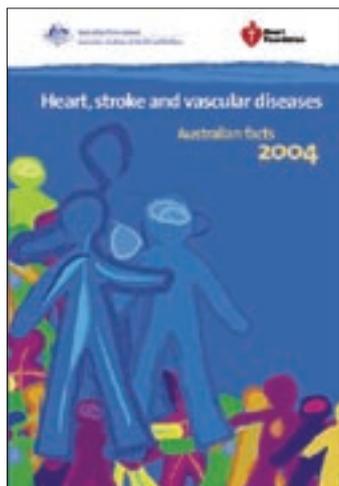
- The most common mental health disorders (mood swings, depression, anxiety) take up fewer resources than the rarer but much more severe disorders such as schizophrenia.
- There has been a decline in the public sector and a rise in the private sector in the number of beds and expenditure per person in psychiatric hospitals.
- Mental health information could be improved with:
 - the development of a mental health casemix classification
 - better information on the mental health workforce
 - analyses of links with mainstream health, disability, welfare, and housing—this will give a better picture of continuity of care issues
 - data on the activity of NGOs (e.g. in residential care)
 - better information on community mental health services
 - regular monitoring of population mental health, both small and more often (CATIs); and big and less often.

- Prof. Sara decried the lack of statistics to assist in areas of: service delivery (where there are often variations in the level of need, distress, and patterns of therapeutic drug use); quality and safety; workforce numbers and distribution; and political discussion around budgeting.
- It would be nice to have:
 - comprehensive, frequent epidemiological data and supporting analysis of local factors
 - measures of demand and need
 - measures of the level and pattern of drug use
 - workforce modelling
 - data to evaluate packages of care—costs and benefits
 - a statistical scaffolding for developing and evaluating information.
- But there are barriers to using data for generating improvement, e.g. lack of skills in analysing and interpreting data. And even when data are put into the public eye, it doesn't automatically produce improvements in service delivery.
- Topics raised in the ensuing lively discussion included:
 - whether recent reductions in the number of psychiatric beds had gone too far
 - how to fill gaps in knowledge, particularly concerning prisoners and the homeless
 - the need to continually monitor the impact of deinstitutionalisation on carers (including family and informal carers)
 - whether we need to revamp our models of addiction, given that there has been a switch from heroin (which has a low impact on psychology) to amphetamines and cannabis (which have higher impacts) – and this is showing up as increased mental health-related admissions relating to drug use
 - how changes in the mix of public and private practitioners may affect the delivery of mental health care
 - the need to monitor the physical co-morbidities of mental illness
 - access to good general medical care and the treatment of chronic pain and depression (and their interrelationship).



The Media and Publishing team extraordinaire, (left to right): Felicity Harrigan, Ainsley Morrissey, Alison Sims, Lauren Di Salvia, Janine Martin, Sarah Aldridge, Amanda Archer (not pictured: Paul Wright and Nigel Harding).

The latest on cardiovascular disease in Australia



The latest and most comprehensive coverage of cardiovascular disease in Australia is contained in *Heart, Stroke and Vascular Diseases—Australian Facts 2004*, released originally by the AIHW in collaboration with the National Heart Foundation of Australia.

The report was launched by the Federal Health Minister, the Hon. Tony Abbott, in Goulburn. The Institute's Director, Dr Richard Madden, and the Principal Executive Officer of the National Heart Foundation of Australia, Dr Lyn Roberts, also attended.

The launch received considerable national media coverage.

It is the third report in a series by the National Centre for Monitoring Cardiovascular Disease, drawing from a vast range of sources. The report presents information on patterns and trends in cardiovascular health and illness, their associated risk factors, treatment and management of the disease. This edition includes new sections on

congenital heart diseases, alcohol consumption and kidney failure as risk factors for cardiovascular disease, and general practice care of people with cardiovascular disease.

The overarching theme of this report is health inequalities, a major issue for this disease group. Certain sections of the Australian population have a greater burden of ill health due to cardiovascular disease than others. Indigenous Australians are more likely to be hospitalised and, depending on their age, up to 10 times more likely to die from cardiovascular disease than the rest of the population. Indigenous Australians have one of the highest rates of acute rheumatic fever and chronic rheumatic heart disease in the world, with death rates from these conditions 19 times those of other Australians. Similarly, Australians who are at a socioeconomic disadvantage are more likely to die from cardiovascular disease than other Australians.

Despite enormous falls in cardiovascular death rates over the past 30 years, cardiovascular disease still affects about 3.7 million Australians overall, 1.1 million have a related long-term disability, and over 50,000 die from it each year. With the growing number of older Australians among whom cardiovascular disease is most common, the burden of this disease is expected to increase in coming decades.

Meteor is coming!

Yes, development of the METadata Online Registry is well under way, and heading for a February 2005 launch.

And to prove that METeOR is no pie in the sky, we are happy to report that the prototype has already been designed and built, and that basic restructuring of the existing Knowledgebase content has been completed.

Of course no successful launch can be held without a plethora of checks and testing, and that is what is happening at the moment—the system and the content are undergoing quality

assurance checks, and user review and consultation, which will guide final developments and refinements.

Next up before blast-off will be authoring of website content and the migration of restructured content into the new system.

Watch this space for more METeOR developments!

For more information on any aspect of the METeOR project please contact David Braddock on (02) 6244 1136.

Australian Hospital Statistics 2002–03

The Institute has recently published its tenth annual report on activity and characteristics of hospitals in Australia.

Australian Hospital Statistics 2002–03 draws data from the Institute's National Hospital Morbidity Database, the National Public Hospital Establishments Database, the National Emergency Department Waiting Times Data Collection and the National Elective Surgery Waiting Times Data Collection.

The report has a focus on time series information, included in the summary *Hospitals at a glance* section and in four other chapters. This collection of time series statistics provides a useful resource for understanding the different and changing roles of public and private hospitals over recent years.

Overall, separations and patient days in Australian hospitals have increased over time. There were 6,653,772 separations from Australian hospitals during 2002–03, up 4% on the previous year. The total number of days spent in hospital by patients increased by 1.5% to 23,550,400 patient days.

Reported public acute hospital admissions increased by 3.2%, to 4.1 million admissions, while for private hospitals, admissions rose by 5.3% to 2.6 million admissions. After adjusting for private hospitals included in the data collected for 2002–03 but not in 2001–02, there was an increase of 3.0% for private hospitals.

The proportion of hospital stays that are same-day is also increasing, up to 54% of total separations in 2002–03. Since 1998–99, the proportion of public hospital admissions that were same-day increased from 45% to 49%, and same day admissions increased from 55% to 62% in private hospitals.

For 2002–03, the average length of stay was 3.5 days, down from 3.9 days in 1998–99. However for patients staying at least one night, the average length of stay has been relatively stable at around 6.5 days.

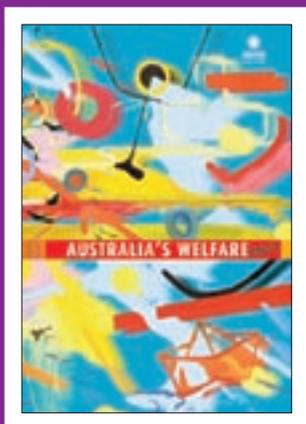
Australian Hospital Statistics 2002–03 also presents a range of hospital performance indicators reported within the context of the National Health Performance Framework. Timely publication of these indicators allows them to be available for inclusion in other reports on health sector performance, such as those produced by the National Health Performance Committee and the Steering Committee for Review of Government Services.

The indicators included in the report showed that:

- Median waiting times for elective surgery in public hospitals in 2002–03 was 28 days, up from 27 days in 2000–01 and 2001–02.
- The average cost per case-mix adjusted separation was \$3,184 in public acute hospitals, mostly comprising non-medical and medical labour costs.
- The proportion of patients in public hospitals receiving emergency department care within the required time was 66% compared with 64% in 2001–02.
- The national rate of caesarean sections per 100 in-hospital births increased from 22.7 to 29.3 over the years from 1998–99 to 2002–03.
- In 2002–03, there were 30.8 separations per 1,000 population for selected potentially preventable conditions. Selected potentially preventable conditions (including acute, chronic and vaccine-preventable conditions) presented in this report are those where hospitalisation is thought to be avoidable if timely and adequate non-hospital care is provided. The national separation rate for vaccine-preventable conditions such as influenza and pneumonia was 0.63 per 1,000 population. Separation rates varied geographically. For chronic diabetes complications, there were 7.0 separations per 1,000 population in major cities compared to 20.7 in very remote regions.

project reports

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Australia's Welfare 2003 features special chapters on informal care and indicators of the welfare of Australia's population. Other topics include welfare expenditure, the welfare services labour force, children's and family services, child protection, housing assistance, services for homeless people, ageing and aged care services and disability services.

Please take a look at the enclosed form for further information on how to order.

Spot AIHW at a Conference and come and say G'day!



Every year AIHW takes up exhibition space at a handful of conferences around the country. Already you may have spotted us back in July at the

Health Informatics Conference in Brisbane (pictured), and at the more recent Australian Population Association Conference here in Canberra in September.

You won't be able to miss our stand. It is incredibly bright and cheerful with big colourful posters adorning the walls. We have a huge array of our publications on display and for sale, both the bestsellers and some of the more obscure subjects. More recently we have been demonstrating the Ageing Research Online Website, and you can also pick up some fun giveaways of course!

All publications sold at conferences receive AIHW's over the counter discount of \$10 off the cover price (\$5 off bulletins).

We always welcome a friendly face and a chat, so come and say G'day!

Come and visit the AIHW stand at the following conferences:

- 17–19 Nov 2004** Maturing Assets: Appreciating an Ageing Australia
37th Annual Conference of the Australian Association of Gerontology, Hilton on the Park, Melbourne
- 25–26 Nov 2004** The Australian Council for Health, Physical Education and Recreation (ACHPER) 2004 Health and Physical Education Conference, Monash University, Melbourne
- 5–12 April 2005** 55th Session of the International Statistical Institute (ISI 2005), Sydney Convention and Exhibition Centre
- 20–22 July 2005** Australian Social Policy Conference, University of NSW, Sydney

National Perinatal Statistics Unit (NPSU)

THE AIHW's oldest collaborating unit marks its 25th birthday this year.

The Sydney-based National Perinatal Statistics Unit (NPSU) had its beginnings in 1979, the result of a Federal Government response to public concerns surrounding the alleged increasing incidence of congenital birth defects associated with the use of herbicides, notably the active constituent 2,4,5-T.

Government research and development funds were made available to set up a unit specialising in perinatal statistics, and a successful application from the University of Sydney led soon afterwards to the establishment of the National Perinatal Statistics Unit at the then Commonwealth Institute of Health, based at Sydney University.

From 1985, NPSU functioned as an external unit of the Australian Institute of Health (now AIHW), contracted through the University of Sydney. Following the Institute's review of the Unit in 1996, it was proposed that the NPSU be relocated to the University of New South Wales (UNSW).

Since July 1997, the Unit has been a part of the UNSW, based in the School of Women's & Children's Health. The Unit is located at the Sydney Children's Hospital, Randwick Hospital Campus.

Since its early years, the Unit's program scope has continued to expand beyond its initial specialisation of statistics on the perinatal period, considered the period from 20 weeks gestation to 28 days after birth.

'For some time, NPSU has been broadening its approach to reporting on perinatal health statistics, which is the purpose for which the Unit was originally set up', said Dr Elizabeth Sullivan, who has headed the team of nine staff for the last two of her six years with NPSU.

'These days, we are well established in providing statistics and information on reproductive health, as demonstrated by our work in the areas of assisted conception, maternal deaths, and the first of our reproductive health indicators reports, released in 2003, which I count as one of our key achievements.

'And because we produce a core data set, information covered in our reports on births, perinatal and maternal deaths and caesarean sections, for example, is incorporated in a number of the Institute's key publications, including *Australia's Health*.'

With issues such as falling fertility rates, the continued trend in rising maternal age and increases in the number of women delaying childbearing hitting the headlines regularly, the work of the NPSU makes a key contribution to enabling well-informed community discussion and decision making on these issues.

'These issues affect tens of thousands of families in Australia each year and national data on such trends can greatly assist in drawing attention to the need for changes in health care', Dr Sullivan said.

Drawing from the Perinatal Statistics series, *Australia's Mothers and Babies 2000* reports that the average age of all mothers in 2000 was 29 years. For those having their first baby, the average age was 27.3 years, continuing the upward trend of recent years. And approximately 1 in 10 mothers in 2000 were having their first baby at age 35 or older. The next volume of this report is due out this year.

Published in 2003, the first national report on the reproductive health of men and women in Australia, *Reproductive Health Indicators Australia 2002*, covers a range of indicators including fertility, subfertility, family planning, pregnancy, childbirth, sexually transmissible infections and cancers of the reproductive tract.

Another report scheduled for release this year is the latest in the Assisted Conception series.

'Our data show that more and more people are using Assisted Reproductive Technology (ART) to assist them in becoming pregnant. It also shows that ART treatment is becoming more successful with about 24% of all fresh cycles started resulting in pregnancy', Dr Sullivan said.

'Moreover, while babies resulting from ART have tended to have lower birth weights and shorter gestational ages than other Australian babies, the incidence of these outcomes is decreasing.'

Maternal Deaths in Australia 1997-99 was released in August and is the 12th in a series of triennial reports on maternal deaths dating back to 1964. Fortunately, says Dr Sullivan, the incidence of maternal deaths in Australia continues to be a downward trend.

'It's quite safe to have a baby in Australia, with the absolute risk of death of mother during pregnancy and the period following childbirth remaining very small, being 1 in 8,423 confinements in the three years from 1997 to 1999.'



Who's who of NPSU:

Back row (left to right): Alex Wang, Paula Laws, A/Prof Deborah Black, A/Prof Sally Tracy, Jishan Dean.

Front row (left to right): Dr Joanne Bryant, Narelle Grayson, Dr Elizabeth Sullivan, Emma Slaytor, Emma Ong.

However, despite general improvements in general health status and reproductive patterns, and access to appropriate general and specialised health care, Dr Sullivan said life-threatening complications during pregnancy and childbirth still occur, often unpredictably.

'Seeking to avoid loss of women's lives in childbearing, and minimising damage to their health, remain issues of critical importance for obstetric and midwifery practice in Australia.'

Over the last three to four years, Dr Sullivan and the NPSU team have seen the continued expansion of the Unit and a broadening of its scope, including the revitalisation of the birth defects series — the first report in the new Birth Anomalies series was released in July.

'We've also implemented a new data collection on Assisted Reproductive Technology and our series on Maternal Deaths is now being reported at a national level.'

The future for the NPSU looks to extend well into middle age, and may even include a name change, which was proposed following the Institute's most recent review of the Unit.

'We are currently looking to rename the unit, so that our name is a more accurate representation of all that we do', Dr Sullivan said.

'We always want to be improving our reports and making them more consumer, practitioner and policy-maker friendly. We have already started down this path to improve their usefulness, having restructured a number of them.

'Another goal is to do much more applied research using the data we collect, including looking at the relationships between the data and the different questions that emerge, and we'd also like to see further strengthening of our data development to help fill the gaps in our knowledge, particularly for our maternal deaths and reproductive health reports.'

NPSU staff

Dr Elizabeth Sullivan has been with the NPSU since 1998 and has been Director for the last two years. Her key research interests include sexually transmitted infections in pregnant women, pregnancy-related morbidity and mortality and standardisation of maternal death reporting.

Jishan Dean is the Unit's Information Technology and Business Manager. Originally from China, she has been with the unit for 11 years, making her the longest serving member of the team. A 'jack-of-all-trades' in the workplace, Jishan is also a keen skier and croquet player.

Emma Ong has been with the Unit for five years as the Administrative Officer and was previously an occupational health assistant with a chemical industrial organisation. At NPSU, she is responsible for a range of administrative duties as well as the efficient day-to-day running of the unit. Emma hails originally from the Philippines.

Joanne Bryant is an IVF Epidemiologist who has worked with the Unit for the past two years in the area of Assisted Reproductive Technology (ART). She is responsible for



setting up the data management systems for the new data collection on ART implemented at the beginning of 2002 and, with the introduction of the new data collection, Joanne has restructured the Unit's ART report. A native of Canada, she recently completed a PhD in health sociology.

Paula Laws has worked as a Research Officer with the NPSU for just over a year, having come from AIHW in Canberra. Her main roles are to manage the National Perinatal Data Collection and to provide secretariat support to the National Perinatal Data Development Committee. Paula has recently finished work on *Australia's Mothers and Babies 2001* and an evaluation of the Perinatal National Minimum Data Set. She is currently working on *Australia's Mothers and Babies 2002*.

Narelle Grayson, a Health Analyst, was seconded to NPSU from AIHW in February this year. After completing the review of the congenital malformations and birth defects data collection report published recently, she is now working on the development of the new Australian Birth Anomalies System and the new series of reports on birth anomalies.

Emma Slaytor has been a Senior Research Officer at the Unit for one year, having worked at NPSU previously in 1999. Her current role involves management of the Maternal Deaths report, with the 1997–99 report released recently. Emma has begun work on the 2000–02 report, due out next year.

Alex Wang, Research Officer, is a medical graduate from Shanghai Medical University. He initially joined the NPSU as a research assistant after migrating to Australia in 2002. Alex has completed a Master of Public Health at UNSW and his main areas of research include the study of perinatal outcomes following the use of ART, an ART linkage study, post-partum haemorrhage and advanced maternal age in Australia.

Sally Tracy is an Associate Professor of midwifery at UTS and joined the Unit this year as an NHMRC post-doctoral research fellow, working on an NHMRC capacity building grant in population health known as HERON. She is working on a number of projects using the Unit's perinatal data.

New website ...coming soon

The AIHW website was originally launched in 1997, with the current version following in 1999, now visited by an average of 2,000 individual visitors every day.

The site has grown steadily in popularity and functionality, with the addition of:

- over 40 multidimensional data cubes
- a new releases alerting system to which you can subscribe
- an online publications catalogue and secure online purchasing service
- secure secretariat services for a number of national and other high-level committees supported by the Institute.

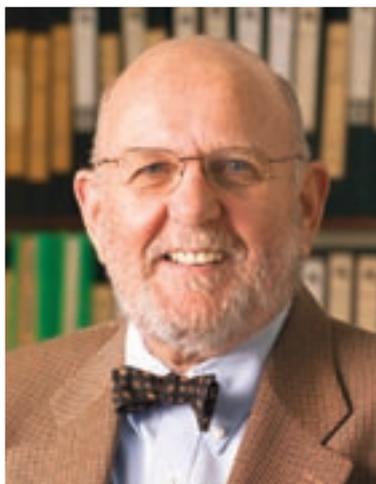
A brief survey conducted last year, to which many Access readers responded, indicated very high overall satisfaction with the website's content. However, the survey confirmed our opinion that improvements to the site's navigation and graphic design were called for.

As a precursor to the redesign, we have commissioned an expert 'clickstream' analysis of visitor activities on our site, to help us understand what our users are seeking and any problems they may be encountering whilst navigating. Armed with this knowledge, we have designed a new information architecture, based on sound usability principles, and we will be contracting a specialist web designer to update the site's look and feel.

Watch out for our refreshed website in the next few months and please tell us what you think — we value your feedback!

Healing the mind

Gavin Andrews, UNSW at St Vincents Hospital, Sydney



The treatment of people with mental disorders is regularly criticised – ‘private psychiatrist deregistered because of sex with patient’, ‘man turned away from psychiatric unit commits suicide’ but headlines miss the work that the private and public mental health services do achieve. ‘Is treatment for the common mental disorders efficient?’ is a question that a research group at UNSW at St Vincent’s Hospital, Sydney, have been grappling with.

They used two concepts—a measure of health gain, and a measure of efficiency. Health gain was the proportion of disability due to a mental disorder that was averted by treatment (expressed as ‘Years Lived with Disability’ averted or YLDs) and efficiency was measured by the cost of averting one ‘Year Lived with Disability’ (expressed as \$/YLD). In most developed countries health care is freely available if a unit of health gain costs less than the average wage, that is, less than the threshold of AUD\$40,000 per YLD.

How efficient is current psychiatric treatment? Using data from the national mental health surveys conducted in 1997 they calculated that about 13%, or one eighth of the burden of mental disorders were being averted by current treatment, in part because only a minority of people with substance use and anxiety disorders had sought treatment. But even with depression and schizophrenia, disorders in which the majority of people seek and get treatment, still only an eighth of the burden was being averted. If the proportion of burden being averted by current treatment was similar across these diseases, the cost effectiveness or efficiency of current treatment was not—depression and anxiety disorders cost some \$20,000/YLD whereas the treatment of alcohol use disorders and schizophrenia cost \$100,000/YLD and \$200,000/YLD respectively, figures well beyond the threshold for an affordable treatment.

How efficient could psychiatric treatment become?

The research group then calculated the improvement that would occur if all the patients currently in treatment got best care, in their words ‘evidence based medicine’. Well, the total cost to the health service would fall slightly (while you pay more for ideal treatments, you don’t pay doctors for treatments that don’t work), the proportion of burden averted would improve from one eighth to a fifth, and the efficiency across all disorders would improve. Even so, the cost of treatment of alcohol use disorders would still be above the affordable threshold and the cost of treatment for schizophrenia would be, at \$100,000/YLD averted, double that affordability threshold.

Is only a fifth of the burden of mental disorders curable?

Well, yes and no. The way the health services function now, yes. But if everyone with a mental disorder got treatment and if all doctors practiced evidence based treatment, the answer is somewhat better. Given ideal conditions about 40% of mental disorders seems curable, and 60% is not, from a low of 50% of anxiety disorders being incurable to a high of 80% of schizophrenia being incurable. No one expects that all people with any serious illness will be cured, but is 40% enough? The researchers then tracked three physical disorders—asthma, rheumatoid and osteo-arthritis—and found that all current and optimal treatments for these disorders were under the affordability threshold, and that given ideal conditions, only 40% of the burden was not able to be averted.

What is the take home message? This work has been published in international journals and some has now been confirmed by other research groups. So we are left with three serious conclusions:

1. The treatment of mental disorders may be less advanced than the treatment of some physical disorders.
2. Wastage, because doctors do not apply correct treatments, is causing unnecessary suffering and costing serious money.
3. If doctors did the right thing and practiced evidence based medicine it would not cost any more.
4. When a large proportion of a disease seem unavertable by present knowledge we should spend serious research monies to learn the cause and mechanism of that disease so we can develop better treatments.



on Edward J Sondik, Director of the US National Centre for Health Statistics

‘AIHW is very, very well respected. There seems to be a real drive for facts, statistical rigour and a sense of public duty within the organisation.’

‘I’m impressed with your website, your dissemination efforts, and with your role in the international statistics community.’

This is high praise indeed, coming from Dr Edward J Sondik, Director of the US National Center for Health Statistics (NCHS), after his visit in June this year as keynote speaker at AIHW’s health conference.

‘I really enjoyed the AIHW conference and thought it went extremely well and, of course, you can be very proud of *Australia’s Health 2004*, the centrepiece of the conference.

‘I was particularly impressed with the attendance by the Minister for Health and Ageing. Hearing him speak so meaningfully added great substance to the implications of the report and the conference in terms of health policy.

‘We have no such conference when we release *Health, US*, our annual publication on national trends in health statistics.

I have long wanted something like you’ve just had and will strongly consider it for the future.’

Dr Sondik has been Director of the National Center for Health Statistics, one of the Centers for Disease Control and Prevention (CDC), since 1997 and relishes his role in heading up the USA’s federal health statistics agency. But how does its work compare to AIHW?

‘The NCHS shares many parallels with what you undertake here in Australia. However, we probably do concentrate more on data collection than AIHW, such as the United States vital statistics collection, but with somewhat less emphasis on analysis.’

NCHS is home to the Vital Statistics System, which provides information on the two most critical measures of health: birth and death. NCHS also conducts a number

of other nationwide surveys that provide information on health status and on the healthcare system. Interview and examination surveys profile the care in hospitals, doctors’ offices, hospices, home health and nursing homes.

‘Our statistics are very widely used. Our vital statistics are crucial in tracking population growth and change in the United States. Our data are also used by researchers who study ageing, hypertension and obesity.

‘The paediatric growth chart used in doctors’ offices around the country comes from us, and we also collect detailed information on diet and nutrition and produce the earliest information on health insurance, providing statistics on what percentage of the population is insured and not insured.’

At first glance, Dr Sondik’s qualifications in electrical engineering don’t seem to fit with a career in health. Passionate about what he does, Ed explains how he ended up working within the field.

‘My academic training at the University of Connecticut was in electrical engineering on the side of control systems, computers, and operations research. During my PhD work at Stanford University, there was an opportunity to work with the Stanford Medical School to redesign the Stanford Hospital and this sparked my interest in health problems and issues.

‘That interest was well and truly cemented while teaching at Stanford, when I was involved in designing two clinical trials — one on cholesterol lowering and the other on changing people’s behaviour relating to diet, smoking and blood pressure.

‘It was fascinating work, with the latter initiative aimed at seeing how the media, coupled with personal interventions, could be used to change personal behaviour.

‘In 1976, I went to the National Institutes of Health to work on a clinical trial design in the National Heart, Lung and Blood Institute and I ended up working there for six years.

‘Following that, in 1982 I moved across to the National Cancer Institute (NCI), where my interest focused more on statistics and mathematical modelling. At one point I was responsible for the SEER Program, the pioneer cancer registry system.’

Continued over page ►

Dr Sondik held several posts within the National Cancer Institute, from Chief of the Biometrics and Operations Research Branch to Deputy Director of the Division of Cancer Prevention Control, as well as Acting Director, NCI.

This laid the foundations for his next professional challenge as the Director of the National Center for Health Statistics, where he also serves as Senior Advisor to the Secretary on Health Statistics, providing technical and policy advice on statistical and health information issues.

'My work in public health has been very rewarding. I think my background in mathematics and statistics and the discipline of operations research have been crucial to me. My experience in mathematical modelling has been invaluable as well.'

Something else invaluable to Ed over the years has been his family. Living in Maryland with wife of 40 years, Ellie, they have a happy and healthy family.

'My son Rob is a commercial producer living in California, and daughter Karen, a lawyer, is based in New Hampshire with our much loved grandson, Max, who is four months old.

'Being our first grandson, Max's arrival was quite an event for us, that's for sure!'

we need to continue research with decision makers to find better ways to present our data and the implications of alternative decisions

When not busy at the office Ed likes nothing better than getting out into the fresh air and beautiful landscape of Maryland's mountains.

'I enjoy hiking a great deal, and Ellie and I try to escape into the mountains regularly. It was a shame I didn't have more time while in Australia to experience some of your bushland. It certainly looked like there was some

great hiking to be done in and around the Canberra region.

'Other pastimes include working in the yard, at my wife's direction of course, and I have been also known to work on a few cars in my time — the dirtier the better!'

Judging by the books on his reading list, Dr Sondik's love of science and engineering covers a wide spectrum of topics. Books recently devoured include *The Great Bridge: The Epic Story of the Building of the Brooklyn Bridge* by David McCullough, *The Da Vinci Code* by Dan Brown, and *Time Travel in Einstein's Universe: The Physical Possibilities of Travel Through Time* by J. Richard Gott.

'I am hoping that this last one will make attending meetings much more efficient!'

So what does the future hold for Dr Sondik and NCHS?

'I'd like to have time for research, especially on modelling of disease and health, and summary health measures. I still haven't seen a single measure that captures issues in a way that elucidates the key decisions. Perhaps there is no such measure, but I think we need to continue research with decision makers to find better ways to present our data and the implications of alternative decisions.

'I'd also like to see our base in informatics improve. At NCHS we've made great strides in re-engineering our major surveys and progressing Vital Statistics, all of which rely critically on informatics.

'There are enormous benefits to be gained here to make CDC's information more accessible to the world, and one of our key priorities is developing our Internet and modern records processing systems to make them more responsive, dynamic, safe and secure.'

Dr Sondik's Center has a pivotal role to play in bringing to life CDC's vision for the future of health in the United States.

'NCHS will be crucial in tracking the progress of the new goals for CDC, laid out in the 'Futures Initiative' by our Director, Dr Gerberding. One of these objectives is to provide the latest public health information at the state and local level, as well as the national level.

'In health in the US, as in many other countries, we have problems with disparities in health outcomes. It's important to learn and understand how various groups in our population fare, especially the factors that point to disparities in health, and to monitor progress in eliminating those disparities. In so doing we need to improve health care quality, and we and other US agencies are working to learn more about our health care quality.'

Although there are obviously many stiff challenges ahead, Dr Sondik's own sense of statistical rigour and public duty means he wouldn't have it any other way. When offered the hypothetical of a life over again, he is adamant that he has already made the right choice in health as a vocation in life.

'Mathematical modelling of the health system and managing the health database for the US would be a great accomplishment, if I wasn't doing what I was doing now. Mixed in with a more than liberal dose of mowing lawns and fixing cars of course!'

Renewal of the National Information Agreement

The May 2004 edition of AIHW ACCESS reported on the renewal of the National Community Services Information Agreement, and of the appointment of Ms Linda Apelt as Chair of the National Community Services Information Management Group.

Since then, there have been similar significant milestones in the national health and housing governance arrangements.

The **National Health Information Agreement (NHIA)** provides the foundation and framework for national health information collections. The Statistical Information Management Committee (SIMC) is responsible for oversight of the Agreement under the general direction of the National Health Information Group (NHIG). The AIHW provides the Deputy Chair and Secretariat of the SIMC.

The previous Agreement expired on 31 May 2004 and was extended until 31 August 2004, pending the signing by all jurisdictions of a revised agreement.

At its meeting on 9 June 2004, AHMAC endorsed the revised NHIA.

The revised Agreement retains the scope and main features of the previous Agreement, with minor changes to reflect the current national health information governance arrangements and contemporary approaches to privacy, data linkage and moves to greater consistency between health, housing and community services data.

The revised Agreement commences on 1 September 2004 and will remain in effect for five years (from 2004 to 2009), but can be varied or terminated at any time by agreement of the parties, with a specific requirement for a review to commence within 12 months of the Agreement's coming into effect and a further review within the 12 months prior to the expiry date of the Agreement.

The Australian Government Department of Veterans' Affairs is, for the first time, a party to the NHIA.

Most recently, the Housing Ministers' Advisory Committee on 12 August renewed the **National Housing Data Agreement** and the **Agreement on National Indigenous Housing Information**.

The National Information Agreements provide a framework for national information and data infrastructure activities in the AIHW's three areas of responsibility. The national commitment to their continuing support demonstrated throughout the review process for each Information Agreement is a strength of Australia's health and welfare information sectors.

For further information on the NHIA or SIMC, please contact Margaret Blood (margaret.blood@aihw.gov.au).

Recent releases all prices include GST

September 2004

AIHW Access no. 17	Cat. No. PER 25	FREE
Australia's Mothers and Babies 2001	Cat. No. AUS 51	\$30.00
Diversity amongst Older Australians in Capital Cities 1996–2011	Cat. No. HWE 27	\$10.00
Health Expenditure in Australia, 2002–03	Cat. No. PHE 55	\$25.00
Spinal Cord Injury, Australia 2002–03	Cat. No. INJ 64	\$25.00

August 2004

Commonwealth-State Housing Agreement User Guide for 2001–02 data: Public Housing and the Aboriginal Rental Housing Program	Cat. No. HOU 107	\$26.00
Commonwealth-State Housing Agreement User Guide for 2002–03 data: Public and state owned and managed Indigenous housing	Cat. No. HOU 109	\$26.00

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August 2004

Data Set Specification, Acute Coronary Syndrome (clinical), National Health Data		
Diabetes Management and the Allied Workforce: An Overview of Workforce Mapping Techniques and Related Data Issues	Cat. No. HWI 70	FREE
National Health Data Dictionary Version 12 Supplement	Cat. No. HWI 70	\$22.00
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National Summary of the 2001 and 2002 Jurisdictional Reports		
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Rheumatic heart disease: all but forgotten in Australia except among Aboriginal and Torres Strait Islander peoples	Cat. No. AUS 48	\$10.00

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The Child Dental Health Survey, Australia 2000	Cat. No. DEN 131	\$20.00
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June 2004

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May 2004

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AIHW Access no. 16	Cat. No. HWI 68	FREE
Commonwealth Rent Assistance, June 2002: A Profile of Recipients	Cat. No. AUS 45	\$10.00
Community Aged Care Packages Census 2002	Cat. No. AGE 35	\$26.00
Health System Expenditure on Disease and Injury in Australia 2000–01	Cat. No. HWE 26	\$25.00
Heart, Stroke and Vascular Diseases: Australian Facts 2004	Cat. No. CVD 27	\$30.00

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