



**Australian Government**

**Australian Institute of  
Health and Welfare**

# **Data sources for monitoring overweight and obesity in Australia**

## **Appendices**

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# Appendix A: Data sources template

## Template for describing relevant data sources

Full name of the survey or data collection		
Type of data source	For example, survey type (registry or administrative) and scope (national, state or regional).	
Brief description	Brief outline of data source and information relevant for monitoring conditions associated with overweight and obesity.	
Purpose(s)	Main stated purpose or purposes of the data source.	
Collection methodology	Key features of the collection methodology (administrative or survey) and data collection method (computer-assisted telephone interview, self-completion, administrative).	
Scope (theoretical coverage of relevant population)	Population that is potentially covered.	
Coverage (actual)	Actual population covered (response rate).	
Geographic coverage	National, state or other	
Frequency/timing	Year(s) in which data have been collected	
Basic collection count	For example, treatment episodes, separations, etc.	
Size	Sample size or number of records in most recent reference period.	
Collection management organisation	The organisation chiefly responsible for collection and managing the data.	
Further information	A web link with further information.	
Data access	For example, publicly available or request needed.	
Priority information areas		
Modifiable risk factors	Nutrition	Self-reported/measured/unclear
	Physical activity	Self-reported/measured/unclear
	Alcohol intake	Self-reported/measured/unclear
Environmental risk factors	For example, neighbourhood walkability or food environment variables.	
Related conditions	Any data collected on accepted conditions related to overweight and obesity.	
Prevalence	Waist circumference	Self-reported/measured/unclear
	Height and weight	Self-reported/measured/unclear

Prevention, treatment and management	Prevention, treatment and management (in general practice, other primary health care, specialist and hospital settings and medication use).
Quality of life	Includes pain, disability, functioning, problems at school, work disability, loss of productivity, social participation, and mental health, carer impacts.
Death and disability	Disability, death and burden of disease (as a summary measure of these two factors combined).
Expenditure, costs	To the individual, family members or carers and the health system.
Population demographics	For example, age, sex, location (remoteness and socioeconomic status can be generated from location in some cases), Indigenous status, marital status.

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## Appendix C: In-scope data sources

1. Australian Capital Territory General Health Survey (ACTGHS)	
Type of data source	Survey (state/territory)
Brief description	<p>The ACT General Health Survey (ACTGHS) is one of the main instruments through which the ACT Health Directorate monitors the health of the ACT population and reports on performance indicators. It is administered by professional survey staff, on behalf of ACT Health, by telephone.</p> <p>The ACTGHS was developed in 2007 to address issues around small ACT sample sizes in national surveys, irregularity of national surveys and inability to always meet information needs in a timely manner.</p>
Purpose(s)	<p>The objectives of the ACTGHS are to:</p> <ul style="list-style-type: none"> <li>• monitor changes over time in self-reported health behaviours, health status, health service use, satisfaction with health services, and other factors that influence health</li> <li>• support the planning, implementation, and evaluation of health services</li> <li>• collect health information that is not available from other sources</li> <li>• be responsive to emerging needs for health information</li> <li>• promote research.</li> </ul>
Collection methodology	Computer-assisted telephone interview (CATI) survey. Child interviews are conducted via proxy by the parent or main carer.
Scope (theoretical coverage of relevant population)	Random selection of households within the ACT. Mobile phones were incorporated into the sample frame in 2012.
Coverage (actual)	The survey collects information from an average of 1,300 persons per year, including approximately 500 children via parents or carers.
Geographic coverage	Australian Capital Territory
Frequency/timing	Yearly between 2007 and 2016. The ACTGHS was not conducted in 2017. The 2018 ACTGHS will be conducted in September/October 2018 and continue yearly.
Basic collection count	Persons
Size	~1200 adults and 500 children (aged <15) are surveyed each time the ACTGHS is conducted.
Collection management organisation	Epidemiology Section, ACT Health
Further information	<a href="http://stats.health.act.gov.au/data-collections">http://stats.health.act.gov.au/data-collections</a>

Data access	Some de-identified data on selected topics available publicly by age and sex via <a href="#">ACT Government Open Data Portal</a> . For additional data access, contact ACT Health via <a href="mailto:HealthSurvey@act.gov.au">HealthSurvey@act.gov.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported intake of: <ul style="list-style-type: none"> <li>• fruit and vegetables</li> <li>• soft drink, cordials and sports drinks</li> <li>• sweet and salty snacks, fast food and confectionary.</li> </ul>
	Physical activity	Self-reported: <ul style="list-style-type: none"> <li>• transport to school and work</li> <li>• time spent in screen time</li> <li>• time spent in physical activity per day</li> <li>• participation in sports.</li> </ul>
	Alcohol intake	Self-reported frequency of intake; categorised as single occasion risky levels and lifetime risky levels.
Environmental risk factors	No data	
Related conditions	Diabetes (prevalence) and cardiovascular disease (blood pressure and cholesterol)	
Prevalence	Waist circumference	No data
	Height and weight	Self-reported height and weight for BMI
Prevention, treatment and management	Health service access, use and satisfaction, barriers to health service use and diabetes management activities (not specifically related to overweight or obesity).	
Quality of life	Self-rated health status and psychological distress (not specifically related to overweight or obesity).	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Age, sex, area of residence (North Canberra, South Canberra, Woden, Belconnen, Weston, Tuggeranong, Gungahlin, NSW, Not stated/other), employment status, household structure, marital status, country of birth, mother's country of birth, father's country of birth, main language spoken at home, Indigenous status, level of education, mother's level of education, father's level of education.	

<b>2. Year 6 Australian Capital Territory Physical Activity and Nutrition Survey (ACTPANS)</b>	
Type of data source	Survey (state/territory)
Brief description	<p>The ACT Physical Activity and Nutrition Survey (ACTPANS) has been conducted every 3 years since 2006. It is administered by professional survey staff, on behalf of ACT Health, within the classroom setting.</p> <p>Information about physical activity, nutrition, healthy weight status, attitudes and general wellbeing indicators are collected. Height and weight are also measured.</p>
Purpose(s)	<p>The main objective of ACTPANS is to provide ongoing reliable information about the prevalence, trends and determinants of healthy weight in young people in the ACT.</p> <p>ACTPANS provides data about:</p> <ul style="list-style-type: none"> <li>• BMI distribution and change in distribution over time</li> <li>• the pattern of physical activity undertaken in schools, out of school and active transport to and from school</li> <li>• eating patterns at home and at school</li> <li>• attitudes towards food, eating habits, health, wellbeing and physical activity</li> <li>• the impact of physical activity, eating patterns, attitudes and psychosocial outcomes in predicting BMI.</li> </ul>
Collection methodology	<p>ACTPANS involves 2 components:</p> <ul style="list-style-type: none"> <li>• a brief, self-administered questionnaire on a handheld electronic device (for example, tablet) conducted in a classroom environment</li> <li>• trained research staff measure height and weight in a private and confidential setting.</li> </ul>
Scope (theoretical coverage of relevant population)	<p>The sample frame is based on a stratified two-stage probability sample: schools are first stratified by school sector (government, Catholic and independent) and then a sample of schools are randomly selected, with proportional representation of the three school sectors. Once a school gives consent, all Year 6 children in the school are invited to participate.</p>
Coverage (actual)	<p>All Year 6 students in the ACT are eligible for the survey; ~1,500 students (~30% of this population) are surveyed each time ACTPANS is conducted.</p>
Geographic coverage	Australian Capital Territory
Frequency/timing	<p>Every three years since 2006 (for example, 2006, 2009, 2012, 2015). Data gathering for the 2018 ACTPANS has recently been completed.</p>
Basic collection count	Persons
Size	<p>In 2015, 1,353 students completed the questionnaire component; of these, 1,318 also had their height and weight measured.</p> <p>In 2018, 1,491 ACT Year 6 students from 30 primary schools across the ACT participated in the ACTPANS.</p>

Collection management organisation	Epidemiology Section, ACT Health	
Further information	<a href="http://stats.health.act.gov.au/data-collections">http://stats.health.act.gov.au/data-collections</a> <a href="http://health.act.gov.au/healthy-living/health-improvement">http://health.act.gov.au/healthy-living/health-improvement</a>	
Data access	Some de-identified data on selected topics available publicly by age and sex via <a href="#">ACT Government Open Data Portal</a> . For additional data access, contact ACT Health via <a href="mailto:HealthSurvey@act.gov.au">HealthSurvey@act.gov.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported intake of: fruit, vegetables, soft drink, fast food, meat, fish, sweets, cereals, breads, white meats and milk.
	Physical activity	Self-reported physical activity, including: <ul style="list-style-type: none"> <li>• active transport to and from school</li> <li>• sedentary behaviour</li> <li>• attitudes to physical activity.</li> </ul>
	Alcohol intake	Not applicable
Environmental risk factors	No data	
Related conditions	No data	
Prevalence	Waist circumference	No data
	Height and weight	Measured height and weight for BMI.
Prevention, treatment and management	No data	
Quality of life	Self-assessed health status and questions about whether or not child had been bullied about, or felt bad about, their weight.	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Age, sex, area of residence (North Canberra, South Canberra, Woden, Belconnen, Weston, Tuggeranong, Gungahlin, NSW, Not stated/other), Indigenous status, country of birth, main language spoken at home, school type (Catholic, public or independent).	

<b>3. AusDiab Study</b>	
Type of data source	Longitudinal survey (national)
Brief description	<p>An initial population-based cross-sectional survey conducted in 1999–2000 (baseline) provided the first national prevalence of diabetes and pre-diabetes using an oral glucose tolerance test, and national data on obesity, hypertension and kidney disease.</p> <p>A 5-year follow up was conducted in 2004–05 and a 12-year follow up in 2011–12. These longitudinal data have provided valuable information on the incidence of diabetes, cardiovascular disease and kidney disease for the time period.</p> <p>The study has gathered extensive health information through blood and urine tests, health measurements (height, weight, hip and waist measurements, body fat determination, blood pressure, and 12-lead electrocardiography) and a variety of interviewer-administered questionnaires. Specifically, data collected at baseline include:</p> <ul style="list-style-type: none"> <li>• demographic characteristics (age, sex, ethnicity, socioeconomic position, diabetes status)</li> <li>• lifestyle behaviour (physical activity, TV viewing time, smoking status, alcohol consumption)</li> <li>• medical and family history</li> <li>• health-behaviour related factors (health knowledge, attitudes and practice data, health service utilisation patterns, SF-36 health survey)</li> </ul> <p>Information collected at 5-year and 12-year follow-up are similar to that collected at baseline, and questions on birth weight and medication use were added at both follow-up surveys.</p> <p>Furthermore, in 2011–12, additional questionnaires to examine cognitive function (the Mini Mental State Examination), depression (Centre for Epidemiology Studies Short Depression Scale) and disability (Katz Activities of Daily Living) were added.</p>
Purpose(s)	To examine the prevalence and incidence of diabetes and its complications, as well as hypertension, heart disease and kidney disease and their associated risk factors, to ultimately improve our understanding of how these chronic conditions impact on the health of Australians.
Collection methodology	<p>AusDiab is conducted in the field with a questionnaire and physical testing components.</p> <p>42 sites were randomly selected for participants to attend. Trained research staff took physical measurements and blood and urine samples and interviewers assisted in administering the questionnaire.</p> <p>Participants could complete the questionnaire over the phone and attend local approved pathology labs if they could not attend a testing site.</p>
Scope (theoretical coverage of relevant population)	AusDiab was designed to be representative of the general Australian population aged over 25.

	Sample selection was based on a stratified cluster method. 25,984 households were approached for the baseline study. 28,033 dwellings were approached in total, including 2,049 non-residential dwellings.	
Coverage (actual)	Initial response rate was 55.3% of the in-scope sample. There were 60.6% and 59.8% of the original AusDiab participants attending the 5-year and 12-year follow-up surveys, respectively.	
Geographic coverage	All states excluding ACT in baseline study. ACT added in 2004–05.	
Frequency/timing	1999–2000, 2004–05, 2011–12. There are no future surveys planned.	
Basic collection count	Persons	
Size	11,247 individuals participated in the baseline study in 1999–2000 which was a response rate of 55.3%. Of the 8,798 participants in the second survey (drawn from the original sample) who returned for follow-up in the second survey in 2004–05, 6,400 attended on-site full examination, 137 had laboratory tests only and self-reported information was collected from 2,261 who were unable to return to testing sites. 6,186 individuals participated in the 2011–2012 follow up study of which 4,614 attended on-site full examination, 150 had blood and urine tests only and 1,422 self-reported by telephone questionnaire.	
Collection management organisation	Baker Heart and Diabetes Institute	
Further information	<a href="https://www.baker.edu.au/impact/ausdiab/resources">https://www.baker.edu.au/impact/ausdiab/resources</a>	
Data access	Data can be accessed via written application to <a href="#">the Baker Institute</a> .	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data collected on respondents eating habits, but some questions asked about food and nutrition awareness and associated health outcomes.
	Physical Activity	Self-reported: <ul style="list-style-type: none"> <li>• type and duration of exercise, interviewer determined exercise status of 'sedentary, insufficient or sufficient'</li> <li>• total time spent watching television or videos in the previous 7 days</li> <li>• total sitting time in the previous 7 days (not collected at baseline).</li> </ul>
	Alcohol intake	Self-reported category: <ul style="list-style-type: none"> <li>• never drank alcohol</li> <li>• ex-drinker</li> <li>• heavy drinker</li> <li>• moderate drinker</li> <li>• light drinker.</li> </ul>

		Further information regarding frequency and volume of alcohol intake was collected.
Environmental risk factors	Questions about barriers to physical activity including pollution/noise, safety, accessibility of facilities, lack of footpaths, bike lanes and parks.	
Related conditions	Diabetes, measured blood pressure, hypertension, cholesterol (measured total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides), blood glucose (fasting, 2-hour glucose, HbA1c), heart disease, stroke, chronic kidney disease, back pain (done by mail survey).	
Prevalence	Waist circumference	Measured: <ul style="list-style-type: none"> <li>• hip circumference</li> <li>• waist circumference (to calculate waist circumference status (normal, overweight or obese)).</li> </ul>
	Height and weight	Self-reported and measured: <ul style="list-style-type: none"> <li>• height</li> <li>• weight, using a mechanical beam balance</li> <li>• fat percentage, using bio impedance machine</li> <li>• fat mass</li> <li>• lean body mass</li> <li>• total body water</li> <li>• overweight or obesity classification using BMI.</li> </ul>
Prevention, treatment and management	<p>Self-reported medications, including anti-diabetic medications, oral contraceptive pill, cholesterol lowering and blood pressure control medications.</p> <p>Medication audit datasets are also available for the 2004–05 and 2011–12 surveys.</p> <p>Advice received from medical professionals regarding general health and weight/diabetes management.</p> <p>Participants with diagnosed diabetes were asked whether they had visited a dietitian, diabetes educator, nutritionist, allied health professional, nurse, chemist, pharmacist, psychologist, psychiatrist or general practitioner and whether they had registered on the National Diabetes Service Scheme.</p>	
Quality of life	<p>Information was collected through SF-36 questionnaire at baseline and two follow-up surveys. A Barometer of quality of life was also measured at two follow-up surveys.</p> <p>Psychosocial stress was measured at baseline and 5-year follow-up using the Perceived Stress Questionnaires comprising 30 items assessing feelings of loneliness and isolation, irritability, fatigue, frustration and so forth over the past 12 months.</p> <p>The Centre for Epidemiology Studies Short Depression Scale was used to assess participants' general feelings and behaviours over the last week at 12-year follow-up.</p>	

	These quality of life measures were not specifically related to overweight or obesity.
Death and disability	<p>Participants' vital status is determined by linking all 11,247 participants from the AusDiab cohort to the National Death Index on an annual basis.</p> <p>Disability was measured using the Katz Activities of Daily Living questionnaire at 12-year follow-up for those aged over 60 (not specifically related to overweight and obesity).</p>
Expenditure, costs	Information on health service utilisation were collected for all AusDiab participants, including times admitted to hospital due to chronic conditions and how often participants visited their GP. For participants with diagnosed diabetes, additional questions about diabetes management were added, including how often visited diabetes educators, podiatrists and dietitians, and how often the National Diabetes Services Scheme was used by the participant in the 12 months previous to survey (not specifically related to overweight and obesity).
Population demographics	Age, sex, country of birth, language spoken at home, Indigenous status, marital status, level of education, household income, employment areas, employment status, state or territory of residence, Australian Bureau of Statistics' Socio-Economic Indexes for Areas (ABS SEIFA), ASGS remoteness.



<b>4. Australian Longitudinal Study of Ageing (ALSA)</b>	
Type of data source	Longitudinal (state/territory)
Brief description	<p>The ALSA is a cohort study investigating chronic disease, health and wellbeing. The study gathers both self-reported and bio-medically measured information on people living in South Australia.</p> <p>The study gathers the follow information pertinent to the monitoring of overweight and obesity:</p> <ul style="list-style-type: none"> <li>• measured height, weight, girths, and skin fold thickness</li> <li>• self-assessed weight status</li> <li>• intentions to lose weight</li> <li>• whether participants had changed what they ate in the previous 12 months in direct response to overweight or obesity</li> <li>• changes in weight in the previous 12 months.</li> </ul>
Purpose(s)	The general purpose of the study is to gain an understanding of how social, biomedical and environmental factors are associated with age-related changes in health and well-being of people aged 70 and over.
Collection methodology	<p>At baseline (1992), a comprehensive personal interview and assessment of neuropsychological and physiological functions was undertaken at each person's home, supplemented by questionnaires, biochemistry, and additional clinical studies of physical function. Since then a further 12 waves have been completed (some consisting of short telephone interviews).</p> <p>Data was linked from the Health Insurance Commission on Medicare Benefits Scheme and Pharmaceutical Benefits Scheme resource use and expenditure data for 439 participants for the period 2001–2004.</p>
Scope (theoretical coverage of relevant population)	The sample was drawn from the South Australian electoral roll. In scope were individuals born before 30 June 1922, and their spouses (aged 65 or over in 1992) or co-residents (aged 70 or over in 1992).
Coverage (actual)	<p>2,705 individuals drawn from the electoral roll were eligible for inclusion, and 1,477 were recruited (55%). For the recruited individuals, there were 879 eligible spouses and 24 eligible household members, of whom 597 spouses and 13 household members were recruited (68%). In full, 2,087 individuals were recruited.</p> <p>By 2014, 1,806 (86%) of the participants had died.</p>
Geographic coverage	South Australia
Frequency/timing	Yearly between 1992 and 2014
Basic collection count	Persons
Size	Wave 12 (2013): 1,11 participants
Collection management organisation	The Centre for Ageing Studies, Flinders University.

Further information	<a href="http://www.flinders.edu.au/sabs/fcas/alsa/">http://www.flinders.edu.au/sabs/fcas/alsa/</a>	
Data access	At the time of writing, the Flinders Centre for Ageing Studies (FACS) is in the process of compiling an online archive of all ALSA data. In anticipation of the completion of this project, no new data requests are being taken at this time. For further information on data access, contact FCAS on <a href="mailto:fcas@flinders.edu.au">fcas@flinders.edu.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported nutrition data using the 'You and Your Diet' tool collected in Waves 1, 3, 6, 9, 11 and 12.
	Physical activity	Self-reported measures of exercise and activity levels collected in all Waves except Wave 8.
	Alcohol intake	Self-reported alcohol intake data collected in Waves, 1, 3, 6, 9, 11 and 12.
Environmental risk factors	No data	
Related conditions	Measured blood pressure in Waves 1, 3, 6, 7, 9, 11 and 12 and measured fasting blood samples collected in Waves 1, 3, 9 and 12. Data collected on number of medical conditions, including data on arthritis, hypertension, heart conditions, diabetes, osteoporosis and stroke. Not directly related to overweight and obesity.	
Prevalence	Waist circumference	Measured 'girths' in Waves 1, 3, 6, 7, 9, 11 and 12
	Height and weight	Measured height and weight collected in Waves 1, 3, 6, 7, 9, 11 and 12 for BMI
Prevention, treatment and management	Data collected on medications, health service utilisation, service provider utilisation and surgeries.	
Quality of life	Data collected on psychological attitudes and views in Waves 1, 3, 6, 7, 9, 11, and 12 and emotional health questionnaire in Wave 3. Additional data on self-assessed health status, social support and interaction, general life satisfaction, chronic conditions, depression, personal growth and purpose in life collected across waves. These quality of life measures were not specifically related to overweight or obesity.	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Age, sex, marital status, Indigenous status, living arrangements (lives alone or not alone), country of birth, main language spoken at home, age left school, highest level of educational attainment, annual income, parity, employment status.	

<b>5. Australian Longitudinal Study on Women's Health (ALSWH)</b>	
Type of data source	Longitudinal survey (national)
Brief description	The ALSWH assesses women's physical and mental health, as well as psychosocial aspects of health (such as socio-demographic and lifestyle factors) and their use of health services. The survey includes self-reported height and weight of participants and self-reported food and alcohol intake and physical activity.
Purpose	To provide data about the health of women throughout the life course, in order to inform federal and state government women's health policies. Data are also available to researchers in Australia and overseas for use in independent research projects.
Collection methodology	<p>In April 1996, women in three age groups—18–23 (born 1973–78), 45–50 (born 1946–51), and 70–75 (born 1921–26)—were selected from the Medicare database, which contains the name and address details of all Australian citizens and permanent residents. These women were invited to participate and more than 40,000 agreed to take part in the project for at least 20 years. From 1996 to 2011, each age cohort was surveyed about once every 3 years by postal surveys. In 2011, the 1921–26 cohort began receiving a shortened survey every six months.</p> <p>From 2012 onwards the 1973–78 and 1946–51 cohorts have been offered the choice of completing the survey online. In 2012–13 the ALSWH recruited a new cohort of young women, born 1989–95 (aged 18–23 at the time of completing the survey), who are surveyed annually using an online survey.</p> <p>Sampling from the population was random within each of the original age groups. Women from rural and remote areas were sampled at twice the rate of women in urban areas so the number of women living outside major urban areas were large enough to allow comparisons with women living in major urban areas.</p> <p>Recruitment of the 1989–95 cohort was conducted from October 2012 to December 2013 and was not random. Participants were instead recruited voluntarily, through a variety of means (for example, paid Facebook advertising, promotion through social and traditional media, peer referral). As with the original cohorts, participants were drawn from across the country, and were required to be on the Medicare database to be included in the cohort.</p> <p>The ALSWH has approval to access a number of national and state-based external data sets, including:</p> <ul style="list-style-type: none"> <li>• Medical Benefit Schedule (MBS)</li> <li>• Pharmaceutical Benefits Scheme (PBS)</li> <li>• National Death Index (NDI)</li> <li>• perinatal data collections</li> <li>• cancer registries</li> <li>• admitted patients data collections.</li> <li>• emergency department datasets (WA)</li> <li>• Commonwealth Aged Care datasets.</li> </ul>

Scope (theoretical coverage of relevant population)	Australian women on Medicare database aged 18–23, 45–50, 70–75 in 1996, and from 2013, women aged 18–23 (born in 1989–95).	
Coverage (actual)	40,394 women in the original sample in 1996, which is broadly representative of the Australian female population. A new cohort of women born 1989–95 were recruited to form the newest cohort in 2012–2013. 17,013 women aged 18–23 were included in this cohort. Demographic characteristics of these women have been compared with those of women aged 18–23 at the 2011 Census, and while the ALSWH cohort are generally similar, they have a higher proportion of women with university level education.	
Geographic coverage	Australia	
Frequency/timing	First surveyed in 1996. Then yearly from 1998–2018 as follows: 1989–95 cohort: 2013, 2014, 2015, 2016, 2017, 2018 1973–78 cohort: 1996, 2000, 2003, 2006, 2009, 2012, 2015, 2018 1946–51 cohort: 1996, 1998, 2001, 2004, 2007, 2010, 2013, 2016 1921–26 cohort: 1996, 1999, 2002, 2005, 2008, 2011, six-monthly from November 2011.	
Basic collection count	Persons	
Size	Samples sizes for the most recent waves are as follows: 1989–95 cohort: (Survey 5; 2017) 8,495 1973–78 cohort: (Survey 7; 2015) 7,186 1946–51 cohort: (Survey 8; 2016) 8,622 1921–26 cohort: (Six month survey 13; May 2018) 877	
Collection management organisation	The University of Newcastle and the University of Queensland, funded by the Department of Health.	
Further information	<a href="https://www.alswh.org.au/about/about-the-study">https://www.alswh.org.au/about/about-the-study</a>	
Data access	Data may be accessed via formal application to the Data Access Committee of ALSWH. For further information see <a href="https://www.alswh.org.au/how-to-access-the-data/alswh-data">https://www.alswh.org.au/how-to-access-the-data/alswh-data</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported: <ul style="list-style-type: none"> <li>• fruit and vegetable intake</li> <li>• soft drink, dairy, tea and coffee intake</li> <li>• exclusion of food groups</li> </ul>

		<ul style="list-style-type: none"> <li>• Dietary Questionnaire for Epidemiological Studies (Version 2), Melbourne: Cancer Council Victoria, 1996</li> <li>• 24-hour dietary recall (myfood24) data collected from 1989–95 cohort in Survey 4 (not yet available for public use).</li> </ul>
	Physical activity	Self-reported physical activity (including activity level, for example, moderate, vigorous) and sitting time.
	Alcohol intake	Self-reported: <ul style="list-style-type: none"> <li>• frequency of alcohol consumption</li> <li>• amount of alcohol consumed on a day when alcohol is consumed (1–2 up to 9 or more)</li> <li>• frequency of binge drinking.</li> </ul>
Environment risk factors	A range of environmental risk factor variables collected across cohorts, including: <p>1921–26 cohort</p> <ul style="list-style-type: none"> <li>– Whether respondent feels safe in neighbourhood and whether it is safe to walk in neighbourhood (survey 2)</li> <li>– Regularity of work hours (survey 7)</li> </ul> <p>1946–1951 cohort</p> <ul style="list-style-type: none"> <li>– Sources of lifestyle change information (for example, books, magazines or television) (survey 5)</li> </ul> <p>1973–78 cohort</p> <ul style="list-style-type: none"> <li>– Main form of transportation on week days and weekends (survey 4)</li> <li>– Whether had stairs at home, work, or on usual routes on week days and weekends (survey 7)</li> </ul> <p>1989–95 cohort</p> <ul style="list-style-type: none"> <li>– In the last 6 months, how frequently respondent read nutrition information or ingredient information on food labels (survey 2).</li> </ul>	
Related conditions	Range of conditions, including hypertension, diabetes, back pain, and anaemia.	
Prevalence	Waist circumference	No data
	Height and weight	Self-reported height and weight for BMI
Prevention, treatment and management	Self-reported: <ul style="list-style-type: none"> <li>• health service use (GPs, specialists, hospital use) (not specifically related to overweight or obesity)</li> <li>• having had cholesterol, blood pressure and blood sugar checked</li> <li>• weight-loss surgery (gastric banding, gastric sleeve, gastric bypass)</li> <li>• methods of weight control (for example, Weight Watchers, meal replacements, diets); of satisfaction with current weight/shape; of desired weight</li> <li>• medications, vitamins, supplements or herbal therapies.</li> </ul>	

Quality of life	Self-reported health and wellbeing (not specifically related to overweight or obesity).
Death and disability	Linked data from National Death Index (including cause of death). Linked data from Admitted Patients Data Collections, cancer registries and Aged Care (Commonwealth) datasets.
Expenditure, costs	Linked data from the MBS and PBS databases.
Population demographics	Age, country of birth, highest level of education attainment, employment status, SEIFA, household income, parity, marital status, state of residence, residential post code, occupation, ARIA+.

<b>6. Bariatric Surgery Registry (BSR)</b>	
Type of data source	Registry (national)
Brief description	<p>The Bariatric Surgery registry was developed in response to a need identified by the Obesity Surgery Society of Australia and New Zealand (OSSANZ) to track outcomes of bariatric surgery.</p> <p>OSSANZ undertook a tender process and partnered with the Monash University School of Public Health and Preventative Medicine (SPHPM) as registry custodian. OSSANZ commissioned a report from this group which was delivered in March 2010.</p> <p>A call was made to all surgeon members of OSSANZ in June 2013 asking them to register their interest in participating in the Registry. A further call was made in June 2014.</p> <p>As at 30 June 2018, there have been a total of 109 hospitals and 171 surgeons that have contributed to the Registry since 2012. In the past 2017–2018 financial year, there were 147 surgeons from 98 hospitals across Australia and New Zealand actively contributing data to the Registry.</p>
Purpose(s)	<p>The BSR has a primary aim of measuring quality and safety in bariatric surgery, but also serves to track the outcomes of bariatric surgery patients longitudinally. The longitudinal follow up element of the registry serves the additional purposes of:</p> <ul style="list-style-type: none"> <li>• confirm the outcomes from clinical trials on bariatric surgery at a community level</li> <li>• measure the change in diabetes status and treatment over time in the study population</li> <li>• translate recorded health outcomes into practice guidelines</li> <li>• improve the safety and manage the risk of bariatric surgery</li> <li>• improve resource allocation decisions to improve the efficiency of health expenditure.</li> </ul>
Collection methodology	<p>Data are collected at the hospital, surgeon's practice or surgeon's room at which the procedure has been performed and can be entered directly into the Registry's database, BSR-<i>i</i> or sent via paper based forms to the Registry for data entry. Peri-operative (up to 90 days post procedure) and annual follow up data is collected either by the surgeons entering data to the BSR-<i>i</i>, sending through data forms to the Registry for data entry or the BSR Call Centre calling participants directly. Annual follow up is only captured for those participants who had a primary procedure.</p>
Scope (theoretical coverage of relevant population)	All persons undertaking bariatric procedures at participating hospital sites across Australia and New Zealand.
Coverage (actual)	<p>Since commencement in February 2012, Explanatory Statements that invite patients to participate in the Registry have been sent to a total of 50,399 patients who had their operation before or on 30 June 2018. As at 30 June 2018, the Registry has captured</p>

	51,277 procedures performed on 47,575 participants and of which the Registry has relevant data capture for.	
Geographic coverage	All States and Territories in Australia (ACT will join participation during the 2018/2019 period) and all regions of New Zealand where bariatric procedures are performed.	
Frequency/timing	Annually from 2012	
Basic collection count	Participants Procedures (primary and revision)	
Size	47,575 participant records as at 30 June 2018	
Collection management organisation	Monash University	
Further information	<a href="https://www.monash.edu/medicine/sphpm/registries/bariatric">https://www.monash.edu/medicine/sphpm/registries/bariatric</a>	
Data access	Applications for access to aggregate data can be made to Monash University. For more information see <a href="https://www.monash.edu/_data/assets/pdf_file/0003/937254/bsr-clinical-quality-registry-reporting-policy-v1.1.pdf/">https://www.monash.edu/_data/assets/pdf_file/0003/937254/bsr-clinical-quality-registry-reporting-policy-v1.1.pdf/</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	No data
Environmental risk factors	No data	
Related conditions	Diabetes status, diabetes treatments and post-surgery diabetes outcomes.	
Prevalence	Waist circumference	No data
	Height and weight	Measured for BMI by participating surgeons
Prevention, treatment and management	Type of primary or revision surgery, need for re-operation, performed, unplanned return to theatre, unplanned admissions ICU and readmissions to hospital.	
Quality of life	Record of adverse events, where available for all participants.	
Death and disability	All participant deaths are recorded and categorised as 'unrelated to procedure, 'likely related to procedure' and 'not determined as yet.'	
Expenditure, costs	No data	
Population demographics	Age, sex, suburb, state, postcode, Indigenous status.	



<b>7. Bettering the Evaluation and Care of Health (BEACH) Survey of General Practice</b>	
Type of data source	Survey (national)
Brief description	<p>BEACH began in April 1998 and closed in June 2016 after 18 years of continuous data collection. BEACH was a continuous national study in which ever-changing random samples of about 1,000 individual general practitioners (GPs) participated each year. Each participating GP recorded details of 100 consecutive GP-patient encounters with consenting patients.</p> <p>The BEACH data set collected the MBS item claimed in each consult, medications prescribed, referrals given and the coded reason for encounter (including codes for obesity, overweight and weight management).</p> <p>A number of sub studies using BEACH data, known as Supplementary Analysis of Nominated Data (SAND), have been conducted, some of which focus specifically on the management of overweight and obesity by GPs. Patient reported height and weight were also reported in SAND studies.</p>
Purpose(s)	<p>The BEACH program collected information on the clinical activities in general practice in Australia including:</p> <ul style="list-style-type: none"> <li>• characteristics of GPs</li> <li>• characteristics of patients at encounters</li> <li>• reasons people seek medical care</li> <li>• problems managed.</li> </ul> <p>For each problem managed the following information was gathered:</p> <ul style="list-style-type: none"> <li>• medications prescribed, advised, provided</li> <li>• clinical treatments and procedures provided</li> <li>• referrals to specialists and allied health services</li> <li>• test orders including pathology and diagnostic imaging.</li> </ul>
Collection methodology	<p>Collection was continuous with 20 GPs responding per week. Each GP reported on 100 consecutive consultations. All consultations were recorded if they resulted in a management action (for example, a prescription or referral) including indirect consultations such as those by telephone. A paper-based data collection system was used. Encounters were weighted according to each GP participant's Medicare claims activity for the year. Information is available in annual publications, or in detail through data request submissions.</p>
Scope (theoretical coverage of relevant population)	<p>Random sample of 1,000 GPs annually across Australia, selected from Medicare records collecting information on almost 100,000 GP patient encounters. In 2015, in Australia, there were 34,367 GPs in clinical roles according the AIHW medical workforce report (AIHW 2016).</p>

Coverage (actual)	<p>There was an incentive for GPs to fill in the survey. Participating GPs earned clinical audit points towards their Quality Improvement and Continuing Professional Development requirements through the Royal Australian College of General Practitioners and/or the Australian College of Rural and Remote Medicine.</p> <p>The final participating sample for 2015–16, consisted of 921 practitioners, representing 25.6% of those who were contacted and available, and 44 additional GPs that commenced participation later in the survey process.</p> <p>The BEACH database includes information for almost 1.8 million encounters from 17,707 participating GPs.</p>	
Geographic coverage	Australia	
Frequency/timing	Continuous collection from 1998 to 2016.	
Basic collection count	GP encounters	
Size	In 2015–2016, 965 practicing GPs responded.	
Collection management organisation	The Family Medicine Research Centre, University of Sydney.	
Further information	<a href="http://sydney.edu.au/medicine/fmrc/beach/">http://sydney.edu.au/medicine/fmrc/beach/</a>	
Data access	<p>Some data are available publicly via the University of Sydney website <a href="http://sydney.edu.au/medicine/fmrc/beach/data-reports/public/index.php">http://sydney.edu.au/medicine/fmrc/beach/data-reports/public/index.php</a></p> <p>For further information about accessing BEACH data, contact Christopher Harrison: <a href="mailto:christopher.harrison@sydney.edu.au">christopher.harrison@sydney.edu.au</a></p>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	Self-reported intake collected by participating GPs (how often consume drinks containing alcohol, number of standard drinks consumed per day, how often have 6 or more standard drinks on one occasion).
Environmental risk factors	No data	
Related conditions	The BEACH project collects the GP management of chronic conditions related to overweight and obesity (for example, type 2 diabetes).	
Prevalence	Waist circumference	No data

	Height and weight	Self-reported and measured height and weight for adults and children for BMI— recorded in relevant consultations.
Prevention, treatment and management	Measures of frequency of counselling/advice on nutrition/weight by GPs, medication prescribed, treatments provided for each recorded problem, referrals to specialists, emergency departments or hospitals, and investigations ordered (included pathology tests and diagnostic imaging).	
Quality of life	No data	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Age, sex, postcode of residence, non-English speaking background status, Indigenous status, health care card and veteran's affair status, remoteness of home location (as per the Australian Statistical Geography Standard).	

<b>8. Burden of disease studies: the Australian Burden of Disease Study (2016 — using 2011 data) and the Australian results of the Global Burden of Disease Study (2015)</b>	
Type of data source	Derived (national)
Brief description	<p>Burden of disease studies provide a comprehensive assessment of the health of Australians. The studies provide information about health loss due to mortality and health loss due to disability.</p> <p>Burden of disease studies use a metric called the disability-adjusted life year (DALY) to quantify years of life lost due to premature death, as well as years of life lived with disability from disease and injury.</p> <p>Burden of disease analysis provides detailed estimates of the burden of mortality and disability for each disease and injury category by sex and age. It also assesses the burden attributable to major risk factors.</p> <p>The Australian Burden of Disease Study collects data and reports on the burden (percentage of linked disease), both fatal and non-fatal, attributable to high body mass. Specific studies on the impact of overweight and obesity as a risk factor for chronic conditions in the year 2011 used age and sex specific BMIs from measured height and weight in the Australian Health Survey 2011–12. Waist circumference was not included in this analysis as relative risks are aligned with BMI.</p>
Purpose(s)	To assess and compare the relative impact of different diseases, risk factors and injuries on populations.
Collection methodology	<p>Prevalence, incidence, duration and severity by disease or injury are estimated based on various data sources, such as survey, registry and administrative data.</p> <p>Mortality data are drawn from vital registrations.</p> <p>Disability weights in the 2015 Global Burden of Disease Study were derived from large-scale household surveys across 5 countries and an open-access internet survey.</p> <p>Disability weights used in the 1990 global and 2003 Australian studies were assigned based on advice from focus groups of health experts. (Disease weights are used in the calculation of years lived with disability (YLD). They quantify social preferences for different states of health.)</p> <p>This information was brought together to calculate years of life lost (YLL), YLD and DALYs measures.</p>
Scope (theoretical coverage of relevant population)	All Australians (including an Indigenous analysis in the Australian Burden of Disease Study 2011).
Coverage (actual)	Gaps in the data mean that the coverage is not complete.
Geographic coverage	Australia

Frequency/timing	The Australian study has been published in 1999, 2007 and 2016. The next study is expected to be published in 2019 using 2015 data. Data from 2003 and 2011 (published in the 2007 and 2016 studies, respectively) are currently being revised where methods have changed and for new linked diseases.	
Basic collection count	DALYs, YLL, YLD	
Size	Not applicable	
Collection management organisation	<p>Australian Burden of Disease Study: AIHW 2007 Issue: School of Population Health, University of Queensland and AIHW</p> <p>Global Burden of Disease Study: 2015 (Institute for Health Metrics and Evaluation)</p> <p>1990 WHO (World Health Organization)</p>	
Further information	<p>Australian Burden of Disease Study, next issue <a href="http://www.aihw.gov.au/burden-of-disease/">http://www.aihw.gov.au/burden-of-disease/</a></p> <p>Global Burden of Disease Study <a href="http://www.healthmetricsandevaluation.org/">http://www.healthmetricsandevaluation.org/</a></p>	
Data access	<p>Applications for data access for AIHW collections can be made via formal request <a href="https://www.aihw.gov.au/our-services/data-on-request">https://www.aihw.gov.au/our-services/data-on-request</a></p>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	No data
Environmental risk factors	No data	
Related conditions	Proportion of disease burden from other conditions attributed to high body mass, including cancers, cardiovascular disease, musculoskeletal conditions, endocrine conditions and kidney disease.	
Prevalence	Waist circumference	No data
	Height and weight	No data
Prevention, treatment and management	No data	
Quality of life	No data	
Death and disability	<p>YLL due to premature death, as well as YLD from disease and injury.</p> <p>Specifically includes burden of disease caused by overweight and obesity.</p>	

Expenditure, costs	No data
Population demographics	2016 Australian Burden of Disease Study: results presented by age, sex, socioeconomic position, remoteness, state or territory of residence, Indigenous status.

<b>9. Busselton Health Study</b>	
Type of data source	Survey (state/regional)
Brief description	<p>The Busselton Health study encompasses a range of longitudinal and point prevalence studies undertaken in the population of Busselton, WA. The Busselton Health Study commenced in 1966 and is globally recognised as one of the longest running population health research programs of its kind.</p> <p>The 52 year engagement with the Busselton population has resulted in a collection of data from over 20,000 participants and has been used to produce over 450 publications in the medical research and scientific literature.</p> <p>Research activities undertaken as part of the Busselton Health Studies are diverse and encompass a wide range of health conditions and measures. These have included cardiovascular disease, respiratory disease, diabetes and endocrine disorders, gastrointestinal, kidney and liver diseases, cancer, obesity, sleep disorders, cognition and genetic epidemiology. Extensive information on demography, lifestyle and behaviour have also been collected at each of the studies along with blood samples for biochemical measures and genetic studies.</p> <p>Most surveys included a detailed questionnaire focussing on lifestyle and general health history, a number of physical measurements and tests, and blood samples were collected for biochemical, haematological and immunological analyses and DNA extraction (later surveys only).</p> <p>Previous studies include the Busselton Diabetes study (2008–10) and the Burden of Obstructive Lung Disease Study (2007–08).</p> <p>Current studies under the Busselton Health Study project are The Busselton Healthy Ageing Study (2010–15), and the Busselton Baby Boomer Study (2016–20).</p>
Purpose(s)	The Busselton Health Studies aims are to develop a better understanding and management of disease and illness.
Collection methodology	<p>Series of cross-sectional (age, gender-stratified, drawn from Electoral Roll) and longitudinal (follow-up) surveys of previous attendees. Standardised questionnaires, anthropometric and clinical assessments, haematology and biochemistry, and bio-banking of specimens (serum/plasma/DNA) at most surveys.</p> <p>DXA Body Composition measures (%body fat/fat mass/visceral fat) (since 2010).</p>
Scope (theoretical coverage of relevant population)	Residents residing within the City of Busselton, Local Government Boundary, Western Australia (Current population ~32,000).
Coverage (actual)	~20,000 across all health studies
Geographic coverage	Busselton, Western Australia

Frequency/timing	<ul style="list-style-type: none"> <li>• 1966–1987: Repeat cross-sectional surveys <ul style="list-style-type: none"> <li>– Adults — 1966 (n=3,394), 1969 (n=3,680), 1972 (n=3,885), 1975 (n=3,635), 1978 (n=4,006), 1981 (n=3,940), 1987 (n=1,120)</li> <li>– Children — 1967 (n=1,614), 1970 (n=1,598), 1973 (n=1,489), 1977 (n=556), 1983 (n=1,730)</li> </ul> </li> <li>• 1990: Respiratory and Sleep Survey of adults (n=1,293)</li> <li>• 1994–1995: Follow-up survey of adults (n=5,909) who attended any survey between 1966 and 1987</li> <li>• 2003–2004: Iron and Cognition survey of adults — (n=1,011)</li> <li>• 2005–2007: Respiratory/Gastrointestinal and Cardiovascular focused cross-sectional survey (n=2,932 Adults and 1,335 Children)</li> <li>• 2007–2008: Burden of Obstructive Lung Disease Study (BOLD) (n=663 adults aged &gt;40 from 05/07 survey)</li> <li>• 2008: Busselton Diabetes Study (BDS1) — Wave 1 (487 adults with diabetes and aged-matched controls)</li> <li>• 2009: Busselton Diabetes Study (BDS2) — Wave 2 (208 adults with diabetes)</li> <li>• 2010–2015: The Busselton Healthy Ageing Study (BHAS) (n=5,107 adults born 1946–1964)</li> <li>• 2016–2021: The Busselton Baby Boomer Study (BBBS) — Follow up survey of the BHAS Cohort</li> </ul>	
Basic collection count	Persons	
Size	Data on over 20,300 individuals attending any one of the BHS surveys as listed above.	
Collection management organisation	The Busselton Health Study Research Group at the School of Population and Global Health, University of Western Australia manages and maintains the Busselton Health Study database on behalf of the Busselton Population Medical Research Institute (BRPMRI).	
Further information	<a href="http://bpmri.org.au/">http://bpmri.org.au/</a>	
Data access	Applications for data access can be made to the BPMRI: <a href="http://bpmri.org.au/research/database-access.html">http://bpmri.org.au/research/database-access.html</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported: <ul style="list-style-type: none"> <li>• whether currently on a special diet (1969, 1972, 1975, 1978, 1981)</li> <li>• whether changed diets (1969)</li> <li>• reason for changing diets</li> </ul> Consumption of specific foods: bran (1975, 1981), bread (1975, 1977), butter/margarine (1975, 1977),



		<p>cheese, eggs, coffee, tea, cream, ice-cream, yoghurt, fish fruit (1975, 1977), meat (1975, 1977), milk, (1975, 1977), vegetables, added salt, snacks, soft drinks (198, 1983), sugar, honey, type of water (1969, 1972). All collected in 1975 only unless otherwise specified.</p> <p>Self-reported 'diet' (1994–95) for adults and 'food allergies' (2005–07) for children.</p> <p>Self-reported frequency of intake of meat, dairy, bread, cereal, vegetables and fruit (Q's based on 2004 NHS AIHW) (2010–2015).</p> <p>123 item self-reported BMES–Food Frequency Questionnaire–FFQ (2016–2021).</p>
	Physical activity	<p>Self-reported:</p> <ul style="list-style-type: none"> <li>• whether changed exercise in the last 3–5 years (1969, 1972)</li> <li>• reason for changing exercise</li> <li>• whether exercises regularly (1975)</li> <li>• how often is exercise done (1975, 1981)</li> <li>• hours of exercise per week (1975)</li> <li>• whether plays sports (1972, 1975, 1978)</li> <li>• hours of light, moderate, vigorous activity at home, work or at leisure (1987).</li> <li>• walking, moderate and vigorous exercise for adults in 1994–95 and 2005–07</li> <li>• International Physical Activity Questionnaire (IPAQ) (2010–15, 2016–21)</li> <li>• self-reported time spent in sedentary and sitting behaviour at home and work (2016–21).</li> </ul>
	Alcohol intake	<p>Self-reported:</p> <ul style="list-style-type: none"> <li>• alcohol intake ever (1966, 1969, 1972, 1975, 1978, 1981, 1987)</li> <li>• alcohol intake amount (1975, 1978, 1987)</li> <li>• self-rated alcohol intake level (1966, 1969, 1972)</li> <li>• when started drinking (1969, 1972)</li> <li>• when stopped drinking (1969, 1972)</li> <li>• alcohol intake measures collected for adults in 1994–95 and 2005–07 and for children in 2005–07.</li> <li>• alcohol intake over last 12 months (Q's based on 2004 NHS AIHW) (2010–15)</li> </ul>

		<ul style="list-style-type: none"> <li>alcohol intake over last 12 months (BMES–Food Frequency Questionnaire–FFQ, Beverages with alcohol), (2016–21).</li> </ul>
Environmental risk factors	No data	
Related conditions	<p>Measured total cholesterol. (1969, 1972, 1975, 1978, 1981, 1967, 1973, 1977, 1987, 1994–95, 2005–07, 2010–15, 2016–21) and insulin (1966, 1969, 1978, 1970), measured blood pressure (all collections except 1973), self-reported history of high cholesterol, high triglycerides, heart trouble hypertension, stroke and family history of heart attack death. Measured blood pressure for adults in 1994–95 and 2005–07 and children in 2005–07.</p> <p>Self-reported diabetes status (ever or now, ever treated for, when diagnosed, treatment type, whether treated by diet, when started insulin, ever had sugar in urine, whether had diabetes during pregnancy and family history of diabetes).</p> <p>Self-reported family history of obesity collected in 1994–95 for adults.</p>	
Prevalence	Waist circumference	Measured in adults in 1994–95, 2005–07, 2010–15 and 2016–21, and in children 2005–07.
	Height and weight	<p>Measured, for BMI, in all collections. Additional measures of:</p> <ul style="list-style-type: none"> <li>opinion of own weight (1969, 1972)</li> <li>whether respondent gains weight easily</li> <li>whether weight changes in the last year, and reason (1978, 1981)</li> <li>maximum and minimum weights after age 25, and when (1987)</li> <li>weight at age 20</li> <li>weight at age 25 (1987)</li> <li>whether respondent has lost more than 5 kgs in past year. Whether respondent is on a special diet or activity to manage weight (2016–21).</li> <li>lowest weight as an adult, highest weight as an adult (women only) (2016–21).</li> </ul>
Prevention, treatment and management	Consent obtained for linkage of study data with WA Data Linkage System (1994–95 — linked), (2005–07, 2010–15, 2016–21 — not currently linked)	
Quality of life	Self-assessed health status (1966, 1969, 1972, 1975, 2010–16, 2016–21).	
Death and disability	Whether has any disease or incapacity (1966, 1969, 1972, 1975, 2005–07, 2010–15, 2016–21) and activities of daily living questionnaire (2016–21) — not directly related to overweight or obesity. Consent obtained for linkage of study data with WA Data	

	Linkage System (1994–95 — linked), (2005–07, 2010–15, 2016–21 — not currently linked)
Expenditure, costs	No data
Population demographics	Date of birth, sex, marital status, when married, education, income, accommodation/dwelling type, occupation, country of birth, when arrived in Australia, family ethnic background, religion.

<b>10. Childhood Determinants of Adult Health (CDAH) Study</b>	
Type of data source	Longitudinal survey (national)
Brief description	<p>The Childhood Determinants of Adult Health (CDAH) study is a cohort study with follow-up of 8,498 children who participated in the 1985 Australian Schools Health and Fitness Survey when aged 7 to 15. Data are collected on measures of lifestyle, physical characteristics and mental health via the completion of questionnaires and physical assessments. The first follow up of the cohort was conducted in 2004–06 and the second in 2009–11. A third is underway (2017–2019).</p> <p>This dataset contains the following data on overweight and obesity: BMI, waist circumference, and skinfold measurements.</p>
Purpose(s)	The study's long-term aim is to determine the contribution of childhood factors to the risk of developing cardiovascular disease and type 2 diabetes in later life.
Collection methodology	<p>Data collection is a combination of clinic assessments, self-completed surveys (paper and online) and CATIs, as follows:</p> <ul style="list-style-type: none"> <li>• 1985: Survey and physical assessment</li> <li>• 2004–06: Survey and physical assessment</li> <li>• 2009–11: Survey only</li> <li>• 2017–19: Survey and physical assessment.</li> </ul>
Scope (theoretical coverage of relevant population)	A nationally representative sample of Australian school children aged 7 to 15 sampled from 109 schools.
Coverage (actual)	<p>1985: response rate 66% to 71%, depending on the particular measure.</p> <p>2004–06: response rate 47% to survey and 28% to clinic assessment (variable depending on the particular measure).</p> <p>2009–11: response rate 36% to survey.</p> <p>2017–19: response rate to be determined.</p>
Geographic coverage	Australia
Frequency/timing	<p>Year(s) in which data have been collected:</p> <p>1985, 2004–6, 2009–11, 2017–19.</p>
Basic collection count	Persons
Size	<p>The initial cohort that participated in 1985 consisted of 8,498 children aged 7–15.</p> <p>2,208 men and 2,363 women completed a follow-up questionnaire at age 24–34 in 2004–06.</p> <p>At the last completed second follow-up (2009–2011), 3,035 participants completed surveys.</p>

Collection management organisation	Menzies Institute for Medical Research, University of Tasmania.	
Further information	<a href="http://www.menzies.utas.edu.au/research/diseases-and-health-issues/research-projects/childhood-determinants-of-adult-health-cdah-study">http://www.menzies.utas.edu.au/research/diseases-and-health-issues/research-projects/childhood-determinants-of-adult-health-cdah-study</a>	
Data access	Request for access CDAH data for collaborative projects with CDAH investigators should be directed to Professor Alison Venn of the University of Tasmania.	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported using a 24-hour food record at initial collection, and using the Food Frequency and Habits Questionnaire at follow-up.
	Physical activity	Self-reported physical activity data were collected using the International Physical Activity Questionnaire. Pedometer data were also collected at each adult follow-up. Physical fitness measures were also collected in 1985 and at 2004–06 follow-up, including: 1985 <ul style="list-style-type: none"> <li>• sit ups</li> <li>• standing long jump</li> <li>• push ups</li> <li>• sit and reach</li> <li>• 50m run</li> <li>• 1.6km run</li> <li>• grip strength</li> <li>• shoulder push and pull</li> <li>• physical work capacity test (PWC) on a bicycle ergometer.</li> </ul> 2004–06 <ul style="list-style-type: none"> <li>• standing long jump</li> <li>• PWC</li> <li>• grip strength</li> <li>• shoulder push and pull</li> <li>• leg and back strength.</li> </ul>
	Alcohol intake	Self-reported alcohol intake by type and frequency.
Environmental risk factors	No data	

Related Conditions	Included measures of blood cholesterol, fasting blood lipids (total cholesterol, HDL-cholesterol and triglycerides), and blood pressure for children aged 9, 12 and 15. Measurements were repeated at 20 year follow up, as well as additional measurements of glucose and insulin. Measures will be repeated again at 30 year follow-up. Questions about family and personal history of heart disease and diabetes were also included at follow up.	
Prevalence	Waist circumference	Measured
	Height and weight	Self-reported and measured height and weight for BMI
Prevention, treatment and management	MBS and PBS data for a sub-sample, self-reported medication.	
Quality of life	Self-assessed health status (using the SF-36 in adults at follow up), self-reported emotional wellbeing and self-reported social support. Note these questions were not asked specifically in relation to body weight.	
Death and disability	Death (through NDI linkage)	
Expenditure, costs	No data	
Population demographics	Age, sex, area of residence (major city, inner regional or outer regional/remote), marital status, highest level of educational attainment, parent's highest level of educational attainment and occupation.	

<b>11. Great South Coast Childhood Obesity Monitoring Study</b>	
Type of data source	Survey (regional)
Brief description	All schools from six government regions of South-West Victoria were invited to participate. Passive (opt-out) consent was used to collect measured anthropometric and self-reported behavioural data from children in years 2, 4, and 6, aged 7–12.
Purpose(s)	The main stated aims of the collection is to establish a sustainable childhood obesity monitoring system in regional Australia to collect accurate anthropometric and behavioural data, provide timely feedback to communities and build community engagement and capacity.
Collection methodology	<p>All primary schools were invited to participate through written invitations to the school principals in 2015 (N=84) and 2017 (N=83) as one school closed. Once schools participation was confirmed, all students in years 2, 4 and 6 were invited to participate through a written plain language statement and opt-out consent form for each child's parent/guardian which was distributed after a formal presentation (5–10 minutes) to students by the study manager at each school. In 2015 Catholic school students participated under an opt-in consent procedure which switched to opt-out in 2017. Schools were also invited to increase awareness of the study by placing the provided newsletter item in their respective school newsletters.</p> <p>On data collection days within schools the study manager and local health promotion/council staff attended each school to conduct measurements. All personnel had received training on the accurate collection of height, weight and behavioural information among school children, with particular attention and training on student safety and wellbeing. All personnel had a current Victorian Working with Children Check.</p> <p>During a 50-minute class period, a group of 25–30 children typically completed the behavioural and wellbeing questionnaire (Years 4 and 6) and had their height and weight measurements taken (Years 2, 4 and 6). Measurements were taken in a private area, away from other students' views, recordings taken in silence and the weight scale blocked from view. Two measurements of height and weight were taken and recorded to the nearest 0.1 cm (height) and 0.1 kg (weight) with a third measure taken if these two measurements differed by 0.5. The mean of all measurements were used. The International Obesity Task Force's age and sex-specific BMI growth references were used to classify healthy weight, overweight and obesity.</p> <p>The self-reported behavioural questionnaire examining demographic characteristics (DOB, gender, language spoken at home, postcode, country of birth and ancestry), physical activity (duration spent in moderate-to-vigorous physical activity in the previous 7days), sedentary behaviour (duration spent in</p>

	screen-based behaviours for recreation outside of school in the previous 7 days), usual dietary intake (frequency of fruit, vegetable, takeaway, sugar sweetened beverages, packed snacks and water), sleep behaviours (duration, quality, efficiency) and wellbeing (self-rated physical and psychosocial wellbeing) were collected.	
Scope (theoretical coverage of relevant population)	All schools from six government regions of South-West Victoria were invited to participate. Passive (opt-out) consent was used to collect measured anthropometric and self-reported behavioural data from children in years 2, 4, and 6, aged 7–12.	
Coverage (actual)	In 2015, 46 of 67 (69%) of Government/Independent schools participated under an opt-out consent approach. Within these 46 Government/Independent schools 77% of children agreed to participate. In 2017, 50 of 66 (76%) of Government/Independent schools participated under an opt-out consent approach. Within these schools, 81% of children agreed to participate and were present on the day of data collection.	
Geographic coverage	South-West Victoria	
Frequency/timing	Every two years since 2015 in Term 2 (April to June)	
Basic collection count	Persons	
Size	2015: 46 government and independent schools, and 1,903 of 2,473 invited students (77%). 2017: 57 government, independent and Catholic schools, and 2,232 of 2,642 invited students (81%) participated.	
Collection management organisation	Deakin University	
Further information	Contact: Dr Claudia Strugnell <a href="mailto:claudia.strugnell@deakin.edu.au">claudia.strugnell@deakin.edu.au</a> Mr Nicholas Crooks <a href="mailto:n.crooks@deakin.edu.au">n.crooks@deakin.edu.au</a>	
Data access	Please contact Dr Claudia Strugnell for further information on data access <a href="mailto:claudia.strugnell@deakin.edu.au">claudia.strugnell@deakin.edu.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported
	Physical activity	Self-reported duration spent in moderate-to-vigorous physical activity in the previous 7 days and time spent in screen-based behaviours for recreation outside of school.
	Alcohol intake	Not applicable
Environmental risk factors	No data	
Related conditions	No data	



Prevalence	Waist circumference	No data
	Height and weight	Measured height and weight for BMI
Prevention, treatment and management	No data	
Quality of life	The 23-item Paediatric Quality of Life Inventory 4.0 (PedsQL)™ generic core scale <sup>36</sup> was used to measure children's perceived health-related quality of life (HRQoL).	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Date of birth, sex, main language spoken at home, postcode, country of birth and ancestry.	

<b>12. Household, Income and Labour Dynamics in Australia (HILDA) Survey</b>	
Type of data source	Longitudinal Survey (national)
Brief description	<p>The HILDA Survey is a representative longitudinal survey of Australian households that started in 2001. The survey follows the lives of over 17,000 Australian residents per year and if possible, participants are followed over their lifetime.</p> <p>The primary objective of the HILDA Survey is to support research within 3 broad inter-related areas:</p> <ul style="list-style-type: none"> <li>• income dynamics—with a focus on how households respond to policy changes aimed at improving financial incentives</li> <li>• labour market dynamics—with a focus on low-to-middle income households, female participation, and work-to-retirement transitions</li> <li>• family dynamics—focusing on family formation, wellbeing and separation.</li> </ul> <p>Data from the HILDA Survey are used by researchers and policy makers across Australia and internationally.</p> <p>Questions on height and body weight were included for the first time in Wave 6 of the study (2006) and repeated each year since. Waist measurement has been collected in wave 13 and 17.</p> <p>Waves 7, 9, 13 and 17 included complementary questions on dieting behaviour and perceptions about, and satisfaction with, body weight.</p> <p>BMI was calculated from the self-reported height and weight of participants. The rationale for not included height and weight in the interviewer administered portion of the survey was to avoid causing discomfort in respondents, which may lead to biased responses.</p>
Purpose(s)	The aim of the HILDA Survey is to provide annual longitudinal statistics describing the ways in which people’s lives are changing in Australia. The HILDA Survey collects information on households and family life, income and wealth, employment and unemployment/joblessness, and life satisfaction and well-being.
Collection methodology	The majority of the individual interviews are conducted face-to-face (up to 10% are completed by telephone). A self-complete questionnaire (SCQ) is also filled out by the respondents. The health-related questions span the interview and the SCQ with most in the SCQ.
Scope (theoretical coverage of relevant population)	The Wave 1 sample was restricted to people living in private dwellings. People who were homeless or living in an institution were excluded from the scope of the sample. If the sample members subsequently move into non-private dwellings (such as nursing homes) they are followed and interviewed where possible. A general population wide top-up to the sample was added in 2011, which includes recent arrivals to Australia since 2001.

Coverage (actual)	<p>People living in private dwellings in Australia in 2001 are followed over time. The HILDA Survey aims to remain representative of the Australian population, but recent immigrants arriving in Australia since 2001 are under-represented. Two approaches have been taken to address this issue: 1. recent immigrants who join the household of a sample member automatically become permanent sample members; 2. a general population wide top-up sample was added in 2011 which included recent immigrants arriving since 2001.</p> <p>People living in remote and very remote areas are under-represented in the sample.</p> <p>The household level response rate in Wave 1 was 66% with 7,682 responding households (and 13,969 individuals) interviewed. In Wave 16, 64.6% of those individuals interviewed in Wave 1 (who were still in-scope) were interviewed. The household level response rate of the top-up sample in Wave 11 (2011) was 69% with 2,153 households (and 4,009 individuals) interviewed. In Wave 16, 81% of those individuals interviewed in Wave 11 (remaining in-scope) were interviewed.</p>	
Geographic coverage	Australia	
Frequency/timing	Annually since 2001	
Basic collection count	Persons in households	
Size	Sample size for most recent reference period (wave 16): 9,750 households (including original and top-up sample), with 17,694 persons interviewed.	
Collection management organisation	Melbourne Institute: Applied Economic and Social Research, Melbourne University.	
Further information	<a href="https://melbourneinstitute.unimelb.edu.au/hilda">https://melbourneinstitute.unimelb.edu.au/hilda</a>	
Data access	Applications for data access can be made to the University of Melbourne. For further information see <a href="https://melbourneinstitute.unimelb.edu.au/hilda/for-data-users/ordering-hilda-survey-data">https://melbourneinstitute.unimelb.edu.au/hilda/for-data-users/ordering-hilda-survey-data</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	<p>Self-reported:</p> <ul style="list-style-type: none"> <li>• number of days per week eating breakfast</li> <li>• number of days per week eating fruit (including tinned, frozen, dried and fresh)</li> <li>• number of serves of fruit on days when fruit was eaten</li> <li>• frequency of intake for red meat, processed meats, breads, desserts, cereals, legumes, fish, pasta, poultry, snack food and fried potato products.</li> </ul> <p>Data collected in Waves 7, 9 and 13.</p>

	Physical activity	Self-reported (frequency of participation in at least 30 minutes of physical activity). Data collected in each wave. More detailed information was collected in Wave 13, including: <ul style="list-style-type: none"> <li>total time (minutes/hours) spent in moderate or vigorous physical activity over the last 7 days</li> <li>number of days moderate or vigorous activity exceeded 180 minutes and is for more than one day.</li> </ul>
	Alcohol intake	Self-reported alcohol intake, including frequency and number of standard drinks usually consumed on an occasion. Data collected in each wave.
Environmental risk factors	No data	
Related conditions	In each wave, the survey collects broad information on whether participants have any long-term health condition, impairment or disability that restricts them in their everyday activities, and has lasted or is likely to last for 6 months or more.  In certain waves more detailed data on serious health conditions are collected, including arthritis, type 2 diabetes, heart disease and high blood pressure/hypertension.	
Prevalence	Waist circumference	Self-reported, Wave 13 and 17
	Height and weight	Self-reported for BMI, Wave 6–17
Prevention, treatment and management	Variables for 'currently on a diet to lose weight' and 'how often has dieted to lose weight in the last 12 months' in Waves 7, 9, 13 and 17.	
Quality of life	Body weight classifications (for example, underweight, normal weight, overweight) were analysed against measures of quality of life from data collected in Wave 6 and 7, including physical functioning, general health, vitality, social functioning and mental health.	
Death and disability	Disability and death data provided (not specifically related to overweight or obesity).	
Expenditure, costs	Family expenditure data are collected (not specifically related to overweight or obesity).	
Population demographics	Age, sex, country of birth, language background (English speaking or non-English speaking), Indigenous and immigrant status, education level, household income, employment status, marital status, parental status, suburb/town of residence, SEIFA, ASGS remoteness.	

<b>13. Jean Hailes for Women's Health Survey</b>	
Type of data source	Survey (national)
Brief description	The Jean Hailes Women's Health Survey is a national study designed to collect information on health behaviours and literacy from women aged over 18 living in Australia. The survey collects information on perceptions of weight, weight management practices (for example, crash diets and fasting) and weight-related health concerns.
Purpose(s)	<p>The Women's Health Survey was designed to:</p> <ul style="list-style-type: none"> <li>• examine perceived gaps in women's health information as identified by women (and, in 2015 and 2016, health professionals)</li> <li>• understand future health needs of women living in Australia</li> <li>• explore and describe trends in women's health behaviours focusing on diet, exercise, mental health and health screening behaviours.</li> </ul> <p>The survey in turn informs future directions of Jean Hailes for Women's Health; a national not-for-profit organisation aiming to improving the knowledge of women's health throughout the various stages of their lives.</p> <p>The survey collects information on self-perceived weight status—for example, underweight, slightly overweight—and physical activity levels. The survey also collects some information on overweight and obesity related health conditions, such as elevated blood pressure, but participants are not asked whether any of the related conditions are directly connected to excess weight.</p>
Collection methodology	<p>Online non-representative self-report survey. Participants are recruited through established Jean Hailes communication channels and community partners. Invitations to participate, accompanied by links to the survey, are published through the Jean Hailes website, social media and email updates.</p> <p>The survey has a level of selection bias, as participants who take part are more likely to be motivated, health conscious and aware of their health needs than non-participants. In addition, participants are self-selecting and hence the results of this survey may not necessarily represent the health needs and status of women in the general Australian population.</p>
Scope (theoretical coverage of relevant population)	Women are considered in scope if they are 18 or older, residing in Australia and able to access the online survey or able to sit with a translator and complete the survey. The sample is self-selecting, as participants volunteer to participate via social media and other platform links.
Coverage (actual)	Survey is self-selecting and not representative
Geographic coverage	Australia

Frequency/timing	Yearly from 2015	
Basic collection count	Persons	
Size	<p>2015: total of 3,325 individuals—2,798 women and 527 health professionals</p> <p>2016: total of 3,236 individuals—3,035 women and 201 health professionals</p> <p>2017: 10,377 women</p> <p>2018: participant numbers pending</p>	
Collection management organisation	Jean Hailes for Women's Health	
Further information	<a href="https://jeanhailes.org.au/survey2017/">https://jeanhailes.org.au/survey2017/</a> <a href="https://jeanhailes.org.au/survey2018/">https://jeanhailes.org.au/survey2018/</a>	
Data access	The data are not currently available for access. Survey reports are available at the above links.	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported nutrition information using a 12 month food frequency questionnaire and information collected on diets and weight control activities.
	Physical activity	Self-reported: <ul style="list-style-type: none"> <li>whether respondent had completed at least 2.5 hours of moderate activity per week</li> <li>barriers to physical activity</li> </ul>
	Alcohol intake	Self-reported intake over the past 12 months
Environmental risk factors	No data	
Related conditions	Self-reported blood pressure, cholesterol, blood sugars and diabetes	
Prevalence	Waist circumference	No data
	Weight and height	Self-reported height and weight for BMI
Prevention, treatment and management	Number of GP visits annually for own health, confidence in asking questions and discussing health issues with own doctor, source of health information, access to a doctor or health services. Not directly related to overweight and obesity.	
Quality of life	Data collected on 'embarrassment about self-image during physical activity' in direct relation to self-assessed weight status.	
Death and disability	No data	

Expenditure, costs	Affordability of appointments with health professionals and costs associated with healthy eating explored in 2018.
Population demographics	Age, state of residence, remoteness (as per the Australian Statistical Geography Standard), marital status, level of education, employment status, main language spoken at home, country of birth, parity.

<b>14. Kindergarten Health Check (Australian Capital Territory)</b>	
Type of data source	Survey (state/territory)
Brief description	<p>Registered nurses employed by ACT Health conduct the Kindergarten Health Check in all ACT primary schools throughout the year.</p> <p>An information package is sent home from the school at the beginning of the year to obtain consent and explain what is involved.</p> <p>A parent-answered questionnaire is employed as well as a physical check. This health check includes vision, hearing, height, weight and development.</p> <p>Results are sent to parents and family GPs with the consent of the family.</p>
Purpose(s)	To provide ACT Health with information and data on health and wellbeing for ACT children, monitor child health trends in the ACT, and help in the assessment and planning of health services.
Collection methodology	Following administration of the parent-answered questionnaire, registered nurses employed by ACT Health attend ACT schools and take biomedical measurements for vision, hearing and body mass.
Scope (theoretical coverage of relevant population)	All kindergarten aged children in the ACT. This is an average of 5,600 annually over last 4 years (range: 5,368–5,783).
Coverage (actual)	<p>In the last 4 years:</p> <ul style="list-style-type: none"> <li>parent-answered questionnaire: average 5,130 (range: 4,790–5,340)</li> <li>response rate: 91.5%</li> <li>completed full health check (questionnaire and physical check): average 4,790 (range: 4,520–4,940)</li> <li>completion rate: 86%</li> </ul>
Geographic coverage	Australian Capital Territory (excluding Jervis Bay)
Frequency/timing	Yearly from 2014 (data availability varies)
Basic collection count	Persons
Size	<p>2014–2017</p> <p>Questionnaire responses: 20,528 records</p> <p>Health check data: 19,172 records</p>
Collection management organisation	ACT Health, Academic Unit of General Practice
Further information	<a href="http://health.act.gov.au/our-services/women-youth-and-children/school-health">http://health.act.gov.au/our-services/women-youth-and-children/school-health</a>



Data access	To apply to access these data please contact <a href="mailto:KindyHealthAUGP@act.gov.au">KindyHealthAUGP@act.gov.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Parent reported estimation of daily fruit and vegetable intake
	Physical activity	Parent reported estimation of daily physical activity
	Alcohol intake	Not applicable
Environmental risk factors	No data	
Related conditions	No data	
Prevalence	Waist circumference	No data
	Height and weight	Measured height and weight for BMI
Prevention, treatment and management	No data	
Quality of life	No data	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Sex, age at health check, suburb/postcode of residential address, Indigenous status.	

<b>15. Growing up in Australia: the Longitudinal Study of Australian Children (LSAC)</b>	
Type of data source	Longitudinal survey (national)
Brief description	<p>The LSAC is a longitudinal survey investigating the contribution of children's social, economic and cultural environments to their adjustment and wellbeing.</p> <p>The LSAC provides information about overweight and obesity in participating children, and risk factors for overweight and obesity in children. This dataset collects the following data about overweight and obesity:</p> <ul style="list-style-type: none"> <li>• physical measurements of participating children, including height, weight, body fat, girth and blood pressure</li> <li>• BMI</li> <li>• birth weight.</li> </ul> <p>Data provided by LSAC may also be used to evaluate children's exposure to the obesogenic environment, as data is collected about employment of young people—including whether they have worked in fast food establishments.</p>
Purpose(s)	To identify policy opportunities for improving support for young people and their families and for early intervention and prevention strategies.
Collection methodology	The study began in 2004 with two cohorts—families with 4–5 year old children and families with 0–1 year old infants. Children, parents, carers, childcare workers and teachers were surveyed. A range of survey methods have been used, such as face-to-face interviews, self-completed questionnaires, physical measurements of children, Time Use Diaries, an Events History Calendar, audio computer-assisted self-interviews and computer-assisted telephone interviews. The sample was selected from Medicare Australia's enrolment database.
Scope (theoretical coverage of relevant population)	Families of 18,814 selected children received letters of invitation to take part in the study.
Coverage (actual)	The final response to the recruitment of children was 54% of those families who were sent the initial letter (10,090 children), with participants representative of Australia's children population.
Geographic coverage	Australia
Frequency/timing	From 2004, the recruited families have been interviewed every 2 years. In addition, mail-out questionnaires were sent to families in 2005, 2007 and 2009. A one-off Child Health Checkpoint was offered to participating families in 2015–16, including a physical health assessment. Wave 8 fieldwork began in 2018 and will continue into early 2019.
Basic collection count	Persons
Size	2014 (Wave 6): 7,301 participants

Collection management organisation	The Australian Government Department of Social Services (DSS), the Australian Institute of Family Studies (AIFS) and the Australian Bureau of Statistics (ABS) conduct the LSAC. Colmar-Brunton Social Research and I-view/NCS Pearson, private social research companies, undertook the Wave 1 data collection. The Australian Bureau of Statistics undertook data collection for Waves 2 to 8.	
Further information	<a href="http://www.growingupinaustralia.gov.au">http://www.growingupinaustralia.gov.au</a>	
Data access	Applications for data access can be may to the DSS via the National Centre for Longitudinal Data. For more information see <a href="https://dataverse.ada.edu.au/dataverse/nclcd">https://dataverse.ada.edu.au/dataverse/nclcd</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	<p>Self or parent-reported:</p> <ul style="list-style-type: none"> <li>intake of breast-milk, other milks, fruit juice, vegetables, fruits and other food groups</li> <li>food diary for children over 10 years old.</li> </ul> <p>Parent reported:</p> <ul style="list-style-type: none"> <li>foods excluded in pregnancy</li> <li>servees of fruit and vegetables per day.</li> </ul>
	Physical activity	<p>Time Use Diary contains physical activity.</p> <p>Parent-reported :</p> <ul style="list-style-type: none"> <li>number of days per week at least 30–60 minutes of moderate exercise is done</li> <li>after school activities including team sports and individual sports activities</li> <li>mode of transport to school.</li> </ul>
	Alcohol intake	<p>Self-reported:</p> <p>Parents:</p> <ul style="list-style-type: none"> <li>average daily alcohol consumption</li> <li>frequency of binge drinking.</li> </ul> <p>Children:</p> <ul style="list-style-type: none"> <li>frequency of consumption</li> <li>age at first drink.</li> </ul>
Environmental risk factors	No data	
Related conditions	Measured blood pressure	
Prevalence	Waist circumference	Measured
	Height and weight	Measured height and weight for BMI. Additional measure of body fat.

Prevention, treatment and management	Hospital stays, linked MBS and PBS data, but not specific to overweight and obesity.
Quality of life	<p>Kidscreen Quality of Life Scale:</p> <p>The next questions ask about how you've been feeling over the last week. Have you felt fit and well? 1 Not at all; 2 Slightly; 3 Moderately; 4 Very; 5 Extremely</p> <p>The next questions ask about how you've been feeling over the last week. Have you felt full of energy? 1 Not at all; 2 Slightly; 3 Moderately; 4 Very; 5 Extremely</p> <p>These are not specifically related to overweight or obesity.</p>
Death and disability	Variables for collection of data on disability (not specifically related to overweight or obesity).
Expenditure, costs	Linked Medicare data (not specifically related to overweight or obesity).
Population demographics	Age, sex, main language spoken at home, Indigenous status, family structure, employment status, education level, SEIFA, parents' country of birth and educational level, remoteness (ASGS-SA2, SA3 and SA4).

<b>16. Longitudinal Surveys of Australian Youth (LSAY)</b>	
Type of data source	Longitudinal survey (national)
Brief description	<p>The Longitudinal Surveys of Australian Youth (LSAY) is a research program that tracks young people as they move from school into further study, work and other destinations. It uses large nationally representative samples of young people to collect information about education and training, work, financial matters, health, social activities and related issues. Since 2003, the initial survey wave has been integrated with the OECD Programme for International Student Assessment.</p> <p>The survey data provides information about height, weight and some physical and sedentary activities.</p>
Purpose(s)	To increase the understanding of key transitions and pathways in the lives of young people, particularly from compulsory schooling to further education, training and employment.
Collection methodology	<p>Data are initially collected through a combination of school achievement tests and a questionnaire administered at school. Subsequent data are gathered through annual telephone interviews. Since 2012, survey participants have had the option to complete their interview online.</p> <p>From the second wave, participants from the newest cohort who commenced the program in 2015 (Y15) were able to choose between computer-assisted telephone interviews (CATI) and computer-assisted web interviews (CAWI).</p>
Scope (theoretical coverage of relevant population)	<p>1995 (Y95) and 1998 (Y98) commencing cohorts: Australian Year 9 students.</p> <p>2003 (Y03), 2006 (Y06), 2009 (Y09) and 2015 (Y15) commencing cohorts: Australian 15-year-old secondary school students.</p>
Coverage (actual)	A year-on-year response rate of about 85%–90% is maintained over the life of each cohort, with a final sample size of about 28.5% of the original sample (on average).
Geographic coverage	Australia
Frequency/timing	LSAY participants are surveyed annually over a ten-year period from age 15 to 25. Six cohorts having commenced the program to date in 1995 (Y95), 1998 (Y98), 2003 (Y03), 2006 (Y06), 2009 (Y09) and 2015 (Y15).
Basic collection count	Persons
Size	<p>Commencing sample:</p> <p>Y95 – 13,613</p> <p>Y98 – 14,117</p> <p>Y03 – 10,370</p>

	Y06 – 14,170 Y09 – 14,251 Y15 – 14,530 Final (or most recent) sample: Y95 (2006) – 3,914 Y98 (2009) – 3,596 Y03 (2013) – 3,741 Y06 (2016) – 3,343 Y09 (2017) – 3,518 Y15 (2017) – 4,654	
Collection management organisation	National Centre for Vocational Education Research	
Further information	<a href="https://www.lsay.edu.au/data/scope">https://www.lsay.edu.au/data/scope</a>	
Data access	Applications for data access can be made to the Australia National University via the Australian Data Archive Dataverse portal. For more information see <a href="https://www.lsay.edu.au/data/access">https://www.lsay.edu.au/data/access</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Whether respondent eats breakfast/dinner (Y15 only).
	Physical activity	Self-reported physical activity time and sitting time, and whether the respondent plays sport.
	Alcohol intake	No data
Environmental risk factors	No data	
Related conditions	No data	
Prevalence (per cent by BMI)	Waist circumference	No data
	Weight and height	Self-reported height and weight for BMI
Prevention, treatment and management	No data	
Quality of life	<ul style="list-style-type: none"> <li>• Self-assessed health status</li> <li>• Kessler Psychological Distress Scale (K6)</li> <li>• Life satisfaction; happiness with: <ul style="list-style-type: none"> <li>- Your future</li> <li>- The work you do</li> <li>- What you do in your spare time</li> <li>- How you get on with people</li> </ul> </li> </ul>	

	<ul style="list-style-type: none"> <li>- The money you get each week</li> <li>- Your social life</li> <li>- Your independence</li> <li>- Your career prospects</li> <li>- Your life at home</li> <li>- Your standard of living</li> <li>- The way the country is run</li> <li>- The state of the economy</li> <li>- Where you live</li> <li>- Your life as a whole</li> <li>• Big Five Personality Inventory (BFI-10)</li> <li>• Perceptions about self and school</li> <li>• Bullying</li> <li>• Social support (Y15)</li> <li>• Transience/homelessness (Y15)</li> <li>• Volunteering and caring</li> <li>• Leisure activities.</li> </ul> <p>These quality of life measures were not specifically related to overweight or obesity.</p>
Death and disability	<ul style="list-style-type: none"> <li>• Disability or health problem which limits the amount or type of work that you do.</li> <li>• Type of disability or health problem: <ul style="list-style-type: none"> <li>- arms/legs/hands</li> <li>- sight</li> <li>- hearing</li> <li>- skin/allergies</li> <li>- breathing/asthma/bronchitis</li> <li>- heart/blood pressure</li> <li>- stomach/liver/kidney/digestive problems</li> <li>- diabetes</li> <li>- mental health, nervous or emotional condition,</li> <li>- epilepsy</li> <li>- dyslexia/other learning problems</li> <li>- chronic fatigue/post-viral syndromes</li> <li>- other problems or disabilities.</li> </ul> </li> </ul> <p>These disability measures were not specifically related to overweight or obesity.</p>
Expenditure, costs	No data

Population demographics	Age, sex, location postcode, Indigenous status, immigration status, main language spoken at home, ASGS remoteness, SEIFA, marital status.
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<b>17. Footprints in time: the Longitudinal Study of Indigenous Children (LSIC)</b>	
Type of data source	Longitudinal survey (national)
Brief description	<p>The LSIC generates quantitative and qualitative data that can be used to provide a better insight into how children's early years affect their development.</p> <p>The study collects the following data of relevance to overweight and obesity:</p> <ul style="list-style-type: none"> <li>• interviewer measured height and weight (including for study child's mother in Wave 1)</li> <li>• BMI</li> <li>• diet</li> <li>• physical activity</li> <li>• birth weight.</li> </ul>
Purpose(s)	To explore how early childhood affects later life outcomes for Aboriginal and Torres Strait Islander children and to improve the understanding of, and policy response to, the diverse circumstances faced by Aboriginal and Torres Strait Islander children, their families and communities.
Collection methodology	<p>The study focuses on 11 sites chosen to cover the range of socioeconomic and community environments where Aboriginal and Torres Strait Islander children live. Agreement and approval to participate in the study was sought from communities and Elders in these sites before research within the communities began, as well as individual informed consent from all parents participating in the study.</p> <p>Most families in the study were recruited using addresses provided by Centrelink and Medicare Australia. Other informal means of contact such as word of mouth, local knowledge and study promotion were also used to supplement the number of children in the study.</p> <p>The LSIC employed Indigenous interviewers to survey cohorts of Indigenous children aged from 6 months to 2 years (Baby cohort, or B cohort) and from 3 years 6 months to 5 years (Child cohort, or K cohort) in Wave 1. The design allows data covering the first 9 or 10 years of Aboriginal and Torres Strait Islander children's lives to be collected in 6 years.</p> <p>Children, parents and carers were surveyed using face-to-face interviews. Additionally, physical measurements were taken of the children. Child-care workers and teachers were surveyed using self-completed questionnaires.</p>
Scope (theoretical coverage of relevant population)	Footprints in Time was designed to select approximately 150 children in each of the 11 sites, providing a sample of 1,650 children. The study selected Indigenous children born between December 2003 and November 2004 (K cohort) or between December 2006 and November 2007 (B cohort).

Coverage (actual)	<p>Due to difficulties in sample recruitment related to small resident populations and geographic spread, for some sites it was not possible to find sufficient numbers of children to meet the study's targets. In other sites the number of eligible children was in excess of the required sample.</p> <p>In practice, the K cohort consists of children born in 2003, 2004 and 2005 and the B cohort consists of children born in 2006, 2007 and 2008.</p> <p>Response rates for each wave are as follows:</p> <p>Wave 2: 85.9%</p> <p>Wave 3: 81.8%</p> <p>Wave 4: 75.8%</p> <p>Wave 5: 76.2%</p> <p>Wave 6: 76.2%</p> <p>Wave 7: 77.5%</p> <p>Wave 8: 77.9%</p> <p>Wave 9: 79.7%</p>
Geographic coverage	<p>Eleven sites in Australia. No study sites were located in the ACT or Tasmania.</p> <p>The LSIC sample is not nationally representative; however, it sufficiently reflects the distribution of Aboriginal and Torres Strait Islander children aged between 0 and 5 years in the states and territories and among urban, regional and remote areas.</p>
Frequency/timing	Yearly since 2008
Basic collection count	Persons
Size	<p>Sample size of children only:</p> <p>Wave 1: 1,671</p> <p>Wave 2: 1,435</p> <p>Wave 3: 1,404</p> <p>Wave 4: 1,283</p> <p>Wave 5: 1,258</p> <p>Wave 6: 1,239</p> <p>Wave 7: 1,253</p> <p>Wave 8: 1,255</p> <p>Wave 9: 1,268</p>
Collection management organisation	Australian Government Department of Social Services

Further information	<a href="https://www.dss.gov.au/about-the-department/publications-articles/research-publications/longitudinal-data-initiatives/footprints-in-time-the-longitudinal-study-of-indigenous-children-lsic">https://www.dss.gov.au/about-the-department/publications-articles/research-publications/longitudinal-data-initiatives/footprints-in-time-the-longitudinal-study-of-indigenous-children-lsic</a>	
Data access	Applications for data can be made to the DSS. For more information, see <a href="https://dataverse.ada.edu.au/dataverse/nclid">https://dataverse.ada.edu.au/dataverse/nclid</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Parent reported: <ul style="list-style-type: none"> <li>what the study child had to eat and drink the previous day, including snacks and a range of food types (Waves 1–5)</li> <li>serves of fruit and vegetables child eats each day (Wave 6).</li> </ul>
	Physical activity	Self-reported outside of school activities, including physical activity oriented hobbies for child and whether parent plays sport or exercises.  Parent-reported hours spent by child watching TV, and playing electronic games during the week as well as how many days per week child spent an hour or more doing physical activity (Waves 1, 3, 4 and 7).
	Alcohol intake	Self-reported for parents in Wave 2 and 5 whether drink alcohol and frequency of binge drinking.
Environmental risk factors	No data	
Related conditions	Data collected on health conditions and disability for parents and children (not specifically related to overweight or obesity).	
Prevalence	Waist circumference	No data
	Height and weight	Children measured for all waves, parents measured for Wave 1. BMI derived for children in all waves.
Prevention, treatment and management	Hospital, health professional and doctor visits, not in direct relation to weight status or overweight and obesity related conditions.	
Quality of life	Self-reported quantitative measures of quality of life (not specifically related to overweight or obesity).	
Death and disability	Data collected on disability in parents and children (not specifically related to overweight or obesity).	
Expenditure, costs	No data	
Population demographics	Age, sex, state and/or territory of residence, Indigenous status, household size, income of family, tribal identification, main language spoken, level of relative isolation, Index of Relative Indigenous Socioeconomic Outcomes, SEIFA, parental education level and income.	

<b>18. Medicare Benefits Schedule (MBS) claims data</b>	
Type of data source	Administrative (national)
Brief description	<p>The Medicare Benefits Scheme (Medicare) is Australia's universal health insurance scheme. Medicare provides access to:</p> <ul style="list-style-type: none"> <li>• free treatment as a public patient in a public hospital</li> <li>• free or subsidised treatment by practitioners such as doctors, including specialists, participating optometrists, or dentists and other allied health practitioners (specified services only).</li> </ul> <p>All Australian residents, and overseas visitors covered by a reciprocal health-care agreement requiring immediate medical attention, are eligible for subsidised treatment under Medicare.</p> <p>The Medicare Benefits Schedule (MBS) is a listing of services that qualify for a benefit under the <i>Health Insurance Act 1973</i>. The associated MBS claims data comprises information on all medical and allied health services for which Medicare benefits were paid. These services include GP and specialist attendances, tests and procedures, provided to non-inpatients, and to private inpatients of public and private hospitals.</p> <p>The MBS claims data does not include details of services to public patients in public and private hospitals, nor does it include services provided under the Department of Veterans' Affairs National Treatment account. There is limited information about why a service was used.</p> <p>Details of services to public patients in public and private hospitals and details of services in public outpatient or accident and emergency departments are captured in separate hospitals data sets.</p> <p>MBS statistics include information on characteristics of patients who received Medicare-funded services, including weight-loss surgeries. The MBS data collection includes six surgical obesity items. These item numbers can be analysed for trends in the weight loss surgeries performed in Australia.</p>
Purpose(s)	The purpose of Medicare is to provide people with subsidised medical services. The resultant MBS claims data provides broad information on the type of services used and the benefit paid by Medicare for the service.
Collection methodology	Providers or patients submit claims for payment reflecting Medicare activity.
Scope (theoretical coverage of relevant population)	All Australian residents and eligible overseas visitors.
Coverage (actual)	Information will be missing if individuals or doctors fail to lodge claim information. This should be a rare occurrence, as there is a financial incentive to do so. Statistics are not available on services to public patients in public or private hospitals, or in public accident and emergency departments, or in public outpatient clinics or on services provided under the Department of Veterans' Affairs National Treatment Account.
Geographic coverage	Australia

Frequency/timing	Ongoing	
Basic collection count	Number of subsidised medical services, fees charged and Medicare benefits paid.	
Size	Not applicable	
Collection management organisation	Medicare is managed by the Department of Health and administered by the Department of Human Services.	
Further information	<a href="https://www.humanservices.gov.au/individuals/medicare">https://www.humanservices.gov.au/individuals/medicare</a>	
Data access	Medicare group reports are publicly available from the DHS, see <a href="http://medicarestatistics.humanservices.gov.au/statistics/mbs_group.jsp">http://medicarestatistics.humanservices.gov.au/statistics/mbs_group.jsp</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	No data
Environmental risk factors	No data	
Related conditions	No data	
Prevalence	Waist circumference	No data
	Height and weight	No data
Prevention, treatment and management	Where there are specific items in the MBS for weight loss and related procedures, such as gastric banding, utilisation statistics can be compiled for services resulting in payment of a Medicare benefit. However, statistics are not available on GP or specialist attendances resulting in the provision of advice on weight loss. There are specific items in the MBS for the treatment of conditions related to overweight and obesity, such as Type 2 diabetes, the weight status of the patient receiving treatment is not available.	
Quality of life	No data	
Death and disability	No data	
Expenditure, costs	Statistics can be compiled on fees charged and benefits paid, where there are specific items in the MBS for weight loss and related procedures.	
Population demographics	Sex, age, usual residence of patient (various levels such as Statistical Local Area and the Rural, Remote and Metropolitan Areas Classification), Indigenous status.	

<b>19. MedicineInsight (NPS Medicine Wise Data Source)</b>	
Type of data source	Administrative general practice dataset
Brief description	<p>MedicineInsight is a national general practice dataset, collecting monthly longitudinal, de-identified, whole-of-practice data extracted from the clinical information systems (CIS) from consenting general practices across Australia. Data are a by-product of information recorded by GPs and others in their practice for the primary purpose of managing patient consultations.</p> <p>Using both coded and free-text terms from the CIS, MedicineInsight provides details of encounters in general practice, the conditions patients present with, how they are managed and their outcomes over time.</p> <p>Data are available to researchers following approval from the Independent Data Governance Committee.</p>
Purpose(s)	<p>MedicineInsight was established to:</p> <ul style="list-style-type: none"> <li>• support quality improvement activities in participating general practices.</li> <li>• provide national data for post market surveillance of medicines</li> <li>• provide a better understanding of general practice activity in Australia to improve primary healthcare and health outcomes for all Australians.</li> </ul>
Collection methodology	<p>MedicineInsight extracts longitudinal, de-identified, whole-of-practice data from the clinical information system (CIS) of consenting general practices to connect patient conditions with treatments and their outcomes.</p> <p>An extraction tool collects incremental data regularly, allowing the development of a longitudinal database in which patients within practices can be tracked over time. Data are stored in a secure Australian-based data warehouse.</p>
Scope (theoretical coverage of relevant population)	Australian GP patients with at least 3 visits in a 2-year period.
Coverage (actual)	8.6% of practices across Australia participate in the MedicineInsight program. An initial weighting formula has been developed with ABS, to weight the patient encounters by age and state to a nationally representative sample.
Geographic coverage	Australia
Frequency/timing	Data are updated monthly in the data warehouse. Longitudinal data are available for each patient from the time of data entry into the CIS at each practice.
Basic collection count	General practices and patients
Size	650 general practices covering approximately 3,300 GPs and 3.6 million patients with at least 3 visits in a 2-year period (June 2018).

Collection management organisation	NPS MedicineWise	
Further information	<a href="https://www.nps.org.au/medicine-insight/using-medicineinsight-data">https://www.nps.org.au/medicine-insight/using-medicineinsight-data</a>	
Data access	Data access expressions of interest can be submitted to the NPS. For more information, see <a href="https://www.nps.org.au/medicine-insight/using-medicineinsight-data">https://www.nps.org.au/medicine-insight/using-medicineinsight-data</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	Self-reported (data not likely to be complete).
Environmental risk factors	No data	
Related conditions	A range of chronic diseases are coded including diabetes, cardiovascular disease, stroke, chronic kidney disease, and osteoarthritis. The manner in which conditions are coded varies across participating practices. However, diagnoses may grouped by way of NPS algorithms. Data completeness is unknown.	
Prevalence	Waist circumference	No data
	Height and weight	Unknown
Prevention, treatment and management	Treatment and management provided by a GP including medicines prescribed, conditions managed, risk factors and observations recorded, pathology test results received, immunisations given, allergies and adverse events documented, referrals.	
Quality of life	No data	
Death and disability	Data available but not validated	
Expenditure, costs	MBS billing data available for some practices	
Population demographics	Age, sex, Indigenous status (72% data completeness), state of residence.	

<b>20. National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)</b>	
Type of data source	Survey (national)
Brief description	The NATSIHS was a component of the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS)—the largest, most comprehensive health survey of the Australian Indigenous population ever conducted.
Purpose(s)	The 2012–13 NATSIHS was conducted between April 2012 and February 2013. This survey was designed to obtain national benchmark information on a range of health-related issues and to enable the monitoring of trends in the health of the Aboriginal and Torres Strait Islander population over time.
Collection methodology	Trained ABS interviewers conducted a face-to-face interview with an adult member of the household. Parental consent to interview persons aged 15–17 was sought, however some parents preferred to answer survey questions on their behalf. A parent or guardian was asked to answer questions on behalf of all children aged <15. This person is referred to as the child proxy throughout NATSIHS publications, and in other outputs from the survey.
Scope (theoretical coverage of relevant population)	The scope of the survey was all Aboriginal and Torres Strait Islander people who were usual residents of private dwellings in Australia (non-remote, remote and very remote areas of Australia). The sample was designed to provide reliable Aboriginal and Torres Strait Islander estimates for the whole of Australia, for state and territory, for the Torres Strait, and for remote and non-remote areas to a similar level of accuracy to NATSIHS 2004–05.
Coverage (actual)	Of the dwellings in the sample, 80.2% were fully or adequately responding households.
Geographic coverage	Australia
Frequency/timing	2004–05 and 2012–13. Estimated frequency every 10 years.
Basic collection count	Persons
Size	In 2012–13 there were 9,300 respondents, 3,400 of which were from remote areas.
Collection management organisation	Australian Bureau of Statistics
Further information	<a href="http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4454DD168187E303CA257C2F00146279?opendocument">http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4454DD168187E303CA257C2F00146279?opendocument</a>
Data access	Applications for access to microdata products can be made via the ABS. For more information, see <a href="http://abs.gov.au/websitedbs/D3310114.nsf/home/Microdata+Entry+Page">http://abs.gov.au/websitedbs/D3310114.nsf/home/Microdata+Entry+Page</a>  Data obtained in the survey but not presented in the microdata may be available by request from the ABS as statistics in tabulated form.



	Subject to confidentiality and sampling variability constraints, special tabulations can be produced incorporating data items, populations and geographic areas selected to meet individual requirements. These are available on request, on a fee for service basis. Contact the National Information and Referral Service on 1300 135 070 or <a href="mailto:client.services@abs.gov.au">client.services@abs.gov.au</a> for further information.	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported: <ul style="list-style-type: none"> <li>main type of milk consumed</li> <li>daily fruit and vegetable intake</li> <li>frequency of adding salt to food in household</li> <li>whether currently on a diet to lose weight or for other health reasons.</li> </ul>
	Physical activity	Self-reported information on broad levels of physical and screen-based activity.
	Alcohol intake	Self-reported: <ul style="list-style-type: none"> <li>Average daily intake over days recorded (in standard drinks)</li> <li>frequency of binge drinking</li> <li>types of drink consumed on a day binge drinking</li> <li>time since last alcoholic drink</li> <li>days in last week consumed alcohol</li> <li>estimated total weekly consumption.</li> </ul>
Environmental risk factors	Variables for main mode of transport, frequency and type of active transport (for example, walking, cycling or skateboarding) for adults and children aged 5–17.	
Related conditions	Interviewer measured blood pressure. Self-reported history of diabetes, high blood sugar levels, heart disease, circulatory disease, osteoporosis, and kidney disease.	
Prevalence	Waist circumference	Measured for waist-to-hip ratio
	Height and weight	Measured height and weight for BMI
Prevention, treatment and management	Hospital visits and admissions, other health service use (including GPs and allied health services such as dietitians and nutritionists) and consultations with health professionals (not specifically related to overweight or obesity).	
Quality of life	Self-assessed health status, measures of psychological stress using the Kessler 5 tool, and self-reported family stressors (not specifically related to overweight or obesity).  Respondents were also asked about their self-perceived body mass and their satisfaction with current weight.	

Death and disability	Self-reported disability, days off work due to illness or injury and recent injuries (not specifically related to overweight or obesity).
Expenditure, costs	Private health insurance
Population demographics	Age, sex, ASGS remoteness, number of people in household, dwelling type, weekly income, main language spoken at home, highest level of educational attainment, employment status, job type.

<b>21. National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey (NATSINPAS)</b>	
Type of data source	Survey (national)
Brief description	<p>The NATSINPAS was a component of the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS)—the largest, most comprehensive health survey of the Australian Indigenous population ever.</p> <p>The NATSINPAS is the first ABS survey to collect detailed nutrition information from Aboriginal and Torres Strait Islander people. Information for the nutrition component was gathered using a 24-hour dietary recall on all foods and beverages consumed on the day prior to interview. Where possible, at least 8 days after the first interview, respondents in non-remote areas were contacted to participate in a second 24-hour dietary recall via telephone interview.</p>
Purpose(s)	The 2012–13 NATSINPAS was conducted between August 2012 and July 2013. This survey was designed to obtain detailed national benchmark information on nutrition and physical activity. This detailed information has never before been collected for the Aboriginal and Torres Strait Islander population.
Collection methodology	Trained ABS interviewers conducted personal interviews with selected residents in sampled dwellings. Selected persons aged 18 and over in each dwelling were interviewed about their own health characteristics. An adult, nominated by the household, was interviewed for selected children (aged 2 and over) in the household. Selected children aged 15–17 may have been personally interviewed with parental consent. An adult, nominated by the household, was also asked to provide information about the household, such as the combined income of other household members. Children aged 6–14 were encouraged to be involved in the survey, particularly for the physical activity module.
Scope (theoretical coverage of relevant population)	The scope of the survey was all Aboriginal and Torres Strait Islander people who were usual residents of private dwellings in Australia (non-remote, remote and very remote areas of Australia).
Coverage (actual)	Of the dwellings in the sample, 79.2% were fully or adequately responding households.
Geographic coverage	Australia
Frequency/timing	2011–12—estimated frequency every 10 years.
Basic collection count	Persons
Size	4,109
Collection management organisation	Australian Bureau of Statistics

Further information	<a href="http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4454DD168187E303CA257C2F00146279?opendocument">http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4454DD168187E303CA257C2F00146279?opendocument</a>	
Data access	<p>Applications for access to microdata products can be made via the ABS. For more information, see: <a href="http://abs.gov.au/websitedbs/D3310114.nsf/home/Microdata+Entry+Page">http://abs.gov.au/websitedbs/D3310114.nsf/home/Microdata+Entry+Page</a></p> <p>Data obtained in the survey but not presented in the microdata may be available by request from the ABS as statistics in tabulated form. Subject to confidentiality and sampling variability constraints, special tabulations can be produced incorporating data items, populations and geographic areas selected to meet individual requirements. These are available on request, on a fee for service basis. Contact the National Information and Referral Service on 1300 135 070 or <a href="mailto:client.services@abs.gov.au">client.services@abs.gov.au</a> for further information.</p>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Detailed self-reported information on food intake from 2 24-hour dietary recalls, with nutrient intakes derived from these data.
	Physical activity	Self-reported physical activity and sedentary behaviour, including 8 days of pedometer data from 31% of respondents
	Alcohol intake	Detailed self-reported intake of alcohol through the 2 x 24-hour dietary recalls.
Environmental risk factors	Variables for whether used active or inactive transport in the last week, and total minutes undertaken for adults and children aged 5–17.	
Related conditions	Data from the NATSINPAS can be linked with other collected measures in the 'core' component of the AATSIHS, including measured blood pressure, self-reported heart disease, high cholesterol, all diabetes types, and high blood sugar.	
Prevalence	Waist circumference	Interviewer measured via the 'core' component of the AATSIHS.
	Height and weight	Interviewer measured via the 'core' component of the AATSIHS for BMI.
Prevention, treatment and management	No data	
Quality of life	No data	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Age, sex, ASGS remoteness, Indigenous status, marital status, main language spoken at home, highest level of educational attainment, employment status, area of employment, weekly cash income of respondent.	

22. National Health Survey (NHS)	
Type of data source	Survey (national)
Brief description	<p>The ABS National Health Survey (NHS) was designed to collect a range of information about the health of Australians, including:</p> <ul style="list-style-type: none"> <li>• prevalence of long-term conditions</li> <li>• health risk factors such as smoking, overweight and obesity, alcohol consumption and exercise</li> <li>• use of health services such as consultations with health practitioners and actions people have recently taken for their health</li> <li>• demographic and social characteristics.</li> </ul> <p>The NHS measures height, weight and waist circumference for respondents aged 2 and over, as well as self-reported alcohol intake, physical activity and daily intake of fruit and vegetables.</p> <p>The survey is conducted in all states and territories and across urban, rural and remote areas of Australia (other than very remote areas).</p>
Purpose	To collect information about the health status of Australians, their use of health services and health risk factors.
Collection methodology	Trained ABS interviewers, through computer-assisted personal interview.
Scope (theoretical coverage of relevant population)	<p>A representative sample of Australians. For the 2014–15 NHS, persons in scope of the survey were those identified by an adult within each sampled private dwelling as a usual resident of that dwelling. Private dwellings are houses, flats, home units, caravans, garages, tents and other structures used as a place of residence at the time of the survey.</p> <p><i>Very remote</i> areas were not covered, nor were non-private dwellings such as hotels, motels, hostels, hospitals, nursing homes and short-stay caravan parks.</p>
Coverage (actual)	The sample is designed so that within each state or territory, each person has an equal chance of selection and reliable estimates could be produced for each state and territory.
Geographic coverage	All states and territories, Australia. <i>Very remote</i> areas were not included in the NHS.
Frequency/timing	The NHS is ongoing. The first NHS was in 1989–90 with additional surveys in 1995, 2001, 2004–05 and 2007–08, 2011–12 and 2014–15. The first results from the 2017–18 NHS were released in December 2018.
Basic collection count	Persons in households

Size	The 2017–18 NHS included 21,315 people in 16,384 private dwellings.	
Collection management organisation	Australian Bureau of Statistics	
Further information	<a href="http://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001">http://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001</a>	
Data access	<p>Applications for access to microdata products can be made via the ABS. For more information, see: <a href="http://abs.gov.au/websitedbs/D3310114.nsf/home/Microdata+Entry+Page">http://abs.gov.au/websitedbs/D3310114.nsf/home/Microdata+Entry+Page</a></p> <p>Data obtained in the survey but not presented in the microdata may be available by request from the ABS as statistics in tabulated form. Subject to confidentiality and sampling variability constraints, special tabulations can be produced incorporating data items, populations and geographic areas selected to meet individual requirements. These are available on request, on a fee for service basis. Contact the National Information and Referral Service on 1300 135 070 or <a href="mailto:client.services@abs.gov.au">client.services@abs.gov.au</a> for further information.</p>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported information on dietary behaviours including main type of milk usually consumed and usual daily serves of fruit and vegetable. 24 hour recall used in 2011–12.
	Physical activity	Self-reported information on physical activity and sedentary behaviours.
	Alcohol intake	<p>Detailed self-reported intake of alcohol for persons aged 15 and over:</p> <ul style="list-style-type: none"> <li>derived from information about the types and quantities of alcoholic drinks consumed on the 3 most recent days, in the week prior to the interview, on which alcohol was consumed</li> <li>refers to the quantity of alcohol contained in any drinks consumed, not the quantity of the drinks themselves.</li> </ul>
Environmental risk factors	Number of days exercise or walked for transport and duration.	
Related conditions	Interviewer measured blood pressure (not collected in 2007–08), self-reported heart disease, high cholesterol, all diabetes types, and high blood sugar.	
Prevalence	Waist circumference	Measured in 2007–08, 2011–12 and 2014–15.
	Height and weight	Measured in 2007–08, 2011–12, 2014–15 and 2017–18, and self-reported in 1995, 1989–89, 2001 and 2004–05.

Prevention, treatment and management	No data
Quality of life	<p>Participants aged 15 and over in the NHS were asked whether in general they felt their health was: excellent, very good, good, fair, poor.</p> <p>Data were also collected on bodily pain and disability status.</p> <p>These quality of life measures were not specifically related to overweight or obesity.</p>
Death and disability	No data
Expenditure, costs	No data
Population demographics	Age, sex, Indigenous status, place of usual residence, country of birth of respondent and year of arrival in Australia, country of birth of parents, main language spoken at home, proficiency in spoken English, educational qualification, occupation, marital status, household composition.

<b>23. National Hospital Morbidity Database (NHMD)</b>	
Type of data source	Administrative (national)
Brief description	The NHMD is a compilation of episode-level records from admitted patient morbidity data collection systems in Australian hospitals.
Purpose(s)	To provide information on admitted patient care, such as demographic, administrative and length of stay data, as well as data on the diagnoses of the patients, the procedures they underwent in hospital and external causes of injury and poisoning.
Collection methodology	The data supplied are based on the National Minimum Data Set for admitted patient care. Data are supplied to the AIHW by state and territory health authorities under the terms of the National Health Information Agreement.
Scope (theoretical coverage of relevant population)	The scope of the NHMD is episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free-standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not in scope, but some are included.
Coverage (actual)	For 2016–17, almost all public hospitals provided data for the NHMD, with the exception of an early parenting centre in the ACT. The great majority of private hospitals also provided data, the exceptions being the private free-standing day hospital facilities in the ACT.
Geographic coverage	Australia
Frequency/timing	Annually from 1993–94
Basic collection count	Number of separations.  A separation is an episode of care, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation).
Size	There were 11 million separations recorded in the NHMD in 2016–17.
Collection management organisation	The NHMD is compiled by the AIHW from data supplied by the state and territory health authorities under the terms of the National Health Information Agreement.
Further information	<a href="http://meteor.aihw.gov.au/content/index.phtml/itemId/638202">http://meteor.aihw.gov.au/content/index.phtml/itemId/638202</a>
Data access	Data requests can be made to the AIHW. For more information, see: <a href="https://www.aihw.gov.au/our-services/data-on-request">https://www.aihw.gov.au/our-services/data-on-request</a>



Priority information areas		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	No data
Environmental risk factors	No data	
Related conditions	The NHMD collects principal and additional diagnoses information. The NHMD cannot provide information on whether co-occurring diagnoses are directly linked with obesity; diagnoses are not linked and are only found to be co-morbid.	
Prevalence	<p>Reported overweight and obesity among episodes of admitted patient care can be determined using International Statistical Classification of Diseases and related Health Problems, Tenth Revision, Australia Modification (ICD-10-AM) codes.</p> <p>Obesity is only be captured as a diagnosis code if it affects patient management.</p> <p>Obesity may be captured as a supplementary code for chronic conditions, but there has yet to be any analysis from the AIHW as to the data quality of these codes.</p>	
Prevention, treatment and management	Interventions performed in acute admitted settings are recorded using the Australian Classification of Health Interventions. This includes surgical procedures such as gastric banding.	
Quality of life	No data	
Death and disability	The NHMD records a 'discharge' type of death when patient die in hospital but the cause of death is not recorded. The NHMD records diseases and symptoms associated with disability when they are treated in the episode of care. Varying definitions of disability may impact data collection in this instance.	
Expenditure, costs	Funding source and insurance status of admitted patients.	
Population demographics	Sex, age, Indigenous status, area of usual residence (SA2 level), state, Indigenous status, remoteness areas (as per Australian Statistical Geography Standard 2016 for 2016–17 data), country of birth, marital status, SEIFA.	

<b>24. National Key Performance Indicators (nKPI) for Aboriginal and Torres Strait Islander Primary Health Care Data Collection</b>	
Type of data source	Administrative (national)
Brief description	<p>The national Key Performance Indicators (nKPI) for Aboriginal and Torres Strait Islander Primary Health Care data are collected from primary health care organisations that receive funding from the Department of Health to provide primary health care services, mainly to Aboriginal and Torres Strait Islander people.</p> <p>Aggregate service-level data are collected every six months on Census dates of 30 June and 31 December against 24 indicators that have been endorsed by the Australian Health Minister's Advisory Council. The indicators focus on maternal and child health, preventative health, and chronic disease management.</p> <p>nKPI data were first collected in June 2012 following an initial trial in March 2012. The number of organisations participating has increased from 90 services in June 2012 to 228 in December 2017. The 90 services that started in June 2012 had also participated in the Healthy for Life program which collected similar indicator data. To date data have been collected for 10 reporting periods (due to technical issues no data were collected in December 2016) with December 2017 being the most recent collection. Due to changes to the data collection process, data from June 2017 onwards are not comparable with previous reporting periods.</p> <p>The nKPI data are reported back to organisations at the individual service level and compiled for national reporting purposes. The raw data received from health services are checked to identify any data quality issues and, in consultation with services are corrected before being used in reporting.</p>
Purpose(s)	<p>The nKPIs were developed as part of the National Indigenous Reform Agreement, which aims to improve the health of Aboriginal and Torres Strait Islander people. They also help meet targets under the Council of Australian Governments Closing the Gap initiative—in particular, the targets for life expectancy and child mortality—by assisting organisations with their continuous quality improvement, and will support policy and planning at the national and state/territory levels by monitoring progress and highlighting areas for improvement.</p>
Collection methodology	<p>Until June 2016, aggregate nKPI data were extracted from health organisations' clinical information systems (CISs) largely by a single tool. Since June 2017, a new Direct Load reporting process allows a number of CISs to generate data within their clinical system and transmit aggregate data directly to a web-based portal (currently a system called OCHREStreams, but from December 2018 expected to be the Australian Government Department of Health's Health Data Portal). Remaining services submit data to the portal manually. AIHW has access to the data in the portal to undertake data cleaning.</p>

Scope (theoretical coverage of relevant population)	<p>Indigenous regular client population of an Australian Government Department of Health-funded primary health care service that is required to report against the Indigenous primary health care key performance indicators.</p> <p>A regular client is defined as a client who has an active medical record; that is, a client who attended the Department of Health-funded primary health care service at least 3 times in 2 years.</p>	
Coverage (actual)	December 2017: 99% of expected services submitted data.	
Geographic coverage	Australia	
Frequency/timing	Biannually with census dates of 30 June and 31 December.	
Basic collection count	Indigenous regular clients (with the exception of 2 indicators on birthweight—PI01 and PI02).	
Size	Data on overweight and obese Indigenous regular clients is for those aged 25 and over. In December 2017 data was provided for 119,600 Indigenous regular clients aged 25 and over.	
Collection management organisation	AIHW is the data custodian	
Further information	<a href="http://meteor.aihw.gov.au/content/index.phtml/itemId/686315">http://meteor.aihw.gov.au/content/index.phtml/itemId/686315</a> <a href="https://www.aihw.gov.au/reports/indigenous-health-welfare-services/nkpi-indigenous-australians-health-care-2017/contents/table-of-contents">https://www.aihw.gov.au/reports/indigenous-health-welfare-services/nkpi-indigenous-australians-health-care-2017/contents/table-of-contents</a>	
Data access	Data requests can be made to the AIHW. For more information, see <a href="https://www.aihw.gov.au/our-services/data-on-request">https://www.aihw.gov.au/our-services/data-on-request</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	Indicator on the recording of alcohol consumption (PI16) can include data that is self-reported or measured using tests such as AUDIT or AUDIT-C. Indicator on alcohol consumption result (PI17) is based on AUDIT-C only.
Environmental risk factors	No data	
Related conditions	Indicators on chronic disease management for type 2 diabetes and cardiovascular disease are included. As the collection is aggregate, the number of overweight and obese clients who also had either of these conditions cannot be determined.	
Prevalence	Waist circumference	No data
	Height and weight	Measured aggregate data on number of overweight and obese clients only. BMI

		testing may occur in some organisations but is more likely to be measured in clients who look underweight, overweight or obese. This would result in the proportion of overweight or obese Indigenous regular clients appearing higher than it actually is.
Prevention, treatment and management	No data specific to overweight and obesity	
Quality of life	No data	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Age and sex of Indigenous regular clients attending; remoteness, state/territory of organisation only.	

<b>25. National Nutrition and Physical Activity Survey (NNPAS), 2011–12</b>	
Type of data source	Survey (national)
Brief description	<p>The 2011–12 Australian Health Survey (AHS) was designed to obtain national information on the health status of Australians, their use of health services and facilities, and health-related aspects of their lifestyle.</p> <p>As part of the AHS, the National Nutrition and Physical Activity Survey (NNPAS) collected data on physical activity, foods and nutrients consumed, and selected dietary behaviours.</p>
Purpose	<p>The high level objectives for the collection and reporting of food, nutrition and physical activity data in the 2011–12 NNPAS were to:</p> <ul style="list-style-type: none"> <li>• determine food and nutrient intakes in the population as a whole</li> <li>• enable monitoring and reporting of the adequacy of food and nutrient intakes against national dietary guidelines and nutrient reference values</li> <li>• enable comparison of food and nutrient intakes to those reported in previous national surveys</li> <li>• inform the development and evaluation of national food regulatory standards.</li> </ul>
Collection methodology	<p>Trained ABS interviewers conducted personal interviews with selected residents within sampled private dwellings. One person aged 18 and over in each dwelling was selected and interviewed about their own health, including a 24-hour dietary recall and physical activity module. An adult was then interviewed about one child (aged 2 and over) living in the household. Some children aged 15–17 were personally interviewed with parental consent. All selected persons were required to have a follow-up phone interview at least 8 days after the face-to-face interview to collect a further 24-hour recall.</p>
Scope (theoretical coverage of relevant population)	<p>A representative sample of Australians. Persons in scope of the survey were those identified by an adult within each sampled private dwelling as a usual resident of that dwelling. Private dwellings are houses, flats, home units, caravans, garages, tents and other structures used as a place of residence at the time of the survey.</p> <p><i>Very remote</i> areas were not covered, nor were non-private dwellings such as hotels, motels, hostels, hospitals, nursing homes and short-stay caravan parks.</p>
Coverage (actual)	<p>Of the 12,153 people in the final sample, 98% provided the first 24-hour recall (Day 1), with the missing 2% of Day 1 dietary recalls being imputed. The second 24-hour dietary recall (Day 2) had 7,735 participants (64% of total participants). The Day 2</p>

	24-hour dietary recall participation was slightly higher among older respondents, and sex did not appear to be a factor influencing participation.	
Geographic coverage	All states and territories, Australia. <i>Very remote</i> areas were not included.	
Frequency/timing	The NNPAS was conducted between 2011 and 2012, with the previous National Nutrition Survey conducted in 1995. The next NNPAS is planned for 2021–22.	
Basic collection count	Persons in household	
Size	The NNPAS sample comprised 12,153 persons	
Collection management organisation	Australian Bureau of Statistics	
Further information	<a href="http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4363.0.55.001Chapter6502011-13">http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4363.0.55.001Chapter6502011-13</a>	
Data access	<p>Applications for access to microdata products can be made via the ABS. For more information, see <a href="http://abs.gov.au/websitedbs/D3310114.nsf/home/Microdata+Entry+Page">http://abs.gov.au/websitedbs/D3310114.nsf/home/Microdata+Entry+Page</a></p> <p>Data obtained in the survey but not presented in the microdata may be available by request from the ABS as statistics in tabulated form. Subject to confidentiality and sampling variability constraints, special tabulations can be produced incorporating data items, populations and geographic areas selected to meet individual requirements. These are available on request, on a fee for service basis. Contact the National Information and Referral Service on 1300 135 070 or <a href="mailto:client.services@abs.gov.au">client.services@abs.gov.au</a> for further information.</p>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Detailed self-reported information on food intake from 2 24-hour dietary recalls, with nutrient intakes derived from these data.
	Alcohol intake	Detailed self-reported intake of alcohol through the 2 24-hour dietary recalls.
	Physical Activity	Self-reported information on physical activity and sedentary behaviours, as well as pedometer data.
Environmental risk factors	Modes of transport used in the last week, whether used active or inactive transport in the last week, number of time and duration of walking for transport in the last week.	

Related conditions	Data from the NNPAS can be linked with other collected measures in the 'core' component of the AHS, including measured blood pressure, self-reported heart disease, high cholesterol, all diabetes types, and high blood sugar.	
Prevalence	Waist circumference	Interviewer measured via the 'core' component of the AHS.
	Height and weight	Interviewer measured via the 'core' component of the AHS for BMI.
Prevention, treatment and management	No data	
Quality of life	Data are available via the 'core' component of the AHS. Participants aged 15 and over were asked whether in general they felt their health was: excellent, very good, good, fair, poor (not specifically related to overweight or obesity).	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Age, sex, Indigenous status, place of usual residence, ASGS remoteness, SEIFA, country of birth of respondent and year of arrival in Australia, country of birth of parents, main language spoken at home, proficiency in spoken English, educational qualification, occupation, marital status, household composition.	

<b>26. National Mortality Database (NMD)</b>	
Type of data source	Administrative (national)
Brief description	The National Mortality Database (NMD) contains information about deaths registered in Australia since 1964. Information is provided on the underlying cause of death (the disease or condition leading directly to death). From 1997 data are available on the associated causes of death (diseases or conditions other than the underlying cause that contributed to the death).
Purpose(s)	The NMD is used by the AIHW for population-level analyses and monitoring mortality due to all and specific causes of death including chronic diseases; burden of disease research; and to inform Closing the Gap and other Council of Australian Governments indicators. It is also used to fulfil data requests for external researchers.
Collection methodology	Deaths registrations are administered by the Registrars of Births, Deaths and Marriages in each state and territory. Death registration is compulsory. The cause of death is certified by a medical practitioner or a coroner and coded (by the Australian Bureau of Statistics) using the International Classification of Diseases. Demographic characteristics and administrative information about the deceased is included in these data.
Scope (theoretical coverage of relevant population)	Australian death registrations include all deaths that occurred and were registered in Australia, including persons whose place of usual residence was overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars, but are not included in ABS death statistics.
Coverage (actual)	While registration is legally required for all deaths, there can be delays in registration and so not all deaths are registered in the year that they occur. There can also be delays to the ABS receiving notification of the death from the registries due to processing or data transfer lags. On average around 4%–5% of deaths are registered in the year after they occur. These are counted in the deaths data for the following year.  Lags in completion and processing of coroner cases can impact coding of causes of death.
Geographic coverage	Australia
Frequency/timing	The Australian Bureau of Statistics publishes annual summaries of cause of death data. Following a 'return to source' process the AIHW applies for access to these data.
Basic collection count	Number of deaths
Size	There were 158,504 deaths registered in 2016



Collection management organisation	Data source agencies include the Registrars of Births, Deaths and Marriages in each state and territory and the National Coronial Information System. Death registrations are compiled and coded by the ABS to produce cause of death unit record files (COD URF). The AIHW houses annual collections of the COD URFs in the National Mortality Database (NMD).
Further information	Quality declaration: <a href="http://www.abs.gov.au/Ausstats/abs@.nsf/0/D4A300EE1E04AA43CA2576E800156A24?OpenDocument">http://www.abs.gov.au/Ausstats/abs@.nsf/0/D4A300EE1E04AA43CA2576E800156A24?OpenDocument</a>
Data access	Data requests can be made to the AIHW. For more information, see <a href="https://www.aihw.gov.au/our-services/data-on-request">https://www.aihw.gov.au/our-services/data-on-request</a>
<b>Priority information areas</b>	
Modifiable risk factors	No data
Environmental risk factors	No data
Related conditions	No data
Prevalence	No data
Prevention, treatment and management	No data
Quality of life	No data
Death and disability	The ICD has a code for obesity (E66), but it rarely comes up as the underlying cause of death. It may arise in the associated cause of deaths; however, associated causes (should) reflect conditions that contributed to the death, that is, comorbidities are not mandated on the death certificate if they were not involved in causing death.
Expenditure, costs	No data
Population demographics	State of registration, sex, age at death, Statistical Local Area (SLA) area of usual residence), remoteness of usual residence, Indigenous status, country of birth.

<b>27. National Perinatal Data Collection (NPDC)</b>	
Type of data source	Administrative (national)
Brief description	The National Perinatal Data Collection (NPDC) began in 1991 and is a collaborative effort by the AIHW and state and territory health departments. The NPDC is a national population-based cross-sectional collection of data on pregnancy and childbirth. The data are based on births reported to the perinatal data collection in each state and territory in Australia. Midwives and other birth attendants complete notification forms for each birth using information obtained from mothers and from hospital or other records. A standard de-identified extract is provided to the AIHW annually.
Purpose(s)	To collect information on pregnancy and childbirth of mothers, and the characteristics and outcomes of their babies.
Collection methodology	Perinatal data are collected after each birth, usually by midwives or other birth attendants from clinical and administrative records and information systems, including records of antenatal care, the care provided during labour, and the delivery and care provided after the birth. Each state and territory has its own form and/or electronic system for collecting data, which are forwarded to the relevant state and territory health department to form the state or territory perinatal data collection.
Scope (theoretical coverage of relevant population)	All births in Australian hospitals, birth centres and the community. The NPDC covers both live births and stillbirths, where gestational age is at least 20 weeks or birthweight is at least 400 grams, except in Victoria and Western Australia, where births are included if gestational age is at least 20 weeks or, if gestation is unknown, birthweight is at least 400 grams.
Coverage (actual)	Coverage is complete with the exception of 'freebirths'—those without any medical professionals in attendance. Freebirths may be included in the NPDC if they are in scope of the data collection, and the mother or baby present to hospital following birth or the birth is registered with the Registry of Births, Deaths and Marriages. However, this differs by state and territory.
Geographic coverage	Australia
Frequency/timing	Ongoing
Basic collection count	Births/women giving birth
Size	310,247 women and 314,814 babies in 2016
Collection management organisation	Australian Institute of Health and Welfare (AIHW)
Further information	<a href="https://www.aihw.gov.au/about-our-data/our-data-collections/national-perinatal-data-collection">https://www.aihw.gov.au/about-our-data/our-data-collections/national-perinatal-data-collection</a>

Data access	Data requests can be made to the AIHW. For more information, see <a href="https://www.aihw.gov.au/our-services/data-on-request">https://www.aihw.gov.au/our-services/data-on-request</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	No data
Environmental risk factors	No data	
Related conditions	Diabetes therapy, pre-existing diabetes, pre-existing hypertension, gestational diabetes.	
Prevalence	Waist circumference	No data
	Height and weight	Self-reported or measured height and weight for BMI. Jurisdictions supply measured or self-reported in accordance to individual collection methodologies.
Prevention, treatment and management	No data	
Quality of life	No data	
Death and disability	Maternal mortality.  Perinatal mortality including data on stillbirth and preliminary data on neonatal deaths. The National Perinatal Mortality Data Collection that collects more complete information on neonatal deaths and can be linked directly to the NPDC with appropriate jurisdictional permissions.	
Expenditure, costs	No data	
Population demographics	DOB, Indigenous status of mother, Indigenous status of baby, maternal country of birth, area of usual residence (SA2) used to derive ASGS remoteness area and SEIFA, postcode, hospital code, marital status, admitted patient elected accommodation status, sex (baby).	

<b>28. National Secondary Students' Diet and Activity (NaSSDA) survey</b>	
Type of data source	Survey (national)
Brief description	The National Secondary Students' Diet and Activity (NaSSDA) survey was established by Cancer Council Australia and the National Heart Foundation of Australia with the first data collection in 2009–10. The NaSSDA was designed to be a regular monitoring system in which to track Australian adolescents' body weight and dietary and physical activity behaviour at both the state and national level. The NaSSDA also assessed the exposure of adolescents' to food marketing and audited school food and activity environments.
Purpose(s)	Monitor the diet and physical activity behaviours of Australian secondary school students.
Collection methodology	Data on students' dietary, physical activity and sedentary behaviour were collected using a web-based questionnaire and anthropometric measurements (2009–10 and 2012–13) of students' height, weight and waist circumference were taken by trained researchers in a confidential setting. Parental consent was required for students to participate in each component. An audit of the school food and activity environment was also conducted.
Scope (theoretical coverage of relevant population)	All Australian secondary school students in year levels 8 to 11.
Coverage (actual)	Student response rate, 2009–10: 54%; 2012–13: 53%
Geographic coverage	Australia
Frequency/timing	2009–10, 2012–13, 2018 survey is currently in the field
Basic collection count	Persons
Size	2009–10: 12,188 students from 237 schools 2012–13: 8,888 students from 196 schools Approximately 8,000 students from around 100 schools across Australia are expected to participate in the 2018 survey round.
Collection management organisation	Cancer Council
Further information	<a href="https://www.cancer.org.au/preventing-cancer/nutrition-and-physical-activity/national-secondary-students-diet-and-physical-activity-survey.html">https://www.cancer.org.au/preventing-cancer/nutrition-and-physical-activity/national-secondary-students-diet-and-physical-activity-survey.html</a>
Data access	For information on data access please contact <a href="mailto:belinda.morley@cancervic.org">belinda.morley@cancervic.org</a>

Priority information areas		
Modifiable risk factors	Nutrition	Fruit and vegetable consumption, fast food consumption, soft drink, cordials, sports drinks and energy drinks consumption.
	Physical activity	How many days per week respondent was physically active for a total of 60 minutes or more per day.  Number of hours spent on electronic media use on weekdays and weekend days.
	Alcohol intake	Not applicable
Environmental risk factors	<p>Exposure to food marketing in the last month:</p> <p>Seen a special offer, competition or giveaway for a food or drink product in a magazine, on public transport, or at school:</p> <ul style="list-style-type: none"> <li>• Bought an extra food or drink product on display at the supermarket checkout</li> <li>• Bought food or drinks from a vending machine</li> <li>• Received a free sample of a food or drink product at a train stations, shopping centre, supermarket and so forth.</li> <li>• Received an email or text message with a special offer, competition or giveaway related to a food or drink product</li> <li>• Entered a competition you saw on food or drink packaging</li> <li>• Played a game or enter a competition on the Internet that was related to a food or drink product.</li> </ul> <p>Influence of marketing on food choices in the last month:</p> <ul style="list-style-type: none"> <li>• Tried a new food or drink product that you have seen advertised</li> <li>• Chose a fast food outlet because it had a special offer or giveaway with the meal</li> <li>• Chose a food or drink product linked with a movie or sports personality you like</li> <li>• Chose a snack food or soft drink in order to enter a competition or win a prize</li> </ul> <p>Other:</p> <ul style="list-style-type: none"> <li>• Number of televisions in the home</li> <li>• Parental limits on screen time.</li> </ul>	
Related conditions	No data	
Prevalence	Waist circumference	Measured in 2009–10 and 2012–13
	Height and weight	Measured height and weight for BMI in 2009–10 and 2012–13.

Prevention, treatment and management	No data
Quality of life	No data
Death and disability	No data
Expenditure, costs	No data
Population demographics	Age (year level), sex, location (remoteness and socioeconomic status can be generated from location), Indigenous status, main language, country of birth.

<b>29. New South Wales Population Health Survey</b>	
Type of data source	Survey (state/territory)
Brief description	The NSW Population Health Survey is a continuous CATI survey of NSW residents on a wide range of health behaviours and conditions. The survey collects information on health service access and use, self-rated health status, diabetes, BMI, nutrition, kilojoule awareness, sun protection, cancer screening, physical activity, and smoking. The survey is offered to respondents of all ages, with some questions in common for all ages and some questions that are age-specific.
Purpose(s)	The primary purpose of the survey is to provide information on health outcomes, risk factors and behaviours that affect the health of the people in New South Wales, and to support the planning, implementation, and evaluation of state-wide health services and programs. The survey also supports reporting of outcomes, risk factors and behaviours at a Local Health District level for adults on an annual basis, and for children aged 0–15 on a biennial basis.
Collection methodology	Interviews are carried out via telephone continuously between February and December each year. Trained interviewers at a contracted social and market research organisation carry out interviews per protocols specified by the Ministry of Health. From 2012, the Population Health Survey has used an overlapping sampling frame, consisting of landline numbers and mobile phone numbers. Respondents reached via the landline frame are randomly selected within the household using the Kish grid. On the mobile frame, an interview is conducted with the owner of the phone if they're 16 years and older. If a selected respondent is under the age of 15, the interview will be carried out with the parent or main carer. For individuals 16 years and older that have a health condition (for example, stroke) or other issues (for example, hearing or speech impairments) that prevent their direct participation in a telephone survey, an interview is offered by proxy with that individual's carer. Respondents over 16 years of age that live in a household with children are offered the opportunity to participate in a second interview about one of the children in the household. Parents who are unable to recall information about their child's height or weight, or otherwise report implausible values for height and weight are offered a call back for this information at a later date.
Scope (theoretical coverage of relevant population)	The target population for the survey is all residents living in private households with access to a mobile phone or landline. The collection target for each Local Health District is 1,000 respondents, and 300 respondents for Albury Local Government Area. Of the 15,300 respondents, a second collection target is set for 2,200 children aged 0–15 across the state.

Coverage (actual)	In 2017, 15,490 people were interviewed for the survey, of which, 2,190 were children aged 0–15. The survey captured respondents across all Local Health Districts.	
Geographic coverage	New South Wales	
Frequency/timing	Continuous since 2002, with annual reporting. Earlier forms of the survey were administered in 1997, 1998 and 2001.	
Basic collection count	Persons	
Size	2017: 15,490	
Collection management organisation	NSW Ministry of Health	
Further information	<a href="http://www.health.nsw.gov.au/surveys/adult/Pages/default.aspx">http://www.health.nsw.gov.au/surveys/adult/Pages/default.aspx</a>	
Data access	De-identified data are available via HealthStats NSW. For more information, see <a href="http://www.healthstats.nsw.gov.au/">http://www.healthstats.nsw.gov.au/</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported intake of a range of food and drink types.
	Physical activity	Self-reported minutes spent exercising in the last week.
	Alcohol intake	Self-reported frequency of alcohol intake and frequency of binge drinking.
Environmental risk factors	Whether feels safe walking down their street after dark, level of agreement that area has a reputation for being a safe place, usual type of transport to work (including options for active transport and public transport), whether made changes to activity levels as a result of Department of Environment air pollution reports, whether shade is available at local sporting areas, public parks and swimming pools, variables for whether surrounding environment encourages walking for transport (certain geographical areas in certain years only), times per week used neighbourhood footpaths.	
Related conditions	Mental health, asthma, diabetes and high blood pressure history (not specifically related to overweight or obesity).	
Prevalence	Waist circumference	Self-reported (to 2014)
	Height and weight	Self-reported height and weight for BMI
Prevention, treatment and management	Health service access and use, current management of diabetes, medication use (not specifically related to overweight or obesity).	
Quality of life	Self-rated health status, life satisfaction, self-rated mental health, (not specifically related to overweight or obesity).	
Death and disability	No data	
Expenditure, costs	No data	



Population demographics	Age, sex, Local Health District, ASGS remoteness area, SEIFA, country of birth (high level grouping), marital status, Indigenous status, educational attainment and employment status.
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<b>30. New South Wales School Students Health Behaviours Survey</b>	
Type of data source	Survey (state/territory)
Brief description	<p>The NSW School Students Health Behaviours Survey (SSHBS) is a triennial survey of secondary school students aged 12–17. The SSHBS has been managed by the NSW Ministry of Health since 2002. Prior to that, the Survey was managed by the Cancer Council NSW, with the first survey in the series administered in 1984.</p> <p>The SSHBS includes the common core questions from the Australian School Students Alcohol and Drugs questionnaire as well as a set of supplementary questions that vary with each collection year.</p> <p>The common core includes questions on smoking, alcohol consumption, electronic cigarette use, illicit drug use, and misuse of legal substances.</p> <p>The supplementary modules have included questions on height and weight, nutrition and eating, physical activity, sun protection, mental health, injury and study problems.</p>
Purpose(s)	The purpose of the SSHBS is to obtain prevalence estimates for tobacco smoking, alcohol use, use of other (illicit and licit) substances, sun protection, nutrition and eating, physical activity, mental health and wellbeing among NSW secondary school students. The data are also used to compare trends over time and to compare prevalence of certain health indicators in population sub-groups.
Collection methodology	The survey instrument is a self-complete pen and paper questionnaire. Trained research assistants attend selected high schools and give students a practice version of the questionnaire with a sample of the types of questions before administering the full questionnaire to all selected respondents.
Scope (theoretical coverage of relevant population)	<p>The target population is all students in Years 7–12, aged between 12 and 17, enrolled during each survey's collection period in NSW across government, independent and Catholic schools.</p> <p>Schools are selected from within each education sector, with collection targets specified for lower (Years 7–10) and upper secondary (Years 11–12) separately. School collection targets per strata have been specified to approximately represent the overall distribution of students by education sector and year level within the state.</p> <p>Language schools and schools with mature age students are excluded from the sample.</p>
Coverage (actual)	In 2014, the latest year for which information is currently available, the survey was conducted in 112 schools, with useable information captured for 5,353 students. Students from all three sectors and year levels were represented in the final sample.
Geographic coverage	New South Wales
Frequency/timing	Every three years since 1984
Basic collection count	Persons in schools

Size	5,353 student responses in 2014	
Collection management organisation	NSW Ministry of Health	
Further information	<a href="http://www.health.nsw.gov.au/surveys/student/Pages/overview-of-survey.aspx">http://www.health.nsw.gov.au/surveys/student/Pages/overview-of-survey.aspx</a>	
Data access	Authorized users can access the data through <a href="#">Secure Analytics for Population Health Research and Intelligence</a> (SAPHaRI). Other researchers should lodge a data request with the Chief Health Officer stating the aim of the research and the required variables. For more information, see <a href="https://www.health.nsw.gov.au/epidemiology/Pages/nsw-school-students-health-behaviours-survey.aspx">https://www.health.nsw.gov.au/epidemiology/Pages/nsw-school-students-health-behaviours-survey.aspx</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported intake of: <ul style="list-style-type: none"> <li>• fruit and vegetables</li> <li>• bread and cereal</li> <li>• fast food</li> <li>• snacks</li> <li>• soft drink, milk and water.</li> </ul>
	Physical activity	Self-reported: <ul style="list-style-type: none"> <li>• sedentary activities and screen time</li> <li>• weekly physical activity.</li> </ul>
	Alcohol intake	Self-reported frequency of alcohol intake
Environmental risk factors	No data	
Related conditions	No data	
Prevalence	Waist circumference	No data
	Height and weight	Self-reported height and weight for BMI
Prevention, treatment and management	Questions about whether respondent thinks of themselves as too thin, about the right weight, or too fat and whether respondent is trying to lose weight, gain weight, stay the same weight or not trying to do anything about my weight.	
Quality of life	General questions regarding mental health, stress and trouble at school (not specifically related to overweight or obesity).	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	ASGS remoteness, SEIFA, Local Health District (grouped), year level, age, sex, expendable income, Indigenous status, main language spoken at home.	

<b>31. North West Adelaide Health Study (NWAHS)</b>	
Type of data source	Longitudinal Survey (regional)
Brief description	The NWAHS is a longitudinal cohort study investigating chronic disease and health-related risk factors, from both self-reported and biomedically measured information for people living in the north-western region of Adelaide.
Purpose(s)	To make a comprehensive health assessment of the community of north-west Adelaide in order to inform health policy.
Collection methodology	Telephone and self-completed questionnaires and biomedical measurements. Consent was obtained from participants to link to MBS and PBS records.
Scope (theoretical coverage of relevant population)	Households in north-west Adelaide were chosen at random from the Electronic White Pages. The person in each household who was last to have a birthday and over the age of 18 was selected for interview and invited to attend the clinic in Stage 1 for a biomedical examination.
Coverage (actual)	4,056 adults attended the Stage 1 clinic visit, between November 1999 and July 2003; 3,205 of the cohort returned for the Stage 2 clinic visit between May 2004 and February 2006, and 2,487 of the cohort returned for the Stage 3 clinic visit between June 2008 and August 2010.
Geographic coverage	The north-western region of Adelaide, from the suburbs Glenelg to Gawler.
Frequency/timing	Stage 1 was run between 1999 and 2003, Stage 2 between 2004 and 2006 and Stage 3 between 2008 and 2010. Additional telephone surveys were run in 2002 and 2007 and a self-completed questionnaire (mail and online) was done in 2015–16.
Basic collection count	Persons
Size	The original cohort was 4,056 people; 2,487 of these participated in the most recent clinic visit, between June 2008 and August 2010 and 1,562 participated in NW15.
Collection management organisation	The NWAHS is led by the University of Adelaide, in collaboration with the University of South Australia, SA Health, the Institute of Medical and Veterinary Science, The Queen Elizabeth Hospital and the Lyell McEwin Hospital.
Further information	<a href="http://www.nwadelaidhealthstudy.org/">http://www.nwadelaidhealthstudy.org/</a>
Data access	For information on data access, contact <a href="mailto:tiffany.gill@adelaide.edu.au">tiffany.gill@adelaide.edu.au</a>

Priority information areas		
Modifiable risk factors	Nutrition	Self-reported food intake using a food frequency questionnaire and household food habits.
	Physical activity	Self-reported activity for categorisation from sedentary to very active.
	Alcohol	Self-reported frequency of intake for categorisation from low to very high risk.
Environmental risk factors	No data	
Related conditions	<ul style="list-style-type: none"> <li>• Measured blood cholesterol and blood pressure</li> <li>• Arthritis, joint pain, depression, cardiovascular disease (self-report)</li> <li>• Cancer (self-report and registry data)</li> <li>• Diabetes (self-report and measured)</li> <li>• Sleep (self-report and measured)</li> </ul>	
Prevalence (per cent BMI)	Waist circumference	Measured (S1, 2, 3), self-reported NW15
	Height and weight	Measured (S1, 2, 3), self-reported NW15 height and weight for BMI
Prevention, treatment and management	Use of health services (self-reported), Medicare service use and PBS drug use.	
Quality of life	General quality of life data, perception of general health, physical functioning, bodily pain, ability to participate in work and social activities (not specifically related to overweight or obesity).	
Death and disability	No data	
Expenditure, costs	Medicare and PBS costs (not specifically related to overweight or obesity).	
Population demographics	Age, sex, postcode, country of birth, Indigenous status, living arrangements, marital status, number of children, employment status, occupation, pension status, annual gross household income, highest level of educational attainment.	

<b>32. New South Wales Schools Physical Activity and Nutrition Survey (SPANS)</b>	
Type of data source	Survey (state/territory)
Brief description	<p>This survey of NSW school students was designed to update information provided by the 1985 Australian Health and Fitness Survey (NSW case data) and previous NSW surveys of school children conducted in 1997, 2004 and 2010. The current data is from the last survey conducted in the series in 2015. This data source collects the following information relevant to overweight and obesity:</p> <ul style="list-style-type: none"> <li>• measured height, weight and waist circumference</li> <li>• physical activity in and out of school</li> <li>• sedentary behaviour outside of school hours</li> <li>• diet and nutrition at school and at home</li> <li>• school travel</li> <li>• sleep</li> <li>• school nutrition and physical activity environments.</li> </ul>
Purpose(s)	To provide trend information on weight status and associated behaviours of the NSW school-age population and report on the trajectory of the prevalence of childhood overweight and obesity and on key modifiable weight-related behaviours.
Collection methodology	<p>All students were measured for height, weight, and waist circumference. Fundamental movement skills proficiency was assessed among Year 2 and older students, and cardiorespiratory and muscular fitness was assessed among Year 4 and older students. Information on weight-related behaviours was collected by questionnaire where parents of children in Years K, 2 and 4 completed the questionnaire on behalf of their child and students in Years 6, 8 and 10 self-reported this information.</p> <p>A school physical activity environment questionnaire was included in the mail-out of survey information sheets, consent forms and questionnaires sent to each participating school. The principal (or liaison teacher) at the school was asked to complete the questionnaire which sought information on the facilities and staff available for physical activity and sport.</p> <p>Field teams consisted of four groups of four field officers. Officers were 7 experienced teachers seconded from schools and 9 new Personal Development, Health and Physical Education graduates. Officers undertook 8 days of training and orientation prior to data collection, which included 2 practice days. Field manuals were supplied to officers.</p> <p>Data were collected over 7 weeks. Collection took place concurrently in primary schools and secondary schools, in schools from each education sector, and in metropolitan and rural schools, in order to prevent potential bias due to seasonal</p>

	<p>effects and the effects of progression through the school term on participation rates or performance.</p> <p>The survey was administered according to a written protocol and the measures were collected in the following order: anthropometry (undertaken concurrently during the questionnaire administration to children in Years 6, 8 and 10), fundamental movement skill assessment, assessment of standing broad jump and 20-metre shuttle run. The questionnaire took approximately one hour for children in Year 6, and 30 minutes for children in Years 8 and 10, to complete.</p>	
Scope (theoretical coverage of relevant population)	NSW school students in Years K, 2, 4, 6, 8 and 10, in Term 1, 2015. Students from 196 schools in each educational sector (government, Catholic and independent) in urban and rural areas were invited to participate.	
Coverage (actual)	<p>1997: 87% student response rate</p> <p>2004: 65% student response rate</p> <p>2010: School response rate 73%, student response rate 57%</p> <p>2015: 84 schools, 43.9% total response rate (39% for primary schools and 49% for secondary schools). 7,557 students participated which constituted a 61.8% response rate of the student sample (67.9% for primary school and 51.3% for secondary school aged children).</p>	
Geographic coverage	New South Wales	
Frequency/timing	1997, 2004, 2010 and 2015	
Basic collection count	Persons	
Size	1997: 5,518, 2004: 5,407, 2010: 8,100, 2015: 7,557	
Collection management organisation	The NSW Ministry of Health commissioned the Physical Activity, Nutrition and Obesity Prevention Group, Prevention Research Collaboration, University of Sydney to undertake the survey.	
Further information	<a href="http://www.health.nsw.gov.au/heal/Pages/spans-2015-full-report.aspx">http://www.health.nsw.gov.au/heal/Pages/spans-2015-full-report.aspx</a>	
Data access	For further information or to request access to data, all enquiries should be sent to Attn: Executive Director, Centre for Population Health, NSW Ministry of Health via <a href="mailto:MOH-CPH@health.nsw.gov.au">MOH-CPH@health.nsw.gov.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported food intake data collected using a short food frequency questionnaire. Questions about intake of energy and sports drinks included for the first time in 2015.

	Physical activity	Physical activity, sedentary behaviour, and school travel self-reported by children in Year 6 and parent-reported for children in Kindergarten and Year 2. Cardiorespiratory and muscular fitness, and movement skills were measured by researchers.
	Alcohol intake	Not applicable
Environmental risk factors	Transport to and from school (whether private or public transport), presence, availability and use of facilities associated with physical activity, adequacy of school sports and PE facilities, condition of sport/PE equipment, whether PE lessons delivered at least once a week, frequency of PE lessons, number of sport lessons, duration of PE and sport lessons, adults involved in delivery PE and sport (teacher, parents, outside sporting groups etc.), level of support for sport and PE in schools, perceived barriers to enhancing fitness and physical activity in school, school food environment, school canteen prices, school canteen practices, school based health initiatives, family habits (for example, offering sweets as rewards, availability of junk food at home and whether rules are set around screen time).	
Related conditions	No data	
Prevalence (per cent BMI)	Waist circumference	Measured
	Height and weight	Measured height and weight for BMI
Prevention, treatment and management	No data	
Quality of life	Only with regard to dental health measures	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Age, sex, language spoken at home—used to classify cultural background (English speaking, European, Middle Eastern, Asian), Aboriginal and Torres Strait Islander status, school year, suburb and postcode of usual residence—used as a proxy for socioeconomic position (classified as low, middle or high) and to determine locality (Urban and Rural).	



33. Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS)	
Type of data source	Administrative (national)
Brief description	<p>The Commonwealth government subsidises the cost of prescription medicines for most medical conditions through two separate schemes, the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS) for eligible war veterans and their dependants.</p> <p>Most prescriptions are dispensed through community pharmacies, but PBS is also available in private hospitals and through eligible public hospitals to patients on discharge and day patients. In addition, a number of drugs are distributed under alternative arrangements where these are considered more appropriate (Section 100). Examples are the Highly Specialised Drugs program and medicines that are supplied directly to indigenous patients via Aboriginal Health Services in remote areas of Australia.</p> <p>Patients fall into two broad classes: <i>general</i> and <i>concessional</i>. Concessional beneficiaries include pensioners, Health Care card holders, Commonwealth Seniors Health card holders and Veterans card holders.</p> <p>Under the PBS the patient is required to contribute a co-payment which is indexed annually—from 1 January 2018 it was \$39.50 for general patients and \$6.40 for those with a concession card. If a medicine is priced below the relevant co-payment the consumer pays the full price and the prescription is classified as ‘under co-payment’. If a medicine is not listed in the PBS Schedule of Pharmaceutical Benefits, the consumer pays the full price as a private prescription.</p> <p>PBS does not include the following:</p> <ul style="list-style-type: none"> <li>• Private prescriptions</li> <li>• Over the counter (OTC) medicines</li> <li>• Medicines supplied to public hospital inpatients.</li> </ul> <p>The PBS and RPBS data do not generally include the reason a medicine has been prescribed unless the medicine requires an Authority approval (that is, prior approval from the Department of Human Services or the Department of Veterans’ Affairs). ‘Restricted Benefit’ PBS items also are limited to a stated condition, but do not require authority approval.</p> <p>Not all medicines that are prescribed for weight loss will not be identifiable for monitoring purposes in the PBS/RPBS as the majority of these are private prescriptions only.</p> <p><i>Note:</i> Medicines listed as ‘Authority required’ can be prescribed only for the conditions listed in the Schedule of Pharmaceutical Benefits.</p>
Purpose(s)	The PBS and RPBS were established to provide subsidised medicines for Australians.

	PBS/RPBS data includes information on the drug supplied, conditions of supply and limited details about patient, pharmacy and prescriber.	
Collection methodology	PBS/RPBS data is a by-product of the payment system administered by the Department of Human Services (DHS). Prescription data is collected when approved suppliers submit prescriptions online to DHS for payment.	
Scope (theoretical coverage of relevant population)	All Australian residents who hold a current Medicare card, and eligible overseas visitors.	
Coverage (actual)	All PBS/RPBS prescriptions processed by DHS online.	
Geographic coverage	Australia	
Frequency/timing	Ongoing	
Basic collection count	Number of PBS/RPBS scripts	
Size	Not applicable	
Collection management organisation	The PBS is managed by the Department of Health and the RPBS is managed by the Department of Veterans' Affairs. The PBS and the RPBS payment system is administered by the DHS.	
Further information	<a href="http://www.pbs.gov.au">www.pbs.gov.au</a>	
Data access	PBS statistics are publicly available. For more information, see: <a href="https://www.pbs.gov.au/info/browse/statistics">https://www.pbs.gov.au/info/browse/statistics</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	No data
Environmental risk factors	No data	
Related conditions	No data	
Prevalence	Waist circumference	No data
	Height and weight	No data
Prevention, treatment and management	Pharmaceutical use (where the pharmaceutical is listed on the PBS or RPBS and specific for overweight and obesity), approximate location of pharmacy (postcode).	
Quality of life	No data	
Death and disability	No data	
Expenditure, costs	Expenditure by the government and individuals on PBS/RPBS listed pharmaceuticals supplied to patients.	
Population demographics	Age, sex, self-identified Indigenous status, postcode.	

<b>34. Population Level Analysis and Reporting (POLAR) System</b>	
Type of data source	Administrative (state/territory)
Brief description	<p>The POLAR (Population Level Analysis and Reporting) System has been developed by Outcome Health. POLAR provides an 'in practice' software product for GPs, practice managers and other staff to use within their practice to support internal operations, patient centred care, quality improvement and business development.</p> <p>Practices can identify at-risk patients on a range of clinical indicators, audit appropriate medications and immunisations, track patient and practitioner outcomes, improve data quality and pinpoint business development opportunities.</p> <p>De-identified data are also sent from the general practice to its local Primary Health Network (PHN) for analysis to help them identify population health needs, system gaps and work towards developing better health services for the community.</p> <p>POLAR is currently operating within a range of PHNs, primarily across Victoria and NSW. Expansion into other jurisdictions is currently under investigation.</p> <p>POLAR collects data on diagnoses, chronic conditions, medications, immunisations, pathology, radiology, MBS items charged, as well as data on risk factors including blood pressure, BMI, waist circumference, cholesterol, weekly alcohol consumption and smoking status.</p>
Purpose(s)	To enable participating practices to analyse their own data to enhance patient centred care, quality improvement activities and business development. The POLAR System also begins to fill the primary care data gap to support robust population health planning strategies and innovative research.
Collection methodology	Extraction from GP clinical and billing software including Best Practice, Medical Director and Zedmed. Significant mapping across key data fields to ensure consistency (for example, diagnoses, medications, radiology, pathology, immunisation).
Scope (theoretical coverage of relevant population)	All de-identified health records for patients who have attended a general practice using POLAR.
Coverage (actual)	All de-identified patient records.
Geographic coverage	Selected PHNs in Victoria and NSW.
Frequency/timing	Retrospective and ongoing.
Basic collection count	General practice encounters.
Size	Currently, approximately 4.5 million de-identified patient records. This is expected to increase over time.

Collection management organisation	Outcome Health — The POLAR System — and participating PHNs	
Further information	<a href="https://www.outcomehealth.org.au/polar.aspx">https://www.outcomehealth.org.au/polar.aspx</a>	
Data access	For enquires regarding data access, contact <a href="mailto:admin@outcomehealth.org.au">admin@outcomehealth.org.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	No data
	Physical activity	No data
	Alcohol intake	Self-reported weekly intake
Environmental risk factors	No data	
Related conditions	Chronic condition groups (that is, cardiovascular, diabetes, respiratory, musculoskeletal, cancer, dementia/Alzheimer's, mental health, chronic kidney disease, oral), risk factors (for example, blood pressure and cholesterol).	
Prevalence	Waist circumference	Measured
	Height and weight	Measured height and weight for BMI
Prevention, treatment and management	Medication, pathology, radiology, diabetes cycle of care record, care plans and shared health summary uploads.	
Quality of life	No data	
Death and disability	Death, if de-identified patient status marked as deceased. Level of potential disability can be measured by the co-morbidities of chronic conditions.	
Expenditure, costs	MBS items charged	
Population demographics	Age, sex, PHN, Indigenous status, ethnicity, pensioner status, geographical region of residence.	

<b>35. Queensland Preventative Health Survey (QPHS)</b>	
Type of data source	Survey (state/territory)
Brief description	<p>Queensland Government, Department of Health, Preventive Health Branch conducts an annual preventive health telephone survey of adults and children. The survey monitors a range of preventive health risk factors including BMI, physical activity and nutrition.</p> <p>Biennially, results are available for PHN, Hospital and Health Service Areas, and local government areas.</p>
Purpose(s)	To monitor trends in behavioural risk factors in the general populations and to support strategic planning, implementation and evaluation of state-wide health services and programs.
Collection methodology	Data are collected using computer assisted telephone interviewing (CATI). Mobile phones were included as of 2015. Adult data collection typically occurs between October and March; child data collection occurs between October and December.
Scope (theoretical coverage of relevant population)	Queensland residents aged 18 and over. For the child survey, the scope was adults aged 18 and over who were the primary caregiver for a child aged 5–17.
Coverage (actual)	<p>Child</p> <ul style="list-style-type: none"> <li>• 2015: 80%</li> <li>• 2016: 84%</li> </ul> <p>Adult survey response rates:</p> <ul style="list-style-type: none"> <li>• 2015: 65%</li> <li>• 2016: 64%</li> </ul>
Geographic coverage	Queensland
Frequency/timing	<p>Adult: 2002–2008 (biennial), 2009–2018 (annual)</p> <p>Child: 2011, 2013–2018 (annual)</p>
Basic collection count	Persons
Size	<p>Child survey sample sizes:</p> <ul style="list-style-type: none"> <li>• approximately 2,500</li> </ul> <p>Adult survey sample sizes:</p> <ul style="list-style-type: none"> <li>• approximately 12,500</li> </ul>
Collection management organisation	Queensland Department of Health
Further information	<a href="https://www.health.qld.gov.au/phsurvey">https://www.health.qld.gov.au/phsurvey</a>
Data access	De-identified data are available from Queensland Health. For more information, see <a href="https://www.health.qld.gov.au/research-reports/population-health/preventive-health-surveys/detailed-data">https://www.health.qld.gov.au/research-reports/population-health/preventive-health-surveys/detailed-data</a>

Priority information areas		
Modifiable risk factors	Nutrition	Self-reported fruit and vegetable intake, categorised to sufficient and insufficient consumption. Mean daily serves also provided.
	Physical activity	Self-reported and categorised into insufficient or sufficient.
	Alcohol intake	Self-reported and categorised into lifetime and single occasion risk groups
Environmental risk factors	No data	
Related conditions	No data	
Prevalence (per cent by BMI)	Waist circumference	No data
	Height and weight	Self-reported height and weight for BMI
Prevention, treatment and management	No data	
Quality of life	Self-assessed health status, not directly related to overweight and obesity.	
Death and disability	No data	
Expenditure, costs	No data	
Population demographics	Sex, age, SEIFA, ASGS remoteness.	

<b>36. The Raine Study</b>	
Type of data source	Longitudinal survey (state)
Brief description	<p>The Western Australian Pregnancy Cohort (Raine) Study, established in 1989, is one of the largest successful prospective cohorts of pregnancy, childhood, adolescence and adulthood to be carried out anywhere in the world.</p> <p>The Raine Study has grown to be a multi-generational study. A group of young adults (Generation 2) have been followed from before they were born and throughout their life. Their families are also part of the study, with their parents (Generation 1), grandparents (Generation 0) and children (Generation 3) now also involved in the study.</p> <p>The rich data collected on each Raine Study participant is being used by researchers all over the world to better understand, and improve, human health and quality of life.</p> <p>From 1989 to 1992, 2,900 pregnant women entered the study and 2,868 live births were recruited into the Raine Study cohort. These families have provided health, behavioural, environmental, developmental and social information over the past 29 years providing a unique and valuable resource covering a wide range of health and social areas.</p> <p>Follow-up assessment of the Generation2 (Gen2) cohort has been conducted at birth, 1, 2, 3, 5, 8, 10, 14, 17, 18, 20, 22 and 27. Currently the Gen2 28 year follow up is collecting data, focusing on cerebrovascular function and vision.</p> <p>Data on the Raine Study Generation1 (Gen1), the parents, has been collected at a number of the follow ups and in 2015 they were invited to take part in the first follow up independently of their children (Gen1 26 year follow up).</p> <p>Raine children's 'offspring' (Gen3) have also recently had data collected on them, and the grandparents (Gen0) are currently participating in a follow up focussed on breast density.</p>
Purpose(s)	The purpose of the Raine Study is to improve lifelong health and quality of life through research that examines influences, pathways and outcomes from before birth and throughout life's course.
Collection methodology	<p>Between 1989 and 1992, 2,900 pregnant women volunteered to be part of the study at King Edward Memorial Hospital looking a prenatal ultrasound scans when they were 18 weeks pregnant. Some of the mothers were followed up at 24, 28 and 38 weeks gestation. The families then continued with follow-up assessments of their babies. 2,868 babies remained with the study and were examined on the first or second day after birth by a child health nurse in King Edward Memorial Hospital.</p> <p>The initial follow-up of the Raine Study Gen2 as babies and toddlers took place in Princess Margaret Hospital, where the Telethon Institute for Child Health Research was located. The children were examined at</p>

	<p>one, two and three years of age to assess and record their growth and development. The parents (Gen1) of the Raine Study child completed a questionnaire on the child. The babies and toddlers height, weight, blood pressure, physical health and developmental progress were measured. Information on the parents was also collected.</p> <p>When their child was five years old, the parents were asked to complete a questionnaire and to bring their child for a physical assessment at Princess Margaret Hospital. The assessment at age five included a lung function test, allergy testing and a hearing test.</p> <p>The age eight year follow-up of the Raine Study children (Gen2) took place in the newly opened Telethon Institute for Child Health Research in Roberts Road. During this follow-up the Raine Study parents completed questionnaires and their child completed tasks in relation to reading and mathematical ability. The child also did a physical fitness test on an exercise bicycle, and the parents and child provided blood samples.</p> <p>The ten year follow-up focussed on developmental health, with an emphasis on schooling, language development, behaviour and general health, parent health and happiness. The Raine Study participant's school teacher provided information on the school, the child's academic, literacy and numeracy performance and the child's behaviour and special needs.</p> <p>The Raine Study Gen2 participants, their primary and secondary caregivers, school teacher and school principal were asked to complete questionnaires. The child also attended the Telethon Institute for Child Health Research for a physical assessment. A blood sample was provided by the participants and their parents. The Raine Study Gen2 participants also did lung function and allergy testing.</p> <p>A range of measurements including physical fitness and motor competence, diet and nutrition, cardiovascular health, back pain, anthropometric measurements, blood pressure, cognitive tests, liver ultrasounds and lung function testing were performed. Participants and their parents provided a blood sample. The follow up was conducted at the Telethon Institute for Child Health Research during the years when the participants were completing high school. Female participants were involved in a study looking at puberty and menstruation.</p> <p>When the Gen2 participants turned 18 years of age, they were asked to complete a challenge test to examine their stress response. During this study participants were involved in two separate challenge tests and their blood and saliva samples were collected to measure their peak stress hormone levels and the decline in stress hormone levels.</p> <p>The follow-up of the cohort at 20 years of age was conducted at the Lions Eye Institute and participants underwent a comprehensive eye examination. They also had a Dual-energy X-ray Absorptiometry (DXA) scan to measure bone density and body composition, a fibroscan to measure liver stiffness using new technology. Alongside the standard questionnaires the participants completed a questionnaire about thinking behaviours. Male participants were involved in a study examining male fertility.</p>
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	<p>The Gen2 22 year follow up was conducted at the University of Western Australia Centre for Sleep Science. Participants had a sleep study, which involved an overnight stay and an assessment of their sleeping patterns. They also had a comprehensive lung function and asthma test, height and weight measurement, blood pressure, muscle endurance and pressure testing. The cohort participants also provided blood samples and wore activity monitors and completed diaries for 7 days.</p> <p>In 2014, the Raine Study parents (Gen1) completed their first follow up independently of Gen2 .The Gen1 26 year follow up involved the parents attending the University of Western Australia Centre for Sleep Science (as per Gen2 at 22 years) having an overnight sleep study and similar tests with the addition of a DXA scan (body composition) and general vision tests.</p> <p>Researchers have recently completed the follow-ups of the Raine Study participants at age 27. This follow-up concentrated on cardiovascular health and internal fat and involves having an MRI scan. The MRI scan measured ectopic fat (fat around your internal organs). Physical assessment measures for the Gen2 27 year follow up was undertaken at Raine Study House, and included: measurement of height, weight, blood pressure, and whole body blood pressure, as well as providing a fasting blood sample, eye testing. MRI Scan and questionnaires.</p> <p>The Gen3 27 follow up of Raine Gen2 participant's 'offspring' in partnership with the Autism CRC was completed alongside the Gen2 27 year follow up. Participants undertook a series of physical measurements— anthropometric, blood pressure, blood and biological—, questionnaires and activity monitors, conducted at the Telethon Kids Institute.</p> <p>The Gen2 28 year follow up has commenced in 2018 examining core data to compare changes in health and development. Additional assessments of artery and eye function are being conducted to identify genetic and environmental factors associated with impaired function and predict future health. An online questionnaire was administered to the Raine Study Gen 2 participants were they were 26 years old and again at 28 years old. The questionnaire examined the working environment and how this affects an individual's health, work performance and behaviour. The study also looked at how personality and demographics, and their interactions, shape or constrain individuals' opportunities to undertake high quality work and vice versa. The focus on this study was to understand if work situations have changed and what impact it has had on outcomes such as wellbeing, engagement, and adult psychological development.</p> <p>In 2018, the study expanded to include maternal and paternal grandmothers (Generation 0) of the Gen2 cohort. These women were invited to participate in the Gen0 and Gen1 28 year follow up.</p> <p>Women were invited to undertake a breast scan using a non-invasive device called Transillumination Breast Spectroscopy (TiBS), bloods DNA (if required), blood pressure, questionnaires and Breast DXA.</p>
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Scope (theoretical coverage of relevant population)	All babies of pregnant women attending King Edward Memorial Hospital in Subiaco, WA for 18 week prenatal scans and their families.	
Coverage (actual)	<ul style="list-style-type: none"> <li>• 2,900 pregnant women (Gen1) and 2,868 babies (Gen2).</li> <li>• 636 mothers and 462 fathers attended the Gen1 26 year follow up. Eighty eight Gen3 participants attended the study alongside Gen 2 27 year follow up.</li> </ul>	
Geographic coverage	Western Australia	
Frequency/timing	Gen2 follow up studies conducted during pregnancy, at birth, and at 1, 2, 3, 5, 8, 10, 14, 17, 18, 20, 22, 27 and 28 years of age.	
Basic collection count	Persons	
Size	2,086 Gen2 participants were still active in the cohort at the 22 year follow up.	
Collection management organisation	The University of Western Australia, as central agent for an Unincorporated Joint Venture which also includes: Curtin University, The Telethon Kids Institute, Raine Medical Research Foundation, UWA Faculty of Medicine, Dentistry and Health Sciences, Women and Infants Research Foundation, Edith Cowan University, Murdoch University and University of Notre Dame.	
Further information	<a href="https://www.rainestudy.org.au/">https://www.rainestudy.org.au/</a>	
Data access	Researchers who would like to use Raine data must submit a project application. For more information, please see <a href="https://www.rainestudy.org.au/for-researchers/ross-raine-online-submission-system/">https://www.rainestudy.org.au/for-researchers/ross-raine-online-submission-system/</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	<p>Detailed food frequency questionnaire, both self-reported in later follow-up waves and parent/carer reported in earlier waves. Questions also include about eating habits such as whether the respondent eats with family, special diets and cooking methods for certain food types. Data on breastfeeding also collected.</p> <p>Child behaviour checklist collects data on early eating habits and weight status such as overeating, overweight and not eating well.</p>
	Physical activity	<ul style="list-style-type: none"> <li>• Time spent in sedentary activities and screen time (TV, electronic games) per day, week and weekend.</li> <li>• Whether spends leisure time playing sports or other outside activities.</li> </ul>

		<ul style="list-style-type: none"> <li>• Detailed self-reported physical activity over the past week, reasons for exercise and reasons for not being active or increasing exercise.</li> <li>• Numbers of hours per day spent sitting and lying down on a weekday and weekend day.</li> <li>• Physical activity literacy questions.</li> <li>• Pedometer data, accelerometer data.</li> <li>• International Physical Activity Questionnaire (IPAQ) used in follow ups.</li> </ul>
	Alcohol intake	Detailed alcohol intake questionnaire, including types, quantity and frequency of alcohol consumption.
Environmental risk factors	<p>Environmental risk factors, such as whether respondent:</p> <ul style="list-style-type: none"> <li>• Has a garden</li> <li>• Visits parks or playgrounds</li> <li>• Lives in a safe and clean neighbourhood</li> <li>• Lives in a neighbourhood with good street lighting and roads</li> <li>• Has a safe swimming pool</li> <li>• Has adjustable work hours</li> <li>• Has a computer at home</li> <li>• Travel methods — walking, bicycle, car</li> <li>• Participates in sports at schools and whether school sports have representative opportunities for participation.</li> </ul> <p>Study child:</p> <ul style="list-style-type: none"> <li>• Worried about their weight</li> <li>• Consider themselves over/underweight</li> <li>• Trying to eat less/change shape</li> <li>• Frequency of weighing self</li> <li>• Gone without eating to try and change shape or weight</li> <li>• Restricting certain foods to change shape/weight</li> <li>• Adhering to diet rules</li> <li>• Weight thoughts interfere with concentration in class</li> <li>• Episodes of eating an unusually large amount</li> <li>• Afraid of losing control over eating</li> <li>• Couldn't control what or how much ate and number of episodes</li> <li>• Couldn't stop eating once started</li> <li>• Felt guilty after eating</li> <li>• Afraid of gaining weight</li> </ul>	

	<ul style="list-style-type: none"> <li>• Felt fat</li> <li>• Strong desire to lose weight</li> <li>• Made self sick to control weight and number of episodes</li> <li>• Exercised hard to lost weight and number of days/hours</li> <li>• Weight/shape important to self as a person</li> <li>• Unhappy about weight/shape</li> <li>• Uncomfortable about seeing own body or others seeing body</li> <li>• Teased about weight/shape by children at school, children not at school, siblings, parents, teachers, other adults and how often teased</li> <li>• Whether wanted stomach to be empty or had a definite desire for stomach to be flat</li> <li>• Taken laxatives to control weight</li> <li>• Whether shape influence how study child thought of themselves as a person</li> <li>• Weight influenced judgement of self or others</li> <li>• Detailed questions about sleep</li> </ul> <p>Parent of study child:</p> <ul style="list-style-type: none"> <li>• Worried about child's weight</li> <li>• Consider child over/underweight</li> <li>• Concerned about teenager becoming overweight in the future</li> <li>• Worried about nutrition of study child</li> </ul>	
Related conditions	<p>Family history of (self-reported and doctor diagnosed):</p> <ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Cholesterol problems</li> <li>• High blood pressure</li> <li>• Cardiac conditions and heart disease</li> <li>• High blood pressure in pregnancy</li> <li>• Blocked arteries</li> </ul> <p>Study child:</p> <ul style="list-style-type: none"> <li>• Blood chemistry including cholesterol measures</li> <li>• Blood pressure measured</li> </ul>	
Prevalence	Waist circumference	<p>Measured (depending on study wave):</p> <ul style="list-style-type: none"> <li>• Waist circumference</li> <li>• Hip circumference</li> <li>• Waist-hip ratio</li> <li>• Skinfolds</li> </ul>
	Height and weight	<p>Self-reported and measured height and weight for study child and parents, depending on study wave. Fat mass, lean mass, soft tissue mass and bone mineral</p>

		density collected in specific follow up waves.
Prevention, treatment and management	Detailed health service use questionnaire including whether attended GP, physiotherapy, dietician, private specialist or admitted to hospital (including ICD-9 code), study child medication use, parents medication use.	
Quality of life	<ul style="list-style-type: none"> <li>• Negative experiences due to height or weight</li> <li>• SF36</li> <li>• SF12</li> <li>• Body figure perception scale</li> <li>• Generalised Anxiety Disorder test (GAD)</li> <li>• Depression Anxiety Stress Scale (DASS)</li> <li>• Bradburn Happiness Scale</li> <li>• Kessler Psychological Distress Scale (K10)</li> <li>• Becks Depression Inventory</li> <li>• Mental Social Support Index</li> <li>• Dyadic Adjustment Scale</li> </ul>	
Death and disability	Whether respondent receives a disability allowance or mobility allowance, whether respondent had negative experiences due to a physical disability, whether respondent has trouble getting work due to own ill health or disability, whether study child is limited by health problems and the types of limitations experiences.	
Expenditure, costs	No data	
Population demographics	Age, sex, marital status, living arrangements, family structure, family income, employment status, parent's highest level of education, study child's education.	

<b>37. Study of Environment on Aboriginal Resilience and Child Health (SEARCH)</b>	
Type of data source	Longitudinal Survey (state)
Brief description	<p>The Study of Environment on Aboriginal Resilience and Child Health (SEARCH) is a cohort study of Aboriginal children aged 0–17, from urban and large regional centres in New South Wales, Australia. SEARCH focuses on Aboriginal community identified health priorities of: injury; otitis media; vaccine-preventable conditions; mental health problems; developmental delay; obesity; and risk factors for chronic disease. All children have their height, weight, waist circumference and blood pressure measured and complete ear health and hearing assessment. Children aged 1–7 have speech and language assessed and their parents/caregivers complete the Parental Evaluation of Developmental Status. The Study is conducted in partnership with Aboriginal Community Controlled Health Services (ACCHSs), services which provide comprehensive primary health care to Aboriginal people in a culturally appropriate manner.</p> <p>SEARCH is conducted in partnership with four ACCHSs, all of which are located in urban and large regional centres in NSW: Mount Druitt (Aboriginal Medical Service Western Sydney); Campbelltown (Tharawal Aboriginal Corporation); Wagga Wagga (Riverina Medical and Dental Aboriginal Corporation), and Newcastle (Awabakal Newcastle Aboriginal Co-operative). Local Aboriginal data collectors have been recruited and all data collection from participants occurs on site.</p> <p>Like most cohort studies, SEARCH does not provide a representative sample of the Aboriginal population. However, the study may be used to fill current data caps in monitoring overweight and obesity in the population.</p>
Purpose(s)	The aim of SEARCH is to describe and investigate the causes of health and illness in approximately 1,700 urban Aboriginal children aged 0–17, from around 700 families, with a focus on healthy environments and selected child health problems.
Collection methodology	<p>While the SEARCH study is made up of several components, the initial baseline assessment comprises a general health assessment, which includes:</p> <ul style="list-style-type: none"> <li>• questionnaires for participating children and their parents, measurements of height, weight, waist circumference and blood pressure for all participants</li> <li>• ear health and hearing check at an audiology clinic for participants aged 6 months to 17 years</li> <li>• speech, language and development check at a speech pathology clinic for children and a parental evaluation of development status for children aged 1 to 7</li> </ul>

	<ul style="list-style-type: none"> <li>data linkage component to population health databases including GP services, medication and hospital inpatient episodes.</li> </ul> <p>Additional collections in the study include further questionnaires, focus groups, in-depth interviews, audits of housing and longitudinal follow up.</p>	
Scope (theoretical coverage of relevant population)	Aboriginal children aged 0–17 who attend a participating ACCHS, and their parents/caregivers.	
Coverage (actual)	No data	
Geographic coverage	New South Wales	
Frequency/timing	Phase 1 (2008–2012); Phase 2 (2014–18; underway)	
Basic collection count	Persons	
Size	1,669 children and 641 adults in 2012	
Collection management organisation	Sax Institute	
Further information	<a href="https://www.saxinstitute.org.au/our-work/search">https://www.saxinstitute.org.au/our-work/search</a>	
Data access	For further information on the study, submit enquiries to the SEARCH team via <a href="https://www.saxinstitute.org.au/contact-us/">https://www.saxinstitute.org.au/contact-us/</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Reported by parents for children aged 0–17 and self-reported by 12–17 year olds.
	Physical activity	Self-reported by parents and by parents for 4–17 year olds.
	Alcohol intake	Frequency of intake self-reported by parents and by 12–17 year olds.
Environmental risk factors	Neighbourhood safety and walkability (parent/care questionnaire only).	
Related conditions	Disease history, blood pressure (measured).	
Prevalence	Waist circumference	Measured
	Height and weight	Measured height and weight for BMI
Prevention, treatment and management	Data on health service utilization including emergency department admission, hospital admissions, births and deaths, perinatal events, medical benefits schedule (MBS), pharmaceutical benefits schedule (PBS) and vaccination records (Australian Childhood Immunisation Register).	
Quality of life	Variables for stressful life events, mental health, resilience, wellbeing.	

Death and disability	No data
Expenditure, costs	No data
Population demographics	Date of birth, income, education, Indigenous status.



<b>38. South Australian Population Health Survey (SAPHS)</b>	
Type of data source	Survey (state/territory)
Brief description	The South Australian Population Health Survey (SAPHS) monitors population trends in health risk factors and chronic diseases to assist in the planning, implementation and evaluation of health services, policies and programs.
Purpose(s)	SAPHS aims to detect and facilitate understanding of trends in the prevalence of chronic conditions, risk and protective factors, and other determinants of health. These data are used to monitor departmental, state and national priority areas and are linked to key indicators.
Collection methodology	<p>From July 2002 to March 2018, a sample of South Australians were randomly selected from the Electronic White Pages. Introductory letters were sent out to each household selected to inform them of the upcoming telephone survey, inviting the person who had the last birthday in the household to participate in a telephone interview.</p> <p>From July 2018, a dual frame over-lapping sampling technique (mobile phone 70%: landline 30%) is used to collect information from a representative sample of the South Australian population, using Random Digit Dialling (RDD). Standard de-duplication and weighting procedures are administered.</p> <p>The survey is conducted by professional interviewers, using Computer Assisted Telephone Interview (CATI) technology, with an online option for those unable to complete over the phone. Approximately 600 respondents participate each month. Proxy respondents (usually the parent) complete the survey when the selected person in the household is under the age of 16.</p>
Scope (theoretical coverage of relevant population)	South Australian population
Coverage (actual)	Approximately 7,200 respondents per year
Geographic coverage	South Australia
Frequency/timing	Monthly since 2002
Basic collection count	Persons
Size	1,554 children, and 5,614 adults in 2017 calendar year
Collection management organisation	SA Health
Further information	<a href="https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/sa+population+health+survey">https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/sa+population+health+survey</a>

Data access	For information about how to access these data, contact the Population Health Survey team in the Prevention and Population Health Branch at <a href="mailto:Health.PrevandPopHealth@sa.gov.au">Health.PrevandPopHealth@sa.gov.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported or parent-reported (for children) intake of fruit, vegetables, fast food, snacks, sugar sweetened beverages such as soft drinks, sports drinks, energy drinks and flavoured milk, and water.
	Physical activity	Self-reported or parent-reported: <ul style="list-style-type: none"> <li>• activity intensity and frequency (children and adults)</li> <li>• Strength and toning exercises (children and adults)</li> <li>• screen time (children).</li> </ul>
	Alcohol intake	Self-reported frequency and dose to report against single occasion and lifetime risk.
Environmental risk factors	No data	
Related conditions	Self-reported arthritis, osteoporosis, diabetes, high cholesterol and hypertension.	
Prevalence	Waist circumference	No data
	Height and weight	Self-reported height and weight for BMI (parent reported for children)
Prevention, treatment and management	Medical and mental health service use and access to health services, self-reported treatment for high cholesterol, hypertension and diabetes.	
Quality of life	SF1 (self-assessed health status) and Mental health measures including subjective wellbeing, mental health conditions, mental health service use, school suspension (children), suicidal ideation, psychological distress.	
Death and disability	Whether respondent or respondent's child has a disability and whether respondent provides long-term care for a parent, partner, child, other relative of friends who has a disability.	
Expenditure, costs	No data	
Population demographics	Age, sex, postcode and suburb (can yield various locations and socioeconomic status), marital status, sexual orientation, employment status, pension/benefits allowance, country of birth, Indigenous status, language spoken at home, level of education, dwelling, household income.	

<b>39. Tasmanian Population Health Survey (TPHS)</b>	
Type of data source	Survey (state/territory)
Brief description	<p>The Tasmanian Population Health Survey is a component of population health surveillance undertaken by the Department of Health. Information provided by the survey is used to improve the health status of Tasmanians and will assist in the implementation of strategic health planning. The survey collects information on a range of key indicators relevant to monitoring overweight and obesity including:</p> <ul style="list-style-type: none"> <li>• overweight and obesity</li> <li>• fruit and vegetable intake</li> <li>• sugar-sweetened drink intake</li> <li>• physical activity</li> <li>• alcohol consumption</li> <li>• health literacy.</li> </ul>
Purpose(s)	<p>There are five key aims of the survey:</p> <ul style="list-style-type: none"> <li>• provide base-line data for the Healthy Tasmania Strategy</li> <li>• track changes in key lifestyle risk factor indicators</li> <li>• monitor the prevalence of chronic conditions and preventive screening</li> <li>• identify emerging health issues</li> <li>• provide data to local governments and non-government organisations to better target health system improvements.</li> </ul>
Collection methodology	The Social Research Centre—a social research company—conducted the survey employing the CATI collection method.
Scope (theoretical coverage of relevant population)	All non-institutionalised Tasmanian residents aged 18 and over.
Coverage (actual)	<p>Response rates:</p> <ul style="list-style-type: none"> <li>• 2009: 69.8%</li> <li>• 2013: 75%</li> <li>• 2016: 64.4%</li> </ul>
Geographic coverage	Tasmania
Frequency/timing	2009, 2013, 2016
Basic collection count	Persons
Size	<p>2009: 6,319</p> <p>2013: 6,301</p> <p>2016: 6,300</p>
Collection management organisation	Tasmania Department of Health

Further information	<a href="http://www.dhhs.tas.gov.au/publichealth/epidemiology">http://www.dhhs.tas.gov.au/publichealth/epidemiology</a>	
Data access	For information on data access, contact <a href="mailto:michael.long@health.tas.gov.au">michael.long@health.tas.gov.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported: <ul style="list-style-type: none"> <li>• intake of fruit and vegetables per day</li> <li>• type of drinks consumed when thirsty (water, soft drinks, tea, coffee, fruit or vegetable juice, milk, and sports/energy drinks)</li> <li>• type and frequency of sugar-sweetened drink consumption</li> <li>• type of milk consumed (including whole milk, low/reduced fat, skim milk, soy milk and other)</li> <li>• type of current diet (including high protein, low fat, gluten free and vegetarian/vegan).</li> </ul>
	Physical activity	Self-reported: <ul style="list-style-type: none"> <li>• activity levels at work</li> <li>• physical activity including strength based activity</li> <li>• sedentary activities, including weekly sitting time</li> <li>• active transport (for example, walking to and from work).</li> </ul>
	Alcohol intake	Self-reported intake of standard drinks per day/week.
Environmental risk factors	No data	
Related conditions	Chronic conditions including diabetes, hypertension, high blood sugar, arthritis, osteoporosis, heart disease and stroke.	
Prevalence	Waist circumference	No data
	Height and weight	Self-reported height and weight for BMI
Prevention, treatment and management	Use of public health services (including public hospital and community health centres), whether respondent participated in preventative health screening for blood pressure, cholesterol and diabetes/hyperglycaemia.	
Quality of life	Psychological distress, self-reported experiences of mental health problems and self-assessed health status (not specifically related to overweight or obesity).	

Death and disability	No data
Expenditure, costs	No data
Population demographics	Age, sex, region of residence (North, North West and South), SEIFA, number of people in household, country of birth, Indigenous status, highest level of education, employment status, type of work, household income.

<b>40. Ten to Men: the Australian Longitudinal Study on Male Health</b>	
Type of data source	Longitudinal Survey (national)
Brief description	<p>In 2010, the Australian Government released the National Male Health Policy to address the special health needs of Australian males. As part of that policy the Australian Longitudinal Study on Male Health (Ten to Men) was commissioned. Ten to Men is a new longitudinal study of just under 16,000 Australian men and boys between the ages of 10 to 55. It is aimed at identifying the factors that contribute to the poorer health outcomes in Australian males in general, and in particular sub-groups of men and boys. The study aims to generate information that can inform government policy and program development in male health.</p> <p>The survey collects a variety of data useful for monitoring overweight and obesity including BMI, fruit and vegetable intake, and physical activity levels.</p>
Purpose(s)	<p>The objectives of Ten to Men are to:</p> <ul style="list-style-type: none"> <li>• examine male health and its key determinants including social, economic, environmental and behavioural factors that affect the length and quality of life of Australian males</li> <li>• address key research gaps about the health of Australian males such as men's health and risk behaviour in life, while accounting for social, economic and environmental changes</li> <li>• identify policy opportunities for improving the health and wellbeing of males and providing support for males at key life stages, particularly those at risk of poor health.</li> </ul>
Collection methodology	<p>There are four different questionnaires: boys (10 to 14 years), parents of boys, adolescents (15 to 17 years), and adult males (18 to 55 years). The youngest age group (boys aged 10 to 14 years) completed a face-to-face interview. All others received a self-complete paper questionnaire.</p> <p>Participants will be followed up every two to three years.</p>
Scope (theoretical coverage of relevant population)	45,510 males aged 10–55 were confirmed to be in-scope for the study.
Coverage (actual)	Ten to Men has recruited a large group of males aged between 10 and 55. Rural males and young males (aged 10 to 17) were oversampled. The final sample was just under 16,000 male participants (a response rate of 35%) of which approximately 2,000 were adolescents and boys (10 to 17 years). Parents of the 10 to 14 year old boys were also invited to participate.
Geographic coverage	Australia
Frequency/timing	Wave 1 in 2013–14, and Wave 2 in 2015–16
Basic collection count	Persons

Size	15,998—1,087 in 10–14 age group, 1,017 in 15–17 age group. 13,884 in 18–55 age group.	
Collection management organisation	The first two waves of the study were approved by the University of Melbourne Human Research Ethics Committee. From 2018, the study will be overseen by the Australian Institute of Family Studies Human Research Ethics Committee.	
Further information	<a href="https://tentomen.org.au/">https://tentomen.org.au/</a>	
Data access	At the time of writing, the data access process for this collection is under review. For further information, contact <a href="mailto:info@tentomen.org.au">info@tentomen.org.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported daily serves of fruit and vegetables.
	Physical activity	Self-reported minutes of physical activity and screen time, type of transport used to get to and from work.
	Alcohol intake	Self-reported intake.
Environmental risk factors	No data	
Related conditions	Self-reported diabetes, high cholesterol, high blood pressure, stroke, heart failure, and heart attack.	
Prevalence	Waist circumference	Self-reported in 10–14 years questionnaire only.
	Height and weight	Self-reported height and weight for BMI with instructions to respondents to use own scales and measuring tape (adults and 15–17 years questionnaires).
Prevention, treatment and management	Whether attended a GP, emergency department, dietitian, nutritionist, diabetes educator, physiotherapist or youth health service in the previous 12 months (not specifically related to overweight or obesity).	
Quality of life	Self-assessed health status (not specifically related to overweight or obesity).	
Death and disability	Self-reported disability (not specifically related to overweight or obesity).	
Expenditure, costs	No data	
Population demographics	Age, country of birth, main language spoken at home, Indigenous status, highest level of education, employment status.	

<b>41. Victorian Population Health Survey (VPHS)</b>	
Type of data source	Survey (state/territory)
Brief description	<p>The VPHS is a cross-sectional survey that has been conducted each year since 2001. The Victorian Population Health Survey gives an annual assessment of the health status and wellbeing of adults living in Victoria and provides data for key health indicators such as the prevalence of type 2 diabetes, tobacco smoking and levels of overweight and obesity in the population.</p> <p>The VPHS is used to guide policy development and inform planning, reporting and decision making on the health and wellbeing of the Victorian population at all levels of government.</p> <p>The survey collects a variety of data useful for monitoring overweight and obesity including BMI, physical activity, alcohol and fruit and vegetable intake.</p>
Purpose(s)	<p>The survey findings are used to support:</p> <ul style="list-style-type: none"> <li>• the provision of evidence to inform decisions about local priorities for public health and wellbeing plans</li> <li>• planning in non-government health organisations</li> <li>• planning, reporting and decision-making in the Department of Health and Human Services</li> <li>• the measurement of trends over time for key health indicators such as diabetes, smoking prevalence and overweight and obesity.</li> </ul>
Collection methodology	Information is collected via computer-assisted telephone interviews that are conducted annually with people aged 18 and over. The interviewees are randomly selected from households from each of the eight Department of Health and Human Services regions in Victoria.
Scope (theoretical coverage of relevant population)	The survey scope is based on a sample of 7,500 adults aged 18 or older who are randomly selected from households from each of the eight Department of Health and Human Services regions. In 2008, 2011–12, 2014 and 2017 the sample size for the survey was expanded to include Victoria's 79 Local Government Areas (LGAs). The next survey to be conducted at the LGA level is in 2020.
Coverage (actual)	<p>2013: 73.8%</p> <p>2014: 69.6%</p> <p>2015: 72.8% (dual-frame design)</p> <p>2016: 76.5% (dual-frame design)</p> <p>2017: N/A (dual-frame design)</p>
Geographic coverage	Victoria
Frequency/timing	Yearly since 2001
Basic collection count	Persons



Size	2013: 3,550 2014: 33,654 (expanded for LGA level reporting) 2015: 7,698 2016: 7,532 2017: 33,654 (expanded for LGA level reporting)	
Collection management organisation	Victorian Department of Health and Human Services.	
Further information	<a href="https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/victorian-population-health-survey">https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/victorian-population-health-survey</a>	
Data access	For information on data access contact <a href="mailto:data.intelligence@dhhs.vic.gov.au">data.intelligence@dhhs.vic.gov.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported daily fruit and vegetable intake.
	Physical activity	Self-reported physical activity and sedentary behaviour.
	Alcohol intake	Self-reported frequency of intake and frequency of binge-drinking.
Environmental risk factors	Whether had access to quality and variety of foods and barriers—for example, difficulty getting to food outlets due to lack of public transport (2008 survey), whether felt safe walking alone in home street at night (2001–05 surveys).	
Related conditions	Self-reported hypertension, diabetes, heart disease, stroke, osteoporosis and arthritis.	
Prevalence (per cent by BMI)	Waist circumference	No data
	Height and weight	Self-reported height and weight for BMI
Prevention, treatment and management	Whether had a blood pressure check, cholesterol check or check for blood sugar level in the previous 2 years.	
Quality of life	Psychological distress measures, self-assessed health status, social and emotional status and life-satisfaction (not specifically related to overweight or obesity).	
Death and disability	No data	
Expenditure, costs	Whether respondent has private health insurance.	
Population demographics	Age, sex, marital status, household composition, country of birth, country of birth of mother and father, main language spoken at home, highest level of education attainment, employment status, main field of occupation, household income, Indigenous status, area of state (Department of Health and Human Services region).	

<b>42. Western Australia Health and Wellbeing Surveillance System (HWSS)</b>	
Type of data source	Survey (state/territory)
Brief description	The Health and Wellbeing Surveillance System (HWSS) is a continuous data collection initiated in 2002 to monitor the health status of the general population. The collection includes a survey of both adult and child health risk factors and outcomes. The survey collects a variety of data useful for monitoring overweight and obesity including BMI, physical activity and sedentary behaviour and alcohol intake.
Purpose(s)	The key objectives of the HWSS are to: <ul style="list-style-type: none"> <li>• monitor the health and wellbeing of Western Australians using validated reliable indicators</li> <li>• identify health status and lifestyle trends over time</li> <li>• identify emerging and salient issues in a timely manner</li> <li>• identify and report on health-enhancing behaviours as well as risk factor behaviours as well as the relationship between lifestyle choices and health</li> <li>• informing purchasing, program and policy decisions and evaluation</li> <li>• assisting with planning and developing health services.</li> </ul>
Collection methodology	The HWSS is conducted as a Computer Assisted Telephone Interview (CATI). A data collection agency is contracted to conduct the interviews on behalf of the WA Department of Health, Health Survey Unit. The survey is conducted throughout the year, with between 450 and 1,000 persons interviewed each month. Parents who are responding for a child in the household and are unable to recall information about their child's height or weight, or otherwise report implausible values for height and weight are offered a call back for this information at a later date
Scope (theoretical coverage of relevant population)	All Western Australian households listed in the White Pages, of which there were approximately 800,000 records in 2012–13.
Coverage (actual)	Adjusted response rates (for both adult and child surveys, number of people interviewed divided by the eligible contacts): 2014: 85.4% 2015: 85.6% 2016: 84.6%
Geographic coverage	Western Australia
Frequency/timing	Yearly since 2002
Basic collection count	Persons
Size	2014: 6,681 2015: 7,771

	2016: 6,682	
Collection management organisation	WA Department of Health	
Further information	<a href="http://ww2.health.wa.gov.au/Reports-and-publications/Population-surveys">http://ww2.health.wa.gov.au/Reports-and-publications/Population-surveys</a>	
Data access	Requests for data access can be made to WA Department of Health data custodians. For more information, contact <a href="mailto:sarah.joyce@health.wa.gov.au">sarah.joyce@health.wa.gov.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported: <ul style="list-style-type: none"> <li>• daily fruit and vegetable intake</li> <li>• type of milk consumed</li> <li>• intake of fast food (times per week)</li> <li>• breastfeeding.</li> </ul>
	Physical activity	Self-reported physical and sedentary activities, time spent walking for transport.
	Alcohol intake	Self-reported frequency of intake and amount on a single day.
Environmental risk factors	No data	
Related conditions	Self-reported arthritis, heart disease, stroke, osteoporosis, high cholesterol, and diabetes.	
Prevalence	Waist circumference	Removed from survey in 2017.
	Height and weight	Self-reported height and weight for BMI.
Prevention, treatment and management	<p>Questions about when the respondent last had their cholesterol and blood pressure measured by a medical professional.</p> <p>Questions about if any medication is taken for high cholesterol and/or high blood pressure.</p> <p>Health services used in the past 12 months (including primary health care and allied health services).</p>	
Quality of life	<p>General health status, psychological distress measures, suicidal ideation, mental health service use, record of psychosocial events (including moving house, serious illness or injury and financial hardship), record of mental health conditions experienced in the previous 12 months, mental and physical functioning, and questions regarding social and community connections of the respondent.</p> <p>These variables are not directly related to overweight and obesity.</p>	
Death and disability	Questions about whether the respondent or anyone in the respondent's family has a disability, long-term illness or pain that puts a burden on the respondent or their family as a whole.	

	Questions about whether respondent had or has a health problem requiring special equipment for mobility (for example, a cane or wheelchair).
Expenditure, costs	Private health insurance.
Population demographics	Sex, gender, country of birth, SEIFA, ASGS remoteness, Indigenous status, highest level of educational attainment, employment status, fly-in-fly-out work status, shift work status, family structure, current living arrangement, household spending, marital status, household income, pension status, health care card entitlement status, total number of persons in household, demographics of parent/guardian of child, demographics of partner of parent/guardian of child.

<b>43. Western Australia Nutrition Monitoring Survey Series (NMSS)</b>	
Type of data source	Survey (state/territory)
Brief description	<p>The Western Australian NMSS has been conducted by the Department of Health, Western Australia since 1995. The NMSS provides evidence to inform planning and initiatives to improve the health of all Western Australians, through better nutrition. The NMSS is conducted approximately every three years, with seven surveys conducted between 1995 and 2015.</p> <p>The NMSS collects key nutrition data for the WA adult population aged 18 to 64, and provides the health sector and general public with important information about food and nutrition behaviours, and barriers and enablers to healthy eating in Western Australia.</p> <p>The NMSS collects a variety of data useful for monitoring overweight and obesity including self-reported height, weight, waist circumference, perceptions of current weight, intentions of the respondent related to weight (for example, trying to lose weight, trying to gain weight), and intake of selected foods.</p>
Purpose(s)	<p>The aim of the NMSS is to investigate the nutrition knowledge, attitudes, beliefs, and behaviours of Western Australian (WA) adults, as they relate to the Australian Dietary Guidelines (the Guidelines). The survey monitors attempts at dietary change consistent with the Guidelines, and investigates the barriers and promoters to making such changes. It also monitors attitudes towards government public health nutrition promotions.</p>
Collection methodology	<p>Computer Assisted Telephone Interviews (CATI) completed from July to September.</p> <p>The sample was drawn using random digit dialling for surveys in 1995, 1998 and 2001.</p> <p>Surveys thereafter were drawn from the Electronic White Pages for Western Australia by area of residence.</p>
Scope (theoretical coverage of relevant population)	All persons aged 18 to 64 with a phone number listed in the Electronic White Pages for Western Australia by area of residence.
Coverage (actual)	<p>Response rates (completed interview/eligible households contacted):</p> <p>2015: 81.6%</p> <p>2012: 90.0%</p> <p>2009: 87.8%</p> <p>2004: 66.9%</p> <p>2001: 33.4% (sampled using random digit dialling)</p> <p>1998: 29.5% (sampled using random digit dialling)</p> <p>1995: 34.4% (sampled using random digit dialling)</p>
Geographic coverage	Western Australia

Frequency/timing	1995, 1998, 2001, 2004, 2009, 2012 and 2015.	
Basic collection count	Persons	
Size	2015: 1,207 2012: 1,548 2009: 1,284 2004: 1,202 2001: 1,004 1998: 1,004 1995: 1,002	
Collection management organisation	WA Department of Health	
Further information	<a href="http://ww2.health.wa.gov.au/Articles/N_R/Nutrition-Monitoring-Survey-Series">http://ww2.health.wa.gov.au/Articles/N_R/Nutrition-Monitoring-Survey-Series</a>	
Data access	Requests for data access can be made to WA Department of Health. For more information, contact <a href="mailto:epi@health.wa.gov.au">epi@health.wa.gov.au</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported intake of: <ul style="list-style-type: none"> <li>• fruit and vegetables</li> <li>• type of bread</li> <li>• rice, pasta and breakfast cereals</li> <li>• dairy foods (including types)</li> <li>• red meat and fish</li> <li>• sugar-sweetened beverages</li> <li>• water</li> <li>• meals prepared away from home.</li> </ul> Avoidance of foods high in salt or sugar.
	Physical activity	No data
	Alcohol intake	No data
Environmental risk factors	Perceived enablers of healthy eating, availability of fresh fruit and vegetables, whether healthy takeaway foods are available in neighbourhood, whether healthy choices available at food outlets, number of meals purchased from a food outlet in the day prior to survey, availability of healthy choices at last purchase from a food outlet, frequency of choosing healthy foods when buying a meal, perceived importance of having healthy choices available when buying a meal, self-rated food preparation skills, main source of nutrition and dietary information, perceived importance of government food control and regulation, perceived importance of government financial support of food supply and nutrition monitoring activities, perceived importance of government support of activities to promote healthy eating,	

	perceived priority topics for community nutrition and dietary information, and self-assessed food preparation skills.	
Related conditions	Information collected on what health conditions respondents perceived to being associated with diet problems (for example, what diet patterns might be associated with diabetes or heart disease).	
Prevalence (per cent by BMI)	Waist circumference	Self-reported
	Height and weight	Self-reported
Prevention, treatment and management	No data	
Quality of life	No data	
Death and disability	No data	
Expenditure, costs	Questions about costs barriers to accessing and consuming healthy foods.	
Population demographics	Age, gender, area of residence (Perth Metro or rest of WA), language spoken at home, Indigenous status, country of birth, living arrangements, highest level of educational attainment, employment status, annual household income, household money situation, SEIFA.	

<b>44. 45 and Up Study</b>	
Type of data source	Longitudinal survey (state/territory).
Brief description	<p>The 45 and Up Study is a longitudinal study of people from NSW. It follows the health of participants to examine which factors are associated with good or poor health as people age. Survey responses are linked to other health databases, allowing a broad view of health service use and outcomes.</p> <p>The study collects the following information pertinent to monitoring overweight and obesity: height and weight, nutrition and diet, and physical activity.</p>
Purpose(s)	To develop a research resource to boost understanding of how Australians are ageing. This will answer important health and quality-of-life questions and help manage and prevent illness through improved knowledge of health.
Collection methodology	<p>Potential participants were randomly sampled from the Medicare Australia database and mailed a study questionnaire and information leaflet. Individuals from rural areas and those aged 80 and over were oversampled. Participants joined the study by completing the questionnaire and providing signed consent for follow-up and linkage to a range of health databases. Information available through data linkage includes: health service use from the Medicare Benefits Scheme (Medicare) and Pharmaceutical Benefits Scheme (PBS) databases, hospitalisation data from the National Hospital Mortality Database (NHMD) (with details of patterns of care), aged care and mortality data.</p> <p>The Study is also part of the Centre for Health Record Linkages' (CHeReL) Master linkage key. Data linkage to health datasets outside of the CHeReL, including those held by AIHW, are also able to be facilitated with the correct approvals being required.</p>
Scope (theoretical coverage of relevant population)	All NSW residents over the age of 45.
Coverage (actual)	The study recruited 267,153 men and women from the NSW general population at baseline. The response rate to the study is approximately 18%, and represents approximately 11% of the population within the age group in NSW.
Geographic coverage	New South Wales
Frequency/timing	<p>Baseline data collection: 2006–2009</p> <p>Follow-up (wave 1): 2012–2015</p> <p>Follow-up (wave 2): 2017–ongoing</p> <p>Social, Environmental and Economic Factors (SEEF) Study (approximately 60,000 participants participated); 2010.</p> <p>Data linkage began in 2008.</p>



Basic collection count	Persons	
Size	267,153 were recruited at baseline. This number decreases as participants withdraw from the Study.	
Collection management organisation	The Sax Institute	
Further information	<a href="https://www.saxinstitute.org.au/our-work/45-up-study/">https://www.saxinstitute.org.au/our-work/45-up-study/</a>	
Data access	Applications for data access can be made to the Sax Institute. For more information, see <a href="https://www.saxinstitute.org.au/wp-content/uploads/16-2-45-and-Up-fees-and-charges-policy-Feb-2016.pdf">https://www.saxinstitute.org.au/wp-content/uploads/16-2-45-and-Up-fees-and-charges-policy-Feb-2016.pdf</a>	
<b>Priority information areas</b>		
Modifiable risk factors	Nutrition	Self-reported weekly intake of: <ul style="list-style-type: none"> <li>beef, lamb, pork, chicken, turkey, duck, processed meats, fish, seafood and cheese</li> <li>wholemeal bread, breakfast cereals.</li> </ul> Self-reported daily intake of: <ul style="list-style-type: none"> <li>fruit, vegetables and fruit juices.</li> </ul> Type of milk most frequently consumed.
	Physical activity	Self-reported: <ul style="list-style-type: none"> <li>physical activity in the past week (including total time)</li> <li>hours watching TV or using computer</li> <li>hours standing</li> <li>hours sitting (including hours sitting by type of activity)</li> <li>hours driving</li> <li>main mode of transport</li> </ul>
	Alcohol intake	Self-reported intake and days or drinking per week.
Environmental risk factors	No data	
Related conditions	Family history and respondent history of heart disease, hypertension, stroke, diabetes, arthritis and osteoporosis.	
Prevalence	Waist circumference	No data.
	Height and weight	Self-reported height and weight for BMI.
Prevention, treatment and management	Primary health service used from the Medicare database (reason for treatment may not be available). Longitudinal hospitalisation data from the NHMD.	

	<p>Current medications.</p> <p>Whether told by GP to eat fewer high fat foods or more fruit and vegetables.</p>
Quality of life	Self-rated quality of life, functional capacity, level of psychological distress.
Death and disability	Deaths determined by data linkage and questions about whether respondent needs help because of a disability (not specifically related to overweight or obesity).
Expenditure, costs	Costs data from the linked data sources: Medicare, PBS, NHMD. Questions in 2010 survey about whether fruit and vegetable consumption was limited due to money shortage.
Population demographics	Age, sex, postcode (for SA3, SA4, LGA, PHN, ARIA and SEIFA), highest level of educational attainment, employment status, ethnicity, country of birth, year of arrival in Australia, main language spoken at home, Indigenous status, housing type, marital status, sexual orientation annual household income.

## Appendix D: Assessment of equity focused monitoring capabilities of data sources

Source	Indigenous Status	Measures of SEIFA*	ASGS Remoteness	Additional geographical information
ACT General Health Survey	✓	✗	✗	Area of residence (North Canberra, South Canberra, Woden, Belconnen, Weston, Tuggeranong, Gungahlin, NSW, Not stated/other)
ACT Year 6 Physical Activity and Nutrition Survey (ACTPANS)	✓	✗	✗	Area of residence (North Canberra, South Canberra, Woden, Belconnen, Weston, Tuggeranong, Gungahlin, NSW, Not stated/other)
AusDiab	✓	✓	✓	State/territory of residence
Australian Longitudinal Study of Ageing (ALSA)	✓	✗	✗	Postal and residential address
Australian Longitudinal Study of Women's Health (ALSWH)	✗	✗	✗	State, postcode, ARIA+ and rural/remote/metropolitan areas from 1994 DHS
Bariatric Surgery Registry (BSR)	✓	✗	✗	State, suburb and postcode
Bettering the Evaluation and Care of Health (BEACH)	✓	✗	✓	Postcode
Burden of Disease (BOD) Studies	✓	✓	✓	State/territory of residence
Busselton Health Studies	✗	✗	✗	Not applicable (all participants from same local area)
Childhood Determinants of Adult Health (CDAH) Study	✗	✗	✓	Postcode

Great South Coast Childhood Obesity Monitoring Study	x	x	x	Postcode
Household Income and Labour Dynamics (HILDA) Survey	✓	✓	✓	Suburb/town of residence
Jean Hailes Women's Health Survey	x	x	✓	State/territory of residence
Kindergarten Health Check (ACT)	✓	x	x	Suburb of residence, postcode
Longitudinal Study of Australian Children (LSAC)	✓	✓	✓	SA2, SA3 and SA4
Longitudinal Study of Australian Youth (LSAY)	✓	✓	✓	Postcode
Longitudinal Study of Indigenous Children (LSIC)	✓	✓	✓	State/territory of residence, level of relative isolation, and Index of Relative Indigenous Socioeconomic Outcomes
Medicare Benefits Schedule (MBS) Data	✓	x	✓	Statistical Local Area (SLA)
National Prescribing Service (NPS) MedicineInsight Database	✓	x	x	Postcode
National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)	✓	✓	✓	State or territory, greater capital city statistical areas, section of state, Medicare locals**, Medicare local peer groups, indigenous regions, PHNs
National Aboriginal and Torres Strait Islander Nutrition and Physical Activity Survey (NATSINPAS)	✓	✓	✓	State or territory, greater capital city statistical areas, section of state, Medicare locals**, Medicare local peer groups, indigenous regions, PHNs
National Health Survey (NHS)	✓	✓	✓	State or territory, greater capital city statistical areas, section of state, Medicare locals**, Medicare local peer groups, indigenous regions, PHNs
National Hospital Morbidity Database (NHMD)	✓	✓	✓	State, SA2

National Key Performance Indicators for Indigenous Health (nKPI)	✓	✗	✓	State/territory of organisation
National Nutrition and Physical Activity Survey, 2011–12 (NNPAS)	✓	✓	✓	CD, SLA, SA1, SA2, peer groups, Medicare locals**, PHNs, greater capital city statistical areas, section of state
National Morbidity Database (NMD)	✓	✗	✓	SLA of usual residence
National Perinatal Data Collection (NPDC)	✓	✓	✓	Postcode, SA2
NSW Population Health Surveys	✓	✓	✓	Local Health District
NSW School Students Health Behaviours Survey	✓	✓	✓	Local Health District
North West Adelaide Health Survey (NWAHS)	✓	✗	✗	Postcode
The Raine Study	✗	✗	✗	Postcode
NSW School Student Physical Activity and Nutrition Survey (SPANS)	✓	✓	✗	Postcode for locality: urban or rural
Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS)	✓	✗	✗	Postcode
Population Level Analysis and Reporting (POLAR) System	✓	✗	✗	Geographical region of residence
Queensland Preventative Health Survey (QPHS)	✗	✓	✓	Results available biennially by PHN, Hospital and Health Service areas and LGAs
The Study of Environment on Aboriginal Resilience and Child Health (SEARCH)	✓	✗	✗	✗
South Australian Population Health Survey (SAPHS)	✓	✓	✓	Suburb, postcode

Tasmanian Population Health Survey (TPHS)	✓	✓	✗	Region of residence—North, North West and South
Ten to Men: the Longitudinal Study of Men's Health	✓	✗	✗	✗
Victorian Population Health Survey (VPHS)	✓	✓	✓	Area of state (Department of Health and Human Services region)
WA Health and Wellbeing Surveillance System (HWSS)	✓	✓	✓	None
WA Nutrition Monitoring Survey Series (NMSS)	✓	✓	✗	Area of residence (Perth metro or rest of WA)
45 and Up Study	✓	✓	✗	Postcode, SA3, SA4, LGA, LHD, PHN, ARIA+, and Greater Capital City Statistical Areas (GCCSA)

*Notes*

\*Measures of SEIFA include: The Index of Relative Socio-Economic Disadvantage (IRSD), The Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD).

\*\*Medicare locals are now defunct.