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Feature articles on **Indigenous Australians**

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Welcome Dance by Lyndy Delian

44 × 105 cm, contemporary screenprints, pigment inks, stretched dupion silk

Welcome Dance is a combination of two screenprints that depict fingerprints and gum blossoms. The fingerprints represent the body paint of the dancers. The gum blossom artwork honours the place of bush flowers in modern floristry and oil essences, as well as in traditional medicines, jewellery and ceremony. Used together here the two images portray ceremonial dances that greet the sun in the morning



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Dear Readers

Six months into a new government and the pace and appetite for data and information continue to challenge us all. For the AIHW it is strong confirmation of why we exist as an independent statutory body. It is our job to make sure governments and the community have access to reliable, consistent and authoritative data at the national level.

A particular challenge for us is to respond to the desire to measure performance and outcomes in newly articulated policy agendas, where the perfect fit-for-purpose data collection doesn't (yet) exist. Measuring performance and outcomes must often be a compromise. Sensible solutions can only be found by a dialogue that involves the data gurus sitting down together with policy makers and other stakeholders who are keen to see change. When the data gurus work away in isolation (for whatever reason) relying on the distant drums to keep them informed of the policy messages, there are likely to be 'disconnects'. But when there is trust and dialogue, the process can be most effective. So it's great to be closely involved in the development of performance indicators for the new broad healthcare agreements, and to be working in a range of subject matters, such as homelessness, child protection and the push for improvement in the outcomes for Aboriginal and Torres Strait Islander peoples.

There are plenty of challenges on our horizon. In her article in this issue, our Deputy Director Julie Roediger draws out the opportunities and the risks Australia faces in using e-health data for health management and research purposes in the way old-health has been used. As Julie argues, we have solid experience with developing sound and safe information for management and research purposes, while protecting an individual's privacy. This is one of the critical challenges as the e-health work evolves. It is also a key success factor as policy makers and researchers look to the power of data linkage to provide better insights into all sorts of conditions and services. In conjunction with the National E-Health Transition Authority, Julie will be facilitating a series of workshops to better understand the data flows that may be possible and practical in the future e-health world.

Australia is not alone in recognising the need to work through the implications of e-health. I was recently invited to speak at a Canadian summit on the use of e-health information for management and research. Jointly run by the Canadian Institute of Health Information and Canada Health Infoway, the summit theme was 'Build once, use often: harnessing the full power of the EHR (Electronic Health Record)'. It provided me with a very useful insight into developments and compromises in Canada and the UK. We intend to keep well connected with international colleagues searching for the same solutions.

From the Director

Data collections take time and expertise to develop. So we need to keep an eye on the horizon, to work with partners to meet emerging needs. We also need to use the collections in clever ways, through new analyses and data linkage. A key priority for the AIHW is to improve linkage using the National Hospital Morbidity Database. More powerful linkage infrastructure would allow provision of information related to the safety and quality of health care (such as patterns of multiple admissions for patients, including unplanned readmissions), and information on contiguous periods of hospitalisation that are reported as separate episodes. Patient name information would be invaluable for linkage with the National Death Index (for example, for 30-day post-surgery mortality analyses—important measures of the quality of hospital care) and other databases with names or name-based statistical linkage keys. The need for such linkage is increasingly recognised within states and territories, and this is an important strategic area for our national database.

There are many other questions we hope to contribute to, such as: How do we know if general practice activities are delivering value for money? How do we monitor the health effects of climate change in Australia?

For some years now, the Institute has been proactive in driving the development of better data to understand the differences in health and in service provision for Aboriginal and Torres Strait Islander peoples. Many of our activities are highlighted in this issue. We are all very proud that the energy, commitment and skill of Dr Fadwa Al-Yaman, head of the Aboriginal and Torres Strait Islander Health and Welfare Cluster, have been recognised by her Australia Day award of the Public Service Medal. Fadwa was one of only 15 Australian Public Service employees awarded the Medal in the Australia Day Honours list. Within the AIHW, and among those she works with, Fadwa is something of a legend. She stands out for the enormous dedication and high-level technical and analytical skills she brings to her work combined with an ability to cut through difficult problems to achieve high-quality outcomes. She works cooperatively and in genuine partnership with a wide range of stakeholders, including Indigenous advisers. Together with her team, and other colleagues within the AIHW and partner agencies, she has made an important and lasting difference in developing the evidence base on Aboriginal and Torres Strait Islander health and welfare.

I look forward to working together on the emerging opportunities and challenges. ■

Dr Penny Allbon



Penny Allbon

Photo © Irene Dowdy

Indigenous health



programs

AIHW role

The AIHW's role in innovative Indigenous health programs is directly helping health services on the ground while building an important evidence base for the future.

Northern Territory child health checks

Voluntary child health checks and follow-up form a significant part of the Australian Government's emergency measures to protect Aboriginal children in the Northern Territory, announced in June 2007.

As part of the initiative, the AIHW has been contracted to collect the data gathered from the child health checks and to analyse and report on it.

'The AIHW involvement is governed by an agreement with the Commonwealth, the NT Health and Community Services Department and the Aboriginal Medical Services Alliance of the NT. The collaboration among the four agencies to improve health services and so outcomes for Aboriginal children is important and carried out in accordance with the National Aboriginal and Torres Strait Islander Health Data principles', said Dr Al-Yaman, Head of the Aboriginal and Torres Strait Islander Health and Welfare Unit.

The child health checks conducted by health teams collect information on current health status, medical history, social and environmental factors, and any referrals made for follow-up. Each check collects information on 23 health and social conditions, including ear, eye, oral and skin health, nutrition, immunisation, substance use and housing.

An update from the NT Emergency Response shows that at the end of February 2008:

- 63 remote communities have had child health checks (CHCs) undertaken.
- 7 town camp regions have been visited by CHC teams.
- 6,408 NT Emergency Response CHCs have been completed. The estimated total number of CHCs to be carried out, including Medical Benefits Scheme checks, is approximately 8,800.
- 5 NT Emergency Response CHC teams are deployed and CHCs are being performed by local Aboriginal medical services in various regions.

The AIHW's Adriana Van den Heuvel said the comprehensive health checks are providing information on Indigenous health that has never been available before. The Institute is concentrating on making sure that what it reports back is useful.

'We are trying to analyse the information so that it informs policy and programs, which is important in the achievement of a permanent improvement in child health care.

'Information stripped of personal identification is going back to communities to provide them with a picture of their local health service needs. We're trying to get the information to where it is needed, presenting it in a way that makes it clear what local issues are', said Ms Van den Heuvel.

Brendan Gibson from the Commonwealth's Office for Aboriginal and Torres Strait Islander Health said the Institute's role as the data custodian and the provider of independent analysis is crucial.

'The AIHW is already affecting the implementation of the initiative', he said, with information from the Institute being used to help coordinate follow-up services and to inform local communities about their child health service needs.

'It is also a major contributor to the evaluation which will inform future policy making, on the basis of what works and what doesn't', Mr Gibson said.

An additional benefit from the partnerships in this program is the opportunity to gain a broader understanding of Indigenous health and child issues.

'This project is so pertinent and timely, we hope our work makes a difference to policy and to communities', Ms Van den Heuvel said.

The Institute's role is ongoing and it will continue to inform and report to the Commonwealth and to provide advice about data collection and evaluation of the initiative.

'Healthy for Life'

Another initiative leading developments in the innovative use of information is the 'Healthy for Life' program being managed by the Office for Aboriginal and Torres Strait Islander Health in the Australian Government Department of Health and Ageing.

Healthy for Life aims to enhance the capacity of more than 80 Aboriginal and Torres Strait Islander primary health care services to improve the quality of child and maternal health services and chronic disease care.

It is designed to allow health services to step back and review their current service delivery in child and maternal health and chronic disease care, to identify priority action areas for improvement and to develop further services for their community.

As part of the 'Support, Collection, Analysis and Reporting Function' of the program, the AIHW is providing a secure point for the collection and storage of data from health services on key health indicators. This function includes analysis of people's health status and the activities of health service providers.

Aggregated national data as well as service level data are made available to health service providers, allowing them to review what is working and how, in order to improve outcomes.

This is the first time this sort of collection and analysis of primary health care data has been done nationally, according to Dr Al-Yaman.

And the focus is important if there is to be a shift from high rates of acute hospital care to better preventative programs among Indigenous people.

Indigenous health

Indigenous health programs

AIHW role

'In order to improve health outcomes you need the bigger picture of what is happening.

'People use hospitals when things are already serious. The first line of defence is primary health care and we need to shift the balance there to prevention and education rather than treatment alone.

'There are many issues around access to primary health care services, but you also need information to identify needs and to plan. Primary health care data informs that process', Dr Al-Yaman said.

The benefits of collecting this primary care data are enhanced by the program's strategy of providing direct feedback to both policy makers and communities on what services are working and how.

Under the program, services will be able to log in to a secure website and input their data, as well as see their own results together with aggregated national data.

With this critical emphasis on an evidence base and working partnerships, Dr Al-Yaman said policies and services can head in the direction of improving health outcomes.

Improving sexual health

The crucial role of an evidence base is also at the centre of a new sexual health program which the AIHW started working on in May.

Available information shows there are higher rates of sexually transmitted infections (STIs) among young Aboriginal and Torres Strait Islander people compared to non-Indigenous youth.

According to the recent AIHW report, *Young Australians: their health and wellbeing 2007*, notifications among Indigenous young people for the most common sexually transmitted infections, chlamydia and gonorrhoea, accounted for 13% and 64% respectively of notifications for all young Australians for these infections. Young Indigenous people also accounted for 56% of the total number of syphilis notifications for young people.

Under the new program 'Improving the Sexual Health of Aboriginal and Torres Strait Islander Youth', the Office for Aboriginal and Torres Strait Islander Health in the Australian Government Department of Health and Ageing has sought innovative plans from agencies on how to attract young people to engage in treatment and screening, and to thereby ultimately reduce the rate of STIs.

The AIHW's role will be evaluation, and that starts with collecting baseline data before the programs begin.

After the programs are implemented, the AIHW will measure their impact. The Institute will also help services with data collection.

Dr Al-Yaman said it is significant that evaluation and evidence are being considered right from the beginning of a project. 'People are thinking about evaluation at the start of programs, beginning with benchmarks. This is a great role for the AIHW.'

With meaningful evidence of what works and what doesn't, there are even greater opportunities to improve health services and the health status of individual people. ■

health programs

Indigenous

The building block

Indigenous housing and homelessness issues are occupying a prime position on the current national policy agenda.

At its March 2008 meeting, the Council of Australian Governments reaffirmed its commitment to close the gap on Indigenous disadvantage via a range of specific actions across health, education, water supply and affordable housing.

This follows closely on the heels of the announcement made by Prime Minister Rudd as part of the Apology to the Stolen Generation: a new five-year housing strategy for remote Indigenous communities under the bipartisan Joint Policy Commission announced in February.

The current Commonwealth State Housing Agreement (CSHA) is also due to expire in June of this year. Governments have recognised that declining housing affordability is a pressing issue for Australians and improving it is critical to addressing financial stress and disadvantage, including for Indigenous Australians. The new National Affordable Housing Agreement will seek to address these problems. The new agreement is likely to include the major program supporting people experiencing homelessness in Australia, the Supported Accommodation Assistance Program (SAAP).

A Homelessness discussion (Green) paper was tabled in Parliament and issued for formal consultation in May. This will be followed by the policy direction (White) paper that

will provide a plan of action by September 2008. Indigenous homelessness will be addressed in both these papers.

Underpinning the latest flurry of policy activity is the recognition among policy makers and the community alike that housing plays a major role in the health and wellbeing of all Australians—poor housing can put people's health and safety at risk. Beyond the physical bricks and mortar, adequate housing is essential for decent outcomes in health, education, employment, safety, autonomy and social cohesion.

Policy makers also recognise the need for a firm foundation of evidence. In her speech on Indigenous housing to the National Press Club in February, Indigenous Affairs Minister Jenny Macklin highlighted that: 'Inevitably there will be difficult decisions but all these decisions will be driven by one single criterion—evidence...All our policy decision making will be based on a thorough, forensic analysis of all the facts and all the evidence. Once implemented, all programs will be rigorously and regularly evaluated.'

With so much policy activity, and the desire to improve the health and wellbeing of Indigenous Australians in particular, reliable and relevant data and analysis are crucial.

This is where the information, experience and expertise offered by the Australian Institute of Health and Welfare comes in.



housing

Blocks for change

According to the Head of the AIHW's Housing Assistance Unit, Ms Tracie Ennis, the Institute has a great deal of data useful to those working on Indigenous housing and homelessness.

'We have a lot of information to share, to inform the current policy agenda', she said.

In the past six months alone, the Institute has released a range of new reports (see recent releases at right) presenting the latest data and analyses on housing, health and welfare issues, for both Indigenous and non-Indigenous Australians.

They confirm that compared to the non-Indigenous population, a higher proportion of Indigenous Australians live in substandard and overcrowded housing and are homeless. Importantly, these analyses reveal to the current policy debate that Indigenous people (representing 2.5% of the Australian population) are:

- substantially over-represented among the homeless
 - the rate of homelessness for Indigenous Australians (8.5%) is 3.5 times higher than the rate for non-Indigenous Australians
 - 17% of Supported Accommodation Assistance Program (SAAP) clients are Indigenous Australians
 - 72% of Indigenous SAAP clients are women (compared to 57% of non-Indigenous clients) and the most common reason for seeking support is domestic violence and family breakdown

Recent releases

- *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008*, April 2008, Australian Bureau of Statistics and Australian Institute of Health and Welfare
- *Housing assistance in Australia 2008*, February 2008, Australian Institute of Health and Welfare
- *State owned and managed Indigenous housing 2006–07*, January 2008, Australian Institute of Health and Welfare
- *Australia's welfare 2007*, November 2007, Australian Institute of Health and Welfare
- *Indigenous housing indicators 2005–06*, October 2007, Australian Institute of Health and Welfare

AIHW publications are available from the Institute's website www.aihw.gov.au or by calling (02) 6244 1032 or emailing pubs@aihw.gov.au



- 27% of all accompanying children in SAAP are Indigenous. One in every 11 Indigenous children under 5 years of age attended a SAAP agency in 2005–2006, compared to 1 in every 88 non-Indigenous children.
- under-represented as homeowners
 - 34% of Indigenous households were homeowners or purchasers in 2006, up from 31% in 2001 but in comparison to 69% of all Australians
- over-represented in all forms of government assistance provided under the CSHA, except home purchase assistance:
 - the proportion of new recipients of mainstream CSHA housing assistance in 2005–2006 who were Indigenous ranged from 14% for public rental housing to 7.5% for community housing
- subject to high rates of overcrowding and poor dwelling conditions
 - Overall, 14% of Indigenous households were at least one bedroom short in 2006, with the worst overcrowding in Indigenous Community Housing (ICH) where 40% were overcrowded
 - 30% (6,674) of ICH dwellings were in poor condition in 2006; 51 dwellings had no organised sewerage system; and 85 dwellings had no organised electricity supply. A recent report (by Torzillo et al.) from the Fixing Houses for Better Health program showed that only 11% of Indigenous community houses met electrical safety criteria and half did not have the facilities to wash a child. In addition, less than 10% met the criteria for functioning nutritional hardware such as space to safely prepare and store food. Data collected as part of this program is currently available on the AIHW website: <http://www.aihw.gov.au/indigenous/datacubes/fhbh.cfm>

Finding the hidden details

Addressing the AIHW 'Australia's Welfare 2007' conference last December, the South Australian Commissioner for Social Inclusion, Monsignor David Cappo, emphasised the significance of collecting an evidence base to successfully implement social policy reform, and the importance of having the 'persistence and creativity to find the hidden and forgotten details'.

For the Institute, these characteristics are at the heart of its ongoing efforts to improve data collection and analysis of Indigenous health and welfare issues.

There has been significant progress in the quality and availability of statistical information on Aboriginal

and Torres Strait Islander peoples over the last decade in Australia, due to a coordinated approach to information on health, community services and housing sectors and improved data quality and availability in survey, Census and administrative data.

Despite these achievements, many challenges remain. The varying levels of Indigenous identification between different data collections, within each data collection over time, and between regions, make it difficult to assess changes over time and between different regions.

This challenge for organisations such as the AIHW means that work to

improve data collection and analysis is an ongoing priority.

Regardless of the future directions of Indigenous housing policy, Head of the AIHW's Housing Assistance Unit, Ms Tracie Ennis, said there are some 'basic building blocks' that will always be needed to understand the housing outcomes for Indigenous Australians. These include information on dwellings, the people living in them and those who are missing out. Other factors such as housing infrastructure and access to services are also important. The AIHW, in conjunction with governments and service providers, will continue work on improving this information.

Indigenous housing

The building blocks for change

Photo: © iStockphoto.com/
Simon Parker

But while the disadvantages of Indigenous people are increasingly well documented, the important questions about whether improvements are occurring are not easily answered because there are limited time series data of sufficient quality and frequency to show real trends as they emerge.

The ability to answer these questions becomes increasingly important as new policies and programs develop to deal with this inequality. The AIHW's efforts to improve the available data are ongoing (see story, below).

'Now is the time to take stock of what data we are collecting, and to ensure that it best meets the need of measuring outcomes in a timely manner and informs future policy development', Ms Ennis said.

'For example, we are getting ready to review the National Social Housing Surveys, which include surveys of Indigenous families. We expect to review the scope,

content and methodology of these surveys to ensure they meet the needs of the new National Affordable Housing Agreement, as well as the needs of other important initiatives such as the Joint Policy Commission.'

With so many opportunities offered by the current level of policy activity on Indigenous housing issues, the ability to measure and evaluate what is working, and how, will be crucial to making real improvements in the lives of Indigenous Australians in the future. ■

Reference:

Torzillo Paul J et al. 2008. The state of health hardware in Aboriginal communities in rural and remote Australia. *Australian and New Zealand Journal of Public Health* Vol. 32 No.1, 2008.

For example, as a result of an agreement by Housing Ministers in 2005, all states and territories have annually-updated plans to improve the identification of Indigenous households receiving housing assistance. Plans include such tasks as improvements to data collection forms and housing management software. Progress against these plans is reported to Housing Ministers each year, along with an analysis by the AIHW of access by Indigenous households to mainstream housing assistance.

Other work currently being undertaken by the AIHW in conjunction with states and territories includes the development

and testing of a national indicator for dwelling condition. 'When fully implemented, this measure will provide a valuable addition to our understanding of the needs of Indigenous families and of the investment that is required to bring all dwellings up to accepted standards', Ms Ennis said.

The AIHW is in a unique position in that it has extensive data holdings across a wide range of health and welfare areas. There is considerable scope to bring these data together in a way that provides much more information than any one data set on its own. For example, questions such as the pathways of Indigenous households through homelessness

and housing, or the factors that lead to 'successful' tenancies could be explored.

At the same time, work is underway at the AIHW to update the data collection manuals and information it provides to Indigenous community housing organisations to inform and support their data collection activities.

Through these and other activities and partnerships, the AIHW will continue to work with 'persistence and creativity to find the hidden and forgotten details' that will help inform policy reform. ■

People behind the stats

Aboriginal and Torres Strait Islander Health and Welfare Unit

Staff of the Aboriginal and Torres Strait Islander Health and Welfare Unit



The Aboriginal and Torres Strait Islander Health and Welfare Unit (ATSIHWU) started in 2003 with one person and has expanded into one of the largest units at the AIHW with 22 staff members.

‘The work on issues relating to Aboriginal and Torres Strait Islander people is important and challenging but very rewarding’, said Dr Al-Yaman.

‘The work program has expanded to include Indigenous housing and a broad range of health and welfare issues.

‘Through my work I meet a lot of people who are also passionate about this work and are fun to work with.’

I am privileged to do something that I really like doing, and feel passionate about the work that I believe will make a difference.

The ATSIHWU focuses on analyses and reporting on the health and welfare of Aboriginal and Torres Strait Islander peoples.

The Unit’s work includes data development, work on improving data quality, collection and reporting of data on health status and determinants of health, and collection of data for program evaluation. This is in addition to the collection of primary health care and other data to assess the quality of service delivery and improved outcomes for Aboriginal and Torres Strait Islander clients using health services.



Fadwa Al-Yaman

Aboriginal and Torres Strait Islander Health and Welfare Unit head Dr Fadwa Al-Yaman was awarded a 2008 Public Service Medal. Dr Al-Yaman has a background in immunology and health population and was recognised for outstanding public service in improving the accuracy and reliability of the data on Indigenous Australians contained in information collections for health, housing and community services.

The Unit analyses and reports on the health and welfare of Aboriginal and Torres Strait Islander peoples.

‘The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples is one of our most important publications’, said Dr Al-Yaman.

This publication has been produced every two years in collaboration with the Australian Bureau of Statistics. It presents the most up-to-date information on important issues such as employment, income, education, housing and homelessness, health status, mortality, disability and ageing, mothers and children, risk factors and access to health services and community services.

‘It compares the status of Indigenous people with that of the non-Indigenous population’, said Dr Al-Yaman.

The *Aboriginal and Torres Strait Islander Health Performance Framework* report is another important publication that the Unit produces every two years.

The Unit produced the biennial report *The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples in collaboration with the Australian Bureau of Statistics (ABS).*

The publication reports against 70 measures covered by three tiers—health status and health outcomes, determinants of health status, and health systems performance. Trends over time are presented to help policy makers monitor progress and contribute to future policy, and improve planning and program delivery.

The Unit is setting a cracking pace with 14 projects on the go at present, including four major projects—the Healthy for Life project, the Northern Territory Emergency Response (NTER) Child Health Check Initiative (CHCI) project, the Aboriginal and Torres Strait Islander Health Performance Framework project and Improving Sexual Health in Aboriginal and Torres Strait Islander Youth project.

Closing the gap in life expectancy for Aboriginal and Torres Strait Islander peoples is one of the government's key commitments.

Healthy for Life is a program funded by the Australian Government's Department of Health and Ageing Office of Aboriginal and Torres Strait Islander Health which focuses on child and maternal health and chronic disease. The AIHW is responsible for data development, analysis and reporting. Data are submitted from primary health care services participating in the Healthy for Life program through a web-based information system.

The NTER CHCI project has recently expanded to include more than the initial task of data entry, analysis and reporting of the Child Health Check forms produced as a result of the NT Intervention. The project now also includes the electronic transfer of CHCI data, chart review data collection, dental services data collection and audiology services data collection.

The *Aboriginal and Torres Strait Islander Health Performance Framework* report is due out this year, and work is continuing on the extensive list of subject areas covered in this biennial publication.

The aim of the newest project on Improving Sexual Health is to increase the number of Aboriginal and Torres Strait Islander youth accessing testing and treatment services for sexually transmissible infections, as well as to reduce the level of risk behaviour among young people and contribute to the development of best practice approaches.

Staff in the Unit are also involved in various national committees, including the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data, which is part of the Australian Health Ministers Advisory Council, the National Aboriginal and Torres Strait Islander Health Officials Network, the Prisoners Health Information Group, Overcoming Indigenous Disadvantage Indigenous Working Group, Child Health Check Memorandum of Understanding Management Group and

the Steering Committee for the Aboriginal and Torres Strait Islander Health Performance Framework report.

Dr Al-Yaman also chairs the Data Development Reference Group for Healthy for Life and the Steering Committee for Best Practice Guidelines on Indigenous Identification.

The Unit works closely with the Office for Aboriginal and Torres Strait Islander Health in the Department of Health and Ageing, the ABS, the Department of Families, Housing, Community Services and Indigenous Affairs, the Overcoming Indigenous Disadvantage working group for the Productivity Commission, the Northern Territory Department of Health and Community Services, and Aboriginal primary health care services involved in the Healthy for Life program.

The Unit also collaborates with the Darwin-based Menzies School of Health Research, the National Perinatal Statistics Unit at the University of New South Wales, the National Centre in HIV Epidemiology and Clinical Research at the University of New South Wales, the Aboriginal Medical Services Alliance—Northern Territory and various other state and territory government departments.

'The staff bring a wealth of experience from many years working in the community sector, other government departments and with various Aboriginal and Torres Strait Islander communities and organisations', stated Dr Al-Yaman.

'Their qualifications range from bachelor degrees in psychology, science, social science, anthropology, sociology, English, Indigenous studies and demography to graduate diplomas in epidemiology and population health to PhDs in biochemistry, statistics and mathematics.'

If Dr Al-Yaman had extra time and resources, she would like to do more work with university-based researchers, and there is potential for future collaborative work with the Australian Institute of Aboriginal and Torres Strait Islander Studies, the Cooperative Research Centre for Aboriginal Health and the National Aboriginal Community Controlled Health Organisation. ■

Working in partnership

AIHW and the Office for Aboriginal and Torres Strait Islander Health

Almost one year on from the Australian Government's announcement of emergency measures to protect Aboriginal children in the Northern Territory, it is clear that strong partnerships underpin the initiative's progress and its future.

An integral part of the emergency response has been voluntary child health checks and at the time of writing over 8,700 checks had been undertaken in remote communities and outstations across every region in the NT.

The Australian Government Department of Health and Ageing's Office for Aboriginal and Torres Strait Islander Health (OATSIH) has responsibility for planning and mobilizing the resources for the child health checks. This has involved the direct recruitment, training and deployment of child health check teams that include a doctor and up to three nurses, and administrative support staff. Increasingly, Aboriginal Community Controlled Health Services and the Northern Territory Department of Health and Community Services are working with OATSIH on the Child Health Checks and follow-up services.

An important part of the initiative is ongoing examination of its implementation and impact, and in view of that a memorandum of understanding (MoU) to cooperate on an evaluation was signed between OATSIH, the AIHW, the Northern Territory Health and Community Services, and the Aboriginal Medical Services Alliance of the Northern Territory.

OATSIH's Brendan Gibson said the Institute's 'crucial role' is as data custodian and to provide independent analysis.

To support the four-party MoU, another agreement between OATSIH and the AIHW was signed, contracting the Institute to collect the data from the health checks, build a database of information, undertake analysis and produce reports.

Dr Gibson said the AIHW has worked hard to understand the needs of the project and proven to be a responsible and professional partner.

'The Institute's role is professional and expert data collection and analysis. Its independence is also important', he said.

The information gathered from the child health checks is significant in terms of determining the health needs of individuals and communities and planning follow-up health services.

Each child health check takes an age-specific history of medical conditions, including general health, immunisations and development. For children aged 12 to 16 years, questions about alcohol, tobacco, other substances, mood, self-harm and sexual health (if indicated) apply. Social history, such as living conditions, is also covered.

It is a comprehensive examination similar to a thorough check-up by a GP of height, weight, eyes, ears, teeth, skin, heart sounds, lungs and abdomen, as well as other matters such as a finger prick blood test for haemoglobin level (anaemia), and possibly glucose (diabetes) in older children.

De-identified copies of child health checks are sent to the AIHW to enter into a database, after which the Institute analyses the information and provides ongoing reports to OATSIH. The Institute has also been able to provide expert advice on data collection issues.

Dr Gibson said the information received back from the Institute has already been used to coordinate follow-up services and planning in individual communities for health services.

'It is already affecting the implementation of the initiative. It is also a major contributor to the evaluation which will inform future policy making, on the basis of how successful we've been in reaching children with child health checks and follow-up services.' ■

E-health and old-health

a hippo, happening relationship for the noughties



By Julie Roediger, AIHW Deputy Director

For health statisticians the e-health agenda engenders both excitement and trepidation. On the one hand, the prospect of timely reporting, rich in clinical data and joined up across the service-delivery silos, is stats heaven. On the other, the transition threatens to disrupt good time-series data, consent models present the prospect of unrepresentative collections and it's unclear how we will keep supporting public health research, policy development and program management.

The AIHW has a lead role, on behalf of the nation, to ensure that statistical reporting functions—which also support accountability arrangements—can continue through the changes to e-health. Up to now attention has, understandably, been on clinical uses.

But the National E-Health Transition Authority's (NEHTA) realisation work has revealed substantial potential benefits in the secondary uses arena such as better planning and demand management, better epidemiology and public health. As well as improving outcomes for the patient, the data generated by e-health could provide a rich research base.

This represents a substantial complication. The number of stakeholders, even for narrow definitions of clinical use, is great and the diversity of opinions is even greater, with many people, myself included, having different visions for e-health on Mondays, Wednesdays and Fridays.

Bringing in the secondary users could invite a clash between two large, ponderous entities each committed to their cause. Hippos are not known for happily sharing their waterhole and the resultant thrashing about could threaten the fragile accord between the layers of government, and lose hard-won momentum.

When NEHTA was first established, it started with the essential foundation elements of an e-health system: an architecture, a benefits framework and information-sharing standards, while the Department of Health and Ageing was rolling out broadband connectivity and a range of functions. These activities didn't bring them to any great extent into the same pond as the old-health statisticians. We met, we spoke, we cared, but afterwards we returned to our respective ponds.

But some of the greatest benefits will come from the secondary uses, and some of the greatest assets to the e-health agenda have been developed within the old-health structures that have evolved around those secondary uses.

Let's consider some of the functions performed by the old-health system that could be performed by the emerging e-health system and how failing to consider these at the beginning will undermine the long-term benefit of e-health.

Consider, for example, reimbursement. From a clinical perspective it may not matter whether a vaccination is delivered by a GP or a practice nurse. But the distinction is critical for reimbursement.

Monitoring compliance with, and outcomes of, best practice protocols is a clear potential benefit of e-health, but if patient preferences cannot be recorded then deviations from evidence-based protocols can't be explained.

In Australia, improving the health of Aboriginal and Torres Strait Islander Australians is a critical priority, but if Indigenous status is not recorded, then the information has limited utility for policy development and program management.

om the Deputy Director

If access to the clinical elements of a de-identified record is limited by the consent model, then the data have limited utility for population health monitoring.

For pandemic monitoring it will be essential for records to include current contact details as well as usual place of residence.

If these secondary uses are not considered during design then it will be very hard to retrofit them. In working collaboratively with the e-health developers, the custodians of secondary uses in the old-health world are working to ensure that our agenda is not taken backwards on issues such as these. But we also have a lot to offer in taking the e-health agenda forwards. Many of the challenges facing e-health are the same challenges that old-health has been managing for years:

- balancing the appetite for more information against the cost and workforce needed to collect and analyse it
- simultaneously managing the need for agile responses to questions of the day while supporting the methodical process of ensuring that what is asked for can be collected, will be comparable and will actually measure what it's trying to measure, and
- the need to protect individual privacy without unnecessarily tying up information that promotes the health of all Australians.

The old-health governance system has developed a strong practice of balancing these tensions across a wide range of use-cases with disciplined cost-benefit analyses. There is much of value to be built upon in terms of knowledge, process and relationships.

So perhaps these two hippos can build on some of the existing strengths while redressing some of the shortcomings of the existing system, and replacing some of the parts that will no longer fit. The old challenges are

still there for e-health and some of the existing responses will work. But there are new challenges too, such as:

- The glacial pace of old-health won't work for e-health and less bureaucratic ways of ensuring quality and stakeholder engagement are needed.
- Old-health usually saw government owning the software development activities and therefore didn't require vendors at the table. That won't work in e-health.
- Old-health managed the health information environment by dividing it into manageable chunks—admitted hospital patients, GP visits, pharmaceuticals—and managed these in stove-pipes. E-health as it is managed in Australia also does this. Standards, term sets etc. are developed for each separate discipline. But now they are developed within an overarching architecture.

What is emerging slowly and still needs to be nurtured, is a single, multi-polar system where it is acknowledged that decisions about privacy and consent in one part of the system have flow-on ramifications for other parts of the system. Ideally, maps that bridge between old-health and e-health will be developed and implemented under a single governance system. It's only a fledgling idea and has only recently made tentative inroads into the governance system.

The e-health agenda is starting to bring together a wider range of stakeholders and develop a common language and habit of communication. I'm optimistic about this and the AIHW will be working hard in 2008 to bring these two strands of work together. E-health won't be a big bang technology change. It will be an evolution, building on the strengths of the current system, because it works and because people only change incrementally and, ultimately, this is all about the people. ■

AIHW developing performance indicators for the new health care agreements

At the request of all nine health ministers (Commonwealth, states and territories), a team of Institute staff is busy researching and consulting on the development of performance indicators for the next round of Australian Health Care Agreements.

AIHW Director Penny Allbon outlined the Institute's task as 'developing a set of indicators that get to the heart of how Australians think their health and aged care system should be judged'.

The new health care agreements are moving beyond their previous focus on public hospitals to cover the whole health and aged care system, including public health, primary and community health, and long-term care. The indicator suite that the AIHW recommends to ministers must therefore be broad in scope, suitable for public reporting, relate to accountabilities and responsibilities of different levels of government, and reflect the aspirations and goals of the health system, as well as specific priority reform areas. Candidate indicators are assessed against a number of criteria, including that they are amenable to action, are important to the public and policy makers, are unlikely to encourage perverse incentives, and relate to a clear direction for reform.

A number of related strands of work on health and aged care sector goals and performance and the new health care agreements are also currently in full swing. For example, the Australian Government has established the National Health and Hospitals Reform Commission, which has been asked to provide advice on performance benchmarks and practical reforms to the Australian health system. One of its terms of reference is: 'By April 2008, the Commission will provide advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of care.'

The AIHW and the Health Reform Commission have been communicating regularly to ensure that these exercises inform each other.

The Institute project team of Jenny Hargreaves, John Goss, Louise York and Louise O'Rance has assessed hundreds of potential indicators and consulted with representatives from a wide range of stakeholders. Further consultation, including with Commonwealth, and state and territory governments, is underway.

Ms Hargreaves commented: 'The project is providing a terrific opportunity for us to talk to a wide range of stakeholders about what aspects of the health and aged care system are important to them. Their inputs are invaluable for our work to develop the indicator set and will also help to shape other work developing and reporting health sector information.'

'It has been fantastic working on a project so integral to health system reform', enthused Louise O'Rance, reaching for (yet another) coffee.

Consultations so far have highlighted the great interest that many sectors of the health and aged care system have in developing and using comparable, meaningful performance indicators. A number of stakeholders are already engaged in developing and considering indicators relevant to their particular place in the system.

The project team is not restricting the selection of indicators to existing indicators or those that relate to an existing data source. In fact, sometimes the data to measure potential indicators are 'aspirational', or simply non-existent. This is one of the most challenging aspects of the task. ■

Report profile

Occupational asthma in Australia

Summary

Asthma is a chronic inflammatory disease of the airways that affects more than 2 million Australians. Occupational exposure accounts for up to 15% of new asthma cases in adults.

A clear causal relationship can sometimes be established between the disease onset and exposure to agents in the workplace (known as occupational asthma). Together with pre-existing asthma provoked or worsened by environmental conditions or substances at work (work-aggravated asthma), it is one of the most commonly reported occupational respiratory diseases in Australia and other developed countries.

As a type of asthma with known causes, occupational asthma is largely preventable through effective control of exposure to causal agents.

This report includes a discussion of the monitoring and surveillance of the disease and its risk factors.

This bulletin addresses several key questions regarding this form of asthma:

1. What is occupational asthma? (How is it defined, what are the different types, and in what ways does it differ from 'normal' and work-aggravated asthma?)
2. What causes it? (What are the factors that increase the risk of occupational asthma and which occupations present the greatest risks?)
3. How common is the disease? (What is the prevalence and incidence of occupational asthma in Australia?)
4. What are its consequences? (How does occupational asthma affect the individual and the health care system?)

The epidemiology (prevalence and incidence) of occupational asthma can be used to target where interventions are needed and to monitor and evaluate their effects.

This report was produced by the Asthma, Arthritis and Environmental Health Unit of the Institute.

About the unit

The Asthma, Arthritis and Environmental Health Unit (AAEHU) monitors asthma, arthritis and osteoporosis nationally. It also reports on the impact of the environment on the health of the Australian population. A major component of the Unit's work is to study the role of primary care in managing asthma, arthritis and other chronic diseases. Information is also generated on several diseases and conditions in which the external environment plays an important role, such as infectious diseases, allergies and musculoskeletal problems. ■



Fast facts

Occupational Asthma in Australia:

- 1,000–3,000 new cases of occupational asthma are diagnosed each year in Australia.
- These cases constitute about 9–15% of adult-onset asthma attributed to exposures at work.
- People with occupational asthma often have to change jobs or careers to relieve their symptoms; hence, work disruption and economic hardship are common consequences of the disease.
- Although not curable, occupational asthma is largely preventable through actions that avoid or reduce exposure to workplace sensitizers and irritants.

Primary contact

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Improving access to data... and making better use of it through data linkage

Well-managed and effectively presented on-line interactive data can provide detailed and timely information while preserving confidentiality. Interactive data products complement our published reports in providing more flexible access and outputs for those who need and want this.

The Institute has made a wide range of data available on its website in an accessible and interactive format. There are interactive Excel spreadsheets and pivot tables, data catalogues (HTML-based) and interactive COGNOS data cubes. Work is underway to add other data cubes, including public hospital establishments, welfare expenditure and disease expenditure.

Feedback from users indicates that the interactive data are well used. Importantly, interactive data enable Institute staff to spend more time on core work while clients save money by running their own custom data queries and getting the answers automatically.

Data that are currently accessible online include:

- Alcohol and other drug treatment data cubes
- Australian Cancer and Mortality (ACIM) data
- Chronic disease indicators
- Disability data cubes
- Expenditure data cubes
- General practice data

- General Record of Incidence of Mortality (GRIM)
- Mental health admitted patient data cubes
- METeOR
- National hospital morbidity data cubes
- Elective surgery waiting times interactive data
- Risk factor data
- Indigenous data on housing and household conditions (Fixing Houses for Better Health)

Public Hospital Establishments data cubes (pending).

Linking national data is another area where the AIHW already has demonstrated leading-edge capability and we are continually expanding this promising area to provide insight into patient experiences and to link activities to outcomes.

A key priority is linkage of the National Hospital Morbidity Database. More powerful linkage infrastructure is vital to a more patient-centred approach, so that issues relevant to the safety and quality of health care can be better examined. At the moment we know how many episodes there are in hospitals, but we don't know what this means for the people involved. Only with data linkage can we use the existing data to understand patterns of multiple admissions for patients, including unplanned re-admissions, and information on repeat periods of hospitalisation that are currently reported as separate episodes. Patient name information would be invaluable



Image © iStockphoto/Felix Mock

At the Institute we are particularly keen on enhancing data access, and capitalising on the new information environment—so keen that they are two of our five key strategic directions for the next three years!

for linkage with the National Death Index (for example, for 30-day mortality analyses) and other databases with names or name-based statistical linkage keys (SLKs).

The need for such linkage is increasingly recognised within states and territories, and this is an important strategic area for our national database as well.

The Institute has already made a significant investment in data linkage at the national level over a number of years. Some of the key outcomes include:

- the establishment and maintenance of the National Death Index for both internal purposes and the use of external researchers
- the development and initial implementation of the standard Community Services Statistical Linkage Key (CS SLK), which is being included in an increasing number of national data collections. The standard CS SLK was developed by the AIHW for use in the Home and Community Care National Minimum Data Set, but first implemented in the Commonwealth–State and Territory Disability Agreement National Minimum Data Set. In addition to these two collections, it is

currently in use in the Supported Accommodation Assistance Program (SAAP) collection, the Aged Care Assessment Program collection and the Juvenile Justice collection

- the development of the ‘event-based’ method of data linkage that allows linkage of hospital and residential aged care data
- linkage of data across several residential and community-based aged care programs (the hospital-to-residential-aged-care linkage demonstration project is now close to completion and is producing interesting and policy-relevant results)
- linkage of educational performance data with child protection data
- feasibility work on linkage across child protection, SAAP and juvenile justice collections
- internal person-based linkage within programs (for example, seven years of juvenile justice data are linked at the person level, allowing analysis of pathways in and out of that system). ■

Head of Health Care Safety and Quality Unit

Vicki Bennett

Vicki Bennett joined the AIHW in June 2007, after spending almost two years in Fiji on an AusAID development assignment, working as the manager for health information services.

Prior to Fiji she worked at Medicare Australia and was responsible for internal and external requests for Medicare and PBS data and worked very closely with the AIHW.

Ms Bennett has over 17 years experience in health information and has worked in every part of the health sector from government departments and agencies



Photo © Irene Dowdy

through to urban and rural hospitals and acute and sub-acute health care.

As head of the Health Care Safety and Quality Unit, Ms Bennett has responsibility to develop and maintain a national system of information that enhances the safety and quality of health care across Australia. ■

Head of Finance and Commercial Services Unit

Andrew Tharle



Photo © Irene Dowdy

Andrew Tharle has excellent financial and strategic budget experience, with over 10 years experience as a senior financial officer in an Australian Government agency.

He has relevant experience in a small agency under a Board, having been at the Australian Fisheries Management Authority for 10 years prior to joining the AIHW. Mr Tharle

has previously worked for a couple of small accounting firms and is CPA qualified with a Bachelor of Commerce from the Australian National University.

Andrew heads up the Finance and Commercial Services Unit, which provides services that support the Institute's financial and business operations. The key responsibilities of the Unit are advising on strategies and policies for the optimal use of the Institute's financial resources to achieve its business objectives. ■

Our people

Our people

Head of Housing Assistance Unit

Tracie Ennis

Tracie Ennis, a self confessed science/maths nerd, heads up the Housing Assistance Unit (HAU). With a background in human biology, Tracie mostly worked in the public sector in a range of departments including Agriculture, Fisheries and Forestry, Immigration, and Health and Community Services. She has also worked as a laboratory technician, a pharmaceutical representative, a debt collector and a nursery owner/manager.

Tracie has over five years experience in the HAU, which has provided her with a sense of history and understanding of the issues relating to the area.

The Housing Assistance Unit is broadly responsible for data development, collection and annual reporting against



the Commonwealth State Housing Agreement. The HAU also recently took on responsibility for Indigenous community housing and is currently waiting to see what the new National Affordable Housing Agreement will look like, as it will have quite an impact on the work the Unit does. ■

Head of Mental Health Services Unit

Gary Hanson



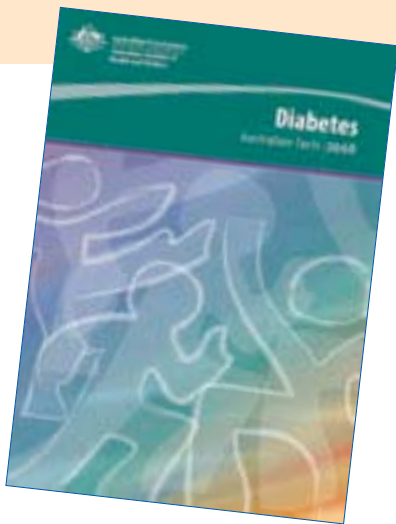
As a registered psychologist in the ACT, Gary Hanson brings to the AIHW a wealth of experience, from his 22 years as a military psychologist and a further 8 years in a civilian position as the Senior Research Manager with the Directorate of Strategic Personnel and Planning with the Department of Defence.

Mr Hanson has extensive experience in survey design and analysis, project management, optical scanning and text recognition, web surveying, text and data mining, applied personnel research and quantitative and qualitative analysis.

As Head of the Mental Health Services Unit, Mr Hanson is responsible for the three National Minimum Datasets (NMDS)—the Mental Health Establishments NMDS, the Residential Mental Health Care NMDS and the Community Mental Health Care NMDS. His unit also publishes the *Mental health services in Australia* report annually, an important national resource discussing the characteristics and activity of Australia's mental health services. ■

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Report profile



Diabetes: Australian facts 2008

Summary

Diabetes mellitus (diabetes) is a disease marked by high blood glucose levels resulting from defective insulin production, insulin action or both (WHO 1999). It is one of the leading chronic diseases in many countries, and is now reaching epidemic levels.

Diabetes: Australian facts 2008 provides an overview of diabetes and its impact on the Australian community. The report presents the latest available statistics on diabetes, including information on risk factors, complications, health service use, and the impact of the disease (including mortality) on Australians. The report includes both summary and trend data related to diabetes in Australia and information useful for health professionals, policy makers, academics and other interested readers.

Diabetes is associated with a range of complications including coronary artery and peripheral vascular disease, stroke, diabetic neuropathy, amputations, renal failure and blindness, and can cause much disability, poor quality of life and premature death, especially if left undiagnosed or poorly controlled (IDF 2006).

The overall rise in diabetes is largely driven by an increase in the prevalence of Type 2 diabetes; however, Type 1 diabetes and gestational diabetes are also on the rise.

This is the second national report on diabetes compiled by the National Centre for Monitoring Diabetes at the AIHW, and is funded by the Australian Government Department of Health and Ageing.

About the unit

The Cardiovascular Disease and Diabetes Unit includes the National Centre for Monitoring Diabetes and the National Diabetes Register. We aim to help reduce the impact of cardiovascular disease and diabetes in Australia by informing community discussion and decision making. We analyse a range of data on cardiovascular disease and diabetes; collect data on diabetes; and provide information on the number of people with these diseases, their functioning and disability, use of health services, risk factors and deaths. ■

Fast facts

- Diabetes affects 1 in 25 people in Australia.
- About 700,000 Australians, or nearly 4% of the population, had clinically diagnosed diabetes in 2004–05, and many others have diabetes without knowing it.
- If left unchecked, 1 in 14 adults or an estimated 380 million people worldwide are predicted to have diabetes by 2025 (International Diabetes Federation (IDF) 2006).
- In 2003, diabetes accounted for over 5% of the disease burden in Australia.
- In 2004–05 people with diabetes were twice as likely to have had a heart attack, and four times as likely to have had a stroke.
- Nearly a third of people starting treatment for end-stage kidney disease did so because of their diabetes, and almost 3,400 people with diabetes had lower limb amputations.

Primary contact

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Director's Canada trip

As mentioned in her Director's column in this issue, Penny Allbon was invited to Canada at the end of January as guest speaker at a Health Information Summit, called 'Build once, use often: harnessing the full power of the EHR (Electronic Health Record)'. Penny was the guest of our sister organisation in Canada, the Canadian Institute of Health Information, which arranged the Canadian Summit in conjunction with Canada's electronic health enabling organisation, Canada Health Infoway.

Dr Allbon said the Summit was a very useful opportunity to understand more about how Canada and the UK were approaching the statistical use of electronic health records, and gave her some good insights into issues that will help us navigate our way into this new world. Summit participants were also very happy with the insights she provided from Australia.

Unfortunately for Dr Allbon, although the Summit was at the Kananaskis Resort in the Rockies in the middle of winter, she didn't have a chance to do any skiing...but she did come home with some photos and a dose of the flu. ■



Thinking globally update

Diabetes: Australian Facts goes international

Hot on the tail of the release of the National Centre for Monitoring Diabetes' flagship publication, *Diabetes: Australian facts 2008*, Lynelle Moon, Indrani Pieris-Caldwell and Mardi Templeton presented results from the report at the International Diabetes Federation Western Pacific Congress in Wellington, New Zealand (30 March–2 April). The three oral presentations made at the Congress were:

- Complications of diabetes and their effect on people with diabetes in Australia
- Diabetes prevalence, hospitalisations and deaths in different population groups of Australia, and
- Gestational diabetes mellitus estimates: what is the current picture in Australia?

All three presentations were well received. Prevention of diabetes through risk factor control, the long-term complications of the condition and the impact of diabetes within different population groups were strong themes arising throughout the four-day conference. ■



Photo © Irene Dowdy

Lynelle Moon and Indrani Pieris-Caldwell

An Australian in Paris

Michael de Looper joined the AIHW way back in May 1988, soon after its establishment. He began in the Health Labour Force Unit, had a brief stint in the Nutrition Unit (when there was one), and also worked in the Executive Unit. But most of his time at the AIHW has been in various permutations of the Population Health Unit.

For many years Michael has been the Australian data 'correspondent' for the Organisation for Economic Cooperation and Development (OECD), headquartered in Paris. His contact with OECD led him to be offered a two-year position in the Health Division at the OECD's headquarters commencing in September 2007. The AIHW was pleased to grant Michael leave to accept the position.

Michael assists in maintaining and developing the large OECD Health Database, with special responsibility for the sections on mortality, morbidity and health determinants. A current focal area of work is the development of new indicators for monitoring chronic diseases, children's health and mental health. Michael is also examining the feasibility of including cross-national indicators of health

inequality. The work requires good knowledge of national and cross-national health data and surveys, and the policy settings in which these are used.

He finds work and life in Paris both varied and challenging. Michael continues to stay in touch with his colleagues at the AIHW.

You can read more about OECD here: www.oecd.org ■



Michael de Looper and family

News in brief

Australia's welfare 2007

The 'Australia's Welfare 2007: Disadvantage and Diversity' conference attracted almost 300 delegates from around Australia.

The one-day conference, held in the nation's capital, provided a forum for debate and discussion on some of the issues facing Australia's welfare. Topics included; indicators of the welfare of Australia's population, ageing and aged care services, disability and disability services, assistance for housing, services for people experiencing homelessness, and welfare services expenditure and labour force.

The Hon. Tanya Plibersek, Minister for Housing, officially launched the publication, *Australia's welfare 2007*, which has been released biennially for the past 16 years. ■



Penny Allbon (centre) with members of the media and publishing teams

AIHW World's Greatest Shave Fundraiser

AIHW staff bared their scalps and coloured their locks to raise funds for the Leukaemia Foundation's 'World's Greatest Shave Fundraiser' on Friday 14 March.

Six men and one brave woman shaved their heads for cash, in order to raise funds for the charity. Many AIHW staff supported the event, without losing their locks, by colour-spraying their hair or supporting a fellow shaver through donations.

The event was a great success with the AIHW raising over \$2,000 for the Leukaemia Foundation. ■



(clockwise from top) Neil Angel, Andrew Tharle, Karin Cerasani, Stirling Lewis, Mark Cooper Stanbury

AIHW staff on the big screen

Move over Nicole Kidman, make way for the latest stars of the AIHW's promotional video. Promoting the Institute as 'more than just a place to work', the video shows several AIHW employees discussing life at the Institute. A big thank you to the Business Group and the folks at Screencraft, for their fantastic work in putting this together.

Thanks also to all the superstars and starlets involved in the video. We wish you all the best in your future acting/spokespeople careers. The AIHW promotional recruitment video can be found on the AIHW website. ■



Recent publications

Adoptions Australia 2006–07

Child welfare series No. 44

CAT. NO. CWS 32 • \$25.

Australian hospital statistics 2006–07

Health services series no. 31

CAT. NO. HSE 55 • \$42.

Australia's mothers and babies 2005

Perinatal statistics series no. 20

CAT. NO. PER 40 • \$30.

Australia's welfare 2007

CAT. NO. AUS 93 • \$60.

BreastScreen Australia monitoring report 2004–2005

Cancer series no. 42

CAT. NO. CAN 37 • \$26.

Cardiovascular disease and its associated risk factors in Aboriginal and Torres Strait Islander peoples 2004–05

Cardiovascular disease series No. 29

CAT. NO. CVD 41 • \$29.

Cervical screening in Australia 2005–2006

Cancer series no. 41

CAT. NO. CAN 36 • \$28.

Child protection Australia 2006–07

Child welfare series no. 43

CAT. NO. CWS 31 • \$26.

Diabetes: Australian facts 2008

Diabetes series no. 8

CAT. NO. CVD 40 • \$40.

Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004–05

Health and welfare expenditure series no. 32

CAT. NO. HWE 40 • \$28.

General practice activity in Australia 2006–07

General practice series no. 21

CAT. NO. GEP 21 • \$32.

Older Australia at a glance (4th edition)

CAT. NO. AGE 52 • \$45.

Maternal deaths in Australia 2003–2005

Maternal deaths series no. 3

CAT. NO. PER 42 • \$30.

National palliative care performance indicators: results of the 2007 performance indicator data collection.

CAT. NO. HWI 99 • \$24.

National public health expenditure report 2005–06

Health and welfare expenditure series no. 32

CAT. NO. HWE 39 • \$30.

Rural, regional and remote health: indicators of health status and determinants of health

Rural health series no. 9

CAT. NO. PHE 97 • INTERNET ONLY.

2007 National Drug Strategy Household Survey: first results

Drug statistics series no. 20

CAT. NO. PHE 98 • FREE.



focus on Indigenous health expenditure

Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004–05

- ▶ This statistical snapshot is taken from the recent publication *Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004–05* which was the fourth in this series of publications. More detailed information is available from <http://www.aihw.gov.au/expenditure/indigenous.cfm>.

Overall and per person health expenditures

- ▶ Between 1995–96 and 2004–05 there has been little change in the per person health expenditure ratio for Indigenous compared to non-Indigenous Australians.
- ▶ In 2004–05, \$1.17 per person was spent on Aboriginal and Torres Strait Islander health for every \$1.00 spent on the health of non-Indigenous Australians.
- ▶ Average total health expenditure per Aboriginal and Torres Strait Islander was \$4,718 compared with \$4,019 per person estimated for non-Indigenous Australians.
- ▶ Total health expenditure for Aboriginal and Torres Strait Islander peoples was estimated at \$2,304 million in 2004–05, or 2.8% of national expenditure on health services, the same proportion as for 2001–02.

Public versus private services

- ▶ Aboriginal and Torres Strait Islander people are high users of public hospital and community health services, and comparatively low users of medical, pharmaceutical, dental and other health services which are mostly privately provided.
- ▶ Sixty-eight per cent of total health spending for Aboriginal and Torres Strait Islander peoples was for public hospital services (46%) and government community health services (22%). Less than one-third of health spending for non-Indigenous Australians was for these services (27% and 4% respectively).
- ▶ Medicare benefits paid and PBS expenditure per Indigenous person were estimated to be around half that of the non-Indigenous average (45% and 51%

respectively). Similarly, expenditure on dental and other health practitioners by Indigenous people was 40% of the non-Indigenous average.

Funding sources

- ▶ In 2004–05 the Australian Government provided 45% of total funding for health expenditure for Aboriginal and Torres Strait Islander peoples. The state and territory governments provided 48%—the remaining 8% came from private sources, including out-of-pocket payments. For non-Indigenous people, the Australian Government funded 48% of total health expenditure, the state and territory governments funded 20% and 31% was from private sources.
- ▶ Total per person government-funded expenditure was much higher (58% higher) for Aboriginal and Torres Strait Islander peoples than for non-Indigenous people—\$4,356 and \$2,763 respectively.
- ▶ Interestingly, government health expenditure on Indigenous people is about the same as government health expenditure on non-Indigenous people who have low income levels.

Growth in expenditure

- ▶ In the six years to 2004–05, expenditure by governments for Aboriginal and Torres Strait Islander peoples rose by 23% in real terms (after adjusting for inflation).
- ▶ State and territory governments contributed 56% (\$447 million) of the growth in expenditure and the Australian Government contributed 44% (\$352 million).
- ▶ Public hospitals were the largest single source of increase—\$302 million.
- ▶ The largest proportional growth was in Australian Government grants to the Aboriginal Community Controlled Health Organisations, which grew by 83% over the six years, or, after adjusting for inflation, from \$320 per person (at 2004–05 prices) in 1998–99 to \$426 per person in 2004–05. ■