Australian Government

Australian Institute of Health and Welfare

access

2012

25

25 years at the AIHW
page 4

New National Health Workforce Data – a step in the right direction
page 10

Specialist Homelessness Services Collection: first results
page 12

Looking ahead: cancer projections for 2020
page 14

Years

www.aihw.gov.au

Inside

Reduce your impact on the environment and your paper trail by switching to our online version of *AIHW access*. Register online at **www.aihw.gov.au/access/subscribe.cfm**.

Hello and welcome to this mid-year edition of *AIHW Access*.

Long-time *Access* readers and followers of the AIHW may know that on 1 July 2012 we will reach the milestone of 25 years of providing quality statistics and information to the community and government.

That's right, 25 years since the (then) Australian Institute of Health was established in 1987. It's not a particularly long history as far as organisations go, but so much has been achieved since 1987 that I feel it is an honour for those of us who currently work at the AIHW to be the custodians of the Institute's proud history and indeed its destiny.

In this issue of *Access* you will be able to read about some of the milestones (there have been no millstones that I am aware of) in our history. Of course, the most significant governance change was the inclusion of the welfare responsibilities in 1991, and our subsequent name change to the one we have today.

Two of our current staff have been here for the entire journey—Judith Abercromby, currently Head of our Ageing and Aged Care Unit, and Joanne Maples, currently our Parliamentary Liaison Officer in the Governance Unit. Both have seen all the Institute's many changes since 1987. A number of other original staff left in recent years.

For the rest of us—AIHW staff past and present, and our clients and stakeholders—we can get a sense of the magnitude of the changes with a few comparisons between the AIH in 1987–88 and the AIHW in 2011–12:

	AIH 1987–88	AIHW 2011–12
Staff	68	370
Executive (incl. Director)	5	9
Operating Units	11	41
Total revenue	$3.6m	about $50m
Annual appropriation	$3.4m	$17.4m
External funding	$0.2m	about $33m
Number of websites managed	0	5
Number of publications produced	14 (start-up phase)	>150
Collaborating Units	3	4

We are planning to mark this special occasion in several ways with our staff, previous staff, and former Board members.

Publicly, we will be highlighting our 25-year history through our **www.aihw.gov.au** website, this special edition of *AIHW Access*, and the next AIHW annual report. And we will certainly be acknowledging the occasion at our upcoming *Australia's health 2012* conference and launch on 21 June at the National Convention Centre in Canberra.

Happy reading and here's to the next 25 years!

David Kalisch
Director (CEO), AIHW

Dr Leonard Smith (October 1987–December 1992)

Mr Tim Skinner (February 1993– September 1993)

Professor Bruce Armstrong (January 1994–January 1996)

1987
The Australian Institute of Health (AIH) is established as a statutory authority on 1 July. It was described at the time as an 'independent health research and statistics agency within the Commonwealth Community Services and Health portfolio'.

1988
The first Australia's health biennial report is produced.

1989–90
National agreement is reached on information to be collected on institutional health care.

1991–92
The Institute's role and functions expand to include welfare-related information and statistics, with its name changing to the Australian Institute of Health and Welfare (AIHW). The Institute is formally selected as a World Health Organization Collaborating Centre. The first Data Catalogue is produced.

1992–93
The National Health Information Agreement and National Welfare Data Agreement are signed. The first National Health Data Dictionary is published.

1993
The first Australia's welfare biennial report is produced.

1993–94
Development of the Disability Services Minimum Data Set begins. The Institute hosts an international workshop on the classification of disability. The National Health Labour Force Collection and National Hospital Morbidity Database are established.

1994–95
The Institute holds a National Health Information Forum to help identify priorities for the next 5–10 years. The Disability Services Minimum Data Set is established and the first Australian health indicators report published.

1996–97
The National Community Services Information Agreement is endorsed and signed by the Commonwealth and the states and territories. The first MoU between the AIHW and the Department of Health and Family Services is signed. The first joint AIHW–Australian Bureau of Statistics report on The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples is released. The AIHW's first website is launched. The Institute contributes strongly to national data development in the areas of housing assistance (both long-term and short-term), disability services and child protection.

1997–98
Institute policies on privacy and data security are reviewed. The first National Community Services Data Dictionary is produced and development begins on the National Minimum Data Set for Community and Mental Health Care.

1998–99
The National Public Health Information Development Plan is produced. The Institute receives an award for excellence in data management from the Australian Branch of the Data Management Association for the National Health Information Knowledgebase (forerunner of today's Metadata Online Registry—METeOR). The first national data collection on community housing is completed and the first collection of performance data for Indigenous community-managed housing begins. Important data development work in child and youth health, mental health and palliative care is completed. The Institute is invited to be the Australian clearinghouse for adoptions data.

1987   1993   1994   1996

Board Chairs

The Institute is governed by a 15-member Board.

Emeritus Professor Peter H Karmel, AC, CBE (July 1988–June 1992)

Professor Fiona J Stanley, AC (July 1992–June 1995)

Professor Janice Reid, AM (July 1995–June 2001)

– Key achievements

Dr Richard Madden (January 1996–January 2006)

Dr Penny Allbon (February 2006–December 2010)

Mr David Kalisch
(December 2010–present)

1999–00
The first national Burden of Disease and Injury study and the first national report on the health status of young Australians (aged 12–24), Australia's Young People: Their Health and Wellbeing 1999, are published. The National Housing Data and National Indigenous Housing Information Agreements are signed. Several policies and guidelines to ensure the secure handling of data holdings in accord with proposed changes to the Privacy Act are introduced.

2000–01
An MoU with the Department of Family and Community Services (now FaHCSIA) is signed. The AIHW Act is amended in June 2001 to expand the scope of the Ethics Committee to cover welfare functions. The National Drug Strategy Household Survey is developed. The first National Housing Assistance Data Dictionary is produced.

2001–02
The Institute plays a major role in the implementation of the WHO's International Classification of Functioning, Disability and Health in Australia. It also contributes to the development and implementation in Australia of the Organisation for Economic Cooperation and Development's International Classification for Health Accounts. The AIHW Act is amended to allow for a single AIHW Health and Welfare Ethics Committee rather than the previous two committees.

2002–03
The Institute hosts the 2002 meeting of Heads of WHO Collaborating Centres for the Family of International Classifications. An MoU with the Department of Veterans' Affairs is signed. The first comprehensive report on diabetes, Diabetes Australian Facts 2002, is produced.

2003–04
The Charter of Corporate Governance is developed. The Institute undertakes substantial development work in the management of metadata to support national data standards in health, community services and housing assistance.

2004–05
Building on the development work of the previous year, the Institute releases its new Metadata Online Registry (METeOR). Health and Ageing Minister Tony Abbott and the Family and Community Services Minister Senator Kay Patterson launch two significant publications, the 2004 National Drugs Survey Household Survey report and A Picture of Australia's Children, respectively.

2006 -07
A relationship with the Canadian Institute for Health Information is established. A database of Pharmaceutical Benefits Scheme-subsidised prescription pharmaceuticals dispensed to people with respiratory diseases is set up. The Institute is commissioned to do all the detailed analysis for the Aboriginal and Torres Strait Islander Health Performance Framework

2008–09
The Institute plays a key role in the development of indicators for the Intergovernmental Agreements relating to health care, housing and homelessness, disability, and Indigenous reform. The Reconciliation Action Plan is launched.

2009–10
There is a large increase in staff numbers at the AIHW to support the development and reporting of data for the national performance indicators required by the Council of Australian Governments reform process, and for the development of a new Specialist Homelessness Services Collection to replace the old Supported Accommodation Assistance Program (SAAP) collection. The online Closing the Gap Clearinghouse is launched, in collaboration with the Australian Institute of Family Studies.

2010–11
The electronic Validata® data validation tool, which significantly enhances and speeds production of timely and quality data, is developed. Creative Commons BY licensing for publications and the website is implemented. A new online AIHW Indigenous Observatory and the MyHospitals website are launched.

2011-12
The new Specialist Homelessness Services data collection is launched. Development of an indicator-based reporting framework for early childhood development begins. The Institute is the first agency to be accredited as an Integrating Authority.

2006   **2010**   **2012**

Dr Sandra Hacker, AO
(August 2001–June 2004)

The Hon. Peter Collins, AM, QC
(August 2004–July 2011)

The Hon. Dr Andrew Refshauge,
MB, BS, FAICD (July 2011–present)

Community. Engaged. Honest.

Three of the AIHW's longest-serving staff members were asked to describe the Institute in one word — these are their choices.

Between them, Judith Abercromby, Joanne Maples and Nigel Harding have clocked up nearly 70 years at the Institute, with the 'fossil' trophy (an abacus solemnly passed from one fossil to the next) for the oldest of the old-timers belonging to Judith. She has a mountain of fond and funny memories, like standing in a library with little else but carpet and a phone on the floor. Shelves were on order, but there were no journals or books. The library, like so many other things the AIHW has achieved over its 25 years, had to be built from scratch.

Then there were the possums, semi-regular visitors to the offices, who brought work to a halt by falling through the ceiling or sleeping on the only fax machine. Unfortunately, the building pest controller could only be summoned by sending a fax. These were the days when the AIHW was known as the Australian Institute of Health and occupied Bennett House, a renovator's delight, in Acton. Staff would have lunch at the old Canberra Hospital cafeteria. Judith remembers pacing around the hospital car park in the early stages of labour, and being greeted by AIHW colleagues arriving for the day's work. They were also the days when everyone had a sink and a mirror in their office as they occupied what had previously been the nurses' quarters.

Judith, Joanne and Nigel all agree that the Institute has always been 'different' to other public service departments and agencies, and in the early days was regarded by some as a 'quaint academic backwater'.

All have witnessed enormous growth: in staff, budgets and reputation. The staff has grown from fewer than 70 to about 350, and while Nigel says, 'the days when you knew everyone are gone', all believe that the Institute has retained a 'family' feel that sets it apart from many other workplaces.

They say one of the biggest changes, and at times hurdles, has been the move away from the Institute's academic roots — in the early days staff would often follow lines of research based on personal interest and planned 'with a few mates in the car park'.

'The Institute had an academic colour and focus and saw itself as a branch of academia,' Nigel says. It was a feeling that was enhanced by being located next to the ANU.

Joanne's strong feeling of an AIHW family is enhanced by the fact that she has had three children since she joined in 1988, including 'the first baby born to Institute staff'. What started as a temporary transfer to the Screening Evaluation Coordination Unit has become a career winding through a half-dozen positions in both statistical and corporate groups, to a position today in the Governance Unit.

She says one of the fantastic aspects of working at the Institute has been the flexibility to work part-time to suit her life circumstances, including raising her children.

Another thing she loves is the 'fantastic young people arriving each year with a range of skills and backgrounds to add to the expertise here already', although she laments that such 'beautiful young people' insist on 'wearing black or navy – like a standard APS uniform!'

She says while the AIHW has far more policies and procedures than in the 1980s, it has grown and matured well.

'We were set up to improve health information because there was such a dearth. I think there is a general belief that we are doing something that is valuable for informing public policy; this is what the Institute started with and it is still doing it today.'

Joanne flicks through the first annual report to show that many of today's arrangements were there from the beginning, including links with three collaborating units, national information committees and external funders.

Asked to nominate a milestone, she chooses METeOR. 'Taking this on was an important decision for the Institute. It was really innovative at the time, and internationally people looked at the Institute with envy.'

If she has a regret, it is that the Institute no longer has a Health Technology Unit, which was established in the first year to assess new and established health-care technologies.

Nigel left Brisbane to join the Institute in 1991, taking on the role as Publications Manager. His health interest stems from 2 years working as an orderly at the Royal Brisbane Hospital. There was no media or communications team when he started, so before long he took on the role of writing media releases 'because there was no one else to do it'. Today he heads the Communications, Media and Marketing Unit— a position he has been appointed to twice, after leaving the Institute for a couple of years to work at the National Health and Medical Research Council.

He says one of the Institute's greatest strengths is that it 'tells it like it is. Our integrity has ensured our survival.'

For him, the stand-out milestones have been the provision of more timely data, particularly hospital statistics that were 'years behind' when the Institute began, and the Institute's role in developing and reporting on national health performance indicators. The launch of the Aboriginal health and welfare report in 1997 was another highlight. 'The Governor-General launched it in Darwin and it was huge front-page news everywhere the next day.'

He says one of biggest challenges has always been to communicate the results of the Institute's work in a way that 'can be easily understood and in a digestible fashion'.

Judith's career has spanned several areas of the Institute, from the library, website, intranet and publications to her current position as the head of the Ageing and Aged Care Unit, which she took up in late 2010. She says that 'after 23 years in corporate, it's good to see the other side of the Institute'.

Judith chose the word 'Community' to describe the Institute. In the past two-and-a-half decades she has moved offices and buildings numerous times, seen Directors come and go, and watched as units were formed and restructured. She says that through it all the staff's dedication to their jobs and friendships has endured.

'People here really care about what they do. I have a lot of lasting friendships that were formed here.'

The event that most sticks in her memory was when Dr Michael Wooldridge, then Health and Family Services Minister, launched the AIHW's first website in October 1996.

'We were not the first [government agency] to get a website, nor the last. But for me it was a particularly momentous occasion.'

Asked why they have stayed so long, all had pretty much the same answer: 'Because it is a nice place to be.'

ABOVE: From left to right – Emma Petrie, Genevieve Whitlam, Judith Abercromby, Alex Ness, Nigel Harding and Joanne Maples.

Social. Progressive. Welcoming.

Graduates Alex Ness, Genevieve Whitlam and Emma Petrie joined the Institute in November and like the AIHW 'old-timers' were asked to select a word describing their workplace.

Alex works in the Data Linkage Unit, laughs at the suggestion he is a data geek and says he found pretty much from his first day on the job that he 'fitted in better here' than at his previous workplaces.

He believes his word, 'Social', encompasses a range of Institute characteristics, including friendliness, a relaxed approach, an emphasis on work-life balance and an active sporting calendar. He points to the organisation's involvement in the Global Corporate Challenge as another indication of how well it encourages and supports its employees, and is still able to smile at the fact that he ruptured his Achilles tendon in January playing a game of social squash with a work colleague.

Alex was working as a research assistant at the Institute of Criminology when he applied for the AIHW graduate program. He has a psychology degree and says data analysis and research suit his personality more than the face-to-face side of the discipline.

At the moment he is working on a large-scale project looking at mortality rates for end-stage kidney disease, and believes the Institute offers a breadth of work opportunities that will enable him to develop his skills across many areas.

Genevieve is also a psychology graduate, but unlike Alex has worked as a family therapist in disability and child protection. After 5 years 'at the ground level watching families struggling to get food on the table for their kids', she decided it was time to see the other side of the picture.

She says, 'When you are working directly with clients, the collection of data can seem a process which is a bit removed from your core business. Now, working at the AIHW, I can see the importance of the accurate reporting and collection of this data and how it can inform policy.'

Inspired by her mother's career as a nurse, Genevieve's first job was as a carer for people with severe cerebral palsy.

'I have always wanted to do meaningful work.' While she does miss aspects of working with parents and children, she says the AIHW's work is meaningful in a different way.

'On the ground level you notice things that could be done better. Here, it is about the 'how'. How can we can support improvement?; the nuts and bolts of getting it to happen is a big challenge.'

Genevieve works in the Functioning and Disability Unit and is studying a double master's degree in public health and health management. She says if more people in need are to be helped, it's crucial that the systems between the client and service provision are more efficient. She believes the Institute has a central role in the dissemination of accurate data to inform policy and improve these systems and processes, hence her word 'Progressive'. 'We are trying to improve processes.'

Emma works in the Publishing Services Unit. She joined the Institute from ACT Health and before that worked for a Melbourne media training company after finishing postgraduate studies in editing and communications.
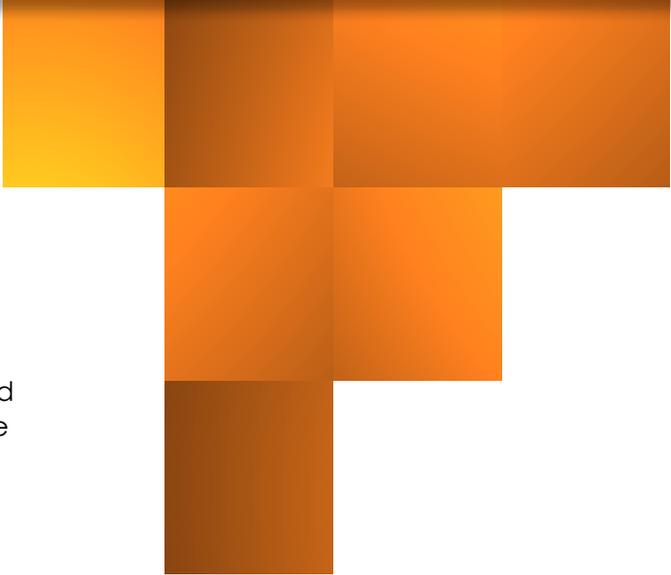
Her focus at the moment is on improving and broadening her editing skills and experience and her long-term goal is to write fiction full time. In the meantime, she sees herself at the AIHW for the 'foreseeable future', partly because of the welcoming atmosphere she has found since joining.

She says the Institute offers an environment that is more accepting of work-life balance than the private sector, and also believes that being at arm's length from government leads to a much calmer work environment where 'everyone reacts to what we do' rather than the opposite.

New National Health Workforce Data – a step in the right direction

Australia has a new national system for registering a number of key health workforce groups. The AIHW, in collaboration with Health Workforce Australia, is the custodian of the National Health Workforce Data Set (NHWDS) that describes these professionals and the work they do.

The NHWDS combines data from the National Registration and Accreditation Scheme (NRAS) with health workforce survey data collected when annual registrations are renewed. The mandatory registration process is administered by the Australian Health Practitioner Regulation Agency (AHPRA) and includes an optional survey that collects additional demographic and workforce information.

All practitioners in these professions must be registered with the AHPRA to practise in Australia, and this applies whether they trained in Australia or overseas. The AHPRA manages the NRAS, which replaced jurisdiction-based registration with a single national registration and accreditation system. As part of this scheme, the AHPRA supports National Health Practitioner Boards, which regulate registered health professions under nationally consistent legislation. Registration for each profession is granted by the relevant boards, subject to applicants meeting the standards and policies set by each.

At its introduction, the NRAS covered registration for 10 health professions, with another four scheduled for inclusion from 1 July 2012 (see below). In all, this represents more than 530,000 registered health professionals.

Professions included in the National Registration and Accreditation Scheme

Since 1 July 2010, these professions have been regulated:

- chiropractors
- dental practitioners (including dentists, dental hygienists, dental prosthetists and dental therapists)
- medical practitioners
- nurses and midwives
- optometrists
- osteopaths
- pharmacists
- physiotherapists
- podiatrists
- psychologists.

From 1 July 2012, these health professions will be included:

- Aboriginal and Torres Strait Islander health practitioners
- Chinese medicine practitioners
- medical radiation practitioners
- occupational therapists.

ABOVE: From left to right – Stephen Dent, Janice Miller, Vicki Bennett and Ian Titulaer, from the AIHW's Labour Force Unit.

First results already released

The first report produced by the AIHW using this new data set was *Medical Workforce Survey 2010*, released in April this year. This report is on the AIHW website at **http://cms.aihw.gov.au/ publication-detail/?id=10737421480**. It provides nationally consistent estimates of the medical workforce, and data not readily available from other sources, such as: the types of work medical practitioners do and their job setting; the number of hours worked in a clinical or non-clinical role, and in total; and the numbers of years employed in the medical workforce. The survey also provides information on registered medical practitioners who are not undertaking clinical work or employed.

Its key finding followed those of previous surveys, which showed that the number of medical practitioners in Australia was increasing (13% between 2006 and 2010) and the supply of doctors in outer regional areas had improved.

The proportion of women in the workforce also continued to grow, from 34% in 2006 to 37% in 2010, while the average age of all practitioners remained stable at 46.

The average weekly hours worked by employed practitioners decreased slightly from 43.5 in 2006 to 43.3 in 2010. Average hours worked by men decreased slightly, while those worked by women increased.

The supply of practitioners varied across areas of remoteness, ranging from 400 full-time equivalent practitioners per 100,000 people in *Major cities* to 185 per 100,000 people in *Outer regional* areas.

Between 2006 and 2010, the number of employed practitioners in *Major cities* increased by 10.0% and in *Outer regional* areas by 11.9%, which was more than the population growth in these areas.

10 new publications in 2012

During the remainder of 2012, the AIHW Labour Force Unit will publish reports on each of the 10 professions re-registered in 2011, starting with nursing and midwifery due for release in June.

Each report will outline demographic information, as well as provide important information on work patterns and locations.

Workforce needs for the future

The NHWDS is a key component of the data collected in the health sector, which helps describe existing practitioners and plan for future needs. Health Workforce Australia uses the data set for its planning and projections to ensure Australia has a sustainable health system to meet existing and emerging health-care needs.

Specialist Homelessness Services Collection: first results

Despite Australia's ongoing economic prosperity, homelessness continues to affect a large number of people. The implementation of the Specialist Homelessness Services Collection (SHSC) on 1 July 2011 was a significant milestone in the availability of data about people who receive assistance because they are homeless or at risk of homelessness.

The SHSC, which is collected and reported each month by agencies that provide services targeted to homeless people and those at risk of homelessness, collates information about all clients who receive services. This includes data about clients':

- recent and current circumstances at the time they present to the agency
- circumstances at the end of each month (while they receive support)
- circumstances at the end of the period of support
- assistance received throughout the support period.

Some basic information is also collected on clients who seek assistance because they are homeless, or at risk of homelessness, but do not receive assistance.

The SHSC replaced the Supported Accommodation Assistance Program (SAAP) National Data Collection (NDC), which had been reported by agencies since 1996. The SHSC has a number of advantages over the SAAP NDC, including:

- capturing more comprehensive data about all clients
- capturing more complete data about children who receive assistance from specialist homelessness agencies
- better data collection and validation tools
- more regular data collection (monthly rather than six-monthly).

This means that, as well as providing up-to-date data on all clients who receive services from specialist homelessness agencies, there is greater potential to highlight populations of interest. This is evident in the recently released report, *Specialist Homelessness Services Collection: first results (September quarter 2011)*, which presents data for July to September 2011. The report outlines the major findings of the collection (see the highlighted box on page 13), as well as focusing on five groups of special interest. Highlights from those groups include:

Indigenous clients

- 19% of clients were of Indigenous origin.
- Indigenous clients are relatively young compared with non-Indigenous clients—39% are under 18 compared with 29% of non-Indigenous clients.

Children

- Most children who were clients of agencies in the September quarter 2011 were under 10 (58%, or 18% of all clients), 20% were 10–14 and 22% were 15–17.
- One-third of all children (32%) attended the agency on their own.

People escaping domestic and family violence

- People escaping domestic and family violence (including children) were predominantly female, and 22% were children under 10.
- Forty-three per cent of all clients who were identified as escaping domestic and family violence received accommodation services, and 19% did so for more than 6 weeks.

People experiencing primary homelessness

- Males were more likely to have experienced primary homelessness (that is, slept rough, lived in non-conventional accommodation, or in an improvised dwelling or car) shortly before (or during) their period of support from the agency. Males accounted for 55% of this population.
- Children and young people (aged under 18) accounted for 21% of clients who had experienced primary homelessness.

People leaving care and custodial settings

- Five per cent of all clients who received assistance from an agency had recently left a care or custodial setting—40% of these clients received services after leaving a care setting such as a hospital, 33% after leaving a custodial setting (such as an adult correctional facility), and 27% were young people who had a care or protection order in place when they became clients.
- Most clients in these client groups received accommodation services as part of their support.

What the report found:

- In this quarter, an estimated 91,627 clients were assisted by specialist homelessness agencies, of which 59% were female.
- Eighteen per cent of clients were under 10 and half under 25.
- In 31% of support periods, clients had lived in short-term or emergency accommodation in the month before presenting for support, and 19% had 'slept rough'.
- Most clients presented to agencies alone (66%), but more than one-third presented with children or were themselves children.
- Domestic and family violence was the most common main reason for seeking assistance (26%).
- Short-term or emergency accommodation was identified as a need for clients in 32% of support periods, medium-term/transitional housing in 23% of support periods and long-term housing in 26% of support periods.
- Accommodation was provided in 16% of all support periods in the quarter.
- 'Assistance to sustain a tenancy or prevent tenancy failure or eviction' was identified as a client need in 21% of support periods.
- Based on closed support periods, some modest improvements over the quarter were evident for clients as a whole in relation to their housing situations:
  - Before and at the end of support, most clients were living in a house, townhouse, or flat (65% at the beginning of support; 66% at the end).
  - There was a small decrease in clients who had no dwelling, were living in a motor car or in an improvised dwelling (10% at the beginning of support; 7% at the end).
- The report can be found on the AIHW website **http: aihw.gov.au/ publication-detail/?id=10737421507**.

Looking ahead: cancer projections for 2020

Cancer has touched the lives of most Australians in some way. Its impact is felt among individuals, families and the health-care system—and the number of Australians affected is forecast to rise.

Cancer is estimated to be the leading cause of burden of disease in the nation, and the number of new cases is predicted to rise by 40% between 2007 and 2020. This means the number of Australians diagnosed with cancer each year is expected to reach 150,000 by 2020.

'But the news isn't as bad as it sounds,' the Head of the Institute's Cancer and Screening Unit, Christine Sturrock, says.

'The increase in cancer cases is largely a result of an increasing population. So, for many types of cancer, while it looks like the number of cancer cases is climbing, the rate, that is, the number of cases diagnosed per 100,000 people, will actually stay the same.'

The increase in cancer incidence is also linked to Australia's ageing population.

'Cancer is more prevalent in older age groups, so the ageing of Australia's population will also have an impact on cancer rates and prevalence,' Ms Sturrock said.

Cancer projections are important for health service planning and resource allocation in the future.

'Investment decisions in cancer treatment facilities, workforce planning and evaluation of cancer policy rely not only on knowing how many cases of cancer were diagnosed in a given year, but on how many can be expected to be diagnosed in the future,' she said.

The latest report, *Cancer incidence projections, Australia 2011 to 2020*, presents detailed projections of the number of new cases expected to occur each year to 2020. These projections are based on past trends in national cancer incidence data between 1982 and 2007.

The projections are presented for males and females at the national level for all cancers combined, as well as the most commonly diagnosed cancers.

Cancer rates likely to fall for men

For men and boys, the total number of cases is predicted to rise; however, the cancer incidence rate (new cases per 100,000 people each year) is actually predicted to fall.

'Among males, cancer incidence is highly influenced by prostate cancer, which accounts for about 30% of all cases and is the second most common cause of cancer-related death in males after lung cancer,' Ms Sturrock said.

Incidence rates of prostate cancer in Australia have fluctuated since 1982. Early detection and changes in diagnostic procedures have contributed to the sharp increases in the incidence rate in recent decades.

'However, if we assume that prostate cancer incidence will stabilise in the future, then this is expected to lead to an overall fall in cancer incidence rates in males from 595 to 568 cases per 100,000 between 2007 and 2020,' Ms Sturrock said.

Prostate cancer is expected to remain the most common cancer diagnosed among males in 2020, followed by bowel cancer and melanoma of the skin.

Rates of lung, stomach and pancreatic cancer for males are also projected to fall.

'Unfortunately the news isn't so good for other cancers among men,' Ms Sturrock said.

'Rates are expected to rise for cases of melanoma as well as liver, thyroid and testicular cancer.'

Rising rates predicted for women

Among women and girls, the overall cancer incidence rate is projected to rise from about 394 to 408 cases per 100,000 between 2007 and 2020.

'For women, increases are expected in rates of melanoma, lung, liver and thyroid cancer, while rates of stomach cancer are expected to fall,' Ms Sturrock said.

Breast cancer is the most commonly diagnosed cancer in females and is projected to continue to be the most common cancer diagnosed in females in 2020, followed by bowel cancer, melanoma and lung cancer.

'Over time, there have been a number of changes in the incidence trends of breast cancer among women,' Ms Sturrock said.

'For example, there was a sharp increase in the rate of breast cancer diagnosed between 1990 and 1995, which was most likely due to the introduction of mammographic screening programs between 1989 and 1994.

'Between 1995 and 2002, incidence rates slowed and in recent years we have noticed a very slight decrease in rates.

'Unfortunately, it isn't possible to tell if this decrease will continue, and we estimate that age-standardised rates of breast cancer will remain constant at about 113–114 cases diagnosed per 100,000 females each year between 2011 and 2020.'

Screening expected to slow rates of bowel cancer

In Australia, bowel cancer is the second most commonly diagnosed cancer in males.

Bowel cancer also accounts for 10% of all deaths from invasive cancers, making it the second most common cause of cancer-related death after lung cancer.

Based on trends to 2007, incidence rates are projected to fall in men, and remain stable in women. However, the introduction of the National Bowel Cancer Screening Program from 2006 is expected to reduce the incidence of bowel cancer in the long term as pre-cancerous conditions are detected and treated.

Rising rates of melanoma

Exposure to ultra-violet radiation, from both the sun and solariums, is the major cause of melanoma in Australia.

Skin cancer prevention programs have operated in all Australian states and territories since the early 1980s, resulting in a significant slowing in the upward trend of melanoma. But melanoma of the skin is still the third most commonly diagnosed cancer in males.

The incidence of melanoma rose by 151% in males and 46% in females between 1982 and 2007. To what extent this rise is due to an increase in the underlying disease, or due to improved detection methods, is unknown.

'We expect that melanoma in men will continue to increase to about 74 cases diagnosed per 100,000 males in 2020, with the largest increase expected to occur in men aged 65 and over,' Ms Sturrock said.

'Melanoma in women is also expected to increase, with around 45 new cases diagnosed per 100,000 females in 2020.'

Lung cancer drops with decreased smoking

Lung cancer is the fifth most commonly diagnosed invasive cancer in Australia, and causes more deaths than any other cancer in both males and females because of its high incidence rate and low survival rate.

Tobacco smoking is the largest single risk factor for lung cancer in Australia, and is responsible for about 90% of lung cancers in males and 65% in females. Trends in smoking have changed over time and vary for males and females. Rates of smoking in males have dropped from an estimated 58% in 1964 to 18% in 2007. For females, the overall smoking rate peaked in the mid-1970s at about 33%, but more than halved to 15% in 2007.

'The incidence rate of lung cancer among men decreased significantly between 1982 and 2007,' Ms Sturrock said.

'Following this trend, we expect that lung cancer in males will continue to fall from about 58 cases diagnosed per 100,000 males in 2007 to about 49 cases per 100,000 males in 2020.'

Unlike the decreasing trends for men, trends in the rate of lung cancer for women have been increasing since 1982, consistent with the later peak in the smoking rate of women. Increases have slowed since 1990 but lung cancer in females will continue to rise slowly from about 31 per 100,000 females in 2007 to about 36 cases per 100,000 females in 2020.

If the number of Australians who smoke continues to fall, which is expected, the incidence of lung cancer will be further reduced in the future.

Which cancers are on the rise?

- Liver cancer
- Thyroid cancer
- Melanoma
- Testicular cancer
- Lung cancer in females

Which cancers are decreasing?

- Stomach cancer
- Bladder, lung and pancreatic cancer in males

Privacy Awareness Week at AIHW

Privacy Awareness Week occurs in the first week of May each year. The theme for this year was—Privacy: it's all about you.

As the recipient and user of sensitive personal data, the Institute places a high priority on privacy matters. We make it part of our daily business because:

- Firstly, it is the law. This is set out in the Privacy Act and our own legislation, the AIHW Act.

- Secondly, if we do not properly protect the data we receive, our sources may not agree to provide us with sensitive information.

- Thirdly, we want to maintain our reputation for integrity in handling data. With our increasing role in data integration, this has assumed even more importance.

During the week, staff took part in several activities to raise awareness of the Institute's responsibilities in relation to privacy, including a presentation by the Governance Unit on privacy and how it relates to the work of the AIHW Ethics Committee. The Ethics Committee is a key component of the Institute's governance arrangements and oversees the AIHW's privacy and confidentiality obligations.
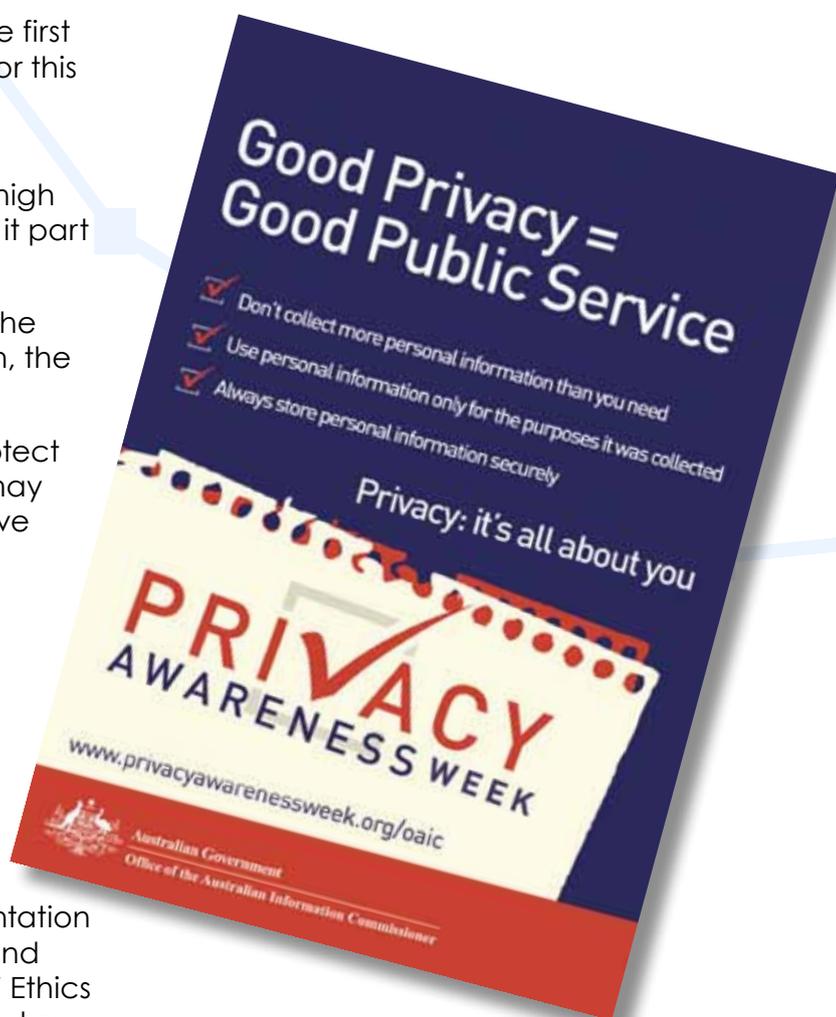
Further information

The AIHW operates under a strict privacy regime, which has its basis in section 29 of *The Australian Institute of Health and Welfare Act 1987*. Our record of protecting the security of the data we hold on the health and welfare of Australians is exemplary. The AIHW Board closely monitors the Institute's performance on maintaining the privacy of its data, and has commissioned and endorsed a range of policies and practices on data privacy.

Further information on privacy at the AIHW is on the AIHW website: **http://www.aihw.gov.au/privacy-of-data/**.

Child protection Australia 2010-11
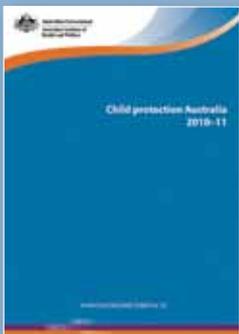
Child Protection Australia 2010–11 is the fifteenth annual comprehensive report on child protection. It provides detailed statistical information on state and territory child protection and support services, and some of the characteristics of the children receiving these services. In Australia, child protection is a state and territory government responsibility. There are significant differences in how each jurisdiction deals with and reports child protection issues that need to be taken into account when making comparisons.

Notifications decreased while substantiations remained stable

Since 2009–10, the number of children subject to a notification decreased by 13% from 187,314 to 163,767. During the same period, the number of children subject to a substantiation of a notification remained relatively stable (increasing by less than 1%) from 31,295 to 31,527. Since 2006–07, the number of children subject to a substantiation of a notification has decreased by 7% from 34,028 to 31,527 (6.9 to 6.1 per 1,000 children).

Number of children on care and protection orders and in out-of-home care continues to rise

Since 2009–10, the number of children on care and protection orders increased by 4% from 37,730 to 39,058 (7.4 to 7.6 per 1,000 children). This increase is consistent with the trend over the last 5 years (increasing by 35% from 28,954 in 2007).

The number of children in out-of-home care has increased by 5% from 35,895 in 2010 to 37,648 in 2011. Since 2007, the number of children in out-of-home care rose by 33% from 28,379 to 37,648 (5.8 to 7.3 per 1,000 children).

The majority of children (93.5%) in out-of-home care at 30 June 2011 were in home-based care—45% in foster care, 46% in relative/kinship care and 2.5% in other types of home-based care. This follows a similar pattern observed in previous years.

Aboriginal and Torres Strait Islander children continue to be over-represented in the child protection system

In 2010–11, Aboriginal and Torres Strait Islander children were almost 8 times as likely to be the subject of substantiated child abuse and neglect as non-Indigenous children (rates of 34.6 and 4.5 per 1,000 children, respectively).

At 30 June 2011, the rate of Aboriginal and Torres Strait Islander children on care and protection orders was more than 9 times the rate of non-Indigenous children (rates of 51.4 and 5.4 per 1,000 children, respectively). Similarly, the rate of Aboriginal and Torres Strait Islander children in out-of-home care was 10 times the rate of non-Indigenous children (rate of 51.7 and 5.1 per 1,000 children, respectively.

National Bowel Cancer Screening Program monitiring report: Phase 2, July 2008–June 2011
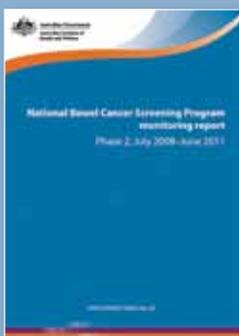
The National Bowel Cancer Screening Program (NBCSP) aims to reduce the incidence, illness and mortality related to bowel cancer in Australia by screening to detect cancers and pre-cancerous lesions in their early stages, when treatment will be most successful.

Phase 2 of the NBCSP ran from 1 July 2008 to 30 June 2011 and invited people turning 50, 55 or 65 between 1 January 2008 and 31 December 2010 to take part. During Phase 2, the program was suspended for about 6 months after the screening test was found to be returning a higher rate of negative results than expected. Remediation actions to retest those who may have been affected were undertaken and the apparent effects are also presented in this report.

How many people participated in Phase 2 of the NBCSP?

About 38% of the 2.1 million people invited in Phase 2 returned a completed bowel cancer screening kit for analysis. This overall participation rate was slightly lower than Phase 1, due to the inclusion of 50 year olds in Phase 2, as participation for the other two ages increased in Phase 2.

How many positive screening results were returned in Phase 2?

About 62,000 participants (7.8%) who returned a valid screening test had a positive screening result. These people were encouraged to follow up this result by visiting their primary health care practitioner for further investigative testing (colonoscopy).

About 71% of those with a positive screening result were recorded as having had a colonoscopy.

How many bowel cancers and adenomas were detected in Phase 2?

One in 33 colonoscopies performed to follow up a positive screening result diagnosed a confirmed (253) or suspected (868) cancer, while advanced adenomas were found in a further 3,333 participants (1 in 11 colonoscopies). Adenomas are benign growths that have the potential to become cancerous, and their removal is likely to lower the risk of future bowel cancers in these patients.

From the available NBCSP data, almost 80% of bowel cancers removed (resected) were in the earliest two (of four) stages of cancer spread.

Were there differences between subgroups participating in the NBCSP?

Women were more likely to screen than men; conversely, men had higher rates of screen-detected bowel cancers and overall bowel cancer incidence and mortality.

Aboriginal and Torres Strait Islander participants, participants who spoke a language other than English at home, and participants who lived in *Inner regional areas* and *Outer regional areas* or areas of lower socioeconomic status had higher rates of positive screening results, yet lower rates of follow-up colonoscopies than other participants.

Further information

Communications, Media and Marketing Unit
Phone: (02) 6244 1032
Email: info@aihw.gov.au

AUSTRALIA'S HEALTH 2012

Australia's health 2012 is the most comprehensive and authoritative source of national information on health and health services in Australia. The report contains information about:

- **Australia's health in context**
- **Living (and dying) in Australia**
- **How healthy are Australians?**
- **Protecting and promoting health**
- **Health behaviours and risks**
- **Causes of ill health**
- **Treating ill health**
- **The economics of health**
- **Health workforce; and**
- **Supporting Australia's health: research and information**

If you are interested in health, *Australia's health 2012* is an essential reference for your bookshelf!

To order copies of *Australia's health 2012* visit **www.aihw.gov.au**.

R.R.P. $60

Follow us on Twitter: **@aihw_aushealth**

In the pipeline...

Conferences

21 JUNE 2012

- ***Australia's health 2012*** report launch and conference.

Events and meetings

JUNE 2012
- 4 June   Audit and Finance.
- 5 June   Ethics Committe.
- 14 June   Board meeting.
- 26 June   MyHospitals meeting.

JULY 2012
- 6 July   Housing and Homelessness Information Management Group Meeting.

Publications

JUNE 2012

- *Insurance and use of dental services: National Dental Telephone Interview Survey 2010.*

- *Trends in the Australian Dental Labour Force, 2000 to 2009: dental labour force collection, 2009.*

- *The health of Australia's males: a focus on five population groups.*

- *Australia's health 2012.*

- *Australia's health 2012: in brief.*

JULY 2012

- *Australia's food and nutrition.*

new releases

Trends in the Australian Dental Labour Force, 2000 to 2009: dental labour force collection, 2009

Published 14 June 2012.

Hospitalisations due to falls in older people, Australia 2008-09

This report is the fifth in a series of reports on hospitalisations due to falls by older people in Australia. It focuses on hospitalised falls that occurred in the financial year 2008–09.

Published 1 June 2012.

Constructing and maintaining houses

This is a Closing the Gap Clearinghouse report

Published 29 May 2012.

Education programs for Indigenous Australians about sexually transmitted infections and blood borne viruses

This is a Closing the Gap Clearinghouse report

Published 29 May 2012.

Engaging Indigenous students through school-based health education

This is a Closing the Gap Clearinghouse report

Published 29 May 2012.

Child Dental Health Survey Australia 2007: 30-year trends in child oral health

The Child Dental Health Survey provides national information on the dental health of children attending school dental services in Australia, and shows that tooth decay is relatively common in Australian children. This publication describes trends in oral health of Australian children between 1989 and 2007. Over this period, caries has declined markedly in the permanent teeth of children aged 12, but declined far less in the deciduous teeth of children aged 6.

Published 25 May 2012.

Australia's public sector medical indemnity claims 2009-10

This report presents data on the number, nature and costs of public sector medical indemnity claims for 2005-06 to 2009-10, with a focus on 2009-10 claims. There were more new claims in 2009-10 (1,620) than in any of the three previous years (about 1,130 to 1,270 claims per year). As in previous years, the three health services most often implicated were Emergency department, General surgery and Obstetrics.

Published 18 May 2012.

Public and private sector medical indemnity claims in Australia 2009-10

This report presents information on public and private sector medical indemnity claims for 2009-10. There were 9,415 medical indemnity claims open at some point during the year, including 2,900 new claims. A total of 2,647 claims were closed during the year. The main clinician specialties allegedly involved in the incidents giving rise to claims were General practice and Obstetrics and Gynaecology.

Published 18 May 2012.

Cervical screening in Australia 2009-2010

Cervical screening in Australia 2009-2010 presents the latest national statistics monitoring the National Cervical Screening Program, which aims to reduce incidence, morbidity and mortality from cervical cancer.

About 57% of women in the target age group of 20-69 took part in the program, with more than 3.6 million women screened in 2009 and 2010. Cervical cancer incidence in this age group remains at a historical low of 9 new cases per 100,000 women, and deaths are also low, historically and by international standards, at 2 deaths per 100,000 women.

Published 1 May 2012.

Australia's hospitals 2010-11 at a glance

Australia's hospitals 2010-11 at a glance provides information on Australia's 1,340 public and private hospitals. In 2010-11, there were 8.9 million hospitalisations, including 2.2 million admissions involving surgery. Public hospitals provided 7.7 million non-admitted patient emergency services, with 70% of patients seen within recommended times for their triage category. This publication is a companion to Australian hospital statistics 2010-11.

Published 30 April 2012.

Australian hospital statistics 2010-11

Australian hospital statistics 2010-11 presents a detailed overview of Australia's public and private hospitals. In 2010-11, there were 8.9 million separations from hospitals including: 4.9 million same-day acute separations; 3.5 million overnight acute separations; and about 367,000 sub-acute and non-acute separations. There were also 7.7 million non-admitted patient emergency services and almost 43 million outpatient services provided by public hospitals.

Published 30 April 2012.

Younger people with disability in residential aged care 2010-11

This bulletin presents data on the Younger People with Disability in Residential Aged Care (YPIRAC) initiative, which aims to reduce the number of people with disability aged under 65 who live in residential aged care. Between 2005-06 and 2010-11, an estimated 1,432 people have been helped, including 250 who have been moved out of residential aged care and into accommodation that better suits their situation, 244 who were successfully diverted away from entering residential aged care, and 456 who were provided with enhanced services while in residential aged care.

Published 26 April 2012.