

**Australasian Mortality Data Interest Group (AMDIG) Face to Face
Meeting
School of Public Health, QUT Kelvin Grove Campus
O Block, C Wing, Room 705
Monday November 29, 2004, 9:00am – 4:00pm**

Minutes

1. Attendance in person

Chair-Richard Madden (RM), Ching Choi (CC), Tara Pritchard (TP), Christine Fowler (CF), Sue Walker (SW) and Garry Waller (GW). Charles Naylor joined the meeting at Item 1.

Attendance by teleconference 1:30 - 3:30:

James Harrison (JH), Renate Kreisfeld (RK), Greg Curry (GC), Len Smith (LS), Heather Booth (HB).

2. Apologies

Stephen Begg, Mary-Lou Fleming, Jessica Pearse.

Face to face meeting

3. Welcome and Introductions

RM welcomed participants and outlined plans for the day. Because of lower numbers than expected the breakout sessions were abandoned in favour of group discussion on each Agenda Item.

4. Previous minutes:

GW circulated previous minutes (AMDIG 23 June 2004 meeting) and a copy of the minutes was tabled. Minutes had been circulated to members with Ron Casey making minor changes to wording.

4.1 Action Items from previous minutes:

4.1.1 Issues from AIHW Conference

RM had not completed this.

4.1.2 QUT mail server problems

Issue of bouncing messages from subscribers with Auto-reply messages resolved by QUT IT Services.

4.1.3 Acts of terrorism

SW had discussions with TP at NCCH Executive Committee meeting about how Australia is approaching this issue. The ABS captures data about incidents of death due to terrorist acts but there will be no change to coding practice or adoption of the new codes suggested by US colleagues.

Noted that this issue is relevant to national disaster planning system but terrorist acts are not currently formally identified or defined. Also relevant for national morbidity data capture.

CC recommended follow up with Commonwealth interdepartmental committee (Mary Murnane is chair) established within Health, to work on disaster planning for Australia.

The ABS is planning re-specification of the deaths system and is including space for user requirements which will be either a flag or new module to capture specific events. The capture of terrorism as an external cause is also a consideration for morbidity data.

Discussion followed about the process for capturing information on Australians who die while overseas. TP stated that overseas deaths of Australian citizens are not currently recorded. All deaths in Australia are collected, even those of visitors to Australia. CF noted that there is no registration system for New Zealanders who die overseas. NZ does collect some information but does not systematically capture information on all deaths of NZ citizens while out of country.

The immigration department is informed of the deaths of Australians outside of Australia

Action: RM to engage with Mary Murnane regarding options for identifying and counting deaths arising from terrorist acts.

4.1.4 NCIS Newsletter Coronial Communiqué

There were issues re publication of details of coroners' cases from each jurisdiction for which JH was to follow up with NCIS. Will check with JH during teleconference.

5. Capacity building for analysis, data collection and processing

In understanding mortality trends, there are two issues to be considered: data and analysis. Data items are collected but quality of the data (such as socio-economic data, occupation etc) is unknown.

A National Minimum Data Set (NMDS) for mortality is currently being developed by the ABS and the NCCH with the aim of standardising data collection from the jurisdictions. The development of the NMDS on mortality data is welcomed by the ABS, NCCH and AIHW. The Registrars-General are also currently discussing standardisation of electronic systems across jurisdictions.

The ABS has also commissioned a project looking at data quality in all of its administrative collections with a view to applying quality tests at each point of processing. Quality indicators are being developed to present and support business cases and to make quality declarations for each collection. The project originated from concerns regarding indigenous data but is now much broader in scope.

TP noted that the ABS has introduced a new system for coding occupational data from 2005 following trials in 2004. The system is a metadata driven automated process which can learn from its own experience.

CN referred to the effect poor documentation by certifiers has on the quality of data collected, and suggested that education campaigns be implemented with the introduction of electronic registration systems. Selected edits within these systems should see an improvement in the quality of documentation and subsequently, in coded data. In New Zealand, a training program for interns is provided through co-ordinators of training.

It was suggested that possibly the Deans of medical schools could be engaged directly regarding the development of documentation and death certification education. However, CN believes 'smart' certification software is the only way to make improvements – but we need to engage with Births Deaths and Marriages Australia (BDMOZ) to ensure that quality issues are discussed.

Note: BDMOZ has now been absorbed by the Council of Australasian Registrars (COAR).

During general discussion regarding ABS relationship with registrars, it was noted that it was necessary to consult registrars on the NMDS for mortality data developments.

Questions were also raised about the ABS Cause of Death Certification Australia booklet that is distributed to medical students and clinicians. GW noted that the current version was produced in October 2001. The booklet

was reviewed at that time and edited to provide ease of access to important information and included a quick reference guide. The booklet is edited and reprinted when ABS stocks decline. It was pointed out the pressure on young doctors, whose responsibility it is to complete the Medical Certificate of Cause of Death (MCOCOD), often for patients whom they have not seen before. There is often reliance on information documented in the medical record although the certifier is required to give his/her best medical opinion as to the COD.

CC asked whether, with the introduction of electronic health records, it would be possible for pertinent information to be populated into the MCOCOD directly from the electronic health record. Agreed that administrative data could be captured this way but that differences in the guidelines for reporting morbidity and mortality data mean that the diagnostic information in medical records is not easily transferable to death certificates in many cases.

ABS' quality processes, query letter action and education of certifiers were further noted. The issue of decreasing confirmatory autopsy rates was raised, the issue being that frequently a different COD is assigned following autopsy compared with the tentative COD prior to autopsy

5.1 Timeliness of data

General discussion was held on the timeliness of reported data released by the ABS. Given that ABS receives data from RGs on a monthly basis, how early can data be made available and what quality issues are there with early release? Can ABS publish monthly preliminary deaths data?

CN stated that fluctuations in deaths, such as increased deaths during heat waves or because of bad batches of drugs of abuse, and the subsequent investigation of these cases is subject to each coroner's jurisdiction. It is difficult to get timely data from coroners as these investigations are generally an ongoing process. Noted differences in coronial processes where a death is referred to the coroner. For example, in Queensland the coroner can change an original certificate to reflect the results of his/her investigation, but in other jurisdictions the death is referred to the coroner who then writes the certificate as part of his/her investigation. The very cases where timely data are needed are usually those cases where it is most difficult to get the data.

5.2 Data collection

Is it possible to make better use of coroners', registrars' and other information to enhance quality and detail of COD? Noted that 60% of male suicide cases had no other information other than the COD identified as suicide i.e. no other diagnoses or multiple cause information is reported. For female suicide cases 40% have no multiple causes reported.

The major question is whether the information is being recorded or captured in the process of investigation. If it is, why isn't it appearing on the MCOCOD? Do all coroners use the same certificate or data collection tool? Need for standardised forms across jurisdictions. The National Coronial Information System (NCIS) data base does not contain all information regarding the circumstances surrounding an injury event. It was noted that doctors tend to limit information in cases of suicide for social or family reasons.

TP stated the ABS is currently looking at the 2003 deaths file. There are concerns about quality of data on NCIS, leading to poorer quality codes which can be assigned. The ABS is to talk with NCIS about this issue. It was noted that the AIHW is on the Board of NCIS but ABS is not. The Victorian Institute for Forensic Medicine (VIFM) has taken over the operations of the NCIS from Monash and their funding base has changed. Queensland is only a recent sign up to the NCIS agreement and was the last state or territory to sign on.

5.3 Data Analysis

Analytical skills in Australia are divided between different disciplines: demographers, public health researchers and geographers. There is no good general idea of the analytical skill levels of Australian researchers in using Australian mortality data and it is therefore unknown how well ABS data can be understood and used.

CC noted that the \$10 million PHERP program is due to finish in June 2005 and queried whether the program had included training in data analysis or only policy making?

RVH thought that it is not clear what should be done with multiple cause information. ABS publishes UCOD and MCOD for particular conditions and produces an increasing number of specific publications using the MCOD data. TP stated that the ABS has a new dissemination strategy. Part of this strategy has been for ABS Output staff taking orders or enquiries from clients to explain and offer the extra benefit of MCOD data. Feedback from staff indicates that there is little or no interest in MCOD data and the response is generally along the lines of "no thanks underlying cause will do". It was pointed out that these are regular large clients with a specific clinical interest, such as the Asthma Foundation, Heart Foundation etc.

GW suggested that perhaps the benefits of MCOD data could be shown by analysing the data that could be used by these regular clients and then demonstrating how much more information MCOD data can provide compared with UCOD data alone.

RVH stated that the AIHW now has 6 years of MCOD data. He stated that the Institute is aiming to develop its mortality data publications from the current table format to more analytical publications to be produced using multiple cause data. The ABS also plans to produce more specialty publications using MCOD data targeted at areas identified in National Health Priorities. RM

questioned what had happened to the expert commentary from the AIHW that used to endorse the annual ABS Deaths publications? This had allowed the AIHW to provide a commentary on a year's deaths data and deal with subsequent media enquiries.

Action: RM to pursue expert commentator on COD.

The best way to present MCODE data, alphabetically or as listed on the MCODE, was raised. RVH further questioned that, if publishing in listed order, how can multiple causes of death from Parts 1 and 2 of the certificate be differentiated. CN queried the value of the effort in choosing a specific order for these COD in Part 2 of the certificate, which he described as somewhat of a 'lottery' as to the order that the certifier documents them. He believes that their ordering really means nothing. RM stated that both orders should be available and TP agreed, noting that it is easier from a processing point of view, if COD don't need to be in a particular order. The Mortality Medical Data System (MMDS) software can supply MCODE from Part 1 in the order they appear on the certificate.

CN pointed out the potential value of electronic death certification and registration to draw out other factors in COD and recommended that a coroner be invited to be part of the AMDIG. He suggested that Victoria's coroner, Graham Johnson has a particular interest in data and would contribute.

5.4 Representatives from other key organisations

GW raised the issue of other organisations to invite to contribute to AMDIG.

RM – Institute of Actuaries of Australia conduct a continuing mortality investigation of Australia. Headed by Professor Leonie Tickle the investigation has links to obtain data from NDI but they currently don't get coded data.

CC – Recommended that we include the Australian Institute for Suicide Research and Prevention (AISRAP).

RM - Child Deaths Commission. Questioned the inclusion of ANZCA Perioperative Mortality Committee and recommended it be removed from the list.

CF- Statistics New Zealand

CN - Australasian Coroners' Society. Suggested that the Victorian state coroner Graeme Johnstone.

Action: GW to modify list of other organisations as per committee recommendations and provide to RM.

Institute of Actuaries of Australia

Child Deaths Commission
Australasian Coroners' Society
Australian Funeral Directors Association
Public Health Association of Australia
Statistics New Zealand
Council of Presidents of Medical Specialists
National Medical Directors of Ambulance Services
ABS Crime and Justice Unit
Australian Institute for Suicide Research and Prevention
Council of Australasian Registrars

Action: RM to write to organisations to seek representatives on Leadership Committee of AMDIG.

6. Access

TP lead the discussion but stated that she hadn't yet liaised closely with Len Smith regarding this issue. The ABS is keen to review access policies to make more ABS data more widely available. TP stated that there were significant problems with processing 2003 deaths data and that the ABS executive had decided to delay the scheduled release of the 2003 data to March rather than December. This was considered unacceptable to users and a decision has now been made to release the COD publication, electronic versions of 3 major tables and the unit record file on 15 December 2004. The COD publication is a concern because its release is always delayed until the final and full URF is available.

The ABS is currently reviewing its dissemination and release practices and aims to have the annual unit record file (URF) ready by July or August of each year. The Bureau is engaging major users of the data in providing feedback and is currently considering releasing 2 editions of deaths data each year; the first will highlight key issues and the second will contain the full URF. TP indicated that the ABS is cognisant that it cannot meet all user needs but it recognises that the data could be of higher quality. Perhaps the ABS may publish data for sophisticated users and also simplified data for 2nd rung users but it is not clear at this time what users really want.

CF pointed out that Australian mortality data is of a very high standard, compared to most other countries. NZ has only just released its 2002 data. RM noted that many countries submit data to WHO much faster than Australia and NZ do.

RM initiated discussion regarding the publication of Year of Registration vs Year of Death data. It was noted that the long delays in coronial investigations are a major factor limiting year of death publication. TP indicated that this has been reviewed as recently as 2002. The ABS is not proposing to change from year of registration publication. It will be publishing some occurrence data

relating to year of death but will continue at the moment with year of registration reporting.

RM then asked why the WHO data set is not in the public domain. TP was not sure - she can't see why the data sent to WHO cannot be placed in public domain. It could be reported by year of death but a year late while waiting for registrations.

Discussion of costs of mortality data issue was held over due to Len Smith's absence, to be raised during teleconference session.

6.1 Data exchange between NDI and ABS

TP reported that data exchange between the NDI, the ABS and the Registrars-General's offices would be easier if named data, which is available to the ABS, were available also to the NDI. RVH commented that providing access to named data would make it much easier to link between Institute and Bureau data. RM stated that he has no philosophical problem with access to named data or linkage between these datasets.

6.2 GRIM Books update

RVH presented an update on progress with the development of the GRIM Books. The AIHW GRIM Books include causes of death data grouped by year of death back to 1964, when ICD-8 first came into use. They also have year of registration as a compromise due to the need for year of registration data for comparison purposes. The latest versions of the GRIM books contain state and territory breakdowns and now cover 140 different COD. Some COD have been removed due to small numbers. The GRIM Books were initially developed for internal use at the AIHW and then were released selectively. Now there is a general interest in the books and questions have been raised about costs and availability.

State and territory books are published by year of death and therefore previous spreadsheets need to be updated annually for accurate state and territory data. The national GRIM Books are published by year of registration.

A simplified version is freely available on the AIHW web site, but more complex books need to be requested and are provided with accompanying explanatory information about what is being seen. CN stated the GRIM Books were very useful for coroners in seeing patterns of deaths.

RM questioned whether more GRIM books will be made available on the web. RVH indicated that this was planned but that the Institute will need to consider the potential consequences of uninformed interpretation of deaths data by outside bodies.

7. Uses of mortality data

General discussion ensued on work towards improving the identification of Indigenous persons, various strategies to improve documentation and compliance, specifically the role of indigenous contact officers and data linkage. ABS has an Indigenous Community Engagement Strategy Office with full time ongoing managers. These individuals have been involved in census testing, testing of forms for an indigenous health survey and initiated a Statistics Reference Group. ABS Queensland is creating an Indigenous Statistics unit, which Tara will head and which will be operational by mid January.

RM reported that concern has been expressed that the ABS has been too conservative in its long term mortality projections. CC indicated that the University of Queensland's Burden of Disease studies also look at projections and queried the methodology used by UQ. He believes projections will be weak if based on ineffective mortality data.

The meeting agreed that mortality projections are too specific a topic for AMDIG and should be removed from the AMDIG agenda.

Action: GW to remove Projections from agenda.

8. Quality

SW reported on the electronic COD notifications being introduced into NSW and ACT. The process has been trialled in NSW public hospitals with a view to introduction on a national basis. This was seen as an ideal opportunity to conduct some Quality Assurance activities by analysing the results of the trial to see whether electronic registration makes a difference to improving the quality of data reported. CN suggested that analyses such as this will aid the argument to roll out the electronic COD notification more vigorously.

CC asked if the electronic system was linked with morbidity systems. SW believed so. CC asked whether a copy of hospital medical record data could be submitted with death certificates – why or why not? SW, CF, CN, GW noted it is not good to link mortality reporting too closely to morbidity data. A thorough understanding of both morbidity and mortality coding rules and guidelines is essential if inpatient data is to be used to complete death certificates.

SW reported on plans by the NSW R-G to facilitate death notification within 48 hours of a death occurring. CN noted that certification and coding for administrative purposes is relatively easy and the quality of data should be sufficient for these purposes, but the epidemiological quality of early information may be lacking. He suggested the inclusion of interactive education of certifiers during the certification process and use of suitable

guidelines would improve quality of documentation and alert the certifier to contradictions in COD statements.

A question was raised regarding the Standing Committee of Attorneys-General (SCAG) and whether there is a formal link to health departments and with Registrars-General?

Action: RM to raise this at SIMC to establish mechanism for collaboration and consultation.

RM asked if BDMOZ has developed a formal relationship with the health sector. ABS indicated that communication and cooperation with BDMOZ is an informal process currently. R-Gs in Australia are the responsibility of the Attorney-General's Portfolio but in NZ are part of the Internal Affairs department. CF stated that, in NZ an annual mortality forum is held, including representation from registrars and coroners. This forum is based on information sharing.

Discussion about the costs of death registration processes was held and the need to develop a collaborative plan for improvements and all chip in to seek resources and make it happen.

9. Methodology and Analysis

9.1 Census linkage

TP reported that ABS will focus on data linkage to connect census data with other ABS data sets and other non-ABS data sets although concerns have been expressed about the public perception of results and concern regarding the linkage of such data. The ABS is attempting to make linkages from census to census, and also to link from census to births and deaths.

CF asked how the linkage will be made. TP is not aware and reported that the ABS has a new Assistant Statistician whose responsibility will be to look at developing a data linkage unit within the Bureau. It seems census linkage will happen but in what form it is not known.

Susan Linacre is the driving force in the ABS and is running a series of focus groups around Australia.

- Any public concerns need to be identified and dealt with early
- Perception of who owns the data
- Majority of people are supportive of Census linkage and most have assumed it was happening anyway.
- Proposal to May managers' meeting at ABS that this is a different move for ABS in linking from census to census and from census to administrative collections.

- Paper re outcomes of focus groups to be widely distributed before May.
- New SES level Assistant Secretary / Statistician position has been created to deal with linkage issues.

RM asked whether such linkage will be governed by the ABS ethics committee. TP reported that the May meeting will consider ethics committee requirements, and that the Federal privacy commissioner will be heavily involved.

CF reported that, in NZ census data is linked with mortality data by age, sex and geographical area. Unnamed data is matched by probabilistic matching techniques. There need to be good reasons before approval is given for indigenous linkage. Cancer data linkage does not use names but Maori mortality rates are created using linked data. CF highlighted that data linkage techniques are used for indigenous identification and an ethnicity box is used to capture the data. There is good general awareness of the need to identify as indigenous in New Zealand.

GW stated he had some references re data linkage in NZ he would circulate to members.

Action: GW to circulate references on Census linkage in NZ to members.

SW asked how are we to do the linkage in Australia. RM felt that there should be retention of census data for epidemiological purposes. The indigenous community are involved in their own processes at the moment through NGATSI and are supportive of the need for mortality data linkage.

RM recommended that a letter approach to key stakeholders and decision makers with 3-4 reasons for linkage of mortality data to other collections related to indigenous mortality, ethnic mortality and other socio-economic information be developed by AMDIG. This should target development of census to mortality data linkage in first instance with particular emphasis on indigenous mortality, then target other populations (eg. overseas births and deaths). This should be associated with census collection of SES and geographical data with mortality. This should take the pressure off the deaths registration system which is expensive and difficult to operate given the circumstances in which data is collected. Use of the census data is cost effective and will become more valuable over time.

It was noted that the linkage can be conducted within the ABS with no external transfer of data or information. AIHW can provide historically named data which the ABS does not have. Most importantly, there is a strong need to use the resultant linked data to justify its creation.

Action: RM to write letter of support to ABS re data linkage.

10. Classification Issues

10.1 ICD Revision Process

RM provided more information about the proposed ICD-11 update that was distributed through the AMDIG Discussion List. Unfortunately no comments were received from AMDIG members, other than ABS and NCCH.

1st steps:

- Evaluation of ICD-10 updates process
- Stock take of current implementation status

Identification of issues that can't be dealt with in ICD-10 structure. This was discussed at the WHO-FIC meeting in Reykjavik and 6 areas of clinical content to be discussed and taken forward by different classification and clinical content groups - Australia's responsibility will be diabetes. The other areas are External Causes, Mitochondrial disease, Cystic fibrosis, Lymphoma and Mental Health.

RM indicated that an evaluation of update process is underway. He also noted that a 2nd edition of ICD-10 is to be published soon (it is currently at the printers) and will be available through the WHOFIC website.

The WHO-FIC also discussed the possibility of creating an "ICD-XM" for morbidity use, whilst retaining the current ICD structure as a subset for mortality reporting to help with time series stability.

10.2 Education

SW indicated her hope that the AMDIG will provide a conduit for education on certification, vital statistics, auto coding and auto coding software. She believes there is room for communication with US NCHS re MMDS. AMDIG should also have a formal link with the WHO-FIC Mortality Reference Group RG and the Update Reference Committee to provide AMDIG feedback regarding classification issues.

Teleconference

Members James Harrison, Renate Kreisfeld and Greg Curry joined meeting via teleconference at 13:30 AEST, Jessica Pearse was unable to join the meeting due to illness.

RM welcomed teleconference members to the meeting and asked GW to brief the teleconference members on what had transpired in the morning sessions. GW invited comments and suggestions from teleconference members during and at the end of each item briefing.

11. Integration of COD and NCIS information.

JH stated that the NCIS has a standard police report of death form which is completed for each injury death and reported to the NCIS. It contains specific sub-components for common types of deaths encountered by the police.

12. Uses of mortality data

JH noted that the MCOD data for Mortality 2002 has recently been released. The RCIS uses MCOD data extensively. The RCIS also have access to Western Australian linked data on injury. He stated the centre is currently investigating the differences in COD and morbidity data for hospitalisations where the mode of separation is reported as death. SW indicated that this is a similar methodology as that being employed in the NCCH Trauma Tracking Study being conducted with the Queensland Trauma Registry.

13. Other Organisations to create links with AMDIG

GC noted that BDMOZ is being absorbed into/superseded by the Council of Australasian Registrars (COAR). That COAR was being developed and would eventually replace BDMOZ as the definitive registrars' group. At a recent meeting, the COAR suggested that meetings and leadership be rotated. The current Head of COAR is Helen Trias, however, and as the next meeting will be in WA, Alan Anderson (the WA R-G) is to take over as Head of COAR. GC to provide details for contact. RM asked whether the AIHW and ABS attended this year's meeting. GC stated that the meeting had an internal planning focus so the ABS and AIHW were not asked to participate.

Concerns were expressed regarding streamlining the process for access to mortality data which currently have to be approved by each R-G. Responses in the past have been fragmented. LS noted that streamlining would be most welcome by researchers.

JH suggested including representation from pathologists and GPs through the Council of Presidents of Medical Specialists and the National Medical

Directors of Ambulance Services. He also thought we should bring the existence of AMDIG to the attention of the International Collaborative Effort (ICE) on auto-coding and the ICE on Injury Statistics. Information and membership of AMDIG should be offered to international organisations with a focus on statistics.

CF queried involvement of a police service representative however RM warned that AMDIG should not go too far outside the Health sector. The police could be on a consultation list but not offered membership of Leadership Committee. The ABS Crime and Justice Unit might be a better representative.

14. Access

LS reported concerns regarding access to mortality data from researchers and journalists and cited recent experience in seeking access to unit record data. He indicated that requesting access is a lengthy process and sometimes access is not possible at all. University sector could potentially be able to access UR data in the same way as other ABS data is available. GC commented that the NSW Registrars are not funded by the NSW State Government and do not operate at the expense of the taxpayer. They are responsible for generating their own operating expenses from goods and services and feel that that a balance must be met between the Public Good and Staying in Business.

LS believes that a reduction in the cost of mortality data would generate greater use of the data and that there would not be a reduction but an increase in revenue to the registrars. TP reiterated that the ABS wants to provide greater access to and use of mortality data. She suggested that papers be developed around modest proposals for the group to consider.

Action: LS and TP to get together to discuss ideas and strategies for consideration by AMDIG.

15. Uses of mortality data

JH identified one of the priority areas for use of the data relates to indigenous identification and suggested record linkage as the ideal remedy for the problem of poor identification. He believes that linkage works and we should explore national and state developments in this area. This is to be discussed at a future meeting.

Action: GW to research and distribute papers on NZ and WA data linkage work.

LS reported on a project at US NCHS which is looking at linkage of death data and other vitals and health collections.

16. Census linkage

The meeting agreed to write and circulate letter from AMDIG supporting census linkage. This will help to populate mortality data with higher quality socio-economic data. TP asked that the letter include some of the priority papers that could be written with linked data.

SW queried interest in morbidity to mortality data linkage. CF stated that this form of linkage is done in NZ. RM indicated that the AIHW could do this within the Institute. JH asked how different coded deaths data would be if access to hospital record data was available to coders. NZ can do this sort of analysis with linked hospital and mortality files.

HB asked if it was possible to link birth and death data. GC stated that the registrars are very interested in developing strong linkages between births and deaths data mainly from a perspective of preventing identity fraud. AMDIG could also take advantage of this stand. It will be about 18 months before the registrars will be able to do this on a large scale but GC is interested in discussing this with researchers in the meantime.

JH indicated that quality data linkage studies have the potential to detect Shipman-like events. Sampling of non-coronial deaths for coronial-like investigation has been suggested. GC noted that the Victorian registrar is required to report on child deaths and can look into the same family for information on siblings.

LS outlined some methodological issues relating to standardisation analyses (direct or indirect). There is a need to reduce publication of age standardised data without testing for effect modification.

17. Communication

GW outlined plans for dissemination of information and communication amongst members.

- Annual Newsletter – plans to publish articles on quality issues and uses of mortality data, timeliness of data, percentage of non-specific codes used and different classifications used.
- Discussion List
Has had settings adjusted and modified by QUT IT services to enable “reply to all” function on “reply” command.
SW noted that the group lost some subscribers during bounce back fiasco and we should recontact them to notify problem has been corrected and to have them re-subscribed to AMDIG.

Action: Garry to contact un-subscribed discussion list members and offer re-subscription.

- Annual workshop – QUT SPH International Health Summer School for 2005 is on work program for NCCH. There is a need for a more refined focus for the 2005 meeting by selecting a few key issues of substance rather than a wide range of issues. JH suggested that some of the work on preventable mortality being done by John Glover et al at the University of Adelaide might be useful.
- JH also noted that data users need to be made aware of changes in trend data due to use of the MMDS automated coding software and vice versa. AMDIG to feedback to NCHS

18. International collaboration

SW noted that she now has a list of mortality focal points in many countries and will explore off shore issues with them. The Secretariat of Pacific Communities may like to be involved in AMDIG. HB recommended that UNESCAP also be contacted.

CC also suggested contact with the Public Health Network.

19. Advocacy

AMDIG to write to :

- Standing Committee of the Attorney's General
- ABS

regarding support for Census Linkage

Other business

Weekly mortality reporting – Cleo Rooney and Gerard Pavilion's paper presented to WHO-FIC meeting Reykjavik was tabled by RM. The process in England since the 1850s is that preliminary death data are reported in the week following death for about 80% of deaths. This involves 600 registrars who populate the report using auto coding. Initial reports are published and public health actions can be taken quickly. RM raised the question "Can we do this here?"

GC thought that the idea is interesting but Australian registrars are not geared to this. Deaths in the UK are registered through the local court. The move to electronic certification and reporting in NSW may make this possible but not all information of interest to public health researchers would be available. JH thought that road deaths where rapid information is available from the police and not through the usual RGs process, might be obtainable.

Other COD reporting may be possible (eg drowning, asthma, anaesthetics) and other environmental circumstances. However there will be a need to consider and manage differences in COD attributed initially to that ascribed after further study. CF noted that NZ does not follow up for further information from certifiers. TP stated that because ABS receives monthly data feeds from RGs, counts of numbers of deaths is certainly possible, but accelerated COD

reporting requires real demonstrated need before it would be considered because of cost implications. It would be good to get more information on English systems of data collection and the advantages and disadvantages of rapid reporting.

JH told the meeting that a forum regarding survey-based injury data (CATI group) is going to be broadly based on the AMDIG model. James will be the link between the two groups.

GW gave a vote of thanks to all participants and asked that work group leaders contact Garry if they need help with activities. Information can be disseminated to wider membership of AMDIG for support and advice if required.

Meeting was closed at 3:45pm.