National Healthcare Agreement: PI 03-Prevalence of overweight and obesity, 2015 QS

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Identifying and definitional attributes

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Data quality

Institutional environment: The Australian Health Survey (AHS) and National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) were collected, processed, and published by the Australian Bureau of Statistics (ABS). The ABS operates within a framework of the *Census and Statistics Act 1905* and the *Australian Bureau of Statistics Act 1975*. These ensure the independence and impartiality from political influence of the ABS, and the confidentiality of respondents.

For more information on the institutional environment of the ABS, including the legislative obligations of the ABS, financing and governance arrangements, and mechanisms of scrutiny of ABS operations, please see ABS Institutional Environment on the ABS website, www.abs.gov.au.

Timeliness: The AHS is conducted every three years over a 12 month period. Results from the Core component of the AHS were released in June 2013.

The Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) is conducted over a 12 month period, approximately every 6 years. Results from the Core component of the 2012–13 AATSIHS were released in June 2014. The previous NATSIHS was conducted in 2004–05.

Accessibility: See *Australian Health Survey: First Results* (cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions* (cat. No. 4364.0.55.002) for an overview of results from the National Health Survey (NHS) component of the AHS. See: A*ustralian Health Survey: Updated Results* (cat. No. 4364.0.55.003) for results from the Core component of AHS. Other information from this survey is also available on request.

The data for NATSIHS are available from the ABS website in the publication *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13* (Cat. no. 4727.0.55.001). See *Australian Aboriginal and Torres Strait Islander Health Survey: Updated Results* (Cat. no. 4727.0.55.006) for results from the Core component of the AATSIHS. Other information from the AATSIHS is also available from the ABS website www.abs.gov.au.

Interpretability:

Information to aid interpretation of the data is available on the ABS website from the *Australian Health Survey: User Guide, 2011-13* (Cat. no. 4363.0.55.001) and the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012-13* (Cat. no. 4727.0.55.002).

Many health-related issues are closely associated with age; therefore data for this indicator have been age-standardised to the 2001 total Australian population to account for differences in the age structures of the States and Territories. Age standardised rates should be used to assess the relative differences between groups, not to infer the rates that actually exist in the population.

Information for the 2015 Report for the Aboriginal and Torres Strait Islander population replaces data supplied for the 2014 Report which was based on the National Aboriginal and Torres Strait Islander Health Survey subset (9300 people) of the full sample (13,000 people). The larger sample size used for the 2015 reporting cycle provides more accurate estimates and allows for analysis at a finer level of disaggregation.

For information on how the results compare between the two samples, see *Comparison of Results in Australian Health Survey: Updated Results* (cat. No. 4364.0.55.003).

Relevance:

The 2011–13 AHS and 2012–13 NATSIHS collected measured height and weight from persons aged 2 years and over. For the purposes of this indicator, Body Mass Index (BMI) values are derived from measured height and weight information using the formula: weight (kg) / height (m)2.

Despite some limitations, BMI is widely used internationally as a relatively straightforward way of measuring overweight and obesity.

Accuracy:

The AHS was conducted in all States and Territories, excluding very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were also not included in the survey. The exclusion of persons usually residing in very remote areas has a small impact on estimates, except for the Northern Territory (NT), where such persons make up approximately 23 per cent of the population. The response rate for the 2011–12 Core component was 82 per cent. Results are weighted to account for non-response.

The AATSIHS was conducted in all States and Territories, including very remote areas. Non-private dwellings such as hotels, motels, hospitals, nursing homes and short-stay caravan parks were excluded from the survey. The final response rate for the Core component of the 2012–13 AATSIHS was 80 per cent. Results are weighted to account for non-response.

As they are drawn from a sample survey, data for the indicator are subject to sampling error. Sampling error occurs because only a small proportion of the population is used to produce estimates that represent the whole population. Sampling error can be reliably estimated as it is calculated based on the scientific methods used to design surveys. Rates should be considered with reference to their Relative Standard Error (RSE). Estimates with RSEs between 25 per cent and 50 per cent should be used with caution. Estimates with RSEs greater than 50 per cent are generally considered too unreliable for general use.

The following comments apply to data for the general and non-Indigenous populations only.

- Data for overweight and obesity are not directly comparable to the 2004–05 NHS due to the difference in collection methodology and possible erroneous estimation of respondent self-reported measurements in 2004–05.
- Data for NT in 2011–12 are not comparable to previous years due to the increase in sample size. Data for the NT for 2007–08 should be used with caution due to large RSEs resulting from the small sample size.
- RSEs for adult overweight and obesity rates by State/Territory and Remoteness Areas are within acceptable limits, except for remote Queensland for which should be used with caution.
- RSEs for child overweight and obesity rates by State/Territory and Remoteness Areas are within acceptable limits, except for inner regional Western Australian and South Australia, outer regional New South Wales and Victoria, and total remote Australia, for which data should be used with caution, and for remote areas in Queensland, Western Australia and South Australia where rates are considered too unreliable for general use.
- The breakdown by State/Territory and Socio-Economic Indexes for Areas (SEIFA) quintiles for adults in general has sampling error within acceptable limits, except quintile 5 in NT which should be used with caution.
- Data by State/Territory and SEIFA quintiles for children in general have sampling error within acceptable limits, except for some quintiles in Tasmania, the Australian Capital Territory and Northern Territory which should be used with caution. Rates for quintile 5 in Tasmania and quintile 1 in the Australian Capital Territory are considered too unreliable for general use.
- Sampling errors for BMI data for adults by State/Territory are within acceptable limits, though rates of underweight for Tasmania and the Australian Capital Territory should be used with caution.
- Sampling errors for BMI data for children by State/Territory are generally within acceptable limits, though rates of underweight for most States/Territories should be used with caution.

The following comments apply to data for the Aboriginal and Torres Strait Islander population:

- Data for overweight and obesity are not directly comparable to the 2004–05 NATSIHS due to the difference in collection methodology and possible erroneous estimation of respondent self-reported measurements in 2004–05.
- Data collected on measured height, weight and waist circumference in the 2012–13 NATSIHS used the same methodology and equipment as the 2011–12 NHS (neither survey collected self-reported measurements), so the two are directly comparable.

Coherence:

The methods used to construct the indicator are consistent and comparable with other collections and with international practise.

Most surveys, including Computer-Assisted Telephone Interviewing (CATI) health surveys conducted by the States and Territories, collect only self-reported height and weight. There is a general tendency across the population for people to overestimate height and underestimate weight, which results in BMI scores based on self-reported height and weight to be lower than BMI scores based on measured height and weight. Therefore, NHS and NATSIHS data for 2004–05 are not comparable with 2011–13 data which are based on measured height and weight.

The age- and sex-specific cutoff points for BMI categories for children are from the work of Cole TJ, Bellizzi MC, Flegal KM & Dietz WH 2000, *Establishing a standard definition for child overweight and obesity worldwide: international survey*, BMJ 320:1240.

The AHS collected a range of other health-related information that can be analysed in conjunction with BMI.

Source and reference attributes

Submitting organisation: Australian Bureau of Statistics

Relational attributes

Related metadata references:

Supersedes National Healthcare Agreement: PI 03-Prevalence of overweight and obesity, 2014 QS
Health, Superseded 14/01/2015

Has been superseded by National Healthcare Agreement: PI 03-Prevalence of overweight and obesity, 2017 QS
Health, Standard 31/01/2017

Indicators linked to this Data Quality statement:

National Healthcare Agreement: PI 03-Prevalence of overweight and obesity, 2015
Health, Superseded 08/07/2016