Table of contents

INITIAL DEMOGRAPHICS........................................................................................................................................ 5
OVERALL HEALTH STATUS.................................................................................................................................. 5
HEALTH CARE UTILISATION.................................................................................................................................. 6
CO-MORBIDITY, INJURY, DISABILITY (HEALTH STATUS) ....................................................................................... 7
CARERS ................................................................................................................................................................. 12
BLOOD PRESSURE (RISK FACTORS) .................................................................................................................... 12
CHOLESTEROL (RISK FACTORS) ....................................................................................................................... 13
PHYSICAL ACTIVITY (PROTECTIVE FACTORS) .................................................................................................... 14
HEIGHT AND WEIGHT - BODY MASS INDEX (BMI) (RISK FACTORS) .................................................................. 15
SMOKING (RISK FACTORS) .................................................................................................................................. 16
ALCOHOL CONSUMPTION (RISK FACTORS) ....................................................................................................... 16
BREASTFEEDING (PROTECTIVE FACTORS) ......................................................................................................... 17
NUTRITION – FOLATE (PROTECTIVE FACTORS) ............................................................................................... 18
NUTRITION - FOOD CONSUMPTION (PROTECTIVE FACTORS) ........................................................................ 18
FOOD SECURITY (SOCIAL FACTOR) .................................................................................................................... 19
CHILDCARE ......................................................................................................................................................... 20
EARLY YEARS ....................................................................................................................................................... 20
SCHOOL PERFORMANCE ..................................................................................................................................... 21
MENTAL HEALTH (CHILDREN) ........................................................................................................................ 21
KESSLER PSYCHOLOGICAL DISTRESS SCALE+ (K10+) (HEALTH STATUS) ....................................................... 22
SUICIDAL IDEATION (HEALTH STATUS) ........................................................................................................... 23
MENTAL HEALTH (HEALTH STATUS) .............................................................................................................. 24
SOCIAL CAPITAL (SOCIAL FACTOR) .................................................................................................................. 25
ECONOMICS ....................................................................................................................................................... 25
CUSTOMER SATISFACTION ............................................................................................................................. 26
RURAL ACCESS TO HEALTH SERVICES ........................................................................................................ 26
LIFE COURSE ..................................................................................................................................................... 26
SOCIAL CHARACTERISTICS ............................................................................................................................ 27
INTRODUCTION

This document outlines the rationale for inclusion of topics in SAMSS. This includes for each health topic, the source of question(s), the target audience and users of the information, justification of the questions (ie public health importance, state or national indicators) and the period of data collection.

The South Australian Monitoring and Surveillance System (SAMSS) is an epidemiological monitoring system that aims to detect and facilitate understanding of trends in the prevalence of chronic conditions, risk and protective factors, and other determinants of health. These data will monitor departmental, state and national priority areas and will be linked to key indicators.

SAMSS commenced in July 2002. Approximately 600 people per month are interviewed using Computer Assisted Telephone Interviewing (CATI) technology.

The topics included in SAMSS were determined by the following criteria:

- The importance of monitoring (evidenced by 1, 2 or 3 below):
  1. Agreed national / state indicators exist for the topic;
  2. The topic is a national or state priority area;
  3. The topic is an emerging issue that is relevant to the department.
- The topic is suitable for monitoring, utilising CATI survey methodology and associated questions are expected to elicit valid and reliable information.
- Information is not readily available from other sources.
- The sample size of SAMSS is sufficient to produce stable prevalence data for the topic.
- The topic area does not require a large number of questions (since the average survey length is 15 minutes).

Topics are reviewed every year for relevance, usefulness and validity based on the data collected and in consultation with experts in the particular topic area.
INITIAL DEMOGRAPHICS

Source:
PROS / CATI Technical Reference Group

Rationale:
These questions are used for weighting the data to be reflective the population. Some of the following questions are only asked of specific gender and/or age groups so we need to ask the initial demographics before the rest of the survey.

Years:
July 2002 to current

OVERALL HEALTH STATUS

Source:
As part of the SF 36, overall health status
Department of Premier and Cabinet

Rationale:
This question is used to report on the South Australia’s Strategic Plan Objective 2 “seeks to improve wellbeing through preventative health, with Target 2.6 Chronic Disease aiming to increase the proportion of South Australians living with chronic disease, whose self assessed health status is good or better, by 5 percentage points by 2014” (now Target 85).

The question chosen is the first question of the MOS Short Form 36 (SF36), and is often referred to as the SF1. Self reported overall health status is commonly used as a general indicator of health and wellbeing. It refers to physical and mental health as assessed by individuals according to their own values and has been found to be a strong indicator of future health care use and mortality. The purpose of this question is to obtain information about health status in a more subjective way, in order to provide an alternative measure to that derived solely from the statistics of illness, death or service use. Monitoring self assessed health may also help understanding about the perceptions of the proportion of people who report good or better health.

Years:
July 2002 to current
HEALTH CARE UTILISATION

Source:
Department of Premier and Cabinet
SA Health

Rationale:
Patterns of health service use can reflect not only patterns of illness, but differences in the availability and accessibility of health services and in the way people choose to use them. Primary care and community health services are usually the first health service visited and these services include care from GPs, physiotherapists and various other practitioners. They play an important role in monitoring an individual’s health and managing many health conditions.

The first question is part of a series of questions used to report on the South Australia’s Strategic Plan Target: T1.7 “Performance in the public sector – customer and client satisfaction with government services: Increase the satisfaction of South Australians with government services by 10% by 2010, maintaining or exceeding that level of satisfaction thereafter”.

The GP Data Synergy Project is investigating how general practice derived data will be of use for activities that inform health planning or service delivery beyond that offered by General Practice Divisions and Networks. In exploring the use of general practice data, SAMSS data is being used to valid the results. As part of this validation, it was raised that GP usage over 12 months is needed as well as usage over 4 week.

Years:
July 2002 to current
CO-MORBIDITY, INJURY, DISABILITY (Health Status)

DIABETES

Source:
PROS / CATI Technical Reference Group

Target audience:
Department of Premier and Cabinet
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA

Rationale:
This question is used to report on the South Australia's Strategic Plan Objective 2 "seeks to improve wellbeing through preventative health, with Target 2.6 Chronic Disease aiming to increase the proportion of South Australians living with chronic disease, whose self assessed health status is good or better, by 5 percentage points by 2014" (now Target 85).

Diabetes is recognised as a state and national health priority area because of the significant burden it places on the community in terms of health, social, economic and emotional costs.

Years:
July 2002 to current

ASTHMA

Source:
PROS / CATI Technical Reference Group

Target audience:
Department of Premier and Cabinet
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA

Rationale:
This question is used to report on the South Australia's Strategic Plan Objective 2 "seeks to improve wellbeing through preventative health, with Target 2.6 Chronic Disease aiming to increase the proportion of South Australians living with chronic disease, whose self assessed health status is good or better, by 5 percentage points by 2014".

Asthma was established as a National Health Priority Area in 1999 due to its high prevalence in Australia, one of the highest in the world. Geographic location, tobacco smoke and other environmental pollutants as well as diet and level of physical activity contribute to the prevalence and/or management of asthma. Monitoring the prevalence of asthma, part of the National Asthma Action Plan, will enable health services or health care providers to plan strategies that best target specific groups or areas in order to reduce the incidence of asthma in the community and subsequently reduce the burden of disease.
COPD

Source: PROS / CATI Technical Reference Group

Target audience: Department of Premier and Cabinet
Health Promotion, SA Health
Health planners from various departments throughout SA Health

Rationale: This question is used to report on the South Australia’s Strategic Plan Objective 2 “seeks to improve wellbeing through preventative health, with Target 2.6 Chronic Disease aiming to increase the proportion of South Australians living with chronic disease, whose self assessed health status is good or better, by 5 percentage points by 2014”.

In 1999, the Australian Burden of Disease and Injury study identified chronic obstructive pulmonary disease (COPD) as the third leading cause of disease burden in Australia, after stroke and ischemic heart disease. COPD is also among the top leading causes of death in Australia. COPD shares common modifiable risk factors, such as tobacco use, unhealthy diet and physical inactivity, with other prominent noncommunicable diseases.

Years: January 2005 to current

CARDIOVASCULAR DISEASE

Source: PROS / CATI Technical Reference Group

Target audience: Department of Premier and Cabinet
Health Promotion, SA Health
Health planners from various departments throughout SA Health

Rationale: This question is used to report on the South Australia’s Strategic Plan Objective 2 “seeks to improve wellbeing through preventative health, with Target 2.6 Chronic Disease aiming to increase the proportion of South Australians living with chronic disease, whose self assessed health status is good or better, by 5 percentage points by 2014”.

Cardiovascular disease is recognised as a state and national health priority area because it is the largest cause of death in Australia, and many of these deaths are preventable. Surveillance data describing cardiovascular disease, and its associated risk factors, are critical to increased recognition of the public health burden of cardiovascular disease, formulating of health care policy, identifying high risk groups, developing strategies to reduce the burden, and evaluating progress in disease prevention and control.
Years:
July 2002 to current

**ARTHRRITIS**

**Source:**
PROS / CATI Technical Reference Group

**Target audience:**
Department of Premier and Cabinet
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA

**Rationale:**
This question is used to report on the South Australia's Strategic Plan Objective 2 “seeks to improve wellbeing through preventative health, with Target 2.6 Chronic Disease aiming to increase the proportion of South Australians living with chronic disease, whose self assessed health status is good or better, by 5 percentage points by 2014”.

“Arthritis” is a term used to describe a disorder of one or more joints and is part of a broader group of disorders of the muscles and bones known as musculoskeletal disorders. Arthritis was established as a National Health Priority Area in 2002 because of the significant burden placed on the community as a result of loss of quality of life, associated with pain and disability, and in terms of economic costs. Osteoarthritis and rheumatoid arthritis are two of the most prevalent forms of musculoskeletal disease within Australia and have been found to place the highest burden on the community. Surveillance data describing arthritis and its associated risk factors are critical to increased recognition of the public health burden of arthritis and the need to improve the quality of life and health outcomes for people with these conditions. The information also assists in formulating health care policy, identifying high risk groups, developing strategies to reduce the burden, and evaluating progress of health promotion programs. Indicators are essential for monitoring the increasing overall prevalence of arthritis.

Years:
July 2002 to current
OSTEOPOROSIS

Source:
PROS / CATI Technical Reference Group

Target audience:
Department of Premier and Cabinet
Health Promotion, SA Health
Health planners from various departments throughout SA Health

Rationale:
This question is used to report on the South Australia’s Strategic Plan Objective 2 “seeks to improve wellbeing through preventative health, with Target 2.6 Chronic Disease aiming to increase the proportion of South Australians living with chronic disease, whose self assessed health status is good or better, by 5 percentage points by 2014”. Osteoporosis is one of the most prevalent forms of musculoskeletal disease within Australia and has been found to place the highest burden on the community. Surveillance data describing osteoporosis and its associated risk factors are critical to increased recognition of the public health burden of osteoporosis and the need to improve the quality of life and health outcomes for people with these conditions. The information also assists in formulating health care policy, identifying high risk groups, developing strategies to reduce the burden, and evaluating progress of health promotion programs. Indicators are essential for monitoring the increasing overall prevalence of osteoporosis.

Years:
July 2002 to current

CANCER

Source:
PROS / CATI Technical Reference Group

Target audience:
Health Regions, SA Health

Rationale:
The questions were included so that all major chronic conditions are now covered in the questionnaire.

Years:
January 2010 to current
LONG TERM ILLNESS - CHILDREN

Source:
Based on WA Children’s Survey
SAMSS Children’s Advisory Committee

Target audience:
Health planners from various departments throughout SA Health

Rationale:
To be assessed

Years:
July 2002 to current

DISABILITY

Source:
Disability services, SA Health
Based on US, Behaviour Risk Factor Surveillance System
SAMSS Children’s Advisory Committee

Target audience:
Disability services, SA Health
Health planners from various departments throughout SA Health

Rationale:
To be assessed

Years:
July 2002 to current
INJURY (FALLS) – 65+ years

Source: ABS?

Target audience:

Rationale:
Analysis undertaken for SA Health Falls Prevention Program

Years:
July 2002 to current

CARERS

Source: ABS?

Target audience:
Health planners from various departments throughout SA Health

Rationale:
Included as a risk factor for ill-health and to monitor carer’s status in SA.

Years:
January 2010 to current

BLOOD PRESSURE (Risk Factors)

Source:
PROS / CATI Technical Reference Group

Target audience:
Health Promotion, SA Health
Health planners from various departments throughout SA Health

Rationale:
National Health Priority Area (NHPA) indicators for monitoring risk factors for heart, stroke and vascular disease and other NHPAs.
High blood pressure is a risk factor for coronary heart disease, stroke and peripheral vascular disease. The risk of stroke or coronary heart disease is up to four times greater among people with high blood pressure than among non-affected people of the same age. People on treatment for high blood pressure are also at an increased risk. The proportion of males and females with hypertension
increases with age. High blood pressure is known to be more prevalent in lower socio-economic groups. Both systolic and diastolic blood pressures are predictors of cardiovascular disease at all ages, although systolic blood pressure is a stronger predictor of death due to coronary heart disease. Mean systolic blood pressure among migrants generally increases with length of residency in Australia. These indicators are essential for monitoring trends in risk factors for cardiovascular disease and diabetes complications, and patterns of disease co-morbidity.

**Years:**
July 2002 to current

### CHOLESTEROL (Risk Factors)

**Source:**
PROS / CATI Technical Reference Group

**Target audience:**
Health Promotion, SA Health
Health planners from various departments throughout SA Health

**Rationale:**
National Health Priority Area (NHPA) indicators for monitoring risk factors for heart, stroke and vascular disease and other NHPAs.

NHPA indicators for monitoring risk factors for heart, stroke and vascular disease and other NHPAs. High blood cholesterol levels are a major risk factor for coronary heart disease and stroke. The prevalence of high blood cholesterol tends to increase with age, and is more common in males than females in most age groups. Among males aged 25-64 years, those who lived alone or were previously married had about 1.5 times higher rate for elevated blood cholesterol than did those with partners or dependents. High blood cholesterol is known to be more prevalent among females in lower socioeconomic groups. These indicators are essential for monitoring trends in risk factors for cardiovascular disease and diabetes complications, and patterns of disease comorbidity.

**Years:**
July 2002 to current
PHYSICAL ACTIVITY (Protective Factors)

Source:
PROS / CATI Technical Reference Group (SNAPS)
“Physical activity measure for children and adolescents: recommendations on population surveillance”, Prof Adrian Bauman, Prevention Research Collaboration (PRC), Sydney Public Health, Sydney University.

Target audience:
COAG
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA ie planners
Local government requirements for Public Health Act.

Rationale:
South Australia’s Strategic Plan Objective 2 seeks to improve wellbeing through preventative health, with Target 2.3 Sport and Recreation (existing): To exceed the Australian average for participation in sport and physical activity by 2014. This requires an examination of the proportion of adults participating in at least 30 minutes of moderate physical activity on 5 or more days of the week (Sufficient activity).

The National Prevention Agency on Preventive Health advises COAG, through the Australian Health Ministers Conference (AHMC), on national priorities and options for preventative health. The Strategy sets a number of ambitious targets, one of which is to Halt and reverse the rise in overweight and obesity. One indicator of the progress of this target is an aim to increase the proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week by 5 per cent from baseline for each state by 2013; 15 per cent from baseline by 2015.

National Health Priority Area (NHPA) indicators for monitoring risk factors for heart, stroke and vascular disease and other NHPAs.

Children and adolescents need at least 60 minutes (and up to several hours) of moderate to vigorous physical activity every day. Sedentary behaviour in childhood influences health in adulthood and is a predictor of body mass index and being overweight in children. It is recommended that during leisure time, children and adolescents should not spend more than 2 hours a day using electronic media for entertainment (for example, computer games, television, or the internet), particularly during daylight hours. A document titled “Physical activity measure for children and adolescents: recommendations on population surveillance” produced by Prof Adrian Bauman, Prevention Research Collaboration (PRC), Sydney Public health, Sydney University, examines existing physical activity measurements among children and adolescents between the ages of 5 to 17 years for surveillance. The PRC have proposed a “minimal data set” to include in existing surveillance systems which consist of four questions: one question refers to the 60 minute guideline and three questions refers to sedentary behaviour.. This would be comparable to the Australian Secondary School Alcohol and Drug (ASSAD) short question (derived from the current European-wide surveillance tool, Health Behaviour in School Children (HBSC)).

Years:
July 2002 to current
HEIGHT AND WEIGHT - BODY MASS INDEX (BMI) (Risk Factors)

Source:
PROS / CATI Technical Reference Group
Behavioural Risk Factor Surveillance System (BRFSS) USA

Target audience:
Department of Premier and Cabinet
COAG
Health Promotion, SA Health
Dashboard (Commonwealth National Health Care Agreement (NHCA))
Health planners from various departments throughout SA Health
Various Local Government Councils in SA ie planners
Local government requirements for Public Health Act.

Rationale:
South Australia’s Strategic Plan Objective 2 seeks to improve wellbeing through preventative health, with Target 2.2 Healthy Weight, aiming to increase the proportion of South Australians 18 and over with healthy weight by 10 percentage points by 2014.

The National Partnership Agreement on Preventive Health (NPAPH) has been established through the Council of Australian Governments (COAG) to address the rising prevalence of lifestyle-related chronic diseases. The NPAPH seeks to contribute to achieving medium to long term outcomes that include: increasing the proportion of children and adults at healthy body weight by three percentage points within ten years; and increasing the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15 per cent within six years. The Commonwealth, the States and Territories have agreed to meet a number of performance benchmarks including: increase in proportion of children and adults at unhealthy weight held at less than five per cent from baseline for each state by 2013; and proportion of adults at healthy weight returned to baseline level by 2015.

National Health Priority Area (NHPA) indicators for monitoring risk factors for heart, stroke and vascular disease and other NHPAs.

Years:
July 2002 to current
**SMOKING (Risk Factors)**

**Source:**
PROS / CATI Technical Reference Group (SNAPS)

**Target audience:**
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA ie planners
Local government requirements for Public Health Act.

**Rationale:**
Smoking is the single largest preventable cause of premature death and disease in Australia. Smoking is associated with cardiovascular diseases, diabetes, cancer and respiratory diseases. Smoking behaviour is known to vary over time and by population sub-groups. Overall, the number of deaths from tobacco are increasing worldwide. In South Australia, smoking behaviour is monitored by the Cancer Council South Australia utilising the Population Research and Outcome Studies’ annual Health Omnibus Survey. A limited number of questions related to smoking behaviour are included in SAMSS to facilitate analysis of smoking behaviour in conjunction with other SAMSS data.

**Years:**
July 2002 to current

**ALCOHOL CONSUMPTION (Risk Factors)**

**Source:**
PROS / CATI Technical Reference Group (SNAPS)

**Target audience:**
COAG
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA
Local government requirements for Public Health Act.
Dashboard (Commonwealth National Health Care Agreement (NHCA))

**Rationale:**
Alcohol is the second largest cause of preventable death and hospitalisation in Australia. It is estimated that in 1997 there were 3,290 deaths attributable to high risk drinking and 72,302 hospitalisations. Much harm can also be associated with alcohol consumption, with regular drinking at higher levels bringing a higher risk of some chronic diseases and early death. Bouts of heavy drinking may increase the chances of injury and death; not only for the drinker but others as well, and excess alcohol consumption has other serious economic and social implications. Principal among alcohol related deaths and hospital episodes were cirrhosis of the liver, alcohol dependence, stroke, suicide and motor vehicle accidents. Misuse of alcohol also contributes to injury including interpersonal violence, particularly assaults, domestic violence and child abuse. Recently however, lower levels of alcohol consumption has been identified as having health benefits for some people, such that it may contribute to a reduction in the risk of heart disease in middle age.
Both the level and pattern of alcohol consumption have been found to be indicators of alcohol-related health and social problems. In general, the average level of alcohol consumption is related to mortality and specific causes of death and disease, and measures of total and risky or high risk consumption predict acute and chronic harms. It is important to monitor alcohol consumption through population surveys, so that we better understand how the consumption of alcohol is related to other chronic conditions, so groups at high risk of harm from alcohol consumption can be identified, and policy and health promotion programs can be directed towards these groups. The information collected will be used to assist in developing aims, strategies, health promotion activities and intervention programs for these target groups.

**Years:**
July 2002 to current

---

**BREASTFEEDING (Protective factors)**

**Source:**
Australian Food and Nutrition Monitoring Unit, Commonwealth Department of Health and Aged Care
SAMSS Children’s Advisory Committee

**Target audience:**
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA

**Rationale:**
Breastfeeding is considered the most appropriate method for feeding infants and is closely related to immediate and long-term health outcomes. Exclusive breastfeeding to the age of six months gives the best nutritional start to infants and is now recommended by a number of authorities. The WHO Expert Consultation then recommended exclusive breastfeeding for six months, then introduction of complementary foods and continued breastfeeding thereafter. Although the majority (80–90 per cent) of women in Australia commence breastfeeding, just under a third of them have introduced other foods or have stopped breastfeeding by three months. There is also evidence of considerable variation between socio-economic groups in terms of both the acceptance and the maintenance of breastfeeding in the Australian community: women in higher socio-economic groups are more likely to breastfeed.

The Dietary Guidelines for Children and Adolescents in Australia recommends that breastfeeding should be encouraged and supported.

Breastfeeding has been identified as a priority area for action. The NHMRC Dietary Guidelines for Children and Adolescents (NHMRC DGC&A) recommends exclusive breastfeeding for the first 6 months of life, introduction of complementary foods at 6 months of age and continuation of breastfeeding until at least 12 months of age and beyond as desired by mother and infant.

**Years:**
July 2002 to current
NUTRITION – Folate  (Protective Factors)

Source:
PROS / CATI Technical Reference Group (SNAPS)

Target audience:
Pregnancy Outcome Unit, SA Health
Department of Premier and Cabinet; COAG; Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA

Rationale:
Neural tube defects (NTDs) are a group of major congenital structural abnormalities of the brain, skull and spinal cord. To prevent neural tube defects, 400 micrograms of folate per day is recommended for women of child-bearing age. South Australian neural tube defect rates were 1.3 per 1,000 live births in 2002. These rates are monitored through pregnancy outcome statistics. Folate-related knowledge and behaviour have been assessed through surveys.

Three strategies, singly or in combination for the primary prevention of Neural Tube Defects, have been promoted in Australia: fortification of foods with folate, promotion of periconceptional use of folate supplements, and promotion of diets high in natural sources of folate.

Years:
July 2002 to current

NUTRITION - Food Consumption (Protective Factors)

Source:
PROS / CATI Technical Reference Group (SNAPS)

Target audience:
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Department of Premier and Cabinet; COAG; Health Promotion, SA Health
Various Local Government Councils in SA
Local government requirements for Public Health Act.

Rationale:
South Australia’s Strategic Plan Objective 2 seeks to improve wellbeing through preventative health, with Target 2.2 Healthy Weight, aiming to increase the proportion of South Australians 18 and over with healthy weight by 10 percentage points by 2014. The data presented here are collected by the South Australian Monitoring and Surveillance System (SAMSS). Strategy 1 is to assist the community to know and act on health eating, physical activity and healthy weight guidelines.

The National Partnership Agreement on Preventive Health (NPAPH) has been established through the Council of Australian Governments (COAG) to address the rising prevalence of lifestyle-related chronic diseases. The NPAPH seeks to contribute to achieving medium to long term outcomes that include: increasing the proportion of children and adults at healthy body weight by three percentage points within ten years; and increasing the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15 per cent within six years.
The Commonwealth, States and Territories have agreed to meet a number of performance benchmarks. One indicator of the progress of this target is an aim to increase the mean number of daily serves of fruit and vegetables consumed by children and adults by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state by 2013; and 0.6 for fruits and 1.5 for vegetables from baseline by 2015.

Epidemiological research has shown that diets high in vegetables and fruit have health benefits, particularly in relation to the prevention of diseases such as cardiovascular disease, stroke, type 2 diabetes and several major forms of cancer. The inadequate consumption of fruit and vegetables has been linked with developmental and behavioural problems, cancer and other conditions.

The Dietary Guidelines for Australians
- suggest that we should include milks, yoghurts, cheeses and/or alternatives. Milk is one of the most complete of all foods, and is the richest source of calcium in the Australian diet. Milk is also important contributors to protein, vitamin A, riboflavin, vitamin B12 and zinc. It is important to choose reduced-fat varieties.
- suggest that we should limit consumption of fried savoury snack foods such as potato crisps; choose those fried in sunola or cottonseed oil; choose predominantly unsaturated vegetable oils such as sunflower, canola, corn, soya, olive and flaxseed rather than animal fats, palm or coconut oil, or hydrogenated vegetable oils (often of unspecified origin); and limit consumption of sausages, fatty mince, processed meats and ‘luncheon meats’ (that is, higher fat meat products). Many fast or take away foods are made up of these foods, and thus are not recommended.
- recommended that adults could consume water at least 2.5 litres per day.
- suggest that we consume only moderate amounts of sugars and food containing added sugars. Many soft drinks have high levels of sugar, and thus are not recommended.

Other foods such as fried potatoes, processed meats and takeaway style foods are linked to the increased prevalence of obesity. The ongoing monitoring of the intake of these foods is necessary to gauge whether public health promotions/interventions are successful and to provide information on the distribution and frequency of fat intake.

Years:
July 2002 to current

**FOOD SECURITY (Social Factor)**

**Source:**
Based on ABS National Survey
SAMSS Children’s Advisory Committee

**Target audience:**
Health Promotion SA; Health planners from various departments throughout SA Health
Various Local Government Councils in SA
Local government requirements for Public Health Act.

**Rationale:**
Food security has been defined by the World Food Summit as the assured ability of access to a safe, nutritious and affordable food supply. It includes at a minimum the ability to access food without resorting to emergency feeding programs and the ability to access food in socially acceptable ways (ie without resorting to stealing or scavenging). Food insecurity is measured when this access is not available.
It is estimated that more than 5% of the general population of Australia are likely to be food insecure with higher prevalence rates amongst populations who are known to experience increased levels of relative poverty (such as young people, the elderly, single person households, unemployed people, homeless people, injecting drug users, and, those on low or insecure incomes).

It is recognised that a telephone interviewing instrument such as SAMSS will not capture some of the “hard to reach” populations who are most likely to experience food insecurity, such as those without a telephone connected and homeless people. SAMSS will provide information on food insecurity for the general population of South Australia. As food insecurity is closely related to poverty, SAMSS will monitor household food insecurity related to lack of financial resources.

**Years:**
July 2002 to current

**CHILDCARE**

**Source:**
Based on WA Children’s Survey
SAMSS Children’s Advisory Committee

**Target audience:**
Health planners from various departments throughout SA Health

**Rationale:**
To be assessed.
(To assess the relationship between children who attend childcare and their health).

**Years:**
July 2002 to current

**EARLY YEARS**

**Source:**
Based on WA Children’s Survey
SAMSS Children’s Advisory Committee

**Target audience:**
Health planners from various departments throughout SA Health

**Rationale:**
To be assessed.
(To assess the relationship between children early years and their health).

**Years:**
July 2002 to current
SCHOOL PERFORMANCE

Source:
Based on WA Children’s Survey
SAMSS Children’s Advisory Committee

Target audience:
Mental Health Unit, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA

Rationale:
To be assessed.
(To assess the relationship between children school performance and/or issues such as bullying and their health).

Absenteeism from primary school has adverse effects on a child’s educational and social development. They miss out on critical stages of development with their peers and are less likely to achieve academic progress and success. Absenteeism can also exacerbate issues of low self-esteem, social isolation and dissatisfaction.

School connectedness and supportive social relationships have been associated with lower levels of absenteeism, delinquency, aggression, substance use and sexual risk behaviour, and higher levels of academic achievement and self-esteem amongst children.

Conversely, bullying is associated with lower academic achievement, feeling ‘unsafe’ at school, depression, a number of psychosomatic conditions and contributes to maladjustment of children at school.

Years:
July 2002 to current

MENTAL HEALTH (children)

Source:
Based on WA Children’s Survey
SAMSS Children’s Advisory Committee

Target audience:
Mental Health Unit, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA ie planners
Local government requirements for Public Health Act.

Rationale:
To be assessed.
It is estimated that as many as 20% of children are affected by mental health problems in modern societies. Children with mental health problems experience suffering, functional impairment, exposure to stigma and discrimination, and increased risk of premature death. In Australia, mental health problems and disorders accounted for the second highest burden of disease among children in 2003. These conditions have implications for a child’s psychosocial growth and development, health-care requirements, educational and occupational attainment and their involvement with the justice system.

Years:
July 2002 to current

KESSLER PSYCHOLOGICAL DISTRESS SCALE+ (K10+) (Health Status)

Source:
Kessler 10 Psychological Distress Scale
PROS / CATI Technical Reference Group (SNAPS)

Target audience:
Department of Premier and Cabinet
COAG
Mental Health Unit, SA Health
Health Promotion, SA Health
Dashboard (Commonwealth National Health Care Agreement (NHCA))
Health planners from various departments throughout SA Health
Various Local Government Councils in SA ie planners
Local government requirements for Public Health Act.

Rationale:
South Australia’s Strategic Plan Objective 2 seeks to improve wellbeing through preventative health, with Target 2.7 Psychological Wellbeing, aiming to decrease the proportion of South Australians 18 and over with psychological distress to equal or lower than the Australian average for psychological distress by 2014. The Headline KPI is the percentage of people who report high or very high psychological distress receiving mental health services; and the associated KPI (3.2) is the number of South Australians receiving health professional help who are at risk or are already experiencing mental health problems.

Years:
July 2002 to current
SUICIDAL IDEATION (Health Status)

Source:
Four questions from the 28 item General Health Questionnaire (GHQ-28)

PROS

Target audience:
Mental Health Unit, SA Health
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA ie planners
Local government requirements for Public Health Act.

Rationale:
The National Suicide Prevention Strategy (NSPS) is a major program for the Mental Health and Suicide Prevention Programs Branch in the Commonwealth Department of Health and Ageing (DoHA). It provides the platform for Australia’s national policy on suicide prevention with an emphasis on promotion, prevention and early intervention for mental health.

In 1995, Australia was one of the first countries to establish a specific national suicide prevention strategy when DoHA initiated “Here for Life” which focused on young people at higher risk of suicide. This brief expanded with the launch of the NSPS in 1999, as a growing body of evidence reflected concern for the risk of suicidal behaviours developing across the whole-of-life span.

One of the main objectives of the NSPS is to “Improve the evidence base and understanding of suicide prevention”.

The NSPS has four key inter-related components:
- The Living Is For Everyone (LIFE) Framework, which sets an overarching evidence based strategic policy framework for suicide prevention in Australia;
- The National Suicide Prevention Strategy Action Framework, which provides a time limited workplan for taking forward suicide prevention investment and leverage;
- The National Suicide Prevention Program (NSPP) is the Australian Government funding program dedicated to suicide prevention activities. The funding allocation covers two streams of activities:
  - Mechanisms to promote alignment with and enhance state and territory suicide prevention activities.

The National Suicide Prevention Strategy promotes suicide prevention activities across the Australian population as well as for specific at-risk groups. Some of the groups of individuals targeted under the Strategy include:
- People in rural and remote areas
- Aboriginal and Torres Strait Islander people
- Men
- Youth
- People bereaved by suicide
- People who have self-harmed or attempted suicide (A significant number of people who have taken their own lives have previously carried out an act of self-injury).

Years:
July 2002 to current
MENTAL HEALTH (Health Status)

Source:
PROS (1997 South Australian Mental Health Survey developed with mental health professionals)

Target audience:
Department of Premier and Cabinet
Mental Health Unit, SA Health
Health Promotion, SA Health
Health planners from various departments throughout SA Health
Various Local Government Councils in SA ie planners
Local government requirements for Public Health Act.

Rationale:
Mental health was established as a national health priority area in 1996. The National Health Priority Areas Report: mental health 1998 set out a number of key national indicators to improve the mental health of Australians, particularly in relation to depression.

The National Health Priority Areas Report on Mental Health defines mental health as 'the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective wellbeing, optimal development and the use of cognitive, affective and relational abilities'. In 2007, Australia Bureau of Statistics (ABS) conducted a national survey interviewing 8800 Australians aged 16 - 85 years to present the prevalence of mental health around Australia. The results showed that of the 16 million Australians aged 16–85 years, almost half (45% or 7.3 million) had a lifetime mental disorder, ie a mental disorder at some point in their life. One in five (20% or 3.2 million) Australians had a 12-month mental disorder. There were also 4.1 million people who had experienced a lifetime mental disorder but did not have symptoms in the 12 months prior to the survey interview.

Mental health problems are estimated to affect one in five Australians at some stage in their lives. ABS figures (1995 survey) show that more than one million Australians are estimated to suffer from a mental disorder with depression being the most common recent, long term disorder. While mortality rates as a result of mental health problems are low compared with other National Health Priority Areas, the hospitalisation rate is higher, especially for the 25-44 years age group. There are a number of different conditions considered when gauging the status of one’s mental health, and these include a range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people. Mental health problems encompass a number of different areas including anxiety, depression, stress, psychological distress and suicide. These are areas for which information is often collected.

It is estimated that depression will be the second largest contributor to the world’s disease burden by 2020. It has also been found that, of all mental disorders, depression is the most pervasive and costly. There is a need for depression in Australia to be assessed via wider population health-based research and evaluation agendas and this need has been defined by the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, and the National Action Plan for Depression.

Anxiety disorders include obsessive-compulsive disorder, panic disorder and panic disorder with agoraphobia, social anxiety disorder, specific phobias, post traumatic stress disorder and generalised anxiety disorder. Stress related problems include work related stress and post traumatic stress disorder. Other mental health problems are less severe and of shorter duration than mental health illnesses, but they may develop into mental illness. Information about mental health conditions needs to be collected to enable a more comprehensive and longitudinal picture of the mental health of the population. Anxiety and depressive symptoms may also be gauged by considering the level of non-specific psychological distress in the population.
Years:
July 2002 to current

**SOCIAL CAPITAL (Social Factor)**

**Source:**
Various - predominantly from work undertaken by Prof Fran Baum, Flinders University
CATI TRG

**Target audience:**
Health Promotion, SA Health
Health planners from various departments throughout SA Health

**Rationale:**
Mainly used as a covariate (relationship with health status/risk factors).
Social capital represents the degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms, and social trust, and facilitate coordination and cooperation for mutual benefit. Although there are still varying definitions of the term and what it encompasses, most social capital conceptualizations refer to it as networks of people deriving benefit from common interaction with each other.
Many studies have shown the powerful health effects of social connectedness. The mechanisms by which this social capital is beneficial to health are not clearly delineated, but social networks are believed to promote better health education, better access to health services, informal caring, and enforcing or changing societal norms that impact on public health (e.g. smoking, sanitation and sexual practices).
The Victorian Population Health Survey (VPHS) 2002 found that people with few social networks were more likely to report fair to poor health and to be experiencing some level of psychological distress. The study identifies higher network scores were associated with those who lived in rural areas, older age groups, those who were Australian born and those who were employed. Higher network scores were also associated with a range of benefits including an increased ability to get help in an emergency, feeling valued by society, accepting diversity and better health outcomes.

Years:
July 2002 to current

**ECONOMICS**

**Source:**
Health Outcomes Literature

**Rationale:**
Only economic indicator (other than income) included in the questionnaire.
Mainly used as a covariate (relationship with health status/risk factors).

Years:
July 2002 to current
Customer Satisfaction

Source:
Department of Premier and Cabinet
SA Health

Target audience:
Department of Premier and Cabinet
SA Health

Rationale:
These questions are used to report on the South Australia’s Strategic Plan Target: T1.7 “Performance in the public sector – customer and client satisfaction with government services: Increase the satisfaction of South Australians with government services by 10% by 2010, maintaining or exceeding that level of satisfaction thereafter.” These questions were based on the Canadian Common Measurement Tool (CCMT) for Customer Satisfaction. All adults aged 16 years and over, who had used at least one South Australian public health service in the last four weeks, were asked questions relating to customer satisfaction and the public health service they had used.

Years:
July 2009 to current

Rural Access to Health Services

Source:
Karen Dixon, Pam Pratt, SA Country Health

Rationale:
Links with State Strategic Plan regarding improved access to health services closer to where people live. The CHSA Patient Journey Initiative has gathered information about access to health services for people living in rural and remote South Australia and the challenges they face. It is important for SA Health that access to health services for all is considered and monitored and actions taken as appropriate to resolve problems.

Years:
July 2011 to current

Life Course

Source:
Professor John Lynch, Dr Cathy Chittleborough

Rationale:
A need has arisen to include additional questions to obtain data on early-life socio-economic position (SEP), for determining aetiological pathways between SEP and health over the life course and health. These additional questions will supplement existing indicators currently in SAMSS, as they will enable the surveillance of the family structure, housing status and money situation, during a person’s early
life. These material and social resources influence a person’s health and wellbeing as they progress through life.

Years:
January 2009 to current

**SOCIAL CHARACTERISTICS**

Rationale:
Mainly used as a covariate and to identify target groups (relationship with health status/risk factors etc).

Years:
July 2002 to current

**Baby sleeping practices**

Source:
Public Health and SA Health Promotion (Nicola Spurrier)

Rationale:
Monitor impact of “Safe Sleeping Policy”.

Years:
January 2012 to current