National Healthcare Agreement: PI 03-Prevalence of overweight and obesity, 2014 QS

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Identifying and definitional attributes

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Data quality

Institutional environment: The Australian Health Survey (AHS) and Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) 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 for scrutiny of ABS operations, please see ABS Institutional Environment.

Timeliness: The AHS is conducted every three years over a 12 month period. Results from the 2011–12 Core component of the AHS were released in June 2013.

The AATSIHS is conducted approximately every six year over a 12 month period. Results from the 2012–13 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) component of the AATSIHS will be released in November 2013. The previous NATSIHS was conducted in 2004–05.

Accessibility: See *Australian Health Survey: First Results, 2011–12* (ABS cat. no. 4364.0.55.001) and *Australian Health Survey: Health Service Usage and Health Related Actions, 2011–12* (ABS cat. no. 4364.0.55.002) for an overview of results from the National Health Survey (NHS) component of the AHS. See: *Australian Health Survey: Updated Results, 2011–12* (ABS 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* (ABS cat. no. 4727.0.55.001). Other information from the survey is available on request.

Interpretability:

Information to aid interpretation of the data is available from the *Australian Health Survey: Users' Guide, 2011–13* (ABS cat. no. 4363.0.55.001) on the ABS website.

Data for the general and non-Indigenous populations replaces data supplied for the 2013 reporting cycle which was based on the NHS subset (20,500 people) of the full sample (32,000 people). The larger sample size (the full sample or Core) supplied for the 2014 reporting cycle provides more accurate estimates and allows for analysis at a finer level of disaggregation. For more information on the structure of the AHS, see Structure of the Australian Health Survey.

For information on how the results compare between the two samples, see Comparison of Results in *Australian Health Survey: Updated Results, 2011–12* (ABS cat. no. 4364.0.55.003).

Information on how to interpret and use the NATSIHS data appropriately is available from Explanatory Notes in *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012–13* (ABS cat. no. 4727.0.55.001) and also from the *Australian Aboriginal and Torres Strait Islander Health Survey: Users' Guide, 2012–13* (ABS cat. no. 4727.0.55.002).

Many health-related issues are closely associated with age, so 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.

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 only a minor impact on estimates for individual states and territories, except for the Northern Territory, 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 2012–13 NATSIHS component 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 Northern Territory for 2007–08 should be used with caution due to large RSEs resulting from the small sample size for Northern Territory in 2007–08.
- RSEs for adult overweight and obesity rates by state/territory and Remoteness Areas are generally within acceptable limits, except for remote areas in all jurisdictions and outer regional areas in Victoria 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 Northern Territory which should be used with caution. For children, remoteness and SEIFA disaggregations by state/territory should generally be used with caution.
- Adult overweight and obesity rates by age and sex generally have acceptable levels of sampling error at the state/territory level, though some of the rates for females in Northern Territory should be used with caution.
- Sampling errors for BMI data for adults by state/territory are generally within acceptable limits, though rates of underweight for most states/territories for both adults and children should be used with caution.
- Rates of overweight and obesity for adults by state/territory and disability status are within acceptable limits. For children with disability, rates of overweight and obesity should generally be used with caution.

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

- Data for overweight and obesity is not directly comparable to the 2004–05 NATSIHS due to the difference in the collection methodology and the possible erroneous estimation of respondents' 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. This includes the 2004–05 NATSIHS and 2004–05 NHS. This means 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 and NATSIHS 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, 2013 QS
Health!, Superseded 14/01/2015

Has been superseded by National Healthcare Agreement: PI 03-Prevalence of overweight and obesity, 2015 QS
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Indicators linked to this Data Quality statement:

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