

National Healthcare Agreement: PI 02-Incidence of selected cancers, 2015 QS

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Identifying and definitional attributes

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Data quality

Data quality statement summary:

- The 2010 and 2011 incidence data for NSW and the ACT were not available for inclusion in the 2011 version of the Australian Cancer Database (ACD). The development of the new NSW Cancer Registries system has resulted in a delay in processing incidence data for 2010 onwards and therefore the most recent NSW data available for inclusion in the ACD are for 2009. Full details about this situation are given on the web page <http://www.cancerinstitute.org.au/data-and-statistics/accessing-our-data/availability-of-nsw-central-cancer-registry-data>. As the coding of ACT cancer notifications is contracted to the NSW Cancer Registry, the most recent data available for the ACT are also for 2009. The 2010 and 2011 incidence data for NSW and the ACT were estimated by the Australian Institute of Health and Welfare (AIHW). Although the estimation procedure has been shown to be reasonably accurate for estimating overall cancer incidence, its accuracy with respect to individual cancers will vary. Until the actual 2010 and 2011 cancer data are available from these jurisdictions caution should be exercised when comparing the 2010 and 2011 NSW, ACT and Australian data with data from previous years. The estimates of 2010 and 2011 incidence in NSW and ACT cannot be disaggregated by Indigenous status, remoteness area or socioeconomic status. The Australian totals for these tables do not include NSW and ACT.
- This indicator only counts one year of incidence data. For jurisdictions that record relatively small numbers of cancers, rates may fluctuate widely from year to year; these changes should be interpreted with caution.
- The completeness of Indigenous identification in cancer registry data varies between jurisdictions. Those with sufficiently complete identification to enable reliable reporting of cancer incidence rates are NSW, Qld, WA and NT. Indigenous data for the other jurisdictions are not published.
- The Cancer Institute NSW (CINSW) uses an imputation method to impute missing Indigenous status for reporting purposes. This may lead to differences between the Indigenous rates presented for NSW in this Indicator and the Indigenous rates presented in CINSW incidence reports.
- The incidence rate in Indigenous Australians may fluctuate considerably from year to year due to the behaviour of rare events in small populations.
- Remoteness area and socioeconomic status are based on Statistical Area Level 2 (SA2) of residential address at the time of diagnosis.
- Incidence rates based on counts of between 1 and 4 persons have been suppressed because of statistical unreliability (relative standard error $\geq 50\%$).

Institutional environment: The National Cancer Statistics Clearing House (NCSCH), housed at the AIHW, is a collaborative partnership between the AIHW and the Australasian Association of Cancer Registries (AACR). Cancer incidence data are supplied to the AIHW by state and territory cancer registries. These data are compiled by AIHW to form the Australian Cancer Database (ACD). All jurisdictions have legislation requiring mandatory reporting of all cancer cases with the exception of basal cell carcinoma of the skin and squamous cell carcinoma of the skin.

Timeliness: Data available for the 2015 COAG Reform Council report are based on cancers diagnosed in 2007–2011, noting that cancers for 2010 and 2011 in NSW and ACT are based on estimates.

Accessibility: The NCSCH provides summary cancer incidence and mortality data annually via the AIHW website where they can be downloaded free of charge. A biennial report, *Cancer in Australia*, is published and is also available on the AIHW website where it can be downloaded without charge. More specialised data can be requested via the AIHW website.

Interpretability: While numbers of new cancers are easy to interpret, calculation of age-standardised rates is more complex and the concept may be confusing to some readers. Information on how and why age-standardised rates have been calculated and how to interpret them is available in all AIHW cancer publications presenting data in this format, e.g. *Cancer in Australia: an overview, 2014*. Information about the Australian Cancer Database is available on the AIHW website.

Relevance: The data used to calculate this indicator are accurate and of high quality. The mandatory reporting of cancers and the use of Estimated Resident Populations (ERPs) based on Census data for denominators provides the most comprehensive data coverage possible. The data are appropriate for this indicator.

Accuracy: The 2010 and 2011 incidence data for NSW and the ACT were not available for inclusion in the 2011 version of the Australian Cancer Database (ACD). The development of the new NSW Cancer Registries system has resulted in a delay in processing incidence data for 2010 onwards and therefore the most recent NSW data available for inclusion in the ACD are for 2009. Full details about this situation are given on the web page <http://www.cancerinstitute.org.au/data-and-statistics/accessing-our-data/availability-of-nsw-central-cancer-registry-data>. As the coding of ACT cancer notifications is contracted to the NSW Cancer Registry, the most recent data available for the ACT are also for 2009. The 2010 and 2011 incidence data for NSW and the ACT were estimated by the Australian Institute of Health and Welfare (AIHW). Although the estimation procedure has been shown to be reasonably accurate for estimating overall cancer incidence, its accuracy with respect to individual cancers will vary. Until the actual 2010 and 2011 cancer data are available from these jurisdictions caution should be exercised when comparing the 2010 and 2011 NSW, ACT and Total data with data from previous years. The estimates of 2010 and 2011 incidence in NSW and ACT cannot be disaggregated by Indigenous status, remoteness area or socioeconomic status. The Australian totals for these tables do not include NSW and ACT.

The 2009 incidence data for NSW and the ACT provided to the AIHW excluded the provisional death-certificate-only cases. The reason the provisional DCO cases were not available is explained on the web page <http://www.cancerinstitute.org.au/data-and-statistics/accessing-our-data/availability-of-nsw-central-cancer-registry-data>. The AIHW has estimated the number of provisional DCO cases in 2009 for each cancer, sex and age group based on the numbers observed for 2004–2008. Overall for the five cancers covered in the Indicator, about 1.2% of NSW cases and 1.4% of ACT cases are estimated DCO cases. The percentage varies by cancer type.

For Indigenous status, the numerator for 'Indigenous' is the number of people who self-reported that they were Indigenous at the time of diagnosis. 'Other' includes those who self-reported that they were not Indigenous at the time of diagnosis and those who chose not to identify as either Indigenous or non-Indigenous.

The completeness of Indigenous identification in cancer registry data varies between jurisdictions. Those with sufficiently complete identification to enable reliable reporting of cancer incidence rates are NSW, Qld, WA and NT. Indigenous data for the other jurisdictions are not published. As stated above, 2010 and 2011 incidence data for NSW are estimated and Indigenous status for these estimates is not available. Therefore, in 2010 and 2011 the 'total' column in Table 2.2 excludes NSW and the figures therein cannot be compared to their pre-2010 counterparts.

Socioeconomic status rankings (by Index of Relative Socio-Economic Disadvantage (IRSD) score) are calculated by SA2 using a population-based method at the Australia-wide level. That is, the quintiles are national quintiles, not state and territory quintiles.

An SA2-to-remoteness-area concordance and SA2-to-socioeconomic-status concordance were used to allocate remoteness area and socioeconomic status to each record on the ACD based on the person's SA2 of residence at time of diagnosis.

Caution is required when examining differences across remoteness area and socioeconomic status categories. The SA2 of a person is determined by the cancer registry based on the address provided by the person. Some people may supply an address other than that where they normally reside or the details the person provides may not correspond to a valid address meaning that their cancer record cannot be allocated to a remoteness area or socioeconomic status category at all. Such records are excluded from the tables and this may affect some remoteness area and socioeconomic categories more than others. Also, because the concordances are based on the 2011 census, SA2 boundaries may have changed over time and these can create inaccuracies.

Due to the very small number of diagnoses involved, disaggregation by Indigenous status, or remoteness area, or socioeconomic status by state and territory is not necessarily robust.

This indicator only counts one year of incidence data. For jurisdictions that record relatively small numbers of cancers, rates may fluctuate widely from year to year; these changes should be interpreted with caution.

Incidence rates based on counts of between 1 and 4 persons have been suppressed because of statistical unreliability (relative standard error $\geq 50\%$).

This indicator is calculated on data that have been supplied to the AIHW and undergone extensive checks at both the source cancer registry and the AIHW. The state and territory cancer registries have checked the tables and given their approval for the AIHW to supply them to the Productivity Commission.

Coherence:

These data are published annually by the AIHW. While there are sometimes changes to coding for particular cancers, it is possible to map coding changes to make meaningful comparisons over time.

Not all state and territory cancer registries use the same ICD-10 code groupings to classify certain cancers, e.g. the AIHW defines bowel cancer as ICD-10 codes C18–C20 whereas some cancer registries also include C21. This may mean that data presented here are different to those reported by jurisdictional cancer registries, for certain cancers. The definitions used in this Indicator are as follows.

- Bowel cancer: ICD-10 codes C18–C20
- Lung cancer: ICD-10 codes C33–C34
- Melanoma of the skin: ICD-10 code C43
- Breast cancer in females: ICD-10 code C50 and sex female
- Cervical cancer: ICD-10 code C53.

The Cancer Institute NSW (CINSW) uses an imputation method to impute missing Indigenous status for reporting purposes. This may lead to differences between the Indigenous rates presented for NSW in this Indicator and the Indigenous rates presented in CINSW incidence reports.

The incidence rate in Indigenous Australians may fluctuate considerably from year to year due to the behaviour of rare events in small populations.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes [National Healthcare Agreement: PI 02-Incidence of selected cancers, 2014 QS](#)
[Health!](#), Superseded 14/01/2015

Has been superseded by [National Healthcare Agreement: PI 02-Incidence of selected cancers, 2016 QS](#)
[Health!](#), Superseded 31/01/2017

Indicators linked to this Data Quality statement: [National Healthcare Agreement: PI 02-Incidence of selected cancers, 2015](#)
[Health!](#), Superseded 08/07/2016