

Where do the data in this report come from?

The indicators come from a number of different sources, usually routine administrative datasets that collect information at a population level from a number of sources.

Diagnosis data: Obtained from records of the number of people diagnosed with chronic hepatitis B (classified in surveillance systems as 'unspecified' but here assumed to be chronic), which is notifiable by the diagnosing laboratory in all states and territories.

Monitoring and treatment data: Derived from data provided by Medicare Australia of the number of HBV viral load tests reimbursed by the MBS, and the number of prescriptions for HBV medications by the PBS. The number of people considered to be 'engaged in care' is the sum of those receiving viral load testing annually and those receiving antiviral treatment for HBV.

HCC data: Obtained from state and territory cancer registries, which collect information about the number of people who are diagnosed with cancer from diagnosing clinicians and laboratories.

Immunisation data: Obtained from the Australian Childhood Immunisation Register, on which nearly all children in Australia have the details recorded of their vaccinations.

Population data: Derived from data held by the Australian Bureau of Statistics, specifically the five-yearly Census of Population and Housing or the Estimated Resident Population projections.

Where do the prevalence data come from?

Prevalence data are estimated through the Census-based method, where the prevalence in priority populations (such as those born overseas, Aboriginal and Torres Strait Islander people, people who inject drugs, and men who have sex with men) is applied to the total population to give an estimate of the total number of people living with CHB. Full details of this method can be found in the first Medicare Local Mapping Report, available at ashm.org.au/hepatitis-b/mapping.

Why do data for the same indicator differ between some areas of the report?

The time period for which some data are available is limited - for example, treatment data have only been available at the Medicare Local level since mid-2013. In order to examine trends over time at a state and territory level, these data have been supplemented with information from other sources, which can provide slightly different estimates. When reporting the current estimate of treatment uptake in your state or territory, use the data in Table 5 (page 22).

In addition, time periods provided by Medicare Australia may not be calendar years, so these numbers may not match yearly estimates based on a standard year.

How can a fraction of a person (e.g. 6.7 people) be notified with CHB?

The notifications presented in Table 9 (page 37) are often approximations, because the data are collected according to the postcode of residence of the person diagnosed, and then allocated to LGAs based on standard statistical boundaries. When a postcode is part of more than one LGA, which is often the case, the number of cases will be allocated according to the proportion of the population who lives there - resulting in fractions of cases.

Why do the total figures in the tables sometimes not add up?

As the data are presented according to geographic area, there will always be a small number of people for whom there is insufficient information - in the Census, in surveillance data, or in Medicare - to have their residential address or state of residence classified. These people have been included in totals although they do not appear in any of the subordinate geographic areas.

Are there some people who have not been counted in these data?

No dataset can be 100% complete (or 100% accurate), with gaps often relating to the system of reporting. Although rare in each case, these data will not include people who have been diagnosed with CHB or HCC but have not had their diagnosis notified to the relevant authority, and children who are not registered with the ACIR. Importantly, immunisation, monitoring, and treatment data will not include people who are not eligible for, or registered with, Medicare.

Why are data missing for some Medicare Locals? Why are data missing from Medicare Locals in some sections but not others?

In accordance with the agreements made with the data custodians, and in order to protect the privacy of individuals, some counts have been suppressed if they were below a certain number. This includes any Medicare Local or LGA where:

- fewer than 20 patients received viral load testing or treatment through Medicare
- fewer than 5 people were diagnosed with HCC
- fewer than 5 people were registered as conscientious objectors to vaccination
- fewer than 5 people were diagnosed with CHB.

HCC data were also suppressed for a given Medicare Local when the data were missing for more than half of the LGAs that make up that Medicare Local, due to the resultant unreliability of these estimates.

Because there was a high level of suppression of viral load testing numbers according to Medicare Local, these numbers have been suppressed when presenting viral load testing rates (Table 10, page 52), but have been imputed to generate an

estimate of proportion in care (Table 13, page 58), where identification is prevented due to the use of a composite figure.

Why are the HCC data not compared by state and territory or a national figure provided?

The methods by which HCC incidence data are calculated vary between jurisdictions, which means that the resulting estimates cannot be compared between states or territories, or collated to establish a national summary figure.

List of abbreviations

CHB	Chronic hepatitis B
HBV	Hepatitis B virus
HCC	Hepatocellular carcinoma (liver cell cancer)
LGA	Local Government Area