2019 REVIEW OF THE DUST DISEASES SCHEME

Macquarie Room, Parliament House, Sydney

Wednesday, 2 October 2019

QUESTIONS ON NOTICE

QUESTION 1:

[Transcript – pages 26-27]
The CHAIR: Can I flip that. Let us assume you are already doing the triangulation of the other data, would requiring specialists to notify have an adverse impact on the data set?
Dr McANULTY: It may be useful and again it is something we are considering and need further consideration of. We are not ruling it out at all.
The CHAIR: What I am saying is when we have icare here, and other evidence—we have had the bus, for example—we think people are being missed. That is only applicable to a certain amount of people who were employed as well. We know that there are people that are probably heading off down through another path and are falling through some of the gaps. I would need to be convinced that us making a recommendation that specialists should notify would not have an adverse impact on the data. I think there could be a range of benefits. There could be no benefits. I would be happy with both of those outcomes. At the moment it seems like what we do have is missing people.
You can take it on notice if you like but could you answer whether you genuinely believe that if we recommended that specialists notify—Mr Shoebridge is right, their own college has said it should be notifiable—whether that would create an adverse impact on the data set and may lead to an adverse outcome rather than neutral or beneficial?
Dr McANULTY: For any source of data as long as you explain the limitations and caveats for the compilation of the data that avoids adverse effects.

ANSWER:

Mandatory notification is unlikely to provide an accurate indication of the incidence and prevalence of silicosis in NSW or a timely method for identifying the source of illness.

A better understanding of the burden of disease in NSW would likely come from triangulation of information from sources such as the icare screening program, NSW Health's hospital admission administrative dataset and the Australian Coordinating Registry cause of death data, which are collected in a clearly defined and systematic way. While these datasets have limitations and do not capture all cases of silicosis, they may allow estimates of the burden of disease to be calculated and trends to be monitored over time.

Experience from other notifiable conditions is that doctors notify only a proportion of cases. This is because doctors are busy, their first priority is the clinical care of patients and there is little incentive for doctors to notify. Notification takes time away from provision of clinical care and provides no direct clinical benefit to the patients who are being notified.

For instance under the Queensland scheme, doctors are required to complete a six-page form which must be submitted via a secure email service.

Compared with the datasets mentioned above, the completeness with which doctors notify the conditions they diagnose may be more prone to variation over time, as doctors' awareness of notification requirements will vary over time.

If silicosis was made a notifiable condition by doctors, the number of cases notified would therefore likely provide a misleading picture of the burden of silicosis in NSW and it would need to be considered in the context of the other sources mentioned above.

As many patients will be diagnosed with silicosis years after the exposure to the source of their illness, there will be limitations in regulatory authorities' ability to use the information to identify and prevent workplace exposures to silicosis in a timely way.

QUESTION 2:

[Transcript page 27]
Mr DAVID SHOEBRIDGE: What is your understanding of the prevalence of silicosis in New South Wales now?
Dr McANULTY: We do not have good information on that.
Dr BROOME: No.
Mr DAVID SHOEBRIDGE: What are you doing to get better information on it?
Dr BROOME: More broadly, I suppose people suffer from a range of conditions and we in the health system use a range of data sources to look at those conditions. We, for example, have looked at our data to see what patterns there are in silicosis. One of the things about surveillance, often you do not get complete notification but it indicates trends. You can identify if things are going up. The data we have probably helps to do that already.
Mr DAVID SHOEBRIDGE: Can you give us on notice what the data is?
Dr BROOME: We have actually got some numbers that we could talk through.
Dr McANULTY: These are reports of silicosis admissions and first time admissions for patients to New South Wales hospitals. It depends on being coded correctly. In 2017, all ages, there were 18 reported admitted to hospital. Similar data ranging back to 2005, 48, and ups and downs. A general long-term decline. I mentioned 18 in 2018, in 2017 there were 29. There is a table we can provide.
Mr DAVID SHOEBRIDGE: In 2018?
Dr McANULTY: In 2018 there were 18.
Mr DAVID SHOEBRIDGE: In 2017 there were 29?
Dr McANULTY: That is right.

ANSWER:

A brief report is attached in TAB A.

QUESTION 3:

[Transcript page 27]
Mr DAVID SHOEBRIDGE: One of the recommendations of the Committee from earlier this year was a case finding study which would identify something like what we saw in Queensland, get that sort of data. Is that on track, is that happening?
Dr McANULTY: Again, that is where working with Safe Work, who are the regulators, and their system organisations—we are happy to work with them.
The CHAIR: Have you been asked to participate in such a case study?
Dr McANULTY: We would have to check on that.

ANSWER:

NSW Health has not been asked to participate in a case finding study for silicosis.

QUESTION 4:

[Transcript page 29]
The Hon. ANTHONY D'ADAM: On notice could you have a look at 5.2.2 in the final report of the task force, which I understand you were on, Dr McAnulty? Could you provide a bit more elaboration of the benefits of option one versus option two?
Dr McANULTY: Yes, on notice.

ANSWER:

NSW Health has reviewed the Final Report of the Manufactured Stone Industry Taskforce tendered to the committee on 26 September 2019. Section 5.2.2 of this document does not present options. NSW Health understands, based on a draft report tendered to the Committee by Mr David Shoebridge MLC that option 1 is to create provisions in the Work Health and Safety Act 2011 to require mandatory notification by medical practitioners to SafeWork NSW. Option 2 is to make silicosis a notifiable disease under the Public Health Act 2010 which would require notification to the Secretary of the Ministry of Health.

If the primary purpose of notification is to identify workplaces for regulatory inspection, then it is most likely to be successful if the regulator, SafeWork NSW, is able to receive the required data and that the data can legally be used for the intended purpose. While NSW Health will assist

where possible, it is important that SafeWork NSW has as direct access to the notification system and its management as possible. The best option is the one that is legally feasible and achieves these ends.

SUPPLEMENTARY QUESTION

QUESTION 1:

Further to the evidence provided at the hearing, can NSW Health provide an estimate for the cost of establishing a Dust Diseases register and an estimate of its annual ongoing costs.

ANSWER:

There have been calls for a register of silicosis to be established, but there is yet to be agreement on the purpose and scope of that register. The resources required to establish and maintain a register will depend on what it is intended to do. If a register is simply a list of cases, the resource requirements would be relatively small, but so would the potential benefit. If it was to ensure that all workers exposed to silicosis risk were regularly screened, diagnosed and managed, then the resource requirements would likely be far larger. Costings cannot be estimated until the purpose and scope of a registry are defined.

Hospital admissions and deaths from silicosis in NSW

Health Protection NSW

1 October 2019

Introduction

This report uses routinely collected administrative data to show the number of hospital admissions and deaths from silicosis among residents of NSW. The data have some limitations and should be considered in the context of other information, for example information reported by icare about the number of cases of silicosis among people who have been screened. Hospitalisation and death represent the more severe end of the spectrum of silicosis and so do not capture people who have the disease and who have not been admitted to hospital of died. In addition, there may be inaccuracies in coding of silicosis among people admitted to hospital or who have died.

Methods

Hospital admissions data were obtained from the NSW Ministry of Health's *Admitted Patient, Emergency Department and Deaths Register* (APEDDR), which includes all episodes of hospital care provided by NSW hospitals. Records were obtained for all hospital admissions of NSW residents with a primary or secondary diagnosis of silicosis (ICD 10 code J62.8) between 2001 and 2018. The APEDDR includes a patient identifier for each record, allowing analysis by patient as well as episode. 2018 is the most recent year with complete data. The APEDDR does not include admission of NSW residents to hospitals outside NSW.

Deaths data were extracted from the Cause of Death Unit Record File obtained from the Australian Coordinating Registry and held in the NSW Ministry of Health's SAPHaRI database for the years 2001 to 2017. 2017 is the most recent year for which cause-specific mortality data are available. The classification of cause of death is preliminary from 2014 onward and therefore subject to change.

First, we assessed trends in the number of episodes of hospital care by aggregating the total number of episodes by year and age-group. A single pa-

tient may have multiple episodes of care, either because they are admitted to hospital several times or because one hospital visit includes transfers within or between hospitals. In this analysis, episodes of care may include Emergency Department–only admissions and admissions to rehabilitation units. Estimates of the number of episodes of hospital care do not provide an accurate reflection of the incidence of new cases.

Second, we estimated the number of first-time admissions to hospital with a primary or secondary diagnosis of silicosis. First-time admissions provide a better indication of new cases of silicosis because they reflect a person's first interaction with the hospital system, although this first interaction could occur several years after they developed disease. To identify first-time admissions, we initially excluded all patients admitted between 2001 and 2004 from the data set. Among those remaining, we identified the first episode of care from 2005 onward.

Third, we assessed the trend in number of deaths by aggregating the total number deaths where silicosis was coded as an underlying or contributory cause of death.

Results

Hospital admissions

Figure 1 shows a decline in the the total number of hospital admissions where silicosis was the primary or secondary diagnosis between 2005 and 2018. Figure 2 shows the trends by age. There have been very few episodes of care among people age less than 40. There is has been no clear trend among those aged 40 - 59, and a declining trend among those aged over 60.

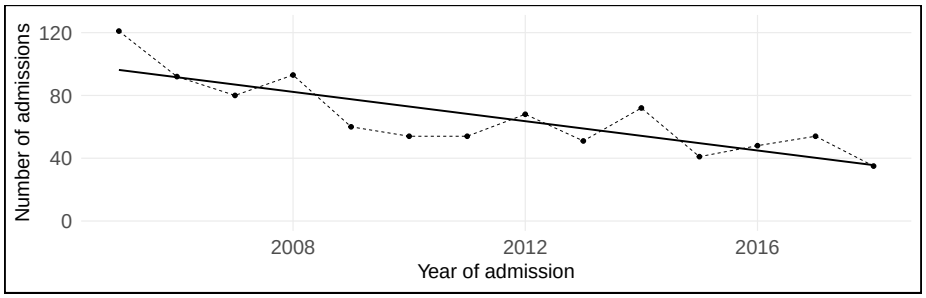

Figure 1: Total number of admissions to NSW hospitals where silicosis was the primary or secondary diagnosis, 2005 - 2018.

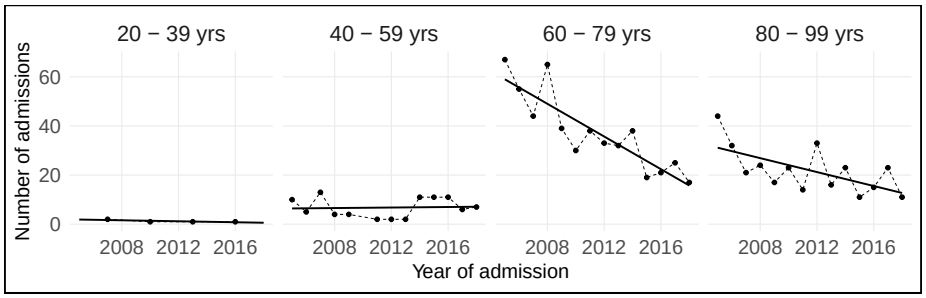

Figure 2: Number of admissions to NSW hospitals where silicosis was the primary or secondary diagnosis by age-group, 2005 - 2018.

Table 1: Number of admissions to NSW hospitals where silicosis was the primary or secondary diagnosis, 2005 - 2018.

	Age group				
Year	20 - 39	40 - 59	60 - 79	80 - 99	**All**
2005	0	10	67	44	**121**
2006	0	5	55	32	**92**
2007	2	13	44	21	**80**
2008	0	4	65	24	**93**
2009	0	4	39	17	**60**
2010	1	0	30	23	**54**
2011	0	2	38	14	**54**
2012	0	2	33	33	**68**
2013	1	2	32	16	**51**
2014	0	11	38	23	**72**
2015	0	11	19	11	**41**
2016	1	11	21	15	**48**
2017	0	6	25	23	**54**
2018	0	7	17	11	**35**

First-time hospital admissions

Figure 3 shows a decline in the number of first-time hospital admissions where silicosis was the primary or secondary diagnosis between 2005 and 2018. Figure 4 shows the pattern by age group. There are no clear trends among those aged less than 60 and declining trends among those aged over 60.

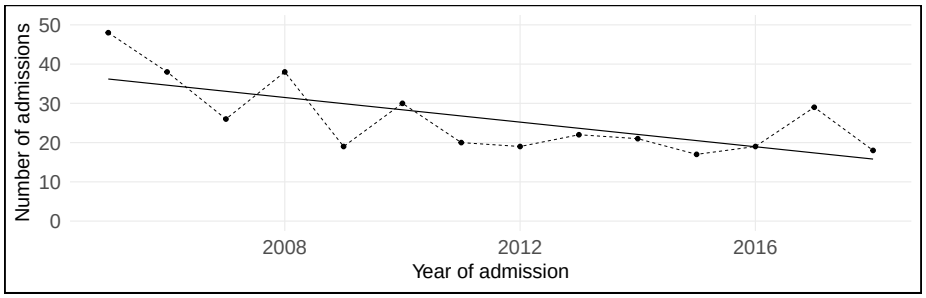

Figure 3: Number of first-time admissions to NSW hospitals where silicosis was the primary or secondary diagnosis, 2005 - 2018.

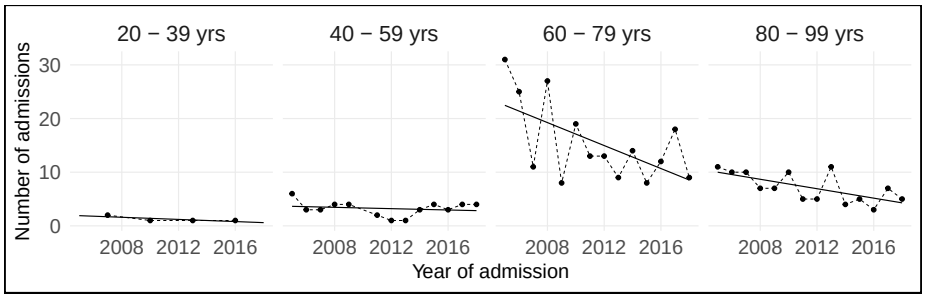

Figure 4: Number of first-time admissions to NSW hospitals where silicosis was the primary or secondary diagnosis by age-group, 2005 - 2018.

Table 2: Number of first-time admissions to NSW hospitals where silicosis was the primary or secondary diagnosis by age, 2005 - 2018.

	Age group				
Year	20 - 39	40 - 59	60 - 79	80 - 99	**All**
2005	0	10	67	44	**48**
2006	0	5	55	32	**38**
2007	2	13	44	21	**26**
2008	0	4	65	24	**38**
2009	0	4	39	17	**19**
2010	1	0	30	23	**30**
2011	0	2	38	14	**20**
2012	0	2	33	33	**19**
2013	1	2	32	16	**22**
2014	0	11	38	23	**21**
2015	0	11	19	11	**17**
2016	1	11	21	15	**19**
2017	0	6	25	23	**29**
2018	0	7	17	11	**18**

Deaths

Figure 5 shows a decline in the number of deaths where silicosis was an underlying or contributing cause between 2005 and 2017. Figure 6 shows the patterns by age. There were no deaths from silicosis among people aged less than 40 between 2005 and 2017 and very few deaths among those aged 40 to 59. There was a decline in the number of deaths among those aged 60 - 79 and a slight increase in the number aged over 80.

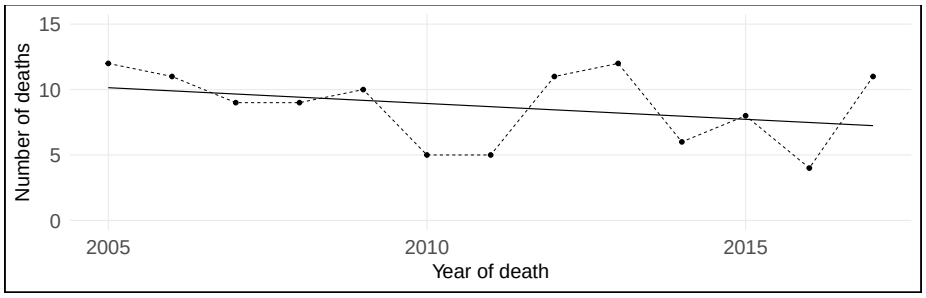

Figure 5: Total number of deaths where silicosis was an underlying or contributing cause, 2005 - 2017.

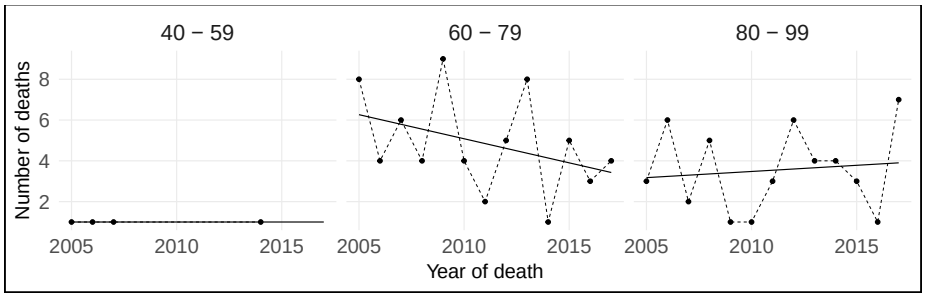

Figure 6: Number of deaths where silicosis was an underlying or contributing cause by age-group, 2005 - 2017.

Table 3: Number of deaths where silicosis was an underlying or contributing cause, NSW, 2005 - 2017.

	Age group			
Year	40 - 59	60 - 79	80 - 99	**All**
2005	1	8	3	**12**
2006	1	4	6	**11**
2007	1	6	2	**9**
2008	0	4	5	**9**
2009	0	9	1	**10**
2010	0	4	1	**5**
2011	0	2	3	**5**
2012	0	5	6	**11**
2013	0	8	4	**12**
2014	1	1	4	**6**
2015	0	5	3	**8**
2016	0	3	1	**4**
2017	0	4	7	**11**