

AGREEMENT

BETWEEN

THE HEALTH AUTHORITIES OF

THE STATES AND TERRITORIES OF AUSTRALIA

AND

THE AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE

AND

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

AND

THE COMMONWEALTH OF AUSTRALIA

for the purposes of this Agreement represented by the

AUSTRALIAN BUREAU OF STATISTICS

AND

DEPARTMENT OF HEALTH AND AGEING

AND

DEPARTMENT OF VETERANS' AFFAIRS

AND

DEPARTMENT OF HUMAN SERVICES

Commencement date: December 2011

Concerning the establishment of structures and processes through which the Commonwealth, State and Territory health and statistical authorities will develop agreed programs to improve, maintain and share national health information.

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PART A: PURPOSE AND SCOPE OF THE AGREEMENT

1. Purpose

- 1.1. The aim of the National Health Information Agreement (hereafter referred to as NHIA or the Agreement) is to improve the health of all Australians through the provision of information to support better planning and practice in health promotion, the prevention, detection and treatment of diseases and injury and health maintenance and rehabilitation. The NHIA will govern structures and processes through which Commonwealth, State and Territory health and statistical authorities work together to improve, maintain and share national health information.
- 1.2. To do this the Agreement's purpose is to ensure the availability of nationally consistent high quality health information to support policy and program development, and improve the quality, efficiency, effectiveness and accountability of health services provided to individuals and populations. The Agreement will promote the collection, compilation, analysis and dissemination of relevant, timely, accurate and reliable health information.
- 1.3. Nationally consistent health information also supports public discussion of health matters and research by health researchers and health professionals. The Agreement will therefore also improve opportunities for governments, health professionals, non-government organisations and consumer groups to share and use health information.

2. Scope

- 2.1. The scope of the Agreement is all nationally significant health-related information, as determined by the Australian Health Ministers' Advisory Council (AHMAC), including clinical and statistical information and processes that generate information, including information generated by e-health.
- 2.2. The Agreement will complement related Intergovernmental Agreements (such as information requirements of the Intergovernmental Agreement on Federal Financial Relations (IGAFFR)), including by overseeing national infrastructure to facilitate national consistency of data, and efficient provision of accurate and timely data as required by such Agreements. (**Schedule A** lists current major Agreements.)
- 2.3. This Agreement is not intended to create any legal obligation upon any of the signatories, (hereafter referred to as Parties) either as between them or as between a Party and any other person.

3. Principles

- 3.1. The Agreement will:
 - a) enable the collection and facilitate the use of health information in the national interest by implementing a commitment by Parties to working together to collect and facilitate the use of health information in the national interest;
 - b) benefit the Australian community, through better and more timely information, leading to appropriate provision of services, improved health outcomes and improved efficiency;
 - c) encourage strategic planning to ensure activities focus on areas where they are likely to lead to meet highest priority needs;

- d) improve national consistency of data, through development and implementation of agreed standards;
- e) improve the integration of clinical and statistical standards to facilitate seamless communication and facilitate a continuum of health information, avoiding duplication or incompatible or inconsistent data collection and flows;
- f) take account of available funding and human resources in balancing national benefits of information activities against imposition on jurisdictions and other data providers and managers;
- g) assist, where possible, consistency with information activities under related agreements, such as in community services and in non-government sectors;
- h) maximise efficiency of data management and access to data by researchers, policy makers and the community, through a "single provision, multiple use" basis for information sharing, within the constraints of privacy, confidentiality and other relevant legislation and data custodianship protocols;
- i) improve reporting and evaluation, to maximise efficiency and usefulness of information; and
- j) increase the participation in consistent national data management of stakeholders not currently covered by the agreement, including in the e-health area.

3.2. These principles will underpin all activities performed under this Agreement.

3.3. Core activities covered by the Agreement include:

- a) facilitation or establishment of nationally agreed projects in health information management;
- b) development and maintenance of a National Health Data Dictionary (NHDD) to underpin data development and collections;
- c) development of health data classifications and standards;
- d) endorsement of National Minimum Data Sets (NMDSs) and data set specifications (as defined in the NHDD) containing data elements consistent with NHDD definitions and classifications;
- e) integration and harmonisation of health, community services, housing assistance and income support data definitions, classifications and standards where possible;
- f) data linkage across health and other social policy sectors; and
- g) dissemination of consistent national information.

Part B: NATIONAL INFORMATION INFRASTRUCTURE

4. Introduction

- 4.1. Health information under this Agreement will be collected and maintained nationally with the approval of AHMAC, and within the framework of the national health information governance arrangements outlined in PART D below, and Schedule B to this Agreement.

5. Standards, definitions and classifications

- 5.1. All parties will agree and comply with standards, definitions, classifications and protocols for data collected for the purposes of national information collections within the scope of this agreement. Data standards adopted by Australian Bureau of Statistics (ABS) and authoritative international organisations will be employed wherever possible and variations made explicit when this is not possible.
- 5.2. The NHDD will be the authoritative source of data definitions. NMDSs will be agreed, collected and mandated for use by Parties to the Agreement. A list of currently agreed NMDSs is at Schedule C.

6. National standards governance

- 6.1. An endorsing body identified by AHMAC will be responsible for endorsing national standards based on recommendations from the relevant data subcommittees and in conjunction with the Australian Institute of Health and Welfare (AIHW) in its role as metadata registrar, in line with arrangements in Schedule B.
- 6.2. The parties agree that the endorsing body will facilitate management of any boundary issues which might emerge between e-health or clinical standard setting processes and statistical processes, in consultation with the National E-Health Transition Authority (NEHTA) or other bodies as necessary.

7. National Standards approval process

- 7.1. Bodies endorsed by AHMAC or its equivalent will determine the information and data standards for the data development process.
- 7.2. An AHMAC-delegated committee(s) will oversee the development and approval of:
 - Data standards for inclusion in the NHDD;
 - NMDSs for national implementation;
 - Best practice Data Set Specifications (DSS) for inclusion in the NHDD; and
 - National e-health informatics standards.
- 7.3. The Metadata On-line Registry (METeOR) will be used for metadata standards to create, store and manage metadata through the development and approval process
- 7.4. The AIHW will undertake a registrar and data standards expertise role on behalf of the appropriate information and data standards endorsing body.

8. Collection of information

- 8.1. Information will be collected in such a way that it is timely and of high quality.

- 8.2. Definitions and standards endorsed under this Agreement will be applied rigorously to ensure that information is capable of national comparison.
- 8.3. Responsibility for the quality and completeness of contributed data will remain with the Party providing the data.
- 8.4. A business case will need to be made for the development of any new NMDs or changes to NMDs taking account of value for money and strategic priority. Approval of business cases will be the responsibility of an AHMAC delegated Committee.

PART C: DATA SHARING AND USE

9. Data sharing

- 9.1. The Parties to the Agreement recognise that access to high quality, nationally consistent, health information is essential for the conduct of research and analysis and to inform the development and implementation of policies for improving health outcomes for all Australians.
- 9.2. The owner of the information is the original collecting authority. Consistent with the National Health Reform Agreement (NHRA), the owner can set publication conditions on the use of data by Commonwealth and State/Territory Departments, while agencies identified in Clause B97 of the NHRA will be able to access relevant data for the purposes set out in the NHRA. For other purposes, not covered by the NHRA, the owner can set reasonable conditions on access to and use of data provided, including timely approval for release for anything other than the uses agreed when it was provided. In the absence of any specific conditions being attached to data access and use by data owners, where NMDs protocols exist, they will be followed. The owner shall not impose undue limitations on data access and use, and shall allow bona fide researchers to access de-identified data for the purposes of research and analysis.
- 9.3. Information collected and maintained by the Parties to the Agreement will be released in a way consistent with agreed national protocols, definitions and standards. Sound statistical practice will be followed by signatories with respect to non-identified data, for example to ensure it is not disaggregated to a level that would enable identification of groups or individuals. However, in general, release of otherwise unpublished information should be in accordance with the NMDs Data Quality Statements which will increasingly be developed, for NMDs and individual data items, as well as for performance indicators.
- 9.4. Information will be made available nationally to all levels of the health system according to ethical and privacy considerations discussed elsewhere in this document (referred to in Clause 10 of the Agreement).
- 9.5. The Parties will strive to maximise the efficiency of data provision and access, on a "single provision/multiple user" basis, taking account of their legislative and other responsibilities regarding how the data may be shared.
- 9.6. Any transfer or storage of data for national collections will be in a manner that minimises the risk of unauthorised access.

- 9.7. New protocols to facilitate and streamline processes authorising a range of uses for the release and use of data may be developed in the life of the Agreement, and included in Schedules.
- 9.8. National statistical data linkage which supports research and analysis on health and related issues will be considered by the parties on a case by case basis in accordance with agreed privacy and ethical guidelines and the legislative structures and/or frameworks established by governments.

10. Privacy

- 10.1. Policies and practices which protect the privacy of individuals' information and ensure the responsible handling of health information will provide the foundation for the information collected and published under the auspices of this Agreement.
- 10.2. Information will be collected, disseminated, secured, linked and otherwise used in such a way as to comply with obligations that arise from any legislation, ethical guidelines and practices and/or contracts to protect the privacy and/or confidentiality of any individual or organisation to which it may refer. Data access and usage Conditions imposed by information owners, as mentioned in clause 9.2 shall also be adhered to.
- 10.3. All obligations regarding privacy and confidentiality of data survive the termination of this Agreement.

PART D: OPERATION OF THE AGREEMENT

11. Introduction

- 11.1. The Agreement is a multilateral agreement between the Parties and operates under the auspices of the Standing Council on Health (SCH) and AHMAC.
- 11.2. The Parties acknowledge that the names and/or roles of government entities may change over time. In such cases this Agreement will continue to apply to the successor of such entities, unless the entity withdraws from the Agreement, in accordance with Clause 17.3 of the Agreement.
- 11.3. AHMAC will be the ultimate authority for resolving issues relating to the Agreement including determination of national priorities, the work program and other management matters.
- 11.4. The National E-Health and Information Principal Committee (NEHIPC), and a number of its sub-committees currently have specific responsibilities for matters related to the Agreement. **Schedule B** sets out the roles of various committees and agencies under the Agreement.

12. Funding for national health information

- 12.1. The costs of implementing agreed activities will generally be met by the Parties as a component of their own work programs. However, reciprocal arrangements may be made between the Parties to meet specific needs for additional collections, specific analyses or provision of additional expertise.
- 12.2. Proposals for alternative resourcing may be developed where national benefit can be identified. Thus, funding may be sought under the Agreement from AHMAC where work on specific health information infrastructure

imposes additional costs on a signatory, where there are economies of scale to be gained, or where joint action of the Parties contributes to meeting the objectives of the Agreement.

13. National health information Work Program

- 13.1. There will be a rolling work program agreed by AHMAC.
- 13.2. The Work Program will take account of resource constraints on the parties and on strategic priorities spelled out in a five year work program which will be agreed by AHMAC.
- 13.3. The Work Program will outline projects which will be undertaken. It will include a detailed program for the coming year, describing specific projects and the agencies responsible for coordinating and managing them.
- 13.4. A report on the progress of these projects will be submitted annually to the appropriate AHMAC-nominated committee.

14. Extension of the collections

- 14.1. Every attempt will be made to involve other sectors collecting and using health information in the processes of this Agreement.

15. Relationship to health information provided under Council Of Australian Government (COAG) arrangements

- 15.1. As a general principle, wherever possible, existing data provision and collection processes should be used, but the Parties to this Agreement acknowledge that COAG Agreements may mandate health information reporting requirements or may establish authorities charged with mandating health information reporting requirements. Such agreements are listed at Schedule A to this Agreement. All data standards and data development processes set out in this agreement must be consistent with the objectives and provisions of the NHRA. Where there is any inconsistency between this agreement and the NHRA, the provisions of the NHRA shall have precedence.
- 15.2. The Parties agree to work on eliminating any identified inconsistencies between the information requirements specified under this Agreement and those specified under COAG agreements (including by authorities established under COAG agreements). The requirements specified under COAG agreements will prevail for the purpose of those agreements, until those inconsistencies are eliminated.

16. Duration of the Agreement:

- 16.1. The Agreement will be an ongoing Agreement that will continue until the Parties to it determine that a new Agreement is necessary.
- 16.2. A Post Implementation Review Report will be produced after twelve months for an AHMAC-designated committee (currently NEHIPC) consideration, outlining whether the NHIA is functioning as expected, any issues that have arisen and how they have been addressed. AHMAC, or a delegated AHMAC body, may also call for additional reviews of the agreement, and its operation, from time to time during the life of the agreement.

17. Variation to the Agreement

- 17.1. The Agreement may be amended at any time by agreement in writing between all the Parties.

17.2. Additional parties may become Parties to the Agreement if all existing Parties agree.

17.3. A Party proposing to withdraw should give six months notice. If a Party withdraws, the Agreement will continue to operate in respect of all other Parties.

18. Dispute resolution mechanism

18.1. Should any dispute arise in relation to this Agreement, the Parties will attempt to resolve it in good faith, if necessary by seeking decision from the relevant AHMAC-designated committee (currently NEHIPC). If the matter cannot be resolved the Parties agree that it will be escalated to AHMAC and, if necessary, to SCH or COAG.

19. Termination of the Agreement

19.1. The Agreement may be terminated at any time by agreement in writing of the remaining Parties.

20. Roles and responsibilities of Parties to the Agreement

20.1. All parties to the Agreement agree to:

- a) adhere to the national standards provisions of this Agreement;
- b) collectively administer the Agreement;
- c) participate in the management of projects for which individual agencies share responsibility;
- d) support national information infrastructure in the health sector;
- e) provide information for NMDSSs that have been approved by AHMAC and comply with their specifications;
- f) actively and cooperatively pursue the resolution of any difficulties that arise in the provision and collection of health data, including provide suggestions for improving the quality and relevance of minimum data set items;
- g) provide representation on the AHMAC-designated committee overseeing the Agreement, and on other Standing Committees as agreed by that committee;
- h) act as the responsible agency for specific projects as agreed;
- i) provide information and specialist advice on activities and collections for which they have responsibility; and
- j) acknowledge an obligation to use best endeavours to provide data within agreed time lines and actively pursue improvement in the consistency, timeliness and accuracy of data provided, to the standard of the best jurisdiction.

20.2. In addition, specific responsibilities of parties to the Agreement are set out in **Schedule B**.

21. Schedules to the Agreement

21.1. Where deemed appropriate by the Parties, specific protocols and arrangements to facilitate the operation of this Agreement will be included as Schedules to the Agreement and updated as necessary over time.

21.2. Any change to a Schedule or addition or removal of a Schedule, will constitute a variation and must comply with Clause 17.1 of the Agreement.

22. Date of Commencement of the Agreement.

The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

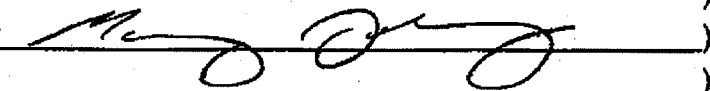
23. Counterparts

This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

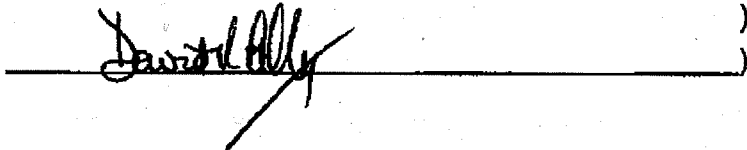
In witness whereof this Agreement has been made the 11th day of Nov. 2011 and signed.

SIGNED for and on behalf of the New South Wales
Health Department

by



Director - General, in the presence of



Date of Commencement of the Agreement.


The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

22. Counterparts

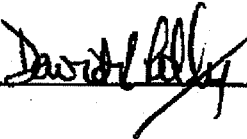
This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the 11th day of November 2011 and signed

SIGNED for and on behalf of Department of Health
Victoria

by )
)
)

Secretary, in the presence of)
)
)

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22. Date of Commencement of the Agreement.

The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

23. Counterparts

This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.


In witness whereof this Agreement has been made the 23RD day of DECEMBER 2011 and signed

SIGNED for and on behalf of the State of Queensland
represented by Queensland Health

by Dr Tony O'Connell

Director - General, in the presence of

Allison Costa



22. Date of Commencement of the Agreement.


The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

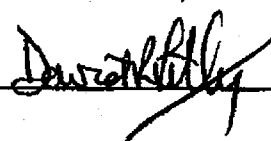
23. Counterparts

This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the 11th day of November 2011 and signed

SIGNED for and on behalf of the Department of Health,
South Australia

by  _____)
)
)
)

Chief Executive, in the presence of
 _____)
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)

22. Date of Commencement of the Agreement.

The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

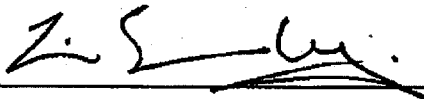
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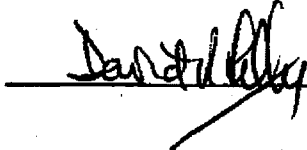
In witness whereof this Agreement has been made the 11th day of November 2011 and signed

SIGNED for and on behalf of the Department
of Health, Western Australia

by



Director-General, in the presence of



22. Date of Commencement of the Agreement.

The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

23. Counterparts

This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the 11th day of November 2011 and signed

SIGNED for and on behalf of the Department of Health and Community Services, Northern Territory

by _____)
)
)

Chief Executive Officer, in the presence of)
)
)

David L. Kelly

22. Date of Commencement of the Agreement.

The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

23. Counterparts

This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the 11 day of NOVEMBER 2011 and signed

SIGNED for and on behalf of ACT Health

by _____)
_____)
_____)

Chief Executive, in the presence of)
_____)
_____)

David H. Alley

22. Date of Commencement of the Agreement.

The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

23. Counterparts

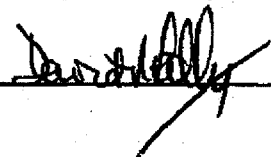
This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the 11th day of November 2011 and signed

SIGNED for and on behalf of the Commonwealth of Australia acting through the Department of Health and Ageing

by  _____)
)

Secretary of the Department, in the presence of

 _____)
)

22. Date of Commencement of the Agreement.


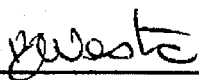
The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

23. Counterparts

This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the 2nd day of DECEMBER 2011 and signed

SIGNED for and on behalf of the
Australian Institute of Health and Welfare

by 
_____)
DAVID KALISCH,)
Director, in the presence of)

_____)

22. Date of Commencement of the Agreement.

The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

23. Counterparts

This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the 12th day of December 2011 and signed

SIGNED for and on behalf of the
Australasian Commission on Safety and Quality in Health Care

by William LAWRENCE

)
)
) *William Lawrence*

Director in the presence of AMY WINTER
Amy CEO

)
)
) *Amy Winter*
)
)

22. Date of Commencement of the Agreement.


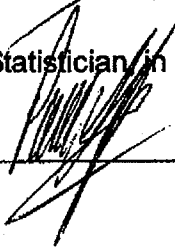
The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

23. Counterparts

This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the *23rd* day of *December* 2011 and signed

SIGNED for and on behalf of the Commonwealth of Australia acting through the Australian Bureau of Statistics

by  _____)
)
)
Australian Statistician, in the presence of _____)
)
)
 _____)

22. Date of Commencement of the Agreement.


The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

23. Counterparts

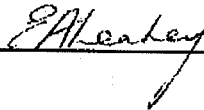
This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the *24* day of *December* 2011 and signed

SIGNED for and on behalf of the Commonwealth of Australia acting through the Department of Veterans' Affairs

by  _____)
)
)

Secretary, in the presence of)
)

Elizabeth Leakey  _____)
)

22 Date of Commencement of the Agreement.

The Agreement will commence on 31 December 2011. It supersedes any predecessor Agreement that may otherwise remain in force.

23 Counterparts

This Agreement may be signed in counterpart and the counterparts taken together all constitute the same Agreement.

In witness whereof this Agreement has been made the 12th day of December 2011 and signed

SIGNED for and on behalf of the Commonwealth of Australia acting through the Department of Human Services

by *K. Campbell*)
)
)
Secretary, in the presence of)
)
J. Halse)

GLOSSARY

Classifications: Systems of categories to which entities are assigned according to established criteria. Health classifications consist of hierarchical systems of codes. Classifications support data analysis.

Data linkage: The bringing together (linking) of information from two or more different data sources that are believed to relate to the same entity—for example the same individual or the same institution. The term is used synonymously with 'record linkage'.

Data Set Specifications (DSS): Metadata sets that are not mandated for collection but are recommended as best practice.

Indicator: A key statistical measure selected to help describe (indicate) a situation concisely, to track change, progress and performance, and to act as a guide to decision making.

Metadata: Metadata provides the underlying definitions and representation that supports collection, reporting and use of data within a specific context. For the national metadata registries, metadata is structured information that describes data about aspects of the systems the user community manages and for which they want to compare and share information.

National e-health information standards: The National E-Health Standards consists of a collection of standards and specifications that are essential guidance for those who develop, sell, support, buy and implement e-health software in Australia. A catalogue provides a list of the standards recommended by, and specifications sourced or developed by, NEHTA, and is updated regularly.

National Health Data Dictionary: The published Australian National Standard of data definitions recommended for use in Australian health data collections and the National Minimum Data sets agreed for mandatory collection and reporting at national level. The NHDD is the authoritative source of health data definitions used in Australia where national consistency is required. The Dictionary is designed to improve the comparability of data across the health field. It is also designed to make data collection activities more efficient by reducing duplication of effort in the field, and more effective by ensuring that information to be collected is appropriate to its purpose.

National Health Reform Act 2011: The National Health Reform Act 2011 as amended from time to time, including the amendments proposed by the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011."

National Minimum Data Set (NMDS): A minimum set of data elements agreed for mandatory collection and reporting at a national level. An NMDS agreement includes specified data elements as well as the scope of the application of those data elements. The agreement to collect a specified set of data elements is essentially a policy issue. The National Health Data Dictionary, identifies data elements from National Minimum Data Sets.

National Standards: Nationally approved rules for the development, collection, processing and dissemination of official statistics. They are a set of components which, when used together produce consistent and high-quality statistical output (about the concepts which underpin the statistical variables) across collections and over time. Data standards describe the agreed meaning and acceptable representation of data for use within a defined context.

Terminologies: The whole sphere of language used in the health system. It includes both Clinical Terminology and Classifications and their components. A standard clinical terminology enables the clinical descriptions used in clinical communications to be accurately recorded and consistently interpreted. A common terminology gives healthcare providers a high level of confidence in the information that they record, send and retrieve, ensuring continuity of care for patients across different times, settings and care providers.

Source: drawn largely from AIHW definitions and descriptions

ACRONYMS

ABS	Australian Bureau of Statistics
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers' Advisory Council
COAG	Council of Australian Governments
CRC	COAG Reform Council
DHS	Department of Human Services
DOHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
IGAFFR	Intergovernmental Agreement on Federal Financial Relations
IHPA	Independent Hospital Pricing Authority
JSCHIS	Joint Standing Committee on Health Informatics Standards
METeOR	Metadata Online Registry
NAGATSIHID	National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data
NEHIPC	National E-health and Information Principal Committee
NEHTA	National E-Health Transition Authority
NHA	National Healthcare Agreement
NHCIOF	National Health Chief Information Officers' Forum
NHDD	National Health Data Dictionary
NHIRF	National Health Information Regulatory Framework (Working Group)
NHIA	National Health Information Agreement
NHISSC	National Health Information Standards and Statistics Committee
NHRA	National Health Reform Agreement
NHPA	National Hospital Performance Authority
NMDS	National Minimum Data Sets
NPA	National Partnership Agreement
PCEHR	Personally Controlled Electronic Health Record
SCH	Standing Council on Health

SCHEDULE A: RELATED AGREEMENTS AND PROCESSES

PART A COUNCIL OF AUSTRALIAN GOVERNMENT (COAG) AGREEMENTS

This Schedule lists COAG Agreements which contain reporting requirements for health information and data. Further detail on specific agreements and their requirements can be accessed through the internet.

- 1. The Intergovernmental Agreement on Federal Financial Arrangements (IGAFFR) (2008)**
- 2. The National Healthcare Agreement (NHA) (2008).**
 - 2.1. A number of National Partnership Agreements (NPAs) that contain defined data reporting requirements are associated with the NHA, including those covering:
 - 2.1.1. Improving Public Hospital Services;
 - 2.1.2. Hospitals and Health Workforce Reform
 - 2.1.3. Preventive Health;
 - 2.1.4. Closing the Gap in Indigenous Health Outcomes.
 - 2.1.5. Essential Vaccines
 - 2.1.6. Elective Surgery Waiting Lists
- 3. National Health Reform Agreement (NHRA) (2011)**

PART B STANDING COUNCIL ON HEALTH AGREEMENTS

- 4. National E-health Strategic Plan**

PART C RELATED SECTORAL AGREEMENTS

- 5. National Community Services Information Infrastructure Agreement**
- 6. National Housing and Homelessness Information Infrastructure Agreement**

SCHEDULE B: GOVERNANCE ROLES AND RESPONSIBILITIES

1. Background

- 1.1. A series of national committees has been established to manage this Agreement and undertake specific tasks associated with the development and maintenance of national health information. The key responsibilities of these committees in relation to this Agreement and related matters are set out in this Schedule. Some responsibilities which do not relate closely to this Agreement may not be listed.
- 1.2. These committees have their own Terms of References, which provide more detail about their roles.

2. The Australian Health Ministers Advisory Committee (AHMAC)

- 2.1. The AHMAC directs work under the Agreement including through determination of national priorities, endorsing the work program and resolving issues which cannot be resolved by lower level committees.
- 2.2. Currently, the **National E-Health and Information Principal Committee (NEHIPC)** is the AHMAC Principal Committee in charge of arrangements under the Agreement including responsibility for overseeing the implementation of the NHIA itself. NEHIPC has responsibility, under AHMAC, for recommending national health information requirements including planning, statistics and research. It also is responsible for endorsing national information standards.
 - Under its current Terms of Reference a key role of NEHIPC is to advise AHMAC on national priorities for collaboration in e-health and information management requirements to improve system management practices. NEHIPC's responsibilities include endorsing the work plans of e-health and information committees and endorsing national information standards.
 - A number of standing committees and sub-committees currently operate under NEHIPC, including the National Health Information Statistics and Standards Committee (NHISSC), National Health Chief Information Officers Forum (NHCIOF), Joint Standing Committee on Health Informatics Standards (JSCHIS), National Health Information Regulatory Framework (NHIRF) working group and the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID).
 - Under NEHIPC the NHISSC oversees the development of, and endorses: data standards for inclusion in the National Health Data Dictionary; National Minimum Data Sets (NMDSs) for national implementation; best practice Data Set Specifications for inclusion in the NHDD; and national e-health informatics standards.
 - The NAGATSIHID advises AHMAC and NEHIPC on ways of improving the quality and availability of data and information on Aboriginal and Torres Strait Islander health and health service delivery.
- 2.3. In line with Clause 11.2 of the NHIA, agreed changes to the names or responsibilities of AHMAC committees may lead to amendments to Schedules, without revisiting the Agreement itself. Similarly any changes to current structures and clarification of roles and responsibilities may need to be reflected in changes to Schedules, without revisiting the Agreement itself.

3. The Australian Bureau of Statistics (ABS):

3.1. The Australian Bureau of Statistics, consistent with its functions, including statistical coordination, is responsible for:

- collecting, compiling, analysing and disseminating statistics and related information for which they have specific responsibility;
- developing and promoting compliance with statistical standards; and
- providing specialist advice in relation to statistics.

4. The Australian Institute of Health and Welfare (AIHW):

4.1. The AIHW is responsible for:

- Receiving, cleansing and disseminating information as a key national custodian of administrative health data collections and promoting national consistency of definitions and collections;
- managing data collected by the AIHW under the Agreement in accordance with the *Australian Institute of Health and Welfare Act 1987*, other relevant legislative requirements, and the Agreement;
- in consultation with the ABS, developing specialised statistical standards and classifications relevant to health and health services;
- undertaking specific research, using national data, to improve the efficiency and effectiveness of the health care system;
- assisting other Parties to the Agreement in using and interpreting national health information;
- ensuring that the NHDD and other quality control standards are maintained and enhanced to encourage accuracy and consistency in the collection and reporting of health information;
- Undertaking the role of metadata registrar for the Agreement;
- Making METeOR education and training resources available to stakeholders; and
- convening and providing secretariat assistance to the NHISSC, and the NAGATSIHID and support to the chairs of those Committees.

5. The Commonwealth Department of Health and Ageing, the Commonwealth Department of Veterans' Affairs (DVA), the Commonwealth Department of Human Services (DHS) and State and Territory Health Authorities

5.1. These agencies will be responsible for:

- ensuring that the information they collect, maintain and collate is consistent with the national protocols, definitions and standards contained in the NHDD and other guidelines endorsed by NEHIPC;
- maintaining the information they collect under the aegis of the Agreement in such a way that it can be readily made available to approved individuals, groups and authorities for purposes which require access to national health information kept under the terms of the Agreement; and
- ensuring that the information they hold is maintained in such a way as to ensure that the privacy provisions of the Agreement are observed.

6. The Independent Hospital Pricing Authority

- 6.1. The National Health Reform Act 2011 defines the functions of the IHPA as including to develop and specify classification systems for health care and other services provided by public hospitals; determine data requirements and data standards to apply in relation to data; and requirements and standards relating to patient demographic characteristics and other information relevant to classifying, costing and paying for public hospital functions.
- 6.2. The National Health Reform Act 2011 specifies that the IHPA may undertake data collection and research, including by commissioning others to undertake specified studies and research.

7. The National Health Performance Authority

- 7.1. The National Health Reform Act 2011 defines the functions of the NHPA as including provision of clear and transparent quarterly public reporting, monitoring against the performance measure and standards, and development of additional performance indicators as appropriate.

8. The Australian Commission for Safety and Quality in Health Care

- 8.1. The National Health Reform Act 2011 defines the functions of the ACSQHC as including collecting, analysing and interpreting information on health safety and quality matters.
- 8.2. The National Health Reform Act 2011 specifies that the ACSQHC formulate and promote the use of indicators relating to healthcare safety and quality matters.

9. The National E-Health Transition Authority

- 9.1. Since 2005 NEHTA has played a critical role in setting the specifications for electronic health information systems that will be adopted by jurisdictions. Work to date has included defining clinical terminologies and information messaging specifications and designing unique consumer and care provider identifiers for use in Australia. NEHTA's role shares a considerable boundary with work undertaken by NEHIPC, especially through the NHIRF Working Group and through the JSCHIS.

10. Standards Australia

- 10.1. Standards Australia is a public company which develops internationally aligned Australian Standards and facilitates the accreditation of other Standards Development Organisations. It acts as the coordination point for Australian representation at International Standards meetings.
- 10.2. Standards Australia have a role in converting NEHTA specifications into consensus based Australian Standards.

11. Other entities

11.1. Non-government groups and data can be included under the coverage of the Agreement through funding and other arrangements or licensing requirements.

SCHEDULE C:

LIST OF CURRENT NATIONAL MINIMUM DATA SETS.

Outpatient care NMDS

Admitted patient mental health care NMDS

Residential mental health care NMDS

Elective surgery waiting times (census data) NMDS

Alcohol and other drug treatment services NMDS

Admitted patient care NMDS

Non-admitted patient emergency department care NMDS

Admitted patient palliative care NMDS

Community mental health care NMDS

Public hospital establishments NMDS

Mental health establishments NMDS

Elective surgery waiting times (removals data) NMDS

Government health expenditure NMDS

Perinatal NMDS

Source: AIHW