

**AGREEMENT**

**BETWEEN**

**THE HEALTH AUTHORITIES OF**

**Commencement date: 1 October 2013**

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

**Signatories to the Agreement: Commonwealth, States and Territories**

Signed for and on behalf of the Department of Health by



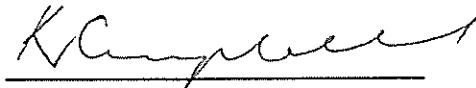
Jane Halton  
Secretary for the Department of Health  
Date 8/10/13

Signed for and on behalf of the Northern Territory by



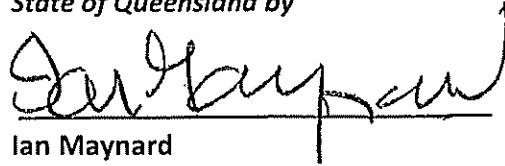
Jeffrey Moffet  
Chief Executive Department of Health  
Date

Signed for and on behalf of Department of Human Services



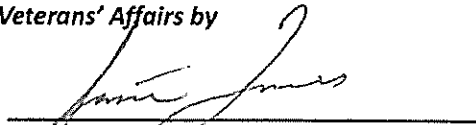
Kathryn Campbell  
Secretary of the Department of Human Services  
Date 31 OCT 13

Signed for and on behalf of the State of Queensland by



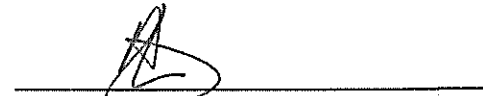
Ian Maynard  
Director-General Queensland Health  
Date 30 SEP 2013

Signed for and on behalf of the Department of Veterans' Affairs by



Simon Lewis  
Secretary for the Department of Veterans' Affairs  
Date 31/10/13

Signed for and on behalf of the State of South Australia by



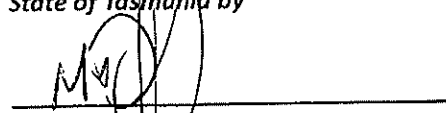
David Swan  
Chief Executive Department for Health and Ageing  
Date

Signed for and on behalf of the Australian Capital Territory by



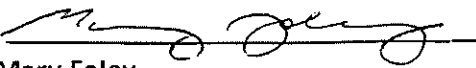
Peggy Brown  
Director General Health Directorate  
Date

Signed for and on behalf of the State of Tasmania by



Matthew Daly  
Secretary Department of Health & Human Services  
Date 21.10.13

Signed for and on behalf of the State of New South Wales by



Mary Foley  
Director General Ministry of Health New South Wales  
Date

Signed for and on behalf of the State of Victoria by



Pradeep Philip  
Secretary for the Department of Health Victoria  
Date

Signed for and on behalf of the  
State of Western Australia by



Bryant Stokes

Director General WA Department of Health

Date 30.10.2013

*Signatories to the Agreement: other entities*

Signed for and on behalf of the  
Australian Commission on Safety and Quality  
in Health Care by

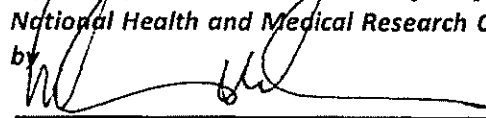


Debora Picone AM

Chief Executive Officer

Date 26/11/13

Signed for and on behalf of the  
National Health and Medical Research Council  
by



Warwick Anderson AM

Chief Executive Officer

Date 25/7/13

Signed for and on behalf of the  
Australian Institute of Health and Welfare by

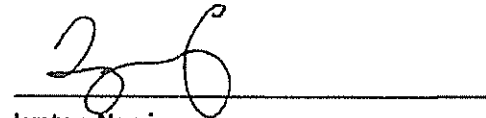


David Kalisch

Director and Chief Executive Officer

Date 22/07/2013

Signed for and on behalf of the  
National Health Funding Body by

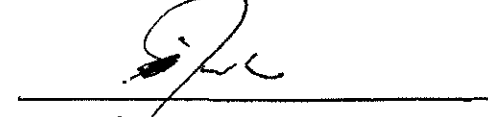


Lynton Norris

Chief Executive Officer

Date 19 November 2013

Signed for and on behalf of the  
Australian Bureau of Statistics by

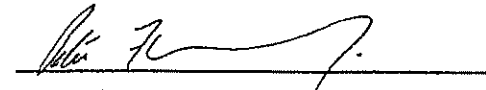


Brian Pink

Australian Statistician

Date 02/08/13

Signed for and on behalf of the  
National E-Health Transition Authority by

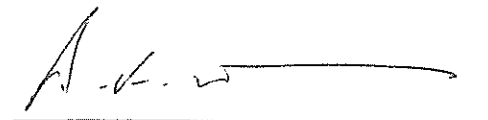


Peter Fleming

Chief Executive Officer

Date

Signed for and on behalf of the  
Independent Hospital Pricing Authority by

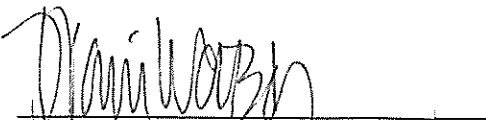


Tony Sherbon

Chief Executive Officer

Date 25/10/13

Signed for and on behalf of the  
National Health Performance Authority by



Diane Watson

Chief Executive Officer

Date 1 October 2013.

**CONTENTS**

RECITAL ..... 5

PART A: OPERATIONAL PROVISIONS ..... 5

Parties..... 5

Commencement and Terms..... 5

Variation to or termination of the Agreement ..... 5

Dispute resolution mechanism..... 5

Obligations ..... 6

PART B: PURPOSE AND SCOPE OF THE AGREEMENT ..... 6

Purpose ..... 6

Scope ..... 6

PART C: PRINCIPLES ..... 7

Governing Principles ..... 7

Operational guiding principles ..... 8

*Development*..... 8

*Production and distribution* ..... 8

*Use* ..... 8

Core activities..... 9

PART D: GOVERNANCE ..... 9

Roles and Responsibilities..... 9

PART E : NATIONAL INFORMATION INFRASTRUCTURE ..... 10

Standards, definitions, classifications, terminology and protocols ..... 10

National Data Standards approval process..... 11

Collection of information ..... 11

Data usage ..... 11

PART F: OPERATION OF THE AGREEMENT..... 12

National Health Information Strategic Directions and Work Program ..... 12

Funding for national health information..... 12

Relationship to health information provided under the Council Of Australian  
Government (COAG) arrangements ..... 12

Schedules to the Agreement ..... 12

GLOSSARY..... 13

ACRONYMS .....	17
LIST OF SCHEDULES .....	19
SCHEDULE A: RELATED AGREEMENTS AND PROCESSES.....	20
SCHEDULE B: GOVERNANCE ROLES AND RESPONSIBILITIES IN RELATION TO THE NHIA .....	21
SCHEDULE C DATA SHARING .....	26
SCHEDULE E - NATIONALLY AGREED INDICATORS LIST .....	30
SCHEDULE F - PROCESS AND TIMEFRAMES FOR DEVELOPMENT OF NMDS, DSS AND PERFORMANCE INDICATORS .....	38

## **RECITAL**

1. In entering this National Health Information Agreement (hereafter referred to as NHIA or the Agreement) the signatories recognise that they have a mutual interest in developing, reporting and using nationally consistent health information.
2. The aim of the NHIA is to improve the health of all Australians through the provision, use of and access to information to improve performance and reporting, support allocation of funding and support better planning and practice in health promotion, the prevention, detection and treatment of diseases and injury and health maintenance and rehabilitation.

## **PART A: OPERATIONAL PROVISIONS**

### **Parties**

3. This Agreement is between the Commonwealth and the States and Territories, and other national bodies as outlined on the front of this Agreement.

### **Commencement and Terms**

4. The Agreement will commence on 1 October 2013. It supersedes any predecessor Agreement that may otherwise remain in force, acknowledging that the privacy obligations under the previous agreement remain.
5. The Agreement will be an ongoing, continuing until the Parties to it determine that a new Agreement is necessary or the Agreement should be terminated.
6. The Agreement will be subject to a review to be initiated by Australian Health Ministers Advisory Council (AHMAC) at the end of five years of operation to determine the effectiveness of the Agreement and any changes to be recommended to AHMAC. Standing Council on Health (SCoH), or AHMAC, may call for additional reviews of the Agreement, and its operation, from time to time during the life of the Agreement.

### **Variation to or termination of the Agreement**

7. The Agreement including Schedules may be amended by agreement in writing between all the Parties.
8. Additional parties may become Parties to the Agreement if all existing Parties agree.
9. A party proposing to withdraw should give six month notice to AHMAC. If a party withdraws the Agreement will continue to operate in respect of all other parties.
10. The Agreement may be terminated at any time by agreement in writing of the remaining Parties.
11. The Parties acknowledge that the names and/or roles may change over time, without requiring immediate amendment of the Agreement (including the Schedules), of:
  - a) government entities; in such cases this Agreement will continue to apply to the successor of such entities, unless the entity withdraws from the Agreement; and
  - b) Ministerial Committee structures, including those relating to AHMAC. In such cases this Agreement will continue to apply and the successor of such committees will take on the relevant tasks.

### **Dispute resolution mechanism**

12. 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. If the matter cannot be resolved the Parties agree that it will be escalated to AHMAC and, if necessary, to SCoH or COAG.

## **Obligations**

13. This Agreement is not intended to create any legal obligation upon any of the signatories, either as between them or as between a Party and any other person, rather signatories commit to work together to achieve the aim of the Agreement.
14. Parties acknowledge various COAG approved agreements which impose conditions relating to national health information and acknowledge that where there is an area of conflict between these agreements and the NHIA, the COAG approved agreements will prevail.
15. The parties acknowledge that the National Reform Agencies (Independent Hospital Pricing Authority, National Health Performance Authority and the Administrator of the National Health Funding Pool) have prescribed functions under the *National Health Reform Act (2011)* with regards to health information specification, collection and analysis, and where there is conflict with the NHIA, the functions within the Act will prevail.
16. The parties acknowledge Commonwealth/State/Territory legislation may impose conditions relating to health information within that jurisdiction and acknowledge that where there is an area of conflict between the legislation and the NHIA, the legislation will prevail.
17. 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 within the Schedule to this Agreement.

## **PART B: PURPOSE AND SCOPE OF THE AGREEMENT**

### **Purpose**

18. The purpose of the Agreement is to ensure the availability of nationally consistent high quality health information to support policy and program development, and improve the quality, efficiency, appropriateness, effectiveness and accountability of health services provided to individuals and populations. The Agreement promotes the efficient, secure, confidential and timely use of information across the complete lifecycle from development to use and supports reuse of information.
19. The NHIA will govern structures and processes through which Commonwealth, State and Territory health, national statistical authorities and national health reform bodies' work together to improve, maintain and share national health information.
20. 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.

### **Scope**

21. The scope of the Agreement is all national health-related information, including clinical and statistical information, as determined by the AHMAC.

22. In order to ensure consistent national information, the scope of the Agreement will include standards, definitions, classifications and terminologies for data collections and performance indicators.
23. The Agreement is inclusive of the efficient, secure, confidential and timely use of information across the complete lifecycle from development to use.
24. 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.

## **PART C: PRINCIPLES**

### **Governing Principles**

25. These governing principles will underpin all activities performed under this Agreement.
26. The Agreement will:
  - a) provide a structure for the capture through to the use of health information in the national interest by implementing a commitment by Parties to work together to ensure the provision of timely and quality health information in the national interest;
  - b) lead to better and more timely information, through enabling collection, use and access to more relevant and timely quality information;
  - c) provide access to timely, high quality, nationally consistent, health information essential for the conduct of research and analysis and to inform the development and implementation of policies for improving health outcomes for all Australians;
  - d) facilitate and encourage strategic planning to ensure activities focus on areas where they are likely to lead to meet highest priority needs;
  - e) protect the privacy of individuals' information and ensure the responsible handling and reporting of health information will provide the foundation for the information collected and published under the auspices of this Agreement;
  - f) maximise efficiency of data management and access to data by the parties, researchers, policy makers and the community, through a "single provision, multiple use" basis for information sharing, within the constraints of privacy, security, confidentiality and other relevant legislation and data ownership protocols;
  - g) enable an environment where health information is calculated once, verified once and published widely;
  - h) 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;
  - i) reduce the burden associated with data capture and reporting through rationalisation of existing and new health information;
  - j) promote, where possible, consistency with information activities under related agreements, such as in community services, housing and homelessness and early childhood and in non-government sectors;
  - k) ensure consistency of privacy and security measures and standards through the use of Commonwealth Standards provided within the Protective Security Policy Framework issued by the Commonwealth Attorney-General's Department, and Australian Government Information Security Manual issued by the Defence Signals;



- l) support the participation in national health information arrangements by stakeholders not signatories to the agreement;
- m) take into account the management of national data collection on the processes and systems that generate or manage national data including nation data repositories and ehealth operations supporting clinical care; and
- n) apply to outsourced health services provided on behalf of a party.

## **Operational guiding principles**

27. The following operational guiding principles will inform the development of required schedules and support the day to day application of the Agreement:

### *Development*

- a) improving national consistency of data, through development and implementation of agreed standards;
- b) improving the integration of clinical and statistical standards to facilitate communication and a continuum of health information, avoiding duplication or incompatible or inconsistent data collection and flows;

### *Production and distribution*

- c) enabling information to be captured as close as possible to the point of service delivery, with the development and deployment of information capture tools that do not impede the effective delivery of care;
- d) ensuring quality data is provided within agreed timeframes;
- e) ensuring the quality of health information supplied for a particular use is application specific and appropriateness is reviewed when data is considered for another purpose;
- f) ensuring data suppression rules are case specific and only enacted where there is a risk that an individual or commercial-in-confidence information could be disclosed that was previously unknown to the recipients of the data;
- g) ensuring data is maintained in a secure environment and transmitted through secure methods;
- h) supporting transparent data transformation processes, such as shared statistical standards and validation processes;
- i) enabling provision and access to data quality statements;

### *Use*

- j) ensuring potential users of the health information have access to data quality statements and metadata to determine and assess appropriateness of use;
- k) ensuring the existence of information is easily discoverable, either by the world at large or at least by those parties who are entitled to use it;
- l) ensuring that systems for providing access to information give effect to access entitlements and make it as easy as possible for authorised users to obtain the data they need;
- m) improving and reduce unnecessary reporting and evaluation, to maximise process efficiency and the usefulness of information; and

- n) enabling National Minimum Data Set (NMDS) information to be reused without individual approval from the data owner where the data is de-identified and used within the boundaries of its original intent.

## **Core activities**

28. 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), Metadata On-line Registry (METeOR) and associated catalogues to underpin data development and collections;
- c) development of health data definitions, classifications, terminology and standards;
- d) endorsement of new and amended NMDSs and Data Set Specifications (DSS), containing data elements consistent with NHDD definitions and classifications;
- e) endorsement of protocols relating to the management of national data stores;
- f) development of specifications for national indicators;
- g) provide advice to SCoH on the feasibility, benefits and costs of moving towards a single national repository;
- h) integration and harmonisation of health, community services, housing assistance and income support data definitions, classifications, terminologies and standards where possible;
- i) data collection and reporting rationalisation;
- j) data linkage across health and other social policy sectors; and
- k) dissemination of consistent national information.

## **PART D: GOVERNANCE**

### **Roles and Responsibilities**

29. The Standing Council on Health (the Ministerial Council) which reports to the COAG, will:
- a) approve the national health information strategic directions and work plan provided for in this agreement;
  - b) direct AHMAC as necessary on matters of national health and information policy; and
  - c) continue to exercise its responsibilities in relation to national health information outlined in national agreements.
30. The Ministers for Health in each jurisdiction have responsibility for liaising with other portfolio Ministers in respect to any overlapping issues.
31. The AHMAC has responsibility for providing strategic and operational support to the Ministerial Council.
32. The AHMAC will:
- a) work within the Strategic Directions and work program approved by SCoH;
  - b) approve establishment of, additions and amendments to NMDS;
  - c) approve DSSs and data standards;
  - d) 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 and the Australian Bureau of Statistics in its role of formulating statistical standards, in line with arrangements outlined within the Schedule;

- e) 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), Standards Australia and other bodies, as necessary, to ensure maximum utility of data for statistical, data analysis and planning purposes; and
- f) refer to SCoH for decision, matters that are likely to be contentious or require significant resources.

33. All parties to the Agreement agree to:

- a) adhere to the national standard provisions within 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 (as defined in Part E of this Agreement) in the health sector;
- e) provide agreed national health information, complying with approved 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;
- j) acknowledge an obligation to provide data within agreed time lines and actively pursue improvement in the consistency, timeliness and accuracy of data provided; and
- k) inform the development of supporting Schedules as required.

## **PART E : NATIONAL INFORMATION INFRASTRUCTURE**

### **Standards, definitions, classifications, terminology and protocols**

34. All parties will agree and comply with standards, definitions, classifications, terminology and protocols for data collected for the purposes of national information collections within the scope of this agreement. Statistical standards formulated by the Australian Bureau of Statistics (ABS) and authoritative international organisations will be employed wherever possible and variations made explicit when this is not possible.
35. The NHDD will be the authoritative source of data definitions. NMDs will be agreed, collected and mandated for use by parties to the Agreement.
36. The METeOR will be the authoritative source of indicators, which will be agreed, calculated and mandated for use by parties to the Agreement.

## **National Data Standards approval process**

37. Bodies endorsed by AHMAC will determine the information and data standards as part of the data development process.
38. An AHMAC-delegated committee(s) will oversee the development of:
  - a) Recommendations to AHMAC on new NMDSs for national implementation;
  - b) Recommendations to AHMAC on additions to or amendment of existing NMDS for national implementation;
  - c) Data standards for inclusion in the NHDD;
  - d) Data elements within approved NMDS;
  - e) Best practice DSS for inclusion in the NHDD according to agreed timetables;
  - f) Specifications for indicators and associated frameworks; and
  - g) National e-health informatics standards.
39. The METeOR will be used for metadata standards to create, store and manage metadata through the development and approval process.
40. The AIHW will undertake a registrar and data standards expertise role on behalf of the appropriate information and data standards endorsing body.

## **Collection of information**

41. Information will be collected in such a way that it is consistent with nationally agreed definitions, timeliness and quality.
42. Definitions and standards endorsed under this Agreement will be applied rigorously to facilitate national comparison of information.
43. Responsibility for the quality and completeness of contributed data will remain with the Party providing the data for national reporting.
44. A business case will need to be made for the development of any new NMDSs or changes to NMDSs taking account of value for money, strategic priority and single provision multiple use.

## **Data usage**

45. Information collected and maintained by the Parties to the Agreement will be released in a way consistent with agreed national protocols, definitions and standards.
46. 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.
47. Parties support the establishment of broad categories for use of data which would not require individual approval by data owners. Release processes could be managed at a national level without seeking approval each time from the data owners, where data is used within the boundaries of its original intent.
48. All obligations regarding privacy and confidentiality of data survive the termination of this Agreement.

## **PART F: OPERATION OF THE AGREEMENT**

### **National Health Information Strategic Directions and Work Program**

49. There will be Strategic Directions for National Health Information and a rolling work program agreed by SCoH.
50. The Work Program will take account of resource constraints on the parties and on strategic priorities spelled out in a three year work program.
51. 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.
52. A report on the progress of these projects will be submitted annually to SCoH.
53. The National Health Information Strategic Directions and Work program will be available publically to assist in alignment of work priorities and reduce duplication and assist in rationalisation of data development effort.

### **Funding for national health information**

54. 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.
55. 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.

### **Relationship to health information provided under the Council Of Australian Government (COAG) arrangements**

56. 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 the COAG agreements). The requirements specified under COAG agreements will prevail for the purpose of those agreements, until those inconsistencies are eliminated.

### **Schedules to the Agreement**

57. 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.
58. Any change to a Schedule or addition or removal of a Schedule, will constitute a variation and must be approved by AHMAC and agreed in writing by all signatories.

## GLOSSARY

AHMAC means the Australian Health Ministers' Advisory Council which provides strategic and operational support to the COAG Standing Council on Health.

**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.

**Health information means:**

- a) information or an opinion about:
  - i. the health (at any time) of an individual; or
  - ii. an individual's expressed wishes about the future provision of healthcare; or
  - iii. healthcare provided, or to be provided, to an individual;  
that is also personal information; or
- b) other personal information collected to provide, or in providing, healthcare; or
- c) other personal information about an individual collected in connection with the donation, or intended donation, by the individual of his or her body parts, organs or body substances; or
- d) genetic information about an individual in a form that is, or could be, predictive of the health of the individual or a genetic relative of the individual.

**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.

**Health Information Lifecycle:** For the purposes of this agreement information lifecycle means the stage through which every record goes through from its creation to its use. The lifecycle of health information for the purposes of this Agreement have been grouped into three main stages, Development of health information, Production and distribution of health information, and use of health information.

**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.

Metadata Online Registry (METeOR): is Australia's repository for national metadata standards for the health, community services and housing assistance sectors.

Ministerial Council means the COAG Standing Council on Health.

Minister for Health means the Commonwealth Government Minister for Health unless otherwise noted as a State/Territory Health Minister.

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.

National Health Data Dictionary (NHDD): 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.

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, (NHDD) identifies data elements from health National Minimum Data Sets.

National Data Standards: Nationally approved rules for the meaning and acceptable representation of data within a defined context. 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.

National Statistical Standards: Standards formulated by the Australian Bureau of Statistics for the carrying out by official bodies of operations for statistical purposes

Single Provision, Multiple Use health information broad principle definition:

1. *Applies to all nationally significant health-related information. All information required by the national health reform agencies to meet their objectives is nationally significant health-related information. Information requirements specified in all national agreements (including but not limited to the IGA-FFR, the NHA, the NPAs, the NHRA and the NHIA) is also nationally significant health-related information. Nationally significant health-related information can be collected by the*

*Commonwealth Government (and its agencies), State and Territory governments and other sources.*

- 2. Applies across the whole life cycle of health information including: the development and specification of new data, classifications and performance indicators; recording of data for clinical and operational purposes; the production and distribution of health information; and the use of health information.*
- 3. Is about ensuring efficiency in the development, recording, provision, validation and re-supply of health information (that is, single provision). Single provision does not require that each of these steps is undertaken by a central agency; instead, it is about ensuring effective coordination in the development and production/distribution of health information to reduce duplication and overlap (of data and effort), to reduce administrative overheads, avoid unintended operational impacts on service delivery and facilitate data sharing.*
- 4. Is about maximising access to, and the responsible use of, health information by a range of users and for multiple purposes (that is, multiple use). Multiple use may be promoted through a common understanding about the respective roles of health information producers/owners, health information custodians and health information users including clear protocols about access to, and use of, health information.*

Specification is a set of requirements to be satisfied by a material, product or service, which may be developed by a range of public or private organisations and may include established standards. NEHTA develops specifications, which may become standards if they are developed under the governance of Standards Australia.

Standards are defined as documents, established by consensus and approved by a recognized body, that provides, for common and repeated use, rules, guidelines or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context. When developed and approved by a consensus process under the management of Standards Australia they are designated Australian Standards. Where National Data Standards have been determined, they are referenced within Australian Standards as the authoritative source of that information.

Technical Specifications are normative documents that have been subject to a limited form of transparency and do not have the support of the full consensus process normally associated with an Australian Standard. They may be prepared in a field where the subject matter, or related aspect such as the regulatory environment, is undergoing rapid change and where speed of delivery, rather than full consensus, is of paramount importance. In such cases, it would normally be expected that a Standard would eventually be developed to supersede the Technical Specification.

**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.



Clinical Terminology is a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Clinical Terminology covers complex concepts such as diseases, operations, treatments and medicines. Examples of Clinical Terminologies include SNOMED-CT, and the AMT (Australian Medicine Terminology).

## ACRONYMS

ABS	Australian Bureau of Statistics
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
COAG	Council of Australian Governments
CRC	COAG Reform Council
DHS	Department of Human Services
DOH	Department of Health
DSS	Data Set Specification
DVA	Department of Veterans' Affairs
HI	Healthcare Identifier
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
	National Authentication Service for Health

NASH	
NEHTA	National E-Health Transition Authority
NHA	National Healthcare Agreement
NHCIOF	National Health Chief Information Officers' Forum
NHDD	National Health Data Dictionary
NHFB	National Health Funding Body
NHIA	National Health Information Agreement
NHIPPC	National Health Information and Performance Principal Committee
NHISSC	National Health Information Standards and Statistics Committee
NHMRC	National Health and Medical Research Council
NHRA	National Health Reform Agreement
NHPA	National Health Performance Authority
NMDS	National Minimum Data Set
NPA	National Partnership Agreement
PCEHR	Personally Controlled Electronic Health Record
SCoH	Standing Council on Health
SCPR	Standing Committee on Performance and Reporting

## LIST OF SCHEDULES

SCHEDULE
A - Related Agreements and Processes
B – Governance roles and responsibilities in relation to the NHIA
C – Data Sharing and Usage
D – National Minimum Data Sets and Mandated Collections List
E - Nationally Agreed Indicators List
F - Process and timeframes for development of NMDS, DSS and Performance Indicators

## **SCHEDULE A: RELATED AGREEMENTS AND PROCESSES**

### **1. 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.

- a. Intergovernmental Agreement on Federal Financial Arrangements (IGAFFR) (2011)
- b. National Healthcare Agreement (NHA) (2012)
- c. National Health Reform Agreement (NHRA) (2011)

A number of National Partnership Agreements (NPAs) that contain defined data reporting requirements are associated with the NHA or the NHRA, including those covering:

- Improving Public Hospital Services;
  - Hospitals and Health Workforce Reform
  - Preventive Health;
  - Closing the Gap in Indigenous Health Outcomes.
  - Essential Vaccines
  - Improving Health Services in Tasmania
- d. Fourth National Mental Health Plan

### **2. STANDING COUNCIL ON HEALTH AGREEMENTS**

- e. National E-health Strategy
- f. Memorandum of Understanding: Developing an Effective National Ehealth Capability

### **3. RELATED SECTORAL AGREEMENTS**

- g. National Community Services Information Infrastructure Agreement
- h. National Housing and Homelessness Information Infrastructure Agreement

## **SCHEDULE B: GOVERNANCE ROLES AND RESPONSIBILITIES IN RELATION TO THE NHIA**

### **1 Background**

- 1.1 The management of this Agreement including the specific tasks associated with the development and maintenance of national health information are the responsibilities of SCoH, AHMAC and signatories.
- 1.2 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. These committees have their own Terms of References, which provide more detail about their roles.

### **2 Standing Council on Health**

- 2.1 The SCoH will pursue the following COAG strategic themes as its major focus areas:
  1. A Better Health Service and a More Sustainable Health System for Australia
  2. Closing the Gap for Indigenous Australians.
- 2.2 Scope of Standing Council

*The Commonwealth, State and Territory governments have a shared intention to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system. In doing so, part of the Standing Council's work will be to oversee the implementation of the COAG health reforms, which will deliver better health and hospitals by:*

- *helping patients receive more seamless care across sectors of the health system;*
- *improving the quality of care patients receive through higher performance standards, unprecedented levels of transparency and improved engagement of local clinicians; and*
- *providing a secure funding base for health and hospitals into the future.*

*The Council will play an important role in the inter-jurisdictional management of key health reform areas during the implementation of national health reform. It will provide a forum for Governments to address issues of mutual interest under the new health care arrangements and share best practice approaches, particularly with regard to health system management.*

### **National Health Information Agreement**

- 2.3 The Standing Council on Health (the Ministerial Council) which reports to the COAG, will:
  - a) approve the national health information strategic directions and work plan provided for in this agreement;
  - b) direct AHMAC as necessary on matters of national health and information policy;
  - c) continue to exercise its responsibilities in relation to national health information outlined in national agreements.
- 2.4 The Ministers for Health in each jurisdiction have responsibility for liaising with other portfolio Ministers in respect to any overlapping issues.

### **3 The Australian Health Ministers Advisory Committee (AHMAC)**

- 3.1 The AHMAC has a role in providing strategic and operational support to SCoH including advice on health information and performance issues.
- 3.2 The AHMAC directs work under the Agreement including through determination of national priorities, monitoring the work program and resolving issues which cannot be resolved by lower level committees.
- 3.3 Currently, the National Health Information and Performance Principal Committee (NHIPPC) is the AHMAC Principal Committee in charge of arrangements under the Agreement including responsibility for overseeing the implementation of the NHIA itself. NHIPPC has responsibility, under AHMAC, for recommending national health information requirements including planning, statistics and research. .
- Under its current Terms of Reference a key role of NHIPPC is to advise AHMAC on national priorities for collaboration in e-health and information management requirements to improve system management practices. NHIPPC's responsibilities include endorsing the work plans of e-health and information committees and endorsing national information standards.
  - A number of standing committees currently operate under NHIPPC; the National Health Information Standards and Statistics Committee (NHISSC), National Health Chief Information Officers' Forum (NHCIOF), Standing Committee on Performance and Reporting (SCPR), Joint Standing Committee on Health Informatics Standards (JSCHIS), and the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID).
  - Under NHIPPC the NHISSC oversees the development of, and recommends to NHIPPC endorsement of: 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 NHIPPC on ways of improving the quality and availability of data and information on Aboriginal and Torres Strait Islander health and health service delivery.
  - Under NHIPPC the SCPR (in close collaboration with NHISSC) oversees the provision of advice on national priorities for collaboration in information, performance and reporting requirements, including those outlined in the agreement and frameworks; and coordinates a number of performance and reporting activities on behalf of AHMAC and SCoH.
- 3.4 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.
- 3.5 Other AHMAC Principal Committees will have an interest in information and performance issues due to their scope from a program perspective, such as hospitals and community care; some may have information related committees e.g. Mental Health Information Strategy Subcommittee (MHISS) within the Mental Health and Drug and Alcohol Principal Committee. NHIPPC should always be consulted before other principal committees escalate information or reporting issues to AHMAC;

similarly NHIPPC should be cognisant of the need to consult with other relevant Principal Committees on co-joint issues.

## **4 Signatories - Commonwealth/State and Territories**

### **4.1 The Commonwealth Department of Health, the Commonwealth Department of Veterans' Affairs (DVA), the Commonwealth Department of Human Services(DHS) and State and Territory Health Authorities**

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 NHIPPC;
- 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.

## **5 Signatories - Other entities**

The following national bodies acknowledge the principles outlined in the agreement and commit to work within the principles stated, however where there is any conflict between the Agreement and any statutory obligations governing the specific role and responsibilities of particular national bodies, the statutory obligations will prevail.

### **5.1 The Australian Bureau of Statistics (ABS)**

The Australian Bureau of Statistics is the central statistical authority for the Australian Government, and by arrangement, the States and Territories. It is responsible for:

- Collecting, compiling, analysing and disseminating statistics and related information for which they have specific responsibility;
- Ensuring co-ordination of the operation of official bodies in the collection, compilation and dissemination of statistics;
- Formulating, and ensuring compliance, with statistical standards
- Providing advice and assistance in relation to statistics
- Liaising with international organisations on statistical matters
- The operations of the ABS are governed by the *Census and Statistics Act 1905* which provide the ABS with powers in regard to the collection of statistics and strict obligations to protect the confidentiality of responses. The operations of the Australian Bureau of Statistics, including the determination of the ABS work program, are controlled by the Australian Statistician who is an independent statutory office holder.”



## 5.2 The Australian Commission on Safety and Quality in Health Care (ACSQHC)

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

## 5.3 The Australian Institute of Health and Welfare (AIHW)

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.

## 5.4 The Independent Hospital Pricing Authority (IHPA)

- 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.
- 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.

## 5.5 The National E-Health Transition Authority (NEHTA)

- NEHTA was established in 2005, is funded on a cost-share basis as agreed by COAG and is a private company limited by guarantee. The NEHTA Board comprises all of the AHMAC Chief Executives plus one independent member and an independent chair.
- NEHTA is responsible for working with jurisdictions, primary and community healthcare providers, and health IT software vendors to implement the core elements of the national eHealth strategy including healthcare identifiers, standardised clinical terminology, national authentication of healthcare providers, the national product catalogue and standardised eProcurement, and eHealth standards and specifications for clinical documents and messages. NEHTA also has a role in supporting the Commonwealth to implement the Personally Controlled Electronic Health Record (PCEHR) and related systems such as the National Prescribe and Dispense Repository.
- NEHTA represents Australia on the International Health Terminology Standards Development Organisation, together with the US national Library of Medicines which uses SNOMED as clinical vocabulary for quality performance measurement as part of the US 'meaningful use' requirements.

## 5.6 The National Health Performance Authority (NHPA)

- 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.

## 5.7 National Health Funding Body (NHFB)

The function of the NHFB is to assist the Administrator in performing his or her functions under Commonwealth and State and Territory legislation. The NHFB is established as an independent statutory authority under the *Financial Management and Accountability Act 1997*.

## 5.8 National Health and Medical Research Council (NHMRC)

NHMRC is responsible to the Commonwealth Minister for Health. NHMRC's functions come from the statutory obligations conferred by the *National Health and Medical Research Council Act 1992*. The Act provides for the NHMRC to pursue activities designed to raise the standard of individual and public health throughout Australia; foster the development of consistent health standards between the various States and Territories; foster medical research and training and public health research and training throughout Australia; and foster consideration of ethical issues relating to health.

NHMRC is committed to open access and sharing of health information for the purposes of health and medical research, where that research is conducted in accordance with the *National Statement for the Ethical Conduct of Research Involving Humans (2007)*.

## **SCHEDULE C DATA SHARING**

1. The owner of the information is the original collecting jurisdiction. 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, subject to any jurisdictional legislative requirements, ethical guidelines and practices and/or contracts to protect the privacy and/or confidentiality of any individual or organisation to which it may refer. 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.
2. All Parties to the Agreement agree to provide requested data to other Parties of the Agreement within agreed timelines.
3. Parties to the Agreement recognise that the default position is to enable parties to be able to access national data sets without undue restrictions for the purpose of planning and operational improvement.
4. Information will be made available nationally to all levels of the health system according to ethical and privacy considerations discussed within the Agreement.
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.
6. Any transfer or storage of data for national collections will be in a manner that minimises the risk of unauthorised access.
7. National and bilateral statistical data linkage and related data sets to further analysis, policy development, planning and research in health is supported by all parties.
8. The owner shall not impose undue limitations on data access and use, and shall allow bona fide researchers to access non-identifiable data for the purposes of research and analysis.

## 9. SCHEDULE D: LIST OF CURRENT NATIONAL MINIMUM DATA SETS AND OTHER MANDATED COLLECTIONS

### National minimum data sets (NMDS) downloadable documents (last updated 21/06/2012)

Listed below are the National Minimum Data Sets in the health sector. These links will take you to the data sets where they can be download in Word or PDF. All information regarding data sets can be obtained from the following website:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>

#### Name of NMDS and link to onscreen view and Implementation date/s

- [Admitted patient care NMDS 2011-12](#) 01/07/11 to 30/06/12
- [Admitted patient care NMDS 2012-13](#) 01/07/12 to 30/06/13
- [Admitted patient mental health care NMDS 2011-12](#) 01/07/11 to 30/06/12
- [Admitted patient mental health care NMDS 2012-13](#) 01/07/12 to 30/06/13
- [Admitted patient palliative care NMDS 2011-12](#) 01/07/11 to 30/06/12
- [Admitted patient palliative care NMDS 2012-13](#) 01/07/12 to 30/06/13
- [Alcohol and other drug treatment services NMDS 2012-13](#) 01/07/12 to 30/06/13
- [Alcohol and other drug treatment services NMDS 2013-14](#) 01/07/13 to 30/06/14
- [Community mental health care NMDS 2011-12](#) 01/07/11 to 30/06/12
- [Community mental health care NMDS 2012-13](#) 01/07/12 to 30/06/13
- [Elective surgery waiting times \(census data\) NMDS 2009-12](#) From 30/06/2009 to 30/06/2012
- [Elective surgery waiting times \(census data\) NMDS 2012-](#) From 01/07/2012 to 30/06/2013
- [Elective surgery waiting times \(removals data\) NMDS 2009-12](#) From 01/07/2009 to 30/06/2012
- [Elective surgery waiting times \(removals data\) NMDS 2012-](#) From 01/07/2012 to 30/06/2013
- [Government health expenditure NMDS 2008-09](#) 01/07/08 to 30/06/09
- [Government health expenditure NMDS 2009-10](#) 01/07/09 to 30/06/10
- [Mental health establishments NMDS 2011-12](#) 01/07/11 to 30/06/12
- [Mental health establishments NMDS 2012-13](#) 01/07/12 to 30/06/13
- [Non-admitted patient emergency department care NMDS 2011-12](#) 01/07/11 to 30/06/12
- [Non-admitted patient emergency department care NMDS 2012-13](#) 01/07/12 to 30/06/13
- [Outpatient care NMDS 2007-13](#) From 01/07/2007
- [Perinatal NMDS 2012-13](#) 01/07/12 to 30/06/2013
- [Perinatal NMDS 2013-14](#) 01/07/13 to 30/06/2014
- [Public dental waiting times NMDS 2013-14](#) 01/07/13 to 30/06/2014
- [Public hospital establishments NMDS 2012-13](#) 01/07/12 to 30/06/13
- [Public hospital establishments NMDS 2013-14](#) 01/07/13 to 30/06/14
- [Residential mental health care NMDS 2011-12](#) 01/07/11 to 30/06/12
- [Residential mental health care NMDS 2012-14](#) 01/07/12 to 30/06/14

## Data set specifications (DSS) downloadable documents (last updated 21/06/2012)

Listed below are the current Data set specifications (DSS) in the health sector. These links will take you to the data sets where they can be download in Word or PDF.

All information regarding data sets can be obtained from the following website:

<http://meteor.aihw.gov.au/content/index.phtml/itemId/181162>

### Name of DSS and link to onscreen view:

- [Acute coronary syndrome \(clinical\) DSS](#)
- [Breast cancer \(cancer registries\) DSS](#)
- [Cancer \(clinical\) DSS](#)
- [Cardiovascular disease \(clinical\) DSS](#)
- [Computer Assisted Telephone Interview demographic module DSS](#)
- [Diabetes \(clinical\) DSS](#)
- [Elective surgery waiting times \(census data\) DSS 1 January 2012-30 June 2012](#)
- [Elective surgery waiting times \(removals data\) DSS 1 January 2012-30 June 2012](#)
- [Functioning and Disability DSS](#)
- [Health care client identification DSS](#)
- [Health care provider identification DSS](#)
- [Injury surveillance DSS](#)
- [Indigenous primary health care DSS](#)
- [Medical indemnity DSS](#)
- [Non-admitted patient DSS 2012-13](#)
- [Non-admitted patient emergency department care DSS 1 January 2012-30 June 2012](#)
- [Palliative care performance indicators DSS](#)
- [Perinatal DSS 2012-2013](#)
- [Public dental waiting times DSS 2012-](#)
- [Radiotherapy waiting times DSS 2012-](#)
- [Registered health labour force DSS](#)
- [Prisoner health DSS](#)
- [Public hospital establishment address details DSS](#)
- [Surveillance of healthcare associated infection: Staphylococcus aureus bacteraemia DSS](#)

## Independent Hospital Pricing Authority data set specifications

### [Activity based funding: Admitted acute hospital care DSS 2013-2014](#)

*Implementation start date:* ⓘ 01/07/2013  
*Implementation end date:* ⓘ 30/06/2014

### [Activity based funding: Admitted sub-acute and non-acute hospital care DSS 2013-2014](#)

*Implementation start date:* ⓘ 01/07/2013  
*Implementation end date:* ⓘ 30/06/2014

### [Activity based funding: Emergency department care DSS 2013-2014](#)

*Implementation start date:* ⓘ 01/07/2013  
*Implementation end date:* ⓘ 30/06/2014

### [Activity based funding: Emergency service care DSS 2013-2014](#)

*Implementation start date:* ⓘ 01/07/2013  
*Implementation end date:* ⓘ 30/06/2014

### [Activity based funding: Non-admitted patient care aggregate DSS 2013-2014](#)

*Implementation start date:* ⓘ  
*Implementation end date:* ⓘ

### [Activity based funding: Non-admitted patient care DSS 2013-2014](#)

*Implementation start date:* ⓘ 01/07/2013  
*Implementation end date:* ⓘ 30/06/2014

## SCHEDULE E - NATIONALLY AGREED INDICATORS LIST

Note: the following list will be updated to the METeOR format including links once available as per the Indigenous primary health care key performance indicators (2013), on page 33.

<b>Performance Indicator</b>
PI 1 – Proportion of babies born with low birth weight
PI 2 – Incidence of selected cancers
PI 3 – Prevalence of overweight and obesity
PI 4 – Rates of current daily smokers
PI 5 – Levels of risky alcohol consumption
PI 6 – Life expectancy
PI 7 – Infant and young child mortality rate
PI 8 – Major causes of death
PI 9 – Incidence of heart attacks
PI 10 – Prevalence of Type 2 diabetes
PI 11 – Proportion of adults with very high levels of psychological stress
PI 12 – Waiting times for GPs
PI 13 – Waiting times for public dentistry: Recommended category
PI 14 – People deferring access to selected health care due to financial cost
PI 15 – Effective management of diabetes: Recommended category
PI 16 – Potentially avoidable deaths
PI 17 – Treatment rates for mental illness
PI 18 – Selected potentially preventable hospitalisations
PI 19 – Selected potentially avoidable GP-type presentations to emergency departments
PI 20a- Waiting times for elective surgery
PI 20b- Waiting times for elective surgery
PI 21a- Waiting times for emergency department care: Proportion seen on time
PI 21b- Waiting times for emergency department care: Proportion completed within four hours
PI 22 – Healthcare associated infections:
PI 23 – Unplanned hospital readmission rates
PI 24 – Survival of people diagnosed with notifiable cancers
PI 25 – Rate of community follow up within first seven days of discharge from a psychiatric admission
PI 26 – Residential and community aged care places per 1,000 population aged 70+

<b>Performance Indicator</b>
years
PI 27 – Number of hospital patient days used by those eligible and waiting for residential aged care
PI 28 – Proportion of residential aged care services that are three year re-accredited
PI 29 – Proportion of residential aged care days on hospital leave due to selected preventable causes
PI 30 – Elapsed times for aged care services
PI 31 – Proportion of aged residents who are full pensioners relative to the proportion of full pensioners in the general population
PI 32 – Patient satisfaction/experience
PI 33 – Full time equivalent employed health practitioners per 1,000 population (by age group and profession type)
PB a – Close the life expectancy gap for Indigenous Australians within a generation
PB b – Halve the mortality gap for Indigenous children under five by 2018
PB c – Reduce the age-adjusted prevalence rate for Type 2 diabetes to 2000 levels (equivalent to a national prevalence rate (for 25 years and over) of 7.1 per cent) by 2023
PB d – By 2018, increase by five percentage points the proportion of Australian adults and Australian children at a healthy body weight, over the 2009 baseline
PB e – By 2018, reduce the national smoking rate to 10 per cent of the population and halve the Indigenous smoking rate, over the 2009 baseline
PB f – By 2014-15, improve the provision of primary care and reduce the proportion of potentially preventable hospital admissions by 7.6 per cent over the 2006-07 baseline to 8.5 per cent of total hospital admissions
PB g – The rate of <i>Staphylococcus aureus</i> (including MRSA) bacteraemia is no more than 2.0 per 10,000 occupied bed days for acute care public hospitals by 2011-12 in each State and Territory



---

## Indigenous primary health care key performance indicators (2013)

---

### Identifying and definitional attributes

*Metadata item type:* [i](#)

Indicator Set

*Indicator set type:* [i](#)

Other

*METeOR identifier:* [i](#)

457994

*Registration status:* [i](#)

Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

*Description:* [i](#)

As part of the National Indigenous Reform Agreement (NIRA), the Council of Australian Governments (COAG) agreed that the Department of Health and Ageing, in partnership with the state and territory health departments and in collaboration with the Australian Institute of Health and Welfare, would develop a set of national key performance indicators (KPIs) for Indigenous specific primary health care services.

The Indigenous primary health care national key performance indicators (KPIs) will monitor, inform, and provide a direct line of sight between the activities of federal and state- and territory-funded services that provide primary health care to Aboriginal and Torres Strait Islander people, and the COAG Closing the Gap targets, in particular the targets for life expectancy and child mortality.

The indicators will enable monitoring of the contribution of this part of the health system in achieving Closing the Gap targets. The KPIs are intended to:

- indicate the major health issues pertaining to the regular client population of Indigenous-specific primary health care services (especially those of maternal health, early childhood and the detection and prevention of chronic diseases)
- outline the extent to which government-funded Indigenous-specific primary health care services collect, record and review pertinent data on these issues, and
- reveal changes in health risks or outcomes that may be driven by the quality of care that government-funded services provide to their clients.

Initially the KPIs will provide measures of the extent to which various general indicators of individual health and health-related behaviours among the Indigenous population are being captured by a targeted small number of government-funded Indigenous-specific primary health care services.

It is anticipated that, over the next few years, both the level of detail explored by the KPIs and the number of health care services contributing to the KPIs will increase. Further indicators will also be added to the indicator set as new national data definitions are developed and incorporated into the Indigenous primary

health care data set specification (IPHC DSS).

The population of interest in the KPIs is the regular client population of an OATSIH-funded primary health care service that is required to report against the Indigenous primary health care key performance indicators. A regular client is defined as a client who has an active medical record; that is, a client who attended the OATSIH-funded primary health care service at least 3 times in 2 years.

## Relational attributes

*Related metadata references:* [i](#)

See also [Indigenous primary health care DSS 2012-14 Health, Standard 07/12/2011, Indigenous, Endorsed 11/09/2012](#)

Supersedes [Indigenous primary health care key performance indicators \(2012\) Health, Superseded 23/02/2012](#)

Has been superseded by [Indigenous primary health care key performance indicators \(2014\) Health, Standardisation pending 27/02/2013](#)

*Indicators linked to this Indicator set:* [i](#)

[Indigenous primary health care: PI01a-Number of Indigenous babies born within the previous 12 months whose birth weight has been recorded, 2013 Health, Standard 07/12/2011 Indigenous, Endorsed 11/09/2012](#)

[Indigenous primary health care: PI01b-Proportion of Indigenous babies born within the previous 12 months whose birth weight has been recorded, 2013 Health, Standard 07/12/2011 Indigenous, Endorsed 11/09/2012](#)

[Indigenous primary health care: PI02a-Number of Indigenous babies born within the previous 12 months whose birth weight results were low, normal or high, 2013 Health, Standard 07/12/2011 Indigenous, Endorsed 11/09/2012](#)

[Indigenous primary health care: PI02b-Proportion of Indigenous babies born within the previous 12 months whose birth weight results were low, normal or high, 2013 Health, Standard 07/12/2011 Indigenous, Endorsed 11/09/2012](#)

[Indigenous primary health care: PI03a-Number of regular clients who received an MBS Health Assessment for Aboriginal and Torres Strait Islander People \(MBS Item 715\), 2013 Health, Standard 07/12/2011 Indigenous, Endorsed 11/09/2012](#)

[Indigenous primary health care: PI03b-Proportion of regular clients who received an MBS Health Assessment for Aboriginal and Torres Strait Islander People \(MBS Item 715\), 2013 Health, Standard 07/12/2011 Indigenous, Endorsed 11/09/2012](#)

[Indigenous primary health care: PI04a-Number of](#)

Indigenous children who are fully immunised, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI04b-Proportion of Indigenous children who are fully immunised, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI05a-Number of regular clients with Type II diabetes who have had an HbA1c measurement result recorded, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI05b-Proportion of regular clients with Type II diabetes who have had an HbA1c measurement result recorded, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI06a-Number of regular clients with Type II diabetes whose HbA1c measurement result was within a specified level, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI06b-Proportion of regular clients with Type II diabetes whose HbA1c measurement result was within a specified level, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI07a-Number of regular clients with a chronic disease who have received a GP Management Plan (MBS Item 721), 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI07b-Proportion of regular clients with a chronic disease who have received a GP Management Plan (MBS Item 721), 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI08a-Number of regular clients with a chronic disease who have received a Team Care Arrangement (MBS Item 723), 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI08b-Proportion of regular clients with a chronic disease who have received a Team Care Arrangement (MBS Item 723), 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI09a-Number of regular clients whose smoking status has been recorded, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI09b-Proportion of regular clients whose smoking status has been recorded, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI10a-Number of regular clients with a smoking status result, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI10b-Proportion of regular clients with a smoking status result, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI12a-Number of regular clients who are classified as overweight or obese, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI12b-Proportion of regular clients who are classified as overweight or obese, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI13a-Number of regular clients who had their first antenatal care visit within specified periods, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI13b-Proportion of regular clients who had their first antenatal care visit within specified periods, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI14a-Number of regular clients aged 50 years and over who are immunised against influenza, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI14b-Proportion of regular clients aged 50 years and over who are immunised against influenza, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI15a-Number of regular clients with Type II diabetes or COPD who are immunised against influenza, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI15b-Proportion of regular clients with Type II diabetes or COPD who are immunised against influenza, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI16a-Number of regular clients whose alcohol consumption status has been recorded, 2013 Health, Standard 07/12/2011

Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI16b-Proportion of regular clients whose alcohol consumption status has been recorded, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI18a-Number of regular clients with a selected chronic disease who have had a kidney function test, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI18b-Proportion of regular clients with a selected chronic disease who have had a kidney function test, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI22a-Number of female regular clients who have had a cervical screening, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI22b-Proportion of female regular clients who have had a cervical screening, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI23a-Number of regular clients with Type II diabetes who have had a blood pressure measurement result recorded, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI23b-Proportion of regular clients with Type II diabetes who have had a blood pressure measurement result recorded, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI24a-Number of regular clients with Type II diabetes whose blood pressure measurement result was less than or equal to 130/80 mmHg, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

Indigenous primary health care: PI24b-Proportion of regular clients with Type II diabetes whose blood pressure measurement result was less than or equal to 130/80 mmHg, 2013 Health, Standard 07/12/2011  
Indigenous, Endorsed 11/09/2012

## Collection and usage attributes

*National reporting arrangement:* 

Each service funded by OATSIH (the Office of Aboriginal and Torres Strait Islander Health) to provide Indigenous-specific primary health care should record service provision in clinical information management systems that allow the electronic transmission of data for the Indigenous primary health care DSS (IPHC DSS), to be used in the calculation

of the key performance indicators (KPIs).

## **SCHEDULE F – PROCESS AND TIMEFRAMES FOR DEVELOPMENT OF NMDS, DSS AND PERFORMANCE INDICATORS**

The publication *Creating nationally-consistent health information: engaging with the national health information committees* provides relevant information and guidelines

<http://www.aihw.gov.au/publication-detail/?id=6442468336>

### Key Steps in the process

1. Seek advice from the National Health Information Standards and Statistics Committee (NHISSC) Secretariat
2. Seek the National Health Information and Performance Principal Committee's (NHIPPC) approval through the NHISSC to add to the development work onto the NHISSC Work Program (A project summary from along with a business case, if relevant, should be provided – templates attached)
2. Seek advice and training from the METeOR and Metadata Unit, Australian Institute of Health and Welfare.
3. For NMDS and DSSs to be collected from the beginning of a financial year, these must be endorsed by NHIPPC, through NHISSC by 31 December ( ie to start collection from 1 July 2014 endorsement must be obtained by 31 December 2013).

## National Health Information Standards & Statistics Committee

### Project summary form template

<b>Name of project/activity</b>	
<b>Auspice organisation or agency</b> (i.e. the “authority” of the project and the organisation or agency with whom the NHISSC will communicate on a formal basis)	
<b>NHISSC sponsor</b>	
<b>Purpose</b> (i.e. aim of project/ activity and/or reasons for undertaking project)	
<b>Benefit / Outcome to be achieved</b> (Please specify the benefits that are expected as a result of the NHISSC undertaking the work)	
<b>Scope</b> (i.e. the types of persons, services or issues to which the data development activity relates)	
<b>Brief Description</b> (2-3 lines only)	
<b>Group/committee undertaking data development activity/project</b>	<b>Name of group / committee:</b> <b>Name of contact person:</b> <b>Contact persons e-mail address:</b> <b>Contact persons mailing address:</b>



<p><b>Relationship with AHMAC or other government priorities</b></p>	<p>Does the project relate to work required to support AHMAC-sponsored projects/strategies, the National Health Priority Action areas, the National Health Information Development Priorities, the Australian Healthcare Agreements, the National Health Performance Committee indicators, or as part of the ongoing program of NMDS review</p> <p>YES/NO</p> <p>If Yes, please specify which priority _____</p> <p><b>If No, is such agreement anticipated or being sought?</b></p>
<p><b>Consultative mechanisms</b> (i.e. details of consultative arrangements in place to ensure product of activity/project is supported by the relevant stakeholders, including jurisdictional Departments)</p> <p>Please attach a membership list for any working groups involved</p>	
<p>Related projects/data collections</p>	<p>If Yes, please specify?</p>
<p><b>Timeframes / dependencies</b></p>	<p>Is there any urgency associated with the project or another deadline that must be met?</p> <p>Please specify _____</p> <p>Is any other project or work program dependent on completion of this project</p> <p>Please specify _____</p>
<p><b>Project/Activity Timeframe</b></p>	<p>Beginning: <b>End:</b> <b>Any other key milestones:</b></p>
<p><b>Funding source for the project</b> (ie who is paying for the data development activity, who will be paying for the ongoing maintenance)</p>	
<p>Metadata items</p>	<p>Does the project intend using any existing metadata items that are endorsed as national standards for example current metadata items included in the <i>National Health Data Dictionary</i>, <i>National Community Services Data Dictionary</i> or the <i>National Housing Assistance Data Dictionary</i>?</p> <p>If Yes, please specify?</p>

	<p>Is it intended to include these metadata items in the submission, with or without modification? Specify which ones will be modified</p> <p>Any further comment?</p>
Estimated number of metadata items that may be submitted to the NHISSC for consideration as national data standards?	

## Business Case Template

### Specific requirements for a business case for a new National Minimum Data Set or a significant change to an existing National Minimum Data Set

#### Background

Includes:

- origins and rationale for the proposal;
- development process undertaken to date;
- details of national consultation, including details of experts and/or others involved with or consulted during development;
- degree of consensus reached on submitted data elements;
- results of any pilot testing completed or proposed pilot testing arrangements.

#### Detailed purpose and objectives

Includes:

- how the information will be used;
- the likely benefits at the national level (and the likelihood that they will be realised);
- if they deem appropriate, the States and Territories to advise on the likely benefits at the jurisdiction level (and the likelihood that they will be realised).

#### Details of the NMDS:

Includes:

- scope;
- data elements;
- statistical units;
- start date;
- national reporting arrangements;
- other attributes as specified in the National Health Data Dictionary.

#### Implementation issues

Includes:

- any plans and timetables for staggered or phased implementation;
- feasibility of collection;
- notes on likely late or non-participation by jurisdictions;
- notes on effects of these on the NMDS;
- impact on time series reporting.

**Cost implications**

See Attachment A

Note: When completing the costing template include costs to hospitals in addition to direct outlays.

**Commitment statement**

Final, binding comments from the States and Territories on their willingness and ability to implement the NMDS according to the format and timetable proposed.

**Attachment 1 to the Business Case**

Components of the costing	Initial costs	First subsequent year	Second subsequent year	Third subsequent year
Set up and related costs				
Information system costs (including data capture, storage, submission to data repositories, changes to repositories and extraction of data)				
Additional staff numbers or impacts on existing staff				
Training costs				
New documentation and forms or changes to documentation and forms				
Other costs (please specify)				
<b>TOTAL</b>				