

# Data elements

## H – I

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## Health labour force

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000061	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element Concept		
<b>Admin. status:</b>	Current		
	01/07/95		
<b>Definition:</b>	<p>All those in paid employment, unpaid contributing family workers, and unpaid volunteers:</p> <ul style="list-style-type: none"> <li>- whose primary employment role is to achieve a health outcome for either individuals or the population as a whole, whether this is in clinical, research, education, administrative or public health capacities</li> <li>- employed in the health industry defined by the Australian Bureau of Statistics using the Australian and New Zealand Standard Industrial Classification, other than those already included.</li> </ul> <p>The health labour force consists of all those persons included in the health work force plus all those persons not currently employed in the health work force who are seeking employment therein. Health professionals registered in Australia but working overseas are excluded from the national health labour force. Health professionals registered in a particular State or Territory but working solely in another State or Territory or overseas are excluded from the health labour force for that State or Territory.</p>		
<b>Context:</b>	Health labour force statistics and public hospital establishments.		

### Relational and Representational Attributes

<b>Datatype:</b>	
<b>Representational form:</b>	
<b>Representational layout:</b>	
<b>Minimum size:</b>	
<b>Maximum size:</b>	
<b>Data domain:</b>	
<b>Guide for use:</b>	
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	relates to the data element Profession labour force status of health professional vers 1

### Administrative Attributes

<b>Source document:</b>			
<b>Source organisation:</b>	National Health Labour Force Data Working Group		
<b>Information model link:</b>	NHIM Labour characteristic		
<b>Data Set Specifications:</b>		<b>Start date</b>	<b>End date</b>
<b>Comments:</b>			

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## Health outcome

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### Identifying and Definitional Attributes

<i>Knowledgebase ID:</i>	000062	<i>Version No:</i>	1
<i>Metadata type:</i>	Data Element Concept		
<i>Admin. status:</i>	Current		
	01/07/97		
<i>Definition:</i>	A change in the health of an individual, or a group of people or a population, which is wholly or partially attributable to an intervention or a series of interventions.		
<i>Context:</i>	Admitted patient and non-admitted patient care.		

### Relational and Representational Attributes

<i>Datatype:</i>	
<i>Representational form:</i>	
<i>Representational layout:</i>	
<i>Minimum size:</i>	
<i>Maximum size:</i>	
<i>Data domain:</i>	
<i>Guide for use:</i>	
<i>Verification rules:</i>	
<i>Collection methods:</i>	
<i>Related metadata:</i>	

### Administrative Attributes

<i>Source document:</i>			
<i>Source organisation:</i>	National Health Information Management Group		
<i>Information model link:</i>	NHIM Stated outcome		
<i>Data Set Specifications:</i>		<i>Start date</i>	<i>End date</i>

*Comments:*

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## Health outcome indicator

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000063 **Version No:** 1

**Metadata type:** Data Element Concept

**Admin. status:** Current  
01/07/97

**Definition:** A statistic or other unit of information which reflects, directly or indirectly, the effect of an intervention, facility, service or system on the health of its target population, or the health of an individual.

- A generic indicator provides information on health, perceived health or a specific dimension of health using measurement methods that can be applied to people in any health condition.
- A condition-specific indicator provides information on specific clinical conditions or health problems, or aspects of physiological function pertaining to specific conditions or problems.

Epidemiological terminology

- An association exists between two phenomena (such as an intervention and a health outcome) if the occurrence or quantitative characteristics of one of the phenomena varies with the occurrence or quantitative characteristics of the other.
- One phenomenon is attributable to another if there is a casual link between the phenomena. Attribution depends upon the weight of evidence for causality.
- Association is necessary (but not sufficient) for attribution. Associations may be fortuitous or causal. The term relationship is to be taken as synonymous with association.

**Context:** Admitted patient and non-admitted patient care.

### Relational and Representational Attributes

**Datatype:**

**Representational form:**

**Representational layout:**

**Minimum size:**

**Maximum size:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related metadata:**

### Administrative Attributes

**Source document:**

**Source organisation:** National Health Information Management Group

**Information model link:**

NHIM Stated outcome

**Data Set Specifications:** **Start date** **End date**

**Comments:**

## Health professionals attended – diabetes mellitus

### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000804	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	The health professionals that a person has attended in the last 12 months in relation to issues arising from diabetes mellitus.		
<b>Context:</b>	Diabetes (clinical) specific data element.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	N(NNNN)
<b>Minimum size:</b>	1
<b>Maximum size:</b>	5

<b>Data domain:</b>	1	Diabetes educator
	2	Dietitian
	3	Ophthalmologist
	4	Optometrist
	5	Podiatrist
	8	None of the above
	9	Not stated/inadequately described

<b>Guide for use:</b>	Record a code sequentially for each health professional attended. A person may have attended several health professionals in the last 12 months, therefore, more than one code can be recorded sequentially. Example 1: If a person has attended a diabetes educator and a podiatrist in the last twelve months, the code recorded would be 15. Example 2: If all have been seen, the code recorded would be 12345.
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### Verification rules:

<b>Collection methods:</b>	The person should be asked about each type of health professional in successive questions, as follows: Have you attended any of the following health professionals in relation to diabetes mellitus in the last 12 months? Diabetes educator      ___ Yes ___ No Dietitian                ___ Yes ___ No Ophthalmologist        ___ Yes ___ No Optometrist             ___ Yes ___ No Podiatrist                ___ Yes ___ No The appropriate code should be recorded for each health professional attended. If the person answers 'NO' to all the health professionals specified, then code 8 should be applied.
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Code 9 should only be used in situations where it is not practicable to ask the questions.

**Related metadata:** relates to the data element Occupation of person vers 2

## Administrative Attributes

**Source document:** National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

**Source organisation:** National Diabetes Data Working Group

**Information model link:**

NHIM Request for/entry into service event

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS - Diabetes (clinical)	01/01/2003	

**Comments:**

The health professional occupations are assigned the following codes at the occupation level of the Australian Standard Classification of Occupations, Second Edition, Australian Bureau of Statistics, 1997, Catalogue No. 1220.0

Diabetic educator 2512-13

Dietitian 2393-11

Ophthalmologist 2312-19

Optometrist 2384-11

Podiatrist 2388-11

Management of diabetes requires a team approach, comprising selected health professionals, to provide services specific to the individual with diabetes.

All patients with diabetes require diet therapy in conjunction with exercise and/or medication to achieve optimal control of blood glucose, body weight and blood lipids. In insulin treated diabetics, diet management aims to restrict variations in the timing, size or composition of meals that could result in hypoglycaemia or postprandial hyperglycaemia. Based on the Healthy Eating Pyramid, meals should be low in saturated fat, and rich in high-fibre carbohydrates with low glycaemic index (GI). Saturated fats have to be replaced with monounsaturated and polyunsaturated fats.

According to the Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus, a comprehensive ophthalmological examination should be carried out:

- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more
- within five years of diagnosis and then every 1-2 years for patients whose diabetes onset was at age less than 30 years.

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus recommendations include:

- foot examination to be performed every 6 months or at every visit if high-risk foot or active foot problem
- refer to specialists experienced in the care of the diabetic foot if infection or ulceration is present
- to identify the 'high-risk foot' as indicated by a past history of foot problems, especially ulceration, and/or the presence of peripheral neuropathy, peripheral vascular disease, or foot deformity and history of previous ulceration
- ensure that patients with 'high-risk foot' or an active foot problem receive appropriate care from specialists and podiatrists expert in the treatment of diabetic foot problems.

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## Height – measured

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000362	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/03		
<b>Definition:</b>	A person's measured height.		
	In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.		

<b>Context:</b>	Public health, health care and clinical settings:
	Stature is a major indicator of general body size and of bone length and of nutritional and health status of the individual and the community at large. It is important in screening for disease or malnutrition, and in the interpretation of weight (Lohman et al. 1988). Shortness is known to be a predictor of all-cause mortality, coronary heart disease mortality in middle-aged men, and of less favourable gestational outcomes in women (Marmot et al. 1984, Kramer 1988). Measurements of height should be assessed in relation to children and adolescents' age and pubertal status.
	Disease, nutritional, genetic and environmental factors all exert an influence on the height of an individual, hence this variable, together with its related variable weight, is of unique value in health surveillance. It enables the calculation of body mass index which requires the measurement of height and weight (body mass) for adults as well as sex and date of birth for children and adolescents.

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Quantitative value
<b>Representational layout:</b>	NNN.N
<b>Minimum size:</b>	3
<b>Maximum size:</b>	4
<b>Data domain:</b>	Measurement in centimetres to one decimal place 999.9 Not able to be measured

#### Guide for use:

#### Verification rules:

<b>Collection methods:</b>	Measurement protocol:
	Height measurements can be based on recumbent length or standing height. In general, length measurements are recommended for children under 2 years of age and height measurements for others.
	The measurement of height requires a vertical metric rule, a horizontal headboard, and a non-compressible flat even surface on which the subject stands. The equipment may be fixed or portable, and should be described and reported.
	The graduations on the metric rule should be at 0.1 cm intervals, and the metric rule should have the capacity to measure up to at least 210 cm.

Measurement intervals and labels should be clearly readable under all conditions of use of the instrument.

Apparatus that allows height to be measured while the subject stands on a platform scale is not recommended.

Adults and children who can stand:

The subject should be measured without shoes (i.e. is barefoot or wears thin socks) and wears little clothing so that the positioning of the body can be seen. Anything that may affect or interfere with the measurement should be noted on the data collection form (e.g. hairstyles and accessories, or physical problems). The subject stands with weight distributed evenly on both feet, heels together, and the head positioned so that the line of vision is at right angles to the body. The correct position for the head is in the Frankfort horizontal plan (Norton et al. 1996). The arms hang freely by the sides. The head, back, buttocks and heels are positioned vertically so that the buttocks and the heels are in contact with the vertical board. To obtain a consistent measure, the subject is asked to inhale deeply and stretch to their fullest height. The measurer applies gentle upward pressure through the mastoid processes to maintain a fully erect position when the measurement is taken. Ensure that the head remains positioned so that the line of vision is at right angles to the body, and the heels remain in contact with the base-board.

The movable headboard is brought onto the top of the head with sufficient pressure to compress the hair.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement. If the two measurements disagree by more than 0.5 cm, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured height is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over-reporting (Armitage & Berry 1994). For example, a mean value of 172.25 cm would be rounded to 172.2 cm, while a mean value of 172.35 cm would be rounded to 172.4 cm.

Infants:

For the measurement of supine length of children up to and including 2 years of age, two observers are required. One observer positions the head correctly while the other ensures the remaining position is correct and brings the measuring board in contact with the feet. The subject lies in a supine position on a recumbent length table or measuring board. The crown of the head must touch the stationary, vertical headboard. The subject's head is held with the line of vision aligned perpendicular to the plane of the measuring surface. The shoulders and buttocks must be flat against the table top, with the shoulders and hips aligned at right angles to the long axis of the body. The legs must be extended at the hips and knees and lie flat against the table top and the arms rest against the sides of the trunk. The measurer must ensure that the legs remain flat on the table and must shift the movable board against the heels. In infants care has to be taken to extend the legs gently. In some older children two observers may also be required.

In general, length or height is measured and reported to the nearest 0.1 cm. For any child, the length measurement is approximately 0.5–1.5 cm greater than the height measurement. It is therefore recommended that when a length measurement is applied to a height-based reference for children over 24 months of age (or over 85 cm if age is not known), 1.0 cm be subtracted before the length measurement is compared with the reference. It is also recommended that as a matter of procedure and data recording accuracy, the

date be recorded when the change is made from supine to standing height measure.

Validation and quality control measures:

All equipment, whether fixed or portable should be checked prior to each measurement session to ensure that both the headboard and floor (or footboard) are at 90 degrees to the vertical rule. With some types of portable anthropometer it is necessary to check the correct alignment of the headboard, during each measurement, by means of a spirit level. Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of height, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 5 mm and be less than 5 mm within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference. Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

**Related metadata:** supersedes previous data element Adult height – measured vers 1 is used in the calculation of Body mass index vers 2

## Administrative Attributes

**Source document:** The measurement protocol described below are those recommended by the International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996), and the World Health Organization (WHO Expert Committee 1995), which was adapted from Lohman et al. (1988).

**Source organisation:** International Society for the Advancement of Kinanthropometry  
World Health Organization  
The consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing.

### Information model link:

NHIM Physical characteristic

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	

**Comments:** This data element applies to persons of all ages. It is recommended for use in population surveys and health care settings.  
It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.  
National health data elements currently exist for Sex, Date of birth, Country of birth, Indigenous status and smoking. Data elements are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be

presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men, women, children and adolescents although the range will depend on the population.

Ht < 70 cm

70 cm = Ht < 75 cm

75 cm = Ht < 80 cm

... in 5 cm categories

185 cm = Ht < 190 cm

Ht => 190 cm

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## Height – self-reported

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000363 **Version No:** 2

**Metadata type:** Data Element

**Admin. status:** Current  
01/07/03

**Definition:** A person's self-reported height.

**Context:** Public health and health care:  
Stature is a major indicator of general body size and of bone length and of nutritional and health status of the individual and the community at large. It is important in screening for disease or malnutrition, and in the interpretation of weight (Lohman et al. 1988). Shortness is known to be a predictor of all cause mortality and coronary heart disease mortality in middle aged men (Marmot et al. 1984) and of less favourable gestational outcomes in women (Kramer 1988). Self-reported or parentally reported height for children and adolescents should be used cautiously if at all. It enables the calculation of body mass index which requires the measurement of height and weight (body mass) for adults.

### Relational and Representational Attributes

**Datatype:** Numeric

**Representational form:** Quantitative value

**Representational layout:** NNN

**Minimum size:** 2

**Maximum size:** 3

**Data domain:** Measurement in centimetres to the nearest centimetre  
888 Unknown  
999 Not stated/inadequately described

#### **Guide for use:**

#### **Verification rules:**

#### **Collection methods:**

The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.

The data collection form should include a question asking the respondent what their height is. For example, the Australian Bureau of Statistics' National Health Survey 1995 included the question 'How tall are you without shoes?'. The data collection form should allow for both metric (to the nearest 1 cm) and imperial (to the nearest 0.5 inch) units to be recorded.

If practical, it is preferable to enter the raw data into the database before conversion of measures in imperial units to metric. However if this is not possible, height reported in imperial units can be converted to metric prior to data entry using a conversion factor of 2.54 cm to the inch.

Rounding to the nearest 1 cm will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 cm. The following rounding conventions are desirable to reduce systematic over-reporting (Armitage & Berry 1994):

nnn.x where  $x < 5$  – round down, e.g. 172.2 cm would be rounded to 172 cm.

nnn.x where  $x > 5$  – round up, e.g. 172.7 cm would be rounded to 173 cm.

nnn.x where  $x = 5$  – round to the nearest even number, e.g. 172.5 cm would be rounded to 172 cm, while 173.5 cm would be rounded to 174 cm.

**Related metadata:** supersedes previous data element Adult height – self-reported vers 1  
is used in the calculation of Body mass index vers 2

## Administrative Attributes

**Source document:**

**Source organisation:**

**Information model link:**

NHIM Physical characteristic

**Data Set Specifications:** **Start date**      **End date**

**Comments:** This data element is recommended for persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure height.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health data elements currently exist for Sex, Date of birth, Country of birth, Indigenous status and smoking. Data elements are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men and women, although the range will depend on the population. The World Health Organization's range for height is 140–190 cm.

Ht < 140 cm

140 cm = Ht < 145 cm

145 cm = Ht < 150 cm

... in 5 cm categories

185 cm = Ht < 190 cm

Ht => 190 cm

On average, height tends to be overestimated when self-reported by respondents. Data for Australian men and women aged 20–69 years in 1989 indicated that men overestimated by an average of 1.1 cm (sem of 0.04 cm) and women by an average of 0.5 cm (sem of 0.05 cm) (Waters 1993). The extent of overestimation varied with age.

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## Hip circumference – measured

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000370	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/03		
<b>Definition:</b>	<p>A person's hip circumference measured at the level of maximum posterior extension of the buttocks.</p> <p>In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.</p>		
<b>Context:</b>	<p>Public health and health care:</p> <p>Its main use is to enable the calculation of adult Waist-to-hip ratio which requires the measurement of hip circumference and waist circumference.</p>		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Quantitative value
<b>Representational layout:</b>	NNN.N
<b>Minimum size:</b>	3
<b>Maximum size:</b>	4
<b>Data domain:</b>	<p>Measurement in centimetres to the nearest 0.1 cm</p> <p>999.9 Not able to be measured</p>
<b>Guide for use:</b>	<p>As there are no cut-off points for waist-to-hip ratio for children and adolescents, it is not necessary to collect this item for those aged under 18 years.</p>
<b>Verification rules:</b>	
<b>Collection methods:</b>	<p>Measurement protocol:</p> <p>The data collection form should allow for up to three measurements of hip circumference to be recorded in centimetres to 1 decimal place. The data collection form should also have the capacity to record any reasons for the non-collection of hip circumference data.</p> <p>The measurement of hip circumference requires a narrow (&lt; 7 mm wide), flexible, inelastic tape measure. The kind of tape used should be described and reported. The graduations on the tape measure should be at 0.1 cm intervals and the tape should have the capacity to measure up to 200 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the tape measure.</p> <p>The subject should wear only non-restrictive briefs or underwear, a light smock over underwear or light clothing. Belts and heavy outer clothing should be removed. Hip measurement should be taken over one layer of light clothing only.</p> <p>The subject stands erect with arms at the sides, feet together and the gluteal muscles relaxed. The measurer sits at the side of the subject so that the level of maximum posterior extension of the buttocks can be seen. An inelastic tape is placed around the buttocks in a horizontal plane. To ensure contiguity of the</p>

two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body. The tape is in contact with the skin but does not compress the soft tissues. Fatty aprons should be excluded from the hip circumference measurement.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, then take a third measurement.

All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the data base as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured hip circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting. For example, a mean value of 102.25 cm would be rounded to 102.2 cm, while a mean value of 102.35 cm would be rounded to 102.4 cm.

Validation and quality control measures:

Steel tapes should be checked against a 1-metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured hip circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

**Related metadata:** supersedes previous data element Adult hip circumference - measured vers 1 is used in the calculation of Waist-to-hip ratio vers 2

## Administrative Attributes

**Source document:** The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995).

**Source organisation:** World Health Organization (see also Comments)

**Information model link:**

NHIM Physical characteristic

**Data Set Specifications:** *Start date*      *End date*

**Comments:** This data element applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the

errors in waist-to-hip ratio measurements.

Waist-to-hip ratio is therefore no longer a commonly used measure.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present hip circumference data in categories. It is recommended that 5 cm groupings be used for this purpose. Hip circumference data should not be rounded before categorisation

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## Hospital

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000064	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element Concept		
<b>Admin. status:</b>	Current		
	01/07/94		
<b>Definition:</b>	A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.		
<b>Context:</b>	Admitted patient care, admitted patient palliative care, admitted patient mental health care and public hospital establishments.		

### Relational and Representational Attributes

<b>Datatype:</b>	
<b>Representational form:</b>	
<b>Representational layout:</b>	
<b>Minimum size:</b>	
<b>Maximum size:</b>	
<b>Data domain:</b>	
<b>Guide for use:</b>	
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	relates to the data element Establishment sector vers 3

### Administrative Attributes

<b>Source document:</b>	
<b>Source organisation:</b>	National Health Data Committee
<b>Information model link:</b>	
	NHIM Service delivery setting
<b>Data Set Specifications:</b>	<b>Start date</b> <b>End date</b>

<b>Comments:</b>	<p>A hospital thus defined may be located at one physical site or may be a multicampus hospital. A multicampus hospital treats movements of patients between sites as ward transfers.</p> <p>For the purposes of these definitions, the term hospital includes satellite units managed and staffed by the hospital.</p> <p>This definition includes, but is not limited to, hospitals as recognised under Australian Health Care Agreements.</p> <p>Residential aged care services as approved under the <i>National Health Act 1953</i> (Commonwealth) or equivalent State legislation are excluded from this definition.</p> <p>This definition includes entities with multipurpose facilities (e.g. those which contain both recognised and non-recognised components).</p>
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## Hospital boarder

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000065	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element Concept		
<b>Admin. status:</b>	Current		
	01/07/94		
<b>Definition:</b>	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.		
<b>Context:</b>	Admitted patient care.		

### Relational and Representational Attributes

<b>Datatype:</b>	
<b>Representational form:</b>	
<b>Representational layout:</b>	
<b>Minimum size:</b>	
<b>Maximum size:</b>	
<b>Data domain:</b>	
<b>Guide for use:</b>	A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either a qualified or unqualified day.
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	

### Administrative Attributes

<b>Source document:</b>			
<b>Source organisation:</b>	National Health Data Committee		
<b>Information model link:</b>	NHIM Recipient role		
<b>Data Set Specifications:</b>		<b>Start date</b>	<b>End date</b>
<b>Comments:</b>			

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## Hospital census

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### Identifying and Definitional Attributes

<i>Knowledgebase ID:</i>	000066	<i>Version No:</i>	1
<i>Metadata type:</i>	Data Element Concept		
<i>Admin. status:</i>	Current		
	01/01/95		
<i>Definition:</i>	A point in time count by a hospital of all its admitted patients and/or patients currently on a waiting list.		
<i>Context:</i>	Admitted patient care.		

### Relational and Representational Attributes

<i>Datatype:</i>	
<i>Representational form:</i>	
<i>Representational layout:</i>	
<i>Minimum size:</i>	
<i>Maximum size:</i>	
<i>Data domain:</i>	
<i>Guide for use:</i>	
<i>Verification rules:</i>	
<i>Collection methods:</i>	
<i>Related metadata:</i>	relates to the data element Census date vers 2
	relates to the data element Waiting time at a census date vers 2

### Administrative Attributes

<i>Source document:</i>			
<i>Source organisation:</i>			
<i>Information model link:</i>			
	NHIM	Surveillance/monitoring event	
<i>Data Set Specifications:</i>		<i>Start date</i>	<i>End date</i>
<i>Comments:</i>			

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## Hospital insurance status

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000075	<b>Version No:</b>	3
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/97		
<b>Definition:</b>	Hospital insurance under one of the following categories: <ul style="list-style-type: none"> <li>- Registered insurance - hospital insurance with a health insurance fund registered under the <i>National Health Act 1953</i> (Commonwealth)</li> <li>- General insurance - hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insurance</li> <li>- No hospital insurance or benefits coverage under the above.</li> </ul>		
<b>Context:</b>	To assist in analysis of utilisation and health care financing.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric						
<b>Representational form:</b>	Code						
<b>Representational layout:</b>	N						
<b>Minimum size:</b>	1						
<b>Maximum size:</b>	1						
<b>Data domain:</b>	<table> <tr> <td>1</td> <td>Hospital insurance</td> </tr> <tr> <td>2</td> <td>No hospital insurance</td> </tr> <tr> <td>9</td> <td>Unknown</td> </tr> </table>	1	Hospital insurance	2	No hospital insurance	9	Unknown
1	Hospital insurance						
2	No hospital insurance						
9	Unknown						

<b>Guide for use:</b>	<p>Persons covered by insurance for benefits of ancillary services only are included in 2 - no hospital insurance.</p> <p>The 'unknown' category should not be used in primary collections but can be used to record unknown insurance status in databases.</p> <p>This item is to determine whether the patient has hospital insurance, not their method of payment for the episode of care.</p>
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#### Verification rules:

#### Collection methods:

**Related metadata:** supersedes previous data element Insurance status vers 2

### Administrative Attributes

#### Source document:

**Source organisation:** National Health Data Committee

#### Information model link:

NHIM Insurance/benefit characteristic

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
NMDS - Admitted patient care	01/07/1997	30/06/2000

**Comments:**

Insurance status was reviewed and modified to reflect changes to new private health insurance arrangements under the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995*.

Employee health benefits schemes became illegal with the implementation of Schedule 2 of the private health insurance reforms, effective on 1 October 1995.

Under Schedule 4 of the private health insurance reforms, on 1 July 1997, the definition of the 'basic private table' or 'basic table', and 'supplementary hospital table' and any references to these definitions was omitted from the *National Health Act 1953*. All hospital tables offered by registered private health insurers since 29 May 1995 have been referred to as 'Applicable Benefits Arrangements' and marketed under the insurer's own product name.

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## Hospital waiting list

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000067 **Version No:** 2

**Metadata type:** Data Element Concept

**Admin. status:** Current  
01/07/02

**Definition:** A register which contains essential details about patients who have been assessed as needing elective hospital care.  
Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours.  
Patients on waiting lists for elective hospital care can be 'ready for care' or 'not ready for care' (as defined in Patient listing status).

**Context:** Admitted patient care.

### Relational and Representational Attributes

**Datatype:**

**Representational form:**

**Representational layout:**

**Minimum size:**

**Maximum size:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related metadata:** relates to the data element concept Elective care vers 1  
relates to the data element Patient listing status vers 3  
relates to the data element Waiting list category vers 3

### Administrative Attributes

**Source document:**

**Source organisation:**

**Information model link:**

NHIM Assessment event

**Data Set Specifications:** **Start date** **End date**

**Comments:**

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## Hospital-in-the-home care

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000633	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element Concept		
<b>Admin. status:</b>	Current		
	01/07/01		
<b>Definition:</b>	Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.		
<b>Context:</b>	Admitted patient care.		

### Relational and Representational Attributes

<b>Datatype:</b>	
<b>Representational form:</b>	
<b>Representational layout:</b>	
<b>Minimum size:</b>	
<b>Maximum size:</b>	
<b>Data domain:</b>	
<b>Guide for use:</b>	<p>The criteria for inclusion as hospital-in-the-home include but are not limited to:</p> <ul style="list-style-type: none"> <li>- without hospital-in-the-home care being available patients would be accommodated in the hospital</li> <li>- the treatment forms all or part of an episode of care for an admitted patient (as defined in the Admitted patient data element concept)</li> <li>- the hospital medical record is maintained for the patient</li> <li>- there is adequate provision for crisis care.</li> </ul> <p>Selection criteria for the assessment of suitable patients include but are not limited to:</p> <ul style="list-style-type: none"> <li>- the hospital deems the patient requires health care professionals funded by the hospital to take an active part in their treatment</li> <li>- the patient does not require continuous 24-hour assessment, treatment or observation</li> <li>- the patient agrees to this form of treatment</li> <li>- the patient's place of residence is safe and has carer support available;</li> <li>- the patient's place of residence is accessible for crisis care</li> <li>- the patient's place of residence has adequate communication facilities and access to transportation.</li> </ul>
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	<p>relates to the data element Admitted patient vers 3</p> <p>relates to the data element concept Episode of care vers 1</p>

### Administrative Attributes

<b>Source document:</b>	
<b>Source organisation:</b>	National Health Data Committee

**Information model link:**

NHIM Service provision event

**Data Set Specifications:**

*Start date*

*End date*

**Comments:**

## Hours on-call (not worked) by medical practitioner

### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000393	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/97		
<b>Definition:</b>	The number of hours in a week that a medical practitioner is required to be available to provide advice, respond to any emergencies etc.		

<b>Context:</b>	Health labour force:
	Used in relation to issues of economic activity, productivity, wage rates, working conditions etc.
	Used to develop capacity measures relating to total time available.
	Assists in analysis of human resource requirements and labour force modelling.
	Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Quantitative value
<b>Representational layout:</b>	NNN
<b>Minimum size:</b>	3
<b>Maximum size:</b>	3

<b>Data domain:</b>	Total hours, expressed as 000, 001 etc. 999 Not stated / inadequately described
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<b>Guide for use:</b>	Data element relates to each position (job) held by a medical practitioner.
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<b>Verification rules:</b>	Value must be less than 169 (except for 999).
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<b>Collection methods:</b>	There are inherent problems in asking for information on number of hours on-call not worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours on-call not worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.
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<b>Related metadata:</b>	supersedes previous data element Hours worked vers 1 relates to the data element Hours worked by medical practitioner in direct patient care vers 2 relates to the data element Total hours worked by a medical practitioner vers 2
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### Administrative Attributes

<b>Source document:</b>	
<b>Source organisation:</b>	National Health Labour Force Data Working Group

**Information model link:**

NHIM Labour characteristic

**Data Set Specifications:**

NMDS - Health labour force

**Start date**

**End date**

01/07/1997

**Comments:**

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## Hours worked by health professional

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000313 **Version No:** 2

**Metadata type:** Data Element

**Admin. status:** Current  
01/07/97

**Definition:** Hours worked is the amount of time a person spends at work in a week in employment/self-employment. It may apply to hours actually worked in a week or hours usually worked per week, and the National Health Labour Force Collection collects hours usually worked. It includes all paid and unpaid overtime less any time off.

It also:

- includes travel to home visits or calls out
- excludes other time travelling between work locations
- excludes unpaid professional and/or voluntary activities.

Total hours worked is the amount of time spent at work in all jobs.

As well as total hours worked, for some professions the National Health Labour Force Collection asks for hours worked in each of the main job, second job and third job. Hours worked for each of these is the amount of time spent at work in each job.

**Context:** Health labour force:  
Important variable in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling. Used to determine full-time and part-time work status and to compute full-time equivalents (FTE) (see entry for FTE). Often the definition for full-time or FTE differs (35, 37.5 and 40 hours) and knowing total hours and numbers of individuals allows for variances in FTE.

### Relational and Representational Attributes

**Datatype:** Numeric

**Representational form:** Quantitative value

**Representational layout:** NNN

**Minimum size:** 3

**Maximum size:** 3

**Data domain:** Total hours, expressed as 000, 001 etc.  
999 Not stated/inadequately described

**Guide for use:**

**Verification rules:** Value must be less than 127 (except for 999).

**Collection methods:** There are inherent problems in asking for information on number of hours usually worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

**Related metadata:** supersedes previous data element Hours worked vers 1

## Administrative Attributes

**Source document:**

**Source organisation:** National Health Labour Force Data Working Group

**Information model link:**

NHIM Labour characteristic

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
NMDS - Health labour force	01/07/1997	

**Comments:** It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

## **Hours worked by medical practitioner in direct patient care**

### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000392	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/97		
<b>Definition:</b>	The number of hours worked in a week by a medical practitioner on service provision to patients including direct contact with patients, providing care, instructions and counselling, and providing other related services such as writing referrals, prescriptions and phone calls.		
<b>Context:</b>	Health labour force: Used in relation to issues of economic activity, productivity, wage rates, working conditions etc. Used to develop capacity measures relating to total time available. Assists in analysis of human resource requirements and labour force modelling.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Quantitative value
<b>Representational layout:</b>	NNN
<b>Minimum size:</b>	3
<b>Maximum size:</b>	3
<b>Data domain:</b>	Total hours, expressed as 000, 001 etc. 999 Not stated/inadequately described
<b>Guide for use:</b>	Data element relates to each position (job) held by a medical practitioner, not the aggregate of hours worked for all jobs.
<b>Verification rules:</b>	Value must be less than 127 (except for 999).
<b>Collection methods:</b>	There are inherent problems in asking for information on number of hours usually worked per week in direct patient care, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours worked in direct patient care are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.
<b>Related metadata:</b>	relates to the data element Hours on-call (not worked) by medical practitioner vers 2 supersedes previous data element Hours worked vers 1 relates to the data element Total hours worked by a medical practitioner vers 2

## Administrative Attributes

**Source document:**

**Source organisation:** National Health Labour Force Data Working Group

**Information model link:**

NHIM Labour characteristic

**Data Set Specifications:**

NMDS - Health labour force

**Start date**

**End date**

01/07/1997

**Comments:**

It is often argued that health professionals contribute a considerable amount of time to voluntary professional work and that this component needs to be identified. This should be considered as an additional item, and kept segregated from data on paid hours worked.

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## Hypertension – treatment

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000826	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	Whether an individual is currently treated for hypertension (high blood pressure) using antihypertensive medication.		
<b>Context:</b>	Public health, health care and clinical settings.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric						
<b>Representational form:</b>	Code						
<b>Representational layout:</b>	N						
<b>Minimum size:</b>	1						
<b>Maximum size:</b>	1						
<b>Data domain:</b>	<table> <tr> <td>1</td> <td>Yes, currently being treated for hypertension using antihypertensive medication</td> </tr> <tr> <td>2</td> <td>No, not currently being treated for hypertension using antihypertensive medication</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Yes, currently being treated for hypertension using antihypertensive medication	2	No, not currently being treated for hypertension using antihypertensive medication	9	Not stated/inadequately described
1	Yes, currently being treated for hypertension using antihypertensive medication						
2	No, not currently being treated for hypertension using antihypertensive medication						
9	Not stated/inadequately described						
<b>Guide for use:</b>	Record whether or not on treatment for hypertension. Only record yes if on an antihypertensive medication for their blood pressure.						
<b>Verification rules:</b>							
<b>Collection methods:</b>	Ask the individual if he/she is currently treated with anti-hypertensive medications. Alternatively obtain the relevant information from appropriate documentation.						
<b>Related metadata:</b>	<ul style="list-style-type: none"> <li>relates to the data element Blood pressure – diastolic measured vers 1</li> <li>relates to the data element Blood pressure – systolic measured vers 1</li> <li>relates to the data element Cardiovascular medication – current vers 1</li> <li>relates to the data element Date of birth vers 4</li> </ul>						

### Administrative Attributes

<b>Source document:</b>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
<b>Source organisation:</b>	National Diabetes Data Working Group
<b>Information model link:</b>	NHIM Physical wellbeing

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
DSS - Diabetes (clinical)	01/01/2003	

**Comments:**

Hypertension is probably the most important public health problem in developed countries. It is common, asymptomatic, readily detectable, usually easily treatable, and often leads to lethal complications if left untreated.

Elevated blood pressure (Hypertension) is a recognised risk for microvascular and macro vascular complications of diabetes (coronary, cerebral and peripheral).

Hypertension is elevated arterial blood pressure above the normal range (130 to 139/85 to 89 mm Hg) and values above these are defined as hypertension. Lower levels of target blood pressure should be aimed for in specific groups, e.g. in diabetics aim for blood pressure less than 135/80 mm Hg.

Many diabetics fail to control high blood pressure. Among all the diabetics with high blood pressure, 29% were unaware that they had high blood pressure and only slightly more than half were receiving hypertensive medications as treatment. Numbers of studies have shown that good management of blood pressure is at least as important as good control of blood glucose and the reduction of cholesterol in preventing the complications of diabetes.

Antihypertensives - Australian Medicines Handbook: February, 2001. Tight blood control in diabetes usually requires combination therapy as stated by (Australian Diabetes society) Therapeutic Guidelines Limited (05/04/2002).

People taking antihypertensives are also encouraged to make healthy lifestyle changes, such as quit smoking, lose weight and have regular physical activity. The level of blood pressure should generally be established on at least two to four occasions prior to initiating antihypertensive medication.

Systematic reviews of studies that have reported outcomes in patients with diabetes and hypertension indicate that combination therapy is frequently required and may be more beneficial than monotherapy. In the past multi-drug therapy to control hypertension has not been advocated much, but according to the special report published in the American Journal of Kidney Diseases, if ACE inhibitor therapy alone doesn't achieve good blood pressure control, multi-drug therapy should be implemented. ( Heart Center Online)

**References:**

Pahor M, Psaty BM, Furberg CD. Treatment of hypertensive patients with diabetes. Lancet 1998; 351:689-90.

Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. UK Prospective Diabetes Study Group (erratum appears in Br Med J 1999; 318:29).

Br Med J 1998; 317:703-13. Grossman E, Messerli FH, Goldbourt U, Curb JD, Pressel SL, Cutler JA, Savage PJ, Applegate WB, Black H, et al. Effect of diuretic-based antihypertensive treatment on cardiovascular disease risk in older diabetic patients with isolated systolic hypertension.

Systolic Hypertension in the Elderly Program Cooperative Research Group. JAMA 1996; 276:1886-92. Hypertension in diabetes(Australian Prescriber Feb 2002).

American Journal of Preventive Medicine 2002;21.

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## Hypoglycaemia – severe

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000827	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	Whether the individual has had severe hypoglycaemia, which is defined as hypoglycaemia requiring assistance from another party.		

<b>Context:</b>	Public health, health care and clinical settings: Hypoglycaemia is defined as an abnormally low level of glucose in the blood, which occurs when the blood glucose level falls to values low enough to cause symptoms and signs.
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### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	N
<b>Minimum size:</b>	1
<b>Maximum size:</b>	1

<b>Data domain:</b>	1	Yes, has had severe hypoglycaemia requiring assistance from another party
	2	No, has not had severe hypoglycaemia requiring assistance from another party
	9	Not stated/inadequately described

<b>Guide for use:</b>	Record whether or not the person has a history of severe hypoglycaemia requiring assistance.
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#### Verification rules:

<b>Collection methods:</b>	Ask the individual if he/she has had a severe hypoglycaemia requiring assistance. Alternatively obtain the relevant information from appropriate documentation.
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<b>Related metadata:</b>	relates to the data element Glycosylated haemoglobin (HbA1c) – measured vers 1
	relates to the data element Glycosylated haemoglobin (HbA1c) – upper limit of normal range vers 1

### Administrative Attributes

<b>Source document:</b>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
<b>Source organisation:</b>	National Diabetes Data Working Group

**Information model link:**

NHIM Physical wellbeing

**Data Set Specifications:**

DSS - Diabetes (clinical)

**Start date****End date**

01/01/2003

**Comments:**

When reporting:

- Record whether the individual has had severe hypoglycaemia requiring assistance from another party in the last 12 months. The medications used in the treatment of diabetes may cause the blood glucose value to fall below the normal range and this is called hypoglycaemia.

Most hypoglycaemic reactions, however, do not cause long term problems, but the risks of permanent injury to the brain are greater in children under the age of 5 years, the elderly with associated cerebrovascular disease and patients with other medical conditions such as cirrhosis and coeliac disease. The serious consequences of hypoglycaemia relate to its effects on the brain. Rarely hypoglycaemia may cause death.

It is important to know how to recognise and react when someone is unconscious from hypoglycaemia. These people should be placed on their side and the airway checked so that breathing is unhampered and nothing should be given by mouth as food may enter the breathing passages. Treatment needs to be given by injection - either glucagon (a hormone which raises the blood glucose by mobilising liver stores) or glucose itself. Glucagon should be given by injection (usually intramuscular) at a dose of 0.5 units (or mg) in children under the age of 5 years and 1.0 units (or mg) for all older age groups.

All diabetic patients at risk of developing hypoglycaemia should have glucagon at home. Their families need to be shown how to administer it in times of severe hypoglycaemia.

Reference:

Definition corresponds with the Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

Report of the Health Care Committee Expert Panel on Diabetes; Commonwealth of Australia 1991; ISBN 0644143207.

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## Indicator procedure

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000073 **Version No:** 3

**Metadata type:** Data Element

**Admin. status:** Current  
01/07/97

**Definition:** An indicator procedure is a procedure which is of high volume, and is often associated with long waiting periods.

**Context:** Waiting list statistics for indicator procedures give a specific indication of performance in particular areas of elective care provision. It is not always possible to code all elective surgery procedures at the time of addition to the waiting list. Reasons for this include that the surgeon may be uncertain of the exact procedure to be performed, and that the large number of procedures possible and lack of consistent nomenclature would make coding errors likely. Furthermore, the increase in workload for clerical staff may not be acceptable. However, a relatively small number of procedures account for the bulk of the elective surgery workload. Therefore, a list of common procedures with a tendency to long waiting times is useful. Waiting time statistics by procedure are useful to patients and referring doctors. In addition, waiting time data by procedure assists in planning and resource allocation, audit and performance monitoring.

### Relational and Representational Attributes

**Datatype:** Numeric

**Representational form:** Code

**Representational layout:** NN

**Minimum size:** 2

**Maximum size:** 2

**Data domain:**

01	Cataract extraction
02	Cholecystectomy
03	Coronary artery bypass graft
04	Cystoscopy
05	Haemorrhoidectomy
06	Hysterectomy
07	Inguinal herniorrhaphy
08	Myringoplasty
09	Myringotomy
10	Prostatectomy
11	Septoplasty
12	Tonsillectomy
13	Total hip replacement
14	Total knee replacement
15	Varicose veins stripping and ligation
16	Not applicable

**Guide for use:** These procedure terms are defined by the ICD-10-AM (2002) codes which are listed in comments below. Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance.

These are planned procedures for the waiting list, not what is actually performed during hospitalisation.

**Verification rules:** Zero filled, right justified.

**Collection methods:**

**Related metadata:** supersedes previous data element Indicator procedure – ICD-9-CM code vers 2  
is used in conjunction with Procedure vers 5  
supplements the data element Waiting list category vers 3

## Administrative Attributes

**Source document:** International Classification of Diseases – Tenth Revision – Australian Modification ( 3rd edition 2002) National Centre for Classification in Health, Sydney.

**Source organisation:** National Health Data Committee

**Information model link:**

NHIM Service provision event

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
NMDS - Elective surgery waiting times	01/07/2002	

**Comments:** The list of indicator procedures may be reviewed from time to time. Some health authorities already code a larger number of waiting list procedures. The following is a list of ICD-10-AM codes, for the indicator procedures:

Cataract extraction:

42698-00 [195] 42702-00 [195] 42702-01 [195] 42698-01 [196] 42702-02 [196]  
42702-03 [196] 42698-02 [197] 42702-04 [197] 42702-05 [197] 42698-03 [198]  
42702-06 [198] 42702-07 [198] 42698-04 [199] 42702-08 [199] 42702-09 [199]  
42731-01 [200] 42698-05 [200] 42702-10 [200] 42734-00 [201] 42788-00 [201]  
42719-00 [201] 42731-00 [201] 42719-02 [201] 42791-02 [201] 42716-00 [202]  
42702-11 [200] 42719-00 [201] 42722-00 [201]

Cholecystectomy:

30443-00 [965] 30454-01 [965] 30455-00 [965] 30445-00 [965] 30446-00 [965]  
30448-00 [965] 30449-00 [965]

Coronary artery bypass graft:

38497-00 [672] 38497-01 [672] 39497-02 [672] 38497-03 [672] 38497-04 [673]  
38497-05 [673] 38497-06 [673] 39497-07 [673] 38500-00 [674] 38503-00 [674]  
38500-01 [675] 38503-01 [675] 38500-02 [676] 38503-02 [676] 38500-03 [677]  
38503-03 [677] 38500-04 [678] 38503-04 [678] 90201-00 [679] 90201-01 [679]  
90201-02 [679] 90201-03 [679]

Cystoscopy:

36812-00 [1088] 36812-01 [1088] 36836-00 [1097]

Haemorrhoidectomy:

32138-00 [949] 32132-00 [949] 32135-00 [949] 32135-01 [949]

Hysterectomy:

35653-00 [1268] 35653-01 [1268] 35653-02 [1268] 35653-03 [1268] 35661-00 [1268]  
35670-00 [1268] 35667-00 [1268] 35664-00 [1268] 35657-00 [1269] 35750-00 [1269]  
35756-00 [1269] 35673-00 [1269] 35673-01 [1269] 35753-00 [1269] 35753-01 [1269]  
35756-01 [1269] 35756-02 [1269] 35667-01 [1269] 35664-01 [1269] 90450-00 [989]  
90450-01 [989] 90450-02 [989]

## Inguinal herniorrhaphy:

30614-03 [990] 30615-00 [997] 30609-03 [990] 30614-02 [990] 30609-02 [990]

## Myringoplasty:

41527-00 [313] 41530-00 [313] 41533-01 [313] 41542-00 [315] 41635-10 [313]

## Myringotomy:

41626-00 [309] 31626-01 [309] 41632-00 [309] 41632-01 [309]

## Prostatectomy:

37203-00 [1165] 37203-01 [1165] 37203-02 [1165] 37207-00 [1166] 37207-01 [1166]  
37200-00 [1166] 37200-01 [1166] 37203-05 [1166] 37203-06 [1166] 37200-03 [1167]  
37200-04 [1167] 37209-00 [1167] 37200-05 [1167] 90407-00 [1168] 36839-03 [1162]  
36869-01 [1162]

## Septoplasty:

41672-02 [379] 41679-03 [379]

## Tonsillectomy:

41789-00 [412] 41789-01 [412]

## Total hip replacement:

49318-00 [1489] 49319-00 [1489] 49324-00 [1492] 49327-00 [1492] 49330-00 [1492]  
49333-00 [1492] 49345-00 [1492]

## Total knee replacement:

49518-00 [1518] 49519-00 [1518] 49521-00 [1519] 49521-01 [1519] 49521-02 [1519]  
49521-03 [1519] 49524-00 [1519] 49524-01 [1519] 49527-00

## Varicose veins stripping and ligation:

32508-00 [727] 32508-01 [727] 32511-00 [727] 32504-01 [728] 32505-00 [728]  
32514-00 [737]

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## Indigenous status

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000001	<b>Version No:</b> 4
<b>Metadata type:</b>	Data Element	
<b>Admin. status:</b>	Current	
	01/07/03	
<b>Definition:</b>	Indigenous status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin. This is in accord with the first two of three components of the Commonwealth definition. See Comments for the Commonwealth definition.	
<b>Context:</b>	<p>Australia's Aboriginal and Torres Strait Islander peoples occupy a unique place in Australian society and culture. In the current climate of reconciliation, accurate and consistent statistics about Aboriginal and Torres Strait Islander peoples are needed in order to plan, promote and deliver essential services, to monitor changes in wellbeing and to account for government expenditure in this area.</p> <p>The purpose of this data element is to provide information about people who identify as being of Aboriginal or Torres Strait Islander origin. Agencies wishing to determine the eligibility of individuals for particular benefits, services or rights will need to make their own judgements about the suitability of the standard measure for these purposes, having regard to the specific eligibility criteria for the program concerned.</p>	

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric										
<b>Representational form:</b>	Code										
<b>Representational layout:</b>	N										
<b>Minimum size:</b>	1										
<b>Maximum size:</b>	1										
<b>Data domain:</b>	<table> <tr> <td>1</td> <td>Aboriginal but not Torres Strait Islander origin</td> </tr> <tr> <td>2</td> <td>Torres Strait Islander but not Aboriginal origin</td> </tr> <tr> <td>3</td> <td>Both Aboriginal and Torres Strait Islander origin</td> </tr> <tr> <td>4</td> <td>Neither Aboriginal nor Torres Strait Islander origin</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Aboriginal but not Torres Strait Islander origin	2	Torres Strait Islander but not Aboriginal origin	3	Both Aboriginal and Torres Strait Islander origin	4	Neither Aboriginal nor Torres Strait Islander origin	9	Not stated/inadequately described
1	Aboriginal but not Torres Strait Islander origin										
2	Torres Strait Islander but not Aboriginal origin										
3	Both Aboriginal and Torres Strait Islander origin										
4	Neither Aboriginal nor Torres Strait Islander origin										
9	Not stated/inadequately described										

<b>Guide for use:</b>	<p>This data element is based on the Australian Bureau of Statistics' (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS web site as indicated below in the Source document section.</p> <p>The classification for 'Indigenous status' has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:</p> <p>Indigenous:</p> <ul style="list-style-type: none"> <li>- Aboriginal but not Torres Strait Islander origin</li> <li>- Torres Strait Islander but not Aboriginal origin</li> </ul>
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- both Aboriginal and Torres Strait Islander origin

Non-indigenous:

- neither Aboriginal nor Torres Strait Islander origin

Not stated/inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

- primarily when importing data from other data collections that do not contain mappable data
- where an answer was refused
- where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank.

### **Verification rules:**

#### **Collection methods:**

The standard question for Indigenous status is as follows:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait Islander origin?

(For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

No.....

Yes, Aboriginal.....

Yes, Torres Strait Islander.....

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject.

When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them. However, it is strongly recommended that this question be asked directly wherever possible.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).

If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander origin'.

If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander origin' (i.e. disregard the 'No' response).

This approach may be problematical in some data collections, for example when data are collected by interview or using screen-based data capture systems. An additional response category:

Yes, both Aboriginal and Torres Strait Islander.....

may be included if this better suits the data collection practices of the agency concerned.

**Related metadata:** supersedes previous data element Indigenous status vers 3

## Administrative Attributes

**Source document:** Available on the ABS web site. From the ABS Home page ([www.abs.gov.au](http://www.abs.gov.au)) select: About Statistics/About Statistical Collections (Concepts & Classifications) /Other ABS Statistical Standards/Standards for Social Labour and Demographic Variables/Cultural Diversity Variables/Indigenous Status.

**Source organisation:** Australian Bureau of Statistics

### Information model link:

NHIM Social characteristic

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
NMDS - Admitted patient care	01/07/2003	
NMDS - Admitted patient mental health care	01/07/2003	
NMDS - Perinatal	01/07/2003	
NMDS - Community mental health care	01/07/2003	
NMDS - Admitted patient palliative care	01/07/2003	
NMDS - Alcohol and other drug treatment services	01/07/2003	
NMDS - Non-admitted patient emergency department care	01/07/2003	
DSS - Cardiovascular disease (clinical)	01/01/2003	
DSS - Diabetes (clinical)	01/01/2003	
DSS - Health care client identification	01/01/2003	

**Comments:** The following definition, commonly known as 'The Commonwealth Definition' was given in a High Court judgement in the case of *Commonwealth v Tasmania* (1983) 46 ALR 625.

**'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.**

There are three components to the Commonwealth Definition:

- descent
- self-identification
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

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## Indirect health care expenditure

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000326 **Version No:** 1

**Metadata type:** Data Element

**Admin. status:** Current  
01/07/89

**Definition:** Expenditures on health care that cannot be directly related to programs operated by a particular establishment (that is, can only be indirectly related to particular establishments). To be provided at the State level but disaggregated into patient transport services, public health and monitoring services, central and statewide support services, central administrations and other indirect health care expenditure.

**Context:** Health expenditure:  
To improve and substantiate financial reporting in relation to indirect health care expenditure and assist in understanding differences in costs for similar establishments in different States and regions, due to differences in the extent to which support services and other services to residents/inpatients and outpatients of establishments may be provided by the establishment itself or by other bodies.

### Relational and Representational Attributes

**Datatype:** Numeric

**Representational form:** Currency

**Representational layout:** \$999,999,999

**Minimum size:** 2

**Maximum size:** 12

**Data domain:** Australian dollars to the nearest whole dollar

**Guide for use:** Record values up to hundreds of millions of dollars.  
Indirect health care expenditure is to be reported separately for each of the following categories:

- 1 Patient transport services:  
Public or registered non-profit organisations which provide patient transport (or ambulance) for services associated with inpatient or residential episodes at residential establishments within the scope of this data set.  
This category excludes patient transport services provided by other types of establishments (for example, public hospitals) as part of their normal services. This category includes centralised and statewide patient transport services (for example, Queensland Ambulance Transport Brigade) which operate independently of individual inpatient establishments.
- 2 Public health and monitoring services:  
Public or registered non-profit services and organisations with centralised, statewide or national public health or monitoring services. These include programs concerned primarily with preventing the occurrence of diseases and mitigating their effect, and includes such activities as mass chest X-ray campaigns, immunisation and vaccination programs, control of communicable diseases, ante-natal and post-natal clinics, preschool and school medical

services, infant welfare clinics, hygiene and nutrition advisory services, food and drug inspection services, regulation of standards of sanitation, quarantine services, pest control, anti-cancer, anti-drug and anti-smoking campaigns and other programs to increase public awareness of disease symptoms and health hazards, occupational health services, Worksafe Australia, the Australian Institute of Health and Welfare and the National Health and Medical Research Council.

Included here would be child dental services comprising expenditure incurred (other than by individual establishments) or dental examinations, provision of preventive and curative dentistry, dental health education for infants and school children and expenditure incurred in the training of dental therapists.

### 3 Central and statewide support services:

Public or registered services which provide central or statewide support services for residential establishments within the scope of this data set. These include central pathology services, central linen services and frozen food services and blood banks provided on a central or statewide basis such as Red Cross.

### 4 Central administrations:

Expenditures relating to central health administration, research and planning for central and regional offices of State, Territory and Commonwealth health authorities and related departments (for example, the Department of Veterans' Affairs).

### 5 Other:

Any other indirect health care expenditure as defined above not catered for in the above categories. This might include such things as family planning and parental health counselling services and expenditure incurred in the registration of notifiable diseases and other medical information.

#### **Verification rules:**

#### **Collection methods:**

#### **Related metadata:**

## Administrative Attributes

#### **Source document:**

**Source organisation:** National Health Data Committee

#### **Information model link:**

NHIM Recurrent expenditure

#### **Data Set Specifications:**

NMDS - Public hospital establishments

**Start date**                      **End date**

01/07/1989

#### **Comments:**

Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the State level and were also concerned at the lack of uniformity between States. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

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## Individual/group session

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000235 **Version No:** 1

**Metadata type:** Data Element

**Admin. status:** Current  
01/07/89

**Definition:** A group is defined as two or more patients receiving services at the same time from the same hospital staff. However, this excludes the situation where individuals all belong to the same family. In such cases, the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual.

**Context:** Required to distinguish between those occasions of service on an individual patient basis and those servicing groups of patients. This distinction has resource implications.

### Relational and Representational Attributes

**Datatype:** Alphanumeric

**Representational form:** Code

**Representational layout:** ANN.N

**Minimum size:** 5

**Maximum size:** 5

**Data domain:** A12.1 Individual sessions  
A12.2 Group sessions

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related metadata:**

### Administrative Attributes

**Source document:**

**Source organisation:**

**Information model link:**

NHIM Service provision event

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
NMDS - Public hospital establishments	01/07/1989	

**Comments:**

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## Infant weight, neonate, stillborn

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000010	<b>Version No:</b>	3
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/97		
<b>Definition:</b>	The first weight of the live-born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth.		
<b>Context:</b>	Weight is an important indicator of pregnancy outcome, is a major risk factor for neonatal morbidity and mortality and is required to analyse perinatal services for high-risk infants. This item is required to generate Australian national diagnosis related groups.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Quantitative value
<b>Representational layout:</b>	NNNN
<b>Minimum size:</b>	4
<b>Maximum size:</b>	4

**Data domain:** Measured weight in grams

**Guide for use:** For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.

In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.

Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000 g and age is less than 365 days.

**Verification rules:** For the provision of State and Territory hospital data to Commonwealth agencies, this field must be consistent with diagnoses and procedure codes for valid grouping.

**Collection methods:**

**Related metadata:** is used in the derivation of Diagnosis related group vers 1  
supersedes previous data element Stillborn, live born baby, infant weight vers 2

### Administrative Attributes

**Source document:**

**Source organisation:** National Health Data Committee

**Information model link:**

NHIM Physical wellbeing

**Data Set Specifications:**

NMDS - Admitted patient care

NMDS - Perinatal

**Start date**

**End date**

01/07/1997

01/07/1997

**Comments:**

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## Initial visit – diabetes mellitus

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000828	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/01/03		
<b>Definition:</b>	Whether this is the initial visit of the patient to a health professional for diabetes or a related condition after diagnosis has been established.		
<b>Context:</b>	Public health, health care and clinical settings. Diabetes mellitus specific data element.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric						
<b>Representational form:</b>	Code						
<b>Representational layout:</b>	N						
<b>Minimum size:</b>	1						
<b>Maximum size:</b>	1						
<b>Data domain:</b>	<table> <tr> <td>1</td> <td>Yes, this is the initial visit of the patient for diabetes or a related condition after diagnosis</td> </tr> <tr> <td>2</td> <td>No, this is not the initial visit of the patient for diabetes or a related condition after diagnosis</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Yes, this is the initial visit of the patient for diabetes or a related condition after diagnosis	2	No, this is not the initial visit of the patient for diabetes or a related condition after diagnosis	9	Not stated/inadequately described
1	Yes, this is the initial visit of the patient for diabetes or a related condition after diagnosis						
2	No, this is not the initial visit of the patient for diabetes or a related condition after diagnosis						
9	Not stated/inadequately described						
<b>Guide for use:</b>	Record whether or not this is the first visit of the patient to this health professional.						
<b>Verification rules:</b>							
<b>Collection methods:</b>							
<b>Related metadata:</b>	relates to the data element Glycosylated haemoglobin (HbA1c) - measured vers 1						

### Administrative Attributes

<b>Source document:</b>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.		
<b>Source organisation:</b>	National Diabetes Data Working Group		
<b>Information model link:</b>	NHIM Request for/entry into service event		
<b>Data Set Specifications:</b>		<b>Start date</b>	<b>End date</b>
DSS - Diabetes (clinical)		01/01/2003	
<b>Comments:</b>	Used to compare findings or parameters (e.g. blood glucose control) of newly referred individuals with that of those previously seen.		

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## Injecting drug use status

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000432	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/03		
<b>Definition:</b>	The client's use of injection as a method of administering drugs. Includes intravenous, intramuscular and subcutaneous forms of injection.		
<b>Context:</b>	Alcohol and other drug treatment services: The data element is important for identifying patterns of drug use and harms associated with injecting drug use.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric										
<b>Representational form:</b>	Code										
<b>Representational layout:</b>	N										
<b>Minimum size:</b>	1										
<b>Maximum size:</b>	1										
<b>Data domain:</b>	<table> <tr> <td>1</td> <td>Last injected three months ago or less</td> </tr> <tr> <td>2</td> <td>Last injected more than three months ago but less than or equal to twelve months ago.</td> </tr> <tr> <td>3</td> <td>Last injected more than twelve months ago.</td> </tr> <tr> <td>4</td> <td>Never injected</td> </tr> <tr> <td>9</td> <td>Not stated/inadequately described</td> </tr> </table>	1	Last injected three months ago or less	2	Last injected more than three months ago but less than or equal to twelve months ago.	3	Last injected more than twelve months ago.	4	Never injected	9	Not stated/inadequately described
1	Last injected three months ago or less										
2	Last injected more than three months ago but less than or equal to twelve months ago.										
3	Last injected more than twelve months ago.										
4	Never injected										
9	Not stated/inadequately described										

#### Guide for use:

#### Verification rules:

**Collection methods:** To be collected on commencement of treatment with a service.  
For clients whose treatment episode is related to the alcohol and other drug use of another person, this data element should not be collected.

**Related metadata:** is qualified by Client type – alcohol and other drug treatment services vers 3  
supersedes previous data element Injecting drug use vers 1  
relates to the data element Method of use for principal drug of concern vers 1  
relates to the data element Other drug of concern vers 2  
relates to the data element Principal drug of concern vers 2

### Administrative Attributes

#### Source document:

**Source organisation:** Intergovernmental Committee on Drugs NMDS WG

#### Information model link:

NHIM Request for/entry into service event

**Data Set Specifications:****Start date****End date**

NMDS - Alcohol and other drug treatment services

01/07/2003

**Comments:**

This data element is used in conjunction with the data element Commencement of treatment for reporting the NMDS - Alcohol and other drug treatment services, and has been developed for use in clinical settings. A code that refers to a three-month period to define 'current' injecting drug use is required as a clinically relevant period of time.

The data element may also be used in population surveys that require a longer timeframe, for example to generate 12-month prevalence rates, by aggregating codes 1 and 2. However, caution must be exercised when comparing clinical samples with population samples.

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## Intended length of hospital stay

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000076	<b>Version No:</b>	2
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/01		
<b>Definition:</b>	The intention of the responsible clinician at the time of the patient's admission to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date.		
<b>Context:</b>	Admitted patient care: To assist in the identification and casemix analysis of planned same-day patients, that is those patients who are admitted with the intention of discharge on the same day. This is also a key indicator for quality assurance activities.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	N
<b>Minimum size:</b>	1
<b>Maximum size:</b>	1
<b>Data domain:</b>	1 Intended same-day 2 Intended overnight

#### Guide for use:

#### Verification rules:

**Collection methods:** The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.

**Related metadata:** is used in the derivation of Diagnosis related group vers 1  
supersedes previous data element Intended length of hospital stay vers 1

### Administrative Attributes

#### Source document:

**Source organisation:** National Health Data Committee

#### Information model link:

NHIM Planning event

<b>Data Set Specifications:</b>	<b>Start date</b>	<b>End date</b>
NMDS - Admitted patient care	01/07/2001	

**Comments:** Information comparing the intended length of the episode of care and the actual length of the episode of care is considered useful for quality assurance and utilisation review purposes.

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## Intended place of birth

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000077	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/96		
<b>Definition:</b>	The intended place of birth at the onset of labour.		

<b>Context:</b>	Perinatal care:
	Women who plan to give birth in birth centres or at home usually have different risk factors for outcome compared to those who plan to give birth in hospitals. Women who are transferred to hospital after the onset of labour have increased risks of intervention and adverse outcomes.

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Code
<b>Representational layout:</b>	N
<b>Minimum size:</b>	1
<b>Maximum size:</b>	1

<b>Data domain:</b>	1	Hospital
	2	Birth centre, attached to hospital
	3	Birth centre, free-standing
	4	Home
	8	Other
	9	Not stated

#### Guide for use:

#### Verification rules:

#### Collection methods:

<b>Related metadata:</b>	is qualified by Actual place of birth vers 1
	is qualified by Method of birth, version 1
	is qualified by Onset of labour, version 2

### Administrative Attributes

#### Source document:

**Source organisation:** National Perinatal Data Development Committee

#### Information model link:

NHIM Planning event

**Data Set Specifications:** **Start date**      **End date**

**Comments:** The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the States and Territories.

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## Intensive care unit

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000078 **Version No:** 1

**Metadata type:** Data Element Concept

**Admin. status:** Current  
01/07/96

**Definition:** An intensive care unit (ICU) is a designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

**Context:** Admitted patient care.

### Relational and Representational Attributes

**Datatype:**

**Representational form:**

**Representational layout:**

**Minimum size:**

**Maximum size:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related metadata:**

### Administrative Attributes

**Source document:**

**Source organisation:** National Intensive Care Working Group

**Information model link:**

NHIM Service delivery setting

**Data Set Specifications:** **Start date**      **End date**

**Comments:** There are five different types and levels of ICU defined according to three main criteria: the nature of the facility, the care process and the clinical standards and staffing requirements. All levels and types of ICU must be separate and self-contained facilities in hospitals and, for clinical standards and staffing requirements, substantially conform to relevant guidelines of the Australian Council on Healthcare Standards. The five types of ICU are briefly described below:

- Adult intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for patients in need of intensive care services, and have extensive backup laboratory and clinical service facilities to support the tertiary referral role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period; or care of a similar nature.

- Adult intensive care unit, level 2: must be capable of providing complex, multisystem life support and be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for a period of at least several days, or for longer periods in remote areas or care of a similar nature (see ACHS guidelines).
- Adult intensive care unit, level 1: must be capable of providing basic multisystem life support usually for less than a 24-hour period. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours; or care of a similar nature.
- Paediatric intensive care unit: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care; and have extensive backup laboratory and clinical service facilities to support this tertiary role. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period to infants and children less than 16 years of age; or care of a similar nature.
- Neonatal intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of a similar nature.

Definitions for high-dependency unit and coronary care unit are under development.

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## Inter-hospital contracted patient

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### Identifying and Definitional Attributes

**Knowledgebase ID:** 000079 **Version No:** 2

**Metadata type:** Derived Data Element

**Admin. status:** Current  
01/07/00

**Definition:** An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital), and for which the activity is recorded by both hospitals.

**Context:** Admitted patient care:  
To identify patients receiving services that have been contracted between hospitals. This item is used to eliminate potential double-counting of hospital activity in the analysis of patterns of health care delivery and funding and epidemiological studies.

### Relational and Representational Attributes

**Datatype:** Numeric

**Representational form:** Code

**Representational layout:** N

**Minimum size:** 1

**Maximum size:** 1

**Data domain:**

1	Inter-hospital contracted patient from public sector hospital
2	Inter-hospital contracted patient from private sector hospital
3	Other
9	Not reported

**Guide for use:** A specific arrangement should apply (either written or verbal) whereby one hospital contracts with another hospital for the provision of specific services. The arrangement may be between any combination of hospital; for example, public to public, public to private, private to private, or private to public.

#### Verification rules:

**Collection methods:** All services provided at both the originating and destination hospitals should be recorded and reported by the originating hospital. The destination hospital should record the admission as an 'Inter-hospital contracted patient' so that these services can be identified in the various statistics produced about hospital activity. This data element will be derived as follows.

If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 4 or 5 (that is, a hospital (Hospital A) purchases the activity, rather than a health authority or other external purchaser, and admits the patient for all or part of the episode of care, and/or records the contracted activity within the patient's record for the episode of care). Then record a value of 1, if Hospital A is a public hospital or record a value of 2, if Hospital A is a private hospital.

Otherwise if the Contract role is not B, and/or the Contract type is not 2, 3, 4 or 5 record a value of 3.

**Related metadata:**

- is derived from Contract role vers 1
- is derived from Contract type vers 1
- is used in conjunction with Contracted hospital care vers 1
- supersedes previous data element Inter-hospital same-day contracted patient vers 1

## Administrative Attributes

**Source document:**

**Source organisation:** National Health Data Committee

**Information model link:**

NHIM Recipient role

**Data Set Specifications:**

NMDS – Admitted patient care

**Start date**

**End date**

01/07/2000

**Comments:**

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## Interest payments

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### Identifying and Definitional Attributes

<b>Knowledgebase ID:</b>	000245	<b>Version No:</b>	1
<b>Metadata type:</b>	Data Element		
<b>Admin. status:</b>	Current		
	01/07/89		
<b>Definition:</b>	Payments made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow. This does not include the cost of equity capital (i.e. dividends on shares) in respect of profit-making private establishments.		
<b>Context:</b>	Health expenditure: This item has been retained in the data set because of its significance for the private sector. Private profit-making establishments will seek to fund their operations either by loan borrowings (debt capital) or raising shares (equity capital). The cost of either can be significant, although the cost of the latter (that is, dividends on shares) would come out of profits.		

### Relational and Representational Attributes

<b>Datatype:</b>	Numeric
<b>Representational form:</b>	Currency
<b>Representational layout:</b>	\$999,999,999
<b>Minimum size:</b>	2
<b>Maximum size:</b>	12
<b>Data domain:</b>	Australian dollars, rounded to nearest whole dollar.
<b>Guide for use:</b>	Record values up to hundreds of millions of dollars.
<b>Verification rules:</b>	
<b>Collection methods:</b>	
<b>Related metadata:</b>	relates to the data element Establishment type vers 1

### Administrative Attributes

<b>Source document:</b>		
<b>Source organisation:</b>	National Health Data Committee	
<b>Information model link:</b>		
	NHIM Recurrent expenditure	
<b>Data Set Specifications:</b>		<b>Start date</b> <b>End date</b>
	NMDS - Public hospital establishments	01/07/1989

<b>Comments:</b>	The item would not have been retained if the data set was restricted to the public sector. In some States, public hospitals may not be permitted to borrow funds or it may be entirely a State treasury matter, not identifiable by the health authority. Even where public sector establishment borrowings might be identified, this appears to be a sensitive area and also of less overall significance than in the private sector.
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