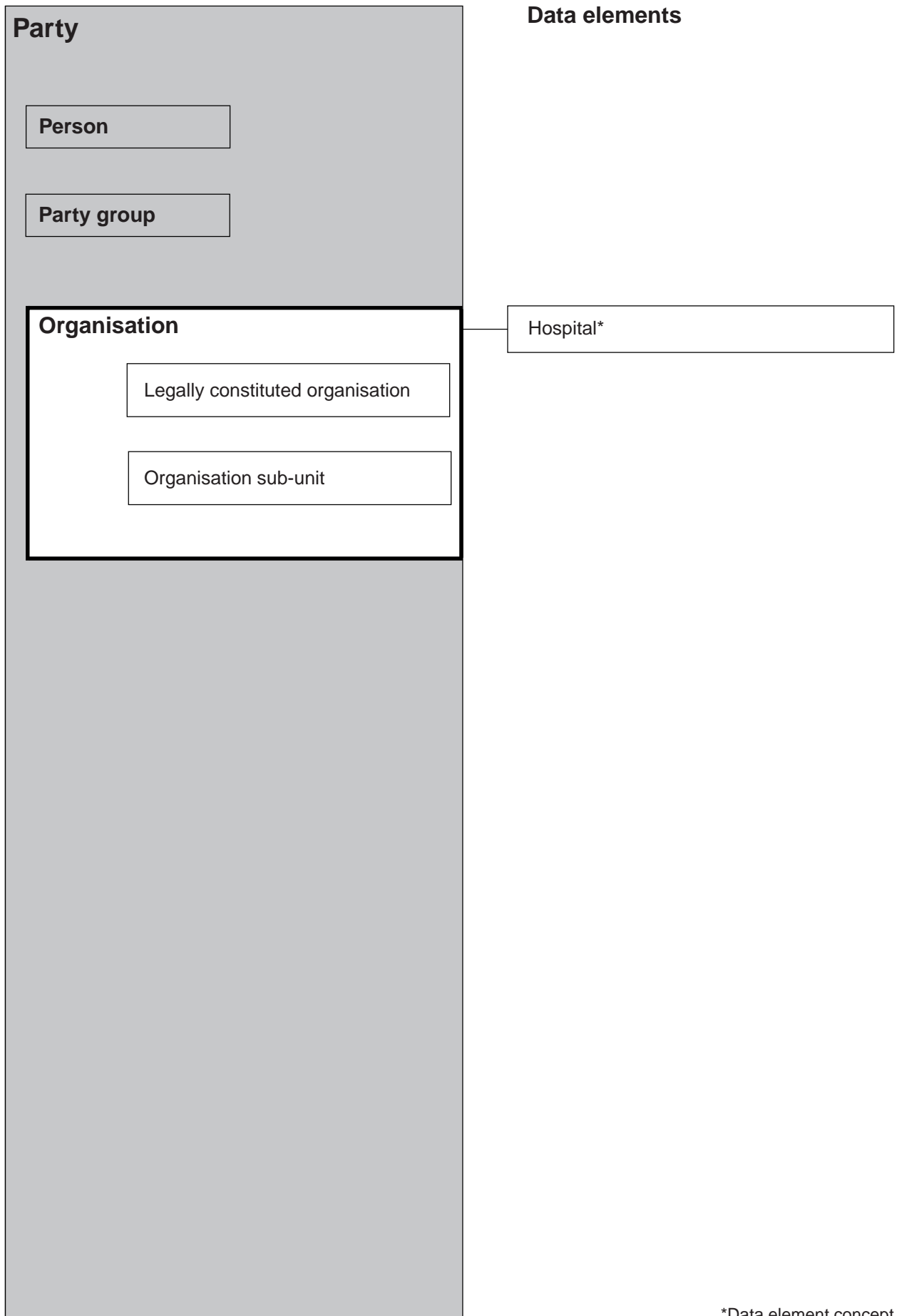


## National Health Information Model entities



## Hospital

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**Admin. status:** CURRENT 1/07/94

### Identifying and definitional attributes

**NHIK identifier:** 000064 **Version number:** 1

**Data element type:** DATA ELEMENT CONCEPT

**Definition:** 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.

**Context:** Institutional health care

### Relational and representational attributes

**Datatype:** **Representational form:**

**Field size:** **Min.** **Max.** **Representational layout:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:** relates to the data element Establishment sector, version 2

### Administrative attributes

**Source document:**

**Source organisation:** National Health Data Committee

**National minimum data sets:**

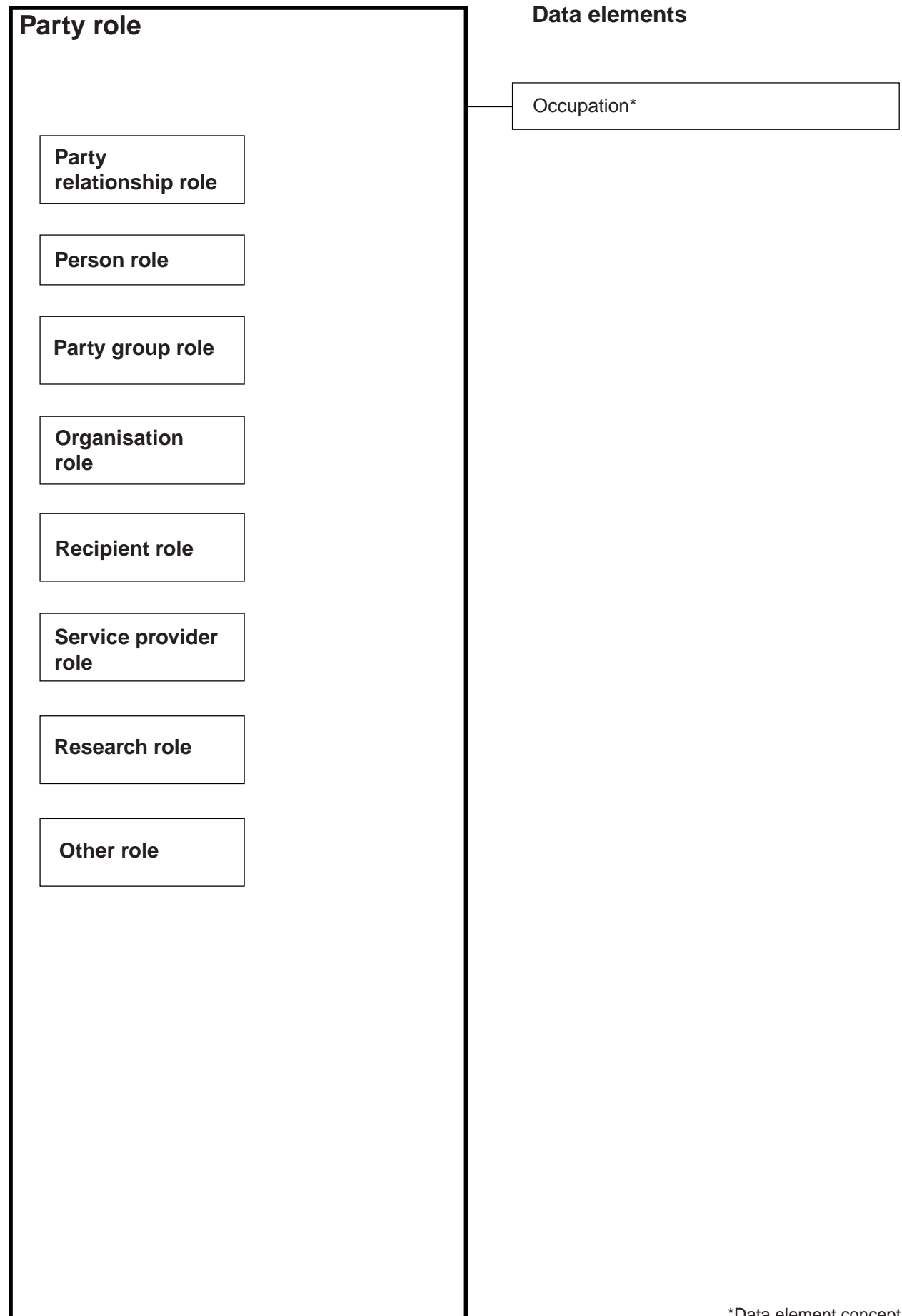
Institutional health care from 1/07/89 to

**Comments:** 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. For the purposes of these definitions, the term hospital includes satellite units managed and staffed by the hospital. This definition includes entities with multipurpose facilities (e.g. those which contain both recognised and non-recognised components).

This definition includes, but is not limited to, hospitals as recognised under the 1993-1998 Medicare Agreements.

Nursing homes as approved under the National Health Act 1953 (Cwlth) or equivalent State legislation and hostels approved under the Aged or Disabled Persons Care Act 1954 (Cwlth) are excluded from this definition.

## National Health Information Model entities



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## Occupation

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**Admin. status:** CURRENT 1/07/97

### Identifying and definitional attributes

**NHIK identifier:** 000229 **Version number:** 1

**Data element type:** DATA ELEMENT CONCEPT

**Definition:** The current occupation of the person is the current job or duties which the person is principally engaged in. This occupation may be in the context of:

- a person as a client or patient, or
- a person as a service provider.

This concept relates specifically to current occupation. A related concept, ie. of lifetime occupation, is of relevance to epidemiological analysis.

### Context:

### Relational and representational attributes

**Datatype:** **Representational form:**

**Field size:** **Min.** **Max.** **Representational layout:**

### Data domain:

**Guide for use:** Occupation is currently recorded on hospital morbidity forms or hospital admission forms in all States and Territories except Victoria. It is coded only in Western Australia and Tasmania. Occupation was recommended by the National Committee on Health and Vital Statistics (1979) as a second-level data item for inclusion in national minimum data sets.

Hall et al. (1986) recommended to the National Committee on Health and Vital Statistics that occupation be collected in both mortality and hospital morbidity data and that there should be a pilot study of the validity and reliability of occupational coding. They noted that occupation is recognised as an important factor in studying disease (Mathews 1983). Principal occupation during lifetime for males is recorded on death certificates. It has been common practice not to record occupation, but only marital status, of females.

However, in the Census, current occupation is recorded. Hence, the Census and mortality registers use different operational definitions of occupation. This makes it impossible to calculate proportional mortality rates by occupation groups by combining mortality and Census data.

The National Committee on Health and Vital Statistics (1979) asked all government health authorities to provide comments on the inclusion of occupation in hospital morbidity collections. The consensus at that time was that, while occupational data would be a useful addition to the database and was collected by some authorities, it was recognised that a number of difficulties existed. For example, a number of older patients would have their occupation recorded as retired and, in the case of occupation-related illness, the current occupation may differ from the occupation responsible for the illness.

The National Occupational Health and Safety Commission has developed a minimum data set for the national monitoring of workplace injuries and

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## Occupation (*continued*)

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### **Guide for use (cont'd):**

diseases of rapid onset (Worksafe Australia 1987). Roder and Holman (1987) argued that complementary data collection mechanisms are needed to ensure that Australia has comprehensive occupational health statistics. The importance of occupation-related ill health has been underlined by the Health Targets and Implementation Committee of the Australian Health Ministers' Advisory Council (1988). Roder and Holman (1987) noted that 'where the contribution of occupational factors is not self-evident, and there are delays of years or even decades between occupational exposure and manifestation of disease, it will not be possible to rely upon workplace reporting'. Rather, data will have to come from those places where diseases are diagnosed and deaths are notified.

Workers compensation data will not be suitable for the surveillance and discovery of diseases not yet known to be work-related. Moreover, the validity of these data for epidemiological surveillance will be suspect in those areas subject to changes in compensation policy.

'Sometimes there are circumstances where workers are fearful of special health risks in their workplaces. Routine data systems can be useful to assess whether prevailing mortality and morbidity rates offer justification for these concerns'.

In such applications, data would be used at a superficial level to ensure that there are sufficient grounds for committing resources to more in-depth studies. Waddell and Holman (1985) have shown the potential value of collecting occupational data in hospital morbidity collections in a preliminary analysis of Western Australian data.

Roder and Holman (1987) made the following recommendations in relation to hospital morbidity collections:

- hospital admission clerks record industry and occupation on discharge forms for all patients aged 15 years and over, as pertaining to the main lifetime job and, where different, the present job;
- the National Occupational Health and Safety Commission prepare guideline manuals to assist hospital admission clerks to record occupational information;
- pilot programs precede the introduction of these initiatives to ensure that the methodology proposed is practical. Thereafter, recording should be introduced incrementally by regions of Australia, with a progressive resolution of any unexpected difficulties;
- occupation be coded using the Australia and New Zealand Standard Industrial Classification and Australian Standard Classification of Occupations, as for Census data.

In relation to the first recommendation, it was noted that a Victorian pilot study (Working Party on Feasibility of Collecting Occupational Data Relevant to Cancer, 1983) had shown that hospital admission clerks can obtain information of a reasonable accuracy on patients' present jobs and industries, and their main lifetime jobs and industries. The misclassification of occupational information obtained in routine collections such as hospital morbidity collections is of the order of 30 per cent (Roder and Holman 1987). This is considered sufficient for initial analyses of trends. Validation checks of USA death registration data have indicated that misclassifications tend to occur at random, thereby effecting an attenuation of correlations with

## Occupation (*continued*)

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**Guide for use  
(cont'd):**

occupational factors, but not a systematic bias (Schumacher 1986). Perhaps more important than the question of accuracy is the tendency in Australia and many other countries to:

- record only the last occupation, not the longest lifetime occupation, as would be more appropriate for long-latency diseases;
- record only retired or pensioner for those age groups contributing most to death statistics;
- provide too vague a description of occupation for specific classification;
- give too little attention to the occupations of women, a legacy from the days when women were seldom part of the paid work force;
- provide no information on industry.

This latter deficiency is important because jobs in individual occupation categories are often heterogeneous across industries. Combined industry-occupation codes provide a much greater specificity and the opportunity to infer exposures by applying job exposure matrices (Roder 1986).

Roder and Holman recommended a style of questioning similar to that used by the Australian Bureau of Census and Statistics in censuses, and to that advocated for the minimum data set for workers compensation statistics. The following aspects should be included:

- the name of the occupation;
- the tasks and duties performed by the decedent;
- the trading name of the employer and, where feasible, the employer's main address;
- the kind of business or service carried out by that business.

The 1991 Australian Census asked the following questions relating to occupation and industry:

29. In the main job held LAST WEEK, what was the person's occupation?

- Give full title.
- For example, Civil Engineer, Draftsman, Accounts Clerk, Fast Foods Cook, 1st Class Welder, Extruding Machine Operator, Coal Miner.
- Armed Service personnel state rank as well as occupation.

30. What are the main tasks or duties that the person usually performs in that occupation?

- Describe as fully as possible.
- For example, preparing drawings for dam construction, recording and paying accounts, cooking hamburgers and chips, welding of high pressure steam pipes, operating plastic extruding machine, operating continuous mining machine.

Occupation is coded using Australian Standard Classification of Occupations (ABS 1986a). This classification is based on a type of work criterion with an emphasis on skill level (length and type of training) and skill specialisation (for

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## Occupation (*continued*)

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### **Guide for use (cont'd):**

example, subject matter knowledge). The structure of the Australian Standard Classification of Occupations has four levels:

8	Major groups	1-digit codes
52	Minor groups	2-digit codes
282	Unit groups	4-digit codes
1079	Occupations	6-digit codes

For example:

Level	Code	Title
Major group	2	Professionals
Minor group	28	Artists and related professionals
Unit group	2805	Designers and illustrators
Occupation	2805-13	Graphic designer

A Computer Assisted Coding system is available from the Australian Bureau of Statistics to assist in coding occupational data to Australian Standard Classification of Occupations codes.

The Commonwealth Department of Community Services and Health informed the working party that it supported the collection of occupation data based on a 2-digit Australian Standard Classification of Occupations code.

Five of the eight morbidity systems currently collect current occupation but, apart from Western Australia, do not code it. The Morbidity Working Party examined the proposal to include current occupation in the National Minimum Data Set - Institutional Health Care and noted the following:

- Most States felt that it was difficult to code, had low level of accuracy and required substantial resources. The Commonwealth Department of Community Services and Health argued that its accuracy was comparable to that of collected items such as principal diagnosis.
- The ABS noted that the limitations of collecting health data in sample surveys were much greater than those of collecting occupational data in administrative collections.
- New South Wales was sympathetic to the concept of collecting socioeconomic data but felt that the resources needed were not available. Several States expressed interest in collecting socioeconomic data if funded by the Commonwealth.
- Victoria has done a study which suggested it might be of limited use at the hospital level, but this would require asking several questions.
- South Australia uses a 2-digit Australian Standard Classification of Occupations code in psychiatric hospitals.
- Western Australia has collected it for years but regards it as neither reliable nor useful (big gaps in data).

The Morbidity Working Party decided not to recommend that occupation be included in the National Minimum Data Set - Institutional Health Care at its first meeting. However, following the request of the Department of Community Services and Health to reconsider this item for inclusion as it is already collected in a majority of systems, the working party subsequently

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## Occupation (*continued*)

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**Guide for use  
(cont'd):**

agreed in principle to endorse the inclusion of occupation in the National Minimum Data Set - Institutional Health Care. It also recommended that the collection of occupational data for in-patients of acute hospitals be tested in trials, using in-hospital surveys (linked to morbidity data) for six- or twelve-month periods in a selected sample of hospitals. Such trials should evaluate the costs and benefits of sampling options versus routine collection for all in-patients.

With regard to psychiatric hospitals, all States collect occupation except New South Wales. The Psychiatric Working Party felt that, given the emphasis on socioeconomic differentials in health, occupation data would be worthwhile collecting and recommended that occupation be included in the National Minimum Data Set - Institutional Health Care for psychiatric hospitals.

In Victoria, lifetime occupation is currently collected on admission to State psychiatric hospitals and upon registration with outpatient and other community services. Codes currently used are a modification of ABS standard codes but revision of the outpatient collection system is now under way, and Victoria will adopt the Australian Standard Classification of Occupations framework (2-digit codes). Revision of the in-patient system will soon follow. The justification for this item is based on the important role that vocational rehabilitation plays in improving outcomes for people with psychiatric disability. Data on the lifetime occupation of clients of psychiatric services assist in the identification of rehabilitation needs and the development of service options. The collection of such data is generally accepted by providers and clients.

Principal lifetime occupation is defined as the occupation the patient has engaged in that accounts for the greatest number of working years.

Collection of lifetime occupation in routine morbidity data collections is likely to be more difficult than current occupation. This should also be evaluated as part of the trial recommended above, and a final decision on which definition to use should then follow.

**Verification rules:**

**Collection methods:**

**Related data:** relates to the data element Profession labour force status of health professional, version 1  
relates to the data element Occupation of person, version 1

### Administrative attributes

**Source document:**

**Source organisation:**

**National minimum data sets:**

**Comments:** There is considerable user demand for data on occupation-related injury and illness, including from Worksafe Australia and from industry, where unnecessary production costs are known in some areas and suspected to be related to others in work-related illness, injury and disability. The report



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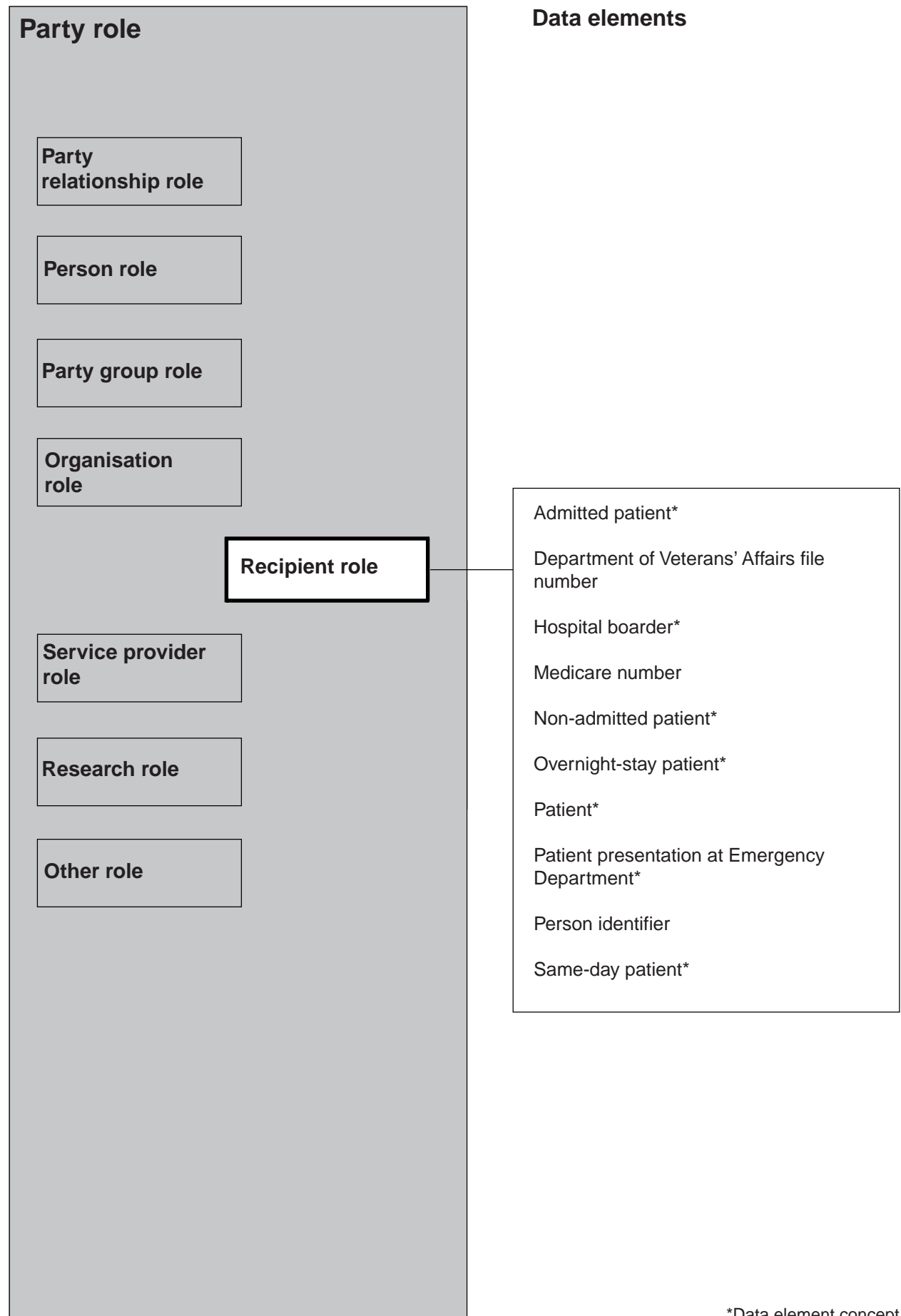
## Occupation (*continued*)

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- Comments (cont'd):** Health for all Australians also identifies occupational related ill health as a focus for health promotion and illness prevention activities.
- Lack of morbidity data is severely hampering the development of preventive interventions in this area. User demand can be expected to grow.
- There is an increasing commitment by governments to reducing inequalities in health status between population subgroups. There is already some evidence of higher incidence of morbidity and mortality in particular occupations, but greater knowledge in this area is required.
- A recent report prepared for the National Occupational Health and Safety Commission (Roder, Holman 1987) recommended that occupation be recorded on hospital discharge forms. This report argued that there has been a recent increase in interest in occupation as a cause of disease and disability in Australia. This is reflected in the establishment of the National Occupational Health and Safety Commission and the steps taken to introduce a minimum data set for monitoring workplace injuries and diseases of rapid onset.
- The minimum data set is a crucial development but the associated data collection system will not cover the whole work force nor all work-related diseases. Complementary data-collection mechanisms will therefore be needed and should be based on death records, hospital records, cancer registries, perinatal and birth defect statistics, communicable disease notifications, sentinel medical practice reporting and household surveys.
- It is recognised that the resulting occupational information, while much improved, will still be limited in quality and detail. However, it will suffice for general analyses of mortality and morbidity in the Australian work force and for developing and initially checking hypotheses of occupational causes of disease. The data will not be adequate for rigorous in-depth studies. Because in-depth studies usually require extensive resources, preliminary analyses of general death and morbidity record systems would be appropriate to ensure that there are sufficient grounds for committing resources to these projects.
- The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be employment status, income, occupation and education.



## National Health Information Model entities



## Admitted patient

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**Admin. status:** CURRENT 1/07/98

### Identifying and definitional attributes

**NHIK identifier:** 000011 **Version number:** 2

**Data element type:** DATA ELEMENT CONCEPT

**Definition:** An admitted patient is a patient who undergoes a hospital's formal admission process as either an overnight stay patient or a same-day patient.

**Context:** Institutional health care.

### Relational and representational attributes

**Datatype:** **Representational form:**

**Field size:** **Min.** **Max.** **Representational layout:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:** supersedes previous data element Admitted patient, version 1  
relates to the data element Patient days, version 2  
relates to the data element Date of change to qualification status, version 1  
relates to the data element Qualification status, version 1  
relates to the data element Number of acute (qualified)/unqualified days for newborns, version 1  
relates to the data element Type of episode of care, version 3

### Administrative attributes

**Source document:**

**Source organisation:**

**National minimum data sets:**

**Comments:** This definition includes all babies who are nine days old or less. However, all newborn days of stay are further divided into categories of qualified and unqualified for Australian Healthcare Agreements and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn meets at least one of the following criteria:

- is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;
- is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care;
- remains in hospital without its mother;
- is admitted to the hospital without its mother.

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## Admitted patient (*continued*)

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**Comments (cont'd):** Acute (qualified) newborn days are eligible for health insurance benefit purposes and should be counted under the Australian Healthcare Agreements.

Days when the newborn does not meet these criteria are classified as unqualified (if they are nine days old or less) and should be recorded as such. Unqualified newborn days should not be counted under the Australian Healthcare Agreements and are not eligible for health insurance benefit purposes.

## Department of Veterans' Affairs file number

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**Admin. status:** CURRENT 1/07/97

### Identifying and definitional attributes

**NHIK identifier:** 000204 **Version number:** 1

**Data element type:** DATA ELEMENT

**Definition:** The Department of Veterans' Affairs file number of the person.

**Context:** Institutional health care: this number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.

### Relational and representational attributes

**Datatype:** Alphanumeric **Representational form:** IDENTIFICATION NUMBER

**Field size:** **Min.** 7 **Max.** 7 **Representational layout:** AAANNNN

**Data domain:**

**Guide for use:** The file reference is a seven digit identifier that can have a State code (N,V,Q,S,W,T) included, and in some circumstances a file type code is added. ACT is included in NSW (N) and NT with SA (S).

Individuals are identified by an alphanumeric code at the end of the file number. A veteran's spouse and children have the same file number but are identified within the DVA Client Database with a segment link or suffix. The segment link and suffix are different and can change. For example, the suffix usually changes when a wife becomes a widow.

Changes to the information system in the Department of Veteran's Affairs may permit the identification of all individual States and Territories in the future.

**Verification rules:**

**Collection methods:**

**Related data:**

### Administrative attributes

**Source document:**

**Source organisation:** Department of Veteran's Affairs, National Health Data Committee

**National minimum data sets:**

**Comments:**

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## Hospital boarder

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**Admin. status:** CURRENT 1/07/94

### Identifying and definitional attributes

**NHIK identifier:** 000065 **Version number:** 1

**Data element type:** DATA ELEMENT CONCEPT

**Definition:** A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

**Context:** Institutional health care

### Relational and representational attributes

**Datatype:** **Representational form:**

**Field size:** **Min.** **Max.** **Representational layout:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:**

### Administrative attributes

**Source document:**

**Source organisation:** National Health Data Committee

**National minimum data sets:**

Institutional health care from 1/07/89 to

**Comments:** A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder. This excludes all babies born in hospital aged 9 days old or less.

## Medicare number

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**Admin. status:** CURRENT 1/07/89

### Identifying and definitional attributes

**NHIK identifier:** 000091 **Version number:** 1

**Data element type:** DATA ELEMENT

**Definition:** Personal identifier allocated by the Health Insurance Commission to eligible persons under the Medicare scheme.

**Context:** Medicare utilisation statistics and institutional health care.

### Relational and representational attributes

**Datatype:** Numeric **Representational form:** CODE

**Field size:** **Min.** 11 **Max.** 11 **Representational layout:** NNNNNNNNNNNN

**Data domain:** Full Medicare number for an individual (ie. family number plus person number)

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:**

### Administrative attributes

**Source document:**

**Source organisation:** National Health Data Committee

**National minimum data sets:**

**Comments:** Under Medicare, each eligible family in the population is assigned a unique identifying number. This number, together with age and sex, provides an essentially unique identifier.



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## Non-admitted patient

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**Admin. status:** CURRENT 1/07/94

### Identifying and definitional attributes

**NHIK identifier:** 000104 **Version number:** 1

**Data element type:** DATA ELEMENT CONCEPT

**Definition:** A patient who does not undergo a hospital's formal admission process.

There are three categories of non-admitted patient:

- emergency department patient
- outpatient
- other non-admitted patient (treated by hospital employees off the hospital site - includes community / outreach services)

**Context:** Institutional health care

### Relational and representational attributes

**Datatype:** **Representational form:**

**Field size:** **Min.** **Max.** **Representational layout:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:** relates to the data element concept Patient, version 1

### Administrative attributes

**Source document:**

**Source organisation:** National Health Data Committee

**National minimum data sets:**

Institutional health care from 1/07/89 to

**Comments:**

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## Overnight-stay patient

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**Admin. status:** CURRENT 1/07/94

### Identifying and definitional attributes

**NHIK identifier:** 000116 **Version number:** 1

**Data element type:** DATA ELEMENT CONCEPT

**Definition:** A patient who, following a clinical decision, receives hospital treatment for a minimum of one night i.e. who is admitted to and separated from the hospital on different dates.

**Context:** Institutional health care

### Relational and representational attributes

**Datatype:** **Representational form:**

**Field size:** **Min.** **Max.** **Representational layout:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:** relates to the data element concept Admitted patient, version 1

### Administrative attributes

**Source document:**

**Source organisation:** National Health Data Committee

**National minimum data sets:**

Institutional health care from 1/07/89 to

**Comments:** An overnight-stay patient of a hospital (originating hospital) who attends another hospital (the destination hospital) for a same-day procedure must be regarded by the originating hospital as an overnight-stay patient, as if the patient had not left for the same-day procedure. For reporting purposes, the procedure is regarded as part of the overnight-stay episode at the originating hospital. The destination hospital must record the patient as a 'contracted same-day patient', thus distinguishing that patient from other same-day patients who were not simultaneously overnight-stay patients at another hospital. Refer to data element Intended length of hospital stay.

An overnight-stay patient in one hospital cannot be concurrently an overnight-stay patient in another hospital. Such a patient must be discharged from one and admitted to the other on each occasion of transfer.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient shall be regarded as part of the overnight episode.

A non-admitted (emergency/outpatient) service provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the

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## Overnight-stay patient (*continued*)

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**Comments (cont'd):** admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

The definition of an overnight-stay patient excludes patients who leave of their own accord, die or are transferred on their first day in the hospital.

## Patient

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**Admin. status:** CURRENT 1/07/95

### Identifying and definitional attributes

**NHIK identifier:** 000117 **Version number:** 1

**Data element type:** DATA ELEMENT CONCEPT

**Definition:** A patient is a person for whom a hospital accepts responsibility for treatment and/or care. There are two categories of patient, admitted and non-admitted patients. Boarders are not patients.

**Context:** Institutional health care

### Relational and representational attributes

**Datatype:** **Representational form:**

**Field size:** **Min.** **Max.** **Representational layout:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:** relates to the data element concept Admitted patient, version 1

### Administrative attributes

**Source document:**

**Source organisation:** National Health Data Committee

**National minimum data sets:**

Institutional health care from 1/07/89 to

**Comments:** While the concept of a person for whom a service is provider accepts responsibility for treatment or care is also applicable to non-institutional health care and to welfare services, different terminology is often used in these other care settings e.g. client, resident.

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## Patient presentation at Emergency Department

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**Admin. status:** CURRENT 1/07/98

### Identifying and definitional attributes

**NHIK identifier:** 000349 **Version number:** 1

**Data element type:** DATA ELEMENT CONCEPT

**Definition:** The presentation of a patient at an Emergency Department occurs following the arrival of the patient at the Emergency Department and is the earliest occasion of being:

- registered clerically; or
- triaged; or
- provided with a service by a treating medical officer or nurse.

(In hospital data collection systems, the time and date of the first contact would be selected from the earliest three different recorded times.)

**Context:** Institutional health care

### Relational and representational attributes

**Datatype:** **Representational form:**

**Field size:** **Min.** **Max.** **Representational layout:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:**

### Administrative attributes

**Source document:**

**Source organisation:**

**National minimum data sets:**

**Comments:**

## Person identifier

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**Admin. status:** CURRENT 1/07/89

### Identifying and definitional attributes

**NHIK identifier:** 000127 **Version number:** 1

**Data element type:** DATA ELEMENT

**Definition:** Person identifier unique within establishment or agency.

**Context:** This item could be used for editing at the establishment or collection authority level and, potentially, for episode linkage. There is no intention that this item would be available beyond collection authority level.

### Relational and representational attributes

**Datatype:** Alphanumeric **Representational form:** CODE

**Field size:** **Min.** **Max.** **Representational layout:**

**Data domain:**

**Guide for use:** Individual establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems.

**Verification rules:**

**Collection methods:**

**Related data:**

### Administrative attributes

**Source document:**

**Source organisation:** National minimum data set working parties

**National minimum data sets:**

Institutional health care from 1/07/89 to

Institutional mental health care from 1/07/97 to

Perinatal collection from 1/07/97 to

Community mental health care from 1/07/98 to

**Comments:** For institutional health care statistics, person identifier is used in conjunction with other data elements recording individual episodes of care or events. To date, there has been limited development of patient-based data ie. linking data within hospital morbidity collections about all episodes of care for individuals.

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## Same-day patient

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**Admin. status:** CURRENT 1/07/94

### Identifying and definitional attributes

**NHIK identifier:** 000146 **Version number:** 1

**Data element type:** DATA ELEMENT CONCEPT

**Definition:** A same-day patient is a patient who is admitted and separates on the same date, and who meets one of the following minimum criteria:

- That the patient receive Same-day Surgical and Diagnostic Services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (C'wlth); or
- That the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (C'wlth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

**Context:** Institutional health care

### Relational and representational attributes

**Datatype:** **Representational form:**

**Field size:** **Min.** **Max.** **Representational layout:**

**Data domain:**

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:** relates to the data element concept Admitted patient, version 1

### Administrative attributes

**Source document:**

**Source organisation:** National Health Data Committee

**National minimum data sets:**

Institutional health care from 1/07/89 to

**Comments:** Same-day patients may be either intended to be discharged on the same day, or intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.

Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient shall be regarded as part of the overnight episode.

Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the

## Same-day patient (*continued*)

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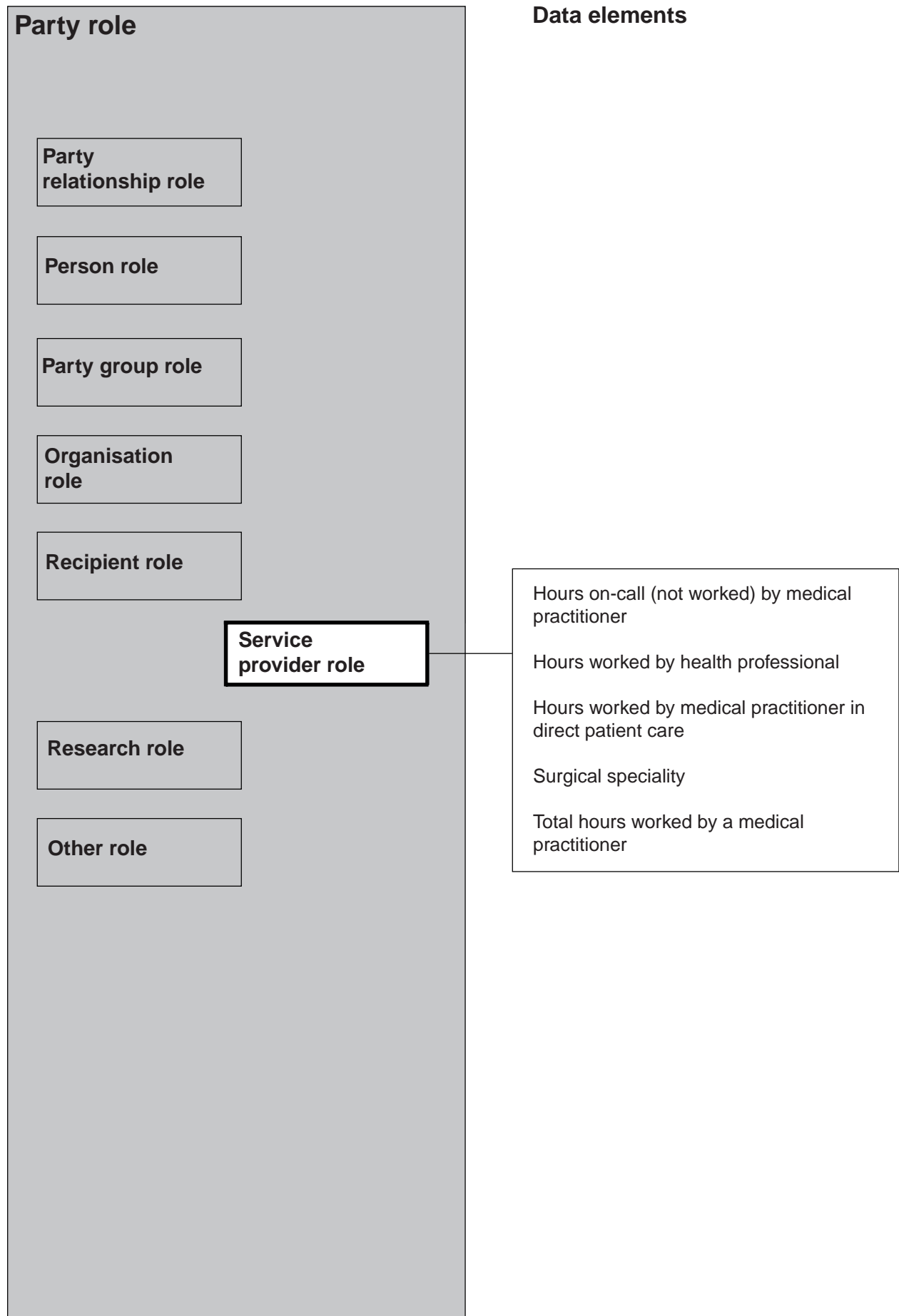
**Comments (cont'd):** admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

Data on same-day patients are derived by a review of admission and separation dates. The data excludes patients who were to be discharged on the same day but were subsequently required to stay in hospital for one night or more.

The National Health Data Committee considered whether or not this definition should include patients who stay one night because their treatment/care cannot normally be given during daylight hours (e.g. sleep study patients). However, these patients are not counted as same-day patients as same-day patients are derived from a review of the admission and separation dates. Until same-day patients are defined as being admitted to hospital for 23 hours or less, there is no easy way of identifying these patients. This issue requires further consideration by the National Health Data Committee.



## National Health Information Model entities



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

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**Admin. status:** CURRENT 1/07/97

### Identifying and definitional attributes

**NHIK identifier:** 000393 **Version number:** 2

**Data element type:** DATA ELEMENT

**Definition:** The number of hours in a week that a medical practitioner is required to be available to provide advice, respond to any emergencies etc.

**Context:** 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

**Datatype:** Numeric **Representational form:** QUANTITATIVE VALUE

**Field size:** *Min.* 3 *Max.* 3 **Representational layout:** NNN

**Data domain:** Total hours, expressed as 000, 001 etc.

**Guide for use:** Code 999 for not stated / inadequately described  
Data element relates to each position (job) held by a medical practitioner.

**Verification rules:** Value must be less than 169 (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 data:** relates to the data element Hours worked by medical practitioner in direct patient care, version 2  
relates to the data element Total hours worked by a medical practitioner, version 2  
supersedes previous data element Hours worked, version 1

### Administrative attributes

**Source document:**

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

**National minimum data sets:**

Health labourforce from 1/07/89 to

**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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## Hours worked by health professional

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**Admin. status:** CURRENT 1/07/97

### Identifying and definitional attributes

**NHIK identifier:** 000313 **Version number:** 2

**Data element type:** DATA ELEMENT

**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

**Field size:** *Min.* 3 *Max.* 3 **Representational layout:** NNN

**Data domain:** Total hours, expressed as 000, 001 etc.

**Guide for use:** Code 999 for not stated/inadequately described

**Verification rules:** Value must be less than 169 (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 data:** supersedes previous data element Hours worked, version 1

### Administrative attributes

**Source document:**

## Hours worked by health professional (*continued*)

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

**National minimum data sets:**

Health labourforce from 1/07/89 to

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

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**Admin. status:** CURRENT 1/07/97

### Identifying and definitional attributes

**NHIK identifier:** 000392 **Version number:** 2

**Data element type:** DATA ELEMENT

**Definition:** 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.

**Context:** 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

**Datatype:** Numeric **Representational form:** QUANTITATIVE VALUE

**Field size:** **Min.** 3 **Max.** 3 **Representational layout:** NNN

**Data domain:** Total hours, expressed as 000, 001 etc.

**Guide for use:** Code 999 for not stated / inadequately described

Data element relates to each position (job) held by a medical practitioner, not the aggregate of hours worked for all jobs.

**Verification rules:** Value must be less than 169 (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 data:** relates to the data element Hours on-call (not worked) by medical practitioner, version 2

relates to the data element Total hours worked by a medical practitioner, version 2

supersedes previous data element Hours worked, version 1

### Administrative attributes

**Source document:**

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

**National minimum data sets:**

Health labourforce

from 1/07/89 to

## Hours worked by medical practitioner in direct patient care (*continued*)

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**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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## Surgical specialty

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**Admin. status:** CURRENT 1/01/95

### Identifying and definitional attributes

**NHIK identifier:** 000161 **Version number:** 1

**Data element type:** DATA ELEMENT

**Definition:** The area of clinical expertise held by the doctor who will perform the elective surgery.

**Context:** Elective surgery: many hospitals manage their waiting lists on a specialty basis. Current data show that the total ready for care times waited and numbers of long wait patients vary significantly between specialities. Furthermore, the hospital capacity to handle the demand for elective surgery varies with specialty.

### Relational and representational attributes

**Datatype:** Numeric **Representational form:** CODE

**Field size:** **Min.** 2 **Max.** 2 **Representational layout:** NN

**Data domain:**

01	Cardio-thoracic surgery
02	Ear, nose and throat surgery
03	General surgery
04	Gynaecology
05	Neurosurgery
06	Ophthalmology
07	Orthopaedic surgery
08	Plastic surgery
09	Urology
10	Vascular surgery
11	Other

**Guide for use:**

**Verification rules:**

**Collection methods:**

**Related data:**

### Administrative attributes

**Source document:**

**Source organisation:** Hospital Access Program Waiting Lists Working Group / National Health Data Committee / Waiting Times Working Group

**National minimum data sets:**

Waiting times from 1/07/94 to

**Comments:** The above classifications are consistent with the Recommended Medical Specialties and Qualifications agreed by the National Specialist Qualification Advisory Committee of Australia, September 1993. Vascular surgery is a

## Surgical specialty (*continued*)

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**Comments (cont'd):** subspecialty of general surgery. The Royal Australian College of Surgeons has a training program for vascular surgeons. The specialties listed above refer to the surgical component of these specialties - ear, nose and throat surgery refers to the surgical component of the specialty otolaryngology; gynaecology refers to the gynaecological surgical component of obstetrics and gynaecology; ophthalmology refers to the surgical component of the specialty (patients awaiting argon laser phototherapy are not included).

It is envisaged that over time category 11 will not be used for elective surgery patients. Currently some health authorities use specialties (e.g. cranio-facial) which do not obviously fit into any one of the major categories. Further discussion is needed to draw up a guideline for mapping subspecialties to the major categories.



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## Total hours worked by a medical practitioner

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**Admin. status:** CURRENT 1/07/97

### Identifying and definitional attributes

**NHIK identifier:** 000394 **Version number:** 2

**Data element type:** DATA ELEMENT

**Definition:** The total hours worked in a week in a job by a medical practitioner, including any on-call hours actually worked (includes patient care and administration).

**Context:** 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

**Datatype:** Numeric **Representational form:** QUANTITATIVE VALUE

**Field size:** *Min.* 3 *Max.* 3 **Representational layout:** NNN

**Data domain:** Total hours, expressed as 000, 001 etc.

**Guide for use:** Code 999 for not stated / inadequately described  
Data element relates to each position (job) held by a medical practitioner, not the aggregate of hours worked in all.

**Verification rules:** Value must be less than 169 (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 data:** relates to the data element Hours worked by medical practitioner in direct patient care, version 2  
relates to the data element Hours on-call (not worked) by medical practitioner, version 2  
supersedes previous data element Hours worked, version 1

### Administrative attributes

**Source document:**

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

**National minimum data sets:**

Health labourforce from 1/07/89 to

**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.

