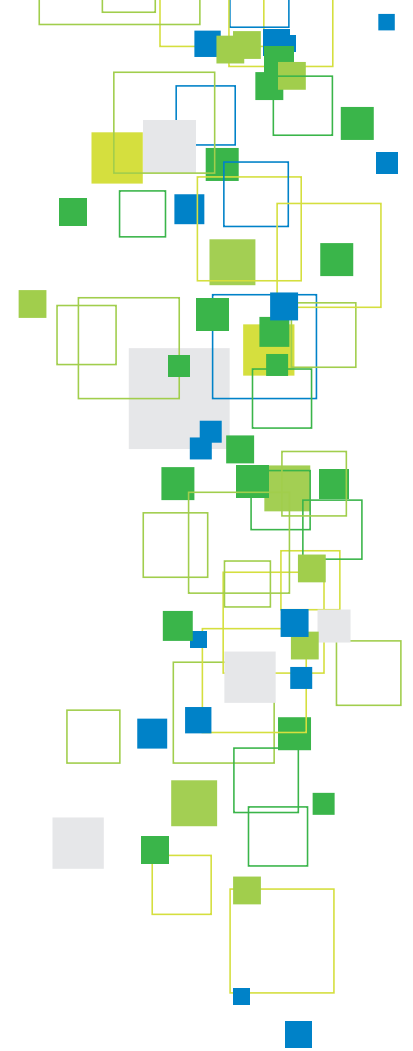




National Health Performance Authority



National Health Performance Authority

Healthy Communities:

Immunisation rates for children in 2012–13

Technical Supplement

Please note: The section of this Technical Supplement on childhood immunisation rates relates only to the reports *Healthy Communities: Immunisation rates for children in 2012–13* (published March 2014) and *Healthy Communities: Immunisation rates for children in 2014–15* (published April 2016). The section on HPV immunisation relates only to the reports *Healthy Communities: Immunisation rates for children in 2012–13* (published March 2014) and *Healthy Communities: HPV immunisation rates for girls in 2013* (published August 2015). Data and methods for childhood and HPV immunisation rates have since been revised. See www.myhealthycommunities.gov.au for the most up-to-date results and methods.

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Please note that there is the potential for minor revisions of this report.
Please check www.myhealthycommunities.gov.au for any amendments.

Table of contents

Summary	iii
Measures of immunisation rates for children	iii
Girls aged 15 years fully immunised against HPV	iv
Immunisation rates for children	1
Box 1: Definition of immunisation rates for children	1
Australian Childhood Immunisation Register	2
Limitations	2
Interpreting the Australian Childhood Immunisation Register data	3
Confidential results	3
Interpret with caution	3
Interpreting the results	3
Internal migration	3
Immigration	4
Identification of Aboriginal and Torres Strait Islander people	4
Immunisation of girls against HPV	5
Box 2: Immunisation of girls against HPV	5
National HPV Vaccination Program Register	6
Limitations	7
Geography levels	8
Medicare Local catchments	8
Statistical Areas Level 3	9
Geographic correspondences	9
References	10
About the Authority	12

Summary

The National Health Performance Authority (the Authority) publishes two streams of reports: Healthy Communities reports and Hospital Performance reports. The Authority bases its performance reports on the 48 indicators agreed by the Council of Australian Governments.

This technical supplement summarises methods used to calculate descriptive statistics and performance indicators presented in *Healthy Communities: Immunisation rates for children in 2012–13*. The content of this supplement assumes that readers possess technical expertise in the creation and use of health information.

The supplement is organised into three sections. The first part of the supplement presents the specification for immunisation rates for children and information about the data source – the Australian Childhood Immunisation Register (ACIR) including limitations, how the data have been confidentialised and what to consider when interpreting results. The second section presents the specification for immunisation of girls against human papillomavirus (HPV) and information about the data source – the National Human Papillomavirus Vaccination Program Register (HPV Register) including limitations. The third part outlines the different geographies used to present data in the report – Medicare Local catchments, Statistical Areas Level 3 and postcodes.

Healthy Communities: Immunisation rates for children in 2012–13 also reports information on girls aged 15 years who were fully immunised against HPV, having received all three of the recommended doses of the HPV vaccine according to the schedule.

Measures of immunisation rates for children

The *Healthy Communities: Immunisation rates for children in 2012–13* report presents information about percentages of all children, and percentages of Aboriginal and Torres Strait Islander children, aged 1, 2 and 5 years who are fully immunised. The numbers of children not fully immunised and the numbers of children with conscientious objection recorded are also reported for each age group. Results are displayed in multiple formats to facilitate understanding of immunisation rates at various geographic levels across Australia.

This information is reported for all 61 Medicare Local catchments and for more than 300 geographic areas known as Statistical Areas Level 3 (SA3). Information is also reported for about 1,500 of 3,000 postcodes (postal delivery areas) covering 96% of children aged 1, 2 and 5 years across Australia registered on the ACIR. The remaining postcodes had too few children residing within them to report percentages reliably. Information is provided online at **www.myhealthycommunities.gov.au** at Medicare Local catchment, SA3 and postcode level. All data have been aggregated for geographic areas using protocols that respect confidentiality.

Definitions of children fully immunised are established under the terms of a piece of federal legislation called *A New Tax System (Family Assistance) Act 1999*. The methods for calculation of immunisation rates for children aged 1, 2 and 5 years can be found in **Box 1, page 1**.

Girls aged 15 years fully immunised against HPV

The *Healthy Communities: Immunisation rates for children in 2012–13* report presents information about the percentage of girls turning 15 years in 2012 who were fully immunised against HPV, having received all three recommended doses of the HPV vaccine according to the schedule. This information is reported for all 61 Medicare Local catchments in Australia.

Immunisation rates for children

Box 1: Definition of immunisation rates for children

Description: The percentage of children fully immunised.

Data source: Data were supplied by the Australian Government Department of Health sourced from the Australian Childhood Immunisation Register (ACIR) for 2012–13. The data are extracted quarterly with reports run for a previous quarter's data at the end of the next quarter. For example, the reports as at 30 September were produced on 31 December. Data were supplied on 6 February 2014.

Numerator: Number of children in the population fully immunised for each age defined as:

- Fully immunised at 1 year means that a child aged 12 months to less than 15 months received their third vaccination for diphtheria, tetanus, whooping cough (DTPa) and polio (IPV), and either their second or third vaccination (dependent on the type of vaccine used) for hepatitis B (hepB) and *Haemophilus influenzae* type b (Hib), all prior to the age of 1 year. It is assumed that all previous vaccinations were received
- Fully immunised at 2 years means that a child aged 24 months to less than 27 months received their third or fourth vaccination (dependent on the type of vaccine used) for diphtheria, tetanus, whooping cough (DTPa) and *Haemophilus influenzae* type b (Hib), their third vaccination for polio (IPV) and hepatitis B (hep B), and their first vaccination for measles, mumps and rubella (MMR), all prior to the age of

2 years. It is assumed that all previous vaccinations were received

- Fully immunised at 5 years means that a child aged 60 months to less than 63 months received their fourth or fifth vaccination (dependent on the type of vaccine used) for diphtheria, tetanus and whooping cough (DTPa), their fourth vaccination for polio (IPV), and their second vaccination for measles, mumps and rubella (MMR), all prior to the age of 5 years. It is assumed that all previous vaccinations were received.

For each age it is assumed that earlier vaccinations in the series have been given. Research published by others has assessed the validity of this assumption.¹

Denominator: Number of children who turned each age between 1 April 2012 and 31 March 2013 in the eligible population i.e. those children who are registered with Medicare on the ACIR.

Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.

Disaggregation: By Medicare Local catchment, Australian Bureau of Statistics Statistical Area Level 3 geography and postcode.

Additional notes

Invalid records are excluded from the numerator and denominator. Examples of invalid records are records where postcodes reported are not valid, the record has an incomplete address, or there has been a return to sender flag on the child's record.

Australian Childhood Immunisation Register

Data on childhood immunisation rates in the report *Healthy Communities: Immunisation rates for children in 2012–13* were sourced from the Australian Childhood Immunisation Register (ACIR) through the Australian Government Department of Health.²

The ACIR commenced on 1 January 1996 and is administered by the Department of Human Services (Medicare). It is the primary means of determining the percentage of children under 7 years of age who have been vaccinated. There have been three unpublished external reviews of the ACIR (1997, 2000 and 2003) that have informed enhancements to its functionality and features.³ However, enhancements and improvements to the ACIR are ongoing, often as a result of advice from the National Immunisation Committee Data Subcommittee.

Commonwealth, state and territory, and local governments use the ACIR to monitor population immunisation levels and services, and to identify regions at risk during disease outbreaks.²

The ACIR data also:

- Enable immunisation providers and parents or guardians to check the immunisation status of a child, regardless of where the child was immunised
- Enable the Register to generate a milestone and optional immunisation history statements that can be used as proof of immunisation status for childcare and school enrolments
- Can be used to help determine a parent's or guardian's eligibility for some Australian Government family assistance payments

- Provide information for the delivery of incentive payments and feedback reports to eligible immunisation providers.²

Recognised immunisation providers submit immunisation data daily to the ACIR via:

- The electronic Medicare online claiming facility
- Secure internet facilities
- Manual processes using a designated form.²

These data are collected and reported for children up to their seventh birthday. The ACIR includes children who may or may not have a Medicare enrolment.

Medicare enrolment data is maintained on the ACIR through nightly data updates from the immunisation providers.

Immunisation notifications that do not comply with Australian Childhood Immunisation Due and Overdue Rules, or which are duplicate notifications, prompt an enquiry to the provider. Where the validity of a notification cannot be established these notifications are rejected.²

As of 2001, immunisations administered overseas that are endorsed by a recognised Australian provider can be submitted to the ACIR. The ACIR maintains records of children with medical contraindications to immunisation and identifies where parents lodge a conscientious objection to immunisation.

Limitations

The ACIR is considered to be a nearly complete population register, with 99% of children registered with Medicare by 12 months of age.³

There are a number of children who are listed on multiple Medicare cards, resulting in the child having more than one Medicare number. All children registered with the ACIR have a single identification number in the Register and where it is known that a child is listed on multiple Medicare cards, they are identified using this number for recording and monitoring immunisations. For the analyses in the report, the postcode that is used is the one linked to the latest processed Medicare record for each child. This means there may be some duplication of child records, however, this has been minimised where possible.³

Interpreting the Australian Childhood Immunisation Register data

Confidential results

Childhood immunisation rates are not reported where the eligible population is less than or equal to 25 children.

Interpret with caution

Although some results are reported where the eligible population is between 26 and 100 children, these results should be interpreted with caution as small data errors can lead to material movements in results. For example, if one occasion of immunisation for a child is not reported in an area where there are 100 children in the eligible population, the results will be under-reported by 1%. This could lead to the geographic area being placed in a lower range for their result.

Interpreting the results

The results reported for each age group for all children, and for Aboriginal and Torres Strait Islander children, are subject to the following caveats.

Ranges

Results describing the range from the highest to lowest percentage of children fully immunised in 2012–13 only include results for geographic areas where the eligible population is greater than 100 children.

Number of geographic areas above or below a specified percentage of children fully immunised

Results describing the number of geographic areas above or below a specified percentage of children fully immunised in 2012–13 include areas where the eligible population is greater than 25 children. Therefore areas are included that have between 26 and 100 children that should be interpreted with caution.

Changes in child immunisation rates from 2011–12 to 2012–13

Results describing changes in the percentages of children fully immunised between 2011–12 and 2012–13 are only reported for geographic areas where the eligible population is greater than 100 children, the percentage change is at least 3 percentage points and the change in the number of children fully immunised is at least three. A change of 3 percentage points was determined based on analysis across the three age groups. This change equates to two standard deviations from the average change across the three age groups at the SA3 level.

Internal migration

Within Australia, a large number of people move homes on a reasonably regular basis. There is no requirement for them to update their Medicare records in a timely manner, and it is likely that this impacts on the currency of addresses, specifically affecting the currency of children's postcodes in the ACIR. No examination about the impact of this has been undertaken for this report.

Immigration

There is a possibility that some data may not be reported for children who were immunised overseas and have not yet attended an Australian immunisation provider to facilitate updating the ACIR or who are currently living overseas but are registered with the ACIR.³ No assessment has been undertaken of any impact on this report.

Identification of Aboriginal and Torres Strait Islander children

The identification of Aboriginal and Torres Strait Islander people in Commonwealth data sets is a complex area, requiring coordination across many points of data collection. Unfortunately, these data are often not complete and do not identify every person who may be of Aboriginal or Torres Strait Islander descent. No assessment has been done on the completeness of identification within the ACIR for the purposes of this report. However, since 2005, reporting of Aboriginal and Torres Strait Islander status in the ACIR data has been considered reliable for reporting immunisation coverage rates at the national and state and territory level.⁴

Immunisation of girls against HPV

Box 2: Immunisation of girls against HPV

The *Healthy Communities: Immunisation rates for children in 2012–13* report presents information about the percentages of girls turning 15 years in 2012 who were fully immunised against human papillomavirus (HPV) according to the schedule.

De-identified unit record data were sourced from the National Human Papillomavirus Vaccination Program Register (HPV Register) in order to estimate HPV vaccination rates for girls who turned 15 years of age in 2012. Data were extracted from the HPV Register on 8 January 2014.

The percentages of girls who turned 15 years in 2012 who had received all three recommended doses of HPV vaccine in accordance with the schedule were estimated at Medicare Local catchment level using the following method.

Numerator: The number of girls turning 15 years of age in 2012 who had received all three doses of HPV vaccine according to schedule.

Denominator: Australian Bureau of Statistics Estimated Resident Population for girls aged 15 years as at 30 June 2012.

Computation: $100 \times (\text{Numerator} \div \text{Denominator})$.

Disaggregation: By Medicare Local catchment.

Additional notes

The data include records for girls turning 15 years in 2012 whose year of birth is 1997 and who

had completed the three-dose course of HPV vaccination in accordance with the Chief Medical Officer guidance. Under this guidance, valid HPV vaccination is considered to have occurred where there is a total interval of 111 or more days between the first and third doses, or for those aged 15 years and under, a gap between the first and third doses of 74 or more days.⁵

Vaccination rates were estimated by Medicare Local catchment using the address of the vaccinated girls and not the address where the vaccine was given. Because most vaccines are given at school, local coverage will be a reflection of the vaccine uptake achieved in the schools that the resident population attends, which may or may not also be located in that geographic area.

HPV vaccine coverage assessment is routinely reported at 15 years of age to allow for completion by all eligible recipients by this age. This is due to the slightly varying ages of administration around Australia (routinely given to children in the first year of high school) and internationally, thus allowing valid comparisons across populations and time periods to be made. Only vaccinations reported to the HPV Register are included.

Records are excluded for:

- Girls whose courses are considered to be incomplete according to the Chief Medical Officer guidelines
- Girls who do not wish their details to be recorded on the HPV Register.

National HPV Vaccination Program Register

Data on HPV vaccination in 15-year-old girls in the report *Healthy Communities: Immunisation rates for children in 2012–13* were sourced from the National Human Papillomavirus Vaccination Program Register (HPV Register).

The HPV Register records information about HPV vaccine doses administered under the national HPV vaccination program in Australia.⁶ The HPV Register is owned by the Australian Government Department of Health and operated by the Victorian Cytology Service.

The national HPV vaccination program is not compulsory and requires parent or guardian consent. The program began in 2007 and was extended to provide HPV vaccination to boys from 2013.⁷ The program currently delivers the HPV vaccine free of charge to:

- 12- and 13-year-old males and females through schools on an ongoing basis
- Males aged 14 to 15 years during 2013 and 2014 through schools on a catch-up basis.

The school-based national HPV vaccination program involves a three-dose schedule, with the second and third doses being delivered at two months and six months after the first dose, to provide the best protection against HPV. Some HPV vaccinations, such as missed doses, may be administered by school immunisation providers, general practitioners (GPs) or community health clinics.⁸

Between 2007 and 2009, the national HPV vaccination program included a two-year 'catch-up' program that was conducted through schools for females aged up to 17 years, and through GPs and community immunisation providers for females aged 18 to 26 years.⁷

Information about HPV vaccinations given in schools is provided to the HPV Register by state and territory governments in New South Wales, Queensland, Western Australia and the Northern Territory, and by local councils in Victoria, South Australia and Tasmania. Information on vaccinations given in the community is provided by the health professional who gave the vaccination. The HPV Register matches the individual vaccination dose notifications it receives to registered individuals to assess vaccination completion.

Consent must be given for information about HPV vaccination to be provided to the HPV Register.

For the school-based program, a parent or guardian must return a signed consent form to their child's school before the HPV vaccination can be administered. There is the provision to opt out of the HPV Register at any time by writing to the HPV Register.

The main aims of the HPV Register are to monitor the uptake rates of HPV vaccination provided by the national HPV vaccination program, support the implementation of the program by providing information to vaccine recipients and providers, and to maintain vaccination records in order to facilitate evaluation of the program's effect on HPV-related cancers and disease.⁶

As well as providing data supporting the management of the vaccination program for the school-based program, data from the HPV Register are used to:

- Provide vaccine recipients, parents or guardians with a completion statement when all three doses of HPV vaccine have been received
- Advise vaccine recipients, parents or guardians if a dose of HPV vaccine has been missed in the school-based program.⁹

Limitations

For doses of HPV delivered in schools as part of the school-based HPV vaccination program, HPV Register data are considered to be close to complete, except for individuals who do not consent to be vaccinated against HPV or who do not consent to their data being provided to the HPV Register.⁷ However, the completeness of data for doses delivered outside of schools as part of the school-based program may vary across Australia.⁷

Reporting of Aboriginal and Torres Strait Islander status to the HPV Register is voluntary and is currently incompletely recorded.⁷ Therefore, it is not possible to report HPV vaccination coverage for Aboriginal and Torres Strait Islander girls aged 15 years in this report.

Not all states and territories monitor the return of consent forms, and therefore it is difficult to determine how many parents or guardians are not consenting to HPV vaccination for their child.⁷

Geography levels

Childhood immunisation statistics are presented in this report by Medicare Local catchment, by the Australian Bureau of Statistics (ABS) Statistical Areas Level 3 (SA3) and by postcode, based on a child's current address postcode in the ACIR, which is drawn from Medicare records held by the Department of Human Services.

HPV vaccination rates for girls turning 15 years in 2012 are presented by Medicare Local catchment, based on the girl's home address in the HPV Register, which is held by the Victorian Cytology Service.

Childhood immunisation statistics in this report have been compiled by applying geographic concordances to the ACIR aggregate statistics at the current child address postcode level. Similarly, HPV vaccination statistics at Medicare Local catchment level have been compiled by applying a geographic concordance to the HPV Register de-identified unit record data at the home address postcode level. This has led to several technical methodological decisions which were required to produce results for this report.

Where postcodes overlapped Medicare Local catchment or SA3 boundaries, numbers of children were attributed to a Medicare Local catchment or SA3 based on the percentage of the population of each postcode in each Medicare Local catchment or SA3. Further, in the postcode to SA3 geographic correspondence file obtained from the ABS, the factors for a number of postcodes either did not equal or sum to one. This was due to boundary misalignment between the original postcode and other maps.

In many instances, counts of children were apportioned between multiple Medicare Local catchments or SA3s. National totals may not correspond to the sums of lower-level statistics

due to rounding. Additionally, rounding of figures was performed at the end of calculations to avoid truncation error.

A small number of postcodes do not map to an SA3 or a Medicare Local catchment, such as postcodes for post offices and delivery centres. The Authority reviewed all such postcodes and devised a method to allocate children to appropriate SA3s where the percentage of children in that postcode was greater than or equal to 10% of the total SA3 population. This process also resulted in improved allocation of children to the Northern Territory Medicare Local catchment. More information about this method is provided in the report *Healthy Communities: Immunisation rates for children in 2011–12, Technical Supplement*.¹⁰

In the SA3 statistics that summarise children fully immunised and children not fully immunised by postcode, those postcodes that were not mapped to an SA3 were assigned to a single row containing unallocated and confidential data. The numbers of children in these postcodes were generally low.

Medicare Local catchments

Medicare Locals are primary health care organisations that plan and fund health services in communities across Australia. There is a network of 61 Medicare Locals across Australia. They help to ensure patients can access the care they need, particularly when a variety of health workers are involved in providing treatments. A Medicare Local catchment is a specific geographic area for which a Medicare Local has responsibility. For this report, statistical information is presented using the boundaries of Medicare Local catchments as released by the Department of Health (see www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocals-lp-1).

Statistical Areas Level 3

Statistical Areas Level 3 (SA3s) are geographic areas defined in the ABS Australian Statistical Geography Standard (ASGS). The aim of SA3s is to create a standard framework for the analysis of ABS data at the regional level through clustering groups of smaller areas called SA2s that have similar regional characteristics. There are 333 SA3s covering the whole of Australia without gaps or overlaps and they are designed to provide a regional breakdown of data across Australia. SA3s generally have a population of between 30,000 and 130,000 people (however, there are approximately 50 with less than 30,000 people and 40 with greater than 130,000 as at 30 June 2012). In the major cities, they represent the area serviced by a major transport and commercial hub. They often closely align to large urban local government areas (e.g. Parramatta, Geelong). In regional areas, they represent the area serviced by regional cities with a population over 20,000 people. In outer regional and remote areas, they represent areas which are widely recognised as having a distinct identity and have similar social and economic characteristics (e.g. Macedon Ranges in Victoria, Southern Highlands in NSW). There are a small number of SA3s with a population defined as 'zero' and they represent very large national parks close to the outskirts of major cities.¹¹

There are 18 additional SA3 special purpose codes to allow reporting of non-geographic categories of data at state and territory level, e.g. counts of people enumerated in the census on long distance trains, buses, aircraft and long haul road transport vehicles, off-shore oil rigs and drilling platforms and on board vessels in Australian waters in or between Australian Ports

and people who have no fixed address such as travellers who move across Australia. These special purpose SA3 codes are not used when converting geographic postcode data to SA3s or Medicare Local catchments.

Geographic correspondences

Geographic correspondences (sometimes referred to as concordances or mapping files) can be used where the location information in an original survey, census or administrative data is not available at the geographic area required for analysis and reporting. Geographic correspondences are a mathematical method for reassigning data from one geographic area (e.g. a postcode of a patient's address in a Medicare enrolment record) to a new geographic area (e.g. Medicare Local catchment or SA3).

In 2012, the Authority commissioned the ABS to compile several correspondences to convert data from defined geographic levels to Medicare Local catchment level using Medicare Local level boundaries and names that were available at the time.

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About the Authority

The National Health Performance Authority has been set up as an independent agency under the *National Health Reform Act 2011*. It commenced full operations in 2012.

Under the terms of the Act, the Authority monitors and reports on the performance of Local Hospital Networks, public and private hospitals, primary health care organisations and other bodies that provide health care services.

The Authority's reports give all Australians access to timely and impartial information that allows them to compare fairly their local health care organisations against other similar organisations and against national standards.

The reports let people see, often for the first time, how their local health care organisations measure up against comparable organisations across Australia.

The Authority's activities are also guided by a document known as the Performance and Accountability Framework agreed by the Council of Australian Governments. The framework contains 48 indicators that form the basis for the Authority's performance reports.

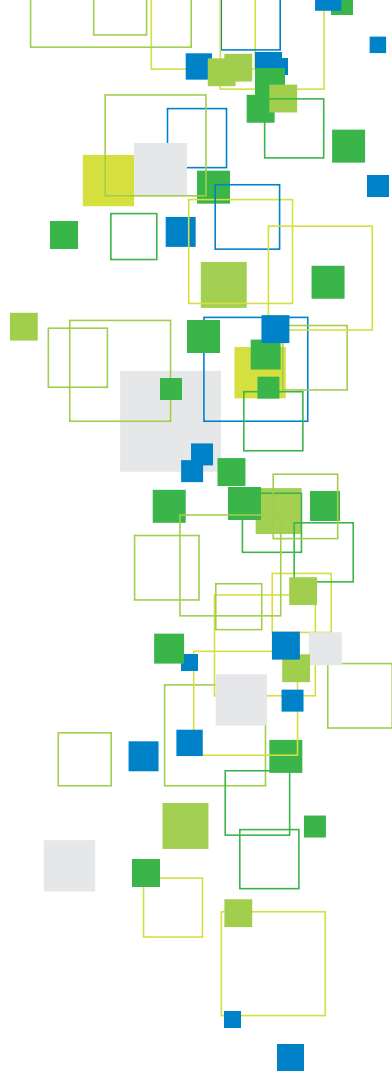
The Authority's role will include reporting on the performance of health care organisations against the 48 indicators in order to identify both high performing Local Hospital Networks, Medicare Locals and hospitals (so effective practices can be shared), and Local Hospital Networks and Medicare Locals that perform poorly (so that steps can be taken to address problems).

The Authority releases reports on a quarterly basis, and also publishes performance data on the MyHospitals website (www.myhospitals.gov.au), the MyHealthyCommunities website (www.myhealthycommunities.gov.au) and on www.nhpa.gov.au

The Authority consists of a Chairman, a Deputy Chairman and five other members, appointed for up to five years. Members of the Authority are:

- Ms Patricia Faulkner AO (Chairman)
- Mr John Walsh AM (Deputy Chairman)
- Dr David Filby PSM
- Professor Michael Reid
- Professor Bryant Stokes AM RFD (on leave)
- Professor Paul Torzillo AM
- Professor Claire Jackson.

The conclusions in this report are those of the Authority. No official endorsement from any Minister, department of health or health care organisation is intended or should be inferred.



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