



Australian Government

Department of Health

Voluntary Indigenous Identifier (VII) Framework

A framework for the collection, release, use
and publication of VII data

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Glossary of Terms

Aggregate data

Aggregate data is produced by grouping information into categories and combining values within these categories, for example, a count of the number of people of a particular age.

Attribute disclosure

This occurs when previously unknown information is revealed about an individual, group or organisation (without necessarily formally re-identifying them).

Australian Bureau of Statistics (ABS)

The ABS is Australia's national statistical agency. Its purpose is to inform Australia's important decisions by delivering relevant, trusted, objective data, statistics and insights.

Australian Health Ministers' Advisory Council (AHMAC)

The Australian Health Ministers' Advisory Council (AHMAC) was the advisory support body to the Council of Australian Governments (COAG) Health Council. It sought to facilitate improvements in the efficiency and effectiveness of the delivery of health services through a coordinated or joint approach on matters of mutual interest. On 12 June 2020, AHMAC was replaced by the National Cabinet Reform Committee on Health reporting to National Cabinet.

Australian Institute of Health and Welfare (AIHW)

The Australian Institute of Health and Welfare (AIHW) is an independent statutory agency that produces authoritative and accessible information and statistics to inform and support better policy and service delivery decisions, leading to better health and wellbeing for all Australians.

Australian Statistical Geography Standard (ASGS)

Introduced in 2011, the Australian Statistical Geography Standard (ASGS) provides a framework of statistical areas used by the Australian Bureau of Statistics (ABS) and other organisations to enable the publication of statistics that are comparable and spatially integrated. The ASGS provides users with an integrated set of standard areas that can be used for analysing, visualising and integrating statistics produced by the ABS and other organisations.

Broad Types of Service (BTOS)

Broad Types of Service are groups of Medicare items for similar service types. BTOS groups are commonly used when reporting use of the Medicare Benefits Scheme.

Cell

A cell is a single box in a data table, or the value in that box.

Confidentiality

Confidentiality refers to protecting the secrecy and privacy of information collected from individuals and organisations, and ensuring that no data is released in a manner likely to enable their identification.

Data custodian

The organisation responsible for the collection, management and release of data. Data custodians have legal and ethical obligations to keep the information they are entrusted with

confidential. In the Department of Health, data custodianship is assigned to the relevant Division.

Data integration / linkage

A set of techniques used to bring together and analyse data from various sources - typically data that relates to the same individual or organisation.

Data quality

Data quality is an assessment of the extent to which a given dataset is fit for a given purpose. Assessments of quality usually include aspects such as accuracy, completeness, reliability, relevance and currency.

Data reduction

A set of statistical techniques to control the risk that individuals or organisations could be identified from a given dataset. Data reduction methods limit the amount of detail available in a table by combining variables or categories or suppressing information in unsafe cells.

Five Safes Framework

A multi-dimensional approach to managing disclosure risk consisting of Safe People, Safe Projects, Safe Settings, Safe Data and Safe Outputs. Each 'safe' is considered both individually and in combination to determine disclosure risks and to put in place mitigation strategies for releasing and accessing data.

Indigenous Health Division (IHD)

The Indigenous Health Division (IHD) of the Commonwealth Department of Health provides policy advice to Government to improve the health and wellbeing of Aboriginal and Torres Strait Islander people. IHD also manages the Indigenous Australians' Health Programme (IAHP) which distributes funding to provide Aboriginal and Torres Strait Islander people with access to effective, high quality and culturally appropriate primary health care services.

Medicare Benefits Schedule (MBS)

The Medicare Benefits Schedule (MBS) is the publicly-funded universal health care scheme for Australian residents. Medicare provides access to free or subsidised treatment by health professionals in general practice, specialist and hospital settings.

Medical Benefits Division (MBD)

The Medical Benefits Division (MBD) of the Commonwealth Department of Health is responsible for providing policy advice to Government on the Medicare Benefits Schedule (MBS) and private health insurance.

My Health Record

My Health Record is an Australian government system that holds a summary of the health information of Australians. Its primary purpose is to facilitate health care by allowing important information to be available to health professionals when needed.

National Health and Medical Research Council (NHMRC)

The National Health and Medical Research Council (NHMRC) is Australia's leading expert body promoting the development and maintenance of public and individual health standards. NHMRC brings together within a single national organisation the functions of research funding and development of advice.

Personal Identification Number (PIN)

The Medicare Personal Identification Number (PIN) is a unique numeric identifier issued for use in identifying each person who has a Medicare claimable service. The Medicare PIN is distinct from the Medicare Card Number.

Population

The set of units from which a dataset is drawn. The VII dataset holds information for those individuals who have chosen to enrol, a subset of the population of Aboriginal and Torres Strait Islander people.

Release

For the purpose of this Framework, release includes making data available to another agency, organisation or person under agreed conditions, and making data available publicly with no or few restrictions.

Remoteness

The Australian Statistical Geography Standard (ASGS) Remoteness Areas divide Australia into five classes of remoteness on the basis of a measure of relative access to services. Access to services is measured using the Accessibility and Remoteness Index of Australia (ARIA+), produced by the [Hugo Centre for Migration and Population Research](#) at the University of Adelaide.

Secondary suppression

The suppression of non-confidential cells in a statistical table to ensure that confidential cells cannot be derived.

Sensitive information

A defined category of personal information under the *Privacy Act, 1988*. It includes information or opinion about a person's racial or ethnic origin, political opinion, religious or philosophical beliefs, sexual orientation, criminal record and health, genetic and/or biometric information.

Suppression

Not releasing information deemed to be a disclosure risk. Data suppression involves removing specific cells from a table or values from a unit record so that people and organisations cannot be re-identified from the released data.

Unit record data

Datasets of records where each record contains information about a particular person or organisation. Also known as microdata.

Voluntary Indigenous Identifier (VII)

The Voluntary Indigenous Identifier (VII) is a database of individuals with a Medicare record who have elected to have their Aboriginal and Torres Strait Islander status recorded.

Weighting

A weight is an amount used to increase or decrease the importance of an item in a dataset. In the case of the VII, Medicare data from people who are less common in the VII dataset than in the population are increased (i.e. have a higher weight) and those who are more common in the dataset than in the population are decreased (i.e. have a lower weight). This process

facilitates an estimate of Medicare use if the whole population of Aboriginal and Torres Strait Islander people were enrolled in VII.

Overview

Since 2002, Aboriginal and Torres Strait Islander¹ people have been able to have their status recorded confidentially on a database called the Voluntary Indigenous Identifier (VII). By February 2021, 650,000 people had enrolled on the VII database.

The VII is primarily used to estimate use of the Medicare Benefits Scheme by Aboriginal and Torres Strait Islander people. This information, grouped together for statistical or reporting purposes, is published in a range of reports and is used to:

- improve policies focused on access to health programs and services
- target funding to specific areas of need
- improve access to benefits and payments
- improve the Department's future health plans and policies for First Nations People.

The *Framework for the Collection, Release, Use and Publication of Voluntary Indigenous Identifier Data* (VII Data Framework) is a set of guidelines that direct how VII data is collected and used.

In the years since the first set of VII guidelines were agreed, a number of important changes have occurred in the Australian Government data landscape. Initiatives around open data, data integration and expanded use of the My Health Record system also provide important context for decisions about use of VII data. This update to the VII Data Framework takes account of these developments.

What is the Voluntary Indigenous Identifier?

The VII database is held with the [Medicare Benefits Schedule](#) (Medicare) database and uses the same Personal Identification Number (PIN) to facilitate matching with Medicare information. Both of these databases are held by Services Australia.

The VII is a standalone database. This means that, when an individual enrolls in the VII, information about their Aboriginal and Torres Strait Islander identification is not generally transferred to other datasets. The only exception to this is the Australian Immunisation Register (AIR). When a person registers with the VII, this information is transferred to the AIR database. Individuals can also be independently enrolled as an Aboriginal and Torres Strait Islander person in AIR. Other datasets record Aboriginal and Torres Strait Islander identification, such as My Health Record, the National Cancer Screening Register, perinatal, mortality and hospital data, but this information may not align with data in the VII.

Data from the VII is used to produce a range of statistics on Aboriginal and Torres Strait Islander people's use of Medicare. The primary use for VII data is to estimate the volume and value of Medicare items claimed by, and on behalf of Aboriginal and Torres Strait Islander people. This data informs Indigenous health policy and expenditure, and is reported in a range of publications including those which monitor progress towards closing the gap in health outcomes between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. As the majority of primary health care services delivered in Australia attract Medicare billing, data generated using

¹ In 1978, the Federal Government adopted a three-part definition, widely accepted as the "Commonwealth Definition", which states that: 'An Aboriginal or Torres Strait Islander is a person of Aboriginal and 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'. The three components of the Commonwealth definition are:

1. descent
2. self-identification,
3. community acceptance.

the VII can also be used to infer overall access to primary health care among Indigenous Australians as compared to the non-Indigenous population.

Enrolment in the VII may occur through checking a box on the Medicare enrolment form, telephoning Medicare to provide this information, or [completing and mailing a form](#) located on the Services Australia website. Individuals can also have identification information removed from their Medicare record by calling Medicare. Identification via the initial Medicare enrolment form is the most common way that individuals enrol on the VII, which has led to higher rates of enrolment among infants and children.

As at 2 February 2021, 650,833 Indigenous Australians were enrolled on the VII database. This represents 74.6% of the estimated total population of Aboriginal and Torres Strait Islander people in Australia² The proportion of people enrolled in the VII differs by age group, sex, state/territory and [remoteness](#)³, which means that estimates for some population groups will be more accurate than others (see the section on *Estimation method and data quality*).

Purpose of this Framework

This framework replaces the previous *Guidelines for the release, use and publication of Medicare Voluntary Indigenous Identifier data*, released in 2012.

This document is intended for data users and potential data users to set out the rules and principles used by the Department when making decisions about the collection, release, use and publication of VII data. It also sets out the legal and ethical obligations for data users, and provides information about the quality of VII data and estimates of Medicare data produced using the VII.

The revised framework takes account of a number of important changes that have occurred in the Australian Government data landscape. These changes include:

- Release of the Australian Government Public Data Policy Statement (December 2015) mandating that “Australian Government entities will make high-value, non-sensitive data available for use by the public, industry and academia”. This is often referred to as the “open by default” standard.
- The Data Integration Partnership for Australia (DIPA), which was announced as part of the 2017-18 Budget. The Government is investing \$130.8 million over three years to maximise the use and value of public data assets.
- Transition of the My Health Record system to opt-out participation, announced as part of the 2017-18 Budget. The opt-out period ran from 16 July 2018 to 31 January 2019.
- Release of the *Framework to guide the secondary use of My Health Record system data* in May 2018. This document outlines the principles for secondary uses of this data, such as for research, policy and planning.
- Data Availability and Transparency Bill 2020 proposes a number of changes to how public sector data custodians share data. If enacted, it will establish the National Data Commissioner as the regulator of the scheme and the National Data Advisory Council to advise the commissioner on the sharing and use of public sector data.

This document also includes information on the legal and ethical obligations for data users, and notes on data quality and interpretation (see Appendices 1 and 2).

² Estimates of the Aboriginal and Torres Strait Islander population are calculated for the Department by the Australian Institute of Health and Welfare. The estimated total Aboriginal and Torres Strait Islander population, as at 31 December 2017, is 769,400.

³ ABS, *The Australian Statistical Geography Standard (ASGS) Remoteness Structure*, as at 15 March 2018.

This document must be read in conjunction with:

- the [National Health \(Privacy\) Rules 2018](#), which support the regulation of claims information obtained under the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme; and
- the [Department of Health's Data Access and Release Policy](#) which sets out the overarching framework governing access to all health program and performance data. The VII Data Framework aligns with the Department's Data Access and Release Policy.

Legal and ethical obligations

The collection, use, release, publication and storage of all Medicare data, including VII data, are protected under:

- section 130 of the [Health Insurance Act 1973](#);
- sections 135A and 135AA of the [National Health Act 1953](#);
- the [Australian Privacy Principles](#) of the *Privacy Act 1988*;
- the [National Health \(Privacy\) Rules 2018](#) issued by the Australian Information Commissioner, and
- [Medical Research Guidelines](#) issued under section 95 of the *Privacy Act 1988*.

This legislation sets standards for the privacy, secrecy, security and confidentiality that must be maintained when handling all Medicare claims information.

The National Health and Medical Research Council's (NHMRC's) [Ethical guidelines for research with Aboriginal and Torres Strait Islander peoples](#) provides advice specific to activities that involve Aboriginal and Torres Strait Islander participants or data. Where research has the potential to infringe on basic ethical principles, review by a [NHMRC registered Human Research Ethics Committee](#) is warranted. Data that already meet the Department's guidelines for aggregation, confidentiality and privacy do not require assessment by an ethics committee.

The Department also has regard to the [National Aboriginal and Torres Strait Islander Health Data Principles](#), as endorsed by the then Australian Health Ministers' Advisory Council (AHMAC) in October 2006 and the [National best practice guidelines for data linkage activities relating to Aboriginal and Torres Strait Islander people](#), published by the Australian Institute of Health and Welfare (AIHW).

An outline of the legal and ethical obligations can be found at [Appendix 1](#).

Privacy notice

The [Medicare enrolment form \(MS004\)](#) includes the following privacy notice:

The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your applications any payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to humanservices.gov.au/privacy

The privacy notice relates to all information provided on the Medicare enrolment form, including information about Aboriginal and Torres Strait Islander status.

The Medicare enrolment form also includes information regarding identification as an Aboriginal and Torres Strait Islander person:

The Aboriginal and Torres Strait Islander Australian question is voluntary. This information will be used to improve government health programs and outcomes for Indigenous people.

The statement regarding the VII is determined by the Indigenous Health Division (IHD) in the Department of Health. Any amendments to this notice must be agreed between the Department of Health and Services Australia through an exchange of letters.

The privacy notice and statement are considered when assessing requests for the release of VII data. Terms used in the notice and statement are interpreted by the Department of Health as follows:

- government includes Australian Commonwealth, State/Territory and local government departments and agencies;
- health programs and outcomes includes programs, policies and initiatives whose primary aim is the provision of medical, pharmaceutical or hospital services, health promotion or disease prevention;
- improve means to increase effectiveness, efficiency or appropriateness;
- provide services includes work to evaluate, audit and/or improve services;
- sharing of data includes both making data available to another agency, organisation or person under agreed conditions, and making data available publicly with no or few restrictions. See also release in the Glossary of terms; and
- voluntary means that the provision, omission or removal of enrolment information from the VII database by an Aboriginal and Torres Strait Islander person will neither permit nor prevent access to any government-administered program or service.

Governance

The Medical Benefits Division (MBD) in the Department of Health is the custodian of the Medicare database and determines policy governing the collection, use, release and publication of Medicare data.

IHD in the Department of Health is the policy custodian of the VII database. This means that IHD determines the policy framework for the collection, use, release and publication of VII data. This includes:

- determining the privacy notice which individuals see when enrolling in the VII database (see the section on *Privacy notice*);
- assessing requests for VII data, or data generated using the VII to estimate the Indigenous population, and providing advice to the Department of Health's Chief Data Steward (currently the Associate Secretary);
- reviewing publications that use VII data; and
- updating this Framework.

As the most common use of VII data is in estimating Indigenous use of Medicare, IHD and MBD work together to assess requests for Medicare data produced using the VII to estimate Indigenous usage.

VII data release is governed under the Department's [Data Access and Release Policy](#) and implemented through the Department's Data Request Assessment Panel (see the section on *How to access VII data that is not publicly available*). This means that the IHD (and MBD where required) provides advice to the Data Request Assessment Panel in relation to requests for VII data. The Data Request Assessment Panel provides advice to the Department's Chief Data Steward, the Associate Secretary, who is the final decision-maker regarding data release.

Collection, storage and maintenance of both Medicare and the VII database is the responsibility of Services Australia.

Uses of VII data

VII data are used by Commonwealth and State/Territory Government departments and agencies and by University researchers.

In this document, VII data refers to both information on the individuals enrolled in the VII database (for example, the number and location of enrollees) and Medicare claims information produced using VII enrolment to estimate use among Indigenous Australians.

The most commonly produced data is estimates of Medicare claims, including:

- the type, number and proportion of Medicare services used by Aboriginal and Torres Strait Islander people,
- the location and prevalence of Medicare services used by Aboriginal and Torres Strait Islander people,
- the amount and proportion of Medicare funding expended on Aboriginal and Torres Strait Islander people; and
- the above estimates for various subgroups of the population defined by age group, sex, State/Territory and the remoteness area of patient's residences.

Medicare data produced using the VII are reported in a large range of publications. The following is a small selection of reports produced using VII data:

- [The Aboriginal and Torres Strait Islander Health Performance Framework](#) (National Indigenous Australians Agency);
- [The Health and Welfare of Australia's Aboriginal and Torres Strait Islander people](#) (Australian Institute of Health and Welfare);
- [Better Cardiac Care measures for Aboriginal and Torres Strait Islander people](#) (Australian Institute of Health and Welfare); and
- [Indigenous Expenditure Report](#) (Productivity Commission).

VII enrolment data may also be released. As individuals could potentially be identified from this type of data, it is usually released in aggregate form only, for example, as statistical tables. While aggregation reduces the risk of attribute disclosure it does not eliminate all risk and therefore data reduction techniques such as cell suppression and minimum geographic boundaries (e.g. ABS Statistical Area Level 3) are also applied. Access to unit record enrolment data is limited to Australian Government Departments and Agencies working on health programs and with a substantiated requirement for this information. For more information, see *Data integration and data linkage* and *Protecting confidentiality*, below.

Estimation method and data quality

Because not all Aboriginal and Torres Strait Islander people are enrolled on the VII database, Medicare data generated using the VII represents an **estimate** of total Medicare use by Indigenous Australians.

Estimates are calculated by weighting the available data using a method developed by the AIHW. Firstly, data is disaggregated by sex, age groups, State/Territory and remoteness areas. Then, the population of individuals enrolled in the VII in each cell is compared to estimates of the broader population to result in a weighting factor. This factor is applied to Medicare data generated by VII-enrolled individuals to achieve estimates of the total population of Aboriginal and Torres Strait Islander people.

As the number of Aboriginal and Torres Strait Islander people enrolled in the VII differs by location, age and sex, weighting factors will differ by cell. In general, cells in which a larger proportion of the population is enrolled in the VII will produce more accurate estimates than cells in which a smaller proportion of the population is enrolled. For this reason, data may not be available at some levels of disaggregation as a suitably accurate estimate cannot be calculated.

As the proportion of Aboriginal and Torres Strait Islander people enrolled in the VII database increases over time, the above weighting process is updated annually by the Medicare Benefits Division in the Department following the end of the financial year. While the overall number of individuals with a VII record is increasing, it should be noted that individuals can choose to have the Aboriginal and Torres Strait Islander identification information both added to, and removed from, their Medicare record at any time.

It should be noted that not all health services delivered to Aboriginal and Torres Strait Islander people are recorded in the Medicare database. Services that are not eligible for a Medicare benefit, such as those delivered in a State or Territory funded service, in a correctional institution or some private hospital services, are not represented in Medicare data.

General information about the MBS should also be considered when using VII estimates of Medicare use among the Aboriginal and Torres Strait Islander population. This information can be found on the [MBS Online](#) website.

How to access VII data

All requests for VII data that is not contained in the annual statistical report are considered under the Department's [Data Access and Release Policy](#) and assessed through the Data Request Assessment Panel process.

Enquiries and applications for VII data should be made in writing to data.release@health.gov.au.

VII data access will only be granted for a stated purpose and cannot be used, shared or published for any other purpose.

Criteria for permitting access to VII data

In deciding whether to release VII data, the Department considers eligible applications against three broad parameters:

1. risk of unauthorised disclosure;
2. the stated purpose of the data collection (and any secondary use); and
3. whether the proposed use is in the public interest⁴.

Underlying this approach, the Department also references the Medicare consent statement (MS004) to guide the types of research projects that can use VII data. Research projects are unlikely to be considered if they feature any of the following characteristics:

- Projects whose primary purpose is not related to human health issues,
- Purely commercial interests (e.g. insurance products), or
- Individual targeting or profiling.

The risk of unauthorised disclosure is assessed using the Five Safes Framework. While there is no universally accepted method of protecting privacy while facilitating data release, the Five Safes Framework has gained considerable national and international support since its introduction in 2003.

The Five Safes Framework differs from traditional approaches to data governance in that it seeks to manage several dimensions of risk independently and in relation to one another, rather than focussing on the data alone. This is more consistent with a nuanced privacy approach, as opposed to completely open access (which does not protect individual privacy), and highly restrictive approaches (which may unnecessarily restrict research and evaluation).

Figure 1, below, displays a schematic of the Five Safes Framework, which is composed of the following five dimensions:

⁴ Release of VII data in the public interest is governed under Section 130(3)(a) of the *Health Insurance Act 1973*.

1. safe projects, which involves an assessment of the project purpose;
2. safe people, which assesses the knowledge, skills and incentives of the proposed data users;
3. safe data, which considers the risk of individuals being identifiable in the data,
4. safe settings, which considers practical controls such as physical and IT security; and
5. safe outputs, which examines the proposed reporting of the data to determine the risk of sensitive information reaching the public domain.



Figure 1. The Five Safes Framework

The basic premise of the model is that data access can be seen as a set of five ‘risk or access dimensions’, as set out in **Table 1**, below.

Table 1. Dimensions of the Five Safes Framework

	Assesses the legal and ethical considerations surrounding use of the data. Questions to assess this dimension include: Is the data use aligned with the consent provided by individuals? Is the data use in the public interest?
	Considers the knowledge, skills and incentives of the data users, and the extent to which the users can be trusted to use the data appropriately. Questions to assess this dimension include: Do the users understand how the data should be used? Do the users have incentives or disincentives to use the data inappropriately?
	Refers primarily to the potential for identification of individuals within the data. Questions to assess this dimension include: Is personally identifying information included in the data (e.g. name, date of birth)? Does the data include exceptional values or combinations of values, such as a 100-year old male in a remote location?
	Refers to practical controls on data access such as a security-controlled computer system, an analysis portal requiring a password or a restricted physical location.
	Covers any residual risk in publishing sensitive information. The most commonly used risk management tool for this dimension is for the assessing organisation to check final outputs before release to the public.

Protecting confidentiality

Medicare claim estimates

The most commonly requested and released information is Medicare claims data which has been scaled to estimate usage by Indigenous Australians using the VII (as described in the section on *Estimation method and data quality*). This data can be used to estimate Medicare expenditure and/or service use by Aboriginal and Torres Strait Islander people at a:

- national level by sex, by age group, by state/territory;
- national level by sex, by age group, by Australian Statistical Geography Standard remoteness area;
- State/Territory level by sex, by age group (excluding Tasmania and the Australian Capital Territory);
- State/Territory level by sex, by Major cities, by Inner regional and by Outer regional areas (for New South Wales, Queensland and Western Australia only); and
- the 31 Primary Health Network (PHN) level boundaries.

Scaled claims data is not sufficiently accurate to support estimation at lower levels of aggregation and will not ordinarily be released in any such format.

Medicare claims data can be released at the overarching level (i.e. all claims against Medicare items in the target time period), or by groups of items. The most common item grouping is Broad Types of Service, consisting of 18 groups:

1. Unreferred attendances – Vocationally Registered GP
2. Unreferred attendances – Enhanced Primary Care
3. Unreferred attendances – Other
4. Unreferred attendances – Practice Nurse items
5. Other Allied Health
6. Specialist attendances
7. Obstetrics
8. Anaesthetics
9. Pathology collection items
10. Pathology tests
11. Diagnostic imaging
12. Operations
13. Assistance at operations
14. Optometry
15. Radiotherapy and therapeutic nuclear medicine
16. Miscellaneous
17. Dental benefits schedule
18. Child dental benefits schedule

More information on the Broad Types of Service groups is available from the [Services Australia website](#).

Requests for data on use of specific Medicare items will be assessed in relation to claim volume. Data from Medicare items with very low claim volumes may not be suitable for release due to low accuracy.

Enrolment data

VII enrolment information consists of the number and characteristics of individuals who have opted to register Aboriginal and Torres Strait Islander status on the VII database. Enrolment data may be used to identify individuals so additional protections are applied to preserve confidentiality.

Enrolment data from the VII may be suitable for release in aggregate form, for example, as statistical tables. Tables are subject to data reduction by the following parameters:

- Geographic boundaries applied at the State/Territory, Australian Statistical Geography Standard remoteness areas, Primary Health Network areas or [Statistical Area Level 3 \(SA3\)](#)⁵.
- Age groups of no fewer than five years (e.g. 0-4 years, 5-9 years etc)
- Sex (male, female)

In addition, suppression is applied to tabular data as follows:

- Cells with fewer than 10 contributing individuals are suppressed. If required, secondary suppression of totals will also be applied.
- Cell dominance will be determined using the 85/90 rule – a cell will be suppressed if one contributor contributes more than 85% of the total or if two contributors contribute more than 90% of the total.

Unless explicit consent is obtained, access to unit record enrolment data is limited to Australian Government Departments and Agencies working on health programs and with a substantiated requirement for this information.

Data integration and data linkage

Project requests which propose to integrate VII data with other datasets will be considered on a case by case basis. The Department uses, as a guide, the [principles of statistical data integration](#) endorsed by the Secretaries Board (comprised of the heads of all Commonwealth government agencies and the Australian Public Service Commission) in 2010 and the [National best practice guidelines for data linkage activities relating to Aboriginal and Torres Strait Islander people](#), developed by the AIHW.

Should the proposed research have the potential to infringe on basic ethical principles, review by a NHMRC registered Human Research Ethics Committee is warranted. For more information, see the section on *Legal and ethical obligations*.

Due to the relatively higher risk of projects which involve integration, more detailed information regarding project methods and outputs is required from those seeking to access VII data for this purpose. This will include, but is not limited to, the following:

- linkage type (deterministic or probabilistic);
- for probabilistic linkage, details of the linkage method;
- detailed information about the data to which VII will be linked;
- precise purpose of integrating VII, particularly where the VII is the sole indicator of Aboriginal and Torres Strait Islander identification;
- any weighting process that will be applied to the resulting dataset;
- data protections including access controls;
- methods to ensure confidentiality is maintained; and
- methods to ensure the accuracy of findings produced using the integrated dataset.

VII data cannot be linked to other data sets if such linkage could reasonably result in individuals being re-identified by this procedure.

⁵ Statistical Areas Level 3 (SA3s) are designed for the output of regional data. SA3s generally have populations between 30,000 and 130,000 persons. They are often the functional areas of regional towns and cities with a population in excess of 20,000, or clusters of related suburbs around urban commercial and transport hubs within the major urban areas.

Projects proposing to integrate VII with other datasets must involve an [Accredited Integrating Authority](#). As at 17 September 2019, the Accredited Integrating Authorities were:

- Australian Bureau of Statistics (ABS);
- Australian Institute of Health and Welfare (AIHW);
- Australian Institute of Family Studies (AIFS);
- Department of Social Services (DSS);
- Queensland Government Statistician's Office (QGSO);
- Centre for Victorian Data Linkage (CVDL); and
- South Australia Northern Territory DataLink (SA NT DataLink).

Note that Accredited Integrating Authorities perform statistical integration but do not determine data release. Organisations or individuals seeking to integrate VII data with another data source must have the express consent of the VII data custodian to receive VII data before integration.

Inclusion of VII data in the National Integrated Health Services Information (NIHSI) Analysis Asset, managed by the AIHW, is currently under consideration by the Department of Health. If approved for inclusion, VII data will be integrated with other health-related datasets, including:

- Medicare Benefits Schedule data,
- Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data,
- Residential Aged Care data;
- Hospital data; and
- National Deaths Index data.

For more information on the NIHSI project, please visit <https://www.aihw.gov.au/our-services/data-linkage/approved-aihw-linkage-projects>.

Interpretation of VII data

There are a number of caveats to the weighting methodology described above (see the section on *Estimation method and data quality*). However, on balance, weighted VII data is more appropriately fit-for-purpose than unweighted VII data, as the degree of any possible error in weighted VII data is far less than the significant underestimation of Medicare activity that results from the use of unweighted VII data.

Medicare data should be interpreted in light of differing levels of access by patients to the Medicare system. Medicare use decreases in more remote areas, which is probably in part due to the generally lower availability of primary health care services in more remote areas and the greater costs involved in accessing those services that are available. While the majority of Aboriginal and Torres Strait Islander people live in major cities or regional areas (81.4%), a greater proportion of Indigenous than non-Indigenous Australians live in remote and very remote areas (18.6% of the Indigenous population compared with 1.5% of the non-Indigenous population⁶). It is also known that Aboriginal and Torres Strait Islander people use Medicare at a lower rate than non-Indigenous Australians. In 2013-14, it is estimated that \$626 in Medicare spend was provided to each Aboriginal and Torres Strait Islander person compared with \$837 per non-Indigenous Australian⁷.

The Department of Health will invest \$3.9 billion over four years (between 2018-19 and 2021-22) into Indigenous health initiatives under the Indigenous Australians' Health Programme (IAHP).

⁶ ABS, [Estimates of Aboriginal and Torres Strait Islander Australians, June 2016](#) (cat. no. 3238.0.55.001)

⁷ Australian Health Ministers' Advisory Council, 2017, [Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report](#), AHMAC, Canberra.

Indigenous-specific funding is complemented by whole of population health programs such as the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme (PBS), public hospital, health workforce and aged care funding.

The Department funds approximately 130 Aboriginal Community Controlled Health Services (ACCHS) and 35 other organisations to deliver comprehensive primary health care services to Aboriginal and Torres Strait Islander people. Most of these services are also able to claim Medicare rebates through the provision of section 19(2) and 19(5) Directions under the *Health Insurance Act 1973*.

The Medicare system covers both primary and secondary/tertiary health care services, but it represents only a portion of Australia's health care system. Additionally, Medicare data only represent services that attract a Medicare benefit and for which a Medicare benefit has been paid. Medicare data therefore do not reflect all primary and secondary/tertiary health care activity by the Australian population, including for Aboriginal and Torres Strait Islander people.

Indigenous Australians also tend to access primary health care through hospital emergency departments at a greater rate than non-Indigenous Australians⁸. These statistics are captured in hospital data, rather than in Medicare data.

Similarly, Medicare data do not represent all secondary/tertiary health care services provided to Aboriginal and Torres Strait Islander people. In-hospital services provided to public patients do not result in a Medicare claim and are not part of the Medicare data. Only services provided to private patients where a Medicare rebate was paid by Services Australia will be included in Medicare data.

Health services provided to people, including Aboriginal and Torres Strait Islander people, within correctional facilities are also not included in MBS data.

Presentation of VII data

In some cases, outputs produced using VII data will require approval by the Department of Health prior to publication. If required, this will be noted at the time of data release through the Data Request Assessment Panel process.

As the number of Aboriginal and Torres Strait Islander people enrolled on the VII dataset increases over time, estimates should always be accompanied by an extraction date.

All data generated using the VII should be accompanied by one or both of the following cautions, included as a table footnote and/or as part of a data quality statement.

The suggested table footnote reads:

Table Footnote

"Medicare data presented by Indigenous status have been weighted for the under-identification in the Voluntary Indigenous Identifier (VII) database. This data was extracted on [date]."

The suggested data quality statement reads:

Data Quality Statement

"Medicare data presented by Indigenous status have been weighted for the under-identification in the Voluntary Indigenous Identifier (VII) database. Indigenous rates are therefore modelled and should be interpreted with caution."

⁸ Australian Health Ministers' Advisory Council, 2017, [Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report](#), AHMAC, Canberra.

These statistics are not derived from the total Indigenous Australian population, but from those Aboriginal and Torres Strait Islander people who have voluntarily identified as Indigenous to Services Australia for recording in the Medicare database. The statistics have been weighted to reflect demographic characteristics of the total Indigenous population, but this weighting process might not address all the differences in the service use patterns of the VII- enrolled population relative to the total Indigenous population.

The level of VII enrolment varies across age group, sex, remoteness and State/Territory sub-groups, and over time, which means that the extent of weighting required varies across jurisdictions and over time. Indigenous rates should also be interpreted with caution due to small population numbers in some jurisdictions.”

Contacts

For more information on the Voluntary Indigenous Identifier dataset, please contact the VII Data Custodian:

Indigenous Health Division, Department of Health

CPHCSustainability@health.gov.au

For information on data release:

Health Economics and Research Division, Department of Health

data.release@health.gov.au

For information on Medicare data:

Health Data Analysis and Strategy Branch, Services Australia

statistics@servicesaustralia.gov.au

To enrol in the VII database:

Visit the **Services Australia website**:

<https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-voluntary-indigenous-identifier>

or call the Aboriginal and Torres Strait Islander Access line on **1800 556 955**.

Appendix 1: Guidance on the legal and ethical obligations for users

The purpose and use of the VII data is linked to the Medicare identification consent statement (MS004), and includes a reference to generating health statistics to improve health programs and outcomes for Aboriginal and Torres Strait Islander people. Research applications that do not align with these general parameters are unlikely to be considered by the Data Request Assessment Panel (DRAP).

VII data cannot be used for research relating to:

- Projects whose primary purpose is not related to human health issues,
- Commercial interests (e.g. insurance products), or
- Individual targeting or profiling.

Approved projects – legal and ethical obligations

For projects approved by the Chief Data Steward, there are privacy and confidentiality conditions that apply to all users. While the table below provides a high-level overview of some of these requirements, users should read all legislative requirements (including those under State and/or Territory legislation) as part of the application process.

Legislation and Guidelines	Selected principles/obligations
Section 130 of the Health Insurance Act 1973 ;	<ul style="list-style-type: none"> • Information that identifies an individual or healthcare provider must not be disclosed by Commonwealth or State employees, except as part of their duties or provisions under the <i>Medicare Guarantee Act 2017</i>, the <i>Dental Benefits Act 2008</i>, and the <i>My Health Records Act 2012</i>.
Sections 135A and 135AA of the National Health Act 1953 ;	<ul style="list-style-type: none"> • “Medicare statistics” includes data from the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS). • Medicare health statistics must not allow identification of a person or health insurer. • PBS statistics that identify a manufacturer can be published. • Users must not seek to obtain unauthorised data from Commonwealth or State Government employees. • Users have the same obligations and liabilities as Commonwealth and State Government employees when receiving a data release. • Data can be released to an authorised Commonwealth entity for the purpose of matching.
Australian Privacy Principles	<ul style="list-style-type: none"> • The Privacy Act covers Australian Government agencies (including Norfolk Island administration) and organisations with annual turnover of more than \$3 million. • The 13 Australian Privacy Principles apply to these organisations.

Legislation and Guidelines	Selected principles/obligations
National Health (Privacy) Rules 2018	<ul style="list-style-type: none"> • Outlines the separation of information stored for the Medicare Benefits Program, Pharmaceutical Benefits Program, and enrolment and entitlement databases. • Information can only be disclosed for <u>medical research</u> where: <ul style="list-style-type: none"> ○ an individual provides informed consent, or ○ the research is conducted in accordance with the guidelines issues by National Health and Medical Research Council under section 95 of the Privacy Act 1988. These guidelines include an assessment of whether the research is in the public interest. • Researchers must provide a written undertaking that Medicare claims information will be securely destroyed at the conclusion of the research project. • Services Australia and the Department of Health are obligated to report annually to the Australian Information Commissioner on linkage activities.
Medical Research Guidelines issued under section 95 of the <i>Privacy Act 1988</i>	<ul style="list-style-type: none"> • Provides a framework for medical research, including epidemiological research, using information held or collected by agencies where it is not practicable to obtain the individual's consent. • Flowchart determining whether the s95 guidelines apply. • States and Territories may also have additional legislation or restrictions that apply to health research, privacy and record management.
National Health and Medical Research Council's (NHMRC's) Ethical guidelines for research with Aboriginal and Torres Strait Islander peoples	<ul style="list-style-type: none"> • Provides a set of principles to ensure research is safe, respectful, responsible, high quality, of benefit to Aboriginal and Torres Strait Islander people and of benefit to research. • The Guidelines also define six core values including spirit and integrity, cultural continuity, equity, reciprocity, respect and responsibility.
National Aboriginal and Torres Strait Islander Health Data Principles	<ul style="list-style-type: none"> • Endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 2006. • Outlines 11 principles to ensure a culturally respectful foundation for the collection, storage and use of the health and health-related information of Aboriginal and Torres Strait Islander people.
National best practice guidelines for data linkage activities relating to Aboriginal and Torres Strait Islander people , Australian Institute of Health and Welfare (AIHW)	<ul style="list-style-type: none"> • Outlines best practice principles for data linkage projects in the context of Closing the Gap reporting where Aboriginal and Torres Strait Islander status is missing or inconsistently reported across key data sets.

Appendix 2: Metadata for the Voluntary Indigenous Identifier (VII)

The VII database is held with the [Medicare Benefits Schedule](#) (Medicare) database and uses a Personal Identification Number (PIN) to facilitate matching with Medicare information. Both of these databases are held by Services Australia.

The VII is a standalone database. This means that, when an individual enrolls in the VII, information about their Aboriginal and Torres Strait Islander identification is not generally transferred to other datasets. The only exception to this is the Australian Immunisation Register (AIR). When a person registers with the VII, this information is transferred to the AIR database. Individuals can also be independently enrolled as an Aboriginal and Torres Strait Islander person in AIR. Other datasets record Aboriginal and Torres Strait Islander identification, such as My Health Record, the National Cancer Screening Register, perinatal, mortality and hospital data, but this information may not align with data in the VII.

Variables on the VII database

The file contains all individuals enrolled in Medicare with a VII status of:

- Aboriginal,
- Torres Strait Islander, or
- Aboriginal and Torres Strait Islander;

However, deceased individuals or individuals that have permanently left the country may be included on this file and where an individual is active on more than one Medicare card, the record with the most recent activation date is selected.

Table 1. VII variables and valid values

Variable Description	Variable	Valid Values
VII Status	VII Code	1 - Aboriginal, 2 - Torres Strait Islander, 3 - Aboriginal and Torres Strait Islander
PIN Number	Cnsmr ID	Patient ID - nine-digit number
Medicare Start Date	Medicare start	DD/Month/YY
Medicare End Date	Medicare end	DD/Month/YY or ongoing (DD/Month/9999)
Start of enrolment (date)	Status start	DD/Month/YY
End of enrolment (date)	Status end	DD/Month/YY or ongoing (DD/Month/9999)
Gender	Gender	M or F
Patient Date of Birth	DoB	DD/Month/YY
Postcode of patient address	Postcode	Four-character string containing: (‘0’, ‘1’, ‘2’, ‘3’, ‘4’, ‘5’, ‘6’, ‘7’, ‘8’, or ‘9’)
Consumer Flag	Consumer Flag	‘Active’ or ‘Inactive’ <i>Active - eligible for Medicare Benefits as at 30 June 2021.</i> <i>Inactive - “Death”, “Card Expiry Date”, “Entitlement” is end dated or has “Departure Date”.</i>

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All information in this publication is correct as at August 2021

