



Australian
Commission on
Safety and Quality
in Health Care

Prioritised Clinical Domains for Clinical Quality Registry (CQR) Development

2026 Methodology Report

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The prioritisation process

The prioritisation of CQRs followed a structured, evidence-based process (Figure 1).

Figure 1 Prioritisation process



Data sources

Below data sources were used in the Prioritised Clinical Domains for Clinical Quality Registry (CQR) Development 2026 report.

Table 1 Data sources

Source	Details
Burden of disease (BoD) report: <i>Australian Burden of Disease Study (ABDS) 2024</i>	worksheet name: S2_Disease_Nature_5yrs years of interest: 2015, 2024 measure of interest: DALY https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2024/data
Health expenditure (cost) report: <i>Health system spending on disease and injury in Australia 2022–23</i>	Download data tables for 2022-23 and 2015-16: <i>Data tables: Health system spending on disease and injury in Australia, 2022–23</i> <i>Data tables: Health system spending on disease and injury in Australia, 2015–16</i> years of interest: 2015-16, 2022-23 worksheet name: Table 1 measure of interest: Total expenditure \$ (constant prices) https://www.aihw.gov.au/reports/health-welfare-expenditure/health-system-spending-on-disease-and-injury-aus/data
Prioritised list of clinical domains for clinical quality registry development (2016)	Below tables were used to identify prioritised diseases from the 2016 report <i>Attachment 5: Burden of disease data for short-listed clinical domains</i> <i>Attachment 6: Cost data for short-listed potential clinical domains</i> https://www.safetyandquality.gov.au/sites/default/files/resources/attachments/prioritised-list-of-clinical-domains-for-clinical-quality-registry-development-final-report.pdf
Admitted Patient Care National Minimum Dataset (APC NMDS) 2023-24	Used to gauge common intervention types and care settings for prioritised CQR domains/diseases

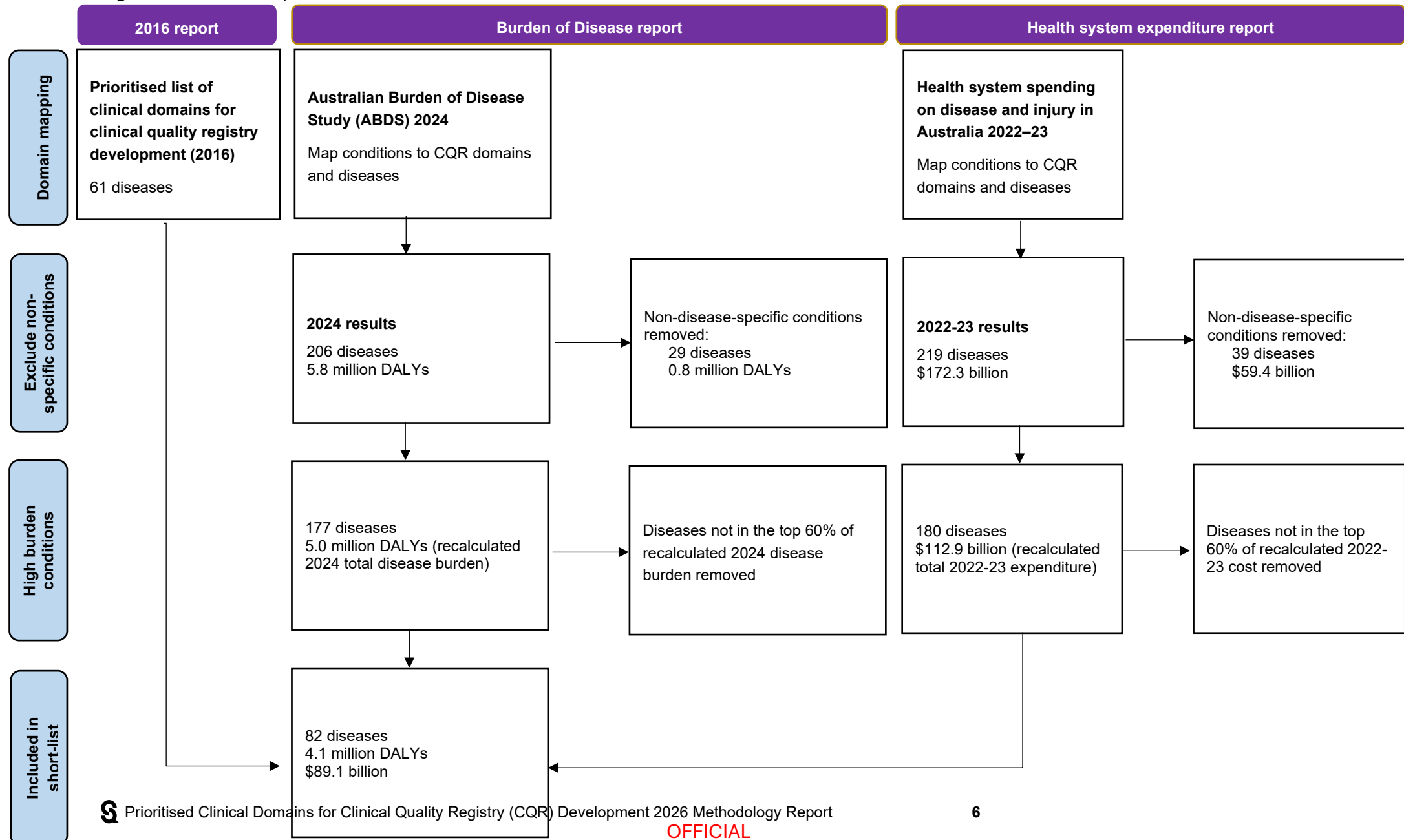
Step 1: Generating an initial list of diseases

Process to generate an initial list of diseases consisted of 3 parts

- map conditions to clinical domains
- remove non-disease-specific conditions
- identify high impact diseases

An overview of the short-listing process is summarised below.

Figure 2 Prioritisation process



Mapping of conditions to clinical domains

The 2026 approach to grouping conditions into domains leveraged the Australian Burden of Disease Study (ABDS) framework, which broadly categorised over 200 conditions into 17 common disease groups.

The ABDS structure described injury in two ways - external cause of injury versus nature of injury. The latter was used in this report as it reflected the type of injury sustained (e.g. spinal cord injury), as opposed to the external event or circumstance that resulted in an injury (e.g. road traffic injury as a pedestrian). For simplicity, where the original ABDS disease group used 'Injury (nature)', the equivalent CQR domain was renamed to 'Injury'.

In most instances, domain assignment aligned with the original ABDS disease group descriptions used in the burden of disease and health system expenditure reports. However for selected conditions, domain reassignments were required to better reflect what was used in the 2016 *Prioritised list of clinical domains for CQR development*. The following conditions were allocated to a domain different to their original ABDS disease groups

- **traumatic brain injury** and **spinal cord injury**: from *Injury* to *Neurological conditions*
- **hip fracture, tibia & ankle fracture, humerus fracture, dislocations, and soft tissue injuries**: from *Injury* to *Musculoskeletal disorders*
- **renal failure**: from *Cardiovascular diseases* to *Kidney and urinary diseases*
- **pregnancy and postpartum care**: from *Well care* to *Reproductive and maternal conditions*
- **gestational diabetes**: from *Reproductive and maternal conditions* to *Endocrine disorders*

Conditions explicitly defined in the prioritised list of the 2016 report were considered still appropriate for inclusion in the current CQR prioritisation process. To acknowledge the foundational work already undertaken, these conditions were retained through to Step 3 (prioritisation). Each condition in the 2016 report was mapped to its corresponding description in ABDS 2024. For instance, where the 2016 report referred to 'diabetes', this aligned to ABDS 2024 conditions 'Type 1 diabetes mellitus' and 'Type 2 diabetes mellitus'.

Removal of non-disease specific conditions

List of non-disease specific conditions removed at Step 1 is provided below.

Table 2 Non-disease-specific conditions excluded from short-listing

Burden of Disease report	Health system expenditure report
Other benign, insitu and uncertain neoplasms	Counseling services
Other blood and metabolic disorders	Donor
Other cardiovascular diseases	Examination and observation NEC
Other chromosomal abnormalities	Family planning

Burden of Disease report	Health system expenditure report
Other congenital conditions	Other benign, insitu and uncertain neoplasms
Other diabetes mellitus	Other blood and metabolic disorders
Other disorders of infancy	Other blood cancers
Other endocrine disorders	Other cancers
Other fractures	Other cardiovascular diseases
Other gastrointestinal diseases	Other chromosomal abnormalities
Other gastrointestinal infections	Other congenital conditions
Other hearing and vestibular disorders	Other diabetes
Other infections	Other disorders of infancy
Other injuries	Other endocrine disorders
Other kidney and urinary diseases	Other fractures
Other leukaemias	Other gastrointestinal diseases
Other malignant neoplasms (cancers)	Other gastrointestinal infections
Other meningitis and encephalitis	Other hearing and vestibular disorders
Other mental and substance use disorders	Other infections
Other musculoskeletal	Other injuries
Other neurological conditions	Other kidney and urinary diseases
Other oral cavity and pharynx cancers	Other leukaemias
Other oral disorders	Other lip, oral cavity and pharynx cancers
Other pneumoconiosis	Other meningitis and encephalitis
Other reproductive conditions	Other mental and substance use disorders
Other respiratory disease	Other musculoskeletal
Other sexually transmitted infections	Other neurological conditions
Other skin disorders	Other oral disorders
Other vision disorders	Other pneumoconiosis
	Other reproductive conditions
	Other respiratory disease
	Other sexually transmitted infections

Burden of Disease report	Health system expenditure report
	Other skin disorders
	Other vision disorders
	Tobacco intervention
	Treatment of hypertension
	Treatment of obesity
	Well dental
	Well person

Excluding non-specific conditions removed approximately 14% of total disease burden (2024 DALYs) and 34% of total cost (2022-23 constant price) in the original AIHW reports.

The remaining list of diseases following removal of non-disease-specific conditions comprised 177 out of 206 conditions from the Burden of Disease report, and a recalculated 2024 total disease burden of 5.0 million DALYs (from 5.8 million DALYs originally reported). Similarly, from the health expenditure report, 180 out of 219 conditions were retained, with a recalculated 2022-23 total expenditure of \$112.9 billion (from the \$172.3 billion originally reported) following removal of non-disease-specific conditions.

Burden of disease

Disability-adjusted life years (DALYs)

DALY is a health gap measure that extends the concept of potential years of life due to premature death to include equivalent years of healthy life lost for individuals living in states of poor health. It provides a composite measure of the impact of disease and injury in a population by estimating the years of life lost and years lived with disability.

Change in burden of disease over time

This 2026 methodology aimed to identify areas of disease burden that experienced high levels of growth (or decline) since the 2016 report. In recognition of disruptions to population health and service provision during the COVID-19 pandemic, the 2026 methodology compared changes in DALYs over time, between a pre-COVID baseline and the most recent post-pandemic data available at the time of analysis.

Domain changes observed (2015 vs 2024) was calculated in 2 ways

- absolute change: percentage change in DALYs for the same domain
- relative contribution to change: percentage of total change in DALYs

The first measure measured domain-specific growth or reduction, independent of other domains. The second assessed a domain's share of total change in disease burden, to determine which domains became more dominant over time.

Cost to the Australian healthcare system

In addition to considering the burden of disease, a cost burden approach for prioritising CQRs ensured that limited resources could be allocated effectively and equitably. Prioritisation based on the economic impacts helped identify which healthcare services and interventions would provide the greatest benefit relative to their cost for the overall population. While AIHW's *Health system spending on disease and injury in Australia 2022–23* report covered health expenditure across 3 broad areas, hospitals still dominated due to their prominent role in the provision of care.

Cost analysis data collection

The 2026 methodology drew on AIHW's Disease Expenditure database (the main source of information in the health system expenditure report), and expanded cost considerations to 3 main areas of health spending outlined below

Table 3 Areas of health system expenditure

Area of expenditure	Description
Hospitals	- public and private hospitals - covers admitted patient care, emergency department presentations, and outpatient services.
Primary Health Care	- Medicare Benefits Scheme (MBS) funded general practitioner and allied health services, plus dental services - Pharmaceutical Benefits Scheme (PBS) prescriptions
Referred medical services	MBS pathology, imaging and specialist services

For more information, please see [Health system spending on disease and injury in Australia 2022–23, Technical notes - Australian Institute of Health and Welfare](#)¹

Cost analysis methodology

Constant prices

AIHW's health system expenditure report provided constant and current (actual) price estimates. Constant price was used as it removed the effect of inflation. Growth based on constant prices therefore provided a better indication of greater service use, population growth or changes in disease burden than unadjusted prices.

Reference year for expenditure constant price estimates was 2022–23. Constant prices estimated what spending would have looked like in earlier years, such as 2015–16, if the

¹ Australian Institute of Health and Welfare. *Health system spending on disease and injury in Australia 2022–23: Technical notes* [Internet]. Canberra (AU): AIHW; 2024 Nov 20 [cited 01 February 2026]. Available from: <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-system-spending-on-disease-and-injury-aus/contents/technical-notes> (accessed 01 February 2026)

same price levels were applied, providing a clearer picture of real growth in health system expenditure over time.

Change in cost over time

A list of diseases and associated constant prices was sorted in descending order. Change in health system expenditure was analysed at two selected time points, to assess absolute expenditure and the trajectory of cost increases.

Each domain's observed change (2015-16 vs 2022-23) was assessed in 2 ways

- absolute change: percentage change in health expenditure for the same domain
- relative contribution to change: percentage of total change in health expenditure

The first aimed to reflect domain-specific growth or reduction, independent of other domains. The second assessed a domain's share of total change in cost, to identify domains that have become more dominant over time in overall cost to the health care system.

Step 3: Prioritisation

Serious consequences associated with poor health

Burden of disease was used as a proxy measure of consequences associated with poor health and highlighted areas where system level improvements could be focused to ensure quality patient care and outcomes, and the going sustainability of the health system.

Each domain was assessed by total disease burden (total DALYs) and growth in disease burden over time (change in DALYs) between 2015 and 2024. Domains with a high burden or a significant contribution to the overall increase in burden will be prioritised. The maximum disease burden score was 3 (1 for total burden, 1 for absolute growth and 1 for relative growth in burden over time).

Total disease burden

Domains were scored based on the individual contribution to the total disease burden estimated for the most recent year of available data, recalculated after exclusion of non-disease specific conditions in Step 1. Cutoff values for percentage of total disease were determined by ordering domains in descending order into quintiles. Domains in the top 20% were given a score of 1, while those in the bottom 20% received a score of 0, with cutoff values outlines below.

Table 4 Domain level scoring for total burden of disease

Percentage of total burden of disease in 2024	Score
$\geq 11.7\%$	1
6.4% - $<11.7\%$	0.75
2.4% - $< 6.4\%$	0.5
1.3% - $< 2.4\%$	0.25
$< 1.3\%$	0

Growth in disease burden over time

This was assessed based on the growth contribution and reflected each domain's absolute growth (percentage change in DALYs) and relative growth (percentage of total change in DALYs across all domains) from 2015 to 2024. The aim was to ensure domains contributing substantially to the overall rise in burden over time were prioritised. Cutoff values for growth percentages were determined by dividing domains into quintiles. Domains in the top 20% for growth had a score of 1, while those in the bottom 20% received a score of 0, given in the tables below.

Table 5 Domain level scoring for absolute growth in burden of disease

Percentage of absolute growth in disease burden	Score
$\geq 31.7\%$, or DALY in reference year is 0	1
23.1% - $< 31.7\%$	0.75
21.4% - $< 23.1\%$	0.5
7.2% - $< 21.4\%$	0.25
$< 7.2\%$	0

Table 6 Domain level scoring for relative growth in burden of disease

Percentage of relative growth in disease burden	Score
$\geq 11.3\%$	1
4.9% - $< 11.3\%$	0.75
2.6% - $< 4.9\%$	0.5
1.0% - $< 2.6\%$	0.25
$< 1.0\%$	0

High cost to the health system

Each clinical domain was assessed from a cost perspective based on the latest hospital cost data including absolute cost and cost growth since 2015-16. Like the assessment of disease burden, category boundaries for cost followed a similar logic, with exact cut-off values guided by the 2022-23 results based on quintiles. High-cost domains signalled substantial resource intensity and system-wide impact. The maximum score for high cost to the health system was 3 i.e. 1 for total expenditure, 1 for absolute growth and 1 for relative growth over time.

Total cost

Clinical domains were assigned a score based on their contribution to the total estimated expenditure for 2022-23 based on constant prices. Domains with a larger expenditure received higher scores, reflecting their overall financial footprint within the health system. Cutoff values for percentage of total health system expenditure were determined by ordering domains in descending order and allocating to quintiles. Domains in the top 20% received the maximum score of 1, while those in the bottom 20% received a score of 0

Table 7 Scoring for total cost

Percentage of total health system expenditure	Score
$\geq 9.4\%$	1
4.1% - $< 9.4\%$	0.75
2.5% - $< 4.1\%$	0.5
1.7% - $< 2.5\%$	0.25
$< 1.7\%$	0

Growth in cost over time

This was assessed in terms of each domain's absolute growth (percentage change in cost within the same domain) and relative growth contribution (percentage of total change in cost across all domains), from 2015-16 to 2022-23. Cutoff values for growth in expenditure were determined by dividing domains into 5 equal groups (quintiles). Domains in the top 20% for each type of growth scored of 1, while those in the bottom 20% scored 0.

Table 8 Scoring for absolute cost growth

Percentage of absolute growth in health system expenditure	Score
$\geq 37.2\%$, or cost in reference year is 0	1
35.3% - $< 37.2\%$	0.75
25.9% - $< 35.3\%$	0.5
12.8% - $< 25.9\%$	0.25
$< 12.8\%$	0

Table 9 Scoring for relative cost growth

Percentage of relative growth in health system expenditure	Score
$\geq 9.1\%$	1
4.2% - $< 9.1\%$	0.75
2.4% - $< 4.2\%$	0.5
1.3% - $< 2.4\%$	0.25
$< 1.3\%$	0

Clinician Support

Clinical support is essential for successful registry implementation, data quality, and sustained use; prioritising domains with strong clinician engagement increases feasibility. The highest level of clinician support was defined as evidence of established clinical leadership and an existing CQR. Domains that did not meet this threshold but were ranked within the top two priorities in the CQR stakeholder survey (and also had an established registry with potential to expand to a national CQR) were assigned a score of 0.75. The full set of clinical scoring criteria is outlined below.

Table 10 Scoring for level of clinical support

Clinical support	Description	Score
Strong	Identifiable champions and demonstrated readiness to support a registry (established CQR and CQR leadership group identifiable)	1
Medium	Interested clinicians or organisations (CQR domain is within the top 2 priority clinical domain from stakeholder survey) but further work is required on registry readiness (state level clinical registry or national level registry with limited participation exists)	0.75
Moderate	Interested clinicians or organisations (but CQR domain is not within the top 2 priority clinical domain from stakeholder survey), with further work is required on registry readiness (registry with potential for expansion exists)	0.5
Low	Limited evidence of interest or feasibility	0

Respondents to the CQR stakeholder survey ranked seven clinical domains in order of priority for CQR improvement or investment. The top 2 clinical domains were *Chronic and complex conditions* and *Acute and emergency services*. Shortlisted CQR domains taken to correspond to these two domains are listed below

- cancer and other neoplasms
- cardiovascular diseases
- endocrine disorders
- gastrointestinal disorders
- injury
- kidney and urinary diseases
- musculoskeletal disorders
- neurological conditions
- respiratory diseases

Integration for intervention and setting based CQRs

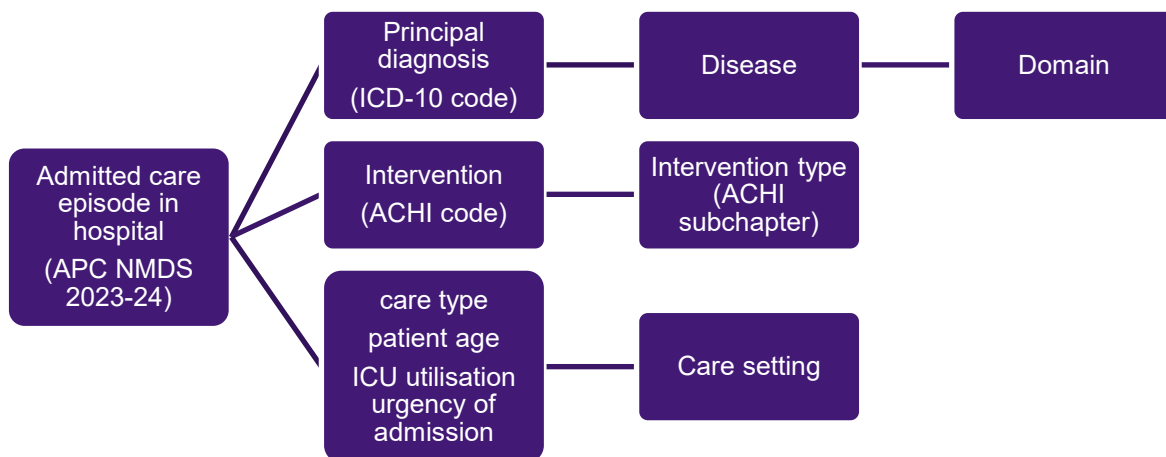
The 2026 report complemented disease-based domains with commonly associated interventions and care types, to support development setting-focused or intervention-based CQRs. To support development of intervention- and setting- based CQRs, routine hospital admission data (Admitted Patient Care National Minimum Dataset 2023-24) was used to illustrate relationship between common interventions and care settings with CQR prioritised domains and diseases. Diseases not on the 2026 prioritised list were excluded.

In Australian hospitals, an admitted episode of care is associated with disease(s) identified by the recorded diagnoses, coded using the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM). Interventions (if any) performed during the same episode are recorded using the Australian Classification of Health Interventions (ACHI) codes.

In the 2026 report, the principal diagnosis (primary reason for hospital treatment) was used to link each care episode to a disease (and therefore CQR domain). Interventions performed in each episode were grouped using ACHI subchapter descriptions to identify the types of procedures most frequently performed for each disease. Hospital care type, patient age, ICU utilisation, and urgency of admission served as proxies to define care settings of interest.

This mapping process is illustrated below.

Figure 3 Mapping prioritised domains and diseases to intervention and care settings



Interventions and diseases

ICD-10 to CQR domain assignment was guided by the ABDS mapping file that linked diseases to ICD diagnosis codes, provided at *Table 2.1: ABDS2018 list of diseases*,

conditions and injuries by ICD-10 code in *Data tables: Australian Burden of Disease Study: Methods and supplementary material 2018*²

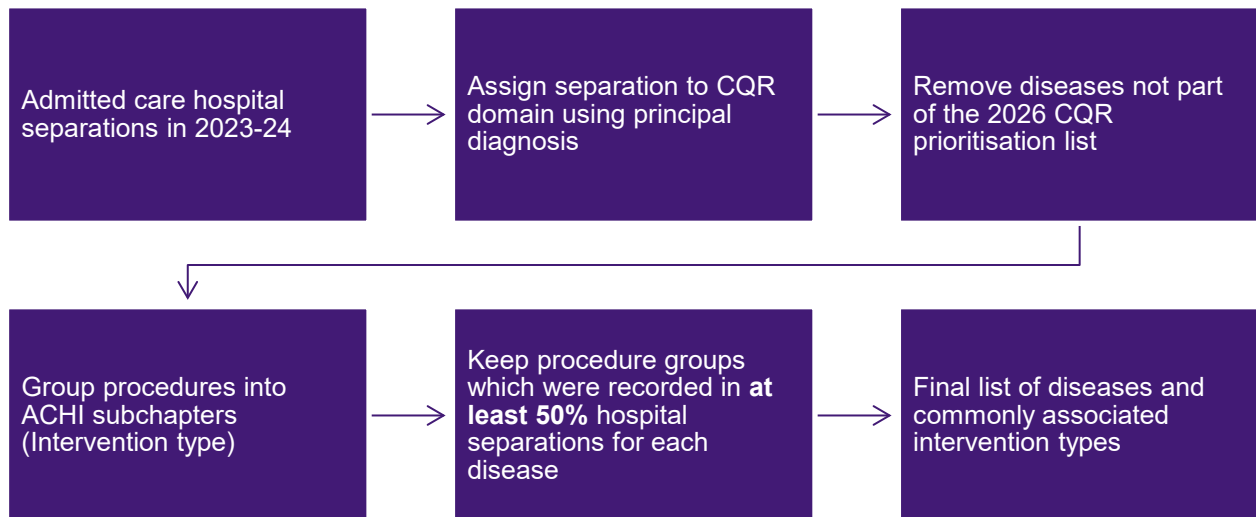
Exceptions this mapping process were

- COVID-19
ICD-10 codes for this condition did not exist in 2018. For the ABDS report, codes used to identify hospital separations for treatment of COVID-19 were U07.1, U07.2 and U10.9
- conditions only in health expenditure report
These conditions are heart failure, renal failure, and pregnancy and postpartum care. ICD-10 to disease concordance were taken from *Table 3: Mapping of ICD-10 AM codes to ABDS groups and conditions* from the *Health system spending on disease and injury in Australia 2022–23* report. ICD-10 codes used across multiple ABDS domains were excluded.

Although the ABDS mapping file was designed to map ICD-10 codes to mortality (instead of morbidity), it provided a pragmatic approach to identify common interventions associated with health conditions using administrative data from the Admitted Patient Care National Minimum Dataset.

The mapping process to associate a CQR domain and disease to intervention type is detailed in below

Figure 4 CQR disease and intervention mapping



² Australian Institute of Health and Welfare. *Australian Burden of Disease Study: Methods and supplementary material 2018* [Internet]. Canberra (AU): AIHW; 2021 Nov 24 [cited 2026 Mar 24]. Available from: <https://www.aihw.gov.au/reports/burden-of-disease/abds-methods-supplementary-material-2018/data>

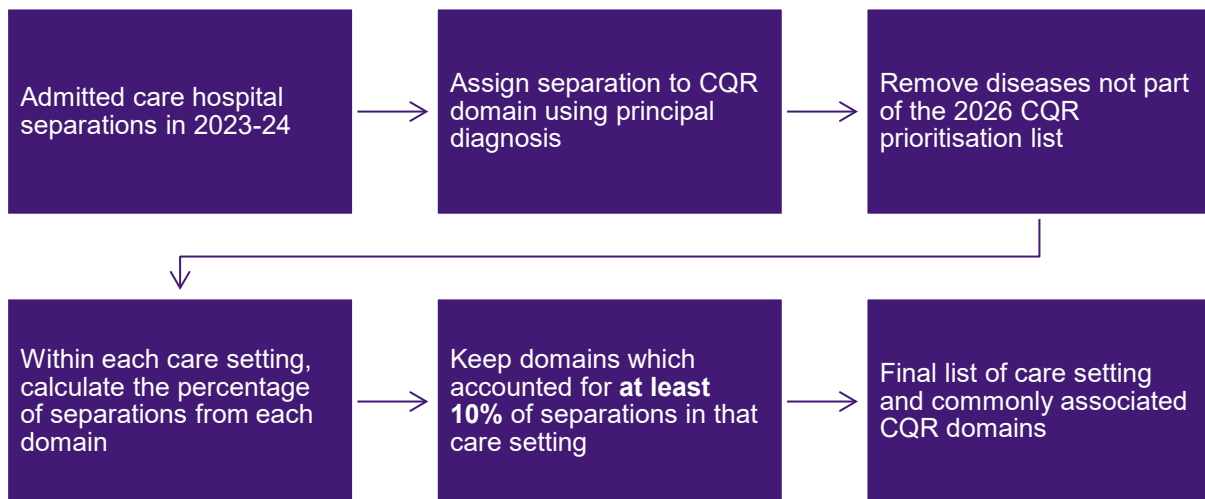
Care settings and CQR domain mapping

The 2026 methodology leveraged existing information in hospital admitted patient data collection, including care type, patient age, ICU utilisation, and urgency of admission. These variables served as proxies to identify disease groups commonly associated with particular healthcare settings.

Proposed settings of interest were emergency admissions, ICU care, paediatric care (including neonates and newborn care), palliative care, rehabilitation and geriatric care together with psychogeriatric care. A common cut-off of 10% was used to determine common CQR domains within a healthcare setting. For example, domains which accounted for at least 10% of emergency admissions for diseases in the 2026 prioritised list.

The mapping process to associate a CQR domain to care setting is detailed in below

Figure 5 CQR domain and care setting mapping





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