

Appendix 3: Technical notes

Definitions

If not otherwise indicated, data elements were defined according to the 2003–04 definitions in the *National Health Data Dictionary* version 12.0 (NHDC 2003) (summarised in the Glossary).

Data presented by state or territory refer to the state or territory of the hospital, not to the state or territory of the usual residence of the patient. The exceptions are Tables 4.5 and 4.8, 8.11 and 9.20, which are based on data on the state or territory of usual residence. In addition, the state or territory of usual residence of the patient is reported against the state or territory of hospitalisation in Tables 7.7, 7.8 and 7.9.

Data presentation

Except as noted, where totals are provided in the tables, they include data only for those states and territories for which data were available, as indicated in the tables. The exceptions relate to tables in which data for some jurisdictions were not published, for confidentiality reasons (private hospitals), or because only one public hospital was represented in the cell, or because a proportion related to a small number of events and was therefore not very meaningful. Data on the length of stay have been suppressed if there were fewer than 10 separations in the category being presented. Information was suppressed if there were fewer than 50 private hospital separations reported for the selected characteristic and fewer than three reporting units (hospitals, or states or territories where the hospitals were not individually identified), or there were three reporting units and one contributed more than 85% of the total separations, or two contributed more than 90%. Data on elective surgery waiting times were suppressed if there were fewer than 10 elective surgery admissions in the category being presented. The abbreviation 'n.p.' has been used in these tables to denote these suppressions.

Throughout the publication, percentages may not add up to 100.0 due to rounding. Percentages and population rates printed as 0.0 or 0 may denote less than 0.05 or 0.5, respectively.

Population rates

Population rates presented in Chapters 2, 4, 7 and 8 are age-standardised, calculated using the direct standardisation method and 5-year age groups. The total Australian population for 30 June 2001 was used as the population for which expected rates were calculated. The Australian Bureau of Statistics' population estimates for 31 December 2003 were used for the observed rates (Table A3.1 accompanying this report on the Internet). The exceptions were Tables 4.6, 4.7, 4.9, 4.10, 8.10, 8.12, 8.13, 9.21, 9.22 and 9.23, and Figures 9, 10 and 8.1, for which the 30 June 2003 population estimates (by Indigenous status, selected countries or regions of birth, Remoteness Areas and quintile of socioeconomic advantage/disadvantage, as appropriate) were used for the observed rates (Tables A3.2, A3.3 and A3.4 accompanying

this report on the Internet). Crude population rates in Chapters 2, 3, 6, 9, 10 and 12 were calculated using the population estimates for 31 December 2003.

Standardised separation rate ratios

For some tables reporting comparative separation rates (Tables 4.5 to 4.10, 8.11 to 8.13 and 9.20 to 9.23), standardised separation rate ratios (SRRs) are presented. The ratios are calculated by dividing the age-standardised separation rate for a population of interest (an observed rate) by the age-standardised separation rate for a comparison population (the expected rate). In these tables a 95% confidence interval for the SRR has also been presented. The calculations are as follows:

Standardised separation rate ratio = observed rate/expected rate

Standard error (SRR) = $\sqrt{\text{observed rate/expected rate}}$

95% confidence interval (SRR) = SRR \pm 1.96 \times Standard error (SRR)

A confidence interval for the separation rate can be obtained by multiplying the upper and lower 95% confidence levels for the SRR by the crude rate for the population.

Thus a standardised separation ratio of 1 indicates that the population of interest (for example, Indigenous peoples) had a separation rate similar to that of the comparison group (for example, other Australians). An SRR of 1.2 indicates that the population of interest had a rate that was 20% greater than that of the comparison population and an SRR of 0.8 indicates a rate 20% smaller. If the 95% confidence interval of the SRR contains 1, the rate for the population of interest is not significantly different (at the 95% confidence level) from that of the comparison population. Similarly, if the 95% confidence interval does not contain 1, then there is a significant difference (at the 95% confidence level).

Newborn episodes of care

The *Newborn* care type was introduced in 1998–99 for the hospital morbidity data to report a single episode of care for all patients aged 9 days or less at admission, regardless of their qualification status and whether they changed qualification status during their hospital stay. Thus these episodes can include qualified days only, a mixture of qualified days and unqualified days, or only unqualified days. Qualified days are considered to be the equivalent of acute care days and *Newborn* episodes with qualified days only are considered to be equivalent to *Acute care* episodes. In this report, *Newborn* episodes with at least one qualified day have been included in all the tables reporting separations. Records for *Newborn* episodes with no qualified days do not meet admission criteria for all purposes, so they have been excluded from this report, except as specified in Chapter 7. The number of patient days reported in this publication for *Newborn* episodes is equal to the number of qualified days, so for newborns with a mixture of qualified and unqualified days the number of patient days reported is less than the actual length of stay for the episode.

Tasmanian and Northern Territory hospitals and private hospitals in South Australia did not report any *Newborn* episodes with a mixture of qualified and unqualified days (Table 7.10), while private hospitals in Victoria did not report most *Newborn* episodes with no qualified days. For Tasmania, where a newborn's qualification status was considered qualified at any point during their episode of care, the entire episode was reported as qualified days. As a consequence of the reporting method used, the number of *Newborns* with qualified days only

will include those that may have had an unqualified component in their stay. For this reason the average length of stay for *Newborns* with qualified days only in Tasmanian public hospitals is not directly comparable to that in other states.

Information on reporting practices for *Newborn* episodes prior to 2003–04 is available in previous *Australian Hospital Statistics* publications (AIHW 2002, 2003, 2004a).

Hospital boarders and posthumous organ procurement

For some states and territories, the data provided to the National Hospital Morbidity Database included records for *Hospital boarders* and for *Posthumous organ procurement* activity (see Glossary). These records were provided on an optional basis as they do not represent admitted patient care.

The records for *Hospital boarders* were excluded from this report. There were 32,758 records for *Hospital boarders* reported to the National Hospital Morbidity Database in 2003–04, mainly from Western Australia, Queensland and the Northern Territory.

Similarly, records for *Posthumous organ procurement* activity were excluded from this report. There were 61 records of *Posthumous organ procurement* reported to the National Hospital Morbidity Database in 2003–04. Most of these records were from Queensland and Western Australia, with small numbers from the Northern Territory and Tasmania. The numbers of records for *Posthumous organ procurement* were similar to the figures reported to the Australia and New Zealand Organ Donation Registry for organ donation in those states/territories during the year ending December 2003 (<http://www.anzdata.org.au/>).

ICD-10-AM coded data

Diagnosis, procedure and external cause data for 2003–04 were reported to the National Hospital Morbidity Database by most states and territories using the third edition of the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification* (ICD-10-AM) (NCCH 2002). For South Australia these data were reported to the National Hospital Morbidity Database using the fourth edition of the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification* (ICD-10-AM) (NCCH 2004).

Data mapping for South Australia

South Australia mapped the data collected using the third edition of ICD-10-AM forward to codes of the fourth edition of ICD-10-AM (NCCH 2004) before providing them to the AIHW. This mapping was undertaken by selecting the most clinically appropriate code in fourth edition ICD-10-AM based on the description of the code in the third edition of ICD-10-AM.

Where mapped codes could be identified (because they were invalid as third edition codes), the AIHW mapped the South Australian data backward to the third edition codes so that national data could be presented in a single classification in this report. The mapped data are not completely equivalent to unmapped data, so this means that the data should be interpreted with these mappings in mind. In this report, 'mapping' refers to the process of

finding an 'equivalent' code between two classifications to enable national data to be presented in a single classification.

The AIHW undertook the mapping using the standard backward maps in the version 4.2 AR-DRG grouper. All diagnosis code maps were many-to-one maps, meaning that several more specific diagnosis codes in the fourth edition ICD-10-AM could be mapped to one diagnosis code in the third edition ICD-10-AM. Procedure code maps were mainly one-to-one maps. There was one many-to-one map, where several fourth edition procedure codes were mapped to one third edition procedure code.

State-specific coding standards

The Australian Coding Standards were developed for use in both public and private hospitals with the basic objective of satisfying sound coding convention according to ICD-10-AM. While all states and territories instruct their coders to follow the Australian Coding Standards, some jurisdictions also apply state-specific coding standards to deal with state-specific reporting requirements. These standards may be in addition to or instead of the relevant Australian Coding Standard, and may affect the comparability of ICD-10-AM coded data.

For example, there are variations in coding standards between jurisdictions with regard to the requirement for the reporting of external cause codes and place of occurrence codes. The Australian Coding Standard requires a place of occurrence code to be reported if an external cause code in the range V00–Y89 has been reported, and requires an activity when injured code to be recorded if the external cause code is in the range V00–Y34. The Western Australian coding standard requires the mandatory recording of a place of occurrence and activity when injured code for all records with a diagnosis code in the range S00–T98, regardless of the external cause code reported and the Victorian coding standard does not require the recording of external cause, place of occurrence or activity when injured if the care type is *Rehabilitation*.

Quality of ICD-10-AM coded data

The quality of coded diagnosis, procedure and external cause data can be assessed using coding audits in which, in general terms, selected records are independently recoded, and the resulting codes compared with the codes originally assigned for the separation. There are no national standards for this auditing, so it is not possible to use information on coding audits to make quantitative assessments of data quality on a national basis. The following information has, however, been provided by the states and territories to provide some insight into the quality of the coded data in the National Hospital Morbidity Database.

No statewide audit was performed on New South Wales data in 2003–04. Hospitals perform formal audits on ICD-10-AM coded data at a local level. Data edits are monitored regularly and consistent errors are identified and rectified by individual hospitals.

No statewide external audit of 2003–04 data was conducted in Victoria. The results of the previous statewide external audit of 2000–01 data indicated that coded data were of high quality and showed continued improvement over the 3 years of this audit.

Coding quality checks are conducted regularly by source hospitals in Queensland, and ICD-10-AM validations are automatically conducted as part of the general processing of morbidity data. In February 2004 the Clinical Classification Management Project was endorsed with a goal of improving the quality of coded morbidity data within Queensland

Health. The 2-year project commenced in August 2004 with the appointment of two clinical classification auditors/educators. The aim of the project is to increase the quality of clinical coded data and to further standardise coding practice.

For the year 2003–04 the Western Australian Department of Health performed audits on random samples of general records from teaching, non-teaching and rural hospitals as well as targeted samples of cases with high risk of error (based on previously compiled error profiles). The audits aimed to assess the accuracy of ICD-10-AM coding and to check compliance with other recording requirements. The codes sent to the Western Australian Department of Health were also checked using the NCCH's Performance Indicators for Coding Quality (PICQ) software and in-house routines. These checks led to an improvement in the coded information.

In 2003–04, South Australia continued its coding data quality program, which is overseen by the South Australia Coding Committee in conjunction with individual coding managers and regional health information management advisory services. Following the external audit findings conducted on 2001–02 data, there has been a significant review of all site-specific coding standards and work processes to ensure compliance with national standards and promotion of consistency in interpretation of conventions between sites.

In Tasmania, hospitals continue to conduct coding quality improvement activities utilising the Australian Coding Benchmark Audit tool and PICQ. Validation of ICD-10-AM data also occurs routinely as the data are processed from the hospitals. A State-wide Recoding Study Working Group was formed to implement recommendations from a previous state-wide recoding study.

The quality of coding in the Australian Capital Territory remains within nationally accepted standards. Over the last 12 months, the Australian Capital Territory has introduced PICQ in the public hospital as a tool in improving the overall coding quality of medical records and completed a coding audit.

The Northern Territory Coders' Forum continued monthly mini-audits throughout the year. These audits involved each hospital coder coding the same specific case, with the answers being reviewed by forum members. In addition to the mini-audits, the hospitals regularly run reports on Error AR-DRGs and review the results of these reports by a manual audit of these medical records. This sometimes results in a change of AR-DRG or a change in the coding of a particular episode of care. The Northern Territory also introduced the NCCH PICQ electronic tool during 2004. The Northern Territory has only reviewed the fatal indicators at present but the tool has been run across all Northern Territory public hospital data for the 2002–03 and 2003–04 morbidity data collection. The 2003–04 data was circulated to all hospitals to provide them with the opportunity to correct and revise their coding errors. This has also led to an emphasis on data quality, coding conventions and the Australian Coding Standards. Northern Territory public hospitals have the ability to run PICQ at their own facility for their own coding quality reviews.

ICD-10-AM codes used for selected analyses

A number of tables in this report use ICD-10-AM codes to define diagnoses and procedures. The codes are presented in Table A3.5 (accompanying this report on the Internet) and relate to:

- Figures 13, 14, 15 and 16 in the 'Hospitals at a glance' section
- Tables 4.5, 4.6 and 4.7, which present statistics on selected procedures

- Tables 4.8, 4.9 and 4.10, which present statistics on selected potentially preventable hospitalisations
- Table 4.14 which presents statistics indicating adverse events associated with hospitalisations
- Tables 9.20, 9.21 and 9.22, which present statistics on renal failure hospitalisations.

Data on geographical location

Data on geographical location are collected on hospitals in the National Public Hospital Establishments Database and on the area of usual residence of patients in the National Hospital Morbidity Database. These data have been provided as state or territory and Statistical Local Area (SLA--a small unit within the Australian Bureau of Statistics' Australian Standard Geographic Classification; ASGC) and/or postcode, and have been aggregated to Remoteness Areas.

The ASGC's remoteness structure categorises geographical areas into Remoteness Areas, described in detail on the Australian Bureau of Statistics' Internet site at <http://www.abs.gov.au/>.

The classification is as follows:

- major cities of Australia
- inner regional
- outer regional
- remote
- very remote.

Geographical location of hospital

The Remoteness Area of each public hospital was determined using geo-coded data (with latitude and longitude) for each hospital in 2001 or on the basis of their SLA, postcode or other location information as detailed in *Australian Hospital Statistics 2002-03* (AIHW 2004a).

Data on the Remoteness Area of hospitals are presented in Chapter 3 (Table 3.2) and Chapter 5 (Table 5.2).

Geographical location of usual residence

Data on the Remoteness Area of usual residence of admitted patients are presented in Figure 10 in the 'Hospitals at a glance' section and in Tables 4.6, 4.9, 8.12 and 9.21. Data on the state or territory of usual residence are reported in Chapter 4 (Tables 4.5 and 4.8), Chapter 7 (Tables 7.7, 7.8 and 7.9) and Chapter 9 (Table 9.20).

The data used for these tables were derived from data supplied by the states and territories for the National Hospital Morbidity Database on the area of usual residence of the patients. The *National Health Data Dictionary* specifies that these data should be provided as the state or territory and the SLA of usual residence. Although most separations included data on the state or territory of usual residence, not all states and territories were able to provide information on the area of usual residence in the form of an SLA code. New South Wales, Victoria, Tasmania, the Australian Capital Territory and the Northern Territory were able to

provide SLA codes both for patients usually resident in the jurisdiction and for patients not usually resident in the jurisdiction. Queensland and South Australia provided SLA codes for patients usually resident in the jurisdiction and postcodes for patients not usually resident in the jurisdiction. Western Australia provided postcodes both for patients usually resident in the jurisdiction and for patients usually resident elsewhere.

The AIHW mapped the supplied area of residence data for each separation to 2003 SLA codes and to Remoteness Area categories. This was undertaken on a probabilistic basis as necessary, using ABS concordance information describing the distribution of the population by postcode, Remoteness Areas and SLAs (2003 and previous years). The mapping process identified missing, invalid and superseded codes, but resulted in 99.4% of records being assigned 2003 SLA codes, and 0.3% of records had a usual residence of *Overseas/Not elsewhere classified* or *Not reported*. Due to the probabilistic nature of this mapping, the SLA and Remoteness Area data for individual separations may not be accurate; however, the overall distribution of separations by geographical areas is considered useful.

Socioeconomic advantage/disadvantage

The Socio-Economic Indexes For Areas 2001 (termed SEIFA 2001 (ABS 2004b)) are generated by the ABS using a combination of 2001 Census data such as income, education, skill level of occupation/unemployment, wealth and living conditions, dwellings without motor vehicles, rent paid, mortgage repayments, and dwelling size. Composite scores are averaged across all people living in areas and defined for areas based on the Census Collection Districts. However, they are also compiled for higher levels of aggregation including Statistical Local Area. The SEIFAs are described in detail on the Australian Bureau of Statistics' Internet site at <http://www.abs.gov.au/>.

The SEIFA Index of Advantage/Disadvantage was generated by the ABS using a combination of Census data, including variables measuring both advantage and disadvantage. A higher score on the index indicates that an area has attributes that measure advantage, such as a relatively high proportion of people with high incomes or a skilled workforce. It also means an area has a low proportion of people with variables that measure disadvantage, such as low incomes, and relatively few unskilled people in the workforce. Conversely, a low score on the index indicates that an area has a high proportion of individuals with variables that measure disadvantage, such as low incomes, more employees in unskilled occupations; and a low proportion of people with variables that measure advantage, such as high incomes or in skilled occupations. Hence, the index offsets any disadvantage in an area with advantage.

Separation rates by quintile of advantage/disadvantage were generated by the AIHW by using the SEIFA scores for this index for the SLA of usual residence of the patient reported for each separation. The most disadvantaged quintile represents the areas containing the 20% of the population with the least advantage/most disadvantage and the most advantaged quintile represents the areas containing the 20% of the population with the least disadvantage/most advantage.

Cost per casemix-adjusted separation

The cost per casemix-adjusted separation (Tables 4.1 and 4.2) is an indicator of the efficiency of public acute care hospitals. It is a measure of the average recurrent expenditure for each

admitted patient, adjusted using AR-DRG cost weights for the resources expected to be used for the separation. A synopsis of the methods used in this analysis is presented below, and more detail is available in *Australian Hospital Statistics 2000–01* (AIHW 2002).

Definition

The formula used to calculate the cost per casemix-adjusted separation is:

$$\frac{\text{Recurrent expenditure} \times \text{IFRAC}}{\text{Total separations} \times \text{Average cost weight}}$$

where:

- Recurrent expenditure is as defined by the recurrent expenditure data elements in the *National Health Data Dictionary* (with depreciation excluded)
- IFRAC (admitted patient cost proportion) is the estimated proportion of total hospital expenditure that related to admitted patients
- Total separations excludes *Newborns* with no qualified days and records that do not relate to admitted patients (*Hospital boarders* and *Posthumous organ procurement*)
- Average cost weight is a single number representing the relative expected resource use for the separations.

Recurrent expenditure

For the medical labour cost category, data are available only for public patients, as private patients are charged directly by their doctor for medical services, and these charges are not included in the recurrent expenditure figures. The proportion of patients other than public patients can vary, therefore medical costs for these patients are estimated, and the expenditure increased to resemble what it would be if all patients had been public patients. The estimation is based on the salary/sessional and VMO expenditure per patient day for public patients, applied to all patients.

Admitted patient cost proportion

To determine the costs associated with admitted patients, an admitted patient cost proportion (or inpatient fraction, IFRAC) is used. The IFRAC was provided to the AIHW for most hospitals by the states and territories and is the proportion of total hospital expenditure that related to the provision of care for admitted patients. For a few small hospitals where the IFRAC was not available, the admitted patient costs were estimated using the Health and Allied Services Advisory Council (HASAC) ratio.

Total separations

The formula used to calculate the cost per casemix-adjusted separation includes all admitted patient separations and their associated costs. It is appropriate to include the acute care separations, which comprise 97% of the total for the hospitals included in the analysis (Table A3.5), as cost weights are available for them. However, the 3% of separations that are not acute care are also included and, as there are no cost weights for these separations, the average cost weight for the acute separations for each hospital is used. This method may affect the estimates of cost-weighted separations (see below) for each state and territory, depending on the proportion of non-acute separations for the state or territory. The non-

acute admitted patients (including rehabilitation care patients) generally have higher costs per separation than acute care patients because, although their daily costs are lower, these patients typically have longer lengths of stay. (See below for examples relating to hospitals in some states.)

Comparisons between the states and territories should therefore take into consideration the uncertainty introduced by these episodes for which the cost weights were unavailable. There is variation in the number and length of stay for the non-acute care separations between jurisdictions (Table A3.5).

To refine the method to remove this anomaly would require estimates of expenditure for acute care for admitted patients (acute care IFRACs). For 2003–04, such estimates were available for some jurisdictions, as presented below.

There is also some variation between states and territories in the ways in which periods of hospitalisation are split into episodes of care (for example, *Newborn* care). In states or territories where there is a clear delineation in funding arrangements between acute and non-acute services, splitting episodes into acute and other components may be different from where there is no such funding delineation.

Average cost weights

Hospital morbidity data provided to the National Hospital Morbidity Database were used to estimate average cost weights for the hospitals reported in this analysis. The 2002–03 version 4.2 cost weights were applied to 2003–04 version 4.2 AR-DRGs as the National Hospital Cost Data Collection 2003–04 weights were not available at the time of publication.

As noted above, because cost weights are only available for acute care separations, the cost per casemix-adjusted separation analysis has applied these cost weights to all separations.

The average cost weight for a hospital or group of hospitals (Table 4.2, for example) is calculated as the number of casemix-adjusted separations divided by the number of separations. It represents in a single number the overall relative expected use of resources by a hospital. For example, a hospital with an average cost weight of 1.08 has an 8% more costly casemix than the national average (by design equal to 1.00).

The average cost weight for a group of hospitals is multiplied by the total number of separations for that group to produce the number of casemix-adjusted separations (the denominator). The term ‘cost per casemix-adjusted separation’ derives from this use of the number of separations adjusted by relative costliness.

The validity of comparisons of average cost weights is limited by differences in the extent to which each jurisdiction’s psychiatric care services are integrated into its public hospital system. For example, in Victoria, almost all public psychiatric hospitals are mainstreamed into acute hospital services and psychiatric patient data are therefore included in the acute hospital reports. Cost weights are not as useful as measures of resource requirements for acute psychiatric care because the relevant AR-DRGs are less homogeneous than for other acute care.

Cost per acute care and non-psychiatric acute care casemix-adjusted separation

Because cost weights are only available for acute care separations, the cost per casemix-adjusted separation analysis applies these cost weights to all separations. Thus, the

methodology would be refined if cost weights became available for other care types, or if the analysis were to be restricted to acute care activity and expenditure. As AR-DRG cost weights are likely to be less useful as measures of resource requirements for psychiatric acute care than for other acute care, a further refinement would be to restrict the analysis to non-psychiatric acute care activity and expenditure.

Restriction to acute care activity requires estimates to be made by the states and territories of expenditure on acute care admitted patients (supplied as acute care IFRACs), and for separations relating to non-acute care patients to be excluded from the analysis. Restriction to non-psychiatric acute care activity requires estimates to be made by the states and territories of expenditure on non-psychiatric acute care admitted patients (supplied as non-psychiatric acute care IFRACs), and of expenditure for separations relating to non-acute care patients and to psychiatric acute care patients to be excluded from the analysis. Psychiatric acute care activity is excluded from the hospital morbidity data by excluding separations if one or more psychiatric care days were reported for the separation (indicating that care was provided in a specialised psychiatric unit).

This methodology is still under development.

New South Wales, Victoria, Western Australia, South Australia, Tasmania and the Northern Territory provided estimates of expenditure on acute care admitted patients, so estimates of the cost per casemix-adjusted acute care separation are presented for these jurisdictions (Table A3.6). Separations were included only if their care type was *Acute*, *Newborn* with at least one qualified day or for which the care type was *Not reported*.

For Victoria and South Australia, the reported acute care and non-psychiatric acute care IFRACs were the same as the IFRACs for all care types for some hospitals that had reported non-acute admitted patient care activity. Those hospitals were excluded from the analysis if they reported more than 1,000 patient days for non-acute separations. For Victoria, 13 hospitals were excluded from the analysis (representing 27% of separations): four *Principal referral hospitals*, one *Specialist women's and children's hospital*, one *Large hospital*, four *Medium hospitals* and two *Small rural acute hospitals*. For South Australia, there were two hospitals excluded (19% of separations): one *Principal referral hospital* and one *Large hospital*.

For New South Wales and Western Australia and Victoria, acute care IFRACs were reported for several hospitals that gave an estimated cost per day of over \$1,000, which was considered an unreasonably high estimate for non-acute care types. Five hospitals with over 1,000 patient days estimated to cost more than \$1,000,000 in total were omitted from the New South Wales data (representing 12% of separations): three *Principal referral hospitals* and two *Medium hospitals*. For Western Australia, there were 2 hospitals excluded (0.3% of separations): two *Medium hospitals*. For Victoria, there was 1 *Medium hospital* excluded.

The estimated cost per acute care casemix-adjusted separation for the hospitals included was \$3,262 in New South Wales, \$3,280 in Victoria, \$3,334 in Western Australia, \$3,152 in South Australia, \$2,958 in Tasmania and \$3,278 in the Northern Territory. The cost per casemix-adjusted separation for all separations in these hospitals was \$3,395, \$3,443, \$3,415, \$3,145, \$3,333 and \$3,377 respectively (Table A3.6), so the effect of restricting the analysis to acute care admitted patients was to decrease the estimated cost by 3.9% in New South Wales, 4.7% in Victoria, 2.4% in Western Australia, 11.3% in Tasmania and 2.9% in the Northern Territory, with South Australia increasing by 0.2%.

The estimated cost per acute non-psychiatric casemix-adjusted separation for the selected hospitals was \$3,228 in New South Wales, \$3,293 in Victoria, \$3,338 in Western Australia and \$3,132 in the Northern Territory (the three small remote hospitals in the Northern Territory were omitted from this analysis due to data problems). The effect of restricting the analysis

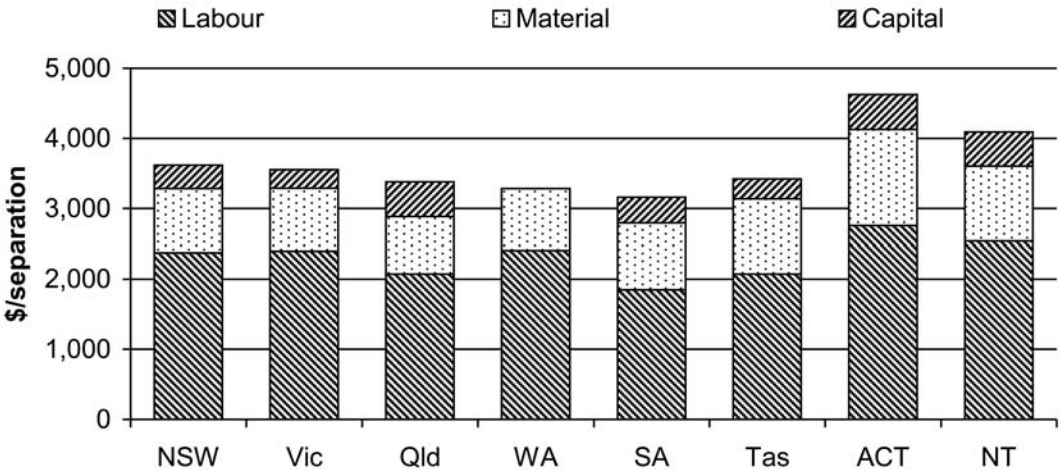
to acute non-psychiatric admitted patients was to decrease the estimated cost by 4.9% in New South Wales, 4.4% in Victoria, 2.3% in Western Australia and 6.9% in the Northern Territory.

These analyses would be further improved if all jurisdictions increased their capacity to separate costs for psychiatric services, other acute services, sub-acute services (e.g. rehabilitation) and non-acute services.

Total cost per casemix-adjusted separation

The cost per casemix-adjusted separation analysis includes only recurrent expenditure, and does not include capital expenditure of any type. There are concerns about the quality and comparability of available capital expenditure data, and they are not provided to the AIHW by all states and territories. The concerns about the comparability of the data include variation among the jurisdictions in the type of expenditure that is defined as recurrent and capital, respectively.

The Steering Committee for the Review of Government Service Provision (SCRGSP) reported total costs per casemix-adjusted separation by state and territory for 2002–03 (SCRGSP 2005). It was defined as the recurrent cost per casemix-adjusted separation plus the capital costs (depreciation and the user cost of capital of buildings and equipment) per casemix-adjusted separation.



- (a) 'Labour' includes medical and non-medical labour costs. 'Material' includes other non-labour recurrent costs.
- (b) 'Capital cost' includes the user cost of capital plus depreciation associated with the delivery of admitted patient services in the public hospitals described in the data for recurrent cost per casemix-adjusted separation. 'Capital cost' excludes land and the user cost of capital associated with land (reported in table 9A.26).
- (c) Variation across jurisdictions in the collection of capital related data suggests the data are only indicative. Capital cost per casemix-adjusted separation data are not available for WA.

Source: SCRGSP 2005

Figure A3.1 Total cost per casemix-adjusted separation, public hospitals, 2002–03^{(a)(b)(c)}

The SCRGSP (SCRGSP 2005) notes that 'depreciation is defined as the cost of consuming an asset's services, and is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital and is equivalent to the return forgone from not using the funds to deliver other government services or to retire debt.

Interest payments represent a user cost of capital and so should be excluded from recurrent expenditure where user costs of capital are calculated separately and added to recurrent costs. Interest expenses were deducted directly from capital costs in all jurisdictions to avoid double counting.'

The total cost per casemix adjusted separation by jurisdiction (including capital costs), as published by SCRGSP for 2002–03, is presented in Figure A3.1. The data exclude the user cost of capital associated with land. Excluding the users cost of capital for land, the total cost per casemix-adjusted separation ranged from \$4,626 in the Australian Capital Territory to \$3,158 in South Australia (SCRGSP 2005).

Further details about the SCRGSP calculation of total cost per casemix-adjusted separation are available in the *Report on Government Services 2004* (SCRGSP 2005).

Relative stay index

Relative stay indexes (RSIs) have been identified as indicators of efficiency and are presented in Tables 2.3, 2.4, 4.1, 4.2, 4.12, 4.13, 12.1 and 12.2. They are calculated as the actual number of patient days for separations in selected AR-DRGs, divided by the number of patient days expected (based on national figures) standardised for casemix. An RSI greater than 1 indicates that an average patient's length of stay is higher than would be expected given the casemix for the group of separations of interest. An RSI of less than 1 indicates that the length of stay was less than would have been expected.

The standardisation for casemix (based on the AR-DRG version 4.2 and age of the patient for each separation) allows comparisons to be made that take into account variation in types of services provided, but does not take into account other influences on length of stay, such as Indigenous status.

The method used is to standardise on the basis of the AR-DRG and age (as a cubic regression). Acute care separations only are included. Excluded from the analysis are:

- AR-DRGs which are overwhelmingly same day: R63Z *Chemotherapy* and L61Z *Admit for renal dialysis*
- AR-DRGs with a length of stay component in the definition
- 'rehabilitation' AR-DRGs
- error AR-DRGs 960Z, 961Z, 962Z and 963Z
- separations for patients who died or were transferred within 2 days of admission
- separations with length of stay greater than 120 days.

These inclusions and exclusions are further detailed in Appendix 4 of *Australian Hospital Statistics 2000–01* (AIHW 2002).

Standardisation methods

Two methods are used for standardisation of the length of stay data, and are analogous to direct and indirect age-standardisation methods. The method used generally in this report is analogous to indirect standardisation where the national rates (ALOS) for each AR-DRG (version 4.2) are applied to the relevant population of interest (number of separations for each AR-DRG in the hospital group) to derive the expected number of patient days. Indirect standardisation methods are generally used when rate information for the population of

interest (ALOS for each AR-DRG in this analysis) is unknown or subject to fluctuation due to small population sizes. This method provides a measure of efficiency for a hospital, or group of hospitals, based on their actual activity. However, an indirectly standardised rate compares a group with a 'standard population rate' so, using this method, rates for different groups are not strictly comparable because each group has a different casemix to which the national ALOS data have been applied. Hence, technically, the indirectly standardised data for hospital groups should be compared with the national average of 1.00.

The second method is analogous to direct standardisation where the rate (ALOS) of each AR-DRG for the group of interest is multiplied by the national population (total number of separations in each AR-DRG) to derive the expected number of patient days. This method provides a measure of efficiency for a hospital, or group of hospitals, and is suitable if all or most AR-DRGs are represented in hospital group. Direct standardisation methods are generally used where the populations and their characteristics are stable and reasonably similar, for example for total separations for New South Wales and Victoria.

Groups can be compared using directly standardised rates as the activity of each group is weighted using the same set of weights, namely the national casemix. However, the ALOS data for AR-DRGs which are not represented in a group need to be estimated. The method used in this report uses an assumption that the missing AR-DRGs for the hospital group had a relative length of stay that was the same as that for the reported AR-DRGs for the hospital group, weighted by the national distribution of the reported AR-DRGs in the group. Another weakness of direct standardisation is that this method can scale up AR-DRGs to have an impact that does not reflect their relative volume in a hospital group. This weakness can be particularly problematic if the low-volume AR-DRGs are atypical.

The indirectly standardised method has been mainly used in this report because of the weaknesses of the directly standardised method. However, the directly standardised methodology has been used (in addition to the indirect standardisation) in Table 2.3 as a time series and in Table 4.13 by state and territory. This allows comparison between the two methods and more direct comparison for those jurisdictions and sectors for which the data are presented. Data for the directly standardised method in the public sector in the Northern Territory are suppressed in Table 4.13, due to problems with using the direct standardisation for hospital groups that reported a limited range of AR-DRGs. For public hospitals in the Northern Territory, fewer than 600 of the 639 DRGs used in the national RSI analysis are represented so results are likely to have been affected by estimation of the missing ALOS data.

Table A3.8 shows the number of AR-DRGs represented in each cell in Table 4.13, so that the number of AR-DRGs for which ALOS was estimated can be derived. For those jurisdictions and sectors for which RSI statistics are presented in Table 4.13, there were between 602 and 639 AR-DRGs represented, meaning that ALOS data was estimated for up to 37 AR-DRGs.

AR-DRG versions

This report uses AR-DRGs version 5.0 (DoHA 2002) to classify separations in most analyses. AR-DRGs version 4.2 (DHAC 2000) is used when data based on cost weights or estimated costs of separation are presented, because cost weight information was not available for AR-DRGs version 5.0 (see Chapters 2, 4, 7 and 12) at the time of publication. AR-DRG version 4.2 was also used for the RSI analysis detailed above.

The differences between the features of AR-DRG version 5.0 and AR-DRG version 4.2 were summarised in Appendix 3 of *Australian Hospital Statistics 2002–03* (AIHW 2004a) and should be taken into consideration when comparing data using the two classifications.

Medicare eligibility status

For *Australian Hospital Statistics 1999–00* (AIHW 2001a) and previous publications, Tables 7.1 to 7.5 in Chapter 7 (previously Chapter 5 in 1999–00, and Chapter 6 from 2000–01 to 2002–03) were based on the data element 'Patient accommodation eligibility status' which incorporated a distinction between patients who were or were not eligible for treatment in accordance with the Australian Health Care Agreements (previously known as the Medicare Agreements) and included a category for Department of Veterans' Affairs patients. For *Australian Hospital Statistics 2000–01* (AIHW 2002), these tables were compiled using four different data elements from version 9.0 of the *National Health Data Dictionary* (NHDC 2000) -- 'Admitted patient election status', 'Department of Veterans' Affairs patient', 'Medicare eligibility status' and 'Compensable status'. From 2001–02, data on Medicare eligibility, patient election status and funding source were provided as separate data elements. This allowed the comparability of these data to be assessed in more detail than previously possible, and highlighted apparent inconsistencies in the way Medicare eligibility was reported among states and territories, in particular in relation to the funding source and patient election status data. Hence, the data on Medicare eligibility status has not been included in Tables 7.2 to 7.5 and 4.12, so that data by funding source can be presented more meaningfully. As these data are not included in Tables 7.2 to 7.5 and 4.12 for this publication, a summary is presented in Table A3.9.

Patient election status and funding source categories

For *Australian Hospital Statistics 2001–02* and subsequent publications, Tables 7.2 to 7.5 (previously Tables 6.1 to 6.4) were based on the data elements 'Patient election status' and 'Funding source for hospital patient'. For the purpose of reporting these data in 2001–02, 2002–03 and 2003–04, the 'Patient election status' for patients whose funding source was reported as *Australian Health Care Agreements* and *Reciprocal health care agreements* was categorised as public. Public psychiatric hospital patients were also categorised as public unless another funding source was reported for them. The 'Patient election status' for patients whose funding source was reported as *Private health insurance*, *Self-funded*, *Workers compensation*, *Motor vehicle third party personal claim*, *Other compensation*, *Department of Veterans' Affairs*, *Department of Defence* or *Correctional facility* was categorised as private. Patients whose funding source was reported as *Other hospital or public authority*, *Other* or *Not reported* were categorised according to the reported 'Admitted patient election status'. For 2003–04, the 'Patient election status' for separations for patients whose funding source was reported as *Other hospital or public authority* in private sector hospitals in Tasmania were categorised as public as the patients were contracted by a public hospital and the 'Admitted patient election status' was not reported.

Tables in Chapters 9, 10 and 12 that present data for public patient separations used 'Patient election status', determined as described above, as the basis for this category.

To facilitate time series comparisons and to provide some continuity between *Australian Hospital Statistics 1999–00*, *Australian Hospital Statistics 2000–01*, *Australian Hospital Statistics 2001–02*, *Australian Hospital Statistics 2002–03* and this publication, the presentation of information for 2001–02, 2002–03 and 2003–04 in Table 7.1 has combined selected funding source categories and included Medicare eligibility status data. In Table 7.1 for 2001–02, 2002–03 and 2003–04, the category *Compensable* includes patients whose funding source was *Workers compensation*, *Motor vehicle third party personal claim* and *Other compensation*, while the category *Other private* includes private patients whose funding source was not *Department of Veterans' Affairs* or *Compensable*. However, caution should be taken when making comparisons over time (Tables 7.1, 9.7, 10.7 and 12.6) as the categories presented are not directly comparable. In previous years there was some variation between jurisdictions in the application of the data element 'Admitted patient election status', with some states and territories using this element to reflect the patient's choice of room or doctor and others to reflect the funding source. Hence, discontinuities may exist because patients with the funding source reported as *Department of Defence* and *Correctional facility* have been categorised as 'private patients' for 2001–02, 2002–03 and 2003–04, whereas they may previously have been reported as 'public patients', for example.

Table A3.5: Summary of separations in public acute hospitals selected for the cost per casemix-adjusted separation analysis^(a) and data for excluded hospitals, states and territories, 2003–04

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Total separations ('000)	1,258	1,160	688	331	353	78	69	70	4,008
Total patient days ('000)	4,743	4,044	2,299	1,145	1,196	305	235	214	14,182
Acute separations^(b)									
Separations ('000)	1,232	1,121	665	326	343	77	67	69	3,900
Patient days ('000)	4,331	3,253	1,992	1,028	1,062	265	204	204	12,340
Acute care psychiatric separations^(c)									
Separations ('000)	23	16	23	6	6	3	1	1	80
Average cost weight ^(d)	1.47	2.30	1.72	1.96	1.97	1.67	2.09	1.78	1.81
Patient days ('000)	240	226	211	81	71	26	14	10	879
Acute care non-psychiatric separations									
Separations ('000)	1,209	1,105	642	320	337	74	66	68	3,820
Patient days ('000)	4,091	3,027	1,780	947	992	240	191	194	11,461
Separations other than acute									
Rehabilitation separations ('000)	16.0	23.6	14.9	2.9	2.1	0.8	1.1	0.7	62.1
Patient days ('000)	247.3	391.9	139.0	68.0	31.3	24.4	14.9	3.7	920.4
Palliative care separations ('000)	4.1	2.9	3.2	0.4	1.4	0.1	0.4	0.0	12.4
Patient days ('000)	43.2	45.8	29.4	4.3	16.3	0.7	6.7	0.6	146.9
Geriatric evaluation and management separations ('000)	0.7	6.6	0.6	0.7	0.0	0.0	0.0	0.1	8.6
Patient days ('000)	7.1	185.4	11.9	5.7	n.p.	0.1	n.p.	1.3	211.6
Psychogeriatric separations	0.3	2.1	0.3	0.0	0.0	0.0	0.0	0.0	2.7
Patient days ('000)	14.5	60.7	8.6	0.8	n.p.	n.p.	n.p.	0.3	85.0
Maintenance separations ('000)	5.2	3.3	4.5	1.4	1.2	0.4	0.3	0.1	16.4
Patient days ('000)	100.4	107.1	117.6	38.1	52.2	14.5	9.2	3.5	442.7
Other separations ('000)	0.0	0.0	0.2	0.0	5.6	0.0	0.0	0.0	5.8
Patient days ('000)	n.p.	0.0	1.1	0.0	34.2	n.p.	0.1	n.p.	35.4
Total separations other than acute									
Separations ('000)	26.3	38.5	23.6	5.4	10.2	1.3	1.7	0.9	108.0
Patient days	412.5	790.8	307.5	117.0	133.9	39.8	30.8	9.3	1,842.1
Psychiatric separations^(c)									
Separations ('000)	24	18	24	6	7	3	1	1	84
Patient days ('000)	252	287	257	82	91	26	14	10	1,018
Data for excluded hospitals^(e)									
Separations for excluded hospitals ('000) ^(b)	67	28	33	36	26	3	2	0	194
Per cent of all separations (%)	5.1	2.3	4.5	9.8	6.8	3.5	2.2	..	4.6
Expenditure for excluded hospitals (\$m)	849	253	241	255	194	31	2	..	1,825
Inpatient fraction for excluded hospitals	0.64	0.55	0.70	0.76	0.94	0.74	1.00	..	0.68
Unadjusted cost per separation	8,081	5,039	5,119	5,376	7,064	7,957	1,180	..	6,441

(a) Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute and multi-purpose services are excluded from this table, as are some small hospitals with incomplete expenditure information. See Appendix 4 for further information.

(b) Includes same day separations, acute and unspecified care type separations and episodes of newborn care with qualified days.

(c) Separations with total days of psychiatric care equal to the total length of stay.

(d) Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and episodes of newborn care with qualified days, using the 2002–03 AR-DRG v 4.2 cost weights (DoHA 2004). An updated version of this table based on 2003–04 AR-DRG v 4.2 cost weights will be made available on the website when available.

(e) Psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute and multi-purpose services. See Appendix 4 for further information.

.. Not applicable.

Table A3.6: Cost per acute casemix-adjusted separation, subset of selected public acute hospitals^(a), New South Wales, Victoria, Western Australia and South Australia, Tasmania and the Northern Territory 2003–04

	NSW	Vic	WA	SA	Tas	NT
Total separations ('000) ^(b)	1,001	828	330	275	78	70
Total patient days ('000) ^(b)	3,732	2,850	1,141	930	305	214
Acute separations ('000) ^(c)	977	798	325	267	77	69
Acute patient days ('000) ^(c)	3,357	2,253	1,025	819	265	204
Proportion of separations acute	97.6%	96.4%	98.4%	97.2%	98.3%	98.7%
Proportion of patient days acute	90.0%	79.1%	89.8%	88.0%	87.0%	95.6%
Total recurrent expenditure (\$m)						
Subset hospitals	4,912	3,638	1,584	1,051	370	243
Hospitals in Table 4.1	6,400	5,117	1,592	1,362	370	243
Proportion	77%	71%	100%	77%	100%	100%
Total admitted patient expenditure (\$m)						
Subset hospitals	3,401	2,662	1,104	821	264	177
Hospitals in Table 4.1	4,454	3,630	1,109	1,048	264	177
Proportion	76.4%	73.3%	99.5%	78.3%	100.0%	100.0%
Total separations ('000)						
Subset hospitals	1,001	828	330	275	78	70
Hospitals in Table 4.1	1,258	1,160	331	353	78	70
Proportion	79.6%	71.4%	99.7%	77.8%	100.0%	100.0%
Costs relating to acute care separations						
Average cost weight ^(d)	1.045	0.959	1.001	0.987	1.047	0.754
Casemix-adjusted acute separations ('000)	1,021	765	325	264	80	52
Acute IFRAC ^(e)	0.650	0.673	0.670	0.763	0.624	0.700
Total acute patient recurrent expenditure (\$m)	3,193	2,448	1,061	802	231	170
Cost per casemix-adjusted acute separation^(e)	3,262	3,280	3,334	3,152	2,958	3,278
Cost per total casemix-adjusted separation (from Table 4.1)	3,451	3,333	3,422	3,036	3,333	3,377
Cost per total casemix-adjusted separation on subset of hospitals	3,395	3,443	3,415	3,145	3,333	3,377
Percentage this exceeds cost per acute separation for subset hospitals	3.9%	4.7%	2.4%	-0.2%	11.3%	2.9%
Cost of not acute separations in subset (\$m)	208	214	43	19	34	7
Per separation (\$)	8,630	7,153	7,983	2,491	26,073	8,133
Per patient day (\$)	557	359	369	171	845	793

(a) Excludes psychiatric, mothercraft, hospices, small non-acute, un-peered and other hospitals, rehabilitation facilities, and multi-purpose services. This subset excludes hospitals where the IFRAC was equal to the acute IFRAC and more than 1,000 not acute patient days were recorded. Also excludes hospitals where the apparent cost of not acute patients exceeded \$1,000 per day and more than \$1,000,000 of apparent expenditure on non-acute patient days was reported

(b) From the National Hospital Morbidity Database. Separations for which the care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded. Details of acute separations and patient days and non-acute separations and patient are presented in Table A3.5.

(c) Acute separations are separations where the care type is *Acute*, *Newborn* with qualified days, or *Not reported*.

(d) Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and episodes of newborn care with qualified days, using the 2002–03 AR-DRG version 4.2 cost weights (DoHA 2003). An updated version of this table based on 2003–04 AR-DRG v 4.2 cost weights will be made available on the website when available.

(e) The acute IFRAC is that portion of recurrent costs which are for acute admitted patients.

(f) Includes adjustment for private patient medical costs: \$136 for New South Wales, \$81 for Victoria, \$71 for Western Australia and \$111 for South Australia and \$83 for Tasmania.

Table A3.7: Cost per acute non-psychiatric casemix-adjusted separation, subset of selected public acute hospitals^(a), New South Wales, Victoria, Western Australia and Northern Territory, 2003–04

	NSW	Vic	WA	NT
Total separations ('000) ^(b)	1,001	828	330	60
Total patient days ('000) ^(b)	3,732	2,850	1,141	214
Acute non-psychiatric separations ('000) ^(c)	959	787	319	58
Acute non-psychiatric patient days ('000) ^(c)	3,177	2,111	943	168
Proportion of separations acute	95.8%	95.1%	96.5%	97.0%
Proportion of patient days acute	85.1%	74.1%	82.7%	78.6%
Total recurrent expenditure (\$m)				
Subset hospitals	4,912	3,638	1,584	204
Hospitals in Table 4.1	6,400	5,117	1,592	243
Proportion	77%	71%	100%	84%
Total admitted patient expenditure (\$m)				
Subset hospitals	3,401	2,662	1,104	177
Hospitals in Table 4.1	4,454	3,630	1,109	177
Proportion	76.4%	73.3%	99.5%	100.0%
Total separations ('000)^(d)				
Subset hospitals	1,001	828	330	60
Hospitals in Table 4.1	1,258	1,160	331	70
Proportion	79.6%	71.4%	99.7%	84.9%
Costs relating to acute non-psychiatric separations				
Average cost weight ^(e)	1.045	0.959	1.001	0.775
Casemix-adjusted acute non-psychiatric separations ('000)	1,002	755	319	45
Acute non-psychiatric IFRAC ^(f)	0.626	0.652	0.645	0.668
Total acute non-psychiatric patient recurrent expenditure (\$m)	3,075	2,371	1,021	136
Cost per casemix-adjusted acute non-psychiatric separation^(g)	3,228	3,293	3,338	3,132
Cost per total casemix-adjusted separation (from Table 4.1)	3,451	3,333	3,422	3,377
Cost per total casemix-adjusted separation on subset of hospitals	3,395	3,443	3,415	3,365
Percentage this exceeds cost per acute non-psychiatric separation for subset hospitals	4.9%	4.4%	2.3%	6.9%
Cost of not acute non-psychiatric separations in subset (\$m)				
Per separation (\$)	7,675	7,107	7,178	23,165
Per patient day (\$)	587	393	419	900

- (a) Excludes psychiatric, mothercraft, hospices, small non-acute, un-peered and other hospitals, rehabilitation facilities, and multi-purpose services. This subset excludes hospitals where the IFRAC was equal to the acute IFRAC and more than 1,000 not acute patient days were recorded. Also excludes hospitals where the apparent cost of not acute patients exceeded \$1,000 per day and more than \$1,000,000 of apparent expenditure on non-acute patients days was reported. NT data restricted to the two principal referral hospitals.
- (b) From the National Hospital Morbidity Database. Separations for which the care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded. Details of acute separations and patient days and non-acute separations and patient are presented in Table A3.5.
- (c) Acute separations are separations where the care type is *Acute*, *Newborn* with qualified days, or *Not reported*. Psychiatric separations are those with psychiatric care days.
- (d) Separations for which the care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.
- (e) Average cost weight from the National Hospital Morbidity Database, based on acute and unspecified separations and episodes of newborn care with qualified days, using the 2002–03 AR-DRG version 4.2 cost weights (DoHA 2003). An updated version of this table based on 2003–04 AR-DRG v 4.2 cost weights will be made available on the website when available.
- (f) The acute non-psychiatric IFRAC is that portion of recurrent costs which are for acute non-psychiatric admitted patients.
- (g) Includes adjustment for private patient medical costs: \$141 for New South Wales, \$88 for Victoria and \$77 for Western Australia and \$23 for the Northern Territory.

Table A3.8: Count of AR-DRGs v 4.2 contributing to the relative stay index, by sector, and medical/surgical/other type of AR-DRG, states and territories, 2003-04

Type of hospital	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals	639	639	636	636	634	624	621	586	639
Medical	333	333	331	333	331	329	328	322	333
Surgical	275	275	275	273	272	265	263	235	275
Other	31	31	30	30	31	30	30	29	31
Private hospitals	616	624	625	614	602	n.p.	n.p.	n.p.	632
Medical	326	328	328	325	314	n.p.	n.p.	n.p.	332
Surgical	261	265	267	261	260	n.p.	n.p.	n.p.	269
Other	29	31	30	28	28	n.p.	n.p.	n.p.	31
All hospitals	639	639	636	636	634	n.p.	n.p.	n.p.	639
Medical	333	333	331	333	331	n.p.	n.p.	n.p.	333
Surgical	275	275	275	273	272	n.p.	n.p.	n.p.	275
Other	31	31	30	30	31	n.p.	n.p.	n.p.	31

n.p. Not published.

Table A3.9: Separations^(a), by Medicare eligibility status and hospital sector, states and territories, 2003–04

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Medicare eligible	1,318,043	1,186,391	718,328	365,791	378,012	80,826	68,578	69,842	4,185,811
Not Medicare eligible	7,305	725	2,684	899	1,097	92	451	274	13,527
Medicare eligibility not reported	187	413	1	556	0	0	0	0	1,157
Total	1,325,535	1,187,529	721,013	367,246	379,109	80,918	69,029	70,116	4,200,495
Private hospitals									
Medicare eligible	710,762	680,674	609,631	289,409	206,183	n.p.	n.p.	n.p.	2,596,496
Not Medicare eligible	1,377	132	2,937	548	28	n.p.	n.p.	n.p.	5,091
Medicare eligibility not reported	6	0	27,479	236	0	n.p.	n.p.	n.p.	39,110
Total	712,145	680,806	640,047	290,193	206,211	n.p.	n.p.	n.p.	2,640,697
All hospitals									
Medicare eligible	2,028,805	1,867,065	1,327,959	655,200	584,195	n.p.	n.p.	n.p.	6,782,307
Not Medicare eligible	8,682	857	5,621	1,447	1,125	n.p.	n.p.	n.p.	18,618
Medicare eligibility not reported	193	413	27,480	792	0	n.p.	n.p.	n.p.	40,267
Total	2,037,680	1,868,335	1,361,060	657,439	585,320	n.p.	n.p.	n.p.	6,841,192

(a) Separations for which the care type was reported as *Newborn* with no qualified days, and records for *Hospital boarders* and *Posthumous organ procurement* have been excluded.

Note: There is some variation between jurisdictions in the reporting of *Not Medicare eligible* and *Medicare eligibility not reported*.

n.p. Not published.