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Variation in hospital admission policies and practices: Australian hospital statistics

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Variation in hospital admission policies and practices: Australian hospital statistics

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Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601
Tel: (02) 6244 1000
Email: info@aihw.gov.au

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Contents

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  - Australian Private Hospitals Association
  - Department of Human Services
  - Department of Veterans' Affairs
  - Independent Hospital Pricing Authority
  - National Chief Health Information Officers Forum
  - Australian Digital Health Agency
  - National Health Funding Body
  - Productivity Commission
  - Private Healthcare Australia
- Day Hospitals Australia (formerly Australian Day Hospital Association)
- Australian Healthcare and Hospitals Association
- Australian Health Service Alliance
- Bupa
- Hospitals Principal Committee of AHMAC
- Mental Health Information Strategy Standing Committee of AHMAC
- Royal Australasian College of Surgeons
- The Australasian College for Emergency Medicine

The report was authored by Sally Mills, with contributions from Clara Jellie, Jenny Hargreaves and Barbara Gray.

Abbreviations

ABF	Activity Based Funding
ACHI	Australian Classification of Health Interventions
ACT	Australian Capital Territory
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
AN-SNAP	Australian National Subacute and Non-acute Patient Classification
APC	admitted patient care
AR-DRG	Australian Refined Diagnosis Related Groups
ED	emergency department
ENT	ear, nose and throat
ESWT	elective surgery waiting time
HITH	hospital-in-the-home
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
MBS	Medicare Benefits Schedule
METeOR	Metadata Online Registry
NAPEDC	Non-admitted Patient Emergency Department Care
NHISSC	National Health Information Standards and Statistics Committee
NHMD	National Hospital Morbidity Database
NMDS	national minimum data set
NNAPEDCD	National Non-admitted Patient Emergency Department Care Database
NNAPC (agg)D	National Non-admitted Patient Care (aggregate) Database
NSW	New South Wales
NT	Northern Territory
PAF	Performance and Accountability Framework
Qld	Queensland
RMHC	residential mental health care
SA	South Australia
SCN	special care nursery
SSU	short stay unit
Tas	Tasmania
Vic	Victoria

WA	Western Australia

Symbols

—	nil or rounded to zero
. .	not applicable
n.p.	not publishable because of small numbers, confidentiality or other concerns about the quality of the data

Summary

For the last 3 decades, hospital statistics have been compiled by the Australian Institute of Health and Welfare on a national basis. The implementation of national standards and definitions has improved greatly the quality and comparability of hospital data over time; however, differences in definitions and recording still exist. This report describes variation in hospital admission policies and practices and how these differences may be impacting on data reported. Drawing on both quantitative analysis and input from a range of stakeholders, it is a valuable resource for data users interested in understanding more about the comparability of Australia's national hospital data, and how best to use and interpret the data.

Key messages

- The clinical needs of patients are paramount in determining the most appropriate pathway for their care. Variation in admission practice can reflect variation in administrative or funding arrangements rather than the nature of clinical care provided to similar patients.
- For overnight-stay patients, there was limited evidence of hospital admission practice variation, with data consistency and comparability being relatively good.
- Variation in same-day hospital admission was greater, and mostly reflected local admission policies and practices.
- Variation in same-day acute care was particularly identified for (but not limited to) chemotherapy, endoscopy and dialysis.
- Variation in same-day admission practice for subacute care (for example, rehabilitation) was also evident, particularly influenced by different admission practices between the private and public hospital sectors.
- Same-day care provided in private day hospitals may differ from that provided in other private hospitals.

Recommendation

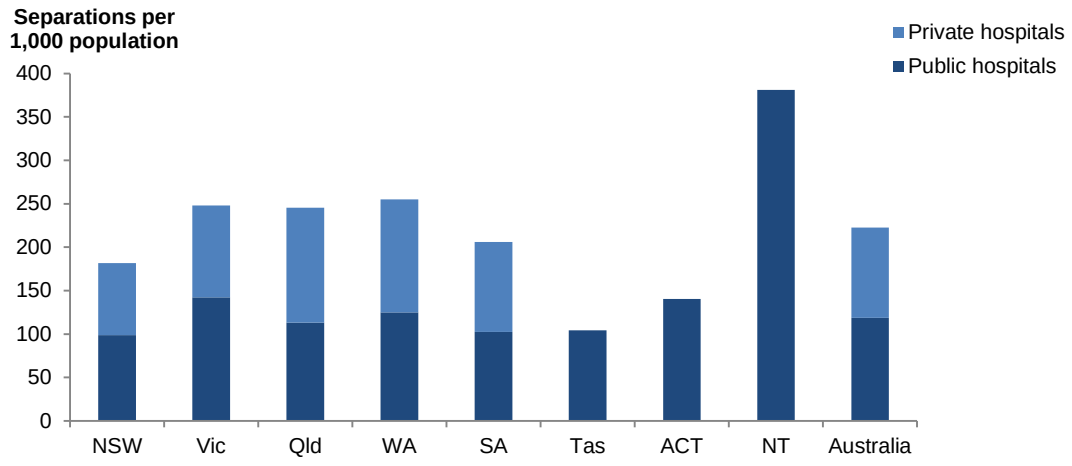
This report is specific to the reporting period 2013–14; the nature and extent of variation identified here may differ from that for other reporting periods, as may the variation in policies and practices that underlie it. For example, a service delivery model may change, a new policy may be introduced, or data quality improvements may be made by jurisdictions and/or individual hospitals. For this reason, there would be value in regularly updating this report (for example, biennially), and conducting a more comprehensive review of admission practice variation less regularly (for example, every 5 years).

Since the conclusion of this work, states and territories have agreed to provide admission and separation time on a best endeavours basis for the national hospital data collection. When these data are available, interpretation of admitted patient activity should be easier because short-stay admissions (for example, admissions less than 4 hours) will be able to be identified. At a national level, stakeholders have also agreed to consider other issues identified in this report as part of ongoing national hospital data development work.

1 Introduction

1.1 Background

Although national definitions for an admission and admitted patient have existed for some years and underpinned the collection of data on admitted patient activity, these have not been sufficient to avoid some variation in the definition and recording of hospital admissions in Australia. For example, in 2013–14, same-day acute separation rates varied across jurisdictions and by hospital sector (Figure 1.1). Although some of this variation could reflect differing needs for care, some is likely to reflect differing choices as to whether care is provided to patients while they are admitted to hospital (and therefore recorded in the data), or in other circumstances.



Note: Data for private hospitals in Tasmania, Australian Capital Territory and the Northern Territory were not published for confidentiality reasons.

Source: AIHW 2015a (Table 2.27).

Figure 1.1: Same-day acute separation rates, public and private hospitals, 2013–14

This report aims to describe variations in admission policies and practices across hospitals in Australia in 2013–14, with the aim of demonstrating how these differences may be impacting on data that are reported. This work was funded by the Australian Health Ministers' Advisory Council (AHMAC), and aimed to improve the comparability and/or interpretability of national hospital data and/or reporting. Key benefits of this work include:

- the compilation of the commonalities and differences in the definition and recording of hospital admissions into a single source
- information to potentially improve measurement or interpretation of national indicators (for performance, quality improvement and benchmarking purposes)
- enhanced documentation on variation in admission practice for inclusion in national reporting outputs and Data Quality Statements.

1.2 Why is this important?

Hospitals are an essential component of the Australian health system. In 2013–14, 40% ($58.8 billion) of all recurrent health expenditure in Australia was for hospitals (AIHW 2015i). In the same period, there were more than 9.7 million separations from hospitals

(AIHW 2015a). High-quality data on hospital activity, which can be used to understand and improve the quality of hospital care, is an important public asset.

For the last 3 decades, hospital statistics have been compiled by the Australian Institute of Health and Welfare (AIHW) on a national basis. The implementation of national standards and definitions has improved greatly the quality and comparability of hospital data over time; however, differences in definitions and recording still exist across hospitals. Many of these differences relate to varied admission policies and practices that result in health-care activity being reflected in relevant data sets in different ways. In addition, the variation is not static, with data often reflecting changes in policies or service delivery models that can occur at varied frequency across jurisdictions, facilities and/or sectors.

Reliable and comparable data are essential in order to draw appropriate conclusions and make effective decisions about the provision of hospital care. For example, robust data are required to guide policy and planning in the management and provision of hospital services, drive improvements in the quality of care, and provide transparency and accountability. National indicators reported for performance or quality improvement purposes are commonly used to understand and evaluate hospital care across states and territories or health service networks; however, the value of these measures will be limited by the comparability of the data on which they are based.

1.3 This report

In addition to this introduction, the report comprises four other chapters. Chapter 2 provides a brief summary of the contextual factors that affect hospital admission practices. Chapter 3 outlines some major areas of variation in the delivery of acute (Section 3.1) and non-acute (Section 3.2) care. Chapter 4 focuses on sources of variation relating to the admission of patients from the emergency department (ED), and Chapter 5 provides a brief summary of the outcomes of this work to date.

This report is specific to the reporting period 2013–14; the nature and extent of variation identified here may differ to that for other reporting periods, as may the variation in policies and practices that underlie it. For example, a service delivery model may change, a new policy may be introduced, metadata may be amended, or data quality improvements may be made by jurisdictions and/or individual hospitals.

At the time of writing, New South Wales did not have an admission policy, but a policy was published just before the release of this report (New South Wales Health 2017). This report has not been updated to reflect that policy, but a broad summary is provided in Table A1.

1.4 Understanding admitted care data

The concept of an ‘admitted patient’ is fundamental to the collection of data in Australia’s major national hospital database, the National Hospital Morbidity Database (NHMD). This database includes data from essentially all public and private hospitals in Australia, and forms a basis of the *Australian hospital statistics* publication series, as well as National Healthcare Agreement performance indicator reporting, the AIHW’s *MyHospitals* website and a range of other reporting outputs. The NHMD is based on data provided by state and territory health authorities for the Admitted patient care national minimum data set (APC NMDS) (<http://meteor.aihw.gov.au/content/index.phtml/itemId/491555>). The AIHW undertakes the collection and reporting of the NHMD under the auspices of the AHMAC through the National Health Information Agreement.

Within the APC NMDS, there are standard, nationally agreed definitions of a hospital admission and admitted patient (Box 1.1). An admission may be formal (representing the commencement of patient treatment and/or care and/or accommodation) or statistical

(representing the commencement of a new episode of care within one hospital stay). These definitions do not stipulate precisely when a patient should be formally admitted. This report focuses primarily on variation in administrative policies and practices that can lead to differences in the count of admitted hospitalisations (formal admissions), although variation in the recording of care type changes (statistical admissions), which will impact the count of admitted activity once defined, is also considered.

The standard definitions of a hospital admission and admitted patient, along with all national metadata standards for health are published in AIHW's Metadata Online Registry (METeOR). Each metadata item in METeOR is provided with a unique identifier (METeOR identifier). Hospitals are defined as health-care facilities established under Commonwealth, state or territory legislation as a hospital or free-standing day procedure unit and authorised to provide treatment and/or care to patients (AIHW 2015a).

Box 1.1: Key definitions

Admission (METeOR identifier 327206)

The process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.

Formal admission:

- The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.

Statistical admission:

- The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay. (AIHW 2015b).

Admitted patient (METeOR identifier 268957)

A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:

- the patient's condition requires clinical management and/or facilities not available in their usual residential environment
- the patient requires observation in order to be assessed or diagnosed
- the patient requires at least daily assessment of their medication needs
- the patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (for example, cardiac catheterisation)
- there is a legal requirement for admission (for example, under child protection legislation)
- the patient is aged nine days or less. (AIHW 2015c)

There is also a definition for **Same-day patient,** in the Glossary.

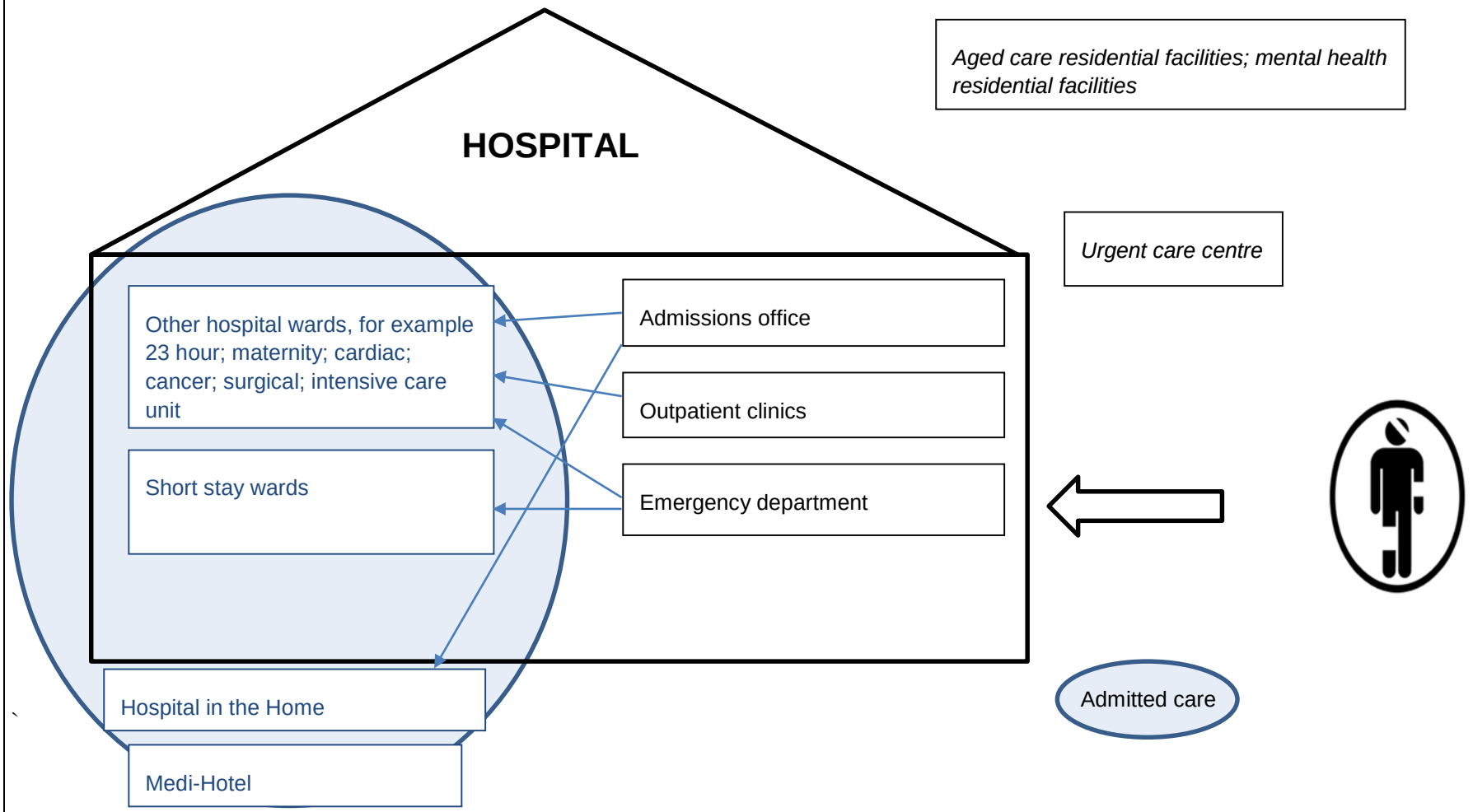
In addition to the APC NMDS, there are several other national minimum data sets that are relevant to this work. For example, there are data sets that overlap with the APC NMDS (such as the Non-admitted Patient Emergency Department Care (NAPEDC) NMDS, which includes data on all presentations to EDs that meet specific criteria, and which includes data on patients who have been admitted but still remain in the ED). There are also minimum data

sets that report data on care provided in other non-admitted settings that may be similar in nature to admitted care in some jurisdictions (for example, the National Residential Mental Health Care NMDS). Data collected specifically for 'Activity Based Funding' purposes are also relevant.

1.5 Pathways to admission

A decision to admit a patient to hospital is made based on the clinical judgment of an appropriate person, usually a medical officer. In some limited circumstances, another health professional (such as a nurse practitioner) may also be approved to make the decision. Although a clinician will still decide whether or not to admit a patient for same-day care, this decision can often be in the context of agreed policies and practices about which setting is the most appropriate for the patient to receive particular types of care and/or treatment.

There are a number of possible pathways a patient may take to formal hospital admission (Figure 1.2). For example, they may be admitted to a short stay unit from the ED, or they may be admitted to a ward from the community. Understanding the many different pathways to hospital admission can assist in highlighting where points of variation in admission practices may take place.



Note: This figure is intended to illustrate possible pathways to formal hospital admission. It is not intended to represent the composition and architecture of all hospitals, or all patient pathways. The number and type of hospital departments, as well as their physical location, will vary across hospitals. For example, not all hospitals have an emergency department.

Figure 1.2: Possible pathways to formal hospital admission

1.6 Sources of variation

There are many sources of variation in hospital admission data. Natural variation in the count of hospital admissions can occur; for example, because of differences in the health status of the population a hospital services or the location of the hospital. There can also be variation due to the data collection process; for example, missing information in hospital records, missing records from services, errors in individual hospital's records, or varied quality of diagnosis coding. Variation in administrative policies and practices (the main focus of this report) can lead to differences in the count of admitted hospitalisations; for example, some hospitals may automatically admit patients for certain procedures or types of care for which others do not generally admit. In addition, variation in care type changes (for example, when an episode of care changes from acute to rehabilitation) can impact the count of admitted activity once defined.

1.7 How variations influence performance reporting

Variation in admission practices may affect the accuracy and coherence of national indicators (for performance reporting and quality improvement purposes). The impact of variation on selected indicators has been highlighted, where relevant, throughout this report. However, Table 1.1 includes a preliminary assessment of reported national indicators that could be affected by variation in hospital admission practices. This list draws on indicators within the National Healthcare Agreement, National Health Performance Framework and Performance and Accountability Framework (PAF). At the time of writing, a review of the National Health Performance Framework and the PAF was underway, therefore the number and nature of indicators reported in the future may change. There is some overlap between the safety and quality indicators in the PAF and the initial set of core, hospital-based outcome indicators recommended for reporting by the Australian Commission on Safety and Quality in Healthcare to support local hospital-level improvement in safety and quality. Where possible, the materiality of variation in practices that may impact an indicator should be noted in reports, if relevant.

Variation in the counting of admissions could also have a range of local and national implications for Activity Based Funding, and are not considered here.

Table 1.1: National indicators that could be influenced by variation in admission policies and practices, National Healthcare Agreement and National Health Performance Framework

Indicator	Description	Comments
National Healthcare Agreement		
PI 17—Treatment rates for mental illness, 2015	Proportion of population receiving clinical mental health services	This indicator reports data by: —public mental health services Individuals recorded on jurisdictional mental health information systems as receiving 1 or more services from state/territory public mental health services, including specialised mental health hospital services, residential mental health care services and community mental health care services. —private Number of individuals receiving specialist psychiatric care in private hospitals with psychiatric beds. —MBS and DVA combined Inclusive of all mental-health-related MBS items and DVA items and includes some ambulatory-equivalent admitted patient mental health service contacts. As currently reported, there is likely to be a considerable over-count of individuals receiving treatment for mental illness, particularly, between the MBS/DVA data and the private hospital data, because most patients accessing private hospital services would access MBS items in association with the private hospital service. The use of statistical linkage would reduce the over-count in the number of people. Variation in admission practices could impact the comparability of data reported within each of the 3 categories above. For example, if the provision of mental health services differs across jurisdictions by hospital sector (for example, similar services are more likely to be provided in private, rather than public, hospitals) or similar services are more likely to be provided as MBS-funded outpatient services rather than same-day inpatient services. The extent to which patients in jurisdictions use services out of scope of the indicator; for example, services provided by private hospitals without designated psychiatric beds would also impact comparability of this indicator. Variation in admission practices would be less likely to impact on the estimate of the total number of clients across all services (if this estimate were available).

(continued)

Table 1.1 (continued): National indicators that could be influenced by variation in admission policies and practices, National Healthcare Agreement and National Health Performance Framework

Indicator	Description	Comments
PI 18—Selected potentially preventable hospitalisations, 2015	Admission to hospital for a condition where the hospitalisation could have potentially been prevented through the provision of appropriate individualised preventative health interventions and early disease management usually delivered in primary care and community-based care settings (including by general practitioners, medical specialists, dentists, nurses and allied health professionals)	This indicator identifies potentially preventable hospitalisations using ICD-10-AM codes. A number of conditions are included in the specification under the categories: vaccine-preventable conditions (for example, influenza, and whooping cough); chronic (asthma, congestive heart failure); and acute (urinary tract infection, cellulitis). Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions. For example, some jurisdictions may admit patients with certain conditions and others may treat them as an outpatient. For example, PPHs for congestive heart failure could be impacted by jurisdictional variation in the provision of admitted cardiac care. For example, an examination procedure such as left ventriculography, is considered an 'automatically admit' procedure on the Victorian and Western Australian 'automatically admit' lists (see Chapter 2), but this procedure is not listed in the PPH spec as a procedure which, when combined with a diagnosis of congestive heart failure, would be considered as a 'valid' or 'potentially not preventable' separation. Data on patients treated in outpatient or emergency departments are not included in this indicator. One possible option that has been suggested to improve the comparability of this indicator is to report overnight separations only, but this is not consistent with the indicator's original intent.
PI 20a—Waiting times for elective surgery (ESWT): waiting time in days		There could be admission practice variation for the types of surgery that is done electively. Theoretically; for example, if cataract extraction was subject to admission practice variation, then there would be flow-on effects for the comparability of ESWT statistics (because they would be based on a different mix of procedures for which people are waitlisted, as opposed to being dealt with in an outpatient setting).
PI 21b—Waiting times for emergency hospital care: Proportion completed within four hours	For all patients presenting to a public hospital emergency department (including publicly funded emergency departments), the percentage of presentations where the time from presentation to physical departure, i.e. the length of the emergency department stay is within four hours	Variation in admission practices for patients admitted from the ED, particularly as short-stay patients could impact this indicator. See 'Short stay admissions from the emergency department' for more information.
PI 22—Healthcare associated infections	*Staphylococcus aureus* bacteraemia (SAB) associated with acute care public hospitals (excluding cases associated with private hospitals and non-hospital care)	The numerator for this indicator is SAB acquired, diagnosed and treated in public acute care hospitals. The SAB episodes reported in the numerator are intended to be associated with both admitted patient care and with non-admitted patient care (including emergency departments and outpatient clinics). Therefore, in theory, variation in admission practices should have less impact than if health-care-associated SAB was associated with admitted care only. The denominator for this indicator is the number of patient days for admitted patient activity, because information on non-admitted activity is not available. The amount of hospital activity that patient days reflect varies among jurisdictions and over time because of variation in admission practices.

(continued)

Table 1.1 (continued): National indicators that could be influenced by variation in admission policies and practices, National Healthcare Agreement and National Health Performance Framework

Indicator	Description	Comments
PI 23—Unplanned hospital readmission rates	Unplanned and unexpected hospital readmissions to the same public hospitals within 28 days for selected surgical procedures	Estimates of readmissions will be influenced by different admission practices, if treatment in an outpatient or emergency department as a non-admitted patient occurs rather than an admitted patient episode. Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
PI 25—Rate of community follow up within first seven days of discharge from a psychiatric admission	Proportion of separations from the mental health service organisation's acute psychiatric inpatient unit(s) for which a community ambulatory mental health service contact, in which the consumer participated, was recorded in the seven days following that separation	This indicator would be influenced by which patients were admitted in the first place.
National Health Performance Framework		
Hospitalisation for injury and poisoning	This indicator measures the number of hospitalisations with a principal diagnosis of injury or poisoning	This indicator could be influenced by jurisdiction's admission policies, particularly the criteria for admission of patients from the ED to an SSU. For example, some jurisdictions may admit patients who are expected to require 2 hours of continuous active management, while other jurisdictions will only admit patients expected to require >4 hours of active care. One possible consequence of this is that patients with less severe injuries or poisoning may be eligible for admission in some jurisdictions and not others.
Selected potentially preventable hospitalisations	See PI 18 above	See PI 18 above
Adverse events treated in hospitals	Adverse events are defined as incidents in which harm resulted to a person receiving health care	The number of separations will depend on the extent to which some 'adverse events' were treated as admitted or non-admitted care in jurisdictions.
Falls resulting in patient harm in care setting	This indicator measures the number of hospitalisations in which a patient was treated for a fall that occurred in hospital	This indicator could be influenced by which patients were admitted in the first place. For example, if hospitals were more likely to admit patients who may have a greater likelihood for a fall due to their profile (e.g. patients attending hospital for rehabilitation care).
Waiting time for emergency department care	See PI 21b above	See PI 21b above
Differential access to hospital procedures		Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions. For example, some procedures in this indicator may be performed as non-admitted care in some jurisdictions and admitted care in other jurisdictions.

(continued)

Table 1.1 (continued): National indicators that could be influenced by variation in admission policies and practices, National Healthcare Agreement and National Health Performance Framework

Indicator	Description	Comments
Performance and Accountability Framework		
Hospital Standardised Mortality Ratio (HSMR) Death in low-mortality Diagnostic Related Groups In-hospital mortality for selected conditions		There are several areas of admission practice variation that can influence these indicators. As discussed in Chapter 4, there are some jurisdictions and/or hospitals where an admitted patient completes the entire treatment and/or care in the emergency department. If these 'admitted' patients die in the emergency department, standardised in-hospital mortality rates of the affected hospitals will be inflated. A similar effect has been noted as a result of variation in admission practices for patients that are dead on arrival at hospital. These issues are mostly relevant to analyses of data before 2012–13, although subsequent examples of admitted episodes of care involving patients who die in the emergency department have been noted. Differences in admission practices could also affect; for example: —national data used in the calculation of indicators such as Death in low-mortality Diagnostic Related Groups (DRGs). Low-mortality DRGs, used to define the indicator, are determined from national data. Some low-mortality DRG codes (for example, gastrointestinal endoscopy and chemotherapy) are subject to admission practice variation. This could impact the type of conditions defined as low-mortality DRG, and the relevance of the measure to some facilities that do not admit for some low-mortality DRG conditions. —the comparability and consistency of variables used to calculate these indicators. For example, a number of data items from the NHMD are used to exclude records from the calculation of the indicators and/or for risk adjustment. These include 'Care type' and 'Urgency of admission'. Some specific issues identified with these data items include: • variation in the way palliative care is coded across jurisdictions, with variation in the allocation of palliative care type and/or the use of the ICD-10-AM diagnosis code 'Palliative care' • variation within and between jurisdictions regarding the coding of 'Urgency of admission' has also been noted (see section 3: *Other issues*).
Unplanned hospital readmission rates for patients discharged following management of selected conditions		See PI 23 above for general summary
Healthcare associated *Staphylococcus aureus* (including MRSA) bacteraemia		See PI 22 above
Rate of community follow up within the first seven days of discharge from a psychiatric admission		See PI 25 above

(continued)

Table 1.1 (continued): National indicators that could be influenced by variation in admission policies and practices, National Healthcare Agreement and National Health Performance Framework

Indicator	Description	Comments
Emergency Department waiting times by urgency category Percentage of Emergency Department patients transferred to a ward or discharged within four hours, by triage category		Variation in admission practices for patients admitted from the ED, particularly as short-stay patients could impact these indicators. See 'Short stay admissions from the emergency department' for more information.
Elective surgery patient waiting times by urgency category		There is an apparent lack of comparability of clinical urgency categories among jurisdictions and hospitals, which could lead to decreased comparability of this indicator if similar procedures are not broadly in the same urgency category, as would be expected. See PI 20a also.
Relative stay index for multi-day stay patients		This indicator could be influenced by variation in care type changes. Substantial variation in the average length of stay for specific Australian Refined Diagnosis Related Groups (AR-DRGs) (for example, related to knee and hip replacements) has been found across hospitals; some of this could be due to variation in practices associated with changing a patient's care type, such as from acute to rehabilitation. See 'Care type changes' for more information.

2 Contextual factors that affect hospital admission

This chapter includes information on high-level contextual factors that affect hospital admission practices in Australia. It includes a discussion on: admission policies; legislation and data standards; models of service delivery; the location of hospitals; and funding models.

2.1 Admission policies, legislation and data standards

State and territory admission policies

All states and territories have developed their own admission policies or guidelines (see Table A1). Broadly speaking, these documents outline rules to ensure that the decision to admit is made consistently, and the associated administrative data are collected in a consistent way. In some jurisdictions, there are separate policies intended to be read in conjunction with the admission policy, such as guidelines relating to short stay units, inter-hospital transfers and hospital in the home. All states and territories also have manuals or specifications outlining definitions and business rules for reporting admitted (and other hospital) data to data sets. Analysis in this report was based on the entire suite of relevant documents available in a state or territory, wherever possible.

At the time of writing, seven jurisdictions (Victoria, Queensland, Western Australia, South Australia, Australian Capital Territory, Tasmania and the Northern Territory) had general hospital admission policies. Separate policies also existed for some individual hospitals in jurisdictions. New South Wales published an admission policy before the release of this report. This report has not been updated to reflect that policy, but a broad summary of the policy is provided in Table A1.

The scope of the policies examined varied across jurisdictions. For example, the admission policy either applied to: all hospitals (public and private) operating in the state or territory; all hospitals where publicly funded care is delivered (that is, public hospitals and private hospitals (public care only); or public hospitals only (including public and private patients).

Legislation and national standards

Commonwealth legislation

Under the *Private Health Insurance Act 2007* the Minister for Health can make Private Health Insurance (Benefit Requirements) Rules. These Rules outline the minimum level of benefits that are payable by private health insurers for hospital treatment (Commonwealth of Australia 2015).

Decisions on whether to admit, or not admit, some patients as same-day cases revolve around explicit inclusions and exclusions for procedures/conditions/services set out by the Commonwealth in the above legislation. In particular, Schedule 3 of the Rules, ‘Same-day accommodation: hospitals in all states/territories’, outlines Type B and Type C procedures, defined by Medicare Benefits Schedule (MBS) item numbers. Type B procedures normally require same-day hospital treatment. Type C procedures do not normally require that a patient be admitted to receive hospital treatment, but they do not preclude a patient from

being admitted. The Rules also include a list of Type A procedures, which normally require overnight care. The nationally agreed definition for same-day patients (see Glossary) refers to these Rules, but requires updating to reflect that private health insurance is now governed under the *Private Health Insurance Act 2007,* not the *National Health Act 1953*.

In broad terms, Type B procedures are procedures that require or include the administration of anaesthesia and/or would need to be undertaken in an 'operating room'. However, there are some exceptions to this; for example, the collection of blood for transfusion, some chemotherapy procedures, and selected ultrasounds.

Hospitals in Australia record procedures and interventions according to the Australian Classification of Health Interventions (ACHI). Although the ACHI was originally based on the MBS—in most cases, the first 5 digits of an ACHI code correspond with a MBS item number—the classification also supports the recording of additional information relating to a procedure. For this reason, there will be additional ACHI codes, beyond the MBS items listed in the Rules, which are conceptually consistent with a Type A or Type B procedure and could therefore be considered to meet the criteria for admission.

In addition to the legislation discussed above, the Australian Government, in collaboration with industry and clinical groups, may also publish guidelines to assist hospitals and health funds in determining private health insurance benefits for private hospital-based care; for example, Guidelines for Recognition of Private Hospital-Based Rehabilitation Services (Department of Health 2015).

State and territory legislation

Jurisdictional legislation which could affect admission practices include:

- mental health legislation

  This can outline the steps that must be taken before involuntarily admitting a patient under a treatment order.

- legislation related to hospital licensing, regulation and/or governance

  This legislation can often define what a hospital is and can stipulate specific instructions about the type of care a patient can be admitted for, particularly in private hospitals. If some private day hospitals are not regarded as a hospital under state and territory legislation they may not supply data to the NHMD; this may be the case for some abortion clinics.

A child protection order (placed under child protection legislation) may also influence the decision to admit a child to hospital.

National standards

As mentioned earlier, there are a number of definitions, agreed by jurisdictions that are included in the APC NMDS. These include: 'Admission' and 'Admitted patient' (see Box 1.1) and 'Same-day patient'. Four jurisdictions—the Australian Capital Territory, Western Australia, Tasmania and the Northern Territory—use the APC NMDS definition of an Admitted patient for their own state/territory criteria for admission, although Western Australia has included one additional criterion related to obstetric care and Northern Territory has provided some additional descriptive text for some criteria. Other jurisdictions have created a separate list of criteria for admission, which is still broadly consistent with the nationally agreed definition of an admitted patient.

The APC NMDS also includes 3 standard data items that relate specifically to the admission component of an episode of admitted care: 'Admission date', 'Admission mode' and 'Admission urgency status'.

2.2 Models of service delivery

Different models of service delivery can impact hospital admission practices, leading to differences in the scope and amount of admitted activity reported. For example, some services are provided as admitted care in some jurisdictions (usually as part of a same-day admission), and non-admitted care in others. Jurisdictions may also implement different clinical pathways for certain types of patients.

2.3 Location of hospital and availability of other health services

The location of a hospital, including the availability and coordination of other health services in the area, could impact hospital admission practices. For example, in more remote hospitals, patients may be admitted for observation in recognition of the long travel time between the patient's home and hospital if their condition was to deteriorate, or similarly patients may be admitted overnight for a procedure that would normally be undertaken on the same day in a less remote region. Northern Territory's admission policy explicitly lists that admission may be warranted for patients living in rural or remote areas, in exceptional circumstances (Northern Territory Department of Health 2015), and other jurisdictions may have similar exceptions.

2.4 Funding models

Public hospitals in Australia are funded on an activity basis (Activity Based Funding—ABF). ABF is a funding model, whereby hospitals get paid for the number and mix of patients they treat (IHPA 2015). Nationally consistent ABF was introduced 1 July 2012 under the National Health Reform Agreement, and since then funding for different types of hospital care has been implemented in stages, starting with funding for acute admitted patients. Before the implementation of ABF nationally, some jurisdictions (for example, Victoria and South Australia) were already funding hospital care on an activity basis.

The classification and counting of patient episodes are 2 critical components of the ABF funding model. Whether or not a patient receives care in the admitted or non-admitted environment will determine how the episode is funded, including the classification used to describe the type of care provided. Variation in the way jurisdictions count and classify patient episodes will therefore impact the implementation of nationally consistent ABF.

Private hospital funding models are a commercial arrangement between private hospitals and health insurers and other funders, with models varying between hospitals. Private insurers and other funders negotiate agreed payment structures within contractual agreements (and consistent with relevant Commonwealth and jurisdictional legislation, where applicable).

3 Admission criteria in detail: points of variation

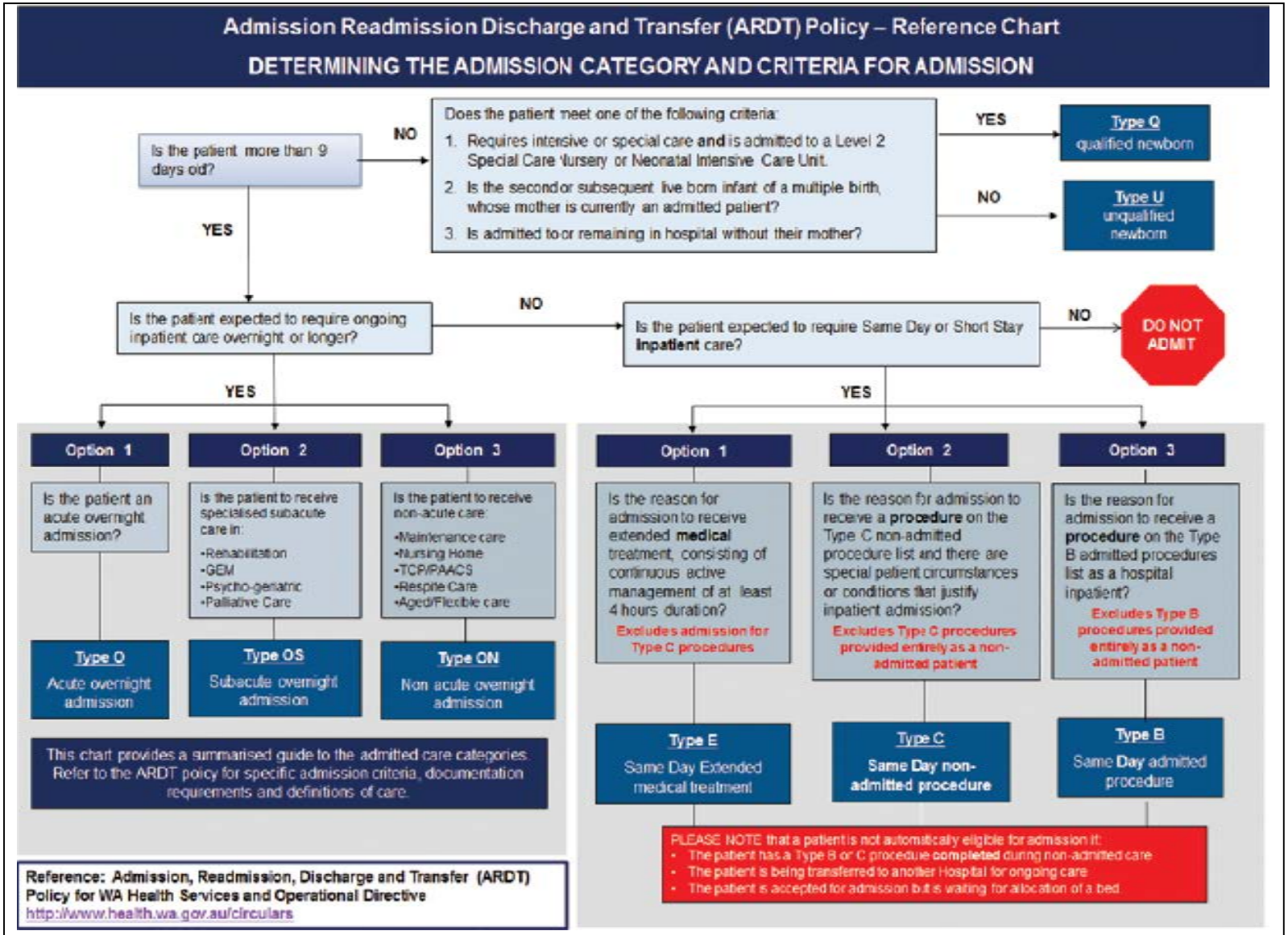
This chapter includes an introductory analysis of the alignment of state and territory hospital admission policies, drawing on available national hospital data where possible. As a starting point, the chapter focuses on those areas of reporting where potential variation in admission practices has already been noted by data custodians and/or users of the data.

The chapter particularly discusses area of variation as they apply to acute admissions (section 3.1), non-acute admissions (section 3.2) and admissions overall (section 3.3), which includes a discussion on mental health-related admissions and hospital-in-the-home care. Most discussion relates to same-day admissions, because it is well-documented in Australian hospital statistics and other hospital reporting products (such as Data Quality Statements) that same-day admissions may not be comparable among states and territories due to variations in admission practices (AIHW 2015a). Jurisdictional audits have also found that inconsistent admission practices are most apparent for patients that require same-day care (SA Health 2013). For mental health, there is also the issue of longer term non-acute public sector care being defined differently in some jurisdictions.

A number of steps can be required to determine a patient's eligibility for admission and how that admission could be recorded or categorised. Figure 3.1 provides an example of this for Western Australia.

Importantly, admission policies do not mandate that every patient who qualifies for admission must be admitted. Although policies stipulate that a patient should meet at least 1 admission criterion in order to be admitted, it is not expected that all patients who qualify for admission are admitted. For example, the medical practitioner may decide that the patient is best treated on an outpatient basis or that a patient could be referred back to the primary care system for management.

While this chapter focuses predominately on differences in jurisdictional admission policies, it is acknowledged that understanding hospitals' compliance with policies is equally important for this work. Where identified, findings from jurisdictional audits have also been considered.



Source: Western Australia Department of Health 2014a.

Figure 3.1: An example of a reference chart to determine admission category and criteria for admission

3.1 Acute care

Same-day admitted care and 'Type B' procedures

As previously mentioned, The Private Health Insurance (Benefit Requirements) Rules 2011 outline specific procedures that are eligible for an insurance benefit. This legislation, with lists of procedures considered to normally require same-day admitted care (Type B) or non-admitted care (Type C), governs decisions about whether or not to admit patients on a same-day basis.

Within the Rules, same-day benefits can also be paid for Type C procedures if a medical practitioner certifies in writing that the admission is justified and in accordance with accepted medical practice (Type C—certified); for example, a patient has multiple comorbidities and requires a higher level of care than could be provided in the non-admitted environment. Type C certified procedures are discussed further later in this report.

The Rules are referenced in all jurisdictional admission policies analysed. Two jurisdictions (Victoria and Western Australia) have developed a list of Type B or 'automatically admit' procedures, based on the Type B procedures in the Rules, for use in their jurisdiction. These lists are generally used as a guide for what episodes of care are reported by hospitals to the jurisdictional health departments as 'admitted', rather than a guide for which types of patients clinicians should admit. The development of the lists involved mapping the MBS item numbers in the Rules to the relevant ACHI codes. Victoria then added any ACHI codes that were not already captured and that were designated as 'operating room' procedure codes in either Version 5 or Version 6 AR-DRGs. Victoria and Western Australia have also developed extended 'Type C' or 'non-admitted' procedure lists, which includes all other ACHI procedures that were not included in their Type B list.

Overall, the Western Australian and Victorian Type B lists were very similar, with inconsistencies across a small number of procedures only (Table A5); for example, percutaneous replacement of heart valves with bioprosthesis, nitric oxide therapy and endoscopic biopsy of kidney were included for one jurisdiction, but not the other.

The next sections focus on variation in admission practices or policies for the following 4 types of procedures: chemotherapy, radiotherapy, endoscopy and dialysis. These procedures were specifically identified by data custodians as procedures for which same-day admissions may not be comparable among jurisdictions.

Chemotherapy

Chemotherapy is defined as the use of drugs (chemicals) to prevent or treat disease, with the term being applied for treatment of cancer rather than for other uses (AIHW 2014a). The AIHW has been advised that the number of episodes of care involving chemotherapy may be an undercount due to the admission processes of public hospitals in New South Wales, South Australia and the Australian Capital Territory. These hospitals generally provide same-day chemotherapy for outpatients on a non-admitted basis. Such non-admitted care can also be provided on the hospital campus, but by private providers and billed to the MBS. In that situation, it may not be regarded as care provided by the hospital, and therefore not reported to the hospitals NMDSs.

In 2013–14, 92% of separations involving chemotherapy occurred on the same day. The age-adjusted same-day separation rate for chemotherapy was 15 per 1,000 population (Table 3.1), but varied more than 4-fold, from 5.7 in New South Wales to 25.3 in Western Australia. Just under two-thirds (65%) of separations occurred in private hospitals, and this

proportion varied across those jurisdictions for which data were published, ranging from 44% in Victoria to 99% in South Australia.

Table 3.1: Same-day separations for chemotherapy by hospital sector, states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals	3,856	86,735	9,078	30,526	315	3,768	900	687	135,865
Private hospitals	43,469	67,724	77,412	34,395	23,975	n.p.	n.p.	n.p.	253,056
All hospitals	**47,325**	**154,459**	**86,490**	**64,921**	**24,290**	**n.p.**	**n.p.**	**n.p.**	**388,921**
				Separations per 1,000 population					
Public hospitals	0.5	13.9	1.9	11.9	0.2	5.9	2.4	3.5	5.4
Private hospitals	5.2	10.6	15.5	13.4	11.9	n.p.	n.p.	n.p.	9.9
All hospitals	**5.7**	**24.5**	**17.4**	**25.3**	**12.1**	**n.p.**	**n.p.**	**n.p.**	**15.3**
Proportion in private hospitals (%)	91.9	43.8	89.5	53.0	98.7	n.p.	n.p.	n.p.	65.1

Notes

1. Includes any same-day separation with a procedure in Block 1920 'Administration of pharmacotherapy', involving use of an antineoplastic agent.
2. Separation rates were directly age-standardised to the 2001 Australian population standard, using 5-year age groups.
3. Data for private hospitals in Tasmania, the Australian Capital Territory (ACT) and the Northern Territory were not published for confidentiality reasons. However, the figures are included in the national totals.
4. Excludes admissions for newborns without qualified days, hospital boarders and posthumous organ procurement.
5. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of NHMD.

In hospital data, chemotherapy specifically designed to prevent the growth of cancer (antineoplastic) is described by a set of codes within the ACHI block 1920 'Administration of pharmacotherapy' with an extension -00 'Antineoplastic agent'. In the MBS, item numbers related to chemotherapy are located within the subgroup, 'Chemotherapeutic procedures', in the Therapeutic procedures category. Table A6 provides a comparison of the chemotherapy ACHI codes included in the Type B lists developed by Victoria and Western Australia. In summary, antineoplastic pharmacological agents administered via intravenous, intra-arterial and intracavitary routes all qualify a patient for same-day admission under the Rules. This is consistent with Victorian and Western Australian policies, with the exception of intra-arterial administration (which does not qualify for admission in those jurisdictions) and administration into spinal canal (intrathecal) (which does qualify).

Information on the type of outpatient care provided by activity-based-funded public hospitals is collected in the National Non-admitted Patient Care (aggregate) Database (NNAPC (agg) D). In this collection non-admitted service events are classified according to the type of clinician who provided the service and the nature of the service provided (Tier 2 Non-Admitted Services classification: IHPA 2015). Episodes of care recorded in this collection may be funded by the MBS.

In 2013–14, there were around 218,000 individual service events for the Tier 2 clinic category, Medical oncology (treatment) (Table 3.2). In Table 3.2, the jurisdictions are listed in population order, so we would expect a decreasing number of episodes from left to right if there was a similar rate of outpatient events (that is, number of service events per person) across the states and territories. Although this collection does not comprehensively cover all public hospital non-admitted patient care, these data (considered with the data above) suggest that chemotherapy is being predominately provided as non-admitted care in public hospitals in New South Wales, for example, and as admitted patient care in Victoria.

Table 3.2: Individual service events (aggregate data) for Tier 2 outpatient clinic, medical oncology (treatment), states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
10.11 Medical oncology (treatment)	144,159	3,091	21,154	6,206	35,626	1,124	999	5,401	217,760

Notes

1. Medical oncology (treatment) is defined as a specialist clinic dedicated to the treatment of tumour cells through drugs or other medical treatments including chemotherapy (IHPA 2013).
2. For 2013–14, the scope of the NNAPC(agg)D was non-admitted patient service events involving non-admitted patients in activity-based funded hospitals. Not all hospitals are activity-based funded, because some receive 'block grant funding'.
3. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW 2015d (Table 3.9).

Radiotherapy

Radiotherapy uses radiation, such as X-rays, to kill or damage cancer cells and stop them growing (Cancer Australia 2015). Around 40% of radiotherapy procedures in the ACHI qualify for hospital admission under the Rules (as either a Type A or Type B procedure) and these were all included consistently in the Western Australia and Victorian lists. These include procedures within the ACHI Block 1789, 'Other Megavoltage radiation treatment' and procedures where an implant with a radioactive source is inserted into the body (brachytherapy) (Table A8).

In 2013–14, there were just under 3,700 same-day separations involving radiotherapy procedures; these constituted one quarter of all separations involving radiotherapy. The age-adjusted same-day separation rate for radiotherapy was 0.1 per 1,000 population, and rates were very similar across jurisdictions (Table 3.3). Just over 40% of same-day separations occurred in private hospitals, with this proportion varying from 3% in Western Australia to 70% in New South Wales.

Of the 3,659 same-day separations, 66% were not listed as a Type A or Type B procedure in the rules (Table 3.3). The variation in inclusion of separations that would not usually qualify could represent admission practice variation (for example, comparing South Australia with the larger states). However, the numbers are relatively small and may represent variation in the type of patients involved. For example, some children require an anaesthetic to receive radiotherapy and this would qualify the patient for admission, regardless of the radiotherapy procedure being undertaken.

Table 3.3: Same-day separations with radiotherapy procedure[(a)] by hospital sector, states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Separations				
Public hospitals	535	1,020	315	186	94	5	n.p.	n.p.	2,157
Private hospitals	1,223	49	62	5	148	n.p.	n.p.	n.p.	1,502
All separations	**1,758**	**1,069**	**377**	**191**	**242**	**n.p.**	**n.p.**	**n.p.**	**3,659**
Separations per 1,000 population[(b)]	**0.2**	**0.2**	**0.1**	**0.1**	**0.1**	**n.p.**	**n.p.**	**n.p.**	**0.1**
Proportion in private hospitals	69.6	4.6	16.4	2.6	61.2	n.p.	n.p.	n.p.	41.0
					Separations that would not usually qualify for admission				
Separations that would not usually qualify for admission[(c)]	1,431	556	264	102	38	n.p.	n.p.	n.p.	2,396
Proportion that would not usually qualify (%)	81.4	52.0	70.0	53.4	15.7	15.0	100.0	100.0	65.5

(a) Includes separations with a radiotherapy procedure (Chapter 18 of ACHI 8th edition).

(b) Separation rates were directly age-standardised to the 2001 Australian population standard, using 5-year age groups. Separate rates for public and private hospitals were not calculated due to small numbers.

(c) Includes separations without any of the radiotherapy procedures that would usually qualify for hospital admission under The Private Health Insurance (Benefit Requirements) Rules 2011; that is, a procedure that is not listed as Type A or Type B. See Table A8 for a full list of these codes.

Notes

1. Data for private hospitals in Tasmania, the Australian Capital Territory (ACT) and the Northern Territory were not published for confidentiality reasons. However, the figures are included in the national totals.
2. Excludes admissions for newborns without qualified days, hospital boarders and posthumous organ procurement.
3. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of NHMD.

In 2013–14, there were around 622,000 individual service events for the Tier 2 clinic category, 'Radiation oncology (treatment)' (Table 3.4). No service events were reported for Tasmania or the Northern Territory, and relatively few for Queensland. This variation may represent variation in reporting of this activity (especially for Tasmania and the Northern Territory) rather than variation in admission practices.

Table 3.4: Individual service events (aggregate data) for Tier 2 outpatient clinic, Radiation oncology (treatment), states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
10.12 Radiation oncology (treatment)	250,764	188,335	18,225	86,207	51,383	0	26,325	0	621,239

Notes

1. Radiation oncology (treatment) is defined as simulation, planning and/or treatment of patients using X-rays, radioactive substances and other forms of radiant energy to lyse or destroy tumour cells (IHPA 2013).
2. For 2013–14, the scope of the NNAPC (agg)D was non-admitted patient service events involving non-admitted patients in activity-based funded hospitals. Not all hospitals are activity-based funded, because some receive 'block grant funding'.
3. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW 2015d (Table 3.9).

Endoscopy

Endoscopy is a procedure used to examine parts of the body visually. A tiny camera on the end of a long tube (endoscope) is inserted directly into the body. Endoscopy can be used to examine many different parts of the body, such as the gastrointestinal tract, kidney or bladder. NHISSC has noted that certain endoscopic procedures may be performed as same-day admitted care in some jurisdictions, and outpatient, non-admitted care in others.

There were 447 ACHI 8th edition codes which involved endoscopy, including a broad range of procedures such as arthroscopy, laparoscopy and pyeloscopy. Most of the 447 codes were included consistently in the Victorian and Western Australian 'automatically admit' lists (Table A7). Only a very small proportion (under 3%) was not included in either jurisdictional list; for example, otoscopy (endoscopy of the ear), panendoscopy via camera capsule, and colposcopy. Codes in scope of one jurisdiction's list and not the other included: some procedures involving endoscopic administration of an agent; endoscopic procedures involving rectal prosthesis; endoscopic procedures involving colonic prosthesis; and laparoscopic gastric bypass.

In the analysis of NHMD data below (Table 3.5), endoscopy separations were defined as separations that involved an endoscopic procedure included in one or both of the jurisdictional 'automatically admit' lists (436 ACHI codes in total). Data were grouped according to the main anatomical regions involved in the procedure so as to align with data on related Tier 2 clinic activity in the NNAPC (agg)D.

Table 3.5: Same-day separations with an endoscopy[(a)] per 1,000 population, by hospital sector, states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Gastrointestinal									
Public hospitals	8.2	11.5	3.8	14.3	2.1	8.4	6.3	10.3	8.3
Private hospitals	22.7	30.4	29.7	21.1	20.8	n.p.	n.p.	n.p.	25.3
All hospitals	30.9	41.9	33.5	35.4	22.9	n.p.	n.p.	n.p.	33.6
All hospitals (number)	250,345	257,304	164,742	91,391	44,058	n.p.	n.p.	n.p.	834,319
Proportion in private hospitals	73.7	72.6	88.9	59.8	91.3	n.p.	n.p.	n.p.	75.5
Urological/gynaecological									
Public hospitals	3.7	5.6	3.3	4.6	4.6	3.7	4.4	3.5	4.3
Private hospitals	5.1	6.0	6.0	6.2	5.1	n.p.	n.p.	n.p.	5.6
All hospitals	8.8	11.6	9.3	10.9	9.7	n.p.	n.p.	n.p.	9.9
All hospitals (number)	69,702	69,903	44,423	27,522	18,134	n.p.	n.p.	n.p.	240,020
Proportion in private hospitals	58.7	51.2	64.5	57.7	53.2	n.p.	n.p.	n.p.	57.0
Orthopaedic									
Public hospitals	0.6	0.9	0.4	0.8	1.2	0.6	0.5	0.7	0.7
Private hospitals	2.5	2.7	2.7	3.2	4.9	n.p.	n.p.	n.p.	2.9
All hospitals	3.1	3.6	3.1	4.1	6.1	n.p.	n.p.	n.p.	3.6
All hospitals (number)	23,947	21,280	15,055	10,535	11,004	n.p.	n.p.	n.p.	85,596
Proportion in private hospitals	81.2	75.9	86.4	79.5	80.0	n.p.	n.p.	n.p.	80.5

(continued)

Table 3.5 (continued): Same-day separations with an endoscopy[(a)] per 1,000 population, by hospital sector, states and territories, 2013–14

Respiratory/ENT									
Public hospitals	0.6	0.9	1.0	0.4	0.4	0.7	0.5	0.5	0.7
Private hospitals	0.9	0.5	0.9	0.4	0.8	n.p.	n.p.	n.p.	0.7
All hospitals	1.5	1.5	1.9	0.9	1.2	n.p.	n.p.	n.p.	1.4
All hospitals (number)	11,052	8,865	9,170	2,241	2,061	n.p.	n.p.	n.p.	34,463
Proportion in private hospitals	58.8	36.1	48.9	50.5	71.3	n.p.	n.p.	n.p.	49.7
Other									
Public hospitals	0.1	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.0
Private hospitals	0.4	0.4	0.4	1.2	0.7	n.p.	n.p.	n.p.	0.5
All hospitals	0.4	0.5	0.5	1.2	0.7	n.p.	n.p.	n.p.	0.5
All hospitals (number)	3,575	2,883	2,298	3,002	1,419	n.p.	n.p.	n.p.	13,452
Proportion in private hospitals	88.6	96.2	96.1	99.1	92.6	n.p.	n.p.	n.p.	94.2
All separations									
Public hospitals	**12.9**	**18.7**	**8.4**	**20.0**	**8.2**	**13.1**	**11.6**	**14.8**	**13.8**
Private hospitals	**31.4**	**39.6**	**39.3**	**31.9**	**32.0**	**n.p.**	**n.p.**	**n.p.**	**34.6**
All hospitals	**44.3**	**58.2**	**47.7**	**51.9**	**40.2**	**n.p.**	**n.p.**	**n.p.**	**48.4**
All hospitals (number)[(b)]	**355,031**	**355,722**	**232,914**	**133,454**	**75,978**	**n.p.**	**n.p.**	**n.p.**	**1,194,528**
Proportion in private hospitals	**71.1**	**68.1**	**82.7**	**61.7**	**80.5**	**n.p.**	**n.p.**	**n.p.**	**71.8**

(a) Includes separations with an endoscopic procedure. See Appendix Table A7 for a full list of the codes and their category for analysis.

(b) A procedure is counted once for the group if it has at least 1 procedure reported within the group. As more than 1 procedure can be reported for each separation, the data are not additive and therefore the totals in the table may not equal the sum of counts in rows.

Notes

1. Separation rates were directly age-standardised to the 2001 Australian population standard, using 5-year age groups.
2. Data for private hospitals in Tasmania, the Australian Capital Territory (ACT) and the Northern Territory were not published for confidentiality reasons. However, the figures are included in the national totals.
3. Excludes admissions for newborns without qualified days, hospital boarders and posthumous organ procurement.
4. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of NHMD.

In 2013–14:

- There were around 1.2 million same-day separations involving an endoscopy, with 72% of these occurring in private hospitals. Private hospital activity is likely to be influenced by the location of private day hospitals specialising in endoscopy, as well as commercial arrangements between private hospitals and health insurers and other funders. For those jurisdictions for which data were published, age-adjusted separations rates ranged from 40 separations per 1,000 population in South Australia to 58 per 1,000 population in Victoria.
- Separations involving a gastrointestinal endoscopy were most common (34 per 1,000 population), followed by urological/gynaecological (10 per 1,000 population).
- For separations involving a gastrointestinal endoscopy, rates across jurisdictions ranged from 23 separations per 1,000 population in South Australia to 42 per 1,000 population in Victoria.

- Orthopaedic endoscopy rates ranged from 3 separations per 1,000 population (Queensland and New South Wales) to 6 separations per 1,000 population in South Australia.
- Other endoscopy rates (for example, involving the nervous or cardiovascular systems) ranged from 0.4 separations per 1,000 population (New South Wales) to 1.2 separations per 1,000 population (Western Australia), with almost all these separations occurring in private hospitals.

Further work examining the extent to which the variation in public hospital rates is not accounted for by private sector provision would be beneficial.

Table 3.6 shows individual service events for Tier 2 outpatient clinics involving endoscopy; the relatively high number of jurisdictions with no events recorded, particularly for the clinics, for 'Endoscopy–orthopaedic' (10.08) and 'Endoscopy–respiratory/ENT' (10.09) suggests that there may be variation in the reporting of this activity by jurisdictions. These data, together with those presented above do not suggest any clear pattern regarding admission practices for different types of endoscopy. However, the relatively high number of service events for 'Endoscopy–gastrointestinal' (10.06) clinics in New South Wales and South Australia compared with other jurisdictions, and the relatively low corresponding separation rates for these jurisdictions suggest that gastrointestinal endoscopy could be more likely to be provided as non-admitted care in New South Wales and South Australia than in other jurisdictions. This could also be the case for urological/gynaecological endoscopy, particularly for New South Wales.

Table 3.6: Individual service events (aggregate data) for Tier 2 outpatient clinic classes involving endoscopy, states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
10.06 Endoscopy—gastrointestinal[(a)]	51,293	5,562	3,256	70	13,647	44	3,305	0	77,177
10.07 Endoscopy—urological/gynaecological[(b)]	14,572	5,362	3,005	4,056	4,975	2,023	0	719	34,712
10.08 Endoscopy—orthopaedic[(c)]	0	0	132	0	0	0	0	1	133
10.09 Endoscopy—respiratory/ENT[(d)]	984	5	294	291	669	0	0	0	2,243

(a) Includes oesophagoscopy, gastroscopy, colonoscopy, duodenoscopy, sigmoidoscopy.

(b) Includes cystoscopy, hysteroscopy, colposcopy.

(c) Includes arthroscopy.

(d) Includes bronchoscopy, medical thoracoscopy, fibre optic examination of the nasopharynx and larynx, nasendoscopy, sinoscopy, otoscopy, endobronchial ultrasound guided biopsy, dilatation of tracheal stricture, bronchial or bronchoalveolar lavage, fine needle aspiration, removal of aspirated foreign bodies.

Notes

1. For 2013–14, the scope of the NNAPC(agg)D was non-admitted patient service events involving non-admitted patients in activity-based funded hospitals. Not all hospitals are activity-based funded, because some receive 'block grant funding'.
2. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW 2015d (Table 3.9) and AIHW unpublished analysis of the NNAPC(agg)D.

Dialysis

Dialysis is an artificial way of removing waste substances from the blood (Kidney Health Australia 2007). In 2013–14, the age-adjusted same-day separation rate for dialysis was 52 per 1,000 population. For those jurisdictions for which data were published, rates ranged from 45 separations per 1,000 population (New South Wales and South Australia) to 75 per 1,000 in Western Australia (Table 3.7). However, Western Australian data may include some double counting of episodes involving inter-hospital contracted care, because the activity is recorded by both (contracted and contracting) hospitals. Just under 20% of same-day separations occurred in private hospitals, with this proportion varying from 10% in New South Wales to 43% in Western Australia.

When dialysis is undertaken as non-admitted care (either in the home or hospital setting), it is generally captured as an outpatient service event. Table 3.8 shows individual service events for outpatient clinics involving dialysis. These data, considered with those in Table 3.7, do not show a clear pattern regarding admission practice for dialysis. For example, the data for New South Wales, suggest that dialysis is more likely to be performed as non-admitted care compared with other jurisdictions.

Table 3.7: Same-day separations for dialysis[(a)] by hospital sector, states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					Separations				
Public hospitals	336,261	291,612	171,364	109,711	67,452	16,344	22,587	60,156	1,075,487
Private hospitals	35,502	41,553	61,474	81,312	21,953	n.p.	n.p.	n.p.	n.p.
All separations	371,763	333,165	232,838	191,023	89,405	n.p.	n.p.	n.p.	1,317,281
Separations per 1,000 population[(b)]	**44.5**	**52.9**	**47.6**	**75.3**	**44.6**	**n.p.**	**n.p.**	**n.p.**	**52.3**
Proportion in private hospitals (%)	9.5	12.5	26.4	42.6	24.6	n.p.	n.p.	n.p.	<25.0

(a) Includes separations with either haemodialysis (ACHI block 1060) or peritoneal dialysis (ACHI block 1061) recorded.

(b) Separation rates were directly age-standardised to the 2001 Australian population standard, using 5-year age groups. Separate rates for public and private hospitals were not calculated due to small numbers.

Notes

1. Data for private hospitals in Tasmania, the Australian Capital Territory and the Northern Territory were not published for confidentiality reasons. However, the figures are included in the national total for Australia.
2. Excludes admissions for newborns without qualified days, hospital boarders and posthumous organ procurement.
3. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of NHMD.

Table 3.8: Individual service events (aggregate data) for Tier 2 outpatient clinic classes involving dialysis, states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
10.10 Renal dialysis—hospital delivered	19,326	410	1	279	0	0	0	9,226	29,242
10.15 Renal dialysis—haemodialysis— home delivered	66,177	27,721	54,358	14,601	2,800	0	0	0	165,657
10.16 Renal dialysis—peritoneal dialysis—home delivered	313,666	170,131	165,880	76,614	29,767	0	0	0	756,058

Note: At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system wide review of ACT Health data and reporting, which will be finalised 31 March 2018

Source: AIHW 2015d (Table 3.9) and AIHW unpublished analysis of the NNAPC (agg)D.

Although data for home dialysis patient education and training is not considered in this report, there may be some variation with the provision of this care across states and territories, with care being provided as either admitted or non-admitted.

Other possible areas of variation

Other areas of possible acute same-day variation that have been identified by stakeholders include:

- The management of vascular access devices commonly used for extended periods, such as a Hickman line or a porta-a-catheter. These devices require regular flushing and checking, which could be undertaken in the admitted or non-admitted setting, depending on the jurisdiction and/or facility.
- Other procedures and/or care such as: eye injections used to treat macular degeneration; the insertion and/or management of intrauterine contraceptive devices; antenatal care and/or screening; angiography; telehealth consultations; transcranial magnetic stimulation therapy (used to evaluate and/or treat neurological conditions); electroconvulsive therapy (see also ‘Mental health-related care’ on page 30); administration of pharmacotherapy and/or blood products for conditions such as Crohn’s diseases and multiple sclerosis; and battery and/or electrode replacements for pacemakers.

Table A9 shows procedures reported for the 20 most common ACHI procedure blocks for same-day acute separations.

3.2 Non-acute care

This section focuses on admission practices relating to non-acute care, in particular rehabilitation care.

Rehabilitation

Rehabilitation same-day admissions

Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or

participation restriction due to a health condition. Common reasons for rehabilitation include osteoarthritis (arthrosis) of the knee and hip.

Table 3.9: Rehabilitation separations[(a)], by hospital sector, same-day or overnight, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Same-day separations	12,587	46	12,110	36	6,341	6	585	3	31,714
Overnight separations	26,509	15,581	12,058	7,100	3,923	889	1,072	245	67,377
Total	39,096	15,627	24,168	7,136	10,264	895	1,657	248	99,091
Rate (number per 1,000)	4.5	2.4	5.0	2.8	5.1	1.4	4.6	1.5	3.8
Proportion same-day	32.2	0.3	50.1	0.5	61.8	0.7	35.3	1.2	32.0
Private hospitals									
Same-day separations	130,594	43	32,791	728	17,593	n.p.	n.p.	n.p.	191,173
Overnight separations	21,798	21,514	10,434	3,824	4,701	n.p.	n.p.	n.p.	64,394
Total	152,392	21,557	43,225	4,552	22,294	n.p.	n.p.	n.p.	255,567
Rate (number per 1,000)	17.4	3.2	8.8	1.8	10.5	n.p.	n.p.	n.p.	9.7
Proportion same-day	85.7	0.2	75.9	16.0	78.9	n.p.	n.p.	n.p.	74.8
All hospitals									
Same-day separations	143,181	89	44,901	764	23,934	n.p.	n.p.	n.p.	222,887
Overnight	48,307	37,095	22,492	10,924	8,624	n.p.	n.p.	n.p.	131,771
Total	**191,488**	**37,184**	**67,393**	**11,688**	**32,558**	**n.p.**	**n.p.**	**n.p.**	**354,658**
Rate (number per 1,000)	**21.9**	**5.6**	**13.8**	**4.6**	**15.6**	**n.p.**	**n.p.**	**n.p.**	**13.6**
Proportion in private hospitals	79.6	58.0	64.1	38.9	68.5	n.p.	n.p.	n.p.	72.1
Proportion same-day	74.8	0.2	66.6	6.5	73.5	n.p.	n.p.	n.p.	62.8
All separations[(b)]	2,871,332	2,488,678	2,071,130	1,070,399	725,614	n.p.	n.p.	n.p.	9,702,304

(a) Admissions with a care type of Rehabilitation care.

(b) Excludes admissions for newborns without qualified days, hospital boarders and posthumous organ procurement.

Notes

1. Data for private hospitals in Tasmania, the Australian Capital Territory (ACT) and the Northern Territory were not published for confidentiality reasons. However, the figures are included in the national totals.
2. Separation rates were directly age-standardised to the 2001 Australian population standard, using 5-year age groups.
3. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of NHMD. See also AIHW 2015a (Table 4.6).

In 2013–14:

- Around 355,000 separations were reported for rehabilitation care, with the proportion of admitted patient care that was rehabilitation care ranging from 1% of all separations in Western Australia to 7% of separations in New South Wales (Table 3.9).

- Separation rates for rehabilitation ranged from 5 separations per 1,000 population in Western Australia to 22 separations per 1,000 population in New South Wales.
- The majority (72%) of separations for rehabilitation occurred in private hospitals. This pattern was consistent across all states and territories for which data was published, with the exception of Western Australia, where 39% of separations occurred in private hospitals.
- Almost two-thirds (63%) of all separations for rehabilitation occurred on the same day. However, this proportion varied greatly among jurisdictions, ranging from less than 1% in Victoria to 75% in New South Wales.
- Compared with other jurisdictions, the proportion of same-day separations for rehabilitation care was relatively low for Victoria and Western Australia (0.2% and 7%, respectively).

The most frequently reported procedures for rehabilitation care separations included physiotherapy, occupational therapy and hydrotherapy (AIHW 2015a: Table 5.23). Some procedures were predominately performed in private hospitals such as hydrotherapy and exercise therapy.

Rehabilitation outpatient care

Rehabilitation is also provided as non-admitted care in public and private hospitals, and in other health service settings, such as private physiotherapy practices. In public hospitals, outpatient rehabilitation services occur mainly in clinics where services are provided by an allied health professional or clinical nurse specialist (allied health and/or clinical nurse specialist intervention) but can also be provided as part of medical consultations provided by a general physician or medical specialist (medical consultation). Table 3.10 lists the Tier 2 outpatient clinic types that provide services that could be similar to some rehabilitation care provided for admitted patients; however, some rehabilitation could also be provided within other Tier 2 clinics. Table 3.10 includes data for both individual and group service events, because many rehabilitation services are also provided in the group setting.

Table 3.10: Individual and group service events (aggregate data) for selected Tier 2 outpatient clinic classes, public hospitals, states and territories, 2013–14

Tier 2 outpatient clinic type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Individual service events									
Medical consultations									
20.47 Rehabilitation	70,923	19,913	5,005	6,034	6,437	2,204	119	1,679	112,314
Allied health and/or clinical nurse specialist interventions									
40.05 Hydrotherapy	38,087	5,059	3,069	5,620	20	1,086	1,114	0	54,055
40.06 Occupational therapy	84,917	82,618	86,185	104,970	14,325	5,261	12,895	3,261	394,432
40.09 Physiotherapy	273,913	168,317	227,357	231,972	96,768	49,590	33,223	7,873	1,089,013
40.11 Social work	69,066	43,439	48,752	54,844	12,159	1,840	18,547	79	248,726
40.12 Rehabilitation	49,510	489,900	3,856	82,298	1,722	1,178	2,928	19	631,411
40.18 Speech pathology	84,911	17,907	36,686	29,192	6,076	5,076	2,525	752	183,125
40.21 Cardiac rehabilitation	78,043	5,130	10,560	17,865	4,837	7,050	22	0	123,507
40.23 Nutrition/dietetics	51,840	53,640	55,832	40,826	15,282	7,163	8,427	2,153	235,163
40.29 Psychology	19,268	11,625	22,999	0	2,493	2,092	2,445	231	61,153
40.31 Burns	631	52	3,934	8,663	2,468	6	75	2,029	17,858
Group service events									
Medical consultations									
20.47 Rehabilitation	3,834	1,266	0	0	0	0	0	93	5,193
Allied health and/or clinical nurse specialist interventions									
40.05 Hydrotherapy	31,491	11,674	5,894	622	2,053	0	0	0	51,734
40.06 Occupational therapy	6,295	1,907	5,606	10,731	214	41	204	101	25,099
40.09 Physiotherapy	27,109	31,347	22,825	67,440	25,296	1,819	9,132	274	185,242
40.11 Social work	638	237	632	1,925	291	41	197	0	3,961
40.12 Rehabilitation	7,894	93,907	99	3,062	1	0	6,639	0	111,602
40.18 Speech pathology	5,160	1,039	2,210	3,908	2,732	22	10	0	15,081
40.21 Cardiac rehabilitation	33,586	1,236	8,583	2,142	3,528	0	1,106	0	50,181
40.23 Nutrition/dietetics	2,007	864	2,556	1,418	70	196	728	0	7,839
40.29 Psychology	2,259	0	607	0	351	113	151	0	3,481
40.31 Burns	0	0	0	0	0	0	0	0	0

Notes

1. For 2013–14, the scope of the NNAPC(agg)D was non-admitted patient service events involving non-admitted patients in activity-based funded hospitals. Not all hospitals are activity-based funded, because some receive 'block grant funding'.
2. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of NNAPC(agg)D.

In 2013–14, there were around 860,500 individual and group service events provided by public hospitals for the Tier 2 clinics 'Rehabilitation' (20.47 and 40.12). In 2013–14, just over two-thirds of these events occurred in Victorian public hospitals.

For those patients who do not require overnight inpatient care, rehabilitation care may be provided through day, half-day or sessional therapy programs. The data provided in this section suggest that these types of episodes could be categorised differently in different states and territories and/or different hospital sectors, with similar rehabilitation care being provided in both admitted and non-admitted settings depending on the location. For example:

- Under licensing provisions for private facilities, care provided as part of a rehabilitation care program is approved by the Queensland Government as an appropriate same-day hospital admission.
- In Victoria, generalised allied health interventions (ACHI Block 1916) that are commonly associated with rehabilitation care are included on the 'Not automatically qualified for Admission List', which applies to both public and private Victorian hospitals.
- According to the Western Australian, Admission, Readmission, Discharge and Transfer Policy, in Western Australia, patients requiring admitted rehabilitation care are expected to require admission for 2 or more days.
- The Guidelines for Recognition of Private Hospital-Based Rehabilitation Services (Department of Health 2015) require that all half- and full-day rehabilitation be admitted in private hospitals, when some jurisdiction admission policies (for example, Victoria and Western Australia) do not allow same-day rehabilitation to be admitted.

In addition, some of the variation in same-day admitted rehabilitation care data is driven by factors related to the supply of data to the NHMD. For example, there is same-day 'admitted' rehabilitation provided in private hospitals in Victoria, but these episodes of care do not meet Victorian admission criteria, and are therefore not considered by Victoria as in scope for reporting to the NHMD. It is possible this practice may also occur for other types of care.

Some of the above inconsistencies within the public hospital sector may be removed with the introduction of the Australian National Subacute and Non-acute Patient Classification Version 4 (AN-SNAP). The AN-SNAP is the ABF classification used for subacute and non-acute care. Under version 4, same-day admissions will need to satisfy the care type definition of rehabilitation (AIHW 2016), which was not a requirement under the previous version.

Longer term rehabilitation-type care

It has also been suggested there may be variation in admission practices for longer term rehabilitation-type-care (including transition care), with care provided in both admitted and residential settings.

3.3 Other points of variation

Mental health-related care

Mental health-related care is provided through a range of services in Australia, including admitted patient hospital services, community-based services such as outpatient services (hospital and clinic-based), residential and outreach services.

In general, patients with mental health problems must meet the same criteria for admission to hospital as any other patients. However, in some cases there may also be legal requirement for admission, under mental health legislation. For example, it may be appropriate for a

person with mental illness to be admitted for assessment or other reasons that would not otherwise meet criteria for admission.

This section focuses on variation in admission practices for mental health care in the hospital setting, and considers how some mental health care provided in the hospital setting may overlap with mental health care provided in other settings, such as residential care settings.

Some potential areas of variation are: same day admissions; admissions for patients treated in the emergency department; residential mental health care service; involuntary admissions; and forensic hospitals.

Same-day admissions

It is known that mental health care may be provided as same-day admitted care in some jurisdictions and outpatient care as others.

The eligibility of patients who attend psychiatric day programs can vary between and within jurisdiction, usually based on the model of the day program. For example, in Queensland, patients who attend psychiatric day or partial day care programs at public hospitals should be recorded as non-admitted patients, but patients who attend psychiatric day or partial day care programs at private hospitals may be admitted under private hospital licensing agreements. Queensland has also noted a lack of consistency in the reporting of child and adolescent day programs, with patients being recorded as either admitted or non-admitted

Electro-convulsive therapy may also be provided as same-day admitted or non-admitted care across states and territories.

The NHMD does not include data from some private hospitals that provide same-day mental health-related care that is regarded as admitted patient care for some purposes, because it is not regarded as admitted patient care for the NHMD purposes. For the first time in 2012–13, *Mental Health Services in Australia* presented data on ambulatory-equivalent mental health episodes collected by the Private Mental Health Alliance Centralised Data Management Service, because this collection was considered a more complete representation of private hospital activity (AIHW 2014b).

Admissions for patients treated in the emergency department

In *Mental Health Services in Australia* (AIHW 2015h), it is noted that the number of public hospital ambulatory-equivalent mental health-related separations for New South Wales may not be directly comparable with other jurisdictions due to variation in admission practices for patients treated in the ED (Table 3.11). Some states and territories have developed specialised units adjacent to the ED (for example, Mental Health Observation Areas) where mental health patients are admitted awaiting assessment and care plan and there may be variation in admission practices to these units across jurisdictions.

Residential mental health care service

State and territory governments provide specialised residential mental health care (RMHC) services on an overnight basis in a domestic-like environment (AIHW 2014c). RMHC services may include rehabilitation, treatment or extended care. The specialised mental health service profile mix for each jurisdiction is different, meaning that some jurisdictions rely heavily on residential services, while others report none. Queensland does not have any RMHC services (AIHW 2014c: Table RMHC.1) and the equivalent services are generally reported as non-acute admitted patient services.

Table 3.11: Public hospital ambulatory-equivalent mental health-related separations[a], with and without specialised psychiatric care, states and territories, 2013–14

	NSW[b]	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Per cent
With specialised psychiatric care	5,869	1,802	1,257	150	186	14	9	0	9,287	32.7
Without specialised psychiatric care	3,729	4,275	6,524	1,966	1,552	237	199	660	19,142	67.3
Total	**9,598**	**6,077**	**7,781**	**2,116**	**1,738**	**251**	**208**	**660**	**28,429**	**100.0**
Rate[c] (separations per 10,000 population)	12.9	10.5	16.6	8.3	10.4	4.9	5.4	27.1	12.2	. .

(a) Includes separations for both public acute and public psychiatric hospitals.

(b) The number of New South Wales separations may not be directly comparable with other jurisdictions due to the variations in admission practices for patients treated in the emergency department.

(c) Rates were directly age-standardised as detailed in the online technical information.

Note: Separations with a care type of 'Newborn (without qualified days)', and records for 'Hospital boarders' and 'Posthumous organ procurement' have been excluded.

Source: AIHW 2015h (Table AMB.1).

Involuntary admissions

As mentioned earlier, it may be appropriate for a person with a mental illness to be admitted to hospital for assessment and/or treatment under mental health legislation. State and territory mental health legislation can differ in the determination of, and categorisation of, the legal status of these patients. This could result in some inconsistencies of the reporting of hospital admissions that involve care of a patient on an involuntary basis (identified through the APC NMDS data item, 'Mental health legal status').

Forensic hospitals

The extent to which these facilities are defined as a 'hospital' for NHMD reporting purposes could vary across jurisdictions. Overall, the number of separations for forensic hospitals is relatively small, but the length of stay for patients is often very long. Therefore, variation in the scope of forensic hospitals across jurisdictions could impact the comparability of length of stay measures.

From 1 July 2015, a new care type, 'Mental health care', has been used. This will impact the comparability of indicators over time, with the number of mental health-related separations likely to increase.

Hospital-in-the-home

For the reporting of data on national admitted patient care, hospital-in-the-home (HITH) care is defined as occurring in the patient's (temporary or permanent) place of residence as a substitute for hospital accommodation and within an episode of care for an admitted patient (AIHW 2015e). In 2013–14, almost 545,000 days of HITH care were reported for over 93,000 admissions (AIHW 2015a: Table 5.36). The main issue to be considered with regard to admission practice variation is whether HITH is, in some cases, substituting for non-admitted care, rather than for admitted patient care in a hospital location, because of eligibility differences for HITH between states and territories.

Most states and territories have HITH programs under which patients are provided with hospital care in the home. Some jurisdictions publish separate guidelines for HITH (Table A3), while others incorporate relevant information into their admission policies and/or technical documentation (Table A1). This section provides a preliminary analysis of some of the variations in HITH across jurisdictions, based on the available information. With the exception of New South Wales, patients receiving HITH are, in principle, required to meet the same admission criteria as patients admitted for in-hospital based care. There are usually also some clinical and contextual factors that must be met; for example, the patient must be clinical stable, the patient's environment must be safe and appropriate, and carer support is available. More examples can be found in the definition of HITH in METeOR (AIHW 2015e). In New South Wales, the HITH program was, at the time of writing, broader, including care that substitutes or prevents admitted patient care, although, when HITH guidelines for New South Wales were revised in mid-2016, the scope was narrowed to care that substitutes admitted care only. At the time of writing, the New South Wales HITH care delivered to prevent a hospital admission is clinically equivalent to, and reported as, non-admitted rather than admitted care (New South Wales Health 2013), and is not considered further in this section.

Type of care

In 2013–14, the rate of separations with HITH was 4 separations per 1,000 population. Rates varied across jurisdictions, ranging from 0.1 separations per 1,000 population in Tasmania to

11 per 1,000 population in South Australia. Separations with HITH were mainly acute (95%), with a small amount of rehabilitation (2%) and other non-acute care also being provided in some jurisdictions (Table 3.12). As service delivery models evolve over time, it is likely that the proportion of HITH episodes delivering subacute and non-acute care will increase.

In South Australia, the proportion of rehabilitation HITH separations (10%) was relatively higher than other jurisdictions, which ranged from 0% to 0.2%. In Victoria, 5% of all HITH separations were for newborn care with qualified patient days. The type of care provided to HITH patients will be influenced by models of care operating within jurisdictions; for example, South Australia has a specific Home Based Rehabilitation Program (SA Health 2013).

Table 3.12: Separations with hospital-in-the-home care, by care type, states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Acute care	99.1	92.9	97.8	99.1	89.6	100.0	99.9	97.9	94.7
Rehabilitation care	0.2	—	0.1	—	10.3	—	0.1	0.1	2.4
Palliative care	—	—	1.8	—	—	—	—	0.2	0.2
Geriatric evaluation and management	—	0.3	0.1	—	—	—	—	0.2	0.1
Psychogeriatric care	—	—	—	—	—	—	—	—	—
Maintenance care	0.1	—	0.1	—	—	—	—	0.1	—
Newborn (qualified days only)	0.5	5.0	—	0.9	—	—	—	0.1	1.9
Newborn (qualified and unqualified days)	—	1.3	—	—	—	—	—	—	0.4
Newborn (unqualified days only)	—	0.6	—	—	—	—	—	1.3	0.2
Other admitted patient care	—	—	—	—	—	—	—	—	—
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total separations (number)	**19,354**	**30,985**	**11,312**	**8,015**	**21,328**	**n.p.**	**n.p.**	**n.p.**	**93,148**
Total separations (number per 1,000)[(a)]	**2.4**	**5.1**	**2.4**	**3.2**	**10.9**	**0.1**	**3.2**	**4.6**	**3.8**
Proportion of same-day separations	**18.8**	**13.8**	**39.8**	**1.9**	**65.9**	**0.0**	**0.1**	**3.1**	**28.6**

(a) Separation rates were directly age-standardised to the 2001 Australian population standard, using 5-year age groups.

Note: At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of NHMD.

Just under 30% of HITH separations were same-day (Table 3.12). This pattern varied across states and territories, ranging from 0% in Tasmania to just under 70% of HITH separations in South Australia. Analysis of the most common principal diagnosis codes recorded for HITH same-day separations showed that the chief reasons for these episodes varied across states and territories (Table 3.13). For example, for Queensland, just under half of the same-day separations had a principal diagnosis related to mental and behavioural disorders, and for Victoria, almost half involved chemotherapy. The most common principal diagnosis code for Northern Territory same-day HITH separations was ‘Singleton born in hospital’. Although the

number of episodes of care with this diagnosis code was small, this indicates a potential issue with data reporting, given that HITH, by definition, should occur outside the hospital.

Table 3.13: Principal diagnosis codes provided for around half of the HITH same-day separations, by state and territory, 2013–14

	Principal diagnosis codes	Proportion of same-day HITH episodes
NSW	Preparatory care for subsequent treatment, not elsewhere classified	47%
	Need for assistance due to reduced mobility	
	Cellulitis of lower limb	
	Nonfamilial hypogammaglobulinaemia	
	Pulmonary embolism without mention of acute cor pulmonale	
	Other specified surgical follow up care	
	Observation for suspected toxic effect from ingested substance	
	Asthma, unspecified	
	Iron deficiency anaemia, unspecified	
	Disorders of iron metabolism	
Vic	Pharmacotherapy session for neoplasm	55%
	Adjustment and management of venous catheter	
Qld	Severe depressive episode without psychotic symptoms	47%
	Schizophrenia, unspecified	
	Depressive episode, unspecified	
	Bipolar affective disorder, unspecified	
WA	Lymphoedema, not elsewhere classified	58%
	Disorders of plasma-protein metabolism, not elsewhere classified	
SA	Wound infection following a procedure, not elsewhere classified	48%
	Other specified surgical follow up care	
	Care involving use of rehabilitation procedure, unspecified	
	Attention to surgical dressings and sutures	
	Other specified coagulation defects	
	Pilonidal cyst without abscess	
Tas	—	
ACT	Not included due to small numbers.	
NT	Singleton, born in hospital	39%

Notes

1. Includes data for all care types.
2. At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of NHMD.

Eligibility of private patients for HITH

From 30 June 2008, as a result of changes to the *Private Health Insurance Act 2007*, health facilities are required to have individual agreements with private health insurers on the rates and services for HITH. This has also led to variation across jurisdictions in the eligibility of private patients for HITH, in both public and private hospitals. At the time of writing, some jurisdictions were working with private insurers to improve access to HITH for private patients. In 2013–14, just under one-quarter of HITH separations occurred in private hospitals, and this proportion varied across jurisdictions (AIHW 2015a: Table 5.36). For those

jurisdictions where data by hospital sector was published, South Australia was the only state with a higher proportion of HITH separations occurring in private hospitals. In 2013–14, private hospital HITH data for New South Wales was not available for reporting in *Australian hospital statistics.*

Additional points of variation

An early analysis of jurisdictional HITH guidelines has identified some other potential areas of variation across jurisdictions; for example:

- **Home birth:** In Victoria, homebirth is included as an eligible HITH admission and recorded in the Victorian admitted database. In Western Australia, HITH was not, at the time of writing, applicable for home birth and hospital staff assistance for home births is therefore not included in the admitted patient data.
- **Patient transfers within same hospital (continuous care):** In some jurisdictions, HITH guidelines state if a patient is transferred to services within the same hospital (for example, to HITH from their in-hospital stay or to in-hospital based care from HITH), this is considered 1 continuous episode of admitted care. Other jurisdictions may record this as 2 episodes of care.
- **Compliance:** In a 2014 medical record audit of HITH, Western Australia found a number of compliance issues (Western Australia Department of Health 2014b). For example, of the 218 episodes reviewed:
  - 31% did not meet the admission criteria for HITH
  - 86% did not comply with the leave reporting requirements
  - 67% of leave days (identified as days where no care was provided) were incorrectly recorded as days of care.

  The audit also found a number of other issues along with general issues of data quality (for example, admission and discharge dates reported incorrectly).
- **Mental health care:** Legislative restrictions may impact the type of mental health care which can be provided under HITH. For example, mental health legislation in some jurisdictions stipulates that admitted mental health care must occur on a hospital ward.

Admission time

The APC NMDS includes admission date—the date on which an admitted patient commences an episode of care. Admission time is not included in the APC NMDS, but is routinely collected (along with admission date) in state and territory admitted data collections. Jurisdictions can allocate admission time differently depending on the patient's route of admission. For example, within one jurisdiction, admission time can align with: the time the patient physically arrives in the admitted ward (for admission from admission clinic); the time when a clinical decision to admit is made (admission from outpatient clinic); or the time the patient physically departs the ED (admission from ED). These rules can also differ across jurisdictions. For example, in the Australian Capital Territory the admission time for a patient admitted via the outpatient clinic is the time a clinical decision to admit is made, and in Victoria it is the time the patient physically leaves the outpatient area (ACT Health 2015:9; Victorian Department of Health and Human Services 2015:23).

These differences will impact comparability of state and territory length of stay data for admissions overall, and for admissions from different settings, particularly for short-stay admissions where time stamps are more important. This would be particularly important if analyses of short-stay separations (for example, less than 4 hours) were conducted

separately to other separations in the future. Further information on admission time in relation to admissions from the ED is provided in Chapter 4.

The consistent collection of admission and separation time at a national level would allow short-stay admissions to be identified, and would improve the understanding of variation in admissions; particularly in relation to same-day care (see Chapter 5).

Certification for admitted care and clinical discretion

There are cases where a patient can be admitted to hospital despite not meeting agreed admission criteria, if appropriate medical certification is provided. Examples of this include patients who will receive a Type C procedure with regional anaesthesia—'Type C (certified)', or patients who require admission for a very short time (for example, less than 1 hour).

As the decision to admit a patient is a clinical one, it is noted that some variation in admission practices will be due to variation in clinical decision making.

Newborn care

Newborn care is a category of the data item, 'Care type'. All jurisdictional admission policies reviewed stipulate that any baby aged 9 days or less can be admitted (Table A2). A newborn patient day is assigned as qualified, based on a nationally agreed definition for qualified newborn days (Table A2: Newborn qualification status). Qualified days are eligible for health insurance benefits purposes, and the Australian Government has a role in stipulating conditions and/or requirements in order for a newborn baby to be qualified, and hence eligible, for Australian government funding.

Jurisdictions collect data on newborn episodes and each day of care is considered qualified or unqualified. For 2013–14 hospital reporting, the AIHW noted variation in the reporting of newborn episodes; for example, Victorian private hospitals did not report all newborn episodes with unqualified days. See Table 3.14 for detailed data by state and territory.

Table 3.14: Separations, by care type, public and private hospitals, states and territories, 2013–14

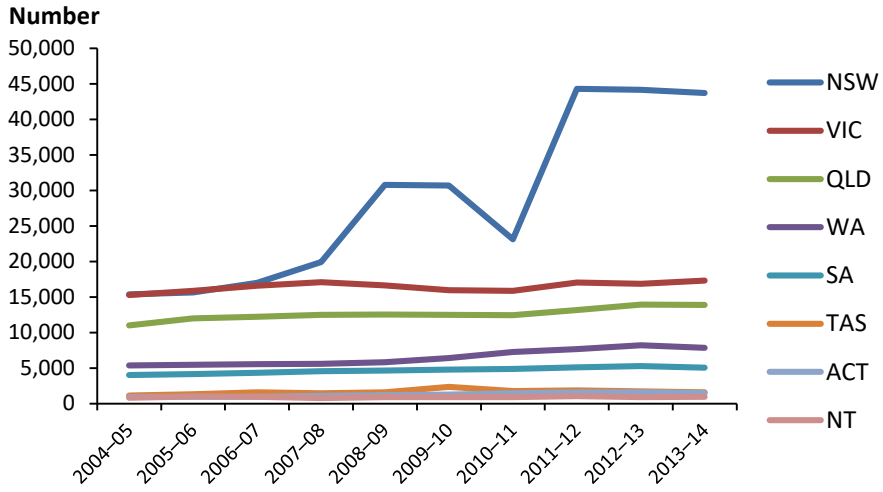
Care type	NSW	Vic[a]	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Acute care	1,664,642	1,454,287	1,032,739	575,631	395,472	109,829	92,628	122,016	5,447,244
Rehabilitation care	39,096	15,627	24,168	7,136	10,264	895	1,657	248	99,091
Palliative care	12,235	7,353	8,051	1,604	1,896	569	550	327	32,585
Geriatric evaluation and management	7,344	18,286	3,825	3,000	1,337	245	168	116	34,321
Psychogeriatric care	893	0	486	881	3	132	21	0	2,416
Maintenance care	10,251	444	6,543	1,718	2,472	895	643	157	23,123
Newborn–qualified days only	33,861	12,012	8,866	4,860	2,849	1,321	1,084	834	65,687
Newborn–qualified and unqualified days	3,197	1,757	2,395	1,054	1,485	130	217	31	10,266
Newborn–unqualified days only	42,041	48,272	36,662	19,945	12,474	2,875	4,051	2,908	169,228
Newborn total	*79,099*	*62,041*	*47,923*	*25,859*	*16,808*	*4,326*	*5,352*	*3,773*	*245,181*
Total[b]	***1,813,562***	***1,558,038***	***1,123,735***	***615,829***	***428,252***	***116,908***	***101,019***	***126,755***	***5,884,098***
Private hospitals									
Acute care	940,208	946,760	934,366	464,478	286,460	n.p.	n.p.	n.p.	3,699,971
Rehabilitation care	152,392	21,557	43,225	4,552	22,294	n.p.	n.p.	n.p.	255,567
Palliative care	303	729	2,349	2,543	294	n.p.	n.p.	n.p.	6,392
Geriatric evaluation and management	1	0	154	5	42	n.p.	n.p.	n.p.	211
Psychogeriatric care	0	6,257	1	857	0	n.p.	n.p.	n.p.	7,116
Maintenance care	73	66	1,325	133	15	n.p.	n.p.	n.p.	1,663
Newborn–qualified days only	6,354	3,250	2,214	1,341	731	n.p.	n.p.	n.p.	14,218
Newborn–qualified and unqualified days	480	293	422	606	0	n.p.	n.p.	n.p.	1,956
Newborn–unqualified days only	16,160	2,341	15,602	9,096	713	n.p.	n.p.	n.p.	47,322
Newborn total	*22,994*	*5,884*	*18,238*	*11,043*	*1,444*	*n.p.*	*n.p.*	*n.p.*	*63,496*
Total[b]	***1,115,971***	***981,253***	***999,659***	***483,611***	***310,549***	***n.p.***	***n.p.***	***n.p.***	***4,034,756***

(a) The reporting of newborns (without qualified days) is not compulsory for the Victorian private sector, resulting in a low number of separations in this category.

(b) Total separations include records for 'Newborn (without qualified days)'.

Source: AIHW 2015a: (Table 4.6).

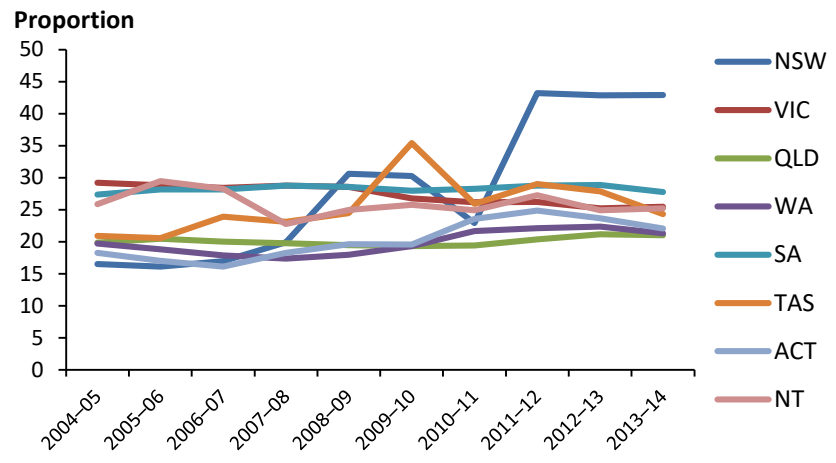
In addition, analysis of newborn care separations between 2004–05 and 2013–14 showed that the number of separations with at least 1 qualified day increased by 6% on average each year. The increase in separations was higher in New South Wales (12%) compared with other jurisdictions, which ranged from 1% (Victoria) to 5% (Australian Capital Territory), and suggests that there may have been a change in how the qualified care definition was applied in New South Wales during this period (see Figure 3.2). In addition, Figure 3.3 shows some fluctuation in the proportion of all newborn separations with at least 1 qualified day during the same period (particularly for New South Wales, Tasmania, Northern Territory and Australian Capital Territory).



Note: At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of the NHMD.

Figure 3.2: Separations for newborn care with at least 1 qualified day by state and territory, 2004–05 to 2013–14



Note: At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of the NHMD.

Figure 3.3: Separations for newborn care with at least 1 qualified day as a proportion of all newborn care separations by state and territory, 2004–05 to 2013–14

During consultation with jurisdictions, the following matters relating to newborn care were raised:

- In practice, some hospital care, which would have once been provided in a special care nursery (SCN), is now provided to newborns on the ward. This care would not meet the current threshold for 'qualified' care because the Australian Government specifically states that qualified benefits are not payable for newborns accommodated in hospital with their mother unless the child is accommodated separately in a specific nursery.

  In a submission to the IHPA, the Women's Healthcare Australasia noted 2 key factors for the increase in 'qualified' care on the ward. Firstly, the demand for special nursery cots has increased over time (due to increased annual birth rates, increased rates of birth by caesarean, and improvements in technologies and knowledge to support pre-term babies) and, secondly, research indicates that infant and maternal outcomes are better when mother and baby are co-located, in an environment supporting skin-to-skin contact and breastfeeding (IHPA 2016).

  There are also questions about the application of the definitional requirement, 'in hospital without mother'. For example, is a baby who is transferred to HITH with its mother (who is discharged home), considered in hospital without mother (qualified) or home with mother (unqualified)?
- One jurisdiction noted that some facilities are registering SCN beds that are situated with the mother and supervised by SCN staff and reporting the care provided to the newborn under these arrangements as 'qualified'.
- A newborn may receive qualified care for a short period of time in a day, but, because qualification status is based on days, not time, this care is not recorded as qualified, and therefore is not eligible for funding. Similarly, smaller facilities, or those located in more rural areas, which do not have a SCN, can commonly provide some 'special nursery care' before the newborn is transferred to a facility with a SCN. This care cannot be recorded as 'qualified' under current Australian Government requirements.

It may be that further consideration of the nationally agreed newborn qualification status definition, and/or further consideration of how newborn episodes of care are collected and reported nationally, is required.

Care type changes and transfers

Care type changes

The APC NMDS includes the data item, 'Care type', which describes the overall nature of care provided to an admitted patient during an episode of care (Box 3.1). Patients changing from one care type to another; for example, from acute to rehabilitation are to be statistically separated and re-admitted, resulting in 2 episodes of care. Variation in care type changes across jurisdictions and/or hospitals will affect the count of admitted activity and has potential implications for the comparison of average length of stay measures.

Box 3.1: Definition of Care type

The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care) (AIHW 2015g).

There is apparent variation among jurisdictions in the use of statistical discharges and the assignment of care types, which may affect the comparability of the data. For example:

- In 2013–14, for public hospitals, the proportion of separations ending with a mode of separation 'Statistical discharge: type change' varied across states and territories from 1.0% (Victoria) to 2.3% (Australian Capital Territory) (AIHW 2015a: Table 5.37). (This can be influenced by structures of hospital services; see 'Transfers' on page 41.)
- Some jurisdictions have noted that incorrect or inappropriate care type changes are a major source of invalid admissions. For example, care type should not change when there is a temporary interruption of a patient's care or a temporary change in ward. Some appropriate care type changes (for example, from acute to palliative care) may also be less likely to be routinely recorded in some jurisdictions, than other care type changes. Queensland noted issues with care type changes, some of which were attributed to lack of understanding about when and how to change care type.
- There is potential variation in how jurisdictions record the care type of a patient (receiving subacute or non-acute care) who undergoes a same-day procedure at the same facility. For example, in Tasmania and the Australian Capital Territory, a subacute patient who undergoes a procedure requiring sedation and/or anaesthetic (with the exception of a local anaesthetic) at the same facility will be assigned a new care type of acute. In this scenario, in Victoria, Western Australia or Queensland; for example, documentation stipulates that the care type should not change. However, data for 2013–14 suggest a change in care type for same-day care is an uncommon occurrence—around 3,400 (0.06%) same-day separations had an admission mode of 'Statistical admission—episode type change'.
- Some jurisdictional policies may strictly stipulate that certain types of care (for example, rehabilitation) should not be performed outside designated wards/services that are equipped/trained to provide such care, while other jurisdictional requirements may differ slightly. These subtle differences could result in different thresholds for a care type change across jurisdictions.
- As discussed earlier, in some jurisdictions, when a patient is admitted to HITH (for example, to HITH from their in-hospital stay or to in-hospital based care from HITH), this is considered 1 continuous episode of admitted care. If this is the case, then it seems possible that only 1 episode of care (and therefore 1 care type) could be reported in the situation where a patient; for example, received acute care in hospital and was then transferred to HITH to receive rehabilitation care? However, current business rules for the reporting of care type stipulate that 2 episodes of care would be reported in the above scenario.
- Palliative care is under-reported in Western Australia for several reasons, including: a lack of understanding about when a patient's care is considered to be solely under a palliative care speciality; uncertainty regarding clinicians' right to admit a patient directly under palliative care; and the administrative and reporting burden associated with palliative care (for example, AN-SNAP reporting requirements and the lack of adequate information systems and/or resources to record the required information).
- The 2013–14 APC NMDS included additional information on the assignment of care type in the data item's 'Guide for use'. This information includes instructions on some of the above issues (for example, dot point 3), and may lead to improvements in the quality and consistency of care type data collected in the future (AIHW 2015g).

Overall, the issues identified with care-type changes appear to be related more to compliance issues (for example, under-reporting of certain care types and inappropriate care type changes), rather than limitations in the current relevant metadata.

Transfers

Patients are commonly transferred between health establishments: for example, between different hospitals, or between campuses of the same hospital. The structures of hospital services will influence transfers in jurisdictions. For example, in one jurisdiction, there may be a separate rehabilitation hospital and, in another, just rehabilitation wards within general hospitals. In the above examples, the patterns for people transferring from acute care to rehabilitation care would be quite different, with more transfers recorded in the first circumstance and more statistical transfers recorded in the second.

Jurisdictions have specific rules regarding how data on patients who are transferred are recorded and some variation in these rules could exist. For example, there is some variation in the extent to which patients who do not qualify for admission, but are awaiting transfer to another facility, are considered within scope of admission to SSU (see 'Short stay admissions from the emergency department' on page 43).

Hospital information systems can also affect how transfers are recorded; for example, in the case of a short-term transfer between hospitals where the patient should technically be admitted and on leave from the original hospital, while being admitted and receiving care in the other hospital. In some jurisdictions, if both the original and receiving hospital use the same information systems, the patient cannot be 'admitted' in both systems and the patient would be discharged and re-admitted to the original hospital, resulting in 2 episodes of care, rather than 1.

Other issues

Cancelled treatment

In some cases, a patient who is admitted may have their treatment subsequently cancelled, and there is variation in how these episodes of care are reported. In some cases, whether or not the episode is recorded will depend on whether care and/or treatment (outside the standard care provided by admitting staff) were provided. In other cases, if the administrative process for admission has been completed on the patient administration system and the patient has presented to the assigned bed and/or ward then the patient is discharged and the reason for discharge recorded in the patient's notes (that is, the episode of care is recorded). This practice may vary across jurisdictions and could influence comparability of overall admission activity.

Contracted care

Most jurisdictions document clear guidelines regarding the recording of information on contracted care. However, some jurisdictions have noted issues with this. For example, if the original hospital and the contracted hospital use the same patient information systems, the patient cannot be, for administrative purposes, 'admitted' in 2 hospitals at the same time. This issue is discussed earlier under 'Transfers'.

In Queensland, some services, such as palliative care, may be provided by non-government organisations under a contractual agreement with the hospitals, and the level of reporting of this activity in the NHMD is unclear.

Election status

It may be that public/private patient election status can change during a patient's stay in hospital. This could affect the way in which episodes of care are recorded, and whether multiple episodes of care are recorded for what is essentially 1 (continuing) episode of care.

Data on clinical trials

Hospitals regularly provide care and/or treatment for patients participating in clinical trials and/or research projects. As part of this process, there will also be hospital patients participating in the research but not receiving any care and/or treatment (the control group). The issue of whether these episodes of care should be included in national hospital reporting was raised, given that they would not, generally, satisfy admission criteria. In 2013–14, there were just fewer than 2,000 separations with a principal diagnosis of Z00.6 'Examination for normal comparison and control in clinical research' program, with episodes recorded in all jurisdictions, except Northern Territory.

4 The transition between non-admitted emergency care and admitted care

One possible outcome for patients presenting at a hospital ED is to be admitted to hospital, including admission to a short stay unit (SSU), admission to elsewhere in the ED, admission to another hospital ward, or admission to hospital-in-the-home. There are differences in practice regarding patient admissions from the ED, and this chapter focuses specifically on jurisdictional variation in this area.

Under the National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), a short stay unit, by definition, should have specific admission and discharge criteria and policies (Box 4.1). Some jurisdictions publish these separate admission criteria for SSUs, as an accompaniment to general criteria for hospital admission. This section provides an analysis of admission practices for patients admitted from the ED based on the available documentation, with a focus on jurisdictional short stay unit admission criteria, policies and/or practices (Table A4). National data on presentations to selected public hospital EDs are collected in the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), based on the NAPEDC NMDS.

4.1 Points of variation

Short stay admissions from the emergency department

One possible pathway for a patient presenting to the ED is admission to an SSU (Figure 1.2). Some jurisdictions publish separate admission criteria or guidelines for SSUs as an accompaniment to general criteria for hospital, and a summary of those available to AIHW is provided in Table A4.

Box 4.1: Definition of a Short Stay Unit

The definition of a 'short stay unit' is as per clause C48 of the National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services, as follows:

(a) designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the ED

(b) have specific admission and discharge criteria and policies

(c) designed for short term stays no longer than 24 hours

(d) physically separated from the ED acute assessment area

(e) have a static number of beds with oxygen, suction, patient ablution facilities

and

(f) not a temporary ED overflow area nor used to keep patients solely awaiting an inpatient bed nor awaiting treatment in the ED.

Some potential points of variation in the use of short stay units are discussed in the following sections.

Expected time patient receives continuous active clinical management

All jurisdictions state that a patient must receive continuous active clinical management in order to be admitted to an SSU. However, the parameters for this can differ across jurisdictions. For example, in most jurisdictions the minimum time required for continuous active management is 4 hours; in the Northern Territory it is 1 hour; and in Victoria, no minimum time is provided. It is also unclear from available documentation, when the clock starts. For example, in Queensland and Western Australia, the minimum 4 hours of active clinical management can occur across the ED and the ED SSU. It is unclear whether this is the practice in other jurisdictions, or whether the clock starts at time of admission to SSU.

Variation in when the clock starts could mean that, in some jurisdictions, the expected time for patients to stay in the SSU (as an admitted patient) could be less than in other jurisdictions. One possible consequence of this is that less 'urgent' or 'sick' patients may be eligible for admission in some jurisdictions and not others.

In addition to variation in policy, there could also be variation in compliance. For example, in a 2012 Corporate Governance Audit, Western Australia found that up to 65% of admissions from the ED were less than 4 hours in duration (Western Australia 2014b), although the situation may have changed in more recent years.

Definitions of 'active clinical management', including 'regular/ongoing observations' and 'continuous monitoring'

There seems to be general agreement across jurisdictions about what is included in these terms, even though a standard definition is not used (Table A4). However, jurisdictions differ in their requirements for the frequency of observations and/or clinical contacts. For example, Queensland requires at least half-hourly observations and South Australia requires hourly observations. Other jurisdictions do not specify a time interval or just require that intervals are evenly spaced.

Transfers to other health facilities

There is some variation in the extent to which patients that do not qualify for admission, but are awaiting transfer to another facility, are considered within scope of admission. For example, in New South Wales and South Australia, policies are that admission of these patients to the SSU may be warranted in some cases, such as in rural hospitals where patients are awaiting transfer to major city hospital (South Australia) or where a bed in the accepting facility has been confirmed available (New South Wales). In Victoria, Queensland and Western Australia, policies are that patients should not be admitted if they are awaiting transfer to another health care facility.

Admissions to the SSU from areas outside the emergency department

One jurisdiction noted that some facilities are admitting patients to an SSU from a hospital ward (rather than from the ED). Where a patient is admitted from is unlikely to have a major impact on the consistency and comparability of data, assuming that standard admission criteria are met, although there may be an operational argument for hospitals/jurisdictions to avoid this process.

Private hospital emergency department admissions

Stakeholders understood that, in some circumstances, private hospitals may be more likely to admit a patient from the ED earlier than public hospitals to allow the patient to access the Medicare reimbursement for any services provided. The length of stay of these patients may be relatively short.

- SSUs generally have a different function to other admitted short-stay wards, which may be close or co-located to the ED, such as Medical Assessment Units and Psychiatric Emergency Care Centres, but some of the issues described earlier may also be relevant to short-stay wards more broadly.
- Lack of consistency in short-stay admission policies has implications for the reporting of national indicators for emergency care (Box 4.2). For example, if short-stay patients are being admitted relatively more frequently or earlier (either to a short-stay ward or virtual ward) then the length of the ED stay for those patients is reduced, thus improving a jurisdiction's ability to meet the National Healthcare Agreement Indicator, 'Waiting time for emergency department care: proportion completed within 4 hours'.

Box 4.2: Emergency care performance indicators

National Healthcare Agreement Indicator #21b, 'Waiting time for emergency department care—proportion completed within four hours'

Waiting times for emergency department care are calculated by subtracting the date/time the patient presents to the emergency department from the date/time the patient physically departed.

The NPA IPHS indicator: 'Admission to hospital from emergency departments'

This indicator includes the percentage of presentations where the length of the emergency department stay is less than or equal to 4 hours, and the length of emergency department stay at the 90th percentile, for all patients presenting to a public hospital emergency department who are subsequently admitted to the same hospital. Length of emergency stay is determined as the time elapsed between presentation and the physical departure of the patient.

Admitted patients with episode of care in the emergency department only

Some patients who spend their entire episode in the ED (outside of an SSU) are admitted in some jurisdictions (for example New South Wales and Tasmania). If the patient subsequently dies in the ED, this variation in practice can impact measures of in-hospital mortality calculated using NHMD data, thus inflating results for those jurisdictions and/or hospitals where admission has occurred. Victorian and Western Australian hospital admission policies stipulate that if a patient's entire episode of care is provided in the ED than the patient should not be admitted, even if they meet a criterion for admission. It is understood from consultation with states and territories that the number of admitted patients who receive their entire episode of care in the ED is decreasing.

Admission date and time

As mentioned earlier, the APC NMDS includes admission date. Admission time is not included in the APC NMDS, but is routinely collected (along with admission date) in state and territory admitted data collections. For patients who present to an ED and are subsequently admitted to hospital, admission date/time is not collected in the NNAPEDCD, although the

date/time the patients' non-admitted clinical care is completed (episode end date/time) and the date/time the patient physically leaves the ED to go to the admitted patient facility is (physical departure date/time).

There is variation in how admission date and admission time is recorded in state and territory admitted data collections for patients admitted from the ED. For example, Queensland and Northern Territory record the patient's admission to hospital as the time the clinical decision to admit was made (Queensland Department of Health 2015:66; Northern Territory Department of Health 2015:9), and Victoria, Western Australia and the Australian Capital Territory record the time the patient physically leaves the ED for a ward or operating theatre/procedure room at the same hospital. Additionally, there could also be variation in how admission date and time is recorded for patients who are admitted to an SSU from an ED.

These principles adopted by jurisdictions have a direct relationship with the recording of specific time stamps in the NNAPEDCD for patients that are admitted to hospital from the ED (Figure 4.1).

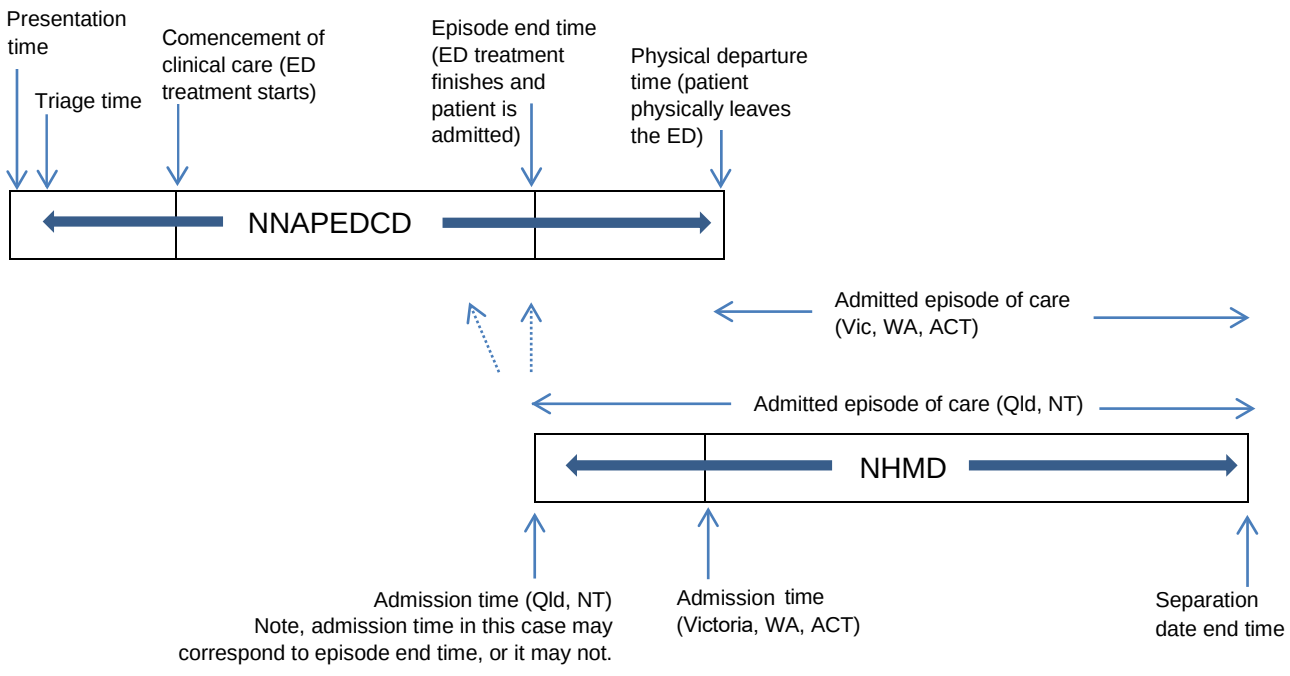


Figure 4.1: Key data points in a patient's pathway from the emergency department to admission to hospital, examples of jurisdictional variation

In this setting, variations in the reporting of admission date/time could affect state and territory comparisons of short admissions, where hours of care are more relevant (for example, measures of a patient's length of stay in an SSU or a 23 hour-ward). Comparability across jurisdictions and hospitals in this measure could be useful for benchmarking and auditing purposes, and evaluation of different models of care (for example, ED streaming).

Depending on the extent to which the episode end time aligns with the clinical decision to admit, these variations could have minimal difference when comparing some jurisdictions. Table 4.1 shows that for those jurisdictions where admission time should, according to their policies, align with the patient's physical departure from the ED (for example, Victoria or ACT), 99%–100% of presentations have the same episode end time and physical departure

time (Table 4.1). This means that, in practice, the commencement of the admitted episode of care could be comparable between these jurisdictions. Comparability between other jurisdictions is less clear.

Table 4.1: Proportion of presentations resulting in admission where episode end time is the same as physical departure time, public hospital emergency departments, states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Proportion of presentations resulting in admission where episode end time = physical departure time (%)	45	99	30	23	100	100	100	5
Number of presentations	718,016	472,510	399,192	178,741	139,545	36,067	34,213	39,256

Note: At the time of publication, there were no known issues with the ACT data contained in this report. However, the ACT is undergoing a system-wide review of ACT Health data and reporting, which will be finalised 31 March 2018.

Source: AIHW analysis of NNAPEDCD.

In addition to the above definitional differences, some jurisdictions also noted considerable variation between facilities in the recording of admission time, and in the quality of time stamps recorded overall.

Other issues identified

Variation in admission practices for patients who died in the ED or patients who were dead on arrival at the ED has been reported, with some jurisdictions admitting these patients to hospital. This variation in practice has impacted the reporting of in-hospital mortality indicators, inflating mortality measures for those facilities affected. Whether this will still be an issue for future data is unclear.

5 Outcomes of this work

This work, which focused specifically on the impact of admission practice variation on hospital data, was part of a national work program conducted under the auspices of the AHMAC to improve the consistency, comparability and/or interpretability of national hospital data. The information collated here stimulated discussion among national stakeholders on potential priority areas for future work related to both data development and the national reporting of hospital data. This section highlights one particular data development task—related to the measurement of the duration of admitted care—which was completed after the project. Several other high-priority data development tasks are under consideration as part of national work to review Australia's health NMDSs, also funded by AHMAC.

5.1 Measurement of the duration of admitted care

Duration of care (the elapsed time between when care starts and is completed), regardless of whether it was admitted or non-admitted care, is an important hospital activity concept and more detailed data on duration would have a number of benefits. In particular, the collection of data on time of admission and separation could:

- increase the comparability of the data overall, as same-day (1 day) separations, which can involve very different levels of care, would no longer need to be considered as equal for reporting purposes. Overnight, short-stay episodes of care (for example, when a patient is admitted at 11 pm and discharged early the subsequent morning) could also be identified. If appropriate, these overnight admissions could be excluded from analyses of overnight admissions on the basis that they are not conceptually similar, and are likely to represent different levels of care
- allow for more accurate calculation of average length of stay, a measure often used to provide insight into hospital efficiency. This could also be useful for Diagnosis Related Groups (DRGs) because, for example, length of stay (based on days not hours) is a variable used to assign some AR-DRGs to hospital episodes
- support analyses of short-stay separations, noting that the threshold (for example, less than 3–4 hours) would need to be agreed. This could provide a better understanding of the extent and nature of care provided by hospitals during short stays, including any variation in admission practice across facilities and jurisdictions. For example, are short stay admissions more common for certain types of conditions and/or care?
- identify 'very short', formal separations for data validation and reporting purposes. Some jurisdictions already routinely review 'short' hospital stays for compliance purposes. For example, from 1 July 2015, Queensland included a data validation check for short stays, with stays of 5 minutes or less flagged in their data collection. Feedback on very short stays could be provided to jurisdictions, via standard AIHW Validata data checks, which could potentially complement and/or improve internal state and territory data checks and/or compliance reporting.

Decisions may also be made to remove very short admissions from national analyses of hospital data, if they are considered to be not representative of typical hospital admissions.

Development and collection of new data items

As outlined previously, the APC NMDS includes admission date—the date on which an admitted patient commences an episode of care. Admission time is not currently included in the APC NMDS, but is routinely collected in state and territory admitted data collections.

Similarly the APC NMDS includes separation date and, although separation time is not included in the APC NMDS, it is also routinely collected in jurisdictions.

In order to capture the duration of admitted care at a national level more accurately, states and territories agreed to the collection of 2 new data items, separation and admission time, on a best endeavours basis from 2017–18. The agreed definitions for separation and admission time are sufficiently broad to support the slight variation in definitions already used by jurisdictions, particularly with regard to admission time.

Once available, the quality and completeness of the 2017–18 data will be assessed with a view to undertake any further development work required to include the items in the APC NMDS. Depending on the quality and coverage of data received, some reporting of duration of admitted care may be available for 2017–18, noting any limitations related to the application of the definition of admission time and separation time and/or, in the scope of hospitals for which data are available.

5.2 Other related work underway

Some other high-priority data development work, related to this project, was also agreed to be undertaken at a national level as part of work to review Australia's health NMDSs. For example, further analysis will be undertaken of the availability and quality of newborn care separations, and there will be consideration of revised national reporting principles in relation to separations involving unqualified care.

Appendix A: Additional material referenced in report

This Appendix includes: further information on the policies referenced in the report (tables A1 to A4); comparison of procedures listed in the admission lists of Victoria and Western Australia (tables A5 to A7); and information on the procedure codes used in analysis (tables A8 and A9).

Table A1: Admission policies in Australia—general summary

Jurisdiction	Admission policy	Document title	Scope	Criteria for admission (as stated in policy)	Criteria exactly the same as METeOR definition of Admitted patient (268957)	Supporting documentation
New South Wales	YES This policy was published just before the release of this report	NSW Health Admission Policy (New South Wales Health 2017) New South Wales Hospital-in-the-Home Guideline (New South Wales Health 2013)	All NSW public hospitals (and publically contracted care in other facilities within NSW)	The patient requires 1 or more of the following: • observation in order to be assessed or diagnosed • daily (or more frequent) management of their treatment and/or medication • clinical management and/or facilities not available at their usual residential environment or a non-admitted setting, or • a procedure/s that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available. In addition a patient aged 9 days or less must be admitted under the following scenarios: • when born in the hospital • when intended to be born in the hospital and the birth occurs within 24 hours of the mother's arrival at the hospital, or • when born at home or another facility and presents to hospital and requires specialist care. A patient may also be admitted where there is a legal requirement for admission. Explanatory text is provided for each of these categories.	YES, however additional examples are provided for criteria and text may vary slightly	NSW Health Admission Policy <http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_015.pdf> New South Wales Hospital-in-the-Home Guideline <http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=GL2013_006 Inpatient Statistics Collection (ISC) - Public Facilities Separations> <http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_210.pdf>

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Table A1 (continued): Admission policies in Australia—general summary

Jurisdiction	Admission policy	Document title	Scope	Criteria for admission (as stated in policy)	Criteria exactly the same as METeOR definition of Admitted patient (268957)	Supporting documentation
Victoria	YES	Victorian Hospital Admission Policy (July 2015)	Public and private hospitals (under *Health Services Act 1988*) Health Services under *Health services* (*Private hospitals and Day Procedure Centres) Regulations 2002.* This Act includes private hospitals and Day procedure centres Includes HITH and Medihotel	There are 8 criteria for admission: • Posthumous Organ Procurement (K) • Qualified newborn • Unqualified newborn • Patient expected to require hospitalisation for minimum of 1 night • Day-only Automatically Admitted Procedures • Day-only Extended Medical Treatment • Day-only Not Automatically Qualified Procedures • Secondary family member (S). **An admitted patient is defined as a patient who:** • meets at least 1 of the 6 Criteria for Admission (not K or S) that define admitted patients; **and** • undergoes the hospital admission process in order to receive treatment or care**.**	NO	Victorian Admitted Episodes Dataset manual <http://www.health.vic.gov.au/hdss/vaed/> Victorian Hospital Admission Policy Fact Sheet 2015–16 <http://www.health.vic.gov.au/hdss/vaed/index.htm> HITH Guidelines <http://www.health.vic.gov.au/hith/guidelines.htm> Framework for medihotels in Victorian public health services 2009 <http://health.vic.gov.au/emergency-care/resources.htm#medihotels>
Queensland	YES	Appendix F: Queensland Health Hospital Admission Criteria: Queensland Hospital Admitted Patient Data Collection	Public and private hospitals	• Expected overnight • Delivery • Newborns • Day only bands 1A, 1B, 2, 3 and 4 • Anaesthetic • Approved same-day program • Type C Professional Attention Procedures • Medical observation and care Explanatory text is provided for each of these categories.	NO	Queensland Health Admitted Patient Data Collection Manual 2015–16 <https://www.health.qld.gov.au/hsu/collections/qhapdc.asp> Queensland Health Guidelines (Emergency department SSU; 23 Hour ward Admission criteria; HITH Guidelines) <https://www.health.qld.gov.au/qhpolicy/default.asp> Queensland HITH Guideline <https://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-379.pdf>

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Table A1 (continued): Admission policies in Australia—general summary

Jurisdiction	Admission policy	Document title	Scope	Criteria for admission (as stated in policy)	Criteria exactly the same as METeOR definition of Admitted patient (268957)	Supporting documentation
Western Australia	YES	Admission, readmission, discharge and transfer policy for WA Health Services (December 2014) <http://www.health.wa.gov.au/CircularsNew/attachments/918.pdf>	Admitted care activity at all hospitals and health care facilities where publically funded care is delivered (e.g. public hospitals and private hospitals—public care only)	For a patient to qualify for admission, 1 or more of the following should apply: • the person's condition requires clinical management and/or facilities only available in an admitted care setting • the person requires regular and periodic observation in order to be assessed or diagnosed • the person requires at least daily assessment of their medication needs • the person requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room, without specialised support facilities and/or expertise available • the patient is aged 9 days or less • there is a legal requirement for admission • obstetric care, admission to manage labour and/or delivery	NO, addition of obstetric care criteria	Circular Operational directive 0540/14. Includes Type B admitted procedures lists and Type C non-admitted procedure list Hospital Morbidity Data System: HMDS reference manual July 2014 (Western Australia Department of Health 2014c)

(continued)

Table A1 (continued): Admission policies in Australia—general summary

Jurisdiction	Admission policy	Document title	Scope	Criteria for admission (as stated in policy)	Criteria exactly the same as METeOR definition of Admitted patient (268957)	Supporting documentation
SA	YES	SA Health: Casemix Funding: Admission Criteria		One of the following conventions must be met to qualify a patient for admission: Overnight admission—the patient, following a clinical decision, receives hospital treatment for a minimum of 1 night. Same day admission—the patient is to receive a same-day surgical and diagnostic service as specified in Bands 1A, 1B, 2, 3 and 4 of the Day Only Procedures manual (March 1999, Commonwealth of Australia) and updates; or the patient is to receive a type C Professional attention procedures as specified in the Day Only Procedures manual (March 1999, Commonwealth of Australia) and updates. Patients undergoing these procedures would not normally be admitted. Where admission is required it must have accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or special circumstances that relate to the patients (e.g. lives in remote location or no one at home to provide care). Newborns—the patient is aged less than 9 days old at the time of admission and at least 1 day in hospital is deemed qualified. All newborns day may be categorised as qualified or unqualified. A newborn day is qualified if the newborn meets at least 1 of: • admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the provision of special care in designated Neonatal Intensive Care Units (NICUs) and designated Special Care Nurseries (SCNs), or • is the second or subsequent live born of a multiple birth, or • remains in hospital after their mother is separated from hospital, or is admitted to hospital without their mother.	NO	Casemix funding for hospitals: Technical bulletins. Admission criteria for short stay admissions <http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/publications+and+resources/manuals+and+handbooks> Also: Screening algorithm for inappropriate same day SA Health: Casemix funding: Admission criteria for ED short-stay admissions

(continued)

Table A1 (continued): Admission policies in Australia—general summary

Jurisdiction	Admission policy	Document title	Scope	Criteria for admission (as stated in policy)	Criteria exactly the same as METeOR definition of Admitted patient (268957)	Supporting documentation
Tasmania	YES	Tasmanian Department of Health and Human Services (2015) Admission and Discharge Manual: counting and recording rules for admitted activity (March 2014) Not online	Public hospitals or sites that provide admitted care Admitted contracted care services are also in scope	A person may be admitted if 1 or more of the following admission criteria apply: 1. The person's condition requires clinical management and/or facilities not available in their usual residential environment; 2. The person requires continuous observation in order to be assessed or diagnosed; 3. The person requires at least daily assessment of their medication needs; 4. The person requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (for example, cardiac catheterisation); 5. The person is aged nine (9) days or less; or 6. There is a legal requirement for admission; for example, under the *Children, Young Persons and Their Families Act 1997* or the *Mental Health Act 2013*.	YES	<https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0008/195308/2015-2016_TAS_Purchasing_and_Funding_Guidlines.pdf>
ACT	YES	Policy: Administration of Hospital Admissions and Discharges	All public hospitals in ACT Local Hospital Network Directorate and contracted hospitals. It applies to both publically and privately admitted patients within these hospitals	A person may be admitted if one or more of the following admission criteria apply: 1. The person's condition requires clinical management and/or facilities not available in their usual residential environment; 2. The person requires continuous observation in order to be assessed or diagnosed; 3. The person requires at least daily assessment of their medication needs; 4. The person requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room, without specialised support facilities and/or expertise available (for example, cardiac catheterisation); 5. The person is aged nine (9) days or less; or 6. There is a legal requirement for admission; for example, under the Mental Health (Treatment and Care) Act 1994.	YES	ACT Health Admitted Patient Activity Data Standards <http://findahealthservice.act.gov.au/c/fahs?a=dlpubpoldoc&document=2839>

(continued)

Table A1 (continued): Admission policies in Australia—general summary

Jurisdiction	Admission policy	Document title	Scope	Criteria for admission (as stated in policy)	Criteria exactly the same as METeOR definition of Admitted patient (268957)	Supporting documentation
NT	YES	Hospital Administrative Admission NT Policy Version 2.0 February 2015	All hospitals in NT	A person may be admitted if one or more of the following apply: • The person's condition requires clinical management and/or facilities not available in their usual residential environment. • The person requires observation in order to be assessed or diagnosed. • The person requires at least daily assessment of their medication needs. • The person requires a procedure/s that cannot be performed in a stand-alone facility, such as a doctor's room, without specialised facilities and/or expertise available (e.g. cardiac catheterisation). • The patient is aged nine days old or less (see section 6.1.2 newborn). This includes all babies born in hospital and babies that present to hospital who are aged 9 days or less. • It is recognised that there may be exceptional circumstances that warrant admission. For example, there may be circumstances under which a decision to admit is made to ensure a person's welfare and/or legal or social factors such as: – Child at risk (Department of Child Protection orders, suspected child abuse) – Adult at risk (e.g. domestic violence) – Patient living in rural or remote areas – Where the treating medical officer decides the patient is to be admitted based on exceptional circumstances, the reasons for admission must be clearly documented in the patient's medical record	YES; however, the exceptional circumstances section is slightly broader	See also policies for separate hospitals: Darwin (RDH) and Alice Springs (ASH) NT Admitted Data Activity Collection Manual

Note: This report was drafted in 2015–16; the documents referenced in this table may have since been updated.

Table A2: Comparison of admission policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Who can admit?		Clinical determination	Clinical determination	Physician or nurse practitioner	Clinical determination	Physician	Medical Officer	Medical officer	Some clinical variation expected in decision to admit.
Newborn		Qualified: Admit if: The patient is nine days old or less at the time of admission and meets at least one of the following criteria: • Admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the provision of special care in designated Neonatal Intensive Care Units (NICUs) and designated Special Care Nurseries (SCNs), or	Admit Any baby aged nine days or less presenting at hospital can be admitted. This includes all babies born in hospital and all babies present at hospital aged 9 days or less. Babies aged 9 days or less in hospital accompanying an admitted patient should be admitted, and not registered as a boarder.	Admit The person is aged nine (9) days or less	Admit The patient is nine days old or less at the time of admission	Admit The person is aged nine (9) days or less	Admit The person is aged nine (9) days or less	Admit The patient is aged 9 days old or less	Excludes stillborn — Newborn qualification status A newborn patient day is qualified if the infant meets at least one of the following criteria (AIHW 2015f): • is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient • is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care • is admitted to, or remains in hospital without its mother.

(continued)

Table A2 (continued): Comparison of admission policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Newborn		• is the second or subsequent live born of a multiple birth, or • remains in hospital after their mother is separated from hospital, or is admitted to hospital without their mother. Public hospitals are expected to admit all unqualified newborns.							A newborn patient day is unqualified if the infant does not meet any of the above criteria — Data on newborn admissions without qualified days are mostly included in the NHMD (and s/t systems) for administrative purposes but excluded from general AHS data reporting. An exception to this is Victorian private hospitals, for which the reporting of newborns without qualified days is not compulsory and Northern Territory do not report newborns with qualified and unqualified days.
The person's condition requires clinical management and/or facilities not available in their usual residential environment		NO	NO	Yes, a criterion	NO	Yes, a criterion	Yes, a criterion	Yes, a criterion	

(continued)

Table A2 (continued): Comparison of admission policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
The person requires continuous observation in order to be assessed or diagnosed		NO	NO	Yes, a criterion	NO	Yes, a criterion	Yes, a criterion	Yes, but NT criterion omits the word 'continuous'	
The person requires at least daily assessment of their medication needs		NO Related to overnight criteria below	NO Related to overnight criteria below	Yes, a criterion	NO	Yes, a criterion	Yes, a criterion	Yes, a criterion	
The person requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room, without specialised support facilities and/or expertise available (for example, cardiac catheterisation)		NO Related to same day admitted procedure criteria below	NO Related to same day admitted procedure criteria below	Yes, a criterion	NO	Yes, a criterion	Yes, a criterion	Yes, a criterion	

(continued)

Table A2 (continued): Comparison of admission policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Patient expected to require hospitalis-ation for minimum of 1 night		O 'Patient expected to require hospitalisation for minimum of one night' The patient is expected to require overnight or multi-day hospitalisation. CFA O should be used where there is an expectation that the patient will require ongoing admitted care. See inclusion and exclusion criteria in document pg. 5).	'Expected overnight' The patient, following a clinical decision, is expected to require hospital treatment for a minimum of one night. This includes patients who are expected to require treatment for a minimum of one night but are separated on the day of admission (e.g. patient is transferred to another hospital, patient dies etc.).	Incorporated in admission decision tree/guidelines (pg. 6)	The patient, following a clinical decision, receives hospital treatment for one night	Implicit in policy (page 9–10)	Implicit in policy	Implicit in policy	Definition of overnight does not just always mean admission and separation date are different (e.g. Victoria exception of patients treated for 4 hours across midnight)
Same-day admitted procedure		Day only automatically admitted procedures (Criteria) In order to meet CFA B, it must be the intention that the patient will:	Day Only Bands 1A, 1B, 2, 3 and 4 (Criteria)	Incorporated in admission decision tree/guidelines (pg. 6). This admission category applies to patients admitted for the purpose of having a procedure on the Type B admitted procedure list.	The patient is to receive a same-day surgical and diagnostic service specified in Bands 1A, 1B, 2, 3 and 4 of the Day Only Procedures manual (Marc 1999 ed., Commonwealth of Australia) and updates: or	Implicit in guidelines (page 9–10).	Implicit in data standards.	Implicit in policy. An Automatically admitted procedure list is mentioned in NT policy (Appendix A). AIHW has not viewed this	Technically these criteria should be broadly consistent because the procedures are stipulated in the Private Health Insurance (Benefit Requirements) Rules 2011, and updated regularly

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Table A2 (continued): Comparison of admission policies in Australia

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Same-day admitted procedure (continued)	—receive at least one procedure listed on the Automatically Admitted Procedure List; AND —receive treatment on a day-only basis. The Automatically Admitted Procedure List is available at <http://www.health.vic.gov.au/hdss/vaed/index.htm>	The patient, following a clinical decision, is expected to require same-day hospital treatment and receives a procedure listed as a Type B procedure in the Private Health Insurance (Benefit Requirement) Rules 2008 (No. 2).	Some type B procedures require anaesthesia/sedation to qualify for admission. This category is mainly applicable to same day elective admissions and could also apply to short stay patients admitted via the ED. In order to meet this admission criterion, it must be the intention that the patient is being admitted for the purpose of: —receiving at least one procedure listed on the Admitted Procedure Type B List, refer appendix 3; and —receiving the treatment on a day-only basis. Therefore the procedure must occur or continue within an admitted care episode.	The patient is to receive a Type C Professional Attention Procedure as specified in the Day Only Procedures manual (Marc 1999 ed., Commonwealth of Australia) and updates. (*Goes on to explain that medical certification is required*)				

(continued)

Table A2 (continued): Comparison of admission policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Anaesthetic		ACHI codes for all major anaesthetics are listed in the Automatically Admitted Procedures List	The patient, following a clinical decision, is expected to require same-day hospital treatment and receives a general, regional or intravenous anaesthetic that was not provided in conjunction with a Type B procedure	ACHI codes for all major anaesthetics are listed in the Automatically Admitted Procedures List	See Comments	See Comments	See Comments	See Comments	The classification for same-day admissions in the Rules (Bands 1–4) are broadly determined by the level of anaesthetic and theatre time required
Legal requirement for admission			Included under Queensland criteria (Expected overnight)	Yes, a criterion There is a legal requirement for admission		Yes, a criterion There is a legal requirement for admission	Yes, a criterion There is a legal requirement for admission	Yes, a criterion	
Obstetric care/delivery			The patient, following a clinical decision is expected to require hospital treatment for the delivery of a baby	Admission to manage labour and/or delivery					

(continued)

Table A2 (continued): Comparison of admission policies in Australia

NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Reporting requirement but do not technically meet admission criteria								
Secondary family member	A patient qualifies for this criterion of admission if: • they do not meet any other CFA but are accompanying a patient who is admitted AND • the location is an Early Parenting Centre. Included in criteria for admission because of obligation to report episode of care in Victorian Admitted Episodes Dataset (VAED).	NO	NO	NO	NO	NO		These are not included in NHMD
Posthumous organ procurement	Included in criteria for admission because of obligation to report episode of care in VAED	NO	NO		NO	These patients are not admitted to hospital but are reported or registered		Data on posthumous organ procurement are mostly included in the NHMD (and s/t systems) for administrative purposes but excluded from general AHS data reporting

Note: This report was drafted in 2015–16; the documents referenced in this table may have since been updated.

Table A3: Comparison of hospital-in-the-home policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Type of care	Admitted and non-admitted (Note: NSW HITH policy changed from 1 July 2016 to include only admitted care)	Admitted (acute only)	Admitted	Admitted	Admitted (acute and subacute only)	Admitted	Admitted	Admitted	
Patient criteria	The patient's condition requires clinical management and/or facilities not available in their usual residential environment. The patient requires observation in order to be assessed or diagnosed. The patient requires at least daily assessment of their treatment/ medication needs.	The patient must meet the criteria of the Victorian hospital admission policy—see Appendix Table A2. HITH can be reported when the patient has been visited in their home (or other residential service not providing admitted care), or a substitute location, by HITH staff providing admitted services to the patient.	Inclusion criteria Care substitutes full hospital admission or a component of a hospital admission. Without a HITH service, the patient would be admitted to hospital for treatment in a traditional hospital bed. Each patient is identified as requiring clinical governance, active treatment and /or monitoring during the HITH episode of care.	The patient must meet the criteria for admission (See Appendix Table A2), and undergo the documented admission process to receive treatment/care over a period of time. The decision to admit and refer a patient to HITH, as with other admitted care, must be made by an authorised medical officer or nurse practitioner.	Hospital at Home Services will be considered eligible for funding under the rules outlined in the chapter 4, 'Funding', provided the services and patients comply with the following criteria: Staff involved in the delivery of care is fully skilled in the acute and subacute care needs of the patient and are available to provide care on a 24 hour a day basis.	No separate policy. Some information included in Admission and Discharge Manual -- Episodes are not recorded as HITH unless the patient is seen at least daily by clinical staff providing inpatient care.	No separate policy. The national HITH care glossary term is referenced in the ACT Health Admitted Patient Activity Data Standards.	No separate policy	As HITH is a substitute for admitted care, many jurisdictions use the national definition of an 'Admitted patient' as their criteria for HITH

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Table A3 (continued): Comparison of hospital-in-the-home policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Patient criteria (continued)	The patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available		All patients require a minimum daily intervention or assessment by the HITH service. A comparable level of care to that provided in the inpatient setting is to be provided by the HITH service to meet all patient needs. A treating authorised practitioner agrees that the care for the patient can be safely provided and managed in the patient's permanent or temporary residence. The patient consents to transfer of care. This is to be documented and evidenced in the patient medical record.	The reason for admission and HITH treatment evidencing level of care requirements will be documented in the medical record. It is also expected that the patient is seen daily or at least 3 days per week by clinical staff providing admitted care.	Hospital at Home Services provide the full range of medical, nursing and allied health acute-care associated with the condition and which would otherwise be provided in the hospital during the full twenty-four hours of the day. Admissions or referrals may be accepted from any of the following care provision points: • Inpatient care areas. • Emergency department. • Outpatient department. • Other clinical events whereby an inpatient episode can be avoided, following assessment/ examination by health unit medical staff.				

(continued)

Table A3 (continued): Comparison of hospital-in-the-home policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Patient criteria (continued)			<https://www.health.qld.gov.au/__data/assets/pdf_file/0016/147400/qh-gdl-379.pdf> Patient has no known allergy to medication prescribed during the HITH episode of care. Telephone with dial out facilities. Working refrigerator with suitable storage room (if required to store medications). For paediatric patients, a guardian must be available and a nominated adult is to be present during treatment of minors.		The health unit assumes medical supervision and duty of care responsibility of the patient while the patient is in the hospital at home program and the services are provided as a continuum of the inpatient care. An exception will be made for those patients where agreement can be negotiated with the patients' General Practitioner to provide the care				

(continued)

Table A3 (continued): Comparison of hospital-in-the-home policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Patient criteria (continued)			Department Of Veteran Affairs (DVA) funded patients, 3rd party insurance funded patients, Workers compensation funded patients and Non Medicare eligible patients.						
Additional criteria for eligibility, relating to service delivery/ patient/ setting	Presence of an acute, subacute or post-acute condition HITH service can safely provide the required patient care which meets evidence based guidelines Patients must be medically stable and not require high clinical support (multi-morbid patients with complex needs are eligible)	In addition to the Victorian hospital admission policy, HITH services develop effective selection criteria such as: - clinical stability of the patient and appropriateness of HITH treatment - provision of equivalent care - safe and appropriate environment - carer support - consent to service - location of care.	See Patient criteria above. In addition, there are several other key eligibility /inclusion criteria documented in the HITH guidelines; for example: Patients are capable of complying with treatment within the care setting. Complex care needs not amenable to a HITH service.	The documentation makes reference to the national definition for HITH care which has some selection criteria for the assessment of suitable patients.	Admission criteria include as a minimum: The patient is willing to be cared for at home. The patient is medically stable. The requirement for care is for a period of up to seven days. The patient is able to communicate effectively, either directly or through an interpreter.	NO	You live in Canberra or Queanbeyan You have a telephone You are self-caring or have a suitable carer Your condition is clinically appropriate for home-based care Your home environment is safe for the delivery of treatment (ACT Health 2016).	Eligibility for Hospital in the Home is restricted to those patients who have a stable clinical condition that is suitable for home management.	

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Table A3 (continued): Comparison of hospital-in-the-home policies in Australia

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Additional criteria for eligibility, relating to service delivery/ patient/setting (continued)	Medical responsibility established and agreed based on HITH Principles Patient resides permanently or temporarily in catchment area Agreement of the patient or substitute decision maker to receive HITH Adequacy of the home environment to provide the needs of daily living Safety of staff in the home is assured Access to a reliable mobile or landline telephone		These include physical, cognitive and/or social care needs that exceed the capability of available support networks (including carers and health care providers). Patients/carers are assessed as competent to provide self-care health interventions; for example: administer medications, suctioning, and percussion as prescribed before acceptance to HITH.		The patient is able to transfer and mobilise safely using aids as required, except for clients who reside in aged care facilities. The patient agrees to be readmitted to hospital should complications necessitating readmission occur. The patient has sufficient support from carers. Telephone communication is available at the patient's home. The patient has easy access to transport.				

Note: This report was drafted in 2015–16; the documents referenced in this table may have since been updated.

Table A4: Comparison of emergency department Short Stay Unit policies and/or guidelines

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
SSU definition	As per clause C48 of the National Health Reform Agreement - National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), the Standing Council on Health, the Commonwealth and states and territories have agreed to implement the following definition of an emergency department (ED) short stay unit, or equivalent, with the following characteristics: (a) designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the ED; (b) have specific admission and discharge criteria and policies; (c) designed for short term stays no longer than 24 hours; (d) physically separated from the ED acute assessment area; (e) have a static number of beds with oxygen, suction and patient ablution facilities; and (f) not a temporary ED overflow area nor used to keep patients solely awaiting an inpatient bed nor awaiting treatment in the ED. (METeOR identifier 525112)								
Policy available?	Emergency department Short Stay Units: policy directive 13 November 2014	Incorporated within general admission policy documents (see Table A1 above) Observation Medicine Guidelines 2009 (require update)	Emergency department SSU Guideline (QH-GDL-352:2014	See 4.1 of Admission, readmission, discharge and transfer policy for WA Health Services	SA Health: Admission criteria for ED Short Stay Admissions Technical Bulletin 01:26	Short stay ward or unit definition included in chapter 2.6.1 of Admission and discharge manual but no separate admission criteria. Assumed that patients admitted to SSU unit meet overall hospital admission criteria.	No separate policy. Patients admitted to a short stay unit must meet one or more of the ACT admission criteria.	See page 6 of Hospital Administrative Admission NT policy, which applies to Extended Emergency Medical Unit	
Admission criteria									
Patients admitted are under the care and management of the ED	YES		YES		YES				This is true of all SSUs, by definition. However, in hospitals where inpatient wards have admitting rights—it may be that the inpatient unit is responsible for care and management not the ED.

(continued)

Table A4 (continued): Comparison of emergency department Short Stay Unit policies and/or guidelines

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Expected combined ED and ED SSU stay of >4 hours and <24 hours.	YES. However, unclear whether this includes time in ED and SSU or just SSU.	The guidelines say between 4 and 24 hours. However, there was agreement from the clinicians that both less than 4 hours and greater than 24 hours were also acceptable.	YES	YES	SA policy stipulates that active clinical intervention of patient is provided for at least four hours. Unclear whether this is intervention across ED and ED SSU or just ED SSU.	YES	YES	A patient receives at least one hour of continuous active management (Hospital Administrative Admission NT policy for Extended Emergency Medical Unit Patients suitable for admission under the ED team include patients requiring observation for four or more hours. (ASH and RDH admission policies)	By definition SSU care is designed for short term stays <24 hours. When does the clock start? Four hours of continuous active management in ED and ED SSU or ED SSU only?
Patients have specific diagnosis and documented management plan	YES	YES	YES	YES				YES	Assume this is required across all jurisdictions.

(continued)

Table A4 (continued): Comparison of emergency department Short Stay Unit policies and/or guidelines

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Patients receive continuous active management (regular observations or continuous monitoring)	'Patients are anticipated to require a period of observation or treatment'	Not stipulated in any policy documents. The requirement is: A short stay patient must have a clearly documented clinical management plan or pathway while in the unit.	YES Patient receives continuous active management, with at least half-hourly observations of vital or neurological signs (assume this based on general admission criteria)	YES Receive a minimum of four hours continuous active management, and that management must occur, at least in part, outside of the ED in an inpatient area	Active clinical intervention is provided for at least four hours during the patient's stay in ED, as evidence by at least four hours of vital signs or four or more clinical contacts	YES Patients receive a minimum of four hours of regular observations or continuous monitoring	YES Patients receive a minimum of four hours of regular observations or continuous monitoring	YES. Regular observations or continuous monitoring. Regular observations may include: —Observations of vital or neurological signs provided on a repeated and periodic basis during the patient's treatment —Provision of repeated and periodic diagnostic or investigative procedures or provision of treatment. Continuous monitoring could include: —Continual monitoring via ECG or similar technologies. Continuous active supervision or treatment by staff.	A standard definition of 'continuous active management' is not used across jurisdictions. However, examples of regular observations and continuous monitoring are similar across jurisdictions. For example. Continuous active management includes: —Tests or investigative procedures —Monitoring of vital or neurological signs (for example, monitoring via ECG or —Treatment provided by a clinician. A patient can be 'observed' or 'supervised' when undergoing treatment by a clinician. Continuous active management does not include continuous blood pressure or pulse monitoring

(continued)

Table A4 (continued): Comparison of emergency department Short Stay Unit policies and/or guidelines

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Comments
Medically reviewed every four hours, at a minimum	YES Minimum 4th hourly observations should be performed or as determined by specialist emergency physician.		YES						

Note: This report was drafted in 2015–16; the documents referenced in this table may have since been updated.

Table A5: Comparison between Victoria's 'Automatically admitted procedures list' and Western Australia's 'Type B procedure list', 2013–14

ACHI code and description	Included in Victoria's list	Included in Western Australia's list
1381500 Central Vein Catheterisation open	NO	YES
1836000 Admin Of Botulinum Toxin Soft Tis NEC	NO	YES
3144101 Removal Of Gastric Band Reservoir	NO	YES
3656100 Closed biopsy of kidney (endoscopic)	NO	YES
3685100 Endoscopic administration of agent into bladder wall	NO	YES
3848808 Percutaneous replacement of aortic valve with bioprosthesis	YES	NO
3848809 Percutaneous replacement of mitral valve with bioprosthesis	YES	NO
3848810 Percutaneous replacement of tricuspid valve with bioprosthesis	YES	NO
3848811 Percutaneous replacement of pulmonary valve with bioprosthesis	YES	NO
4189802 Fibreoptic bronchoscopy with broncho-alveolar lavage [BAL]	YES	NO
9072600 Other destruction of breast (Note: o*ften coded with high intensity focused ultrasound*)	YES	NO
9221000 Nitric oxide therapy	YES	NO
Other inconsistencies found (likely to be due to coding or transposition error when developing lists)[(a)]		
3037531 Gastro-gastrostomy	YES	NO
3051203 Laparoscopic gastric bypass	YES	NO
3052706 Fundoplasty, transoral approach	YES	NO
3200901 Laparoscopic total colectomy with ileostomy	YES	NO
3201201 Laparoscopic total colectomy with ileorectal anastomosis	YES	NO
3680001 Endoscopic replacement of indwelling urinary catheter *(Note: WA stipulates with Cysto/Urethroscopy only, otherwise Type C procedure)*	NO	YES
3680003 Endoscopic removal of indwelling urinary catheter (*Note: WA stipulates with Cysto/Urethroscopy only, otherwise Type C procedure)*	NO	YES
3881200 Percutaneous needle biopsy of lung	NO	YES
4558802 Necklift	YES	NO

(a) Inconsistencies were found for these procedures but it is suspected that there was an error in the development of the lists (for example, codes not updated from previous years, new codes not included or a transposition error) or there were additional caveats which would explain the inconsistency (see replacement/removal of indwelling catheter).

Notes

1. This compares lists based on the ACHI 8th edition. It's possible this comparison table may change very slightly when lists based on the ACHI 9th edition are compared.
2. There were 2 codes included in the WA list (1220300 Polysomnography; 1220301 Overnight Oximetry) that relate to overnight admissions only. These have been excluded from this list.

Table A6: Chemotherapy procedures: Comparison of Victoria's and Western Australia's 'automatically admit' lists

ACHI 8th edition code	ACHI 8th edition description	Included in Victoria's list	Included in Western Australia's list
96199-00	Intravenous administration of pharmacological agent	YES	YES
96196-00	Intra-arterial administration of pharmacological agent	NO	NO
96201-00	Intracavitary administration of pharmacological agent	YES	YES
Other antineoplastic chemotherapy ACHI codes			
96197-00	Intramuscular administration of pharmacological agent	NO	NO
96198-00	Intrathecal administration of pharmacological agent	YES	YES
96200-00	Subcutaneous administration of pharmacological agent	NO	NO
96202-00	Enteral administration of pharmacological agent	NO	NO
96203-00	Oral administration of pharmacological agent	NO	NO
96205-00	Other administration of pharmacological agent, antineoplastic agent	NO	NO
96206-00	Unspecified administration of pharmacological agent	NO	NO
96209-00	Loading of drug delivery device	NO	NO

Table A7: Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Respiratory/Ear Nose and Throat					
41764-00	370	Nasendoscopy	YES	YES	Resp/ENT
41764-01	370	Sinoscopy	YES	YES	Resp/ENT
52035-00	419	Endoscopic laser therapy of upper aerodigestive tract	YES	YES	Resp/ENT
41773-00	421	Endoscopic resection of pharyngeal pouch	YES	YES	Resp/ENT
41764-03	520	Fibreoptic laryngoscopy	YES	YES	Resp/ENT
41849-00	520	Laryngoscopy	YES	YES	Resp/ENT
41855-00	520	Microlaryngoscopy	YES	YES	Resp/ENT
41868-00	522	Division of laryngeal web using microlaryngoscopic techniques	YES	YES	Resp/ENT
41852-00	523	Laryngoscopy with removal of lesion	YES	YES	Resp/ENT
41861-00	523	Microlaryngoscopy with removal of lesion by laser	YES	YES	Resp/ENT
41864-00	523	Microlaryngoscopy with removal of lesion	YES	YES	Resp/ENT
41867-00	523	Microlaryngoscopy with arytenoidectomy	YES	YES	Resp/ENT
41764-04	532	Tracheoscopy through artificial stoma	YES	YES	Resp/ENT
41889-00	543	Rigid bronchoscopy	YES	YES	Resp/ENT
41889-01	543	Bronchoscopy through artificial stoma	YES	YES	Resp/ENT
41898-00	543	Fibreoptic bronchoscopy	YES	YES	Resp/ENT
41892-00	544	Rigid bronchoscopy with biopsy	YES	YES	Resp/ENT
41895-00	544	Rigid bronchoscopy with removal of foreign body	YES	YES	Resp/ENT
41898-01	544	Fibreoptic bronchoscopy with biopsy	YES	YES	Resp/ENT
41898-02	544	Fibreoptic bronchoscopy with broncho-alveolar lavage [BAL]	YES	NO	Resp/ENT

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Respiratory/Ear Nose and Throat (continued)					
41898-03	544	Fibreoptic bronchoscopy with removal of foreign body	YES	YES	Resp/ENT
41892-01	545	Bronchoscopy with excision of lesion	YES	YES	Resp/ENT
41901-00	545	Endoscopic resection of lesion of bronchus by laser	YES	YES	Resp/ENT
90163-00	545	Other endoscopic excision of bronchus	YES	YES	Resp/ENT
41904-00	546	Bronchoscopy with dilation	YES	YES	Resp/ENT
38436-01	549	Endoscopic division of pleural adhesions	YES	YES	Resp/ENT
90169-00	551	Endoscopic wedge resection of lung	YES	YES	Resp/ENT
38421-00	554	Endoscopic pulmonary decortication	YES	YES	Resp/ENT
90171-00	556	Endoscopic pleurodesis	YES	YES	Resp/ENT
38436-00	559	Thoracoscopy	YES	YES	Resp/ENT
38448-01	559	Mediastinoscopy	YES	YES	Resp/ENT
Gastrointestinal					
30473-03	850	Oesophagoscopy	YES	YES	Gastrointestinal
41816-00	850	Rigid oesophagoscopy	YES	YES	Gastrointestinal
30476-00	851	Endoscopic administration of agent into nonbleeding lesion of oesophagus	NO	YES	Gastrointestinal
30476-01	851	Endoscopic administration of agent into nonbleeding lesion of oesophagogastric junction	NO	YES	Gastrointestinal
30478-06	851	Endoscopic administration of agent into bleeding lesion of oesophagus	NO	YES	Gastrointestinal
30478-09	851	Endoscopic administration of agent into bleeding lesion of oesophagogastric junction	NO	YES	Gastrointestinal
30478-10	852	Oesophagoscopy with removal of foreign body	YES	YES	Gastrointestinal
41825-00	852	Rigid oesophagoscopy with removal of foreign body	YES	YES	Gastrointestinal

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Gastrointestinal (continued)					
30490-00	853	Endoscopic insertion of oesophageal prosthesis	YES	YES	Gastrointestinal
30490-01	853	Endoscopic replacement of oesophageal prosthesis	YES	YES	Gastrointestinal
30490-02	853	Endoscopic removal of oesophageal prosthesis	YES	YES	Gastrointestinal
30532-00	854	Oesophagogastric myotomy, laparoscopic approach	YES	YES	Gastrointestinal
30476-02	856	Endoscopic banding of oesophageal varices	YES	YES	Gastrointestinal
30478-11	856	Oesophagoscopy with diathermy	NO	YES	Gastrointestinal
30478-12	856	Oesophagoscopy with heater probe coagulation	NO	YES	Gastrointestinal
30478-19	856	Oesophagoscopy with other coagulation	NO	YES	Gastrointestinal
30479-00	856	Endoscopic laser therapy to oesophagus	NO	YES	Gastrointestinal
30473-04	861	Oesophagoscopy with biopsy	YES	YES	Gastrointestinal
30478-13	861	Oesophagoscopy with excision of lesion	YES	YES	Gastrointestinal
41822-00	861	Rigid oesophagoscopy with biopsy	YES	YES	Gastrointestinal
90297-00	861	Endoscopic mucosal resection of oesophagus	YES	YES	Gastrointestinal
41819-00	862	Other endoscopic dilation of oesophagus	YES	YES	Gastrointestinal
41831-00	862	Endoscopic pneumatic dilation of oesophagus	YES	YES	Gastrointestinal
41832-00	862	Endoscopic balloon dilation of oesophagus	YES	YES	Gastrointestinal
30532-05	863	Oesophagogastric myotomy, laparoscopic approach, with closure of diaphragmatic hiatus	YES	YES	Gastrointestinal
30533-04	863	Oesophagogastric myotomy, laparoscopic approach, with fundoplasty	YES	YES	Gastrointestinal
30533-05	863	Oesophagogastric myotomy, laparoscopic approach, with fundoplasty and closure of diaphragmatic hiatus	YES	YES	Gastrointestinal
30478-07	870	Endoscopic administration of agent into lesion of stomach or duodenum	YES	YES	Gastrointestinal

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Gastrointestinal (continued)					
30481-00	870	Initial insertion of percutaneous endoscopic gastrostomy [PEG] tube	YES	YES	Gastrointestinal
30482-00	870	Repeat insertion of percutaneous endoscopic gastrostomy [PEG] tube	YES	YES	Gastrointestinal
30375-22	873	Transabdominal gastroscopy	YES	YES	Gastrointestinal
30476-03	874	Endoscopic banding of gastric varices	YES	YES	Gastrointestinal
90297-01	880	Endoscopic mucosal resection of stomach	YES	YES	Gastrointestinal
30475-00	882	Endoscopic dilation of gastric stricture	YES	YES	Gastrointestinal
30475-01	882	Endoscopic dilation of gastroduodenal stricture	YES	YES	Gastrointestinal
30527-00	886	Fundoplasty, laparoscopic approach	YES	YES	Gastrointestinal
30527-01	886	Fundoplasty, laparoscopic approach, with closure of diaphragmatic hiatus	YES	YES	Gastrointestinal
90296-00	887	Endoscopic control of peptic ulcer or bleeding	YES	YES	Gastrointestinal
30511-02	889	Laparoscopic adjustable gastric banding [LAGB]	YES	YES	Gastrointestinal
30511-03	889	Laparoscopic nonadjustable gastric banding [LNGB]	YES	YES	Gastrointestinal
30511-06	889	Laparoscopic gastroplasty	YES	YES	Gastrointestinal
30511-07	889	Endoscopic gastroplasty	YES	YES	Gastrointestinal
30511-09	889	Laparoscopic sleeve gastrectomy [LSG]	YES	YES	Gastrointestinal
30512-01	889	Laparoscopic biliopancreatic diversion [LBPD]	YES	YES	Gastrointestinal
30512-03	889	Laparoscopic gastric bypass	YES	NO	Gastrointestinal
90942-01	889	Laparoscopic removal of gastric band	YES	YES	Gastrointestinal
90942-02	889	Endoscopic removal of gastric band	YES	YES	Gastrointestinal
90943-01	889	Other laparoscopic procedures for obesity	YES	YES	Gastrointestinal

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Gastrointestinal (continued)					
90943-02	889	Other endoscopic procedures for obesity	YES	YES	Gastrointestinal
32095-00	891	Endoscopic examination of small intestine via artificial stoma	YES	YES	Gastrointestinal
30478-05	892	Percutaneous endoscopic jejunostomy [PEJ]	YES	YES	Gastrointestinal
92068-00	892	Endoscopic insertion of duodenal prosthesis	YES	YES	Gastrointestinal
92068-01	892	Endoscopic replacement of duodenal prosthesis	YES	YES	Gastrointestinal
92068-02	892	Endoscopic removal of duodenal prosthesis	YES	YES	Gastrointestinal
30568-00	893	Endoscopic examination of small intestine via intraoperative enterotomy	YES	YES	Gastrointestinal
30569-00	894	Endoscopic examination of small intestine via laparotomy	YES	YES	Gastrointestinal
32075-00	904	Rigid sigmoidoscopy	YES	YES	Gastrointestinal
32084-00	905	Fibreoptic colonoscopy to hepatic flexure	YES	YES	Gastrointestinal
32084-02	905	Fibreoptic colonoscopy to hepatic flexure with administration of tattooing agent	YES	YES	Gastrointestinal
32090-00	905	Fibreoptic colonoscopy to caecum	YES	YES	Gastrointestinal
32090-02	905	Fibreoptic colonoscopy to caecum with administration of tattooing agent	YES	YES	Gastrointestinal
90295-00	906	Endoscopic insertion of colonic prosthesis	NO	YES	Gastrointestinal
90295-01	906	Endoscopic replacement of colonic prosthesis	NO	YES	Gastrointestinal
90295-02	906	Endoscopic removal of colonic prosthesis	NO	YES	Gastrointestinal
30375-23	907	Endoscopic examination of large intestine via laparotomy	YES	YES	Gastrointestinal
30479-02	908	Endoscopic laser therapy to large intestine	YES	YES	Gastrointestinal
90308-00	908	Endoscopic destruction of lesion of large intestine	YES	YES	Gastrointestinal
32075-01	910	Rigid sigmoidoscopy with biopsy	YES	YES	Gastrointestinal

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Gastrointestinal (continued)					
32078-00	910	Rigid sigmoidoscopy with polypectomy involving removal ≤9 polyps	YES	YES	Gastrointestinal
32081-00	910	Rigid sigmoidoscopy with polypectomy involving removal of ≥10 polyps	YES	YES	Gastrointestinal
32084-01	911	Fibreoptic colonoscopy to hepatic flexure, with biopsy	YES	YES	Gastrointestinal
32087-00	911	Fibreoptic colonoscopy to hepatic flexure, with polypectomy	YES	YES	Gastrointestinal
32090-01	911	Fibreoptic colonoscopy to caecum, with biopsy	YES	YES	Gastrointestinal
32093-00	911	Fibreoptic colonoscopy to caecum, with polypectomy	YES	YES	Gastrointestinal
30515-04	913	Laparoscopic ileocolic resection with anastomosis	YES	YES	Gastrointestinal
30515-06	913	Laparoscopic ileocolic resection with formation of stoma	YES	YES	Gastrointestinal
32000-02	913	Laparoscopic limited excision of large intestine with formation of stoma	YES	YES	Gastrointestinal
32000-03	913	Laparoscopic right hemicolectomy with formation of stoma	YES	YES	Gastrointestinal
32003-02	913	Laparoscopic limited excision of large intestine with anastomosis	YES	YES	Gastrointestinal
32003-03	913	Laparoscopic right hemicolectomy with anastomosis	YES	YES	Gastrointestinal
32004-02	913	Laparoscopic subtotal colectomy with formation of stoma	YES	YES	Gastrointestinal
32004-03	913	Laparoscopic extended right hemicolectomy with formation of stoma	YES	YES	Gastrointestinal
32005-02	913	Laparoscopic subtotal colectomy with anastomosis	YES	YES	Gastrointestinal
32005-03	913	Laparoscopic extended right hemicolectomy with anastomosis	YES	YES	Gastrointestinal
32006-02	913	Laparoscopic left hemicolectomy with anastomosis	YES	YES	Gastrointestinal
32006-03	913	Laparoscopic left hemicolectomy with formation of stoma	YES	YES	Gastrointestinal
32009-01	913	Laparoscopic total colectomy with ileostomy	YES	NO	Gastrointestinal
32012-01	913	Laparoscopic total colectomy with ileorectal anastomosis	YES	NO	Gastrointestinal

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Gastrointestinal (continued)					
90297-02	914	Endoscopic mucosal resection of large intestine	YES	YES	Gastrointestinal
32094-00	917	Endoscopic dilation of colorectal stricture	YES	YES	Gastrointestinal
30572-00	926	Laparoscopic appendicectomy	YES	YES	Gastrointestinal
90295-03	929	Endoscopic insertion of rectal prosthesis	NO	YES	Gastrointestinal
90295-04	929	Endoscopic replacement of rectal prosthesis	NO	YES	Gastrointestinal
90295-05	929	Endoscopic removal of rectal prosthesis	NO	YES	Gastrointestinal
30479-01	931	Endoscopic laser therapy to rectum	YES	YES	Gastrointestinal
32103-00	933	Per anal excision of lesion or tissue of rectum via stereoscopic rectoscopy	NO	YES	Gastrointestinal
90315-00	933	Endoscopic excision of lesion or tissue of anus	YES	YES	Gastrointestinal
32030-01	934	Laparoscopic rectosigmoidectomy with formation of stoma	YES	YES	Gastrointestinal
30416-00	952	Laparoscopic marsupialisation of liver cyst	YES	YES	Gastrointestinal
30417-00	952	Laparoscopic marsupialisation of multiple liver cysts	YES	YES	Gastrointestinal
30442-00	957	Choledochoscopy	YES	YES	Gastrointestinal
30484-00	957	Endoscopic retrograde cholangiopancreatography [ERCP]	YES	YES	Gastrointestinal
30484-01	957	Endoscopic retrograde cholangiography [ERC]	YES	YES	Gastrointestinal
30452-01	958	Choledochoscopy with stenting	YES	YES	Gastrointestinal
30491-00	958	Endoscopic stenting of other parts of biliary tract	YES	YES	Gastrointestinal
30452-02	959	Choledochoscopy with removal of calculus	YES	YES	Gastrointestinal
30451-02	960	Endoscopic replacement of biliary stent	YES	YES	Gastrointestinal
30451-03	960	Endoscopic removal of biliary stent	YES	YES	Gastrointestinal

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Gastrointestinal (continued)					
30485-00	963	Endoscopic sphincterotomy	YES	YES	Gastrointestinal
30485-01	963	Endoscopic sphincterotomy with extraction of calculus from common bile duct	YES	YES	Gastrointestinal
30445-00	965	Laparoscopic cholecystectomy	YES	YES	Gastrointestinal
30448-00	965	Laparoscopic cholecystectomy with exploration of common bile duct via cystic duct	YES	YES	Gastrointestinal
30449-00	965	Laparoscopic cholecystectomy with exploration of common bile duct via laparoscopic choledochotomy	YES	YES	Gastrointestinal
90294-00	968	Endoscopic excision of lesion of bile ducts or sphincter of Oddi	YES	YES	Gastrointestinal
30452-00	971	Choledochoscopy with dilation	YES	YES	Gastrointestinal
30494-00	971	Endoscopic dilation of other parts of biliary tract	YES	YES	Gastrointestinal
30484-02	974	Endoscopic retrograde pancreatography [ERP]	YES	YES	Gastrointestinal
30491-02	975	Endoscopic stenting of pancreatic duct	YES	YES	Gastrointestinal
30491-03	975	Endoscopic replacement of pancreatic stent	YES	YES	Gastrointestinal
30491-04	975	Endoscopic removal of pancreatic stent	YES	YES	Gastrointestinal
90349-00	975	Endoscopic removal of pancreatic calculus	YES	YES	Gastrointestinal
90294-01	979	Endoscopic excision of lesion of pancreas or pancreatic duct	YES	YES	Gastrointestinal
30390-00	984	Laparoscopy	YES	YES	Gastrointestinal
30393-00	986	Laparoscopic division of abdominal adhesions	YES	YES	Gastrointestinal
30394-01	987	Laparoscopic drainage of intra-abdominal abscess, haematoma or cyst	YES	YES	Gastrointestinal
96189-01	989	Laparoscopic omentectomy	YES	YES	Gastrointestinal
30609-02	990	Laparoscopic repair of inguinal hernia, unilateral	YES	YES	Gastrointestinal
30609-03	990	Laparoscopic repair of inguinal hernia, bilateral	YES	YES	Gastrointestinal

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Gastrointestinal (continued)					
30609-00	991	Laparoscopic repair of femoral hernia, unilateral	YES	YES	Gastrointestinal
30609-01	991	Laparoscopic repair of femoral hernia, bilateral	YES	YES	Gastrointestinal
30473-00	1005	Panendoscopy to duodenum	YES	YES	Gastrointestinal
30473-02	1005	Panendoscopy through artificial stoma	YES	YES	Gastrointestinal
30473-05	1005	Panendoscopy to ileum	YES	YES	Gastrointestinal
30473-07	1005	Panendoscopy to duodenum with administration of tattooing agent	YES	YES	Gastrointestinal
30473-08	1005	Panendoscopy to ileum with administration of tattooing agent	YES	YES	Gastrointestinal
30478-00	1006	Panendoscopy to duodenum with removal of foreign body	YES	YES	Gastrointestinal
30478-14	1006	Panendoscopy to ileum with removal of foreign body	YES	YES	Gastrointestinal
30478-01	1007	Panendoscopy to duodenum with diathermy	YES	YES	Gastrointestinal
30478-02	1007	Panendoscopy to duodenum with heater probe coagulation	YES	YES	Gastrointestinal
30478-03	1007	Panendoscopy to duodenum with laser coagulation	YES	YES	Gastrointestinal
30478-15	1007	Panendoscopy to ileum with diathermy	YES	YES	Gastrointestinal
30478-16	1007	Panendoscopy to ileum with heater probe coagulation	YES	YES	Gastrointestinal
30478-17	1007	Panendoscopy to ileum with laser coagulation	YES	YES	Gastrointestinal
30478-20	1007	Panendoscopy to duodenum with other coagulation	YES	YES	Gastrointestinal
30478-21	1007	Panendoscopy to ileum with other coagulation	YES	YES	Gastrointestinal
30473-01	1008	Panendoscopy to duodenum with biopsy	YES	YES	Gastrointestinal
30473-06	1008	Panendoscopy to ileum with biopsy	YES	YES	Gastrointestinal
30478-04	1008	Panendoscopy to duodenum with excision of lesion	YES	YES	Gastrointestinal

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Gastrointestinal (continued)					
30478-18	1008	Panendoscopy to ileum with excision of lesion	YES	YES	Gastrointestinal
90343-00	1011	Endoscopic procedure proceeding to open procedure	YES	YES	Gastrointestinal
90343-01	1011	Laparoscopic procedure proceeding to open procedure	YES	YES	Gastrointestinal
Urological/gynaecological					
36652-00	1040	Retrograde pyeloscopy	YES	YES	Urological/gynaecological
36627-02	1041	Percutaneous nephroscopy with extraction of renal calculus	YES	YES	Urological/gynaecological
36652-01	1041	Retrograde pyeloscopy with manipulation of renal calculus	YES	YES	Urological/gynaecological
36654-02	1041	Retrograde pyeloscopy with extraction of renal calculus	YES	YES	Urological/gynaecological
36627-00	1043	Percutaneous nephroscopy	YES	YES	Urological/gynaecological
36633-00	1043	Percutaneous nephroscopy with incision of renal pelvis	YES	YES	Urological/gynaecological
36633-01	1043	Percutaneous nephroscopy with incision of renal calyx	YES	YES	Urological/gynaecological
36633-02	1043	Percutaneous nephroscopy with incision of ureter	YES	YES	Urological/gynaecological
36627-03	1046	Percutaneous nephroscopy with diathermy of kidney	YES	YES	Urological/gynaecological
36639-00	1046	Percutaneous nephroscopy with fragmentation and extraction of ≤2 or less calculi	YES	YES	Urological/gynaecological
36645-00	1046	Percutaneous nephroscopy with fragmentation or extraction of single calculus ≥3 cm in any dimension, or for ≥3 calculi	YES	YES	Urological/gynaecological
36654-01	1046	Retrograde pyeloscopy with diathermy to kidney	YES	YES	Urological/gynaecological
36656-00	1046	Retrograde pyeloscopy with fragmentation of renal calculus	YES	YES	Urological/gynaecological
36656-01	1046	Retrograde pyeloscopy with fragmentation and extraction of renal calculus	YES	YES	Urological/gynaecological
36627-01	1047	Percutaneous nephroscopy with biopsy	YES	YES	Urological/gynaecological

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Urological/gynaecological (continued)					
36654-00	1047	Retrograde pyeloscopy with biopsy of kidney	YES	YES	Urological/gynaecological
36821-00	1047	Endoscopic brush biopsy of renal pelvis	YES	YES	Urological/gynaecological
36522-00	1048	Laparoscopic partial nephrectomy	YES	YES	Urological/gynaecological
36525-00	1048	Laparoscopic partial nephrectomy complicated by previous surgery on same kidney	YES	YES	Urological/gynaecological
36516-00	1049	Laparoscopic complete nephrectomy, unilateral	YES	YES	Urological/gynaecological
36516-02	1049	Laparoscopic complete nephrectomy, bilateral	YES	YES	Urological/gynaecological
36516-04	1050	Laparoscopic complete nephrectomy for transplantation, living donor	YES	YES	Urological/gynaecological
36519-00	1051	Laparoscopic complete nephrectomy for removal of transplanted kidney	YES	YES	Urological/gynaecological
36519-02	1052	Laparoscopy complete nephrectomy complicated by previous surgery on same kidney	YES	YES	Urological/gynaecological
36528-00	1053	Laparoscopic radical nephrectomy	YES	YES	Urological/gynaecological
36531-00	1054	Laparoscopic nephroureterectomy	YES	YES	Urological/gynaecological
36558-00	1055	Laparoscopic excision of renal cyst	YES	YES	Urological/gynaecological
36564-00	1057	Laparoscopic pyeloplasty	YES	YES	Urological/gynaecological
36570-00	1057	Laparoscopic pyeloplasty complicated by previous surgery on renal pelvis of same kidney	YES	YES	Urological/gynaecological
36803-00	1065	Ureteroscopy	YES	YES	Urological/gynaecological
36860-00	1065	Endoscopic examination of intestinal conduit	YES	YES	Urological/gynaecological
36860-01	1065	Endoscopic examination of intestinal reservoir	YES	YES	Urological/gynaecological
36818-00	1066	Endoscopic ureteric catheterisation with fluoroscopic imaging of upper urinary tract, unilateral	YES	YES	Urological/gynaecological
36818-01	1066	Endoscopic ureteric catheterisation with fluoroscopic imaging of upper urinary tract, bilateral	YES	YES	Urological/gynaecological
36824-00	1066	Endoscopic ureteric catheterisation, unilateral	YES	YES	Urological/gynaecological

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Urological/gynaecological (continued)					
36824-01	1066	Endoscopic ureteric catheterisation, bilateral	YES	YES	Urological/gynaecological
36821-01	1067	Endoscopic insertion of ureteric stent	YES	YES	Urological/gynaecological
36821-03	1067	Endoscopic replacement of ureteric stent	YES	YES	Urological/gynaecological
36833-01	1067	Endoscopic removal of ureteric stent	YES	YES	Urological/gynaecological
36803-02	1068	Endoscopic manipulation of ureteric calculus via ureteroscopy	YES	YES	Urological/gynaecological
36806-02	1068	Endoscopic extraction of ureteric calculus via ureteroscopy	YES	YES	Urological/gynaecological
36857-00	1068	Endoscopic manipulation or extraction of ureteric calculus without ureteroscopy	YES	YES	Urological/gynaecological
36612-00	1070	Laparoscopic exploration of ureter	YES	YES	Urological/gynaecological
36615-00	1071	Laparoscopic ureterolysis	YES	YES	Urological/gynaecological
36549-01	1072	Laparoscopic ureterolithotomy	YES	YES	Urological/gynaecological
37444-00	1072	Laparoscopic ureterolithotomy, complicated by previous surgery of same ureter	YES	YES	Urological/gynaecological
36825-00	1073	Endoscopic incision of pelviureteric junction or ureteric stricture	YES	YES	Urological/gynaecological
36830-00	1073	Endoscopic ureteric meatotomy	YES	YES	Urological/gynaecological
36809-01	1074	Endoscopic destruction of ureteric lesion	YES	YES	Urological/gynaecological
36806-00	1075	Endoscopic biopsy of ureter	YES	YES	Urological/gynaecological
36821-02	1075	Endoscopic brush biopsy of ureter	YES	YES	Urological/gynaecological
36579-00	1076	Laparoscopic partial ureterectomy	YES	YES	Urological/gynaecological
36579-02	1076	Laparoscopic complete ureterectomy	YES	YES	Urological/gynaecological
36848-00	1077	Endoscopic resection of ureterocele	YES	YES	Urological/gynaecological
36615-02	1078	Laparoscopic ureterolysis with repositioning of ureter	YES	YES	Urological/gynaecological

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Urological/gynaecological (continued)					
36573-00	1079	Laparoscopic repair of divided ureter	YES	YES	Urological/gynaecological
36585-00	1080	Laparoscopic transplantation of ureter into skin, unilateral	YES	YES	Urological/gynaecological
36585-02	1080	Laparoscopic transplantation of ureter into skin, bilateral	YES	YES	Urological/gynaecological
36597-00	1081	Laparoscopic transplantation of ureter into other ureter	YES	YES	Urological/gynaecological
36594-00	1082	Laparoscopic transplantation of ureter into intestine, unilateral	YES	YES	Urological/gynaecological
36594-02	1082	Laparoscopic transplantation of ureter into intestine, bilateral	YES	YES	Urological/gynaecological
36588-00	1084	Laparoscopic reimplantation of ureter into bladder, unilateral	YES	YES	Urological/gynaecological
36588-02	1084	Laparoscopic reimplantation of ureter into bladder, bilateral	YES	YES	Urological/gynaecological
36591-00	1085	Laparoscopic reimplantation of ureter into bladder with bladder flap, unilateral	YES	YES	Urological/gynaecological
36591-02	1085	Laparoscopic reimplantation of ureter into bladder with bladder flap, bilateral	YES	YES	Urological/gynaecological
36618-00	1086	Laparoscopic reduction ureteroplasty	YES	YES	Urological/gynaecological
36803-01	1086	Endoscopic dilation of ureter	YES	YES	Urological/gynaecological
36609-02	1087	Laparoscopic revision of ureterostomy	YES	YES	Urological/gynaecological
36812-00	1089	Cystoscopy	YES	YES	Urological/gynaecological
36812-01	1089	Cystoscopy through artificial stoma	YES	YES	Urological/gynaecological
36833-00	1092	Endoscopic removal of foreign body from bladder	YES	YES	Urological/gynaecological
36842-00	1092	Endoscopic lavage of blood clots from bladder	YES	YES	Urological/gynaecological
36851-00	1092	Endoscopic administration of agent into bladder wall	NO	YES	Urological/gynaecological
37008-00	1093	Laparoscopic cystotomy [cystostomy]	YES	YES	Urological/gynaecological
37008-02	1094	Laparoscopic cystolithotomy	YES	YES	Urological/gynaecological

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Urological/gynaecological (continued)					
36812-02	1095	Endoscopic division of intraluminal bladder adhesions	YES	YES	Urological/gynaecological
36854-00	1095	Endoscopic incision of bladder neck	YES	YES	Urological/gynaecological
36840-03	1096	Endoscopic destruction of a single lesion of bladder ≤2 cm or tissue of bladder	YES	YES	Urological/gynaecological
36845-06	1096	Endoscopic destruction of a single lesion of bladder >2 cm in diameter	YES	YES	Urological/gynaecological
36845-07	1096	Endoscopic destruction of multiple lesions of bladder	YES	YES	Urological/gynaecological
36836-00	1098	Endoscopic biopsy of bladder	YES	YES	Urological/gynaecological
37008-04	1099	Laparoscopic removal of foreign body from bladder	YES	YES	Urological/gynaecological
36840-02	1100	Endoscopic resection of a single lesion of bladder ≤2 cm or tissue of bladder	YES	YES	Urological/gynaecological
36845-04	1100	Endoscopic resection of a single lesion of bladder >2 cm in diameter	YES	YES	Urological/gynaecological
36845-05	1100	Endoscopic resection of multiple lesions of bladder	YES	YES	Urological/gynaecological
36854-02	1101	Endoscopic resection of bladder neck	YES	YES	Urological/gynaecological
37000-00	1102	Laparoscopic partial excision of bladder	YES	YES	Urological/gynaecological
37020-00	1103	Laparoscopic excision of bladder diverticulum	YES	YES	Urological/gynaecological
37004-00	1104	Laparoscopic repair of ruptured bladder	YES	YES	Urological/gynaecological
37023-00	1105	Laparoscopic closure of cutaneous vesical fistula	YES	YES	Urological/gynaecological
37029-00	1105	Laparoscopic closure of vesicovaginal fistula	YES	YES	Urological/gynaecological
37038-00	1105	Laparoscopic closure of vesicointestinal fistula	YES	YES	Urological/gynaecological
37047-00	1107	Laparoscopic enlargement of bladder	YES	YES	Urological/gynaecological
36827-00	1108	Endoscopically controlled hydrodilation of bladder	YES	YES	Urological/gynaecological
37004-01	1108	Other laparoscopic repair of bladder	YES	YES	Urological/gynaecological

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Urological/gynaecological (continued)					
37053-00	1108	Laparoscopic bladder transection and reanastomosis to trigone	YES	YES	Urological/gynaecological
37315-00	1112	Urethroscopy	YES	YES	Urological/gynaecological
36811-00	1114	Endoscopic insertion of urethral prosthesis	YES	YES	Urological/gynaecological
36811-01	1114	Endoscopic insertion of urethral stent	YES	YES	Urological/gynaecological
37318-00	1114	Endoscopic removal of foreign body from urethra	YES	YES	Urological/gynaecological
36854-01	1115	Endoscopic incision of external urethral sphincter	YES	YES	Urological/gynaecological
36815-01	1116	Endoscopic destruction of urethral warts	YES	YES	Urological/gynaecological
37318-01	1116	Endoscopic diathermy of urethra	YES	YES	Urological/gynaecological
37318-02	1116	Endoscopic fragmentation or extraction of urethral calculus	YES	YES	Urological/gynaecological
37318-03	1116	Endoscopic fragmentation or extraction of urethral calculus using laser	YES	YES	Urological/gynaecological
37854-00	1116	Endoscopic destruction of urethral valve	YES	YES	Urological/gynaecological
37318-04	1117	Endoscopic biopsy of urethra	YES	YES	Urological/gynaecological
36854-03	1118	Endoscopic resection of external urethral sphincter	YES	YES	Urological/gynaecological
35637-07	1241	Laparoscopic rupture of ovarian cyst or abscess	YES	YES	Urological/gynaecological
35637-08	1241	Laparoscopic ovarian drilling	YES	YES	Urological/gynaecological
35638-00	1243	Laparoscopic wedge resection of ovary	YES	YES	Urological/gynaecological
35638-01	1243	Laparoscopic partial oophorectomy	YES	YES	Urological/gynaecological
35638-02	1243	Laparoscopic oophorectomy, unilateral	YES	YES	Urological/gynaecological
35638-03	1243	Laparoscopic oophorectomy, bilateral	YES	YES	Urological/gynaecological
35638-04	1244	Laparoscopic ovarian cystectomy, unilateral	YES	YES	Urological/gynaecological

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Urological/gynaecological (continued)					
35638-05	1244	Laparoscopic ovarian cystectomy, bilateral	YES	YES	Urological/gynaecological
35729-00	1245	Laparoscopic transposition of ovary	YES	YES	Urological/gynaecological
90430-00	1246	Other laparoscopic repair of ovary	YES	YES	Urological/gynaecological
35710-00	1248	Falloposcopy	YES	YES	Urological/gynaecological
35638-06	1249	Laparoscopic salpingotomy	YES	YES	Urological/gynaecological
35694-02	1249	Laparoscopic salpingolysis	YES	YES	Urological/gynaecological
35638-07	1251	Laparoscopic partial salpingectomy, unilateral	YES	YES	Urological/gynaecological
35638-08	1251	Laparoscopic partial salpingectomy, bilateral	YES	YES	Urological/gynaecological
35638-09	1251	Laparoscopic salpingectomy, unilateral	YES	YES	Urological/gynaecological
35638-10	1251	Laparoscopic salpingectomy, bilateral	YES	YES	Urological/gynaecological
35638-11	1252	Laparoscopic salpingo-oophorectomy, unilateral	YES	YES	Urological/gynaecological
35638-12	1252	Laparoscopic salpingo-oophorectomy, bilateral	YES	YES	Urological/gynaecological
35694-00	1253	Laparoscopic salpingoplasty	YES	YES	Urological/gynaecological
35694-01	1254	Laparoscopic anastomosis of fallopian tube	YES	YES	Urological/gynaecological
35694-03	1255	Laparoscopic salpingostomy	YES	YES	Urological/gynaecological
90433-00	1255	Other laparoscopic repair of fallopian tube	YES	YES	Urological/gynaecological
35674-01	1256	Fetotoxic injection of ectopic pregnancy via laparoscopy	YES	YES	Urological/gynaecological
35678-00	1256	Laparoscopic salpingotomy with removal of tubal pregnancy	YES	YES	Urological/gynaecological
35678-01	1256	Laparoscopic salpingectomy with removal of tubal pregnancy	YES	YES	Urological/gynaecological
35688-00	1257	Laparoscopic sterilisation	YES	YES	Urological/gynaecological

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Urological/gynaecological (continued)					
35688-03	1257	Laparoscopic electrodestruction of fallopian tubes	YES	YES	Urological/gynaecological
35630-00	1259	Diagnostic hysteroscopy	YES	YES	Urological/gynaecological
35633-02	1261	Hysteroscopy with tubal catheterisation	YES	YES	Urological/gynaecological
35634-00	1262	Division of uterine septum via hysteroscopy	YES	YES	Urological/gynaecological
35622-00	1263	Endoscopic endometrial ablation	YES	YES	Urological/gynaecological
35623-00	1266	Myomectomy of uterus via hysteroscopy	YES	YES	Urological/gynaecological
35633-01	1266	Polypectomy of uterus via hysteroscopy	YES	YES	Urological/gynaecological
35649-01	1266	Myomectomy of uterus via laparoscopy	YES	YES	Urological/gynaecological
90448-00	1268	Subtotal laparoscopic abdominal hysterectomy	YES	YES	Urological/gynaecological
90448-01	1268	Total laparoscopic abdominal hysterectomy	YES	YES	Urological/gynaecological
90448-02	1268	Total laparoscopic abdominal hysterectomy with removal of adnexa	YES	YES	Urological/gynaecological
35750-00	1269	Laparoscopically assisted vaginal hysterectomy	YES	YES	Urological/gynaecological
35753-02	1269	Laparoscopically assisted vaginal hysterectomy with removal of adnexa	YES	YES	Urological/gynaecological
35637-04	1271	Laparoscopic ventrosuspension	YES	YES	Urological/gynaecological
35684-00	1271	Other laparoscopic uterine suspension	YES	YES	Urological/gynaecological
90435-00	1271	Other laparoscopic repair of uterus	YES	YES	Urological/gynaecological
35680-00	1272	Laparoscopic reconstruction of uterus and supporting structures	YES	YES	Urological/gynaecological
35539-04	1279	Vaginoscopy	YES	YES	Urological/gynaecological
35595-00	1285	Laparoscopic pelvic floor repair	YES	YES	Urological/gynaecological
35597-00	1285	Laparoscopic sacral colpopexy	YES	YES	Urological/gynaecological

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Urological/gynaecological (continued)					
35637-02	1299	Laparoscopic diathermy of lesion of pelvic cavity	YES	YES	Urological/gynaecological
35637-10	1299	Laparoscopic excision of lesion of pelvic cavity	YES	YES	Urological/gynaecological
35638-14	1299	Laparoscopic uterosacral nerve ablation [LUNA]	YES	YES	Urological/gynaecological
Orthopaedic					
45857-02	1363	Arthroscopic division of adhesions of temporomandibular joint	YES	YES	Orthopaedic
45855-00	1364	Arthroscopy of temporomandibular joint	YES	YES	Orthopaedic
45857-00	1364	Arthroscopy of temporomandibular joint with removal of loose body	YES	YES	Orthopaedic
45857-01	1364	Arthroscopic debridement of temporomandibular joint	YES	YES	Orthopaedic
48945-00	1395	Arthroscopy of shoulder	YES	YES	Orthopaedic
48948-01	1395	Arthroscopic removal of loose body of shoulder	YES	YES	Orthopaedic
90600-00	1395	Arthroscopic release of adhesions or contracture of shoulder	YES	YES	Orthopaedic
48945-01	1396	Arthroscopic biopsy of shoulder	YES	YES	Orthopaedic
48948-00	1397	Arthroscopic debridement of shoulder	YES	YES	Orthopaedic
48954-00	1397	Arthroscopic synovectomy of shoulder	YES	YES	Orthopaedic
48951-00	1400	Arthroscopic decompression of subacromial space	YES	YES	Orthopaedic
48948-02	1404	Arthroscopic chondroplasty of shoulder	YES	YES	Orthopaedic
48957-00	1404	Arthroscopic stabilisation of shoulder	YES	YES	Orthopaedic
48960-00	1405	Arthroscopic reconstruction of shoulder	YES	YES	Orthopaedic
49118-00	1410	Arthroscopy of elbow	YES	YES	Orthopaedic
49121-00	1410	Arthroscopic drilling of defect of elbow	YES	YES	Orthopaedic

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Orthopaedic (continued)					
49121-01	1410	Arthroscopic removal of loose body of elbow	YES	YES	Orthopaedic
49121-04	1410	Arthroscopic release of elbow contracture	YES	YES	Orthopaedic
49118-01	1411	Arthroscopic biopsy of elbow	YES	YES	Orthopaedic
49109-00	1412	Arthroscopic synovectomy of elbow	YES	YES	Orthopaedic
49121-02	1418	Arthroscopic chondroplasty of elbow	YES	YES	Orthopaedic
49121-03	1418	Arthroscopic osteoplasty of elbow	YES	YES	Orthopaedic
49218-00	1443	Arthroscopy of wrist	YES	YES	Orthopaedic
49221-00	1443	Arthroscopic drilling of defect of wrist	YES	YES	Orthopaedic
49221-01	1443	Arthroscopic removal of loose body of wrist	YES	YES	Orthopaedic
49221-02	1443	Arthroscopic release of adhesions of wrist	YES	YES	Orthopaedic
49218-01	1444	Arthroscopic biopsy of wrist	YES	YES	Orthopaedic
49224-00	1451	Arthroscopic debridement of wrist	YES	YES	Orthopaedic
49224-01	1451	Arthroscopic synovectomy of wrist	YES	YES	Orthopaedic
49224-02	1468	Arthroscopic osteoplasty of wrist	YES	YES	Orthopaedic
49227-00	1468	Arthroscopic pinning of osteochondral fragment of wrist	YES	YES	Orthopaedic
49360-00	1481	Arthroscopy of hip	YES	YES	Orthopaedic
49366-00	1481	Arthroscopic removal of loose body from hip	YES	YES	Orthopaedic
49363-00	1482	Arthroscopic biopsy of hip	YES	YES	Orthopaedic
49557-00	1501	Arthroscopy of knee	YES	YES	Orthopaedic
49560-00	1501	Arthroscopic removal of loose body of knee	YES	YES	Orthopaedic

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Orthopaedic (continued)					
49560-02	1501	Arthroscopic lateral release of knee	YES	YES	Orthopaedic
49557-01	1502	Arthroscopic biopsy of knee	YES	YES	Orthopaedic
49557-02	1503	Arthroscopic excision of meniscal margin or plica of knee	YES	YES	Orthopaedic
49558-00	1503	Arthroscopic debridement of knee	YES	YES	Orthopaedic
49560-01	1503	Arthroscopic trimming of ligament of knee	YES	YES	Orthopaedic
49560-03	1503	Arthroscopic meniscectomy of knee	YES	YES	Orthopaedic
49566-00	1503	Arthroscopic synovectomy of knee	YES	YES	Orthopaedic
49561-02	1511	Arthroscopic removal of loose body of knee with debridement, osteoplasty or chondroplasty	YES	YES	Orthopaedic
49562-02	1511	Arthroscopic removal of loose body of knee with chondroplasty and multiple drilling or implant	YES	YES	Orthopaedic
49561-00	1514	Arthroscopic lateral release of knee with debridement, osteoplasty or chondroplasty	YES	YES	Orthopaedic
49562-00	1514	Arthroscopic lateral release of knee with chondroplasty and multiple drilling or implant	YES	YES	Orthopaedic
49561-01	1517	Arthroscopic meniscectomy of knee with debridement, osteoplasty or chondroplasty	YES	YES	Orthopaedic
49562-01	1517	Arthroscopic meniscectomy of knee with chondroplasty and multiple drilling or implant	YES	YES	Orthopaedic
49558-01	1520	Arthroscopic chondroplasty of knee	YES	YES	Orthopaedic
49558-02	1520	Arthroscopic osteoplasty of knee	YES	YES	Orthopaedic
49563-00	1520	Arthroscopic repair of meniscus of knee	YES	YES	Orthopaedic
49539-00	1522	Arthroscopic reconstruction of knee	YES	YES	Orthopaedic
49542-00	1522	Arthroscopic reconstruction of cruciate ligament of knee with repair of meniscus	YES	YES	Orthopaedic
49700-00	1529	Arthroscopy of ankle	YES	YES	Orthopaedic
49703-02	1529	Arthroscopic removal of loose body of ankle	YES	YES	Orthopaedic

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Orthopaedic (continued)					
49700-01	1531	Arthroscopic biopsy of ankle	YES	YES	Orthopaedic
49703-01	1531	Arthroscopic trimming of osteophyte of ankle	YES	YES	Orthopaedic
49703-04	1531	Arthroscopic synovectomy of ankle	YES	YES	Orthopaedic
49703-03	1544	Arthroscopic repair of osteochondral fracture of ankle	YES	YES	Orthopaedic
49703-05	1544	Arthroscopic chondroplasty of ankle	YES	YES	Orthopaedic
50100-00	1555	Arthroscopy joint, not elsewhere classified	YES	YES	Orthopaedic
50100-01	1560	Arthroscopic biopsy of joint, not elsewhere classified	YES	YES	Orthopaedic
50102-00	1579	Arthroscopic procedure of joint, not elsewhere classified	YES	YES	Orthopaedic
90613-00	1579	Arthroscopic procedure proceeding to open procedure	YES	YES	Orthopaedic
Other					
31000-00	1626	Microscopically controlled serial excision of lesion(s) of skin	YES	YES	Other
90460-00	1330	Amnioscopy	YES	YES	Other
90463-01	1330	Endoscopic fetal reduction	YES	YES	Other
90488-00	1330	Endoscopic ablation of vessels of placenta	YES	YES	Other
37221-00	1161	Endoscopic drainage of abscess of prostate	YES	YES	Other
37224-00	1162	Endoscopic destruction of lesion of prostate	YES	YES	Other
37224-01	1162	Endoscopic resection of lesion of prostate	YES	YES	Other
37215-00	1163	Endoscopic biopsy of prostate	YES	YES	Other
37207-00	1166	Endoscopic laser ablation of prostate	YES	YES	Other
37207-01	1166	Endoscopic laser excision of prostate	YES	YES	Other

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Other (continued)					
37209-01	1166	Laparoscopic radical prostatectomy	YES	YES	Other
37210-01	1166	Laparoscopic radical prostatectomy with bladder neck reconstruction	YES	YES	Other
37211-01	1166	Laparoscopic radical prostatectomy with bladder neck reconstruction and pelvic lymphadenectomy	YES	YES	Other
36815-00	1195	Endoscopic destruction of penile wart	YES	YES	Other
38450-01	643	Thoracoscopic drainage of pericardium	YES	YES	Other
38436-02	645	Thoracoscopic biopsy of pericardium	YES	YES	Other
38447-01	646	Thoracoscopic pericardiectomy, subtotal or complete	YES	YES	Other
38456-06	646	Thoracoscopic excision of lesion of pericardium	YES	YES	Other
35324-00	740	Angioscopy	YES	YES	Other
35551-00	810	Radical excision of pelvic lymph nodes via laparoscopy for gynaecological malignancy	YES	YES	Other
35723-00	810	Laparoscopic pelvic or abdominal lymph node sampling for staging of gynaecological malignancy	YES	YES	Other
35723-02	810	Laparoscopic para-aortic lymph node sampling for staging of gynaecological malignancy	YES	YES	Other
90284-01	812	Laparoscopic removal of lymphocele	YES	YES	Other
31470-00	815	Laparoscopic splenectomy	YES	YES	Other
40903-00	1	Neuroendoscopy	YES	YES	Other
40903-01	12	Biopsy of brain via neuroendoscopy	YES	YES	Other
40012-00	19	Endoscopic third ventriculostomy	YES	YES	Other
39331-00	76	Endoscopic release of carpal tunnel	YES	YES	Other
90049-01	128	Endoscopic thymectomy	YES	YES	Other

(continued)

Table A7 (continued): Endoscopy procedures: Comparison of the Victorian and Western Australia 'automatically admit' lists, and category for analysis

ACHI Code (8th edition)	ACHI Block	Description	In the Victorian list	In the Western Australian list	Category for analysis[(a)]
Not included					
36800-01	1090	Endoscopic replacement of indwelling urinary catheter	NO	YES (with cysto/ Urethroscopy)	Not included
36800-03	1090	Endoscopic removal of indwelling urinary catheter	NO	YES (with cysto/ Urethroscopy)	Not included

(a) The category the procedure code is included in for data published in Table 3.5.

Notes

1. The jurisdiction lists included a small number of ACHI codes that were not in the ACHI 8th edition. Where possible, the AIHW has mapped these to an 8th edition code, based on the original procedure described.
2. A comparison of the endoscopy MBS item numbers included in the Type A or B lists of the rules) and those in the 'automatically admit' lists developed by Victoria and Western Australia was not undertaken.

Table A8: Radiotherapy procedures used in analysis

ACHI code (8th edition)	ACHI description
15600-00 [1789]	Stereotactic radiation treatment, single dose
15600-01 [1789]	Stereotactic radiation treatment, fractionated
15600-02 [1789]	Hemi body irradiation
15600-03 [1789]	Total body irradiation
15600-04 [1789]	Total skin irradiation
15303-00 [1790]	Brachytherapy, intrauterine, low dose rate
15304-00 [1790]	Brachytherapy, intrauterine, high dose rate
15311-00 [1790]	Brachytherapy, intravaginal, low dose rate
15312-00 [1790]	Brachytherapy, intravaginal, high dose rate
15319-00 [1790]	Brachytherapy, combined intrauterine and intravaginal, low dose rate
15320-00 [1790]	Brachytherapy, combined intrauterine and intravaginal, high dose rate
90764-00 [1791]	Brachytherapy, intracavitary, low dose rate
90764-01 [1791]	Brachytherapy, intracavitary, high dose rate
15327-00 [1792]	Brachytherapy with implantation of removable single plane, low dose rate
15327-01 [1792]	Brachytherapy with implantation of removable single plane, pulsed dose rate
15327-02 [1792]	Brachytherapy with implantation of removable multiple planes or volume implant, low dose rate
15327-03 [1792]	Brachytherapy with implantation of removable multiple planes or volume implant, pulsed dose rate
15327-04 [1792]	Brachytherapy with implantation of permanent implant, <10 sources
15327-05 [1792]	Brachytherapy with implantation of permanent implant, ≥10 sources
15327-06 [1792]	Brachytherapy with implantation of removable single plane, high dose rate
15327-07 [1792]	Brachytherapy with implantation of removable multiple planes or volume implant, high dose rate
15338-00 [1792]	Brachytherapy, prostate
15360-00 [1792]	Brachytherapy, intravascular
15539-00 [1799]	Brachytherapy planning, prostate
15541-00 [1799]	Brachytherapy planning, intravascular

Table A9: Procedures[(a)] reported for the 20 most common ACHI procedure blocks for same-day acute separations, public and private hospitals, 2013–14

Procedure block		Public hospitals	Private free-standing day hospital facilities	Other private hospitals	Total
1910	Cerebral anaesthesia	658,367	469,860	1,022,896	2,151,123
1060	Haemodialysis	1,069,314	142,067	99,181	1,310,562
1920	Administration of pharmacotherapy	228,853	76,997	225,303	531,153
911	Fibreoptic colonoscopy with excision	68,153	95,185	162,514	325,852
1008	Panendoscopy with excision	72,226	90,304	151,818	314,348
905	Fibreoptic colonoscopy	67,969	90,746	131,356	290,071
197	Extracapsular crystalline lens extraction by phacoemulsification	64,917	85,095	64,675	214,687
1909	Conduction anaesthesia	68,041	64,948	62,102	195,091
1620	Excision of lesion(s) of skin and subcutaneous tissue	50,611	38,285	65,735	154,631
1265	Curettage and evacuation of uterus	54,117	41,134	49,346	144,597
1893	Administration of blood and blood products	85,786	20,773	36,144	142,703
458	Surgical removal of tooth	11,801	25,068	64,115	100,984
1089	Examination procedures on bladder	39,624	6,226	45,881	91,731
1916	Generalised allied health interventions	55,050	400	32,686	88,136
1005	Panendoscopy	18,905	35,186	27,737	81,828
1259	Examination procedures on uterus	28,906	3,687	33,628	66,221
1873	Psychological/psychosocial therapies	86	0	61,017	61,103
1297	Procedures for reproductive medicine	4,861	32,029	23,788	60,678
209	Application, insertion or removal procedures on retina, choroid or posterior chamber	3,371	43,313	10,227	56,911
1922	Other procedures related to pharmacotherapy	6,145	7,872	34,406	48,423
	Other	726,411	239,197	823,915	1,789,523
	Procedures reported	3,529,635	1,713,500	3,458,806	8,701,941
	No procedure or not reported	594,209	2,413	71,230	667,852
Total separations		**2,899,623**	**872,579**	**1,694,271**	**5,466,473**

(a) A procedure is counted once for the group if it has at least one procedure reported within the group. As more than one procedure can be reported for each separation, the data are not additive and therefore the totals in the table may not equal the sum of counts in the rows.

Source: AIHW 2015a (Table 6.4).

Glossary

Admission

(METeOR identifier 327206)

The process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.

Formal admission:

The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.

Statistical admission:

The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.

Admitted patient

(METeOR identifier 268957)

A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:

- the patient's condition requires clinical management and/or facilities not available in their usual residential environment
- the patient requires observation in order to be assessed or diagnosed
- the patient requires at least daily assessment of their medication needs
- the patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (for example, cardiac catheterisation)
- there is a legal requirement for admission (for example, under child protection legislation)
- the patient is aged nine days or less.

Same-day patient (METeOR identifier 327270)

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

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

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Related publications

This report *Variation in hospital admission policies and practices 2013–14: Australian hospital statistics* can be downloaded for free from the Australian Institute of Health and Welfare (AIHW) website <www.aihw.gov.au/hospitals-publications/>. The website also includes information on ordering printed copies.

More detailed statistics about hospitals and more information on how to interpret the data here can be found in:

AIHW 2015. *Staphylococcus aureus* bacteraemia in Australian hospitals 2014–15: Australian hospital statistics. Health services series no. 67. Cat. no. HSE 171. Canberra: AIHW.

AIHW 2015. Emergency department care 2014–15: Australian hospital statistics. Health services series no. 65. Cat. no. HSE 168. Canberra: AIHW.

AIHW 2015. Elective surgery waiting times 2014–15: Australian hospital statistics. Health services series no. 64. Cat. no. HSE 166. Canberra: AIHW.

AIHW 2016. Admitted patient care 2014–15: Australian hospital statistics. Health services series no. 68. Cat. no. HSE 172. Canberra: AIHW.

AIHW 2016. Non-admitted patient care 2014–15: Australian hospital statistics. Health services series no. 69. Cat. no. HSE 174. Canberra: AIHW.

AIHW 2016. Hospital resources 2014–15: Australian hospital statistics. Health services series no. 71. Cat. no. HSE 176. Canberra: AIHW.

In addition, selected hospitals-related information, for individual hospitals is available at <www.myhospitals.gov.au>.

Please see <www.aihw.gov.au/publications-catalogue/> to access a complete list of AIHW publications relating to Australia's health and welfare.

This report describes variations in admission policies and practices and how these differences may be impacting on national data on admitted patient care in Australia's hospitals. For the reporting period 2013–14, hospital admission practice variation was greatest for short-stay, same-day admissions, with data consistency and comparability relatively good for overnight patients.

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