Appendix 4: Hospitals contributing to this report and public hospital peer groups

Introduction

This appendix includes information on the public and private hospitals contributing to the National Hospital Morbidity Database, the National Public Hospital Establishments Database, the National Elective Surgery Waiting Times Data Collection and the Non-admitted Patient Emergency Department Care Data Collection. Also included is information on the coverage of private hospitals in the National Hospital Morbidity Database that can assist interpretation of the data on private hospital activity. Information on the public hospital peer group classification used in Chapters 2, 4, 5 and 6 is also included.

The entities that are reported as hospitals in the databases and in this report vary, depending on the type of information being reported. Explanatory information is therefore included on this variation, with a summary table on the counts of public hospitals presented for different analyses.

Throughout this report, unless otherwise specified:

- Public acute hospitals and public psychiatric hospitals are included in the public hospital (public sector) category.
- All public hospitals other than public psychiatric hospitals are included in the public acute hospital category.
- Private psychiatric hospitals, private free-standing day hospital facilities and other private hospitals are included in the private hospital (private sector) category.
- All private hospitals other than private free-standing day hospital facilities are included in the other private hospitals category.

Public and private hospitals

There is currently some variation between jurisdictions in whether hospitals that predominantly provide public hospital services, and that are privately owned and/or operated, are reported as public or private hospitals. A selection of these hospitals is listed in Table A4.1 with information on whether they are reported as public or private hospitals.

For 2004–05, the Mersey Community Hospital in Tasmania which previously operated as a private hospital providing predominantly public services on a contracted basis merged with the Northwest Regional Hospital and is now categorised as a public hospital.

These categorisations are the practices for this report and reports produced by other agencies may categorise these hospitals differently. For example Hawkesbury District Health Service and Port Macquarie Base hospital were categorised as private hospitals in *The state of our*

public hospitals, June 2005 report (DoHA 2005b) and *Australian hospital statistics 2002–03* (AIHW 2004a), while they were categorised as public hospitals in both this report and *Australian hospital statistics* 2003–04 (AIHW 2005a). Southern Districts War Memorial Hospital is a private hospital that treats public patients under contract to the Department of Health (SA). Expenditure under the contract is treated as "Purchase of services for public patients from private hospitals under contract" in *Health expenditure Australia 2003–04* (AIHW 2005c). This report and *Australian hospital statistics 2003-04* (AIHW 2005a) categorise Southern Districts War Memorial as a public hospital for services provided under the contract and as a private hospital for services provided to private patients.

Table A4.1: Selected hospitals included in this report that predominantly provide public hospital services, that are privately owned and/or operated

State	Hospital	How reported
NSW	Hawkesbury District Health Service	Public hospital
Vic	Mildura Base	Public hospital
Qld	Noosa	Private hospital
WA	Joondalup	Private hospital
WA	Peel	Private hospital
SA	Southern Districts War Memorial Private Hospital	Public hospital for services provided under the contract and a private hospital for services provided to private patients
SA	Modbury	Public hospital (publicly owned – privately operated)
Tas	May Shaw District Nursing Centre	Public hospital (reports total expenditure only)
Tas	Toosey	Public hospital (reports total expenditure only)

Other changes in hospital ownership or management arrangements can also affect whether hospital activity is reported as public or private. For example, between 2003–04 and 2004–05 two private hospitals in Western Australia were purchased by the Western Australian Department of Health and were amalgamated with two existing public hospitals. Hence the activity associated with the former private hospitals is now included in the activity reporting of the two public hospitals.

The National Hospital Morbidity Database

The National Hospital Morbidity Database includes data relating to admitted patients from almost all hospitals: public acute hospitals, public psychiatric hospitals, private acute hospitals, private psychiatric hospitals and private free-standing day hospital facilities.

Public sector hospitals that are not included are those not within the jurisdiction of a state or territory health authority (hospitals operated by the Department of Defence or correctional authorities, for example, and hospitals located in offshore territories). In addition, for 2004–05, data were not supplied for a mothercraft hospital in the Australian Capital Territory and two tiny hospitals in New South Wales.

Within the private sector, data were not provided for 2004–05 for all private day hospital facilities in the Australian Capital Territory and for the single private free-standing day hospital facility in the Northern Territory. For Victoria, data were not provided for a very small private hospital and a hospital that was opening. Victoria estimated that their data was essentially complete. For Tasmania, some private hospital data were not available for some periods, resulting in an under-enumeration of approximately 21% for Tasmanian private hospitals.

Table A4.4: Coverage of hospitals in the National Hospital Morbidity Database, by hospital sector, states and territories, 2004–05

	Public acute hospitals	Public psychiatric hospitals	Private free-standing day hospital facilities	Other private hospitals
NSW	Complete	Complete	Complete	Complete
Vic	Complete	Complete	Complete	Complete
Qld	Complete	Complete	Complete	Complete
WA	Complete	Complete	Complete	Complete
SA	Complete	Complete	Complete	Complete
Tas	Complete	Complete	Incomplete	Incomplete
ACT	Incomplete	Not applicable	Not included	Complete
NT	Complete	Not applicable	Not included	Complete

Note: Complete—all facilities reported data to the National Hospital Morbidity Database. Incomplete—some facilities did not provide data to the National Hospital Morbidity Database; see text for more details. Not included—there are facilities in this sector for this state or territory, however, no data were provided. Not applicable—there are no facilities in this sector for this state or territory.

Table A4.4 summarises this coverage information by state and territory and by hospital sector, and Tables A4.2 and A4.3 (accompanying this report on the Internet at www.aihw.gov.au) list the public and private hospitals that contributed to the National Hospital Morbidity Database for 2004–05. For public hospitals, also included in the Internet tables is information on their average available bed numbers, their peer group (see below) and the Statistical Local Area and Remoteness Area of their location. The list of private hospitals includes information on whether each was a private free-standing day hospital facility.

There is some variation between states in what is regarded as a hospital and how facilities are licensed and how this impacts the collection. For example in recent years the coverage of the Queensland and Victorian collections expanded to include facilities providing same day services not previously included. The apparent increase for some types of separation in the private sector would have been affected by the registration of relevant facilities as hospitals for the first time in Queensland in 2001 and in Victoria in 2002–03. These facilities had previously been categorised as non-hospital facilities and were therefore out of scope for the National Hospital Morbidity Database.

Coverage estimates for private hospital separations

As not all private hospital separations are included in the National Hospital Morbidity Database, the counts of private hospital separations presented in this report slightly underestimate actual counts.

Over recent years, at the national level there have been slightly fewer separations reported to the National Hospital Morbidity Database (particularly for private free-standing day hospital facilities) than to the Australian Bureau of Statistics' (ABS) Private Health Establishments Collection (ABS 2005) (Table A4.5). The latter collection includes all private acute and psychiatric hospitals licensed by state and territory health authorities and all private free-standing day hospital facilities approved by the Department of Health and Ageing. In 2003–04, the difference was 47,279 separations (1.8%).

Table A4.5: Differences between private hospital separations on the National Hospital Morbidity Database and reported to the ABS's Private Health Establishments Collection, 1999–00 to 2003–04

Year	Private free-standing day hospital facilities		Other private hospitals		Total	
	Separations	Per cent	Separations	Per cent	Separations	Per cent
1999–00	68,907	19.7	53,247	3.0	122,154	5.7
2000–01[(a)]	56,880	15.6	22,688	4.4	81,758	3.5
2001–02[(b)]	56,673	13.1	132,040	6.2	118,064	4.6
2002–03[(b)]	16,584	3.5	99,147	4.7	47,755	1.8
2003–04[(b)]	19,233	3.8	96,009	4.4	47,279	1.8

(a) The type of private hospital establishment was unspecified for Tasmanian private hospitals reporting to the National Hospital Morbidity Database. The differences for private free standing day hospital facilities and other private hospitals exclude Tasmania.

(b) The type of private hospital establishment was unspecified for Tasmanian private hospitals reporting to the National Hospital Morbidity Database and ABS suppressed data for the Australian Capital Territory, the Northern Territory and Tasmania. The differences for private free standing day hospital facilities and other private hospitals exclude Australian Capital Territory, the Northern Territory and Tasmania.

n.a. Not available.

Source: ABS, unpublished Private Health Establishments Collection data, for private hospital data.

For individual states (Tables A4.6a to A4.6j accompanying this report on the Internet at www.aihw.gov.au), the patterns of differences between number of separations reported to the National Hospital Morbidity Database compared to the ABS's Private Health Establishments Collection varied. This reflects the omission of some private hospitals from the National Hospital Morbidity Database. However, there are differences even when both collections are reported to be complete. For example, for 2003–04, more separations were reported to the National Hospital Morbidity Database than to the ABS for private free-standing day hospital facilities in Western Australia. The discrepancies may have been due to the use of differing definitions (e.g. differing counting rules for *Newborn* episodes of care) or different interpretations of definitions, differing definitions of what is a hospital, or differences in the quality of the data provided for different purposes.

At the time of publication of this report, Private Health Establishments Collection data for 2004–05 were not available. When they become available, an estimate will be made of the under-enumeration of separations in the National Hospital Morbidity Database for 2004–05, by comparing it with the 2004–05 Private Health Establishments Collection data. This estimate will be included with *Australian Hospital Statistics 2004–05* on the Internet.

The National Public Hospital Establishments Database

The National Public Hospital Establishments Database holds establishment-level data for each public hospital in Australia, including public acute hospitals, psychiatric hospitals, drug and alcohol hospitals and dental hospitals in all states and territories. The collection only covers hospitals within the jurisdiction of the state and territory health authorities. Hence, public hospitals not administered by the state and territory health authorities (hospitals operated by the Department of Defence or correctional authorities, for example, and hospitals located in offshore territories) are not included. Public hospitals are categorised by the AIHW into peer groups, as described below.

Table A4.2 accompanying this report on the Internet at www.aihw.gov.au lists the public hospitals that contributed to the National Public Hospital Establishments Database for 2004–05. Also included is information on their average available bed numbers, their peer group and the Statistical Local Area and Remoteness Area of their location.

The National Non-admitted Patient Emergency Department Care Database

The National Non-admitted Patient Emergency Department Care Database covers public hospitals that were classified as peer groups A (*Principal referral and Specialist Women's and children's hospitals*) and B (*Large hospitals*) in *Australian Hospital Statistics 2003–04* (see below for more information). Data were also provided for hospitals in other peer groups for some states and territories.

For 2004–05, all states and territories were able to provide data for all public hospitals in peer groups A and B that have emergency departments. The Northern Territory supplied episode-level data for all public hospitals, New South Wales provided data for 14 *Medium hospitals* and two *Small acute hospitals*, Victoria provided data for eight *Medium hospitals*, South Australia provided data for one *Medium hospital* and Western Australia provided data for two *Medium hospitals* and two *Small remote hospitals*. Overall coverage was estimated as about 76% of public hospital accident and emergency occasions of service.

Table 5.1 provides further information on the coverage by public hospital peer group. The list of public hospitals that contributed to the National Public Hospital Establishments Database (Table A4.2 accompanying this report on the Internet at www.aihw.gov.au) includes information on which hospitals were also included in the National Non-admitted Patient Emergency Department Care Database for 2004–05.

The National Elective Surgery Waiting Times Data Collection

The National Elective Surgery Waiting Times Data Collection covers public acute hospitals. However, some public patients treated under contract in private hospitals in Victoria and Tasmania are also included.

All public hospitals that undertake elective surgery are generally included, however, some are not. Based on the proportions of elective surgery admissions that were covered by the National Elective Surgery Waiting Times Data Collection, national coverage was about 86%, and ranged from 100% in the Australian Capital Territory and the Northern Territory, to about 62% in South Australia (Table 6.2). Coverage was highest for *Principal referral and specialist women's and children's hospitals* at 99%, and progressively lower for the *Large hospitals* and *Medium hospitals* groups.

Tables 6.1 and 6.2 provide further information on the coverage by public hospital peer group. The list of public hospitals that contributed to the National Public Hospital Establishments Database (Table A4.2 accompanying this report on the Internet at www.aihw.gov.au) includes information on which hospitals were also included in the National Elective Surgery Waiting Times Data Collection for 2004–05.

Counting public hospitals

Different counts of hospitals are used this report, depending on the type of information being presented and the way in which the hospitals were reported to the National Hospital Morbidity Database and the National Public Hospital Establishments Database. In summary, two counts of hospitals are used (Table A4.7):

- In Chapter 2 and Chapter 3, hospitals are counted generally as they were reported to the National Public Hospital Establishments Database. These entities are generally 'physical hospitals' (buildings or campuses) but may encompass some outposted locations such as dialysis units. Conversely, however, hospitals on the one 'campus' can be reported as separate entities to this database if, for example, they are managed separately and have separate purposes, such as specialist women's services, and specialist children's services. Although most of the hospitals counted in this way report separations to the National Hospital Morbidity Database, some small hospitals do not have separations every year.
- In the cost per casemix-adjusted separation analysis (Table 4.2), entities for which there was expenditure information were reported as hospitals. The small numbers of hospitals in the National Public Hospital Establishments Database with incomplete expenditure information were omitted. In some jurisdictions, hospitals exist in networks, and expenditure data were only available for these networks, so the networks are the entities counted as hospitals for those jurisdictions for these tables.

Data on numbers of hospitals should therefore be interpreted taking these notes into consideration. Changes in the numbers of hospitals over time can be due to changes in administrative or reporting arrangements rather than changes in the number of hospital campuses or buildings.

Counts of private hospitals can also vary, depending on the source of the information. Thus, there may be discrepancies between counts of private hospitals from the ABS's Private Health Establishments Collection presented in Table 2.1 and the lists of private hospitals contributing to the National Hospital Morbidity Database. The states and territories provided the latter information, which may not correspond with the way in which private hospitals report to the Private Health Establishments Collection.

Table A4.7: Numbers of public hospitals reported in this report, states and territories, 2004–05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Chapter 2 and Chapter 3 and Table 5.1	232	144	177	92	79	27	3	5	759
Table 4.2 (expenditure data)	231	94	177	92	73	27	3	5	702

Public hospital peer groups

The Australian Institute of Health and Welfare worked with the National Health Ministers' Benchmarking Working Group (NHMBWG) and the National Health Performance Committee (NHPC) to develop a national public hospital peer group classification for use in presenting data on costs per casemix-adjusted separation. The aim was to allow more meaningful comparison of the data than comparison at the jurisdiction level would allow.

The peer groups were therefore designed to explain variability in the average cost per casemix-adjusted separation. They also group hospitals into broadly similar groups in terms

of their range of admitted patient activity, and their geographical location, with the peer groups allocated names that are broadly descriptive of the types of hospitals included in each category.

The peer group classification is summarised in Table A4.8. Details of the derivation of the peer groups are in Appendix 11 of *Australian Hospital Statistics 1998–99* (AIHW 2000). From 2001–02, the method was adjusted slightly, by replacing the RRMA classification with the Remoteness Area classification for the geographical component of the peer grouping.

A flow chart can be found in *Australian Hospital Statistics 2002-03* (Figure A4.1) to illustrate the assignment of peer groups for almost all hospitals. However, on the advice of jurisdictions, hospitals may be assigned without using this logic, usually in special circumstances such as the opening or closing of a hospital during the year. For 2004–05 Mater Hospital Brisbane was allocated to the *Principal referral* peer group even though it technically grouped to the *Large Major city hospitals* group on advice from the Queensland Department of Health.

Selected characteristics of the hospitals assigned to each peer group for 2004–05 are presented in Table 4.2 (for each state and territory).

Although not specifically designed for purposes other than the cost per casemix-adjusted separation analysis, the peer group classification is recognised as a useful way to categorise hospitals for other purposes, including the presentation of other data. For example, the classification has been used to present data from the National Hospital Cost Data Collection (see Appendix 6), emergency department occasions of service data in Chapter 5 and elective surgery waiting times data in Chapter 6. They have also been used to specify the scopes for national minimum data sets, for example, as noted above for the NMDS for Non-Admitted Patient Emergency Department Care although the use of the peer groups for this purpose is under review.

The peer group to which each public hospital was assigned for 2004–05 is included in Table A4.2 accompanying this report on the Internet at www.aihw.gov.au. In some cases, the establishments defined as hospitals for the cost per casemix-adjusted separation analysis differ from those defined as hospitals for the elective surgery waiting times data or those defined for counts of hospitals presented in Chapters 2 and 3. In these cases, their peer groups may also differ, and these differences are indicated in Table A4.2 accompanying this report on the Internet at www.aihw.gov.au.

Table A4.8: Public hospital peer group classification[(a)]

Peer group	Sub-group	Definition
Principal referral and specialist women's & children's hospitals	Principal referral	Major city hospitals with >20,000 acute casemix-adjusted separations and Regional hospitals with >16,000 acute casemix-adjusted separations per annum.
	Specialist women's and children's	Specialised acute women's and children's hospitals with >10,000 acute casemix-adjusted separations per annum.
Large hospitals	Major city	Major city acute hospitals treating more than 10,000 acute casemix-adjusted separations per annum.
	Regional and remote	Regional acute hospitals treating >8,000 acute casemix-adjusted separations per annum, and remote hospitals with >5,000 casemix-adjusted separations.
Medium hospitals	Group 1	Medium acute hospitals in Regional and Major city areas treating between 5,000 and 10,000 acute casemix-adjusted separations per annum.
	Group 2	Medium acute hospitals in Regional and Major city areas treating between 2,000 and 5,000 acute casemix-adjusted separations per annum, and acute hospitals treating <2,000 casemix-adjusted separations per annum but with >2,000 separations per annum.
Small acute hospitals	Regional	Small Regional acute hospitals (mainly small country town hospitals), acute hospitals treating <2,000 separations per annum, and with less than 40% non-acute and outlier patient days of total patient days.
	Remote	Small remote hospitals (<5,000 acute casemix-adjusted separations but not 'Multi-purpose services' and not 'Small non-acute'). Most are <2,000 separations.
Sub-acute and non-acute hospitals	Small non-acute	Small non-acute hospitals, treating <2,000 separations per annum, and with more than 40% non-acute and outlier patient days of total patient days.
	Multi-purpose services	
	Hospices	
	Rehabilitation	
	Mothercraft	
	Other non-acute	For example, geriatric treatment centres combining rehabilitation and palliative care with a small number of acute patients
Un-peered and other hospitals		Prison medical services, dental hospitals, special circumstance hospitals, Major city hospitals with <2,000 acute casemix-adjusted separations, hospitals with <200 separations, etc.
Psychiatric hospitals		

(a) Only the peer groups above the dashed line are included in the cost per casemix-adjusted separation analyses presented in Chapter 4 and appendix 3.