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Australian Institute of
Health and Welfare

Australian hospital statistics 2012–13



Private hospitals



Australian Government

**Australian Institute of
Health and Welfare**

*Authoritative information and statistics
to promote better health and wellbeing*

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Private hospitals

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Foreword

I am pleased to present *Australian hospital statistics 2012–13: private hospitals*, an authoritative report that provides a comprehensive range of statistics and other information about Australia's private hospitals.

Private hospitals have long played a key role in Australia's health care system and contribute to improving the health of many Australians each year. The Australian Institute of Health and Welfare (AIHW) has released reports about Australia's hospital system over many years, although most publications have focused on the activity of public hospitals. This publication is the first in the AIHW's *Australian hospital statistics* series to focus specifically on private hospitals.

This report brings together statistics from a variety of sources to detail private hospital activity, performance and resources. It presents detailed data from the AIHW's hospitals, health expenditure and health workforce data collections, supplemented with data from other organisations, including the Australian Bureau of Statistics and the Australian Government Department of Health.

The report uses a number of innovations, including:

- the AIHW's newly developed private hospital peer groups classification, to illustrate the diversity of private hospitals across Australia
- mapping of private hospital separation rates for small areas, to illustrate the variation in use of private hospital services.

The detail presented reflects many improvements and enhancements to national data available on private hospitals over recent years, including progress in the availability of some information on hospital safety and quality. However, as documented in this report, there are still many areas where information could be improved.

The AIHW has been pleased to collaborate with private hospital sector stakeholders in the production of this report. We look forward to continuing to work with stakeholders to further improve the availability and comprehensiveness of national data on private hospitals.

David Kalisch

Director

September 2014

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- Broderick Billing (Department of Veterans' Affairs)
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Abbreviations

ABS	Australian Bureau of Statistics
ACHI	Australian Classification of Health Interventions
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ALOS	average length of stay
AR-DRG	Australian Refined Diagnosis Related Groups
ARIA	Accessibility/Remoteness Index of Australia
ASGS	Australian Statistical Geography Standard
CC	complications and/or comorbidities
CCU	cardiac/coronary care unit
COF	condition onset flag
CSCC	catastrophic and/or severe complications and comorbidities
DoH	Department of Health (from 2014)
DoHA	Department of Health and Aging (prior to 2014)
DRG	diagnosis related group
DVA	Department of Veterans' Affairs
ECMO	extracorporeal membrane oxygenation
ECT	electroconvulsive therapy
FTE	full-time equivalent
HHA	Hand Hygiene Australia
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	intensive care unit
METeOR	Metadata Online Registry
MDC	Major Diagnostic Category
n.e.c.	not elsewhere classified
NHA	National Healthcare Agreement
NHMD	National Hospital Morbidity Database
NMDS	National Minimum Data Set

NT	Northern Territory
NSW	New South Wales
PHDB	Private Hospital Data Bureau
PHEC	Private Health Establishments Collection
PPH	potentially preventable hospitalisation
Qld	Queensland
RSI	relative stay index
SA	South Australia
SA2	Statistical Area Level 2
SA3	Statistical Area Level 3
SAB	<i>Staphylococcus aureus</i> bacteraemia
SEIFA	Socio-Economic Indexes for Areas
SEIFA IRSD	Socio-Economic Indexes for Areas Index of Relative Socio-economic Disadvantage
SES	socioeconomic status
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Symbols

..	not applicable
n.a.	not available
n.p.	not publishable because of small numbers, confidentiality or other concerns about the quality of the data
✓	included
×	not included

Summary

In 2012–13, Australia's 601 private hospitals accounted for 45% of the country's 1,347 hospitals and 34% of all hospital beds. These private hospitals employed over 60,000 staff and had a total income of \$11.8 billion.

The private hospitals can be grouped into 2 main categories: the 319 that provide services on a day-only basis ('day hospitals') and the 282 that provide overnight care ('overnight hospitals'). From 2003–04 to 2012–13, the number of beds increased by 9% in private overnight hospitals (from 24,642 to 26,889 beds) and by 51% in private day hospitals (from 1,947 to 2,938 beds).

The diversity of private hospitals

Analyses using the AIHW's new private hospital peer groups showed considerable variation in specialised facilities available, location and activity levels. For example, the 21 *Private acute Group A hospitals* all had 24 hour emergency service and an Intensive Care Unit, were mainly in *Major cities* (95%) and had an average of 33,234 separations in 2012–13. The 71 *Private acute Group D hospitals* had relatively few specialised services, were less likely to be in *Major cities* (63%), and had an average of 4,811 separations. Day hospitals were mainly in *Major cities* (88%). Many specialised in procedures such as endoscopy (56 hospitals), and dialysis (14).

Admitted patient care

In 2012–13, there were about 3.8 million separations in private hospitals in Australia, making up 41% of all separations. Of these, 69% (2.6 million) were same-day separations and 31% (1.2 million) were overnight separations.

Over the ten years to 2012–13, the proportion of separations that were for older age groups increased, with the greatest increase for people over 85 years (145% for males and 110% for females).

Use of private hospitals in 2012–13 was highest for those residing in *Major cities* (175 separations per 1,000 persons) and lowest for those residing in *Very remote areas* (67 separations per 1,000 persons). The highest separation rates included those in Noosa in Queensland, Ku-ring-gai in New South Wales and Holdfast Bay in South Australia.

In 2012–13, the most common same-day procedures included haemodialysis and colonoscopies. For overnight separations, the most common procedures included coronary angiography and caesarean section.

Some private hospitals voluntarily report safety and quality-of-care data. In 2012–13, 127 private hospitals reported rates of *Staphylococcus aureus* bacteraemia, with an average rate of 0.2 cases per 10,000 days of patient care. In audits in late 2013, the average rate of hand hygiene compliance, for the 83 private hospitals for which data were available, was 82%.

Future work

While there have been improvements in recent years, there are still gaps in reporting the performance of private hospitals, and some inherent difficulties in comparing performance between the public and private hospital sectors. National work is ongoing to improve safety and quality indicators for both public and private hospitals.

1 Introduction

Australian hospital statistics 2012–13: private hospitals is a new report in the Australian Institute of Health and Welfare's (AIHW) series of summary reports describing the characteristics and activity of Australia's hospitals.

The AIHW has previously published comprehensive reports about Australia's hospitals for the financial years 1993–94 to 2012–13 (AIHW 2014a and earlier), summary reports including *Australia's hospitals 2012–13 at a glance* (AIHW 2014c) and more detailed reports on some aspects of Australia's public hospitals including *Australian hospital statistics 2012–13: emergency department care* (AIHW 2013d), *Australian hospital statistics 2011–12: elective surgery waiting times* (AIHW 2013c), *Australian hospital statistics 2012–13: Staphylococcus aureus bacteraemia in Australian public hospitals* (AIHW 2013b) and *Australian hospital statistics: national emergency access and elective surgery targets 2012* (AIHW 2013e).

This report presents information focussed on the role of private hospitals in Australia. Private hospitals have long played a key role in Australia's health care system and contribute to the good health of many Australians each year. This report will allow more informed discussion of the private hospital sector and its role within the broader health sector.

This chapter details:

- the scope of the report
- the structure of the report
- data sources used within the report including:
 - the scope of the data sources
 - what type of information is collected
 - differences between the main data sources used in the report
- terminologies used in this report including:
 - common terms relating to admitted and non-admitted patient care
 - classifications relating to remoteness and socio-economic status
 - classifications relating to diagnosis, procedure and casemix data.

Scope of the report

The aim of this report is to provide information about private hospitals in Australia in 2012–13. For the purposes of the *Australian hospital statistics* series of reports, a private hospital is defined as a:

'privately owned and operated institution catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners' (AIHW 2014a).

Private hospitals are licenced to provide services by the relevant state or territory health authority. However, licencing arrangements differ between jurisdictions (Appendix D): for example, day hospitals are not licenced in South Australia.

Private hospitals that receive funds from private health insurers or under the Medicare Benefits Scheme are required to be declared by the Minister for Health as private hospitals

under the *Private Health Insurance Act 2007*. Again, not all private hospitals are declared by the Australian Government: for example, private hospitals providing some cosmetic services are not required to be declared as they do not receive funding from private health insurers or the Medicare Benefits Scheme.

The scope of this report is 'all private hospitals' (including all hospitals licenced as private hospitals by states and territories and those declared as private hospitals by the Australian Government) but excluding those that mainly deliver public hospital services (see below). In practice, the scope depends on the data source being used. The 3 main data sources are the:

- National Hospital Morbidity Database (NHMD), where the scope includes private hospitals that have arrangements with the state and territory health authority to provide data, usually reflecting state and territory licencing arrangements.
- Private Hospital Data Bureau (PHDB), where the scope covers hospitals declared as private hospitals by the Department of Health (DoH) under the *Private Health Insurance Act 2007*.
- Private Health Establishments Collection (PHEC), where the scope covers private overnight hospitals licensed by state and territory health authorities, and all day hospital facilities declared as private by the Minister for Health.

The different data sources are more fully described in the following section.

All services provided by these private hospitals are in scope for this report, including services delivered to public patients under inter-hospital contracted care arrangements. Inter-hospital contracted care refers to where one hospital contracts another hospital to provide a service to a patient (see Chapter 2 for further information).

Private hospitals delivering public hospital services

Some hospitals are private hospitals with respect to state or territory licencing arrangements and/or Australian Government declaration arrangements, but are contracted by state and territory governments to deliver predominantly public hospital services. Box 1.1 outlines some of the characteristics of these hospitals.

In 2012–13, 11 private hospitals delivered predominantly public hospital services under contracted arrangements. Of these, the activity data for 6 hospitals were reported as separate public and private hospitals. The private components for these 6 hospitals have been included in this report and the public components have been excluded.

The remaining 5 hospitals have been excluded from the report, where possible, as the public and private components of their activity were not reported as separate hospitals. Analyses of the activity of these hospitals shows that a high proportion of their activity was delivered to public patients (ranging from 57% to 92%). More information on the excluded hospitals is available at Appendix B.

Note that these 5 hospitals have been excluded from the analyses of NHMD and PHDB data. However, they may be included in data sourced from the Australian Bureau of Statistics' (ABS) *Private hospitals, Australia* publication, which reports on PHEC data.

Box 1.1 Characteristics of 'public contract' hospitals

In its 2009 report, *Public and private hospitals: research report*, the Productivity Commission reported on public and private hospitals. The Commission identified a category of hospital as 'public contract' hospitals, which they described as hospitals:

'managed by non-government entities to provide public hospital services either under contract or, if they are deemed to be public health organisations [by a state government], with a subsidy' (Productivity Commission 2009).

The Productivity Commission found that these hospitals have characteristics more similar to public hospitals than private hospitals. They had higher volumes of outpatient activity and had high volumes of separation activity generally. The ALOS of patients in these hospitals was also more similar to that of public hospitals (Productivity Commission 2009).

Structure of this report

The topics addressed in the report are:

- hospital resources in the private hospital sector (including the number of hospitals, hospital beds, expenditure, specialised facilities and staffing) (Chapter 2)
- an overview of private hospital care (Chapter 3)
- day hospital activity (Chapter 4)
- overnight hospital activity (Chapter 5)
- areas for further development (Chapter 6).

Appendix A provides technical information on the main data sources used for this report, including data quality and factors affecting interpretation of the data.

Appendix B includes notes on the presentation of data, the population estimates used to calculate population rates and analysis methods.

Appendix C provides information on the AIHW private hospital peer groupings used in this report.

Appendix D provides information on private hospital licencing arrangements.

Appendix E consists of supplementary data tables.

The glossary includes definitions for the most common technical terms used in this report. Where the definition relates to data from the NHMD, the definition contains an identification number from the Metadata Online Registry (METeOR), the AIHW's online repository for national metadata standards for the health, community services and housing assistance sectors <www.meteor.aihw.gov.au>. It can be used to access the technical definition on which the glossary item is based.

All tables in this report are available as downloadable Excel spreadsheets on the AIHW website at <www.aihw.gov.au/hospitals/>.

Chapter structure for chapters 3 to 5

Chapters 3, 4 and 5 are structured to address a common set of questions regarding the services provided by private hospitals:

- How much activity was there in 2012–13?

- Who used these services?
- Why did people receive the care?
- How urgent was the care?
- What care was provided?
- Who paid for the care?

Chapter 3 answers these questions in relation to all private hospitals combined, and chapters 4 and 5 focus on answering these questions for day and overnight hospitals respectively.

Data sources

This report draws upon a broad range of data sources from both within the AIHW and other agencies. As noted above, the main data sources are the:

- NHMD
- PHDB
- PHEC.

These 3 collections differ in the number of private hospitals reporting to them (Table 1.1), reflecting the different scopes of the collections, as outlined above. Note that these different sources mean that comparisons between data from the different collections and between different reports should be made with caution.

This report also includes background information on insurance coverage and usage information from the Private Health Insurance Administration Council. Data on hand hygiene and cases of *Staphylococcus aureus* bacteraemia (SAB) for private hospitals were sourced from the *MyHospitals* website, <www.myhospitals.gov.au/>.

National Hospital Morbidity Database

The AIHW's NHMD contains episode-level records (that is, records of every separation) from admitted patient data collection systems in Australian hospitals. The scope of the collection includes all public and private acute and psychiatric hospitals (referred to in this report as 'overnight hospitals') and free standing day hospital facilities and alcohol and drug treatment centres (referred to in this report as 'day hospitals') in Australia. In 2012–13 the majority of private hospitals (91%) provided data to the NHMD (Appendix A).

The collection includes administrative, demographic and clinical data (Table 1.1). Data for the NHMD is based on the Admitted Patient Care National Minimum Data Set, a set of definitions which have been agreed by all state and territory health authorities, the Australian Government and other relevant stakeholders (including the AIHW). The agreed definitions are available on METeOR.

Data from public and private hospitals are provided annually to the AIHW by state and territory health authorities. The latest data available, which have been used in this report, are from the 2012–13 financial year. Tables in this report sourced from *Australian hospital statistics 2012–13* use data from the NHMD.

Within the NHMD, individual hospitals are identified using an establishment identifier. However, when submitting data to the AIHW, some states and territories provide private hospital data under a single establishment identifier. That is, while data for 561 private hospitals are included in the NHMD, there are only 199 establishment identifiers in the collection.

For those jurisdictions it is therefore not possible for the AIHW to identify information about individual private hospitals. This has meant that the NHMD is not able to be used as a data source for analysis about private hospital peer groups. In this report all tables that disaggregate by peer group use data from the PHDB. Further information about the NHMD is available at Appendix A.

Table 1.1: Summary of data items and coverage for each of the main data collections used in this report^(a)

Data item	NHMD	PHDB	PHEC
Hospital resources			
Individual hospital identifier	x	✓	✓
Hospital type (same-day/overnight)	✓	✓	✓
For-profit status	x	x	overnight only
Hospital facilities	x	x	✓
Accreditation	x	x	✓
Number of beds	x	x	✓
Staffing data			
Full time equivalent staff numbers	x	x	✓
Financial data for the hospital			
Income for the hospital	x	x	✓
Recurrent and capital expenditure for the hospital	x	x	✓
Patient demographic data			
Age	✓	✓	✓
Sex	✓	✓	✓
Indigenous status	✓	x	x
Area of usual residence of the patient	✓	✓	x
Activity data			
Admitted patient activity	✓	✓	summary
Procedures performed	✓	✓	summary
Diagnoses	✓	✓	summary
Type of admitted patient care (that is acute, sub-acute and non-acute care)	✓	✓	x
Source of funding for patient episodes	✓	✓	x
Non-admitted patient activity	x	x	summary
Private health insurance status	✓	x	x
Charges applied by the hospital	x	✓	x
Number of private day hospitals included^(b)	284	247	319
Number of private overnight hospitals included^(b)	277	270	282
Total number of private hospitals included^(b)	561	517	601
Total number of separations (millions)	3.8	3.6	4.1

(a) There may be some variation between data collections in how data items are defined or coded. In some instances the data item can be derived from other items in the collection.

(b) Totals for NHMD and PHDB excludes private hospitals which provide predominately public hospital services.

Sources: ABS 2014b, AIHW 2014a, PHDB.

Private Hospital Data Bureau

The PHDB contains episode-level records from hospital patient administration systems in private hospitals. The scope of the collection is private hospitals that are declared by the DoH in accordance with the *Private Health Insurance Act 2007*. Data are supplied to the PHDB by private hospitals on a monthly basis. Data were provided by the DoH to the AIHW for use in this report. The latest data available, which have been used in this report, are from the 2012–13 financial year.

The collection includes administrative, demographic, clinical and financial data (as shown in Table 1.1). The PHDB and NHMD provide a large amount of overlap between data items relating to activity and the PHDB uses many of the same data definitions as the NHMD. Differences between the collections largely relate to hospital charges and information about the number of hours of specialist care (such as in a coronary care unit or a specialist care nursery), which are included in the PHDB but not the NHMD (DoH 2014). Unlike the NHMD, private hospitals within the PHDB are able to be individually identified.

In 2012–13, the PHDB included around 211,000 fewer separations than the NHMD (Table 1.2). This difference was made up of around 80,000 fewer separations for day hospitals and around 130,000 fewer separations for overnight hospitals. In 2012–13, an estimated 84% of private hospitals provided data to the PHDB. It is also estimated that there was 1 month of non-supply of data per hospital, on average (Appendix A).

Further information about the PHDB is available in Appendix A.

Table 1.2: Separations reported to the National Hospital Morbidity Database and the Private Hospital Data Bureau for private day and overnight hospitals, 2012–13

Separations	Day hospital	Overnight hospital	Total
NHMD	866,159	2,977,172	3,843,331
PHDB	785,696	2,846,779	3,632,475

Sources: NHMD; PHDB

Private Health Establishments Collection

The PHEC is an annual survey undertaken by the Australian Bureau of Statistics (ABS). The scope of the collection is ‘all private acute and psychiatric hospitals licenced by state and territory health authorities’ (referred to in this report as ‘overnight hospitals’) and ‘all free-standing day hospital facilities approved by the DoH’ (referred to in this report as ‘day hospitals’), including those which operate for all or any part of the reference year. The collection has coverage of all private health establishments in Australia (ABS 2014b).

The collection includes establishment-level data about the activities, staffing and finances of private hospitals (Table 1.1). The data definitions in the PHEC are predominately sourced from the nationally agreed data definitions available on METeOR with the addition of data items requested by private hospital associations and health authorities (ABS 2014b).

Data used in this report are sourced from the *Private hospitals, Australia* report, published annually by the ABS. Further information about the PHEC is available at Appendix A.

Health expenditure database

The AIHW’s health expenditure database is compiled annually from a wide range of government and non-government sources. The health expenditure database covers all health

expenditure and is generally considered to provide accurate estimates of total and component health expenditure in Australia.

The main source of government expenditure data in the database is the Government Health Expenditure National Minimum Data Set, a set of definitions which have been agreed by all state and territory health authorities, the Australian Government and other relevant stakeholders (including the AIHW). The agreed definitions are available on METeOR.

The ABS, Treasury, DoH, and state and territory health authorities provide most of the data used in the health expenditure database. Other major data sources are the Department of Veterans' Affairs (DVA), the Private Health Insurance Administration Council, Comcare, and the major workers compensation and compulsory third-party motor vehicle insurers in each state and territory.

Further information on the health expenditure database is available on METeOR at <http://meteor.aihw.gov.au/content/index.phtml/itemId/540775>.

National Health Workforce Data Set

Data on the health workforce are compiled annually by the AIHW and held in the National Health Workforce Data Sets. Specific data sets exist for medical practitioners and for nurses and midwives. The National Health Workforce Data Sets are a combination of registration data provided by the Australian Health Practitioner Regulation Agency and survey data collected under the AIHW labour force surveys (administered by the Australian Health Practitioner Regulation Agency during registration).

The National Health Workforce Data Sets contain information on the demographics, employment characteristics, primary work location, and work activity of all professionally registered nurses and midwives and all medical practitioners who renewed their medical registration with the Medical Board of Australia via the National Registration and Accreditation Scheme (introduced on 1 July 2010).

Further information on the National Health Workforce Data Set: medical practitioners is available on METeOR at <http://meteor.aihw.gov.au/content/index.phtml/itemId/558851>. Further information on the National Health Workforce Data Set: nurses and midwives is available on METeOR at <http://meteor.aihw.gov.au/content/index.phtml/itemId/552742>.

Terminology

In this report, terminology has been simplified where possible to assist understanding by a broad audience, however some technical terms are unavoidable in a report of this nature. A glossary has been included at the back of the report. In addition, some of the common terms used through the report are outlined below.

Admitted patient care

Statistics on admitted patients are compiled when an admitted patient (a patient who undergoes a hospital's formal admission process) completes an episode of admitted patient care and 'separates' from the hospital. This is because most of the data on the use of hospitals by admitted patients are based on information provided at the end of the patients' episodes of care, rather than at the beginning. The length of stay and the procedures carried out are then known and the diagnostic information is more accurate.

Separations

In this report, admitted patient care is described using separations. **Separation** is the term used to refer to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Other synonymous terms used in this report are **hospitalisation** and **episode of care**.

Separations are commonly described as **overnight**, when the patient is admitted and discharged on different days, and as **same-day**, when the patient is admitted and discharged on the same-day.

Days of patient care or patient days are the total number of days spent in hospital by all patients who were discharged from hospital during the reporting period. A **patient day** is a day, or part of a day, that a patient is admitted to hospital to receive treatment or care.

Care type

The **care type** describes the overall nature of a clinical service provided to an admitted patient during an episode of care.

Acute care is care where the treatment goal is to cure the condition, alleviate symptoms or manage childbirth.

Sub-acute care is care where the treatment goal is to improve the functioning and/or quality of life of a patient. It includes the following categories:

- *Rehabilitation care* – care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap.
- *Palliative care* – care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure.
- *Geriatric evaluation and management* – care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, which are usually (but not always) an older patient.
- *Psychogeriatric care* – care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance.

Non-acute care is care where the treatment goal is support for a patient with disability or severe level of functional impairment and is also known as maintenance care.

Non-admitted patient care

Data relating to non-admitted patient care provided by private hospitals are sourced from the annual ABS *Private hospitals, Australia* publication. The following definitions are those used by the ABS in the *Private hospitals, Australia* report.

Non-admitted patients are patients who do not undergo a hospital's formal admission process. These include outpatients, accident and emergency patients and off-site (community/outreach) patients.

Non-admitted patient services are counted using **occasions of service**. These are any services provided to a non-admitted patient in a functional unit (for example, radiology) of the

hospital. Each diagnostic test or simultaneous set of related diagnostic tests is counted as 1 occasion of service.

The PHEC includes counts of **accident and emergency** occasions of service. Accident and emergency occasions of service can occur in hospitals with a formal emergency department and in hospitals without a formal emergency department but which treated accident and emergency patients during the year. Separate data on occasions of service in formal emergency departments within private hospitals are not available.

Allied health services are provided by units and clinics for the treatment and counselling of patients. They mainly comprise physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy.

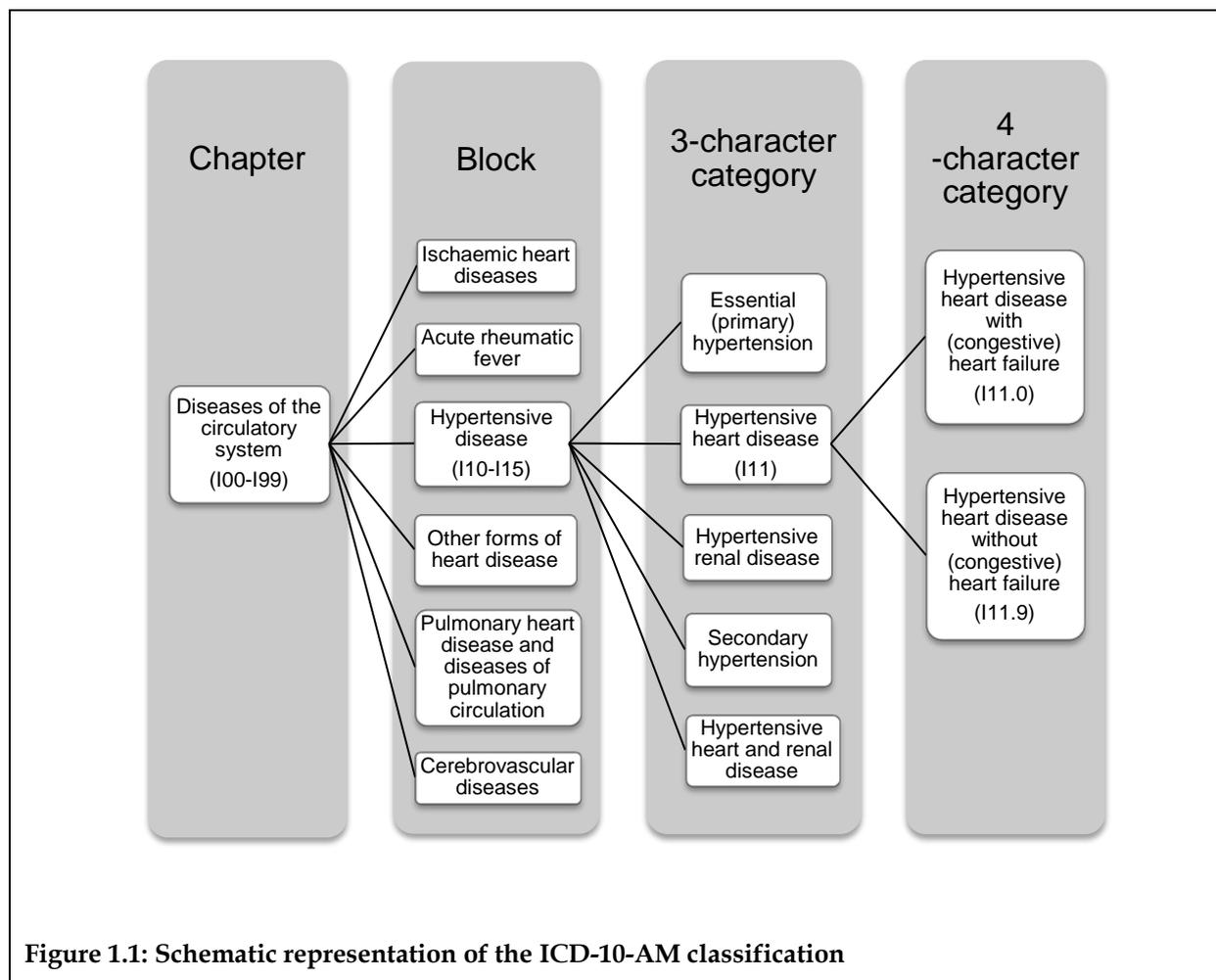
Classifications of clinical data

Diagnoses

For each separation, a **principal diagnosis** is reported. This is the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of admitted patient care. An **additional diagnosis** is a condition or complaint that either coexists with the principal diagnosis or arises during the episode of care. An additional diagnosis is reported if the condition affects patient management.

In 2012–13, diagnoses were reported using the seventh edition of the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification* (ICD-10-AM) (NCCH 2010).

Hospital records are analysed and allocated specific ICD-10-AM code(s) so that these can be easily stored, retrieved and analysed. Conditions are grouped into a hierarchy of chapters, blocks and '3', '4' and '5'-character categories. Figure 1.1 demonstrates an example of the hierarchy: the 3-character category *Hypertensive heart disease* is situated in the block called *Hypertensive disease* and the chapter *Diseases of the circulatory system*. *Hypertensive heart disease* can also be further partitioned into 4-character categories.



Procedures

Where applicable, **procedures** are also reported for separations. One or more procedures can be reported for each separation, but procedures are not undertaken for all separations.

A procedure is a clinical intervention that is surgical in nature, carries an anaesthetic risk, requires specialised training and/or requires special facilities or services available only in an acute care setting. Procedures therefore encompass surgical procedures and non-surgical investigative and therapeutic procedures, such as X-rays. Patient support interventions that are neither investigative nor therapeutic (such as anaesthesia) are also included. In 2012–13, procedures were reported using the 7th edition of the Australian Classification of Health Interventions (ACHI) classification (NCCH 2010).

The ACHI classification is applied to information from medical records to provide coded data on the interventions provided for patients. The classification is divided into chapters by anatomical site and within each chapter using a ‘superior’ to ‘inferior’ (head to toe) approach. These subchapters are further divided into more specific procedure blocks, beginning with the least invasive procedure through to the most invasive. The blocks, which are numbered sequentially, group the very specific procedure codes. Figure 1.2 shows how the procedure block *Examination procedures on larynx* consists of 3 codes and is in the chapter *Procedures on respiratory system*.

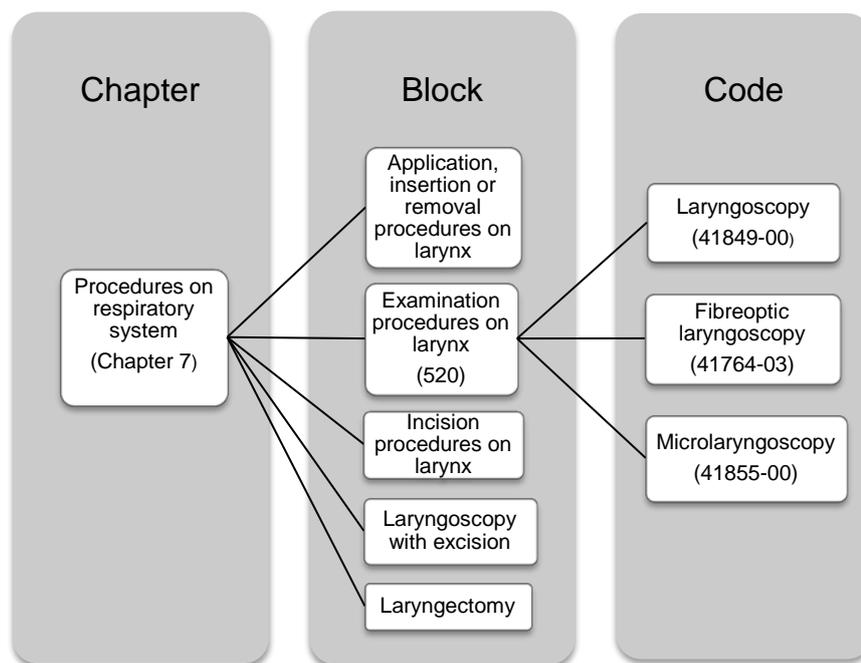


Figure 1.2: Schematic representation of the ACHI classification

Casemix

Casemix is the range and type of patients (the mix of cases) treated by a hospital or other health service. Information about casemix in this report relates to acute admitted patient care and is described using the Australian Refined Diagnosis Related Groups (AR-DRG) casemix classification. This report uses AR-DRG version 6.0x (DoHA 2010) to classify separations.

The AR-DRG system is a classification system which provides a way of relating the number and type of patients treated in a hospital to the resources expected to be used by the hospital. It creates groupings based on similarities in the complexity of a patient's condition as well as the complexity and resources required to perform procedures (ACCD 2014).

The Major Diagnostic Categories (MDC)s are the highest level in the classification and are mostly defined by body system or disease type according to the principal diagnosis, and correspond with particular medical specialties. Some procedures are considered particularly costly and are not grouped according to body system or disease type; separations with these procedures fall into the 'pre-MDC' category.

Figure 1.3 provides an example from this classification system. The AR-DRG *Respiratory infections/Inflammations with catastrophic CC* is listed with other related AR-DRGs under *Respiratory infections/Inflammations*. These AR-DRGs are in the *Medical* partition for the MDC *Diseases and disorders of the respiratory system*.

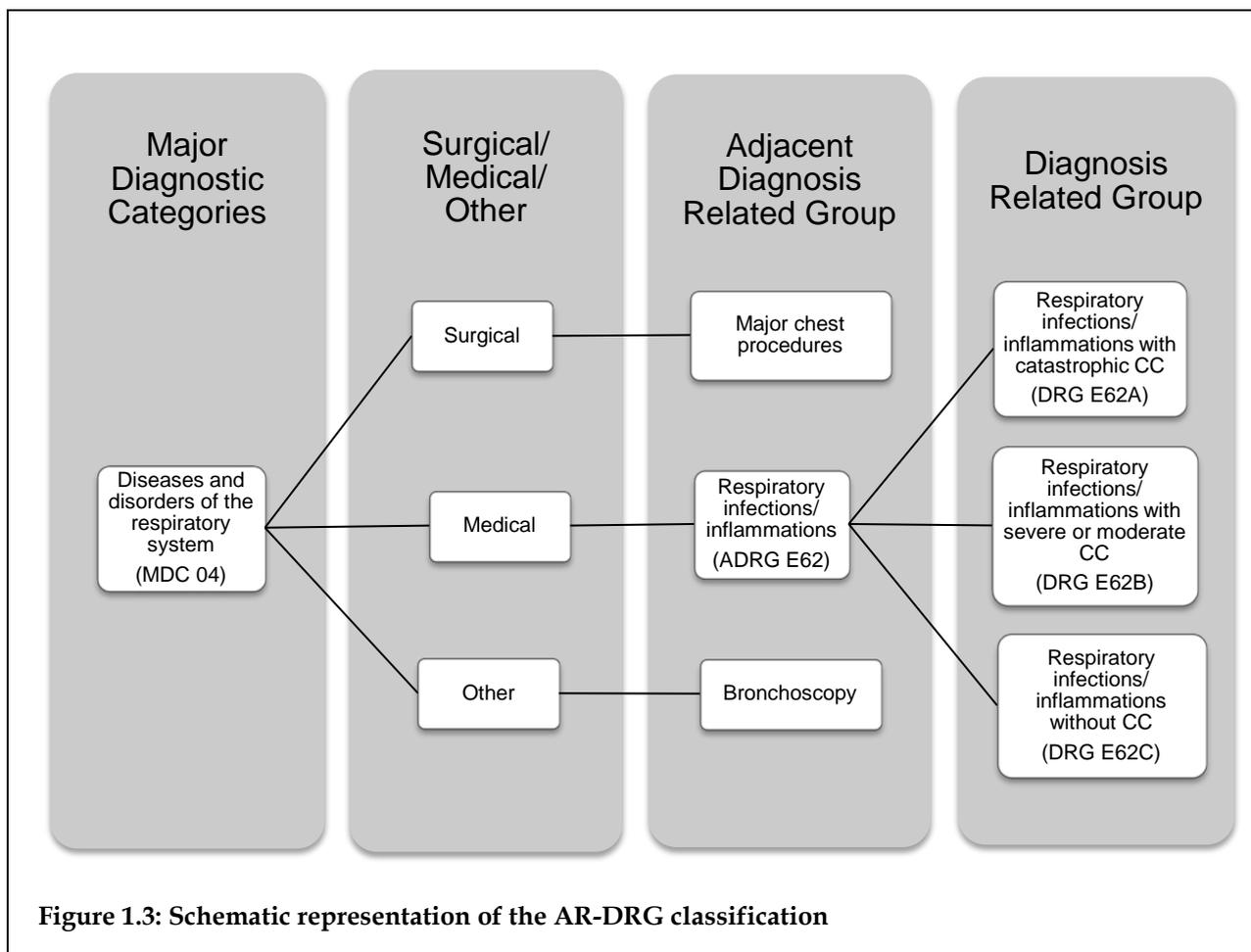


Figure 1.3: Schematic representation of the AR-DRG classification

Analysis methods

Geography

Data on the geographical location of the patient’s usual residence and of the hospital are provided using the ABS’s Australian Statistical Geography Standard (ASGS).

The patient’s usual area of residence is supplied to the NHMD by states and territories as Statistical Area 2, which are areas designed within the ASGS to represent a community that interacts together socially and economically (ABS 2011a). There are 2,196 SA2s, ranging in population from 3,000 to 25,000 persons, and have an average population of about 10,000 persons.

Statistical Area 3s (SA3s) cluster together SA2s with similar regional characteristics. There are 333 SA3s that cover the whole of Australia without overlaps or gaps. Generally the population of an SA3 ranges from 30,000 to 130,000 people. Criteria for clustering include functional aspects (such as clusters of related suburbs around urban commercial and transport hubs), and regional identity (such as geographic and socioeconomic similarities) (ABS 2011a).

More information on the ASGS is available on the ABS website at <www.abs.gov.au>.

Remoteness areas

In this report, remoteness is reported using the Remoteness Structure of the ASGS (ABS 2011a). Areas are classified as *Major cities*, *Inner regional*, *Outer regional*, *Remote* or *Very remote* based on the distance of the area to services. The category *Major cities* includes Australia's capital cities, with the exceptions of Hobart and Darwin, which are classified as *Inner regional*. Note that areas placed in the same broad categories may differ markedly in their economic activities, climate and demography.

More information on remoteness areas is available on the ABS website at <www.abs.gov.au>.

Socio-economic status

Data on socio-economic status groups are reported using the ABS Socio-Economic Indexes for Areas Index of Relative Socio-economic Disadvantage (SEIFA IRSD) (ABS 2013a), based on the area of usual residence of the patient.

The SEIFA IRSD scores each area by summarising aspects of the population, such as low income, educational attainment, unemployment and jobs in relatively unskilled occupations. Areas are ranked by their IRSD score and divided into 5 groups, from the most disadvantaged (worst off) to the least disadvantaged (best off) (ABS 2013a). Each of the 5 groups is called a *quintile* and represents about one-fifth (20%) of the population.

The relative disadvantage scores indicate the collective socioeconomic status of the people living in an area, with reference to the situation and standards applying in the wider community at a given point in time. A relatively disadvantaged area is likely to have a high proportion of relatively disadvantaged people. However, such an area is also likely to have people who are not disadvantaged, as well as people who are relatively advantaged.

More information on SEIFA IRSD is available on the ABS website at <www.abs.gov.au>.

2 The private hospital sector

In 2012–13, the 601 private hospitals accounted for 45% of Australia’s 1,347 hospitals and 34% of all available hospital beds (ABS 2014b; AIHW 2014a). Around 41% of all separations occurred in private hospitals, including 2 out of every 3 separations involving elective surgery (AIHW 2014a).

The growing role for private hospitals in Australia’s health system has been supported by the Australian Government through measures such as the Private Health Insurance Rebate, and reflected in the inclusion of private hospitals in national performance monitoring initiatives, such as those under the National Healthcare Agreement, and in the Performance and Accountability Framework of the National Health Reform Agreement (COAG 2012).

This chapter presents an overview of private hospitals in Australia: the number and types of hospitals, availability of beds, hospital ownership arrangements and funding sources. Data in this chapter are primarily sourced from the ABS *Private hospitals, Australia* report (which uses the PHEC as its data source) for the 2012–13 financial year.

How many private hospitals and private hospital beds were there in 2012–13?

Private hospitals are generally grouped into 2 categories: those that provide services on a same-day-only basis (free-standing day hospital facilities, or ‘day hospitals’) and those that provide overnight care (referred to here as ‘overnight hospitals’). This distinction reflects the fact that, under state and territory regulatory arrangements, overnight care requires the provision of 24-hour qualified nursing care that permits a broader range of medical and surgical procedures to be undertaken.

Some hospitals offering overnight care also provide same-day services. In most states and territories, private day hospitals can be licenced as ‘23-hour’ facilities, allowing for a longer recovery period than other day hospitals.

Note that the data in Table 2.1 is sourced from the ABS PHEC collection. A smaller number of day hospitals report to the PHDB (Table 1.1.). The reason for the discrepancy is unknown, but may be related to the different scopes of the collections. For more information on the differences between the collections, see Chapter 1.

In 2012–13, there were 601 private hospitals in Australia. Roughly half of private hospitals were day hospitals (319 hospitals) and the other half were overnight hospitals (282 hospitals) (Table 2.1). This proportion was also observed for the most populous states (New South Wales, Victoria and Queensland) as well as for South Australia. By comparison, Western Australia and the combined group of Tasmania, the Northern Territory and the Australian Capital Territory had lower proportions of day hospitals.

There were 76 more private hospitals in 2012–13 than in 2003–04, an increase of 14%. In the same period the number of private day hospitals increased by 36%, from 234 to 319. However, there were 9 fewer private overnight hospitals (a decrease of 3%).

In 2012–13, there were almost 30,000 available beds in private hospitals in Australia (ABS 2014b). The total number of available beds in private hospitals increased by 12% from 2003–04 to 2012–13 (Figure 2.1). This included a 51% increase in the number of available beds in private day hospitals.

Table 2.1: Number of hospitals, available beds, private overnight and day hospitals, 2012–13

	NSW	Vic	Qld	WA	SA	Tas, NT & ACT ^(a)	Australia
Number of hospitals							
Overnight hospitals	92	78	54	21	28	9	282
Day hospitals	100	87	52	36	27	17	319
<i>Total</i>	<i>192</i>	<i>165</i>	<i>106</i>	<i>57</i>	<i>55</i>	<i>26</i>	<i>601</i>
Number of beds^(b)							
	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	29,827

(a) Tasmanian, Northern Territory and Australian Capital Territory data were aggregated by the ABS to protect the confidentiality of the small number of hospitals in these states/territories.

(b) Available beds/chairs (average for the year).

Source: *Private hospitals, Australia, 2012–13* (ABS 2014b).

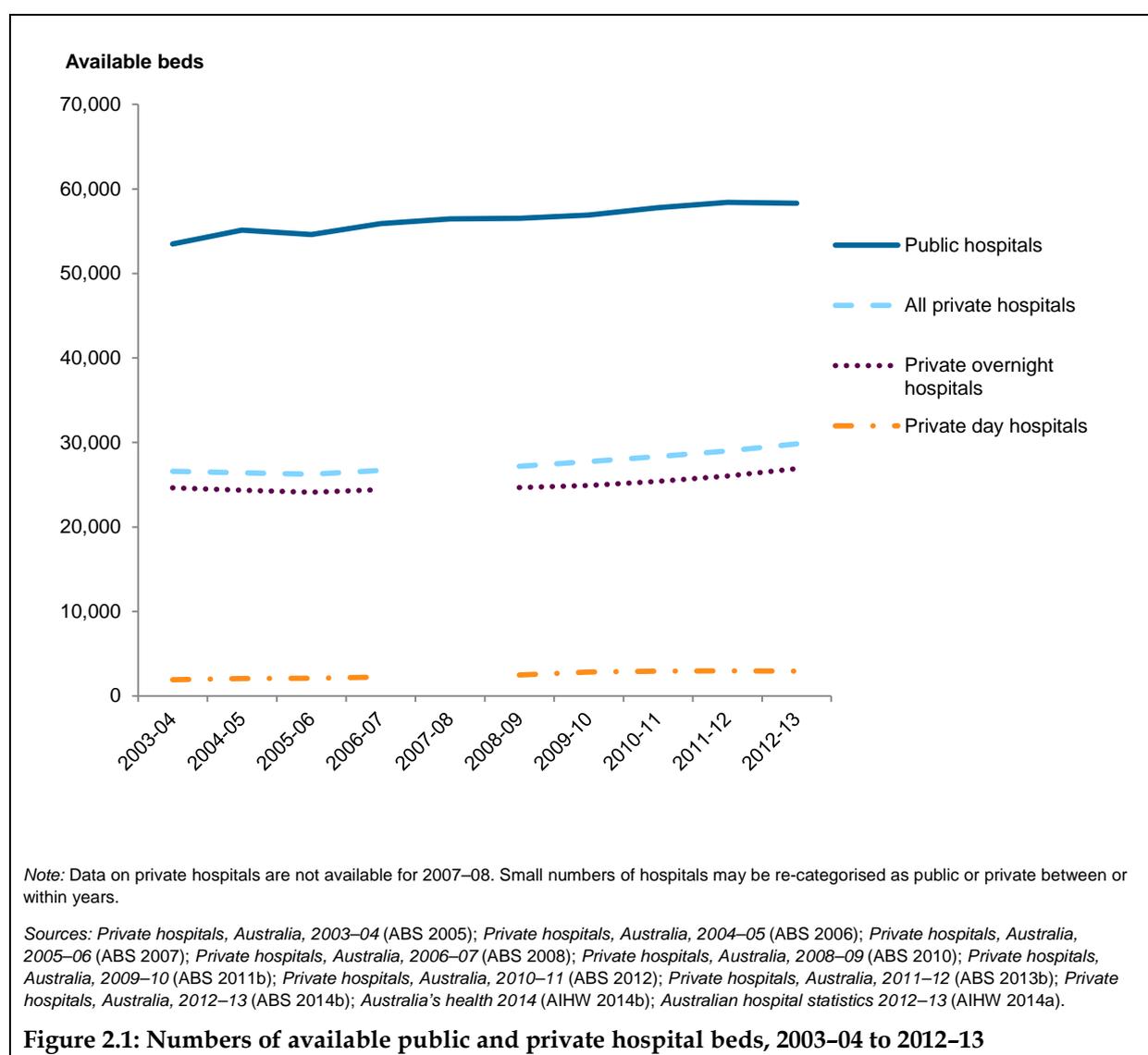


Figure 2.1: Numbers of available public and private hospital beds, 2003–04 to 2012–13

Despite the reduced number of private overnight hospitals, the total number of available beds in these hospitals increased by 9% over this period, from 24,642 to 26,889. Over the decade, more than two-thirds (69%) of the 3,238 additional beds in private hospitals were located in overnight hospitals.

For comparison, during the same period, the number of public hospitals decreased by about 2% and the number of public hospital beds increased by about 9% (AIHW 2014a, AIHW 2014b).

How diverse are private hospitals?

Private hospitals in Australia are very diverse in size and in the type of services they provide for patients. This section provides data to illustrate this diversity, using the AIHW's new private hospital peer groups, outlined in Appendix C. Data on peer groups are sourced from the PHDB to which fewer hospitals provided data in 2012–13 than to the ABS PHEC. Detail on the differences between these collections is provided in Chapter 1.

The diversity of admitted patient services that each peer group provides can be gauged by the average number of AR-DRGs with more than 5 separations reported (Table 2.2). A higher average number indicates that hospitals in that peer group tend to provide care for patients with a broader range of health conditions and provide a wider range of healthcare services.

Differences in service profiles and types of care are also illustrated by the length of time the patient spends receiving care. Patients in private *Mixed sub-acute and non-acute* hospitals had an average length of stay (ALOS) in hospitals of nearly 13 days, considerably longer than the 2.9 days that patients in *Private acute Group A hospitals* on average stayed.

In 2012–13, Australia's private overnight hospitals included:

- 22 *Private acute Group A hospitals*, of which 21 were located in *Major cities*. They had the broadest range of AR-DRGs for which 5 or more separations were reported in 2012–13 (381) and had the largest average number of separations (33,234).
- 36 *Private acute Group B private acute hospitals*, of which 29 were located in *Major cities*. These hospitals had the second largest average number of separations (22,045) and the second broadest range of AR-DRGs (281).
- 49 *Private acute Group C private acute hospitals*, of which 30 were located in *Major cities*. These hospitals had the third largest average number of separations (12,426) and the third broadest range of AR-DRGs (176).
- 71 *Private acute Group D hospitals*, of which 45 were located in *Major cities*. In comparison to other private acute hospitals these hospitals tended to have fewer separations (4,811) and have a smaller range of AR-DRGs (78). The proportion of patient days that were sub-acute and non-acute was larger (21%) than for the *Private acute Group A*, *Private acute Group B* and *Private acute Group C hospitals* (7%, 6% and 11%, respectively).
- 27 private hospitals in the *Psychiatric hospitals* peer group, of which most were in *Major cities*. In this report, they are combined with a single private *Drug and alcohol hospital*. As a combined group, they had a slightly longer average length of stay (3.9 days) and reported a smaller range of AR-DRGs (14) than the private acute hospitals.
- 23 private hospitals in the *Rehabilitation hospitals* peer group, most of which were located in *Major cities*. In comparison to other private hospitals these hospitals tended to mainly provide sub-acute and non-acute care (97% of patient days on average) and to have longer lengths of stay (4.4 days on average).
- 5 private hospitals in the *Mixed sub-acute & non-acute hospitals* peer group. Four of the 5 hospitals were located in *Major cities*. These hospitals provided a slightly wider range of services than *Rehabilitation hospitals* (12 and 7 AR-DRGs for which 5 or more separations were reported respectively).

Table 2.2: The diversity of private hospitals, 2012–13

Hospital type	Major cities	Inner regional	Outer regional	Total	Separations (average)	ALOS (days)	Non-acute care (% patient days)	AR-DRGs 5+ ^(a)
Private acute hospitals								
Group A	21	1	0	22	33,234	2.9	7.4%	381
Group B	29	6	1	36	22,045	2.5	5.8%	281
Group C	30	15	4	49	12,426	2.2	11.0%	176
Group D	45	19	7	71	4,811	2.3	20.8%	78
Specialist overnight hospitals								
Private psychiatric ^(b)	26	1	1	28	5,547	3.9	0%	14
Women's and children's	2	0	0	2	n.p.	n.p.	n.p.	n.p.
Other acute specialised	15	1	0	16	n.p.	n.p.	n.p.	n.p.
Sub-acute and non-acute hospitals								
Rehabilitation	22	1	0	23	5,709	4.4	96.5%	7
Mixed sub-acute & non-acute	4	1	0	5	475	12.6	79.4%	12
Very small hospitals	0	6	0	6	n.p.	n.p.	n.p.	n.p.
Day hospitals								
Dialysis clinics	14	0	0	14	7,272	1.0	0%	1
Endoscopy centres	53	3	0	56	2,731	1.5	0%	9
Eye surgery clinics	38	3	1	42	2,529	1.0	0%	10
Fertility clinics	8	0	0	8	2,416	1.0	0%	6
Haematology and oncology clinics	10	1	0	11	6,678	1.0	1.2%	17
Hyperbaric treatment centres	4	0	0	4	n.p.	n.p.	n.p.	n.p.
Mixed day procedure hospitals	40	15	4	59	3,676	1.0	0%	30
Oral & maxillofacial procedure centres	13	0	0	13	948	1.0	0%	6
Plastic & reconstructive surgery clinics	28	0	1	29	1,357	1.0	0%	13
Reproductive health centres	6	1	1	8	n.p.	n.p.	n.p.	n.p.
Sleep centres	3	0	0	3	750	1.0	0%	3
Unpeered	11	1	0	12	4,446	1.0	5.7%	21
Total	422	75	20	517	7,026	2.3	13.8%	73

(a) Average number of AR-DRGs for which there were at least 5 separations.

(b) 1 *Drug and alcohol hospital* has been combined with 27 *Private psychiatric hospitals* for confidentiality reasons.

Source: PHDB.

Private day hospitals generally had a narrower casemix than private overnight hospitals. In 2012–13, private day hospitals included:

- 14 private hospitals in the *Dialysis clinics* peer group, all located in *Major cities*. On average these hospitals had 7,272 separations in 2012–13.
- 56 private hospitals in the *Endoscopy centres* peer group, of which 53 were located in *Major cities*. On average these hospitals had 2,731 separations in 2012–13.
- 42 private hospitals in the *Eye surgery clinics* peer group, of which 38 were located in *Major cities*. On average these hospitals had 2,529 separations in 2012–13.
- 8 private hospitals in the *Fertility clinics* peer group. All 8 of these hospitals were located in *Major cities*. On average these hospitals had 2,416 day separations in 2012–13.
- 11 private hospitals in the *Haematology and oncology clinics* peer group, of which 10 were located in *Major cities*. On average these hospitals had 6,678 separations in 2012–13.
- 59 private hospitals in the *Mixed day procedure hospitals* peer group, of which 40 were located in *Major cities*. These hospitals had on average 3,639 separations in 2012–13 and the broadest range of AR-DRGs (30) of the *Day hospitals* peer groups.
- 13 private hospitals in the *Oral and maxillofacial procedure centre* peer group, all of which were located in *Major cities*. These hospitals had on average 948 separations in 2012–13.
- 29 private hospitals in the *Plastic and reconstructive surgery clinic* peer group, of which 28 were located in *Major cities*. On average these hospitals had 1,236 separations in 2012–13.
- 3 private hospitals in the *Sleep centre* peer group. All 3 private hospitals in this group were located in *Major cities*. On average these hospitals had 750 separations in 2012–13.

What facilities are provided in private hospitals?

Private overnight hospitals have a wide range of specialist facilities and services, for both admitted and non-admitted patients (Table 2.3). In 2012–13, these included, for example:

- dedicated day surgery units (127 hospitals)
- separate intensive care unit (41 hospitals)
- rehabilitation units (86 hospitals)
- oncology units (80 hospitals)
- sleep centres (70 hospitals)
- labour wards (69 hospitals)
- obstetric/maternity services (69 hospitals)
- high dependency units (57 hospitals) (Table 2.3).

In 2012–13, there were 201 overnight hospitals with operating theatres (72% of overnight hospitals), the same number as in 2003–04. These hospitals had a total of 1,054 operating theatres, 8 more than in 2003–04 (ABS 2005; ABS 2014b). Over the same period the number of operating theatres in day hospitals increased by 48% to 325 and the number of procedure rooms increased by 46% to 260 rooms (ABS 2005; ABS 2014b).

Non-admitted patient services offered by private overnight hospitals in 2012–13 included:

- radiology and organ imaging (10 hospitals)
- pathology (5 hospitals)
- other medical, surgical and diagnostic services (22 hospitals)

- mental health services (8 hospitals)
- allied health services (31 hospitals) (ABS 2014b).

Table 2.3: Number of hospitals with specialised facilities and wards, private overnight hospitals, states and territories, 2012–13

Specialised facilities and wards	NSW	Vic	Qld	WA	SA	Tas, NT & ACT ^(a)	Australia
Labour wards	16	16	17	9	5	6	69
Psychiatric wards/drug and alcohol units ^(b)	22	12	10	6	n.a.	n.a.	56
Emergency departments ^(c)	3	7	7	3	n.a.	n.a.	23
Dedicated day surgery unit	39	33	26	12	12	5	127
Neonatal intensive care unit	n.a.	13	n.a.	7	4	5	n.a.
Separate intensive care unit (ICU)	13	9	12	n.a.	n.a.	n.a.	41
Separate coronary care unit (CCU)	12	9	9	4	n.a.	n.a.	37
Combined ICU/CCU	n.a.	6	5	n.a.	n.a.	n.a.	18
High dependency unit	17	19	10	3	n.a.	n.a.	57
Obstetric/maternity service	16	16	17	9	5	6	69
Specialised paediatric service	4	4	8	3	n.a.	n.a.	21
Cardiac surgery unit	7	9	6	n.a.	4	n.a.	28
Maintenance renal dialysis	5	n.a.	5	3	0	n.a.	15
Oncology unit	17	21	24	8	n.a.	n.a.	78
Rehabilitation unit	35	21	17	6	n.a.	n.a.	86
Sleep centre	16	20	21	5	5	3	70
Residential aged care service ^(d)	0	4	3	n.a.	5	n.a.	13
Geriatric assessment unit	0	n.a.	3	3	n.a.	n.a.	9
Domiciliary care service	n.a.	n.a.	0	0	0	0	n.a.
Hospice/palliative care unit	n.a.	n.a.	8	7	n.a.	n.a.	24
Other specialised units/wards ^(e)	33	34	28	7	11	n.a.	n.a.
All private overnight hospitals^(f)	91	77	54	20	27	9	278

n.a.: not available.

(a) ABS aggregated the data for Tasmania, the Northern Territory and the Australian Capital Territory to protect confidentiality.

(b) Number of hospitals with a psychiatric unit and/or drug and alcohol unit.

(c) Emergency departments defined as those providing levels 4 to 6 of emergency services as defined by the *Guide to the role delineation of health services*, 3rd edition, New South Wales, DoH, 2002.

(d) Including only those residential aged care service which are an integral part of the hospital.

(e) Other includes neurosurgical units; acute spinal cord injury units; burns units; major plastic/reconstructive surgery units; transplantation units; acute renal dialysis units; infectious diseases units; comprehensive epilepsy centres; clinical genetics units; AIDS units; diabetes units; in-vitro fertilisation units; post-acute rehabilitation units and other specialised services.

(f) Not every hospital has specialised wards, units and facilities, while some hospitals have more than 1 type of specialised wards, units and facilities and these are counted in more than 1 row.

Source: *Private hospitals, Australia, 2012–13* (ABS 2014b).

How has this changed over time?

Over recent years, there have been shifts in the patterns of specialised services and facilities offered at overnight hospitals. Among the most commonly reported specialist services in 2012–13, the number of the following had risen since 2003–04:

- cardiac surgery units (28 hospitals compared with 24 hospitals reported in 2003–04)

- high dependency units (57 compared with 47)
- hospice/palliative care units (24 compared with 18)
- oncology units (78 compared with 69)
- psychiatric wards/ drug and alcohol units (56 compared with 46)
- rehabilitation units (86 compared with 49)
- residential aged care services (13 compared with 7)
- separate coronary care units (37 compared with 31)
- separate intensive care units (41 compared with 38)
- sleep centres (70 compared with 53).

The following specialised services decreased in number:

- combined ICU/CCU (18 compared with 25)
- dedicated day surgery units (127 compared with 140) (ABS 2005; ABS 2014b)
- emergency departments (23 compared with 27)
- geriatric assessment units (9 compared with 11)
- maintenance renal dialysis units (15 compared with 17)
- obstetric/maternity services (69 compared with 82)
- specialised paediatric services (21 compared with 27).

Who owns private hospitals?

Private hospitals generally fall into 5 main 'ownership' types:

- for-profit group (that is a group of hospitals owned and/or operated by 1 company)
- for-profit independent
- not-for-profit religious/charitable group
- not-for-profit religious/charitable independent
- other not-for-profit hospitals (comprising bush nursing, community and memorial hospitals).

Not-for-profit hospitals are those that qualify as non-profit organisations with either the Australian Taxation Office or the Australian Securities and Investments Commission.

As illustrated in Figure 2.2, in 2012–13 the majority (61%) of overnight private hospitals were owned by for-profit groups and a further 29% were owned by religious or charitable organisations. The remaining overnight private hospitals were owned by other not-for-profit groups (ABS 2014). Fifty-four per cent of available beds in overnight private hospitals were in hospitals owned by for-profit organisations; 37% in hospitals owned by religious or charitable organisations; and the remaining 9% in hospitals owned by other types of not-for-profit groups.

Private overnight hospitals owned by for-profit organisations tended to be medium-to-large in size in 2012–13, with 34% in the range of 51 to 100 beds. Hospitals owned by religious or charitable organisations ranged in size from 0-25 to over 100 beds, with 42% containing over 100 beds. Around one-third (36%) of the private overnight hospitals owned by other organisations were small in size, with fewer than 26 beds, and one-quarter (26%) had over 100 beds (Figure 2.2). Data on the ownership of day hospitals are not available.

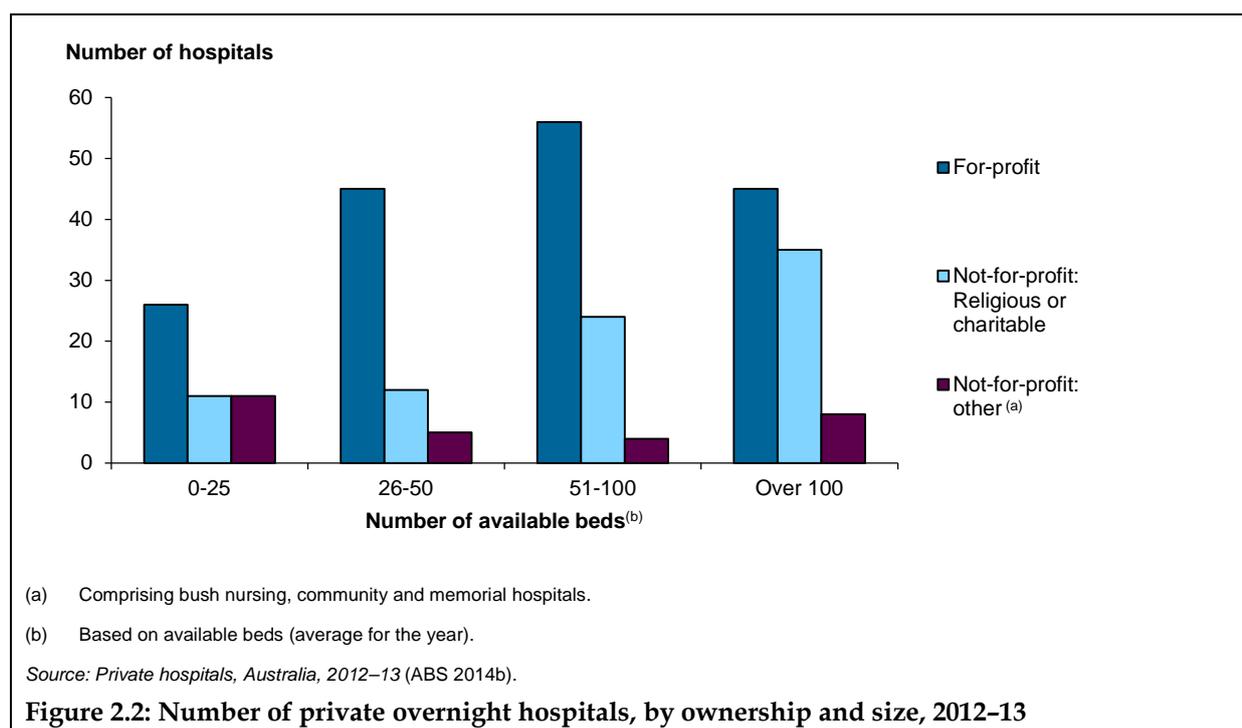


Figure 2.2: Number of private overnight hospitals, by ownership and size, 2012-13

How many staff are in private hospitals?

Two data sources provide information on the staffing of private hospitals in Australia: the ABS PHEC and the AIHW National Health Workforce Data Set. The PHEC includes data provided by private hospitals on all staff they employ. These data do not include data on people who work at the hospitals as consultants and are not employed by the hospitals – an arrangement that is common for medical practitioners in private hospitals.

The National Health Workforce Data Set includes data on medical practitioners and nurses, but not other staffing categories relevant to private hospitals such as allied health professionals. These data provide an indication of the total number of medical practitioners who work in private hospitals, as the survey asks for the number of hours they worked in the previous week in private hospitals, including both salaried and consultant work (AIHW 2014d).

Total staffing

The number of fulltime equivalent (FTE) staff in private hospitals increased by 5% from 57,495 FTEs in 2011-12 to 60,387 in 2012-13. Of these 93% (56,317 FTEs) worked in overnight hospitals (ABS 2014b).

Medical practitioners

In 2012-13, a total of 1,232 FTEs for *Salaried medical professionals* were reported by private hospitals. As a proportion of all staff employed by private hospitals, *Salaried medical professionals* made 2% of overnight hospital staff and 4% of day hospital employees (ABS 2014b).

In 2012, an estimated 16,710 medical practitioners indicated they had worked in private hospitals in the previous week (AIHW 2014d). The majority of these medical practitioners were *Specialists* (71%).

These 16,710 medical practitioners equated to 6,855 FTEs; larger than the 1,232 FTEs reported for *Salaried medical professionals* by private hospitals, and reflecting the activity of consultant medical practitioners.

Nurses

In 2012–13, a total of 34,485 FTE nurses were reported by private hospitals. As a proportion of all staff employed by private hospitals, *Nurses* made up 57% of overnight hospital staff and 52% of day hospital staff. The proportion of day hospital nurses ranged from 62% for ophthalmic surgeries to 46% for gynaecology, fertility treatment and family planning centres (ABS 2014b).

In 2012 there were 37,400 FTE nurses who indicated they had worked in private hospitals in the previous week; including 5,800 FTE enrolled nurses and 31,700 FTE registered nurses (AIHW 2013h).

Other staff

For overnight private hospitals, other staff included *Administrative and clerical staff* (13% of FTE staff), *Domestic and other staff* (15%), *Clinical support staff* (7%) and *Diagnostic and allied health professionals* (5%). For day hospitals, other staff included *Administrative and clerical staff* (26%), *Clinical support staff* (8%), *Diagnostic and allied health staff* (5%) and *Domestic and other staff* (4%) (ABS 2014b).

How much revenue and expenditure?

In 2012–13, total income for private hospitals was estimated to be \$11.8 billion, with day hospitals accounting for \$947 million (8%) and other private hospitals accounting for \$10.9 billion (92%) (ABS 2014b). Overnight and day hospitals reported 95.7% and 95.0% of this income was patient revenue, respectively.

Total expenditure for private hospitals for 2012–13 was \$10.6 billion, of which \$9.9 billion (93%) was spent by overnight hospitals, and the remaining \$770 million was spent by day hospitals. Almost half (48.6%) of the total expenditure was paid as wages and salaries, including on-costs such as employer contributions to superannuation and payroll tax. Wages and salaries amounted to \$4.9 billion (49.2%) and \$319 million (41.4%) of total overnight and day hospital expenditure, respectively.

How are private hospitals funded?

Information in this section comes from a range of sources, including the AIHW's health expenditure database and the Private Health Insurance Advisory Council. Please note that each data source has a different scope and purpose. Information on the Health expenditure data is available in Chapter 1.

In 2011–12, two-thirds (68%) of funding for private hospitals was through private health insurance funds (AIHW 2013f). This comprised 48% health fund payments (for services received by members) and 20% in the form of indirect subsidies through the 30–40% Australian Government rebate on premiums. Payments from individuals made up 12% of total funding to private hospitals (Table 2.4).

Table 2.4: Total expenditure on private hospitals, by source of funding, 2011–12 (\$ million)

	Australian Government			Other government		Non-government				Total
	DVA	DoHA and other ^(a)	Premium rebates ^(b)	State and local	Total	Health insurance funds	Individuals	Other ^(c)	Total	
Private hospitals	924	247	2,293	494	3,958	5,483	1,334	701	7,517	11,475

(a) 'DoHA and other' comprises DoHA funded-expenditure such as through the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme, and other Australian Government expenditure such as for the Specific Purpose Payments (SPPs) associated with the National Healthcare Agreement and health-related National Partnership payments; capital consumption; estimates of the medical expenses tax offset; and health research not funded by DoHA.

(b) Includes the 30–40% rebate on health insurance premiums that can be claimed either directly from the Australian Government through the taxation system or by a reduced premium being charged by the private health insurance fund.

(c) Expenditure on health goods and services by workers compensation and compulsory third-party motor vehicle insurers, as well as other sources of income (for example, rent or interest earned) for service providers.

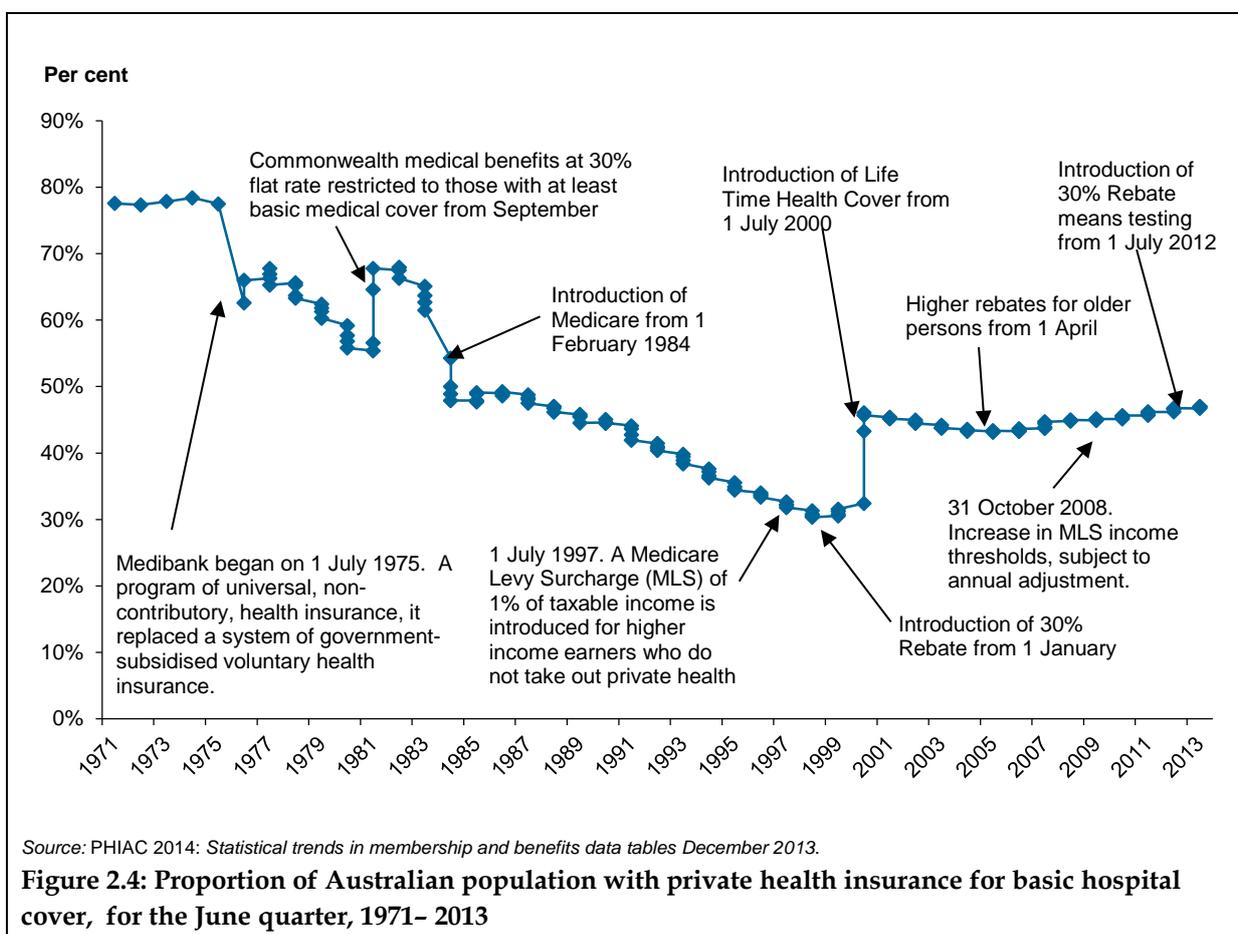
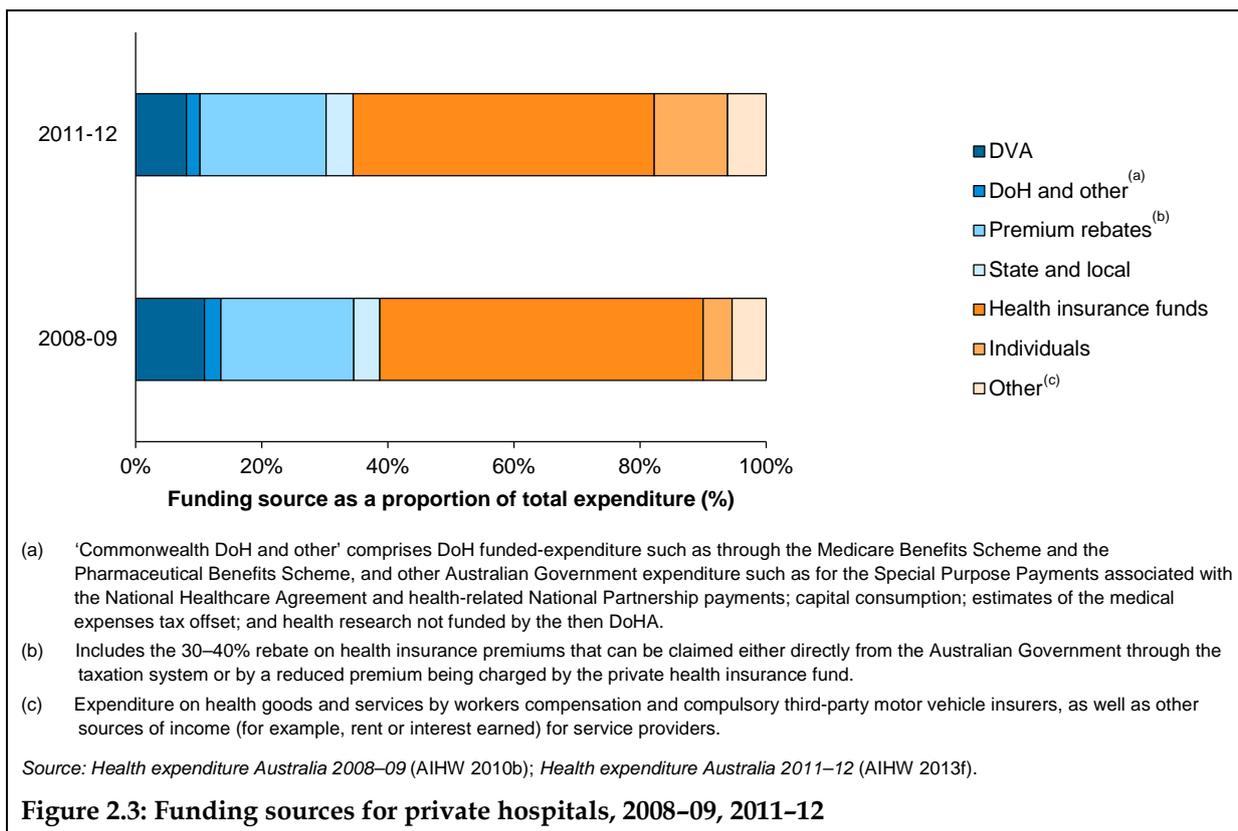
Source: *Health expenditure Australia 2011–12* (AIHW 2013f).

The proportions of funding from private health insurance funds and premium rebates have been relatively stable since 2008–09, increasing by 3 and 1 percentage points, respectively (Figure 2.3). Data were not available for 2007–08. The proportion of funding from the DVA decreased from 11% in 2008–09 to 8% in 2011–12 (AIHW 2010b, AIHW 2013f). Payments from individuals made up 12% of total funding for private hospitals in 2011–12, up from 5% in 2008–09 (AIHW 2010b, AIHW 2013f).

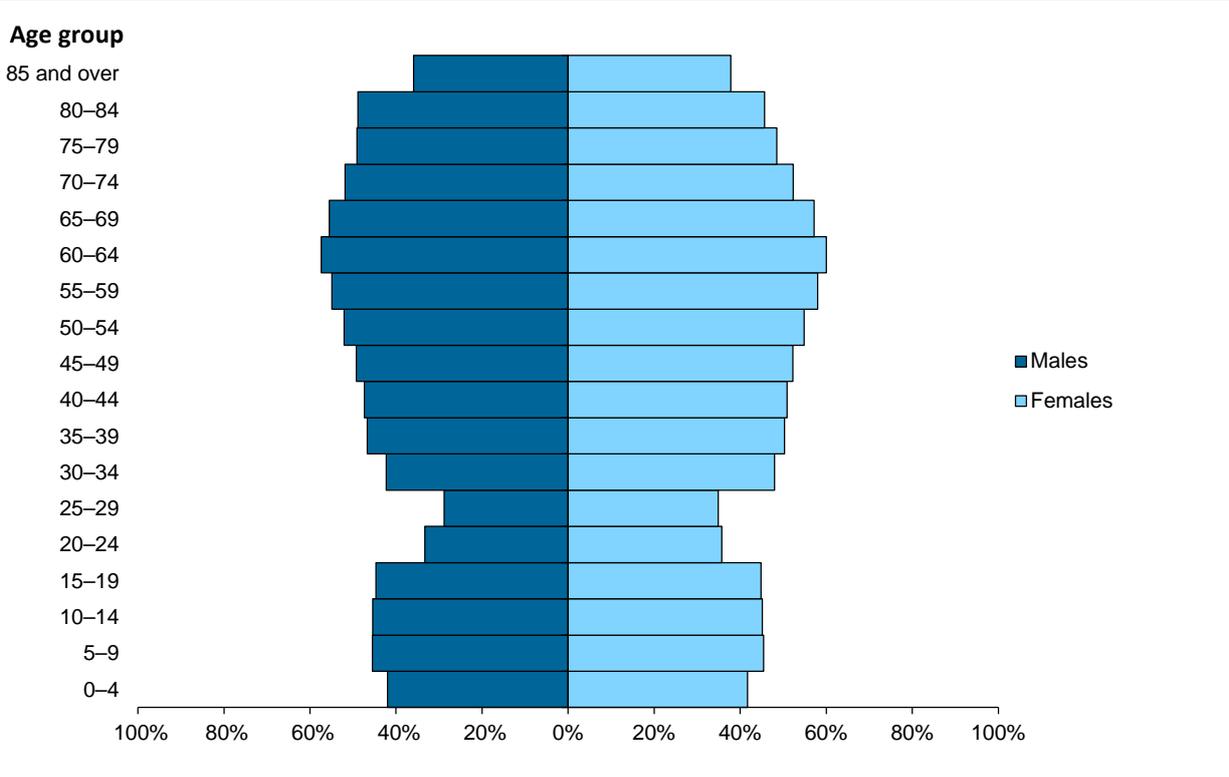
Given the relatively large proportion of funding for private hospitals that is sourced from private health insurance funds, the sector relies in part on individuals who have private health insurance. The proportion of Australians with private health insurance hospital cover increased from 44.9% in the June quarter 2008 to 46.9% in the June quarter 2013 (PHIAC 2014).

Changes in private health insurance membership over time may in part reflect the introduction of specific government measures. Private health insurance data collected from 1971 to 2013 show a pattern of changes to membership following policy changes by the Australian Government (Figure 2.4).

In January 2012 the Australian Government introduced means testing for the Private Health Insurance Rebate. This varied the proportion of insurance premium covered by the rebate depending on income, age and single/family status. From July 2013, the Australian Government discontinued the rebate payment for Lifetime Health Cover loadings. Most recently, in April 2014, the Private Health Insurance Rebate for all insurance products was adjusted annually to take into account growth in the Consumer Price Index and the industry weighted average premium increase (ATO 2014; Private Health Insurance Ombudsman 2014).



In December 2012 (the midpoint of the 2012–13 financial year), just under half (47%) of Australians had private health insurance for hospital treatment. This proportion varied by age and sex (Figure 2.5), with coverage lowest amongst people aged between 25 and 29 years (32%) and highest amongst people aged 60 and 64 years (59%). Overall, roughly the same proportion of males and females had private health insurance for hospital cover (46% and 48%, respectively), although women were more likely than men to have hospital cover between the ages of 25 and 34, with the proportions differing by 6 percentage points.



(a) Population rates were taken from ABS Australian Demographic Statistics, December 2012. ABS cat. no. 3101.0.
 Source: AIHW analysis of *privately insured with hospital treatment cover annual report: sex, age and state: December 2012*.

Figure 2.5: Proportion of the population^(a) with private health insurance for hospital treatment cover, age and sex, December 2012

Relationship with the public sector

In many instances, public and private hospitals do not operate in isolation from each other, but instead provide healthcare services in a coordinated manner. Interactions between public and private hospitals include contracted care arrangements and co-location and resource sharing.

There can also be private sector involvement in public hospital infrastructure development. For example, under some partnership arrangements, the private sector finances and builds new hospital facilities to treat public patients in return for the right to operate the facilities and receive funding from state and territory governments.

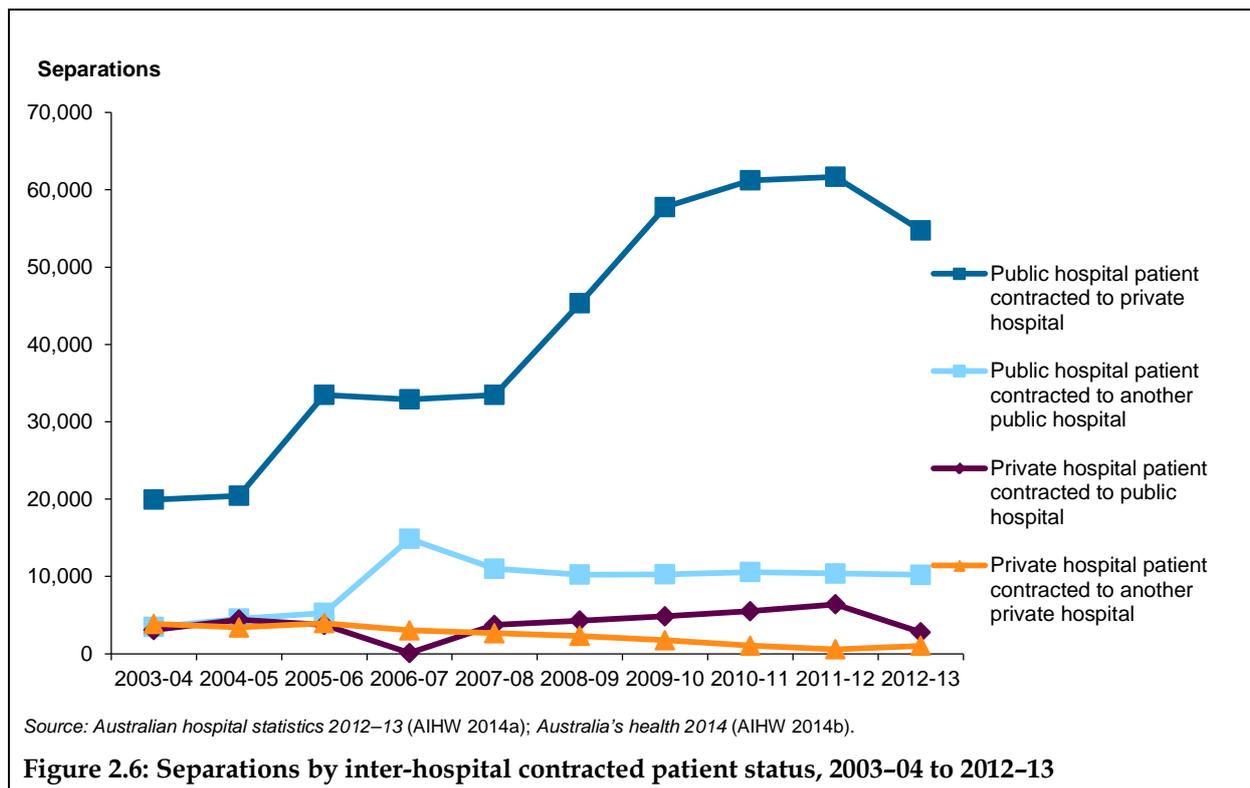
Contracted admitted patient care

Note that the data on contracted admitted patient care is sourced from the NHMD, and thus has a different scope to other data in this chapter. Information on the NHMD is available in Chapter 1.

In some circumstances, hospitals provide care to admitted patients through inter-hospital contracted care arrangements, in which the care is organised and paid for by 1 hospital but provided by another. In 2012–13, about 54,756 separations were contracted by public hospitals to private hospitals - that is, the public hospitals paid for the care and the private hospitals provided the care (Figure 2.6). This represented 80% of all inter-hospital contracted patients, up from 66% in 2003–04 (AIHW 2005, AIHW 2014a). During the same period, the number of separations for care contracted from public to private hospitals almost tripled (2.7 times as high), from 20,000 in 2003–04 (AIHW 2005).

Care for admitted and non-admitted patients can be also contracted by a state or territory health authority or, since their introduction, a Local Hospital Network.

In 2012–13, there were 11 hospitals that were privately owned and/or operated that provided public hospital services predominantly or substantially funded by state governments (AIHW 2014a).



Co-location and resource sharing

Another area for interaction occurs when a private hospital is co-located with a public hospital. This can allow for the sharing of facilities, equipment and staff, can provide greater convenience for doctors, and can enhance patient choice, allowing patients easier access to a wider range of services. In 2012–13 there were 10 private day hospitals and 43 overnight private hospitals co-located with public hospitals (ABS 2014b). Table 2.5 shows the distribution of co-located overnight private hospitals by state.

Table 2.5: Number of overnight private hospitals co-located with a public hospital, 2012–13

	NSW	Vic	Qld	WA	SA	Tas, NT & ACT ^(a)	Total
Private hospitals co-located with a public hospital	15	7	6	5	5	n.a.	43

(a) Tasmanian, Northern Territory and Australian Capital Territory data were aggregated by the ABS to protect the confidentiality of the small number of hospitals in these states/territories.

Source: *Private hospitals, Australia, 2012–13* (ABS 2014b).

3 Overview of private hospital care

This chapter presents an overview of patient care provided by Australia's private hospitals.

Most of the data available relate to the care of patients admitted to private hospitals and make up the majority of the chapter. These data are drawn from the NHMD and include data on admitted acute, and sub-acute and non-acute patient care (see Chapter 1 for further information). Data relating to non-admitted patient care have been sourced from *Private hospitals, Australia* (ABS 2014b).

The data in this chapter are primarily presented split by same-day and overnight separations: the number of same-day separations includes separations from both day and overnight private hospitals (see Chapter 1 for definitions of 'same-day' and 'overnight'). Information on the activity of private day and overnight hospitals is presented in chapters 5 and 6 respectively.

Key terms relevant to admitted and non-admitted patient care are outlined in detail in Chapter 1. Definitions are also available in the glossary. Information on the methods used is available in Appendix B.

What data are reported?

The data in this chapter include administrative, demographic and clinical data. This chapter includes data on admitted patient care in private hospitals in the following broad sections:

- How much admitted patient activity was there in 2012–13?
- How has activity changed over time?
- Who used these services?
- Why did people receive the care?
- How urgent was the care?
- What care was provided?
- How long did patients stay?
- Who paid for the care?

Following this, data on non-admitted patient care in private hospitals are included to answer the following question:

- How much non-admitted patient activity was there in 2012–13?

How much admitted patient activity was there in 2012–13?

In 2012–13 there were about 3.8 million separations in private hospitals in Australia, making up 41% of all hospital separations that year (AIHW 2014a). Of these separations around 2.6 million were same-day separations (Table 3.1). There were nearly 8.9 million patient days in private hospitals. New South Wales had the largest number of same-day separations (780,000) in 2012–13 and Victoria, the largest number of overnight separations (321,000).

Table 3.1: Separations and patient days, states and territories, private hospitals 2012–13

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Separations									
Same-day separations	779,710	622,560	639,081	314,580	206,483	n.p.	n.p.	n.p.	2,646,926
Overnight separations	302,790	320,821	294,580	137,362	91,676	n.p.	n.p.	n.p.	1,196,405
Total	1,082,500	943,381	933,661	451,942	298,159	n.p.	n.p.	n.p.	3,843,331
Patient days	2,464,340	2,310,738	2,219,627	910,944	639,419	n.p.	n.p.	n.p.	8,872,946

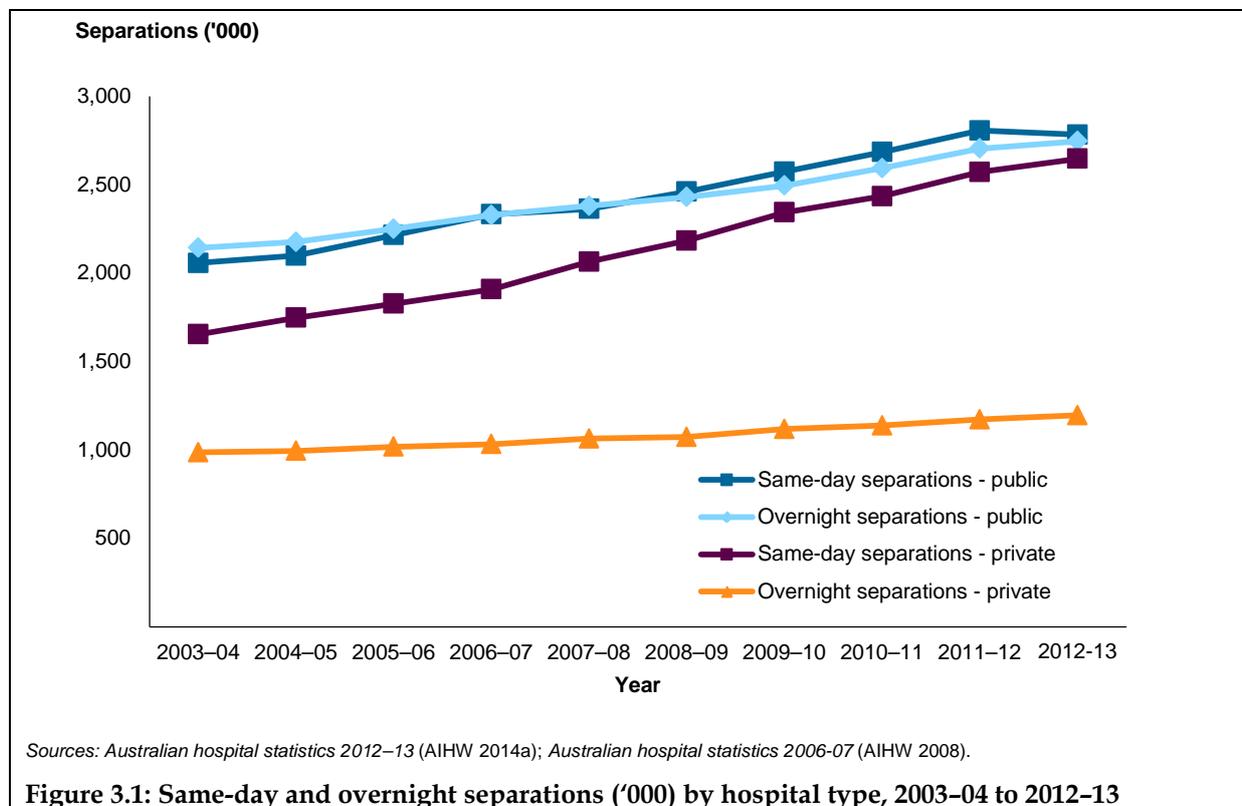
Source: Australian hospital statistics 2012–13 (AIHW 2014a).

How has activity changed over time?

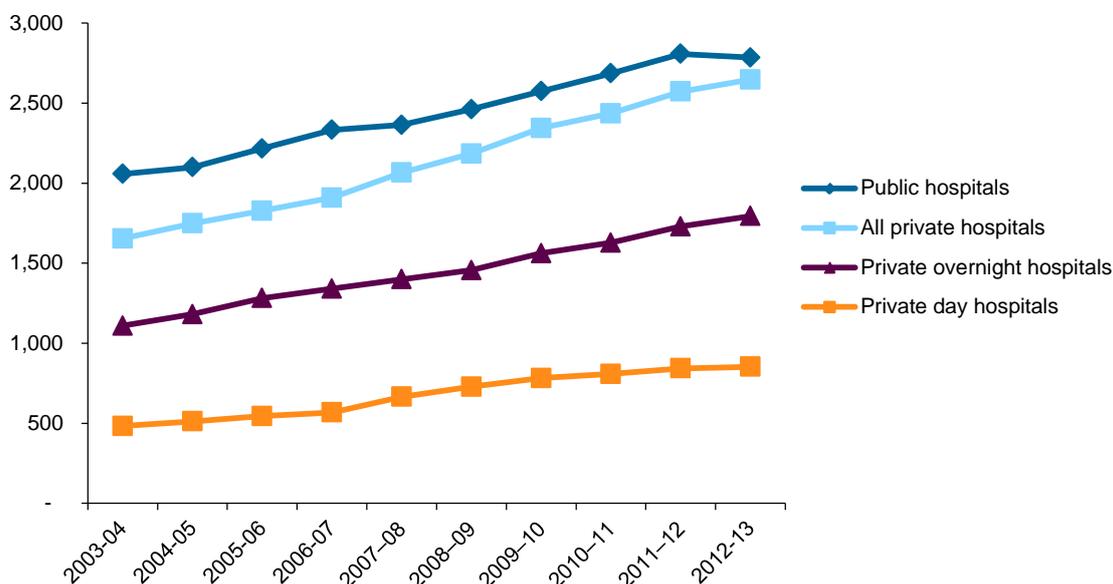
From 2003–04 to 2012–13, the total number of private hospital separations increased by 46% from 2.64 million to 3.84 million. During this period, the number of same-day separations in private hospitals increased 60% from 1.65 million to 2.65 million separations and overnight separations increased 21% from 986,000 to 1.20 million (Figure 3.1).

The total number of private hospital separations for acute care increased by 41% over the decade, from approximately 2.55 million in 2003–04 to 3.59 million in 2012–13. The number of private hospital separations for sub-acute and non-acute care increased more than 3-fold between 2003–04 and 2012–13, from about 76,000 to about 255,000 (AIHW 2005; AIHW 2014a).

Between 2003–04 and 2012–13, there were an additional 370,000 and 680,000 same-day separations in day and overnight private hospitals, respectively (Figure 3.2).



Same day separations ('000)



Sources: Australian hospital statistics 2012–13 (AIHW 2014a); Australian hospital statistics 2006-07 (AIHW 2008).

Figure 3.2: Same-day separations ('000) by hospital type, 2003-04 to 2012-13

Table 3.2: Separations by broad category of service and urgency of admission, private hospitals, 2008-09 to 2012-13

	2008-09	2009-10	2010-11	2011-12	2012-13	Change since 2008-09 (%)
Childbirth	81,390	84,320	80,006	80,782	81,872	+0.6
Specialist mental health	131,378	145,643	130,090	140,091	143,745	+9.4
Emergency						
Surgical	30,596	33,131	36,617	38,678	39,432	+28.9
Medical	123,919	133,212	144,549	146,399	147,663	+19.2
Other	11,203	12,375	13,967	15,692	15,835	+41.3
<i>Total emergency</i>	<i>165,718</i>	<i>178,718</i>	<i>195,133</i>	<i>200,769</i>	<i>202,930</i>	<i>+22.5</i>
Non-emergency						
Surgical	1,206,830	1,265,071	1,291,089	1,349,008	1,371,995	+13.7
Medical	1,006,337	1,084,585	1,147,340	1,227,888	1,289,030	+28.1
Other	665,772	703,378	729,760	746,139	753,759	+13.2
<i>Total non-emergency</i>	<i>2,878,939</i>	<i>3,053,034</i>	<i>3,168,189</i>	<i>3,323,035</i>	<i>3,414,784</i>	<i>+18.6</i>
Total	3,257,425	3,461,715	3,573,418	3,744,677	3,843,331	+18.0

Source: Australian hospital statistics 2012–13 (AIHW 2014a).

Between 2008-09 and 2012-13 there was an 18% increase in the number of separations in private hospitals (Table 3.2). *Emergency* admissions increased more over the period than *Non-emergency* admissions (23% and 19% respectively).

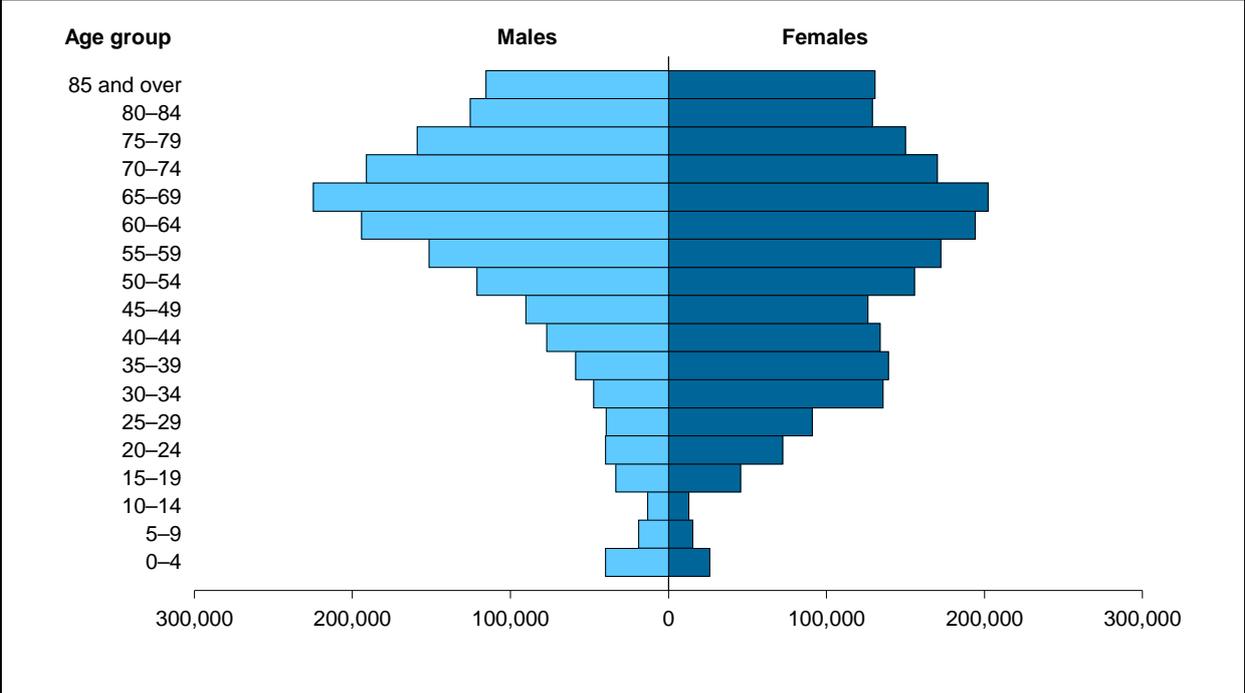
Increases in the number of separations for the *Medical*, *Surgical* and *Other* categories between 2008-09 and 2012-13 differed by the urgency of admission. For *Emergency* admissions, the

Other category showed the greatest increase in separations (41%), whereas for Non-emergency admissions the Medical category showed the greatest increase (28%).

Who used these services?

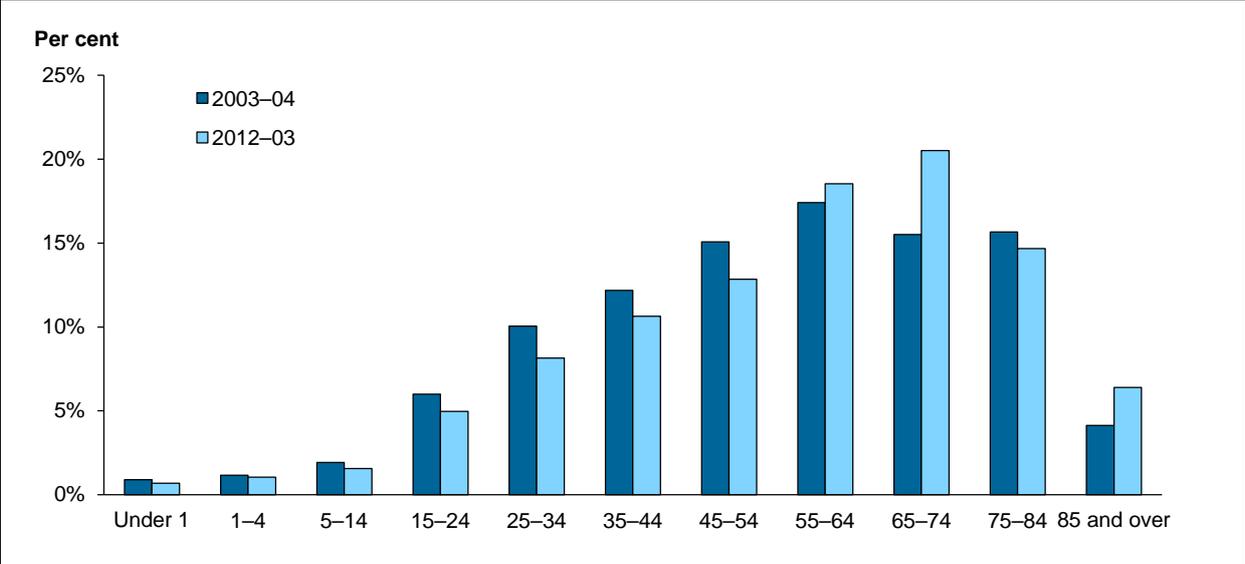
Age and sex

In 2012–13, women accounted for 55% of all private hospital separations. Almost 1 in 5 female separations involved a woman aged between 60 and 69 (Figure 3.3). Almost a quarter of the men who were hospitalised were aged between 65 and 74 (24%).



Source: NHMD.

Figure 3.3: Separations by sex and age group, private hospitals, 2012-13



Sources: Australian hospital statistics 2003-04 (AIHW 2005); Australian hospital statistics 2012-13 (AIHW 2014a).

Figure 3.4: Proportion of separations by age group, private hospitals, 2003-04 and 2012-13

Over the 10 years to 2012–13, the proportion of separations that were for older age groups increased, with the greatest increase in people over 85 years, where separations more than doubled for both men and women (Table 3.3).

In 2003–04, just over half (53%) of separations involved patients who were at least 55 years old. This increased to 60% in 2012–13. This corresponds to almost 920,000 additional separations in this age group (Figure 3.4).

Table 3.3: Separations by sex and age group, private hospitals, 2003–04 and 2012–13

Sex	Age group	2003–04	2012–13	Change since 2003–04 (%)
Males	Under 1	14,546	15,683	+7.8
	1–4	18,469	24,155	+30.8
	5–14	27,490	31,882	+16.0
	15–24	61,252	73,027	+19.2
	25–34	70,142	86,620	+23.5
	35–44	114,299	135,810	+18.8
	45–54	172,515	211,405	+22.5
	55–64	231,790	345,569	+49.1
	65–74	212,264	415,765	+95.9
	75–84	212,448	284,425	+33.9
	85 and over	47,000	115,375	+145.5
	<i>Total^(a)</i>	<i>1,182,215</i>	<i>1,739,730</i>	<i>+47.2</i>
Females	Under 1	9,258	10,370	+12.0
	1–4	12,058	15,807	+31.1
	5–14	23,379	28,229	+20.7
	15–24	97,019	117,995	+21.6
	25–34	194,975	226,762	+16.3
	35–44	207,169	273,314	+31.9
	45–54	225,614	282,117	+25.0
	55–64	228,224	366,659	+60.7
	65–74	197,423	372,472	+88.7
	75–84	201,097	279,196	+38.8
	85 and over	62,225	130,651	+110.0
	<i>Total^(a)</i>	<i>1,458,442</i>	<i>2,103,575</i>	<i>+44.2</i>
Total^(a)		2,640,657	3,843,331	+45.5

(a) Total includes separations for which age or sex of the patient was unknown.

Source: Australian hospital statistics 2003–04 (AIHW 2005); Australian hospital statistics 2012–13 (AIHW 2014a).

Remoteness area

The NHMD includes information on the patient's area of usual residence, which is used to generate categories of remoteness area and SA3 (for more information see Chapter 1.)

In 2012–13, same-day separation rates for private hospitals ranged from 98 per 1,000 persons in New South Wales to 135 per 1,000 in Queensland (Table 3.4). For overnight separations, rates ranged from 38 per 1,000 persons in New South Wales to 62 per 1,000 in Queensland.

Table 3.4: Separations per 1,000 persons, states and territories^(a), private hospitals 2012–13^(b)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Same-day separations	98.2	104.0	134.7	127.3	108.2	n.p.	n.p.	n.p.	109.3
Overnight separations	38.4	52.5	62.3	55.8	48.2	n.p.	n.p.	n.p.	49.3
Total separations	136.6	156.5	197.0	183.1	156.4	n.p.	n.p.	n.p.	158.6

(a) Disaggregation by state is by jurisdiction of the hospital.

(b) Data are age-standardised to the Australian population as at 30 June 2001.

Source: *Australian hospital statistics 2012–13* (AIHW 2014a).

The number of private hospital separations varied across remoteness areas in 2012–13. Use of private hospitals was highest for those residing in *Major Cities* (174.6 separations per 1,000 persons) and lowest for those residing in *Very remote* areas (67.1 separations per 1,000 persons) (Table 3.5).

Table 3.5: Same-day and overnight separations per 1,000 persons by remoteness area, private hospitals, 2012–13^(a)

	Same-day separations	Overnight separations	Total separations
Remoteness of residence^(b)			
Major Cities	122.6	52.0	174.6
Inner Regional	88.6	46.8	135.4
Outer Regional	66.3	37.9	104.2
Remote	63.7	29.5	93.1
Very Remote	44.5	22.7	67.1
Total^(c)	109.3	49.3	158.6

(a) Data are age-standardised to the Australian population as at 30 June 2001.

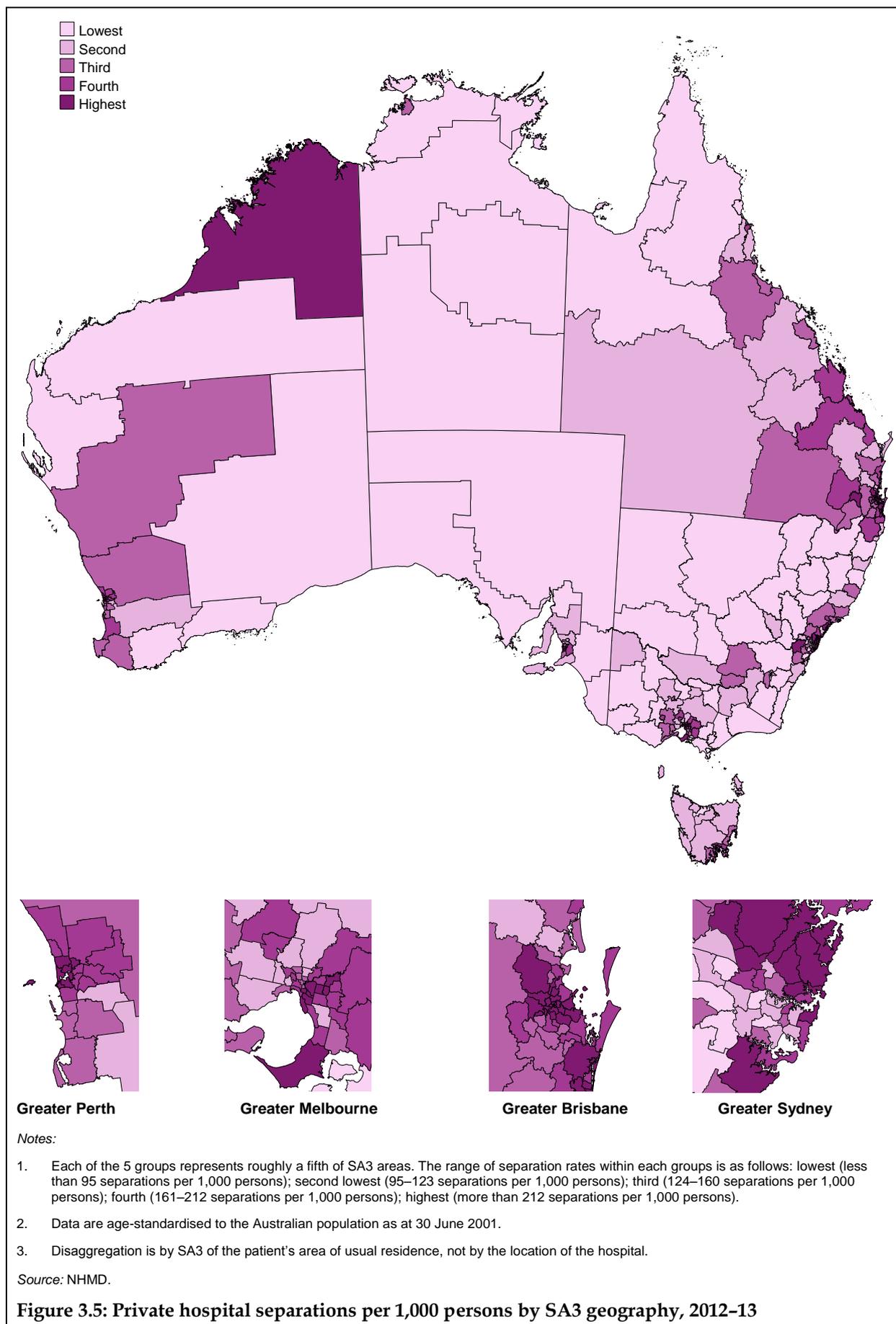
(b) Disaggregation by remoteness area is by the area of the patient's usual residence, not by the location of the hospital. Remoteness of residence is based on the ABS Remoteness area. For more information about Remoteness area see Chapter 1.

(c) The total includes separations for which the remoteness area was not able to be categorised.

Source: NHMD.

The pattern of higher usage rates in *Major cities* is also reflected in Figure 3.5, which shows age-standardised rates of separations per 1,000 persons by SA3. The highest separation rates generally occur around capital cities. The Kimberley region of northern Western Australia was an exception. In 2012–13, 88% of all private hospital separations for people living in the Kimberley were for *Care involving dialysis*.

Separation rates varied over 8-fold among the 333 SA3 regions in Australia. The areas with the highest separation rates included Noosa in Queensland, Ku-ring-gai in New South Wales and Holdfast Bay in South Australia. The areas with the lowest separation rates included Barkly and Alice Springs in the Northern Territory and the Snowy Mountains in New South Wales.



Socioeconomic status

In 2012–13 private hospital separation rates varied between socioeconomic groups (Table 3.6). The highest rates of separation were for those who were least socioeconomically disadvantaged (214.5 separations per 1,000 persons) and the lowest rates of separation were for the most socioeconomically disadvantaged (105.0 separations per 1,000 persons). Rates were more varied for same-day separations (between 71.6 and 149.3 per 1,000 persons for the most and least disadvantaged, respectively) than for overnight separations (between 33.4 and 65.2 per 1,000 persons).

For more information about socioeconomic status categories see Chapter 1.

Table 3.6: Same-day and overnight separations per 1,000 persons by socioeconomic status, private hospitals, 2012–13^(a)

	Same-day separations	Overnight separations	Total separations
Socioeconomic status of area of residence^(b)			
1 (Lowest)	71.6	33.4	105.0
2	85.5	39.3	124.9
3	111.8	49.8	161.7
4	129.3	58.8	188.1
5 (Highest)	149.3	65.2	214.5
Total^(c)	109.3	49.3	158.6

(a) Data are age-standardised to the Australian population as at 30 June 2001.

(b) Disaggregation by socioeconomic status group is based on the area of the patient's usual residence, not by the location of the hospital. These socioeconomic groups represent approximately 20% of the national population, but do not necessarily represent 20% of the population in each state or territory. For more information about socioeconomic status see Chapter 1.

(c) Total includes separations for which socioeconomic status group was not able to be categorised.

Source: NHMD.

Aboriginal and Torres Strait Islander people

Previously, the AIHW has recommended that data on the Indigenous status of patients in private hospitals not be used for national reporting, as the quality of the data is unknown (AIHW 2013g). However, given the focus of this report on private hospitals and their patient characteristics, data on the Indigenous status of patients are reported here, while noting potential data quality issues.

Caution should be used in the interpretation of these data. A recent AIHW study of Indigenous identification in public hospitals estimated that, in 2011–12, about 88% of Indigenous Australians were correctly identified in public hospital admissions data. It is unknown to what extent Indigenous Australians might be under-identified in private hospital admissions data. For more information about Indigenous status data in the NHMD, see Appendix B.

In 2012–13, there were about 31,800 separations reported for Aboriginal and Torres Strait Islander people in private hospitals. About 8% of all separations for Aboriginal and Torres Strait Islander people were in private hospitals whereas 42% of all separations for other Australians were in private hospitals (AIHW 2014a).

Overall, Indigenous Australians had lower separation rates (85.4 separations per 1,000 persons) compared with other Australians (154.3 separations per 1,000). This was particularly the case for overnight separation rates, which were 9.4 separations per 1,000

persons for Indigenous Australians and 49.1 separations per 1,000 person for other Australians (Table 3.7).

Table 3.7: Same-day and overnight separations per 1,000 persons by Indigenous status, private hospitals, 2012–13^(a)

	Indigenous Australians	Other Australians	Not reported	Total ^(b)
Same-day separations				
Separations	28,077	2,511,507	107,342	2,646,926
Separations per 1,000 population	76.0	105.2		108.8
Standardised separation rate ratio	0.7	1.0		
Overnight separations				
Separations	3,733	1,163,480	29,192	1,196,405
Separations per 1,000 population	9.4	49.1		49.5
Standardised separation rate ratio	0.2	1.0		
Total separations				
Separations	31,810	3,674,987	136,534	3,843,331
Separations per 1,000 population	85.4	154.3		158.3
Standardised separation rate ratio	0.5	1.0		

(a) Separation rates by Indigenous status were directly age-standardised, using the projected Indigenous population (low series) as at 30 June 2012, based on the 2001 Census data. The populations used for calculating age-standardised separation rates by Indigenous status have different age groups compared with the populations used to calculate other age-standardised separation rates presented in this report. Therefore, the separation rates by Indigenous status are not directly comparable with the rates by remoteness of residence or socioeconomic status.

(b) Total includes separations for which the Indigenous status was not reported.

Source: NHMD.

Why did people receive the care?

The reason that a patient receives admitted patient care is usually described in terms of the principal diagnosis. Definitions relating to diagnoses and information on the ICD-10-AM are available in Chapter 1.

In 2012–13, more than a quarter of private hospital separations (27%) were for *Factors influencing health status and contact with health services* (this includes, for example, dialysis for kidney disease and chemotherapy for cancer) (Table 3.8). The principal diagnoses for the remaining separations included:

- *Diseases of the digestive system* (13%)
- *Neoplasms* (8%)
- *Diseases of the musculoskeletal system and connective tissue* (8%)
- *Diseases of the eye and adnexa* (6%).

Private hospitals provided services for 72% of all separations for *Diseases of the eye and adnexa*, 62% of all separations for *Diseases of the musculoskeletal system and connective tissue*, and roughly half of separations for both *Neoplasms* and *Diseases of the digestive system* (AIHW 2014a).

As a proportion of all principal diagnoses, separations for *Factors influencing health status and contact with health services* increased 7 percentage points over the decade from 2003–04 to 2012–13. By comparison, separations for *Diseases of the digestive system* decreased by 3

percentage points over the same period of time, with separations for other ICD-10-AM chapters remaining relatively stable (AIHW 2005, 2014a).

Table 3.8: Separations by principal diagnosis in ICD-10-AM chapters, private hospitals, 2012–13

Principal diagnosis chapter		Same-day separations	Overnight separations	Total separations
A00–B99	Certain infectious and parasitic diseases	10,933	12,323	23,256
C00–D48	Neoplasms	213,243	108,688	321,931
D50–D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	38,760	9,674	48,434
E00–E90	Endocrine, nutritional and metabolic diseases	20,634	27,529	48,163
F00–F99	Mental and behavioural disorders	123,492	39,665	163,157
G00–G99	Diseases of the nervous system	37,292	69,905	107,197
H00–H59	Diseases of the eye and adnexa	229,659	9,681	239,340
H60–H95	Diseases of the ear and mastoid process	22,579	6,656	29,235
I00–I99	Diseases of the circulatory system	67,490	111,789	179,279
J00–J99	Diseases of the respiratory system	19,590	75,336	94,926
K00–K93	Diseases of the digestive system	392,582	105,672	498,254
L00–L99	Diseases of the skin and subcutaneous tissue	32,396	14,264	46,660
M00–M99	Diseases of the musculoskeletal system and connective tissue	132,918	176,389	309,307
N00–N99	Diseases of the genitourinary system	108,035	78,508	186,543
O00–O99	Pregnancy, childbirth and the puerperium	53,741	93,123	146,864
P00–P96	Certain conditions originating in the perinatal period	411	11,792	12,203
Q00–Q99	Congenital malformations, deformations and chromosomal abnormalities	6,792	4,358	11,150
R00–R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	147,890	62,020	209,910
S00–T98	Injury, poisoning and certain other consequences of external causes	34,038	79,209	113,247
Z00–Z99	Factors influencing health status and contact with health services	953,293	99,637	1,052,930
	Not reported	1,158	187	1,345
Total		2,646,926	1,196,405	3,843,331

Source: NHMD.

During the same time period, there was an increase in the proportion of same-day activity for diagnoses in the chapter *Certain infectious and parasitic diseases* (30% of separations with a principal diagnosis in this chapter were same-day in 2003–04 compared with 47% in 2012–13). The proportion of same-day separations for diagnoses in the chapter *Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism* also increased during this time, from 69% to 80% (AIHW 2005, 2014a).

How many separations were potentially preventable?

Potentially preventable hospitalisations (PPHs) are those conditions where hospitalisation is thought to have been avoidable if timely and adequate non-hospital care had been provided. Separation rates for PPHs therefore have potential as indicators of the accessibility, quality or

effectiveness of non-hospital care. A high rate of PPHs may indicate an increased prevalence of conditions in the community, poorer functioning of the non-hospital care system or an appropriate use of hospital system to respond to greater need.

There are 3 broad categories of PPHs:

- **Vaccine-preventable:** condition that can be prevented by proper vaccination and include influenza, bacterial pneumonia, tetanus, measles, mumps, rubella, pertussis and polio. The conditions are regarded as preventable, rather than the hospitalisation.
- **Acute:** conditions that may not be preventable, but theoretically would not result in hospitalisation if adequate and timely care (usually non-hospital) was received. They include complicated appendicitis, pyelonephritis, perforated ulcer, cellulitis, pelvic inflammatory disease, ear, nose and throat infections and dental conditions.
- **Chronic:** conditions that may be preventable though behaviour modification and lifestyle change, but they can also be managed effectively through timely care (usually non-hospital care) to prevent deterioration and separation. These conditions include diabetes complications, asthma, angina, hypertension, congestive heart failure and chronic obstructive pulmonary disease.

In 2012–13, about 200,000 separations in private hospitals were classified as PPHs, making up 26% of PPHs in all public and private hospitals that year and 5.2% of all private hospital separations (Table 3.9). The majority involved chronic conditions (53%), of which almost two-thirds involved diabetes complications. A smaller proportion (46%) involved acute conditions. A small proportion (less than 2%) of total PPHs involved vaccine-preventable conditions (AIHW 2014a).

Table 3.9: Separations for potentially preventable hospitalisations, private hospitals, 2012–13

PPH category	Private hospitals
Vaccine preventable conditions	3,138
Acute conditions	92,085
<i>Chronic conditions</i> ^(a)	105,585
Diabetes complications	66,635
Chronic conditions (excluding diabetes)	42,454
Total	200,274
Proportion of total separations (%)	5.2

(a) As more than 1 chronic condition may be reported for a separation, the sum of Diabetes complications and Chronic conditions (excluding diabetes) does not necessarily equal the total number of separations for Chronic conditions.

Source: Australian hospital statistics 2012–13 (AIHW 2014a).

How many separations were due to injury and poisoning?

Some separations for injury or poisoning may also be considered potentially avoidable.

In 2012–13, about 602,000 separations in all hospitals had a principal diagnosis that was in the group *Injury, poisoning and certain other consequences of external causes*. Around 1 in 5 of these (19%) were in private hospitals (Table 3.10).

About 50% of these separations in private hospitals had a principal diagnosis of *Injuries to upper and lower limbs*.

Table 3.10: Separations with a principal diagnosis of injury or poisoning, private hospitals, 2012–13

Principal diagnosis	Private hospitals
S00–S19 Injuries to head and neck	7,495
S20–S39 Injuries to thorax, abdomen, back, spine and pelvis	6,198
S40–S99 Injuries to upper and lower limbs	56,475
T00–T19 Injuries to multi- or unspecified region; foreign body effects	1,367
T20–T35 Burns and frostbite	249
T36–T65 Poisoning and toxic effects	525
T66–T79 Other and unspecified effects of external causes	708
T80–T88 Complications of medical and surgical care	40,214
T89–T98 Other trauma complications; external cause sequelae	16
Total	113,247

Source: Australian hospital statistics 2012–13 (AIHW 2014a).

How urgent was the care?

Admissions to hospital can be categorised as *Emergency* (required within 24 hours) or *Elective* (required at some stage beyond 24 hours). *Emergency* care status is not assigned for some admissions (for example, obstetric care and planned care such as dialysis). This report classifies separations as *Emergency* or *Non-emergency* (which includes elective and other planned care).

In 2012–13, private hospitals accounted for 53% of total non-emergency separations and 8% of total emergency separations (AIHW 2014a).

For private hospitals, around 203,000 separations were emergency admissions in 2012–13; 1% of day separations and 15% of overnight separations. The majority (73%) of these were classed as *Medical* (Table 3.11 below) and were treated overnight.

Around 7 in 10 of the 3.8 million private hospital separations in 2012–13 were non-emergency admissions. Of these, 40% were *Surgical*, 38% were *Medical* and 22% were *Other* care.

What care was provided?

The care that a patient received can be described in terms of the:

- broad category of service – *Childbirth*, *Specialist mental health*, *Medical* (not involving a procedure), *Surgical* (involving an operating room procedure) or *Other* (involving a non-operating room procedure, such as endoscopy)
- care type – acute care, sub-acute care and non-acute care
- MDCs and AR-DRGs
- type of surgical or other procedure undertaken.

Broad category of service

This section presents information describing care in the following broad categories of service:

- *Childbirth*: separations for which the AR-DRG was associated with childbirth (does not include newborn care)
- *Specialist mental health*: separations for which specialised psychiatric care days were reported, excluding separations for *Childbirth*
- *Surgical*: separations for which the AR-DRG belonged to the *Surgical* partition (involving an operating room procedure), excluding separations for *Childbirth* and *Specialist mental health*
- *Medical*: separations for which the AR-DRG belonged to the *Medical* partition (not involving an operating room procedure), excluding separations for *Childbirth* and *Specialist mental health*
- *Other*: separations for which the AR-DRG did not belong to the *Surgical* or *Medical* partitions (involving a non-operating room procedure, such as endoscopy), excluding separations for *Childbirth* and *Specialist mental health*.

A small proportion of private hospital separations in 2012–13 were categorised as involving *Childbirth* (2%) and *Specialist mental health* (4%). *Non-emergency* and *Specialist mental health* separations tended to be same-day, whereas patients hospitalised with an urgency of admission of *Emergency* and separations for *Childbirth* tended to be overnight (Table 3.11).

Table 3.11: Private hospital separations by broad category of service and urgency of admission, 2012–13

	Same-day separations	Overnight separations	All separations
Childbirth	119	81,753	81,872
Specialist mental health	110,179	33,566	143,745
Emergency			
Surgical	4,970	34,462	39,432
Medical	10,930	136,733	147,663
Other	3,798	12,037	15,835
Non-emergency			
Surgical	813,045	558,950	1,371,995
Medical	990,712	298,318	1,289,030
Other	713,173	40,586	753,759
Total	2,646,926	1,196,405	3,843,331

Source: NHMD.

Care type

The care type describes the overall nature of a clinical service provided to an admitted patient during a separation. The care type can be classified as:

- acute
- sub-acute
- non-acute (also called maintenance care).

For more information on care types, see Chapter 1.

Overall, 92% of private hospital admissions in 2012–13 were for acute care (Table 3.12). The amount and proportion of sub-acute care delivered in private hospitals varied considerably across states and territories. Four fifths (81%) of separations for *Rehabilitation care* in New

South Wales occurred in private hospitals, while all *Psychogeriatric care* in Victoria occurred in private hospitals (AIHW 2014a). By contrast, most admitted patient *Palliative care* and *Maintenance care* was reported by public hospitals (85% and 91% respectively) (AIHW 2014a).

Mental health care does not have a specific care type. In 2012–13, most specialist mental health care provided by private hospitals was acute (96%), with a small proportion of sub-acute care (4%) (AIHW unpublished data).

Table 3.12: Separations, by care type, private hospitals, states and territories, 2012–13

Care type	NSW	Vic ^(a)	Qld	WA	SA	Tas, ACT, NT	Total
Acute care	926,838	913,451	888,748	442,753	275,011	n.p.	3,570,183
Newborn—qualified days only	6,954	3,318	2,291	1,465	805	n.p.	15,220
Newborn—qualified and unqualified days	565	290	415	819	0	n.p.	2,211
Sub-acute care							
Rehabilitation care	147,723	20,119	38,128	3,270	22,040	n.p.	240,519
Palliative care	318	693	1,946	2,683	229	n.p.	6,007
Geriatric evaluation and management	0	0	130	0	60	n.p.	204
Psychogeriatric care	0	5,466	6	849	0	n.p.	6,321
Maintenance care	102	44	1,997	103	14	n.p.	2,300
Total^(b)	1,082,500	943,381	933,661	451,942	298,159	n.p.	3,843,331

(a) The reporting of *Newborns* (with unqualified days only) is not compulsory for the Victorian private sector, resulting in a low number of separations in this category.

(b) Total includes records for *Other admitted patient care* and *Not reported*.

Source: Australian hospital statistics 2012–13 (AIHW 2014a).

Between 2003–04 and 2012–13 the number of *Rehabilitation care* separations in private hospitals increased more than fourfold, from 56,000 to 241,000. By contrast, the number of private hospital separations for *Psychogeriatric care* and *Geriatric evaluation and management* both decreased, by 43% and 82% respectively, and *Palliative care* and *Maintenance care* remained relatively stable (AIHW 2005, AIHW 2014a).

Major Diagnostic Categories

This section presents information describing care by Major Diagnostic Categories (MDCs). For more information on MDCs and the AR-DRG classification, see Chapter 1.

In 2012–13, there were more separations in *Surgical* than *Medical* diagnosis related groups (DRGs) in private hospitals (38% and 35% of separations respectively) (Table 3.13). The most common MDC was *Diseases and disorders of the digestive system* (15%) followed by *Diseases and disorders of the musculoskeletal system and connective tissue* (10%). More information on MDCs and AR-DRGs for day and overnight hospitals is available in Chapters 4 and 5, respectively.

Table 3.13: Separations^(a) by Major Diagnostic Category version 6.0x and Medical/Surgical/Other partition, private hospitals, 2012–13

Major Diagnostic Category		Same-day separations	Overnight separations	Total separations
Pre-MDC	Pre-MDC(tracheostomies, transplants, ECMO)	188	3,075	3,263
1	Diseases and disorders of the nervous system	41,776	33,482	75,258
2	Diseases and disorders of the eye	234,344	10,335	244,679
3	Diseases and disorders of the ear, nose, mouth and throat	162,744	66,952	229,696
4	Diseases and disorders of the respiratory system	8,728	97,797	106,525
5	Diseases and disorders of the circulatory system	50,244	124,999	175,243
6	Diseases and disorders of the digestive system	476,801	115,048	591,849
7	Diseases and disorders of the hepatobiliary system and pancreas	5,339	30,392	35,731
8	Diseases and disorders of the musculoskeletal system and connective tissue	157,357	225,980	383,337
9	Diseases and disorders of the skin, subcutaneous tissue and breast	144,257	55,509	199,766
10	Endocrine, nutritional and metabolic diseases and disorders	17,475	30,271	47,746
11	Diseases and disorders of the kidney and urinary tract	289,354	47,201	336,555
12	Diseases and disorders of the male reproductive system	43,569	24,312	67,881
13	Diseases and disorders of the female reproductive system	134,322	42,646	176,968
14	Pregnancy, childbirth and puerperium	56,015	94,547	150,562
15	Newborns and other neonates	1,187	17,675	18,862
16	Diseases and disorders of the blood and blood-forming organs, and immunological disorders	43,422	10,177	53,599
17	Neoplastic disorders (haematological and solid neoplasms)	257,323	11,085	268,408
18	Infectious and parasitic diseases	3,518	11,481	14,999
19	Mental diseases and disorders	94,900	30,109	125,009
20	Alcohol/drug use and alcohol/drug induced organic mental disorders	24,337	7,568	31,905
21	Injuries, poisoning and toxic effects of drugs	9,147	16,683	25,830
22	Burns	127	176	303
23	Factors influencing health status and other contacts with health services	198,515	15,091	213,606
	Error DRGs ^(b)	8,028	2,368	10,396
	Surgical DRG	818,047	630,672	1,448,719
	Medical DRG	922,404	441,684	1,364,088
	Other DRG	722,566	52,603	775,169
Total separations		2,646,926	1,196,405	3,843,331

(a) Separations for which the care type was reported as Acute, or Newborn (with qualified days), or Not reported.

(b) An *Error DRG* is assigned to hospital records that contain clinically atypical or invalid information.

Source: NHMD.

Procedures

This section presents information describing procedures in private hospitals in Australia. For more information on how procedures are reported, see Chapter 1.

In 2012–13, private hospitals accounted for 47% of the separations for which a procedure was reported, although they accounted for 41% of the separations overall. For each private hospital separation, on average 2.3 procedures were reported. About 80% of private hospital separations involved a procedure which was classified as *Non-invasive, cognitive or other intervention* and about 1 out of 5 private hospital separations involved *Procedures on the digestive system* (Table 3.14).

Table 3.14: Separations^(a) with a procedure by ACHI chapters, private hospitals, 2012–13

Procedure	Same-day separations	Overnight separations	Total separations
1–86 Procedures on nervous system	57,966	52,098	110,064
110–129 Procedures on endocrine system	179	8,837	9,016
160–256 Procedures on eye and adnexa	227,349	9,608	236,957
300–333 Procedures on ear and mastoid process	24,320	9,620	33,940
370–422 Procedures on nose, mouth and pharynx	34,633	54,934	89,567
450–490 Dental services	109,537	3,444	112,981
520–570 Procedures on respiratory system	8,164	30,050	38,214
600–777 Procedures on cardiovascular system	47,744	89,526	137,270
800–817 Procedures on blood and blood-forming organs	7,598	17,652	25,250
850–1011 Procedures on digestive system	624,226	153,289	777,515
1040–1129 Procedures on urinary system	318,360	53,037	371,397
1160–1203 Procedures on male genital organs	43,437	28,121	71,558
1240–1299 Gynaecological procedures	178,245	43,950	222,195
1330–1347 Obstetric procedures	1,624	80,161	81,785
1360–1579 Procedures on musculoskeletal system	138,719	199,216	337,935
1600–1718 Dermatological and plastic procedures	149,215	55,302	204,517
1740–1759 Procedures on breast	16,190	22,367	38,557
1786–1799 Radiation oncology procedures	1,308	2,499	3,807
1820–1922 Non-invasive, cognitive and other interventions, n.e.c.	2,086,510	997,187	3,083,697
1940–2016 Imaging services	16,889	19,173	36,062
Separations with one or more procedures reported	2,570,269	1,054,423	3,624,692
Separations with no procedure reported	76,657	141,982	218,639
Total separations	2,646,926	1,196,405	3,843,331
Total procedures reported^(b)	5,268,806	3,459,226	8,728,032

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

(b) Total procedures reported is all procedures (not separations).

Source: NHMD.

What information is available about the safety and quality of the care?

Some information is available on the safety and quality of admitted patient care in hospitals, but the available information does not provide a complete picture. For example there is no routinely available information on some aspects of quality, such as the continuity or responsiveness of hospital services. This applies to both public and private hospitals.

This section presents information that is currently available at the national level on the safety and quality of admitted patient care in private hospitals.

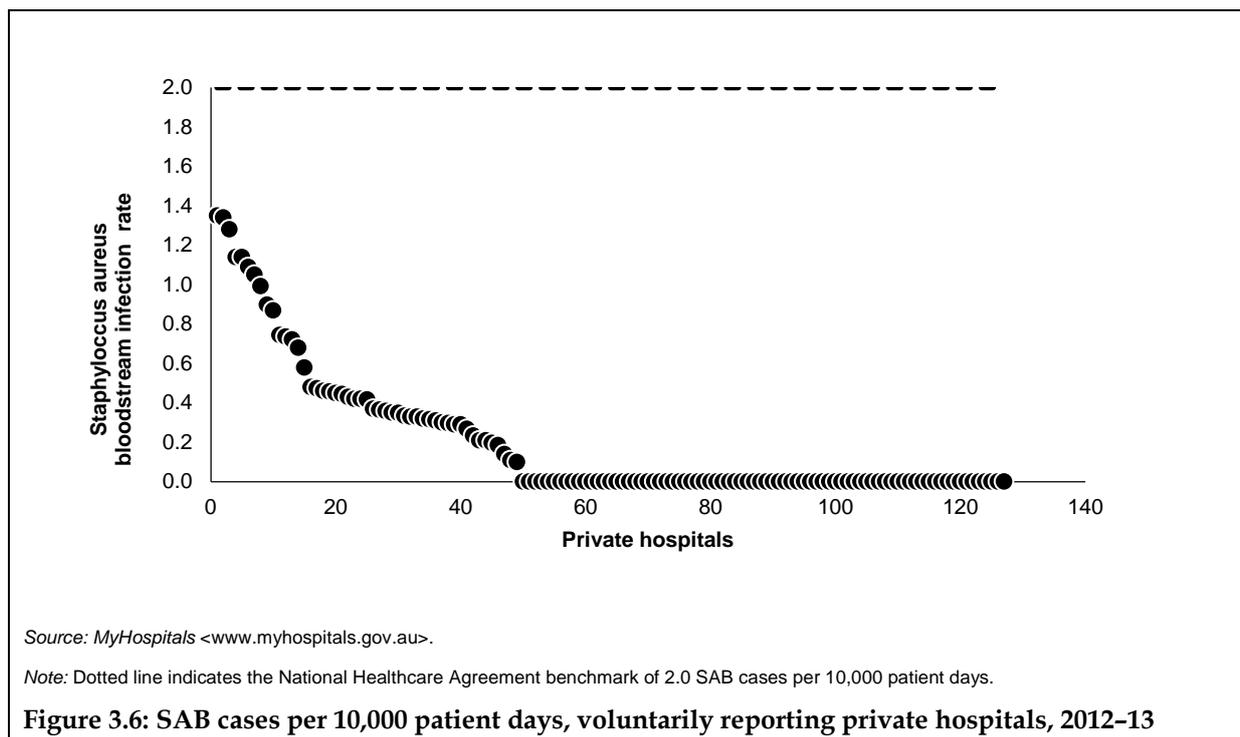
***Staphylococcus aureus* bacteraemia (SAB)**

Staphylococcus aureus bacteraemia (SAB) is regarded as an indicator of the safety of care in Australian hospitals. Patients who develop bloodstream infections such as SAB are more likely to suffer complications that result in a longer hospital stay and an increased cost of hospitalisation. Infections may also result in death. A national benchmark is specified in the National Healthcare Agreement (NHA) for public hospitals that the rate of SAB is no more than 2.0 per 10,000 occupied bed days for acute care public hospitals by 2011 in each state and territory (COAG 2012). The aim is to have as few cases of SAB as possible.

Hospital-associated SAB infections are monitored by surveillance arrangements in public hospitals and many private hospitals. Private hospitals can voluntarily supply their SAB rates for publication on the *MyHospitals* website (MyHospitals 2014). For more information on hospital-associated SAB infections, please refer to *Australian hospital statistics 2011–12: Staphylococcus aureus bacteraemia in Australian public hospitals* (AIHW 2013b)

In 2012–13, 127 private hospitals reported SAB rates for publication on *MyHospitals*, with an average rate of 0.2 cases per 10,000 days of patient care. Seventy-seven of these hospitals reported SAB rates of zero, with the remaining 50 hospitals reporting rates ranging from 0.1 to 1.35 (Figure 3.6). Data for another 5 hospitals were not included on *MyHospitals* as they had fewer than 5,000 patient days, and rates were considered to be unreliable.

These rates should not be generalised to represent the entire private hospital sector as nothing is known of the SAB rates of non-reporting hospitals.



Hand hygiene compliance

Hand hygiene is a general term applying to the use of soap/solution (non-antimicrobial or antimicrobial) and water, or a waterless antimicrobial agent to clean the hands and reduce the number of micro-organisms on them.

Audits of hand hygiene 'moments' are conducted by hospitals up to 3 times per year under the National Hand Hygiene Initiative organised by Hand Hygiene Australia (HHA) (*MyHospitals 2014*). The HHA hand hygiene 'moments' are based on those defined in the World Health Organization Guidelines on Hand Hygiene with some minor modifications made for Australian health care conditions.

A 'moment' is when there is a perceived or actual risk of pathogen transmission from one surface to another via a person's hands. HHA specifies five critical 'moments' when hand hygiene should be performed by healthcare workers. The ideal is to perform hand hygiene correctly in each of these five critical 'moments'. The 5 'moments' are:

1. Before touching a patient
2. Before a procedure
3. After a procedure or body fluid exposure risk
4. After touching a patient
5. After touching a patient's surroundings (*MyHospitals 2014*).

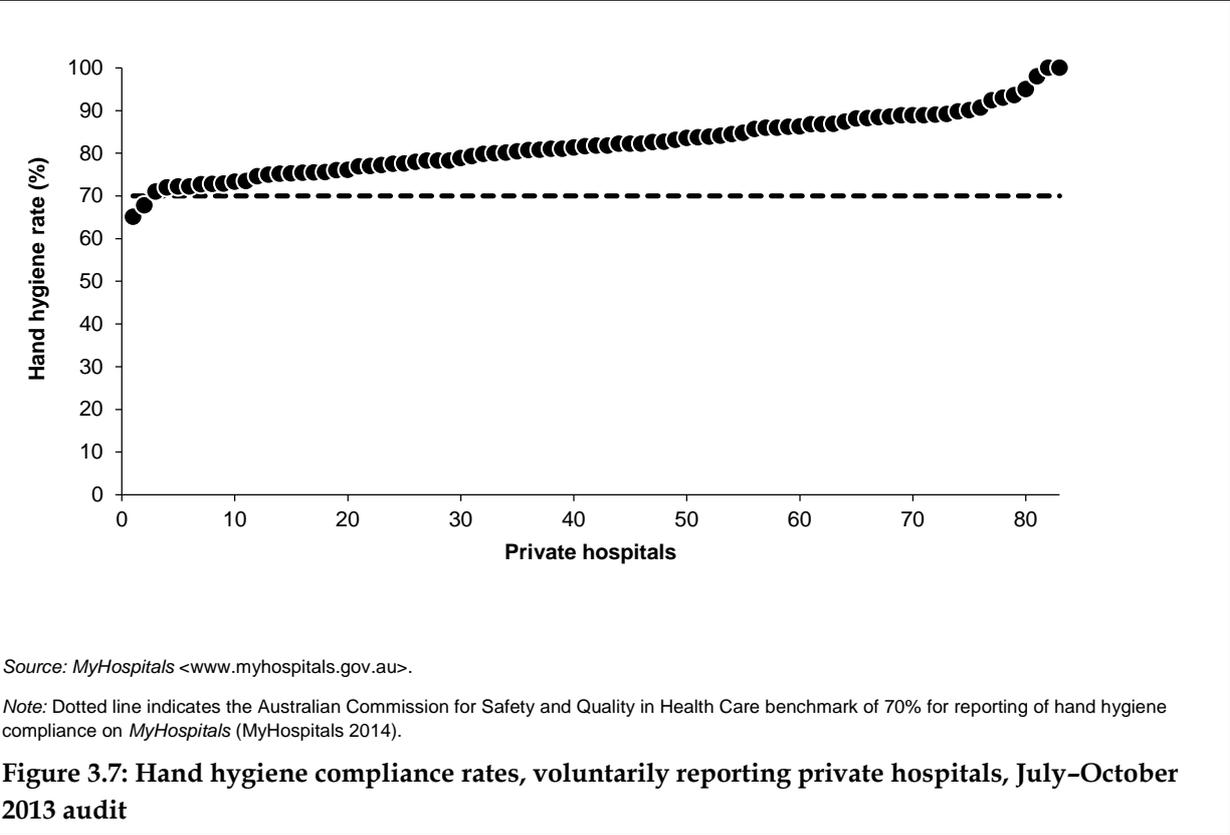
The number of compliant 'moments' observed during an audit and the total number of hand hygiene 'moments' observed are provided by private hospitals to the NHPA to allow calculation of a hand hygiene compliance rate.

Eighty-three private hospitals voluntarily supplied their hand hygiene data for hospital-level presentation on the *MyHospitals* website for the July to October period in 2013 (Figure 3.7).

For these hospitals, the average rate of compliance was 82%, and rates ranged from 65% to 100%. These rates should not be generalised to represent the entire private hospital sector, as nothing is known of the hand hygiene compliance rates of non-reporting hospitals.

In addition to supplying data to *MyHospitals*, private hospitals also supply data on a voluntary basis to HHA for reporting at an aggregate-level. In the third audit period (July-October) in 2013, 168 private overnight hospitals and 70 private day hospitals supplied data to HHA. For these data HHA groups private overnight hospitals by the number of acute admitted patient beds and private day hospitals by the number of procedures performed per annum.

During July to October 2013, hospitals with between 101 and 150 acute admitted patient beds had the highest average rate of compliance (81.9%) and those with more than 400 such beds had the lowest rate (76.4%) for overnight private hospitals. Day hospitals performing between 2,000 and 5,000 procedures had the highest average rate of compliance (81.9%) and those performing more than 5,000 procedures had the lowest rate (71.2%) for private day hospitals. The average compliance rate for public and private hospitals reporting to the HHA was 79% for this period (HHA 2013).



Adverse events treated in hospitals

Adverse events are defined as incidents in which harm resulted to a person receiving health care. They include infections, falls resulting in injuries and problems with medication and medical devices. Some of these adverse events may be preventable.

Separation data include information on diagnoses, places of occurrence and external causes of injury and poisoning that can indicate that an adverse event was treated and/or occurred during the separation. However, other diagnosis codes may also suggest that an adverse event has occurred, and some adverse events are not identifiable using these codes.

Table 3.15: Separations with an adverse event^(a) per 100 separations, private hospitals, 2012–13

Adverse event	Separations	Per 100 separations
External cause of injury or poisoning		
Adverse effects of drugs, medicaments and biological substances	31,273	0.8
Misadventures to patients during surgical and medical care	7,326	0.2
Procedures causing abnormal reactions/complications	106,457	2.8
Other external causes of adverse events	1,128	0.0
Place of occurrence of injury and poisoning		
Place of occurrence: Health service area	149,308	3.9
Diagnoses		
Selected post-procedural disorders	27,968	0.7
Haemorrhage and haematoma complicating a procedure	14,962	0.4
Infection following a procedure	12,480	0.3
Complications of internal prosthetic devices	43,389	1.1
Other diagnoses of complications of medical and surgical care	21,811	0.6
Total separations with an adverse event (any of the above)	153,178	4.0
Length of stay^(b)		
Same-day separations	38,866	1.5
Overnight separations	114,312	9.6
Type of care^(b)		
Acute care separations	133,897	3.7
Sub-acute and non-acute care separations	19,281	7.6
Urgency of admission^(b)		
Emergency admissions	24,705	12.0
Non-emergency admissions	128,473	3.5

(a) Separations that included ICD-10-AM diagnosis and/or external cause codes that indicated an adverse event was treated and/or occurred during the separation.

(b) The categories *Length of stay*, *Type of care* and *Urgency of admission* are not mutually exclusive. Each separation with an adverse event is included in 3 categories; for example as a Same-day separation, an Acute care separation and an Emergency admission.

Source: *Australian hospital statistics 2012–13* (AIHW 2014a).

The data in Table 3.15 can be interpreted as representing selected adverse events in health care that have resulted in, or have affected, a separation, rather than all adverse events that occurred in hospitals. Some of the adverse events included in this table may relate to events that occurred before admission. Condition onset flag (COF) information (see below) can be used to provide other information about adverse events occurring, and treated within, a separation.

It should be noted that the data in the NHMD are collected primarily for the purposes of recording care provided to admitted patients and that their use for purposes such as reporting adverse events has not been validated for accuracy in Australia. The results should therefore be treated with caution.

In 2012–13, 4% of private hospital separations reported 1 or more ICD-10-AM codes indicating 1 or more adverse events (Table 3.15). The proportion of same-day private hospital separations with an adverse event was 1.5%, while 9.6% of overnight private hospital separations had an adverse event.

Separations for sub-acute and non-acute care had higher rates of adverse events than acute care separations (7.6 and 3.7 separations with an adverse event per 100, respectively), and emergency admissions had higher rates of adverse events than non-emergency admissions (12.0 and 3.5 separations with an adverse event per 100, respectively).

About 69% of separations with an adverse event reported *Procedures causing abnormal reactions/complications* and 20% reported *Adverse effects of drugs, medicaments and biological substances*.

What conditions arose during the hospital stay?

This section presents information on conditions that are reported as arising during the hospital stay. These conditions may have led to a higher resource use than initially expected, and may have affected the length of the hospital stay. Conditions that arise during the hospital stay include adverse events (some of which may have been preventable) and therefore may provide information about the safety and quality of the care.

Conditions that arise during a hospital stay can be identified using the COF that is provided for each diagnosis and external cause of injury or poisoning in the patient's record.

The condition onset flag (COF) is a means of differentiating those conditions which arise during, from those arising before, an episode of admitted patient care. This information provides insight into the kinds of conditions patients already have when entering hospital and what arises during the episode. A better understanding of those conditions arising during the episode may inform prevention strategies, particularly in relation to complications of medical care. (NCCC 2013).

The Australian Coding Standard 0048 provides guidance to the assignment of the COF (NCCC 2013):

- A COF of '1' is assigned for a condition which arises during the episode of admitted patient care and would not have been present or suspected on admission. For example:
 - a condition resulting from a misadventure during surgical or medical care in the current episode of admitted patient care
 - an abnormal reaction to, or later complication of, surgical or medical care arising during the current episode of admitted patient care
 - a condition newly arising during the episode of admitted patient care (for example, pneumonia, rash or cyst)
 - a condition impacting on obstetric care arising after admission, including complications or unsuccessful interventions of labour and delivery or prenatal/postpartum management
 - for neonates, this also includes the condition(s) in the birth episode arising during the birth event (for example, respiratory distress, jaundice, feeding problems, neonatal aspiration, conditions associated with birth trauma or newborn affected by delivery or intrauterine procedures).
- A COF of '2' is assigned for a condition previously existing or suspected on admission such as the presenting problem, a comorbidity, chronic disease or disease status.

For 2012–13, the COF data were provided for almost all separations in private hospitals for all states and territories except New South Wales. The information presented in this section therefore does not include New South Wales. See Appendix A for more information on the quality and comparability of the condition onset flag.

In 2012–13, about 154,000 separations in private hospitals recorded a condition with onset during the episode of care (Table 3.16). These accounted for about 5.6% of all private hospital separations.

On average, the proportion of separations with a condition with onset during the separation was higher for overnight separations (16.4%) than for same-day separations (0.4%). For overnight separations, the highest proportion was reported for the *Childbirth* category (47.8%). Overnight separations for *Emergency surgical* care also had a relatively high rate (25.8%).

Table 3.16: Separations with a condition noted as arising during the episode of care, and proportion of total separations^(a) by same-day/overnight status, broad category of service and urgency of admission, private hospitals, 2012–13^(b)

	Same-day		Overnight		Total	
	Separations	Rate	Separations	Rate	Separations	Rate
Childbirth	31	31.1	27,783	47.8	27,814	47.8
Specialist mental health	301	0.4	3,945	16.3	4,246	4.6
Emergency						
Surgical	33	0.7	7,925	25.8	7,958	22.6
Medical	130	1.3	16,280	13.2	16,410	12.3
Other	20	0.5	1,827	16.4	1,847	12.5
<i>Total emergency</i>	183	1.0	26,032	15.8	26,215	14.3
Non-emergency						
Surgical	2,517	0.5	54,623	13.7	57,140	6.0
Medical	3,327	0.5	31,079	14.3	34,406	3.7
Other	1,224	0.2	2,990	9.7	4,214	0.8
<i>Total non-emergency</i>	7,068	0.4	88,692	13.7	95,760	3.9
All separations	7,583	0.4	146,452	16.4	154,035	5.6

(a) The number of separations with a condition reported as arising during the episode of care, divided by the total number of separations in each category.

(b) Excludes data for New South Wales.

Source: *Australian hospital statistics 2012–13* (AIHW 2014a).

Conditions that arise during the hospital stay can be described in terms of the diagnoses and external causes reported for it.

Diagnoses

Table 3.17 presents the 20 most common conditions (diagnoses) in 2012–13 that were reported as having onset during the separation. Six of the 20 most common diagnoses were ‘signs and symptoms’ (including nausea and vomiting, fever and headache) and 3 were diagnoses relating to obstetric conditions.

The most common condition reported with onset during the separation in private hospitals was *Nausea and vomiting* (present in 10.4% of separations reporting a condition with onset during the hospitalisations), followed by *Hypotension* (10.3%) and *Complications of procedures, not elsewhere classified* (9.2%).

Table 3.17: The 20 most common conditions (diagnoses) reported with onset during the episode of care, private hospitals, 2012–13

Condition	Separations ^(a)
R11 Nausea and vomiting	16,081
I95 Hypotension (abnormally low blood pressure)	15,872
T81 Complications of procedures, not elsewhere classified	14,143
E87 Other disorders of fluid, electrolyte and acid-base balance	12,347
O70 Perineal laceration during delivery	11,304
K59 Other functional intestinal disorders	8,959
D64 Other anaemias	6,809
O92 Other disorders of breast and lactation associated with childbirth	6,216
R00 Abnormalities of heart beat	5,826
N39 Other disorders of urinary system	5,498
I48 Atrial fibrillation and flutter	5,270
O68 Labour and delivery complicated by foetal stress [distress]	5,248
R33 Retention of urine	5,095
B96 Other bacterial agents as the cause of diseases classified to other chapters	4,907
R07 Pain in throat and chest	4,867
R50 Fever of other and unknown origin	4,860
A09 Other gastroenteritis and colitis of infectious and unspecified origin	4,173
R51 Headache	3,930
R41 Other symptoms and signs involving cognitive functions and awareness	3,574
J98 Other respiratory disorders	3,474

(a) Excludes data for New South Wales.

Source: NHMD.

External causes of injury or poisoning

External causes of injury or poisoning are assigned the same condition onset flag as the diagnosis to which they relate. *Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure (Y83)* was the most common external causes of injury and poisoning reported as having onset during the separation in 2012–13. *Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure (Y84)* was the second most common external causes of injury and poisoning reported as having onset during the separation (Table 3.18).

The 20 most common external causes included:

- adverse effects of drugs and medicaments (for example, involving analgesics, antipyretics and anti-inflammatory drugs)
- misadventures during procedures (for example, involving an unintentional cut, puncture or haemorrhage)
- falls, including falls involving a bed.

Table 3.18: The 20 most common ICD-10-AM external causes with onset during the episode of care, private hospitals, 2012–13

External cause of injury or poisoning	Separations ^(a)
Y83 Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure	16,391
Y84 Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure	5,775
Y45 Analgesics, antipyretics and anti-inflammatory drugs causing adverse effects in therapeutic use	2,941
Y60 Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care	2,905
Y40 Systemic antibiotics causing adverse effects in therapeutic use	1,479
W18 Other fall on same level	1,074
Y44 Agents primarily affecting blood constituents causing adverse effects in therapeutic use	1,003
W19 Unspecified fall	933
Y43 Primarily systemic agents causing adverse effects in therapeutic use	830
Y52 Agents primarily affecting the cardiovascular system causing adverse effects in therapeutic use	773
X59 Exposure to unspecified factor	772
Y48 Anaesthetics and therapeutic gases causing adverse effects in therapeutic use	682
W01 Fall on same level from slipping, tripping and stumbling	616
Y65 Other misadventures during surgical and medical care	612
Y57 Other and unspecified drugs and medicaments causing adverse effects in therapeutic use	443
W06 Fall involving bed	440
Y49 Psychotropic drugs, not elsewhere classified	438
Y42 Hormones and their synthetic substitutes and antagonists, not elsewhere classified causing adverse effects in therapeutic use	412
Y54 Agents primarily affecting water-balance and mineral and uric acid metabolism causing adverse effects in therapeutic use	369
X78 Intentional self-harm by sharp object	359

(a) Excludes data for New South Wales.

Source: Australian hospital statistics 2012–13 (AIHW 2014a).

How long did patients stay?

Table 3.19 presents the average length of stay (not adjusted for casemix) for patients in private hospitals in 2012–13. In 2012–13, patients in private hospitals stayed on average 2.3 days, down from 2.5 days in 2003–04 (AIHW 2005). For patients who stayed overnight (that is, excluding same-day separations), the average length of stay (ALOS) decreased from 5.6 days in 2003–04 to 5.2 days in 2012–13 (AIHW 2005).

The average length of stay differed by care type. For acute care, patients stayed an average 2.1 days in 2012–13, down from 2.4 days in 2003–04. Overnight acute care patients stayed an average 4.6 days.

Sub-acute care and non-acute care separations lasted longer, at 4.8 and 19.1 days on average, respectively, or 14.7 and 23.9 days, respectively, if same-day separations were excluded.

Table 3.19: Average length of stay, private hospitals, 2012–13

	Separations	Same-day separations	Overnight separations	Patient days	ALOS (days)	ALOS (excluding same-day)
Hospital type						
Day hospitals	866,159	864,727	1,432	866,278	1.0	1.1
Overnight hospitals	2,977,172	1,782,199	1,194,973	8,006,668	2.7	5.2
Total	3,843,331	2,646,926	1,196,405	8,872,946	2.3	5.2
Care type						
Acute care	3,587,976	2,463,017	1,124,959	7,624,185	2.1	4.6
Sub-acute care	253,051	183,430	69,621	1,204,748	4.8	14.7
Non-acute care	2,300	478	1,822	44,002	19.1	23.9

Note: Total for Hospital type includes separations for *Other admitted patient care*.

Source: NHMD.

How does length of stay in private hospitals compare nationally?

Relative stay indexes

Relative stay indexes (RSIs) are calculated as the observed number of patient days for separations in selected AR-DRGs, divided by the expected number of patient days (based on national figures), standardised for casemix. The adjustment for casemix allows variation in the types of services provided to be taken into account.

An RSI greater than 1 indicates that an average patient's length of stay is longer than would be expected given the casemix for the category of interest (for example, hospital sector or jurisdiction). A RSI of less than 1 indicates that the length of stay was shorter than would have been expected. More detail on these methods is included in *Australian hospital statistics 2012–13* (AIHW 2014a).

Table 3.20 presents both indirectly and directly standardised RSIs for all private hospitals for 2008–09 to 2012–13. Overall, in 2012–13 the directly standardised RSI for private hospitals was 1.15 compared to 0.98 for public hospitals, indicating relatively shorter lengths of stay in the public sector compared with the private sector (AIHW 2014a).

Table 3.20 also presents RSI information for the *Medical*, *Surgical* and *Other* categories of AR-DRGs. These figures indicate relatively shorter lengths of stay for *Surgical* and *Other* separations in private hospitals compared to *Medical* separations.

Table 3.20: Relative stay index by Medical/Surgical/Other type of AR-DRG^(a), private hospitals, 2008–09 to 2012–13

	2008–09	2009–10	2010–11	2011–12	2012–13
Indirectly standardised^(b)					
Private hospitals	1.03	1.10	1.04	1.06	1.07
Medical	1.14	1.18	1.15	1.18	1.19
Surgical	0.95	0.96	0.97	0.97	0.98
Other	0.94	0.97	0.94	0.94	0.94
Directly standardised^(c)					
Private hospitals	1.10	1.03	1.11	1.14	1.15
Medical	1.19	1.14	1.20	1.24	1.24
Surgical	0.95	0.96	0.98	0.98	1.00
Other	0.96	0.95	0.97	0.98	1.01

(a) Separations for which the care type was reported as Acute or Newborn with qualified days, or was Not reported. Relative stay index based on all private hospitals using AR-DRG version 6.0x.

(b) The indirectly standardised relative stay index is not technically comparable between public and private hospitals but is a comparison of the hospital group with the national average based on the casemix of that group.

(c) The directly standardised relative stay index is re-scaled so each group represents the national casemix and is therefore directly comparable between cells.

Source: *Australian hospital statistics* (AIHW 2010a; AIHW 2011; AIHW 2012; AIHW 2013a; AIHW 2014a).

Average lengths of stay for selected AR-DRGs

The average length of stay for selected types of separations is regarded as an indicator of the efficiency of hospitals.

The selected AR-DRGs were chosen on the basis of:

- homogeneity, where variation is more likely to be attributable to the hospital's performance rather than variations in the patients themselves
- representativeness across clinical groups (Major Diagnostic Categories) and surgical and medical AR-DRGs
- differences between states and territories and/or sectors
- policy interest (for example, high volumes and/or high cost).

More information on the basis of selection for the AR-DRGs is available in *Australian hospital statistics 2012–13* (AIHW 2014a).

Table 3.21 presents the average length of stay for selected AR-DRGs in private overnight hospitals. In 2012–13 the average length of stay for patients in private hospitals was longer than patients in public hospitals for 12 of the selected AR-DRGs, shorter for 5 and the same for 3 (AIHW 2014a). The difference in average length of stay was greatest for the AR-DRG *Chronic obstructive airways disease without catastrophic complications and comorbidities* (4.3 days for patients in public hospitals and 7.7 days for patients in private hospitals).

The average length of stay was shorter for patients in private hospitals than in public hospitals for *Retinal procedures* (1.0 and 1.3 days respectively) and *Lymphoma and non-acute leukaemia without catastrophic complications and comorbidities* (4.4 and 4.6 days respectively) (AIHW 2014a). More information on the performance indicator Average length of stay for selected AR-DRGs is available in Chapter 3 of *Australian hospital statistics 2012–13*.

Table 3.21: Average length of stay (days) for selected AR-DRGs version 6.0x, private overnight hospitals, 2012–13

Selected AR-DRG	Average length of stay (days) ^(a)
Lymphoma and non-acute leukaemia without catastrophic CC	4.4
Neonate, admission weight >2499g without significant operating room procedure without problem	3.8
Vaginal delivery single uncomplicated without other condition	3.6
Caesarean delivery without CSCC	5.0
Female reproductive system reconstructive procedures without CSCC	2.4
Hysterectomy for non-malignancy without CSCC	3.3
Transurethral prostatectomy without CSCC	2.6
Kidney and urinary tract infections without CSCC	4.4
Other shoulder procedures	1.3
Knee replacement without CSCC	5.8
Hip replacement without catastrophic CC	6.0
Hernia procedures without CC	1.3
Appendicectomy without malignancy or peritonitis without CSCC	2.0
Arrhythmia, cardiac arrest and conduction disorders without CSCC	2.0
Heart failure and shock without catastrophic CC	7.1
Bronchitis and asthma without CC	3.5
Chronic obstructive airways disease without catastrophic CC	7.7
Respiratory infections/inflammations without CC	4.7
Tonsillectomy and/or adenoidectomy	1.0
Retinal procedures	1.0

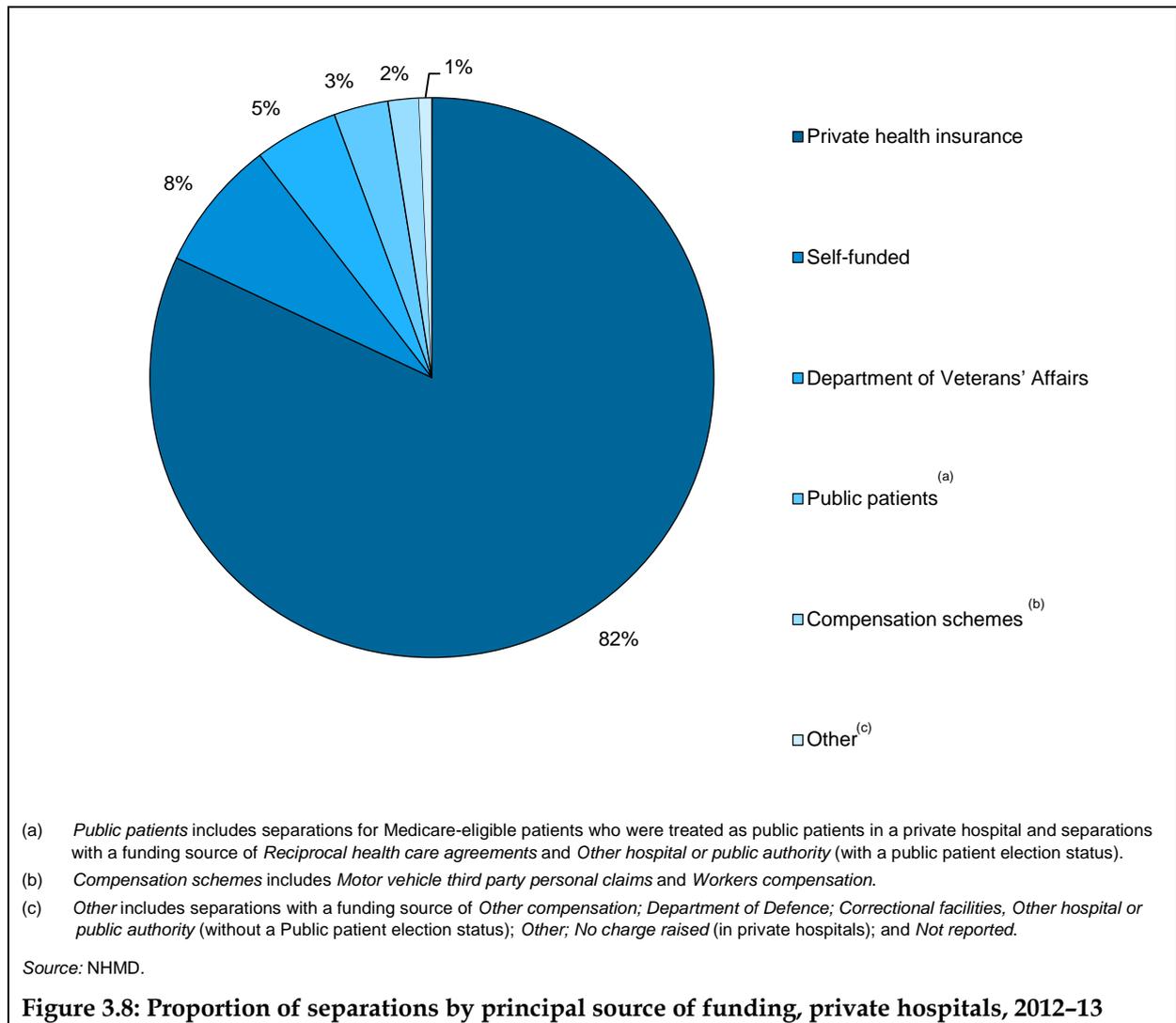
Note: CC—complications and comorbidities; CSCC—catastrophic and/or severe complications and comorbidities.

(a) Separations where care type is Acute, Newborns with qualified days or Not reported and length of stay is less than 120 days.

Source: NHMD.

Who paid for the care?

The funding source describes the principal source of funds for the admitted patient episode. In some instances, the total cost of a separation may be shared between multiple funders. For example, a separation which attracts private health insurance funding may also attract an out-of-pocket cost for the patient. This section reports on the main funder only (that is, the funder responsible for the majority of the cost of the separation).



The most common main source of funding of separations in private hospitals in 2012-13 was private health insurance (Figure 3.8). In 2012-13, more than four-fifths of private separations (82%) were funded by private health insurance, with most of the rest funded by the DVA or self-funded by the patient.

The proportion of private separations funded by private health insurance increased 6 percentage points between 2003-04 and 2012-13 from 76%, whereas the proportions of self-funded separations (separations for which the individual paid for the service themselves) and separations funded by the DVA decreased by 2 and 3 percentage points, respectively.

In 2012-13, private hospitals provided care for 82% of all separations funded by private health insurance and 85% of all self-funded. They also provided 64% of all separations for DVA patients (AIHW 2014a).

More information on source of funding of separations in private day and private overnight hospitals is available in Chapters 4 and 5.

How much non-admitted patient activity was there in 2012–13?

Note that data in this section are sourced from the ABS *Private hospitals, Australia* publication and thus have a different scope to data from the NHMD. For further information on the differences between the data sources, see Chapter 1.

Hospitals provide treatment and care to non-admitted patients through emergency departments, outpatient clinics and a range of other services. This section presents information on non-admitted patient care provided by private overnight hospitals in Australia. Definitions for key terms relating to non-admitted care are included in Chapter 1.

The most frequently reported type of non-admitted patient service provided in private overnight hospitals in 2012–13 was *Allied health services* (about 704,800 occasions of service) which comprised 33% of the 2,152,900 private hospital non-admitted patient occasions of service (Table 3.22).

In 2012–13, there were about 483,600 *Accident and emergency* occasions of service, making up 22% of non-admitted patient services in private overnight hospitals (Table 3.22). Compared to the previous year, the number of *Accident and emergency* occasions of service decreased by around 47,000 (9%) (ABS 2013b, 2014).

Table 3.22: Non-admitted patient occasions of service ('000s), overnight private hospitals, 2012–13

Service type	Non-admitted patient occasions of service
Accident and emergency^(a)	483.6
Medical/surgical/diagnostic	
Radiology and organ imaging	n.a.
Pathology	n.a.
Other	214.7
Mental health	n.a.
Alcohol and drug	n.a.
Pharmacy	n.a.
Allied health services	704.8
Outreach services	
Community health services	n.a.
District nursing services	n.a.
Other outreach services	21.2
Other	156.7
Total	2,152.9

(a) Including hospitals which do not have a formal accident and emergency unit but which treated accident and emergency patients during the year.

Source: *Private hospitals, Australia, 2012–13* (ABS 2014b).

4 Private day hospitals

This chapter presents information on admitted care provided by private day hospitals in Australia. The admitted patient data for this chapter are mainly sourced from the NHMD, with data presented by peer group from the PHDB. For information on differences between these collections, see Chapter 1.

Private day hospitals provide same-day care to patients. A same-day separation is one in which the patient is admitted and discharged on the same date. It should be noted that some same-day hospitals are licenced to provide 23-hour care; that is, a patient can be hospitalised for up to 23 hours and therefore may be admitted on one date and discharged the following day. This allows for these hospitals to perform more complex procedures which require longer recovery times. In 2012–13 private day hospitals reported 1,432 overnight separations to the NHMD, likely reflecting these arrangements.

What data are reported?

The data in this chapter include administrative, demographic and clinical data relating to admitted patients in private day hospitals. This chapter answers the following questions:

- How much admitted patient activity was there in 2012–13?
- Who used these services?
- Why did people receive the care?
- How urgent was the care?
- What care was provided?
- Who paid for the care?

How much admitted patient activity was there in 2012–13?

There were approximately 866,000 separations in private day hospitals in 2012–13. *Mixed day procedure hospitals* were responsible for the highest proportion of activity (27%) and *Sleep centres* for the lowest (0.3%) (Table 4.1).

Table 4.1: Separations for private day hospitals, by peer group, private day hospitals, 2012–13

Private day hospital peer groups	Separations	Proportion of total activity ^(a) (%)
Dialysis clinics	101,804	12.8
Endoscopy centres	152,920	19.2
Eye day surgery clinics	106,205	13.3
Fertility clinics	19,330	2.4
Haematology and oncology clinics	73,462	9.5
Mixed day procedure hospitals	216,868	27.2
Oral and maxillofacial procedure centres	12,318	1.5
Plastic and reconstructive surgery clinics	39,353	4.9
Sleep centres	2,251	0.3
Other ^(b)	18,401	6.7
Unpeered	53,351	2.3
All day hospitals (PHDB data)	796,263	100.0
All day hospitals (NHMD data)	866,159	

(a) Proportion of total activity calculated using PHDB total.

(b) Other includes 4 Hyperbaric treatment centres and 8 Reproductive health centres.

Source: PHDB, NHMD. All data in this table are sourced from the PHDB except where specifically noted.

Who used these services?

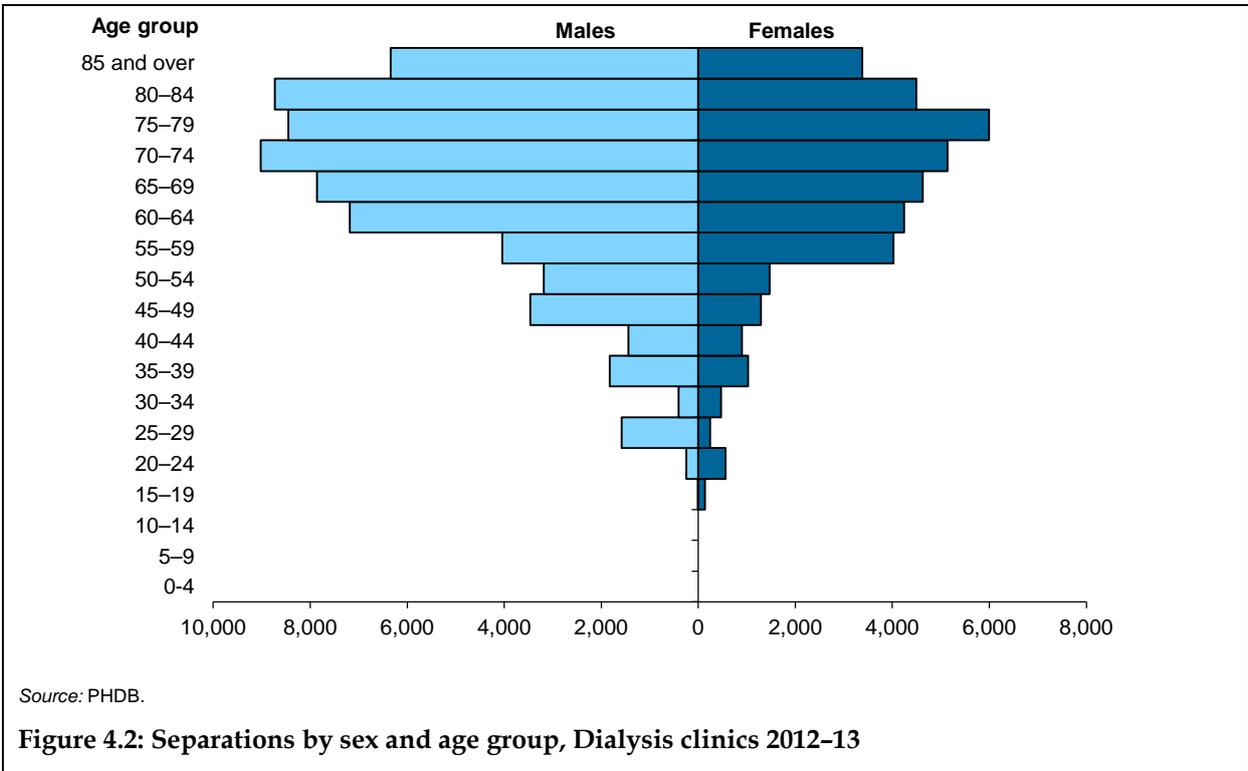
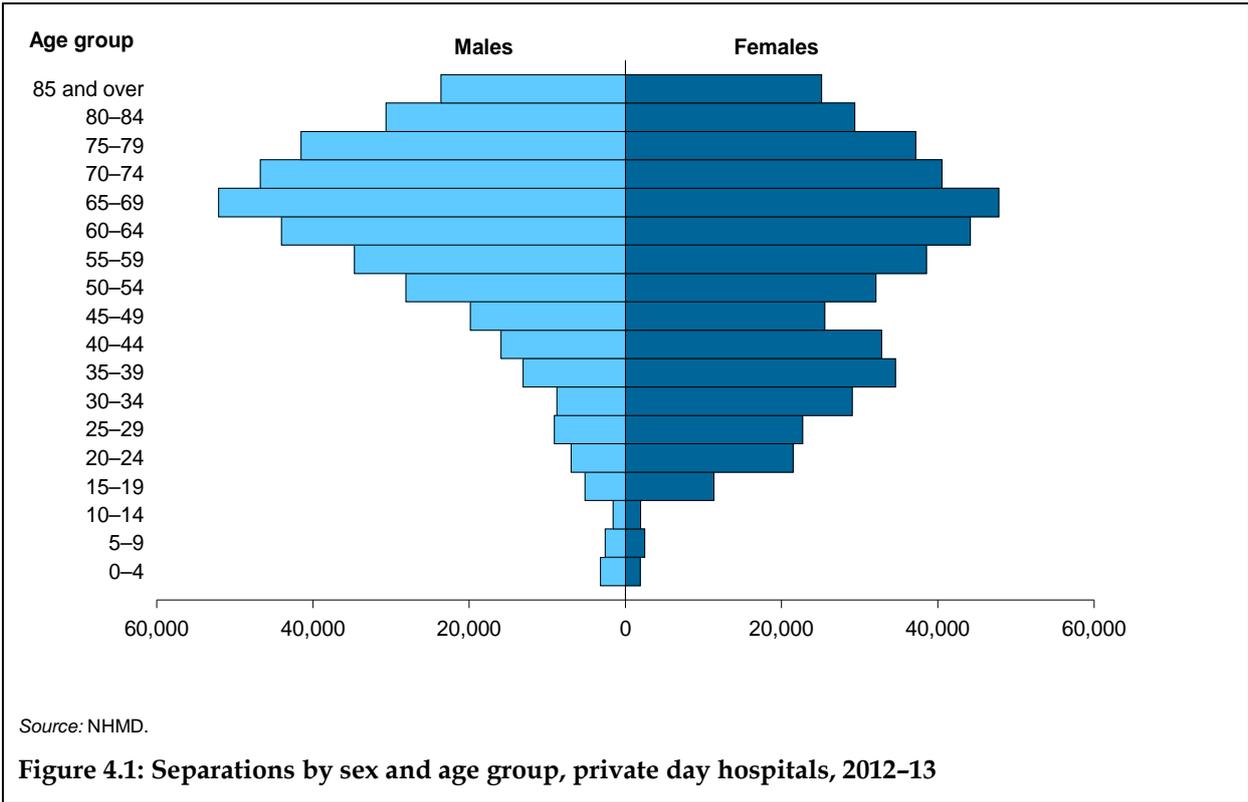
In 2012–13, males accounted for just under half (46%) of patients in private day hospitals (Figure 4.1). Generally there were fewer males than females in each age group, with 2 exceptions: there were more separations for males than females for those aged under 10 years and those aged between 65 and 84 years. People aged 55 and over accounted for 64% of all private day hospital separations.

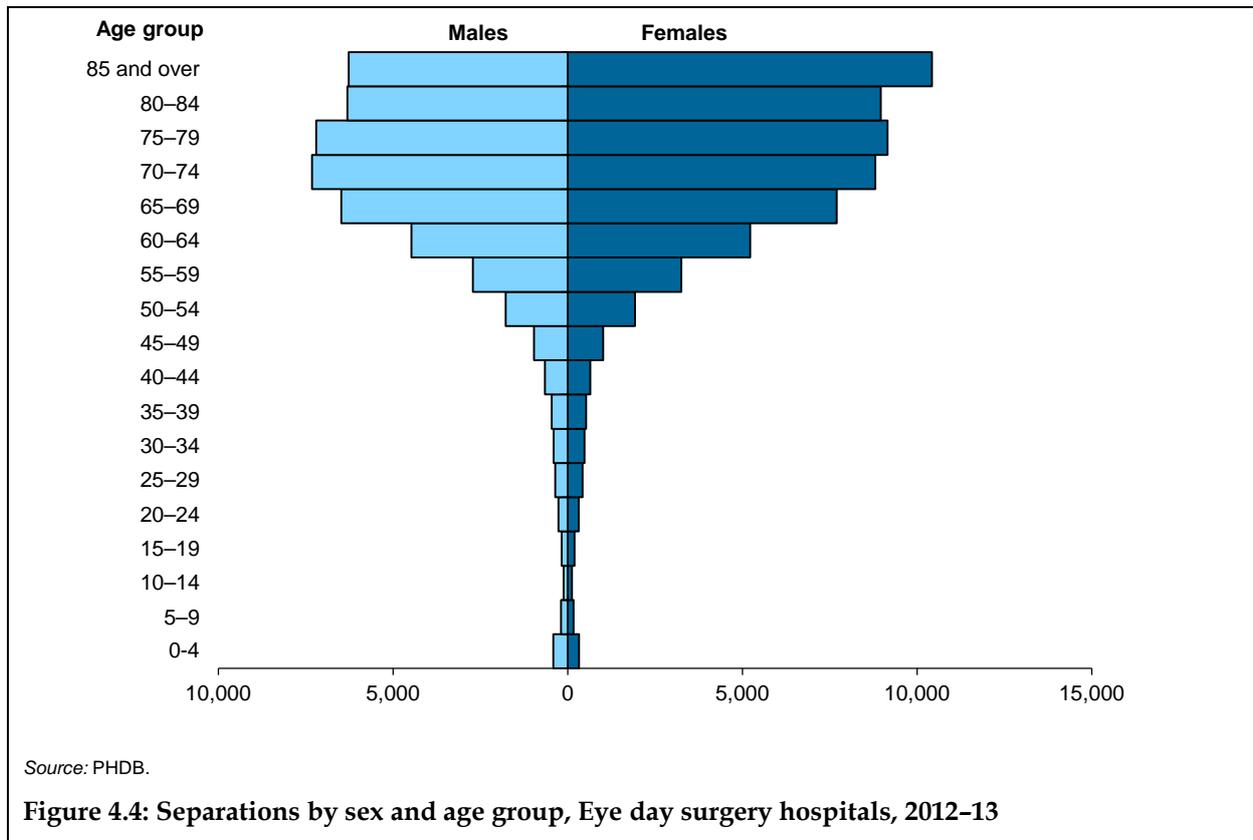
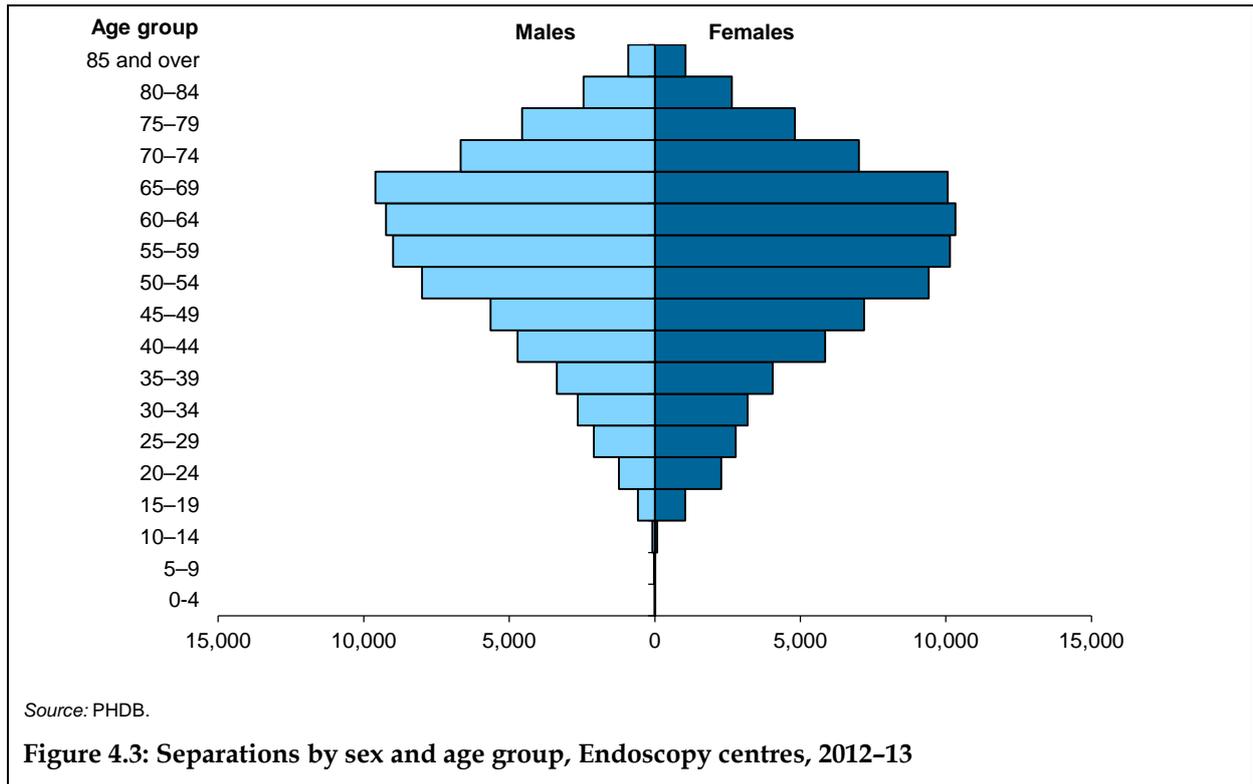
The age and sex distribution of admitted patients differed among peer groups (Figures 4.2 to 4.10). *Eye surgery clinics* (89%) had the highest proportion of separations for people aged 55 and over (Figure 4.4). *Oral and maxillofacial procedure centres* had the highest proportion of separations for patients aged less than 20 years (28%) (Figure 4.8). *Sleep centres* (65%) and *Dialysis clinics* (63%) had the highest proportion of males (Figures 4.2 and 4.10).

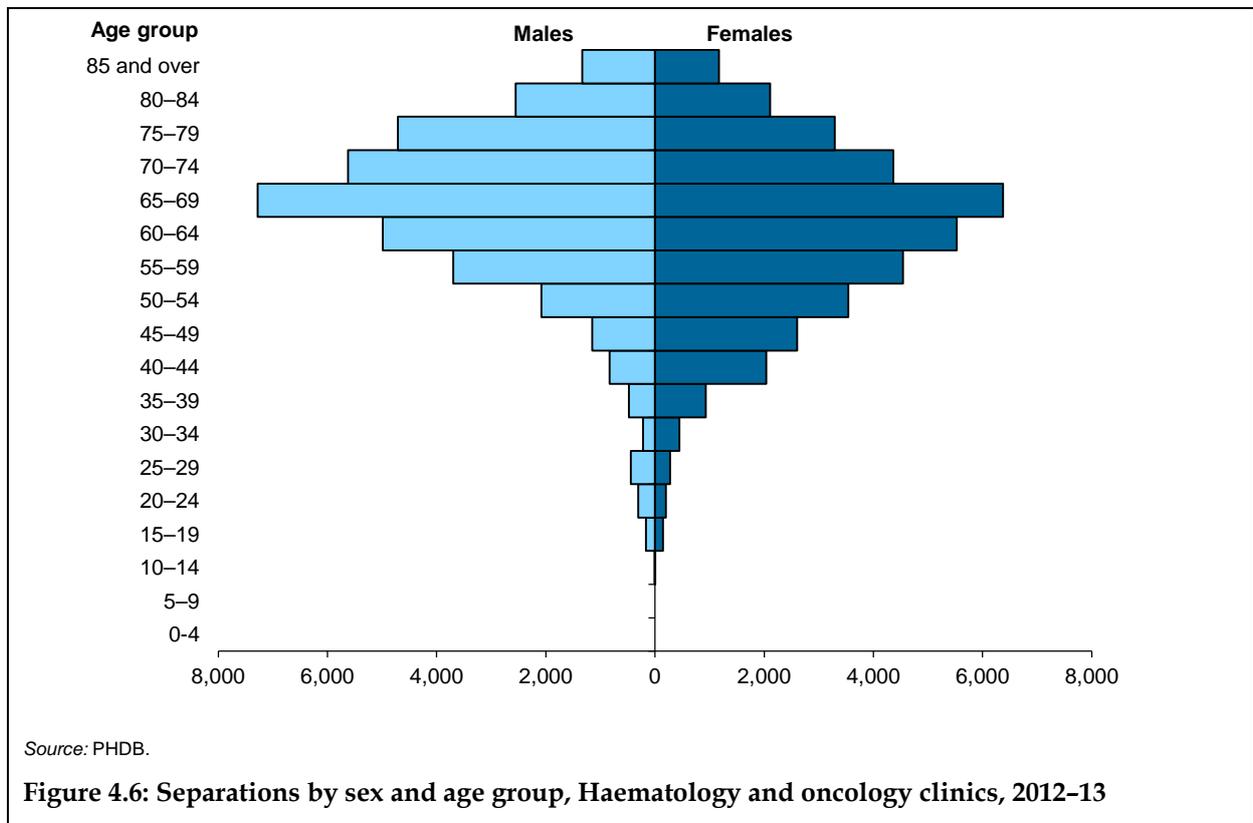
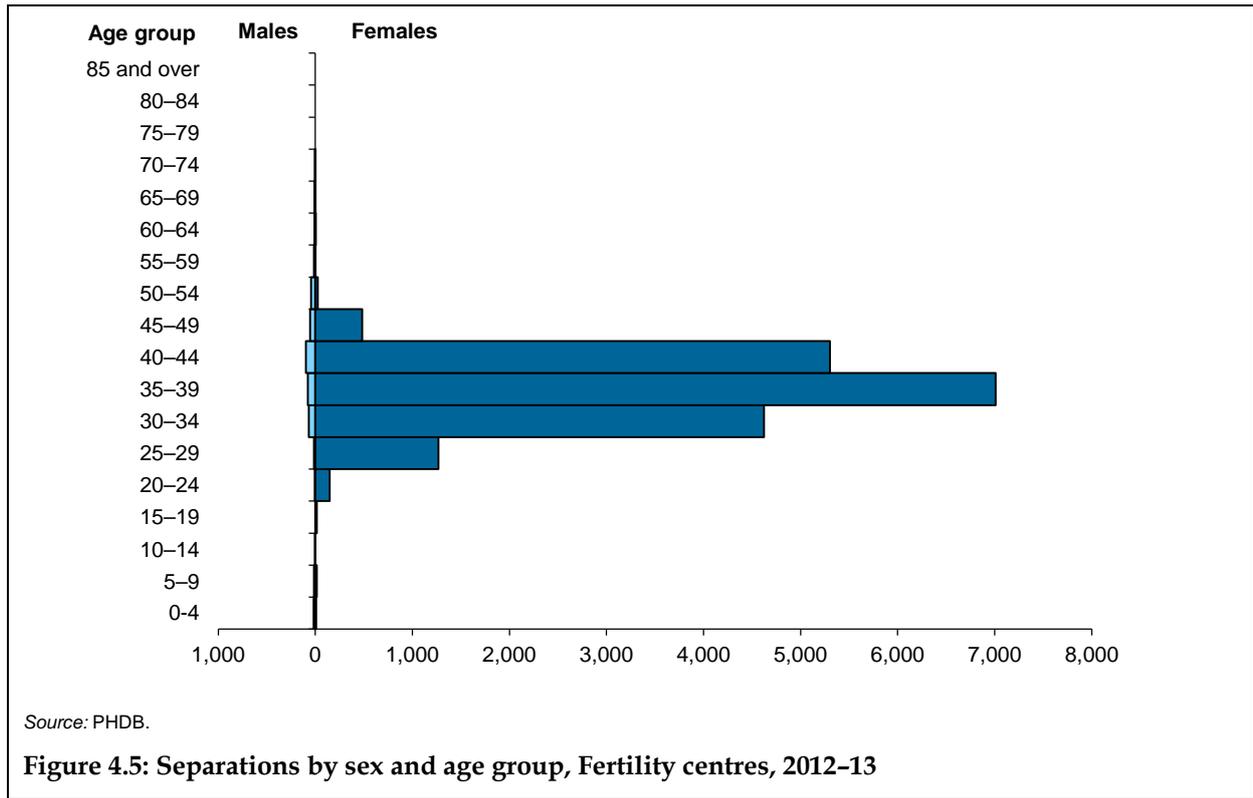
Dialysis clinics (Figure 4.2) treated more men than women (1.6 times as many) and had a high proportion of patients aged 55 years and over (82%). In 2012–13, there were twice as many male patients aged less than 55 (approximately 12,100) than female patients (approximately 6,100).

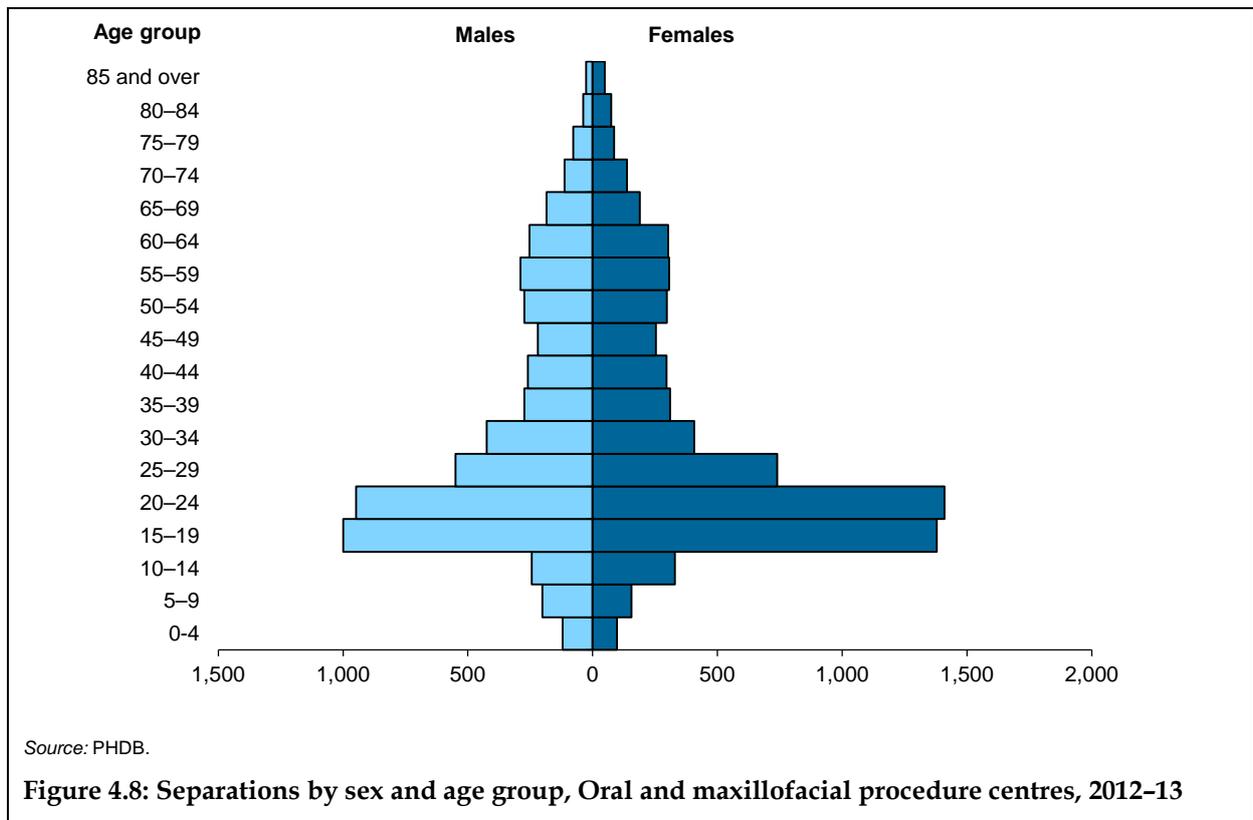
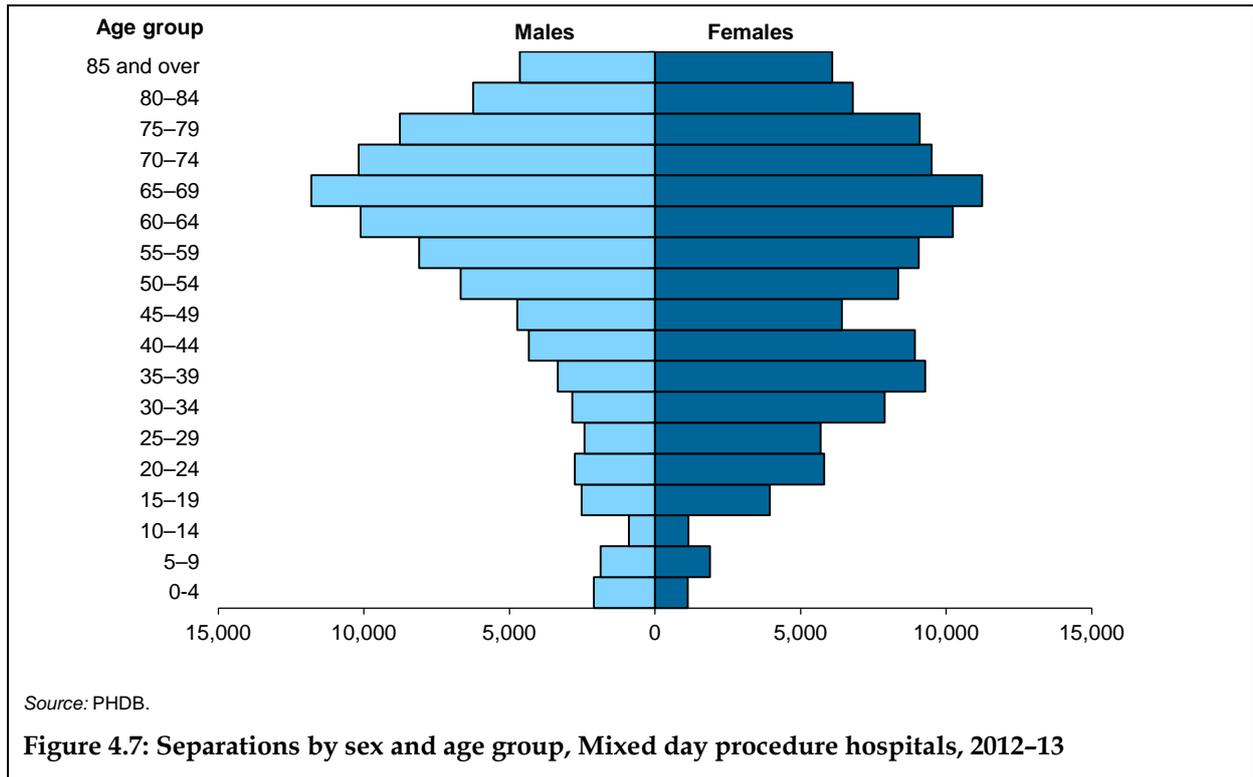
Endoscopy clinics had roughly similar patterns of usage for male and female patients across the age groups (Figure 4.3). People aged 55 and over made up 58% of separations in *Endoscopy clinics* in 2012–13.

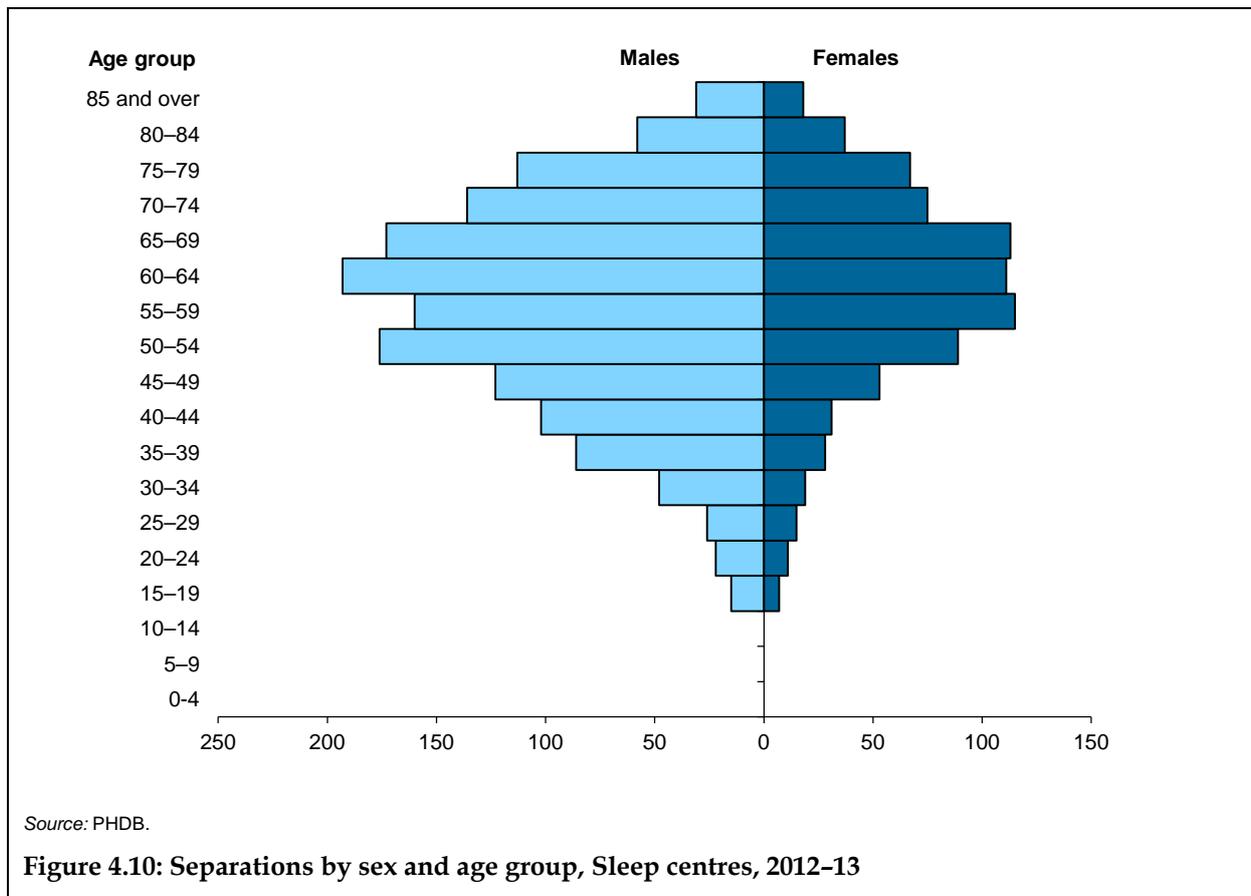
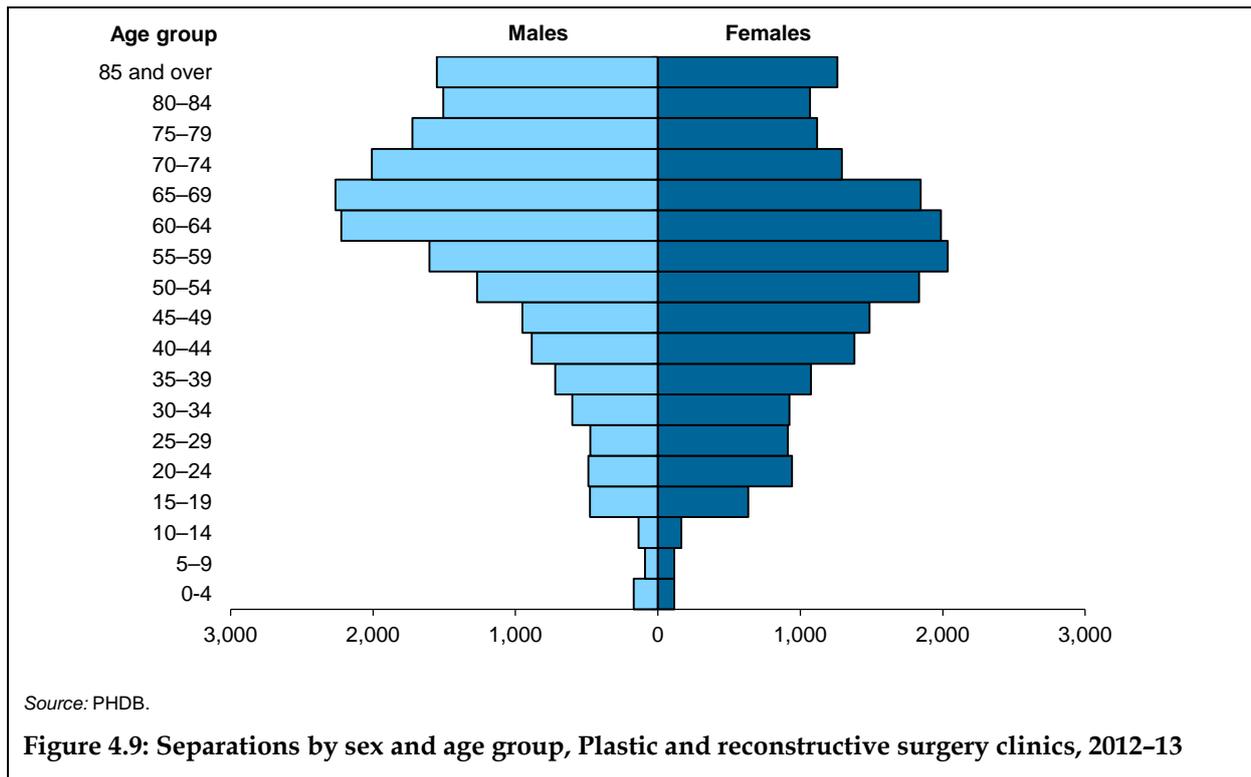
The age groups with the largest number of separations in *Eye day surgery hospitals* were 85 years and over for women and 70 to 74 years for men (Figure 4.4). Female patients accounted for 56% of separations in *Eye day surgery hospitals* in 2012–13.











Overall in 2012–13 there were roughly equal numbers of separations in *Haematology and oncology clinics* for men and women (49% and 51% respectively). However, proportions differed across the age groups: 62% of separations for people aged 25 to 29 were for men, while 71% of separations for people aged 40 to 44 were for women (Figure 4.6).

Fifty-eight per cent of separations in *Mixed day procedure hospitals* were for women, and roughly half (56%) of separations were for persons over the age of 55 years in 2012–13 (Figure 4.7). Women outnumbered men between the ages 10 and 59 and 80 years or older. This was particularly the case at ages 35–39 years, when 74% of separations were for women.

In 2012–13, persons aged between 15 and 24 years made up 38% of all separations in *Oral and maxillofacial procedure centres* (Figure 4.8). More females than males were admitted (66% and 44%, respectively).

In *Sleep centres* in 2012–13, the majority (65%) of patients were male (Figure 4.10). Roughly half the separations were for persons aged between 50 and 69 years.

Remoteness area

The number of separations in private day hospitals varied across remoteness areas in 2012–13. Use of private day hospitals was highest for those residing in *Major cities* (41.3 separations per 1,000 persons) and lowest for those residing in *Very remote* areas (19.6 separations per 1,000 persons) (Table 4.2).

The standardised separation rate ratio shows how rates for each of the remoteness areas compares to the national average, where a number greater than 1 means the rate was higher than the national average. In 2012–13, rates for *Inner regional*, *Outer regional* and *Very remote* areas were lower than the national average (Table 4.2).

Table 4.2: Separations per 1,000 persons by remoteness area, private day hospitals, 2012–13^(a)

	Remoteness area ^(b)					Total ^(c)
	Major cities	Inner regional	Outer regional	Remote	Very remote	
Separations	686,697	113,448	47,937	11,673	3,532	866,159
Separations per 1,000 population	41.3	23.7	21.2	35.9	19.6	35.7
Separation rate ratio	1.2	0.7	0.6	1.0	0.5	

(a) Data are age-standardised to the Australian population as at 30 June 2001.

(b) Disaggregation by remoteness area is by the area of the patient's usual residence, not by the location of the hospital. Remoteness of residence is based on the ABS Remoteness area. For more information about Remoteness area see Chapter 1.

(c) The total includes separations for which the remoteness area was not able to be categorised.

Source: NHMD.

Socioeconomic status

In 2012–13, private day hospital separation rates varied among socioeconomic status (SES) groups. The highest rates of separation were for those who were in areas with the highest socioeconomic status (43.9 separations per 1,000 persons) and the rates of separation were lowest amongst people living in areas with the lowest socioeconomic status (24.6 separations per 1,000 persons) (Table 4.3).

Table 4.3: Separations per 1,000 persons by socioeconomic status, private day hospitals, 2012–13^(a)

	Socioeconomic status of area of residence ^(b)					Total ^(c)
	1 - Lowest	2	3	4	5 - Highest	
Separations	122,784	156,270	179,424	196,710	204,071	866,159
Separations per 1,000 population	24.6	31.1	36.8	42.5	43.9	35.7
Separation rate ratio	0.7	0.9	1.0	1.2	1.2	

(a) Data are age-standardised to the Australian population as at 30 June 2001.

(b) Disaggregation by socioeconomic status group is based on the area of the patient's usual residence, not by the location of the hospital. These socioeconomic groups represent approximately 20% of the national population, but do not necessarily represent 20% of the population in each state or territory. For more information about socioeconomic status see Chapter 1.

(c) Total includes separations for which socioeconomic status group was not able to be categorised.

Source: NHMD.

Aboriginal and Torres Strait Islander people

Previously, the AIHW has recommended that data on the Indigenous status of patients in private hospitals not be used for national reporting, as the quality of the data is unknown (AIHW 2013g). However, given the focus of this report on private hospitals and their patient characteristics, data on the Indigenous status of patients are reported here, while noting potential data quality issues.

Caution should be used in the interpretation of these data. A recent AIHW study of Indigenous identification in public hospitals estimated that, in 2011–12, about 88% of Indigenous Australians were correctly identified in public hospital admissions data. It is unknown to what extent Indigenous Australians might be under-identified in private hospital admissions data. For information about Indigenous status data in the NHMD see Appendix B.

Unlike overall separation rates (see Table 3.7), separation rates in private day hospitals in 2012–13 were higher for Indigenous Australians (58.7 per 1,000 persons) than for other Australians (33.2 per 1,000 persons) (Table 4.4).

Table 4.4: Separations per 1,000 persons by Indigenous status, private day hospitals, 2012–13^(a)

	Indigenous Australians	Other Australians	Not reported	Total ^(b)
Separations	21,174	793,043	51,942	866,159
Separations per 1,000 population	58.7	33.2		35.6
Separation rate ratio	1.7	0.9		

(a) Separation rates by Indigenous status were directly age-standardised, using the projected Indigenous population (low series) as at 30 June 2012, based on the 2001 Census data. The populations used for calculating age-standardised separation rates by Indigenous status have different age groups compared with the populations used to calculate other age-standardised separation rates presented in this report. Therefore, the separation rates by Indigenous status are not directly comparable with the rates by remoteness of residence or socioeconomic status.

(b) Total includes separations for which the Indigenous status was not reported.

Source: NHMD.

How did patients access private day hospitals?

The **mode of admission** records the mechanism by which an admitted patient begins an episode of admitted patient care.

In 2012–13, 99% of all separations in private day hospitals had a mode of admission of *Other*, the term used to refer to all planned and unplanned admissions except transfers from other hospitals and statistical admissions (Table 4.5).

Table 4.5: All separations, by mode of admission, private day hospitals, 2012–13

Mode of admission	Separations
Admitted patient transferred from another hospital	4,446
Statistical admission: care type change ^(a)	0
Other ^(b)	861,705
Unknown	8
Total	866,159

(a) Statistical admission: care type change is where a new admitted patient episode is created as a result of a change in the clinical intent of care (for example, the clinical intent of a patient's care may move from acute care to rehabilitation or palliative care), within the same hospital.

(b) Other is the term used to refer to all other planned and unplanned admissions.

Source: NHMD.

Why did people receive the care?

The reason that a patient receives admitted patient care can be described in terms of the principal diagnosis. (For more information on principal diagnosis and the ICD-10-AM classification, see Chapter 1.)

In 2012–13, about 35% of admitted care in private day hospital separations were for *Factors influencing health status and contact with health services* (which includes, for example, care involving dialysis and chemotherapy) (Table 4.6). About 17% each of separations involved *Diseases of the digestive system* and *Diseases of the eye and adnexa*.

Table 4.6: Separations, by principal diagnosis in ICD-10-AM chapters, private day hospitals, 2012–13

Principal diagnosis chapter		Separations
A00–B99	Certain infectious and parasitic diseases	2,707
C00–D48	Neoplasms	70,813
D50–D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	14,696
E00–E90	Endocrine, nutritional and metabolic diseases	6,477
F00–F99	Mental and behavioural disorders	485
G00–G99	Diseases of the nervous system	4,987
H00–H59	Diseases of the eye and adnexa	144,680
H60–H95	Diseases of the ear and mastoid process	3,012
I00–I99	Diseases of the circulatory system	19,381
J00–J99	Diseases of the respiratory system	3,543
K00–K93	Diseases of the digestive system	148,111
L00–L99	Diseases of the skin and subcutaneous tissue	12,734
M00–M99	Diseases of the musculoskeletal system and connective tissue	17,625
N00–N99	Diseases of the genitourinary system	17,734
O00–O99	Pregnancy, childbirth and the puerperium	35,851
P00–P96	Certain conditions originating in the perinatal period	4
Q00–Q99	Congenital malformations, deformations and chromosomal abnormalities	1,471
R00–R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	46,534
S00–T98	Injury, poisoning and certain other consequences of external causes	8,465
Z00–Z99	Factors influencing health status and contact with health services	305,868
	Not reported	981
Total separations		866,159

Source: NHMD.

Most common principal diagnoses

In 2012–13, the 20 most common specific principal diagnoses accounted for over two-thirds of separations in private day hospitals. The most common was *Care involving dialysis*, which accounted for 15% of separations (Table 4.7). A further 8% were for *Other medical care* (this includes, for example, radiotherapy and chemotherapy), and 7% were for *Other cataract* (cataract conditions excluding those that are age-related or congenital anomalies).

Table E1 in Appendix E includes supplementary data on the ten most common principal diagnoses by funding source.

Table 4.7: Separations for the 20 most common principal diagnoses in 3-character ICD-10-AM groupings, private day hospitals, 2012–13

Principal Diagnosis		Separations
Z49	Care involving dialysis	130,125
Z51	Other medical care	66,996
H26	Other cataract	62,789
Z31	Procreative management (includes in vitro fertilisation)	41,009
H35	Other retinal disorders	40,320
O04	Medical abortion	34,658
C44	Other malignant neoplasms of skin	25,825
R10	Abdominal and pelvic pain	20,613
K21	Gastro-oesophageal reflux disease	19,163
K01	Embedded and impacted teeth	19,111
H25	Senile cataract	18,156
D12	Benign neoplasm of major salivary glands	17,915
Z12	Special screening examination for neoplasms	16,785
K63	Other diseases of intestine	15,790
Z09	Follow-up examination after treatment for conditions other than malignant neoplasms	15,163
I84	Haemorrhoids	13,746
K29	Gastritis and duodenitis	12,705
K57	Diverticular disease of intestine	10,242
R19	Other symptoms and signs involving the digestive system and abdomen	9,815
K92	Other diseases of digestive system	7,854
Other		267,379
Total separations		866,159

Source: NHMD.

How urgent was the care?

Table 4.8 includes information on urgency of admission and whether the separations were considered to be *Childbirth*, *Specialist mental health*, *Surgical*, *Medical* or *Other*. See the section ‘What care was provided?’ in Chapter 3 for more information on these broad categories of service.

In 2012–13, virtually all day hospital separations were *Non-emergency* admissions (Table 4.8).

What care was provided by private day hospitals?

The different types of admitted care that were provided are described here in terms of:

- broad category of service – *Childbirth*, *Specialist mental health*, *Medical* (not involving a procedure), *Surgical* (involving an operating room procedure) and *Other* (involving a non-operating room procedure, such as endoscopy)
- the intent of the care – acute care, sub-acute care and non-acute care
- MDCs and AR-DRGs type of surgical or other procedure undertaken.

Broad category of service

In 2012–13, each of the broad categories of care for *Non-emergency* admissions contributed about one-third of all separations (37%, 33% and 30% of separations for *Surgical*, *Medical* and *Other* separations, respectively) (Table 4.8).

Table 4.8: Separations by broad category of service and urgency of admission, private day hospitals, 2012–13

Broad category or service	Total separations
Childbirth	0
Specialist mental health	0
Emergency	
Surgical	64
Medical	14
Other	19
Non-emergency	
Surgical	319,086
Medical	289,104
Other	257,872
Total separations	866,159

Source: NHMD.

Care type

The **care type** describes the overall nature of a clinical service provided to an admitted patient during an episode of care. For more information on care type, see Chapter 1.

In 2012–13, the majority of separations (99.7%) were classified as *Acute* care (Table 4.9). Essentially all sub-acute and non-acute care provided by private day hospitals was for *Rehabilitation care*.

Table 4.9: Separations by care type, private day hospitals, 2012–13

Care type	Separations
Acute care	863,745
Sub-acute	
Rehabilitation	2,413
Palliative care	0
Geriatric evaluation and management	0
Psychogeriatric care	0
Non-acute care	1
Total	866,159

Source: NHMD

Major Diagnostic Categories

This section presents information on patient care in private overnight hospitals as described by the 23 Major Diagnostic Categories (MDCs). (For more information on AR-DRGs and MDCs, see Chapter 1.)

In 2012–13, *Disorders of the digestive system* (22%) accounted for highest number of total acute care separations in private day hospitals, followed by *Diseases and disorders of the eye* (17%) and *Diseases of the kidney and urinary tract* (16%) (Table 4.10).

Table 4.10: Acute care separations, by major diagnostic category, private day hospitals, 2012–13

Major Diagnostic Category		Total separations
Pre-MDC	Pre-MDC(tracheostomies, transplants, ECMO)	8
1	Diseases and disorders of the nervous system	6,710
2	Diseases and disorders of the eye	147,318
3	Diseases and disorders of the ear, nose, mouth and throat	43,573
4	Diseases and disorders of the respiratory system	1,315
5	Diseases and disorders of the circulatory system	7,578
6	Diseases and disorders of the digestive system	189,455
7	Diseases and disorders of the hepatobiliary system and pancreas	713
8	Diseases and disorders of the musculoskeletal system and connective tissue	20,038
9	Diseases and disorders of the skin, subcutaneous tissue and breast	57,318
10	Endocrine, nutritional and metabolic diseases and disorders	4,923
11	Diseases and disorders of the kidney and urinary tract	135,972
12	Diseases and disorders of the male reproductive system	6,944
13	Diseases and disorders of the female reproductive system	50,048
14	Pregnancy, childbirth and puerperium	35,856
15	Newborns and other neonates	386
16	Diseases and disorders of the blood and blood-forming organs, and immunological disorders	16,322
17	Neoplastic disorders (haematological and solid neoplasms)	71,730
18	Infectious and parasitic diseases	2,666
19	Mental diseases and disorders	486
20	Alcohol/drug use and alcohol/drug induced organic mental disorders	2
21	Injuries, poisoning and toxic effects of drugs	2,436
22	Burns	25
23	Factors influencing health status and other contacts with health services	55,091
Error DRGs ^(a)		6,832
Total		863,745

Note: DRG—diagnosis related group; ECMO—extracorporeal membrane oxygenation; MDC—Major Diagnostic Category.

(a) An *Error DRG* is assigned to hospital records that contain clinically atypical or invalid information.

Source: NHMD.

Most common AR-DRGs

In 2012–13 the 20 most common AR-DRGs accounted for 85% of all day hospital separations. *Haemodialysis* was the most common AR-DRG (15%), followed by *Lens procedures* (9%), and *Colonoscopy, same-day* (9%) (Table 4.11).

Table 4.11: Acute care separations, by 20 most common AR-DRGs version 6.0x, private day hospitals, 2012–13

AR-DRG	Total separations
L61Z Haemodialysis	128,988
C16Z Lens procedures	81,761
G48C Colonoscopy, same-day	77,546
R63Z Chemotherapy	65,126
G46C Complex gastroscopy, same-day	52,601
G47C Other gastroscopy, same-day	51,408
C03Z Retinal procedures	43,377
Z40Z Endoscopy with diagnoses of other contacts with health services, same-day	36,027
O05Z Abortion with operating room procedure	35,601
D40Z Dental extractions and restorations	30,248
J11Z Other skin, subcutaneous tissue and breast procedures	22,757
N07Z Other uterine and adnexa procedures for non-malignancy	21,942
N11Z Other female reproductive system operating room procedures	21,197
Z64B Other factors Influencing health status, same-day	16,572
J08B Other skin graft and/or debridement procedures without CC	12,927
Q61B Red blood cell disorders without catastrophic or severe CC	8,898
J10Z Skin, subcutaneous tissue and breast plastic operating room procedures	8,322
C11Z Eyelid procedures	6,397
960Z Ungroupable	6,319
I68C Non-surgical Spinal Disorders, Same-day	6,174

Note: CC—complications and comorbidities.

Source: NHMD.

Procedures

In 2012–13, almost 1.7 million procedures were reported for separations in private day hospitals (Table 4.12). *Non-invasive, cognitive and other interventions* was the most common procedure chapter, and were reported for 65% of separations. This chapter includes procedure blocks for *Cerebral anaesthesia, Administration of pharmacotherapy, Conduction anaesthesia* and *Administration of blood and blood products, and other procedures related to pharmacotherapy*. The next most frequently reported procedures were *Procedures on digestive system* (27%), *Procedures on eye and adnexa* (17%) and *Procedures on urinary system* (17%).

Table 4.12: Separations with a procedure^(a) reported, by ACHI chapter, private day hospitals, 2012–13

Procedure		Separations
1–86	Procedures on nervous system	12,691
110–129	Procedures on endocrine system	13
160–256	Procedures on eye and adnexa	143,513
300–333	Procedures on ear and mastoid process	3,046
370–422	Procedures on nose, mouth and pharynx	8,349
450–490	Dental services	33,539
520–570	Procedures on respiratory system	282
600–777	Procedures on cardiovascular system	8,569
800–817	Procedures on blood and blood-forming organs	2,308
850–1011	Procedures on digestive system	237,907
1040–1129	Procedures on urinary system	143,459
1160–1203	Procedures on male genital organs	6,643
1240–1299	Gynaecological procedures	85,551
1330–1347	Obstetric procedures	32
1360–1579	Procedures on musculoskeletal system	16,824
1600–1718	Dermatological and plastic procedures	57,639
1740–1759	Procedures on breast	5,414
1786–1799	Radiation oncology procedures	816
1820–1922	Non-invasive, cognitive and other interventions, n.e.c.	565,236
1940–2016	Imaging services	1,051
	Separations with one or more procedures reported	855,628
	Separations with no procedure reported	10,531
Total separations		866,159
Total procedures reported^(b)		1,653,897

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

(b) Total procedures reported is all procedures (not separations).

Source: NHMD.

Most common procedures

In 2012–13, the most commonly reported procedure block in private day hospitals was *Cerebral anaesthesia* (general anaesthesia), reflecting that it is a companion procedure for many other procedures (Table 4.13). *Conduction anaesthesia*, which encompasses local and regional anaesthesia, occurred much less frequently in private day hospitals (57,700 procedures).

Table E2 in Appendix E includes supplementary data on the ten most common procedure blocks by funding source.

Table 4.13: Separations with a procedure^(a) reported for the 20 most common ACHI procedure blocks, private day hospitals, 2012–13

Procedure block	Separations
1910 Cerebral anaesthesia	451,088
1060 Haemodialysis	134,171
911 Fiberoptic colonoscopy with excision	89,988
1008 Panendoscopy with excision	89,348
905 Fiberoptic colonoscopy	87,789
197 Extracapsular crystalline lens extraction by phacoemulsification	80,670
1920 Administration of pharmacotherapy	74,290
1909 Conduction anaesthesia	57,713
1297 Procedures for reproductive medicine	40,696
209 Application, insertion or removal procedures on retina, choroid or posterior chamber	40,685
1265 Curettage and evacuation of uterus	39,798
1620 Excision of lesion(s) of skin and subcutaneous tissue	37,602
1005 Panendoscopy	31,922
458 Surgical removal of tooth	25,774
1893 Administration of blood and blood products	18,483
1651 Local skin flap, single stage	10,696
1922 Other procedures related to pharmacotherapy	6,976
457 Nonsurgical removal of tooth	6,519
1089 Examination procedures on bladder	6,127
1888 Hyperbaric oxygen therapy	6,084

(a) A separation is counted once for the block if it has one or more procedures reported within the block.

Source: NHMD.

How was the care completed?

The **mode of separation** records the status of the patient at the time of separation and, for some categories, the place to which the person was discharged or transferred.

Overall, patients in private day hospitals in 2012–13 most often had *Other* as their mode of separation (99%) (Table 4.14). *Other* can include discharge to usual residence, the patient's own accommodation, or a welfare institution (including prisons, hostels and group homes providing primarily welfare services).

Table 4.14: Mode of separation, private day hospitals, 2012–13

Mode of separation	Separations
Discharge/transfer to an(other) acute hospital	11,037
Discharge/transfer to a residential aged care service ^(a)	10
Discharge/transfer to an(other) psychiatric hospital	2
Discharge/transfer to other health care accommodation	190
Statistical discharge/type change	1
Left against medical advice/discharge at own risk	42
Statistical discharge from leave	2
Died	3
Other ^(b)	854,872
Total	866,159

(a) The separation mode *Discharge/transfer to residential aged care service* excludes where this was the usual place of residence.

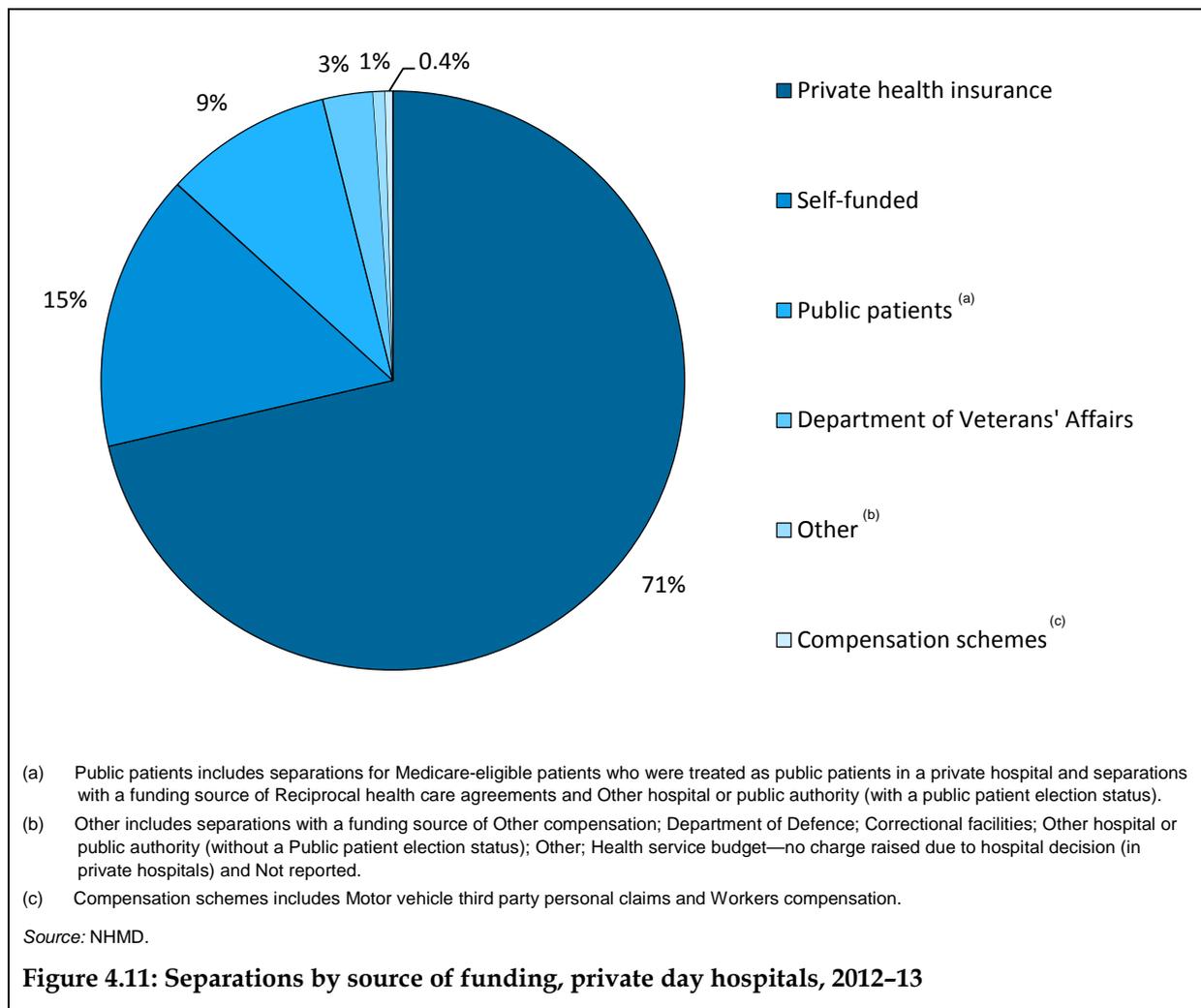
(b) The separation mode *Other* includes *Discharge to usual residence/own accommodation/welfare institution* (including prisons, hostels and group homes providing primarily welfare services).

Source: NHMD.

Who paid for the care?

In 2012–13 the majority of care (71%) in private day hospitals was paid for by *Private health insurance* (Figure 4.13). However, the proportion of care that was self-funded was higher for private day hospitals than for overnight hospitals (15% and 5% respectively). This may reflect the lower cost, and relatively lower complexity of casemix in private day hospitals.

Tables E1 and E2 in Appendix E include supplementary data on funding sources for separations from private day hospitals.



5 Private overnight hospitals

This chapter presents information on admitted patient care provided by private overnight hospitals in Australia.

Private overnight hospitals provide admitted same-day and overnight care as well as non-admitted care to patients. A same-day separation is one in which the patient is admitted and separated on the same date. An overnight separation occurs when the patient is admitted and separated on different dates.

Admitted patient care provided by private overnight hospital care can be acute, sub-acute or non-acute care. **Acute care** refers to care with the intent to cure the condition, alleviate symptoms or manage childbirth. **Sub-acute** care includes *Rehabilitation, Palliative care, Geriatric evaluation and management* and *Psychogeriatric care*. **Non-acute care** is also referred to as *Maintenance care*.

The admitted patient data for this chapter are sourced from the NHMD, with some additional data by peer group from the PHDB. (For definitions of terms and classifications, see Chapter 1.)

What data are reported?

The data in this chapter include administrative, demographic and clinical data relating to admitted patients in private day hospitals. This chapter answers the following questions:

- How much admitted patient activity was there in 2012–13?
- Who used these services?
- Why did people receive the care?
- How urgent was the care?
- What care was provided?
- How long did patients stay?
- Who paid for the care?

Information relating to diagnoses (in the ‘Why did people receive the care?’ section), procedures (in the ‘What care was provided?’ section) and average length of stay (in the ‘How did patients stay?’ section) are presented separately for acute and sub-acute and non-acute care types.

How much admitted patient activity was there in 2012–13?

There were nearly 3 million separations in private overnight hospitals in 2012–13. Of these, 60% were same-day separations (Table 5.1). *Private acute Group B hospitals* provided the highest proportion of activity (28%) and *Mixed sub-acute and non-acute hospitals* provided the lowest (less than 1%) (Table 5.1).

Table 5.1: Separations, by peer group, private overnight hospitals, 2012–13

	Same-day separations	Overnight separations	Total separations	Proportion of total activity ^(a) (%)
Private acute hospitals				
Group A	385,427	345,728	731,155	25.8
Group B	437,281	356,345	793,626	28.0
Group C	380,348	228,525	608,873	21.5
Group D	242,047	99,545	341,592	12.0
Specialist overnight hospitals				
Private psychiatric ^(b)	130,747	24,555	155,302	5.5
Sub-acute and non-acute hospitals				
Rehabilitation	98,219	33,081	131,300	4.6
Mixed sub-acute and non-acute	511	1,864	2,375	0.1
Other overnight hospitals^(c)	41,283	30,706	71,989	2.5
Total (PHDB data)	1,715,863	1,120,349	2,836,212	100
Total (NHMD data)	1,782,199	1,194,973	2,977,172	

(a) Proportion of total activity calculated using PHDB total.

(b) 1 *Drug and alcohol hospital* has been combined with 27 *Private psychiatric hospitals* for confidentiality reasons.

(c) *Other overnight hospitals* includes 6 *Very small hospitals*, 16 *Other acute specialised hospitals* and 2 *Women's and children's hospitals*.

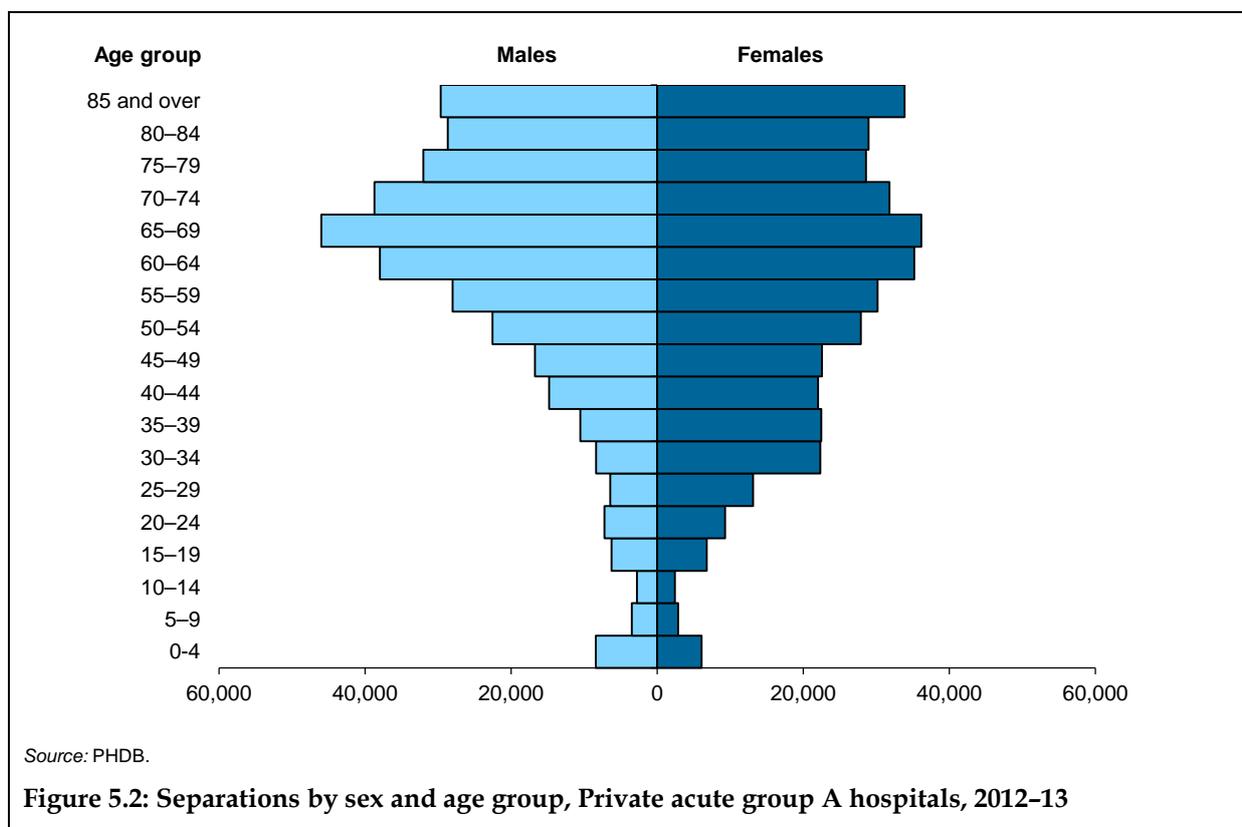
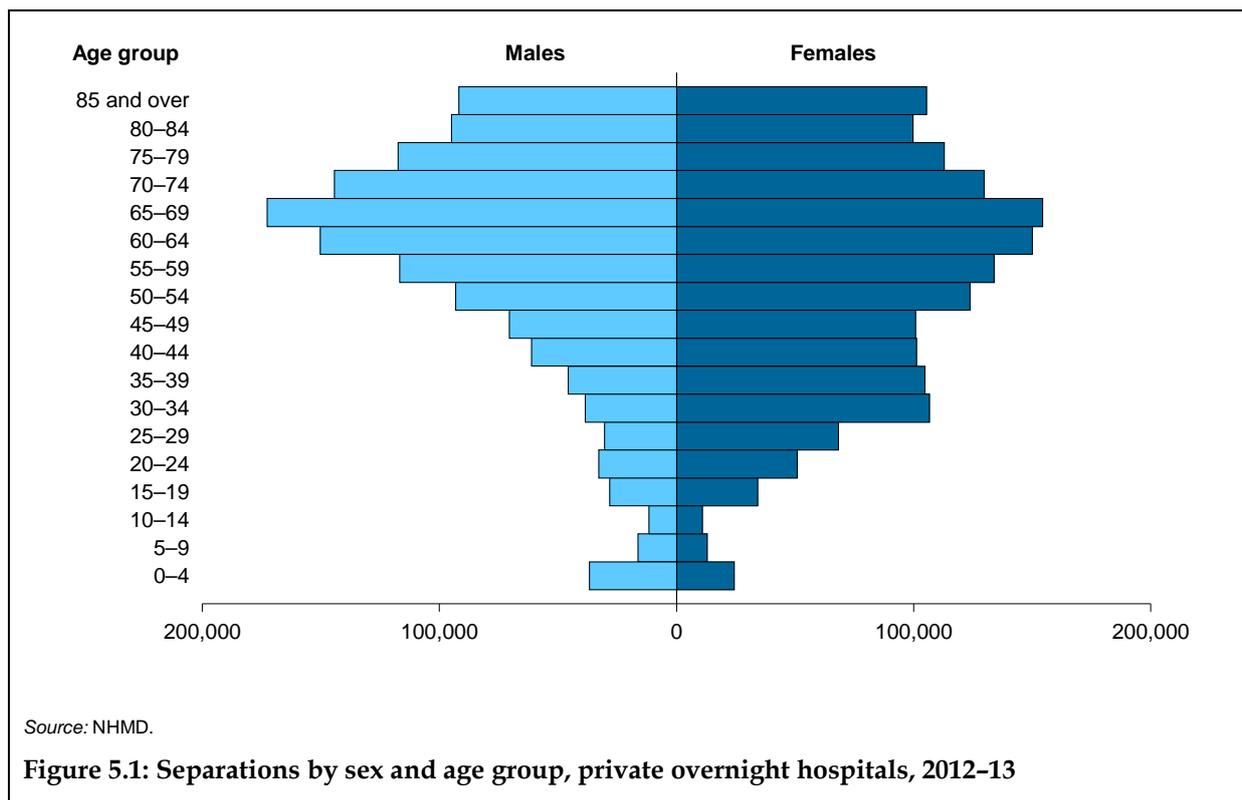
Source: PHDB, NHMD. All data in this table are sourced from the PHDB except where specifically noted.

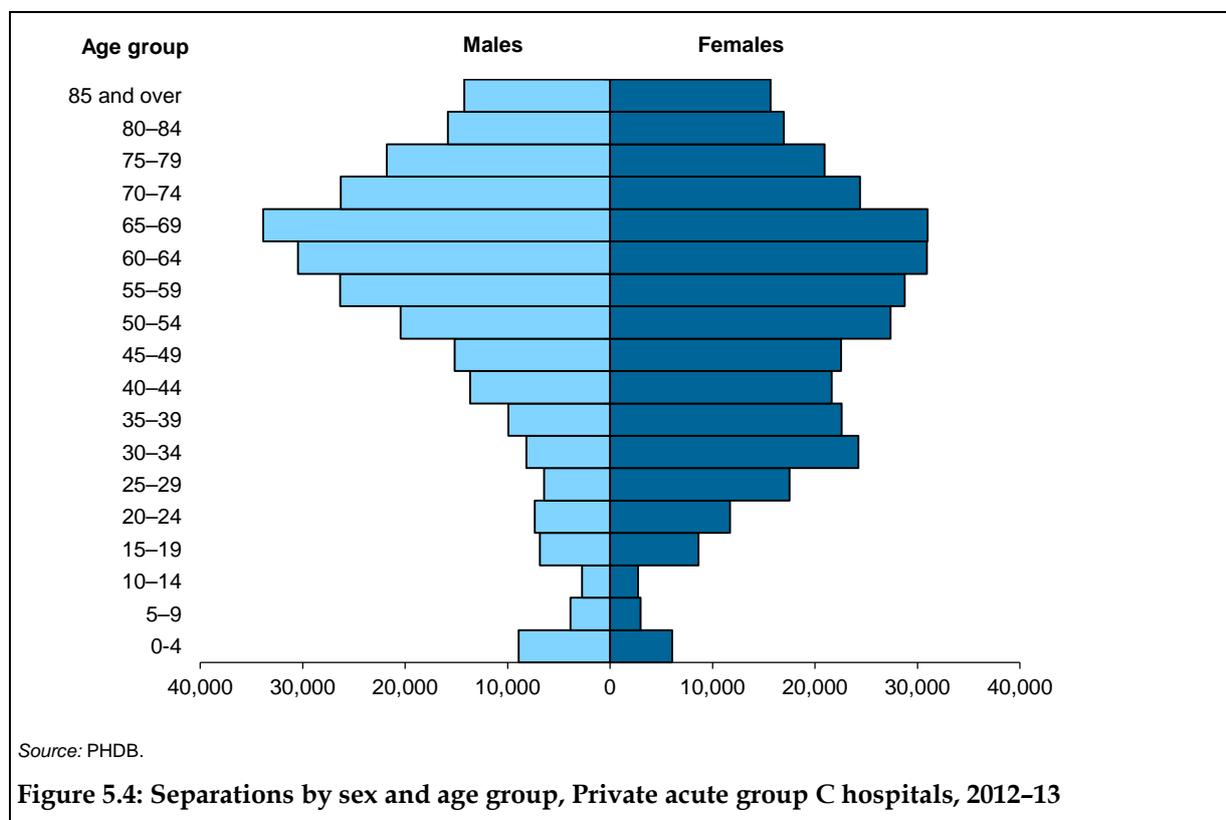
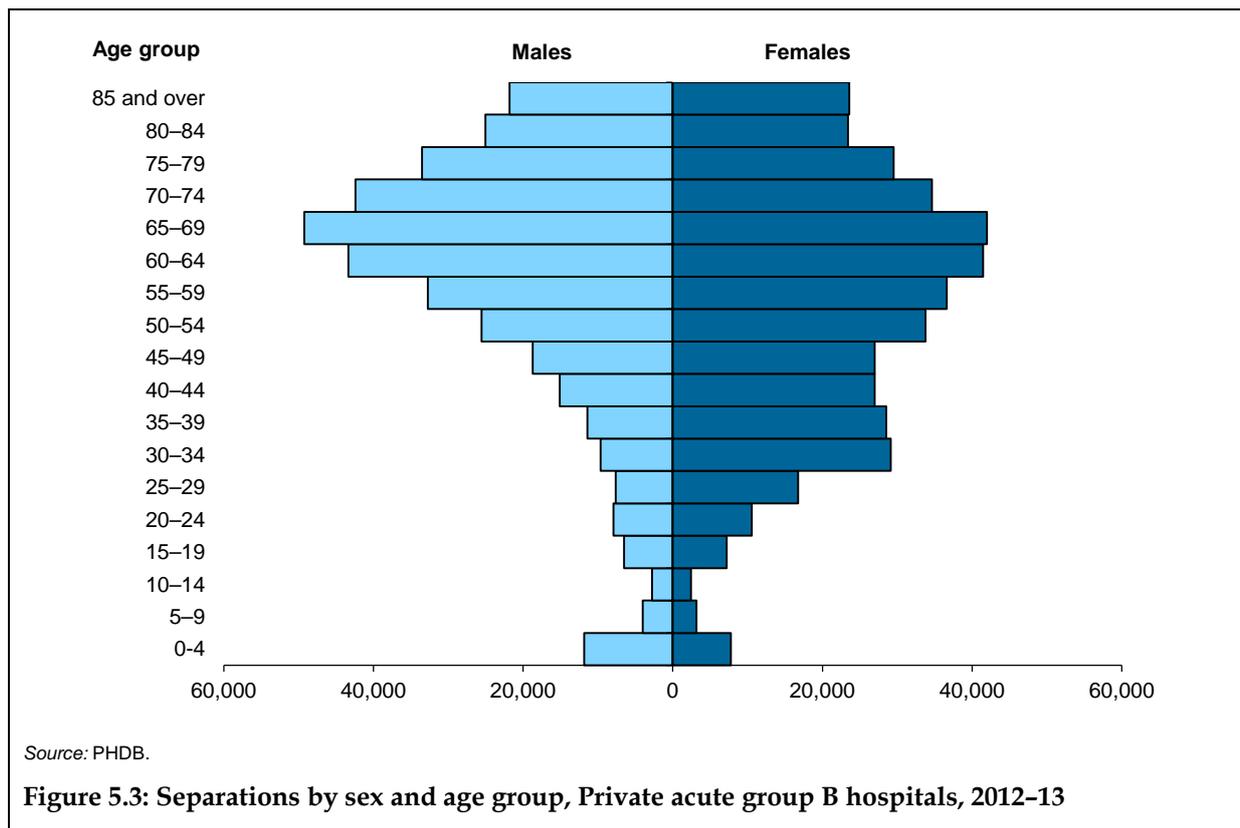
Private overnight hospitals had more same-day separations than overnight separations in 2012–13. The *Private psychiatric hospitals* peer group (including one *Drug and alcohol hospital*) had the highest proportion of same-day separations (84%), followed by *Rehabilitation hospitals* (75%) and *Private acute Group D hospitals* (71%).

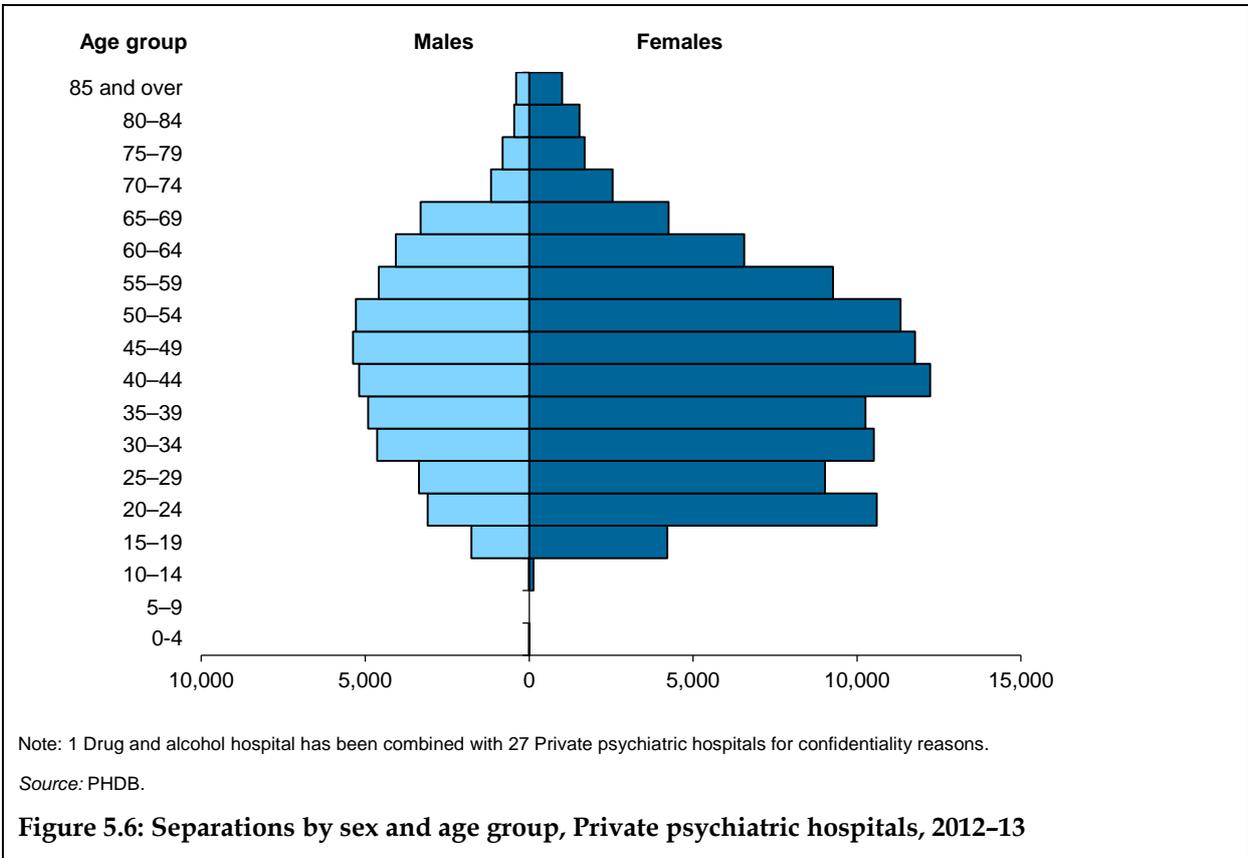
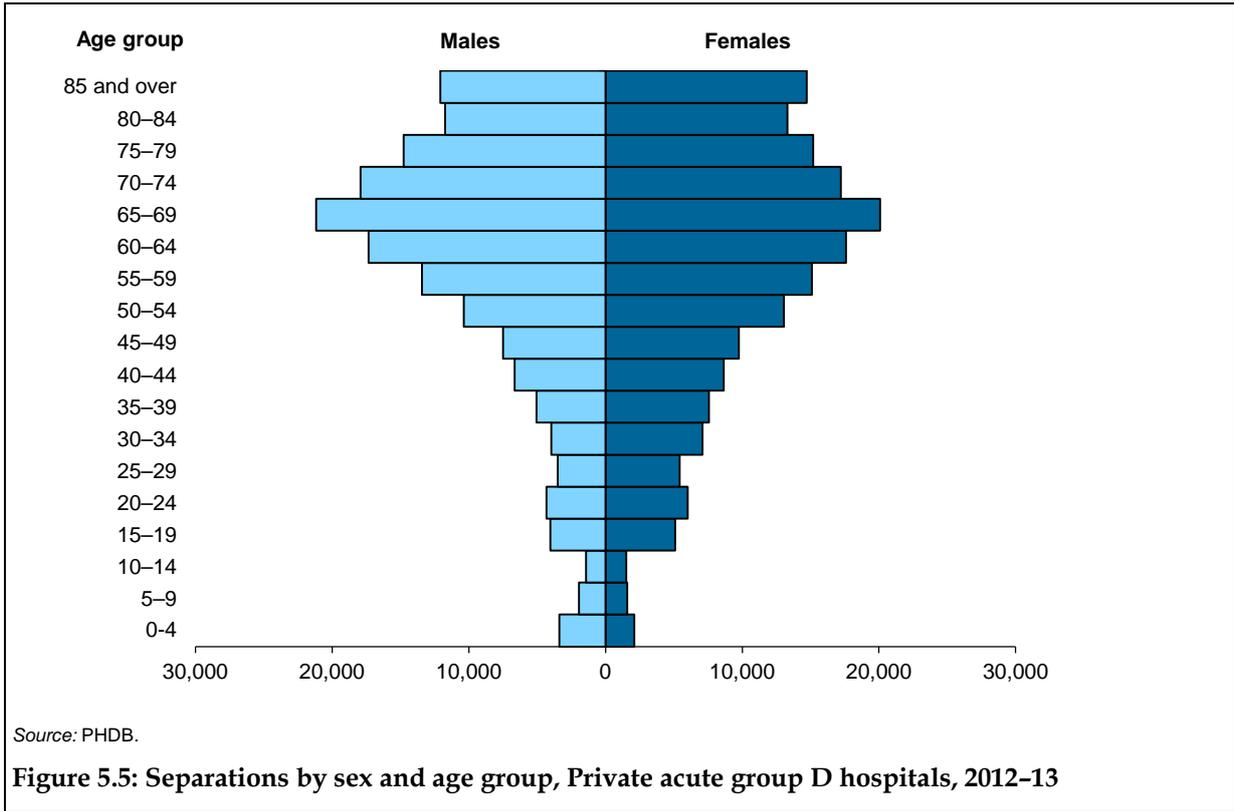
Who used these services?

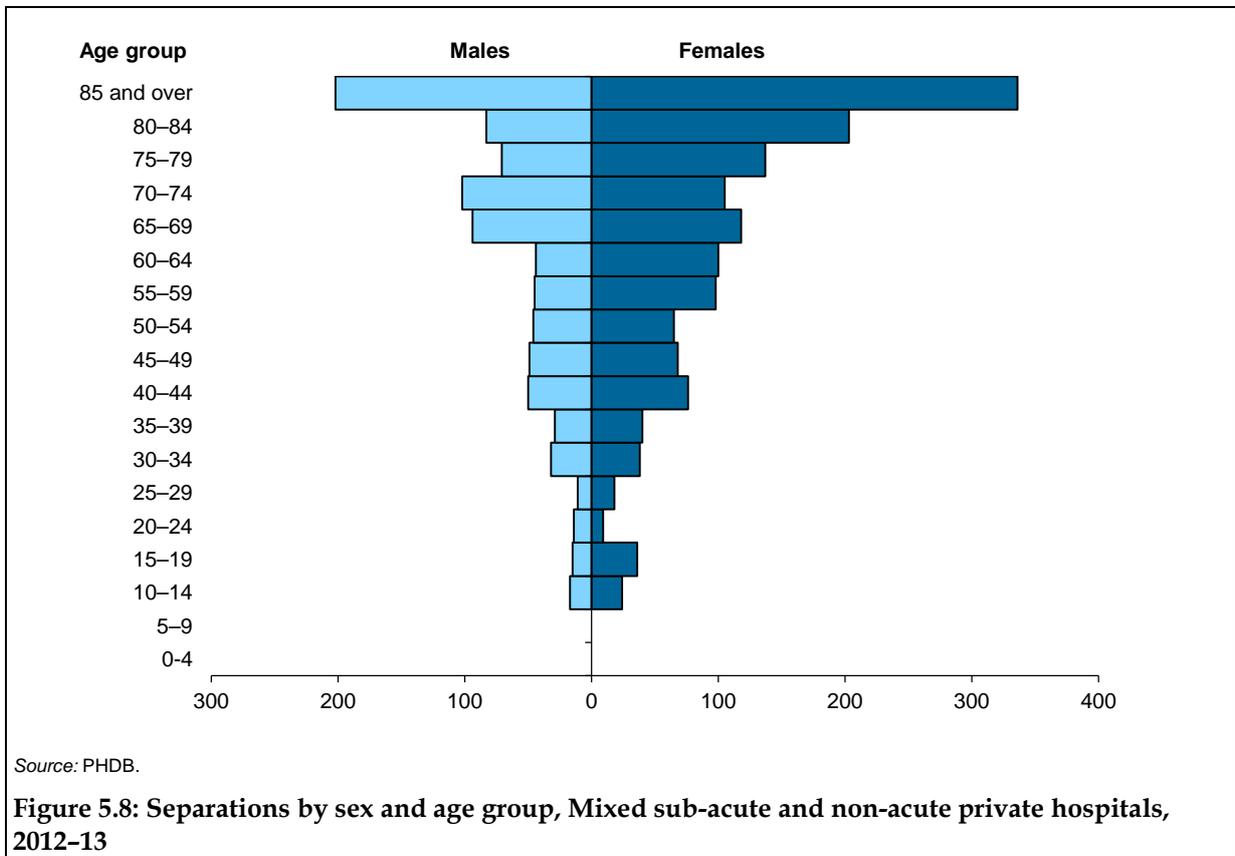
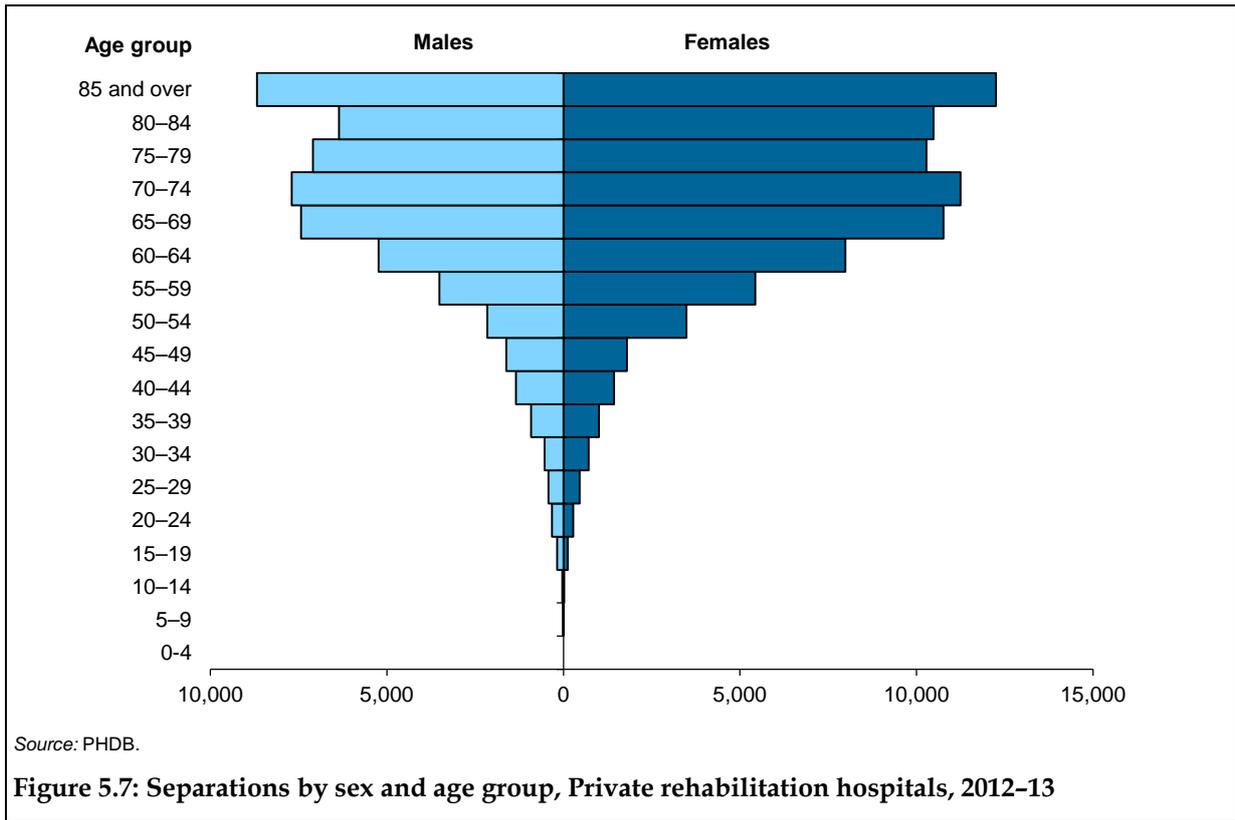
In 2012–13, males accounted for less than half (45%) of patients in private overnight hospitals (Figure 5.1). Similarly, fewer than half the separations in each age group were men, with 2 exceptions; there were more separations for males than females in the age groups between 0 and 14 years and between 65 and 79 years. People aged 55 and over accounted for 59% of all private overnight hospital separations.

For 2012–13 the age and sex distribution of admitted patients differed between private hospital peer groups, as shown in Figures 5.2 to 5.8. In comparison with other private hospital peer groups, *Private psychiatric hospitals* had the lowest proportion of patients over the age of 55 years (27%) and the highest proportion of females (69%) (Figure 5.6). *Rehabilitation hospitals* had a high proportion (87%) of separations for people aged 55 years and over (Figure 5.7).









Remoteness area

Use of overnight private hospitals was highest in 2012–13 for those residing in *Major cities* (51.9 overnight separations per 1,000 persons) and lowest for those residing in *Very remote areas* (22.6 overnight separations per 1,000 persons). Rates for same-day separations were also highest for *Major cities* (81.4 separations per 1,000). Rates differed more for same-day separations (between 81.4 and 24.9 separations per 1,000, for *Major Cities* and *Very remote areas*, respectively) than for overnight separations (between 51.9 and 22.6 separations per 1,000, for *Major Cities* and *Very remote areas*, respectively) (Table 5.2).

Table 5.2: Same-day and overnight separations per 1,000 persons by remoteness area, private overnight hospitals, 2012–13^(a)

	Remoteness area ^(b)					Total ^(c)
	Major cities	Inner regional	Outer regional	Remote	Very Remote	
Same-day separations						
Separations	1,350,413	313,739	102,683	8,954	4,303	1,782,199
Separations per 1,000 population	81.4	64.9	45.2	27.9	24.9	73.6
Separation rate ratio	1.1	0.9	0.6	0.4	0.3	
Overnight separations						
Separations	870,292	224,684	84,626	9,311	3,927	1,194,973
Separations per 1,000 population	51.9	46.7	37.9	29.4	22.6	49.2
Separation rate ratio	1.1	0.9	0.8	0.6	0.5	
Total separations						
Separations	2,220,705	538,423	187,309	18,265	8,230	2,977,172
Separations per 1,000 population	133.4	111.7	83.0	57.2	47.5	122.8
Separation rate ratio	1.1	0.9	0.7	0.5	0.4	

(a) Data are age-standardised to the Australian population as at 30 June 2001.

(b) Disaggregation by remoteness area is by the area of the patient's usual residence, not by the location of the hospital. Remoteness of residence is based on the ABS Remoteness area. For more information about Remoteness area see Chapter 1.

(c) The total includes separations for which the remoteness area was not able to be categorised.

Source: NHMD.

Socioeconomic status

The highest rates of overnight separations were for those who lived in areas with the highest socioeconomic status (65.1 separations per 1,000 persons) and the lowest rates of separation were for those who lived in areas with the lowest socioeconomic status (33.4 separations per 1,000 persons) (Table 5.3). Rates for same-day separation were also highest for those who lived in areas with the highest socioeconomic status (105.6 separations per 1,000) and lowest for those living in the lowest socioeconomic status areas (47.0 separations per 1,000). As with remoteness, there was more variation in rates for same-day separations than for overnight separations.

Table 5.3: Same-day and overnight separations per 1,000 persons by socioeconomic status, private overnight hospitals, 2012–13^(a)

	Socioeconomic status of area of residence ^(b)					Total ^(c)
	1 (Lowest)	2	3	4	5 (Highest)	
Same-day separations						
Separations	235,780	273,858	365,761	401,523	493,811	1,782,199
Separations per 1,000 population	47.0	54.5	75.1	86.9	105.6	73.6
Separation rate ratio	0.6	0.7	1.0	1.2	1.4	
Overnight separations						
Separations	169,339	198,363	242,801	273,129	303,860	1,194,973
Separations per 1,000 population	33.4	39.3	49.8	58.7	65.1	49.2
Separation rate ratio	0.7	0.8	1.0	1.2	1.3	
Total separations						
Separations	405,119	472,221	608,562	674,652	797,671	2,977,172
Separations per 1,000 population	80.4	93.8	124.8	145.6	170.6	122.8
Separation rate ratio	0.7	0.8	1.0	1.2	1.4	

(a) Data are age-standardised to the Australian population as at 30 June 2001.

(b) Disaggregation by socioeconomic status group is based on the area of the patient's usual residence, not by the location of the hospital. These socioeconomic groups represent approximately 20% of the national population, but do not necessarily represent 20% of the population in each state or territory. For more information about socioeconomic status see Chapter 1.

(c) Total includes separations for which socioeconomic status group was not able to be categorised.

Source: NHMD.

Aboriginal and Torres Strait Islander people

Previously, the AIHW has recommended that data on the Indigenous status of patients in private hospitals not be used for national reporting, as the quality of the data is unknown (AIHW 2013g). However, given the focus of this report on private hospitals and their patient characteristics, data on the Indigenous status of patients are reported here, while noting potential data quality issues.

Caution should be used in the interpretation of these data. A recent AIHW study of Indigenous identification in public hospitals estimated that, in 2011–12, about 88% of Indigenous Australians were correctly identified in public hospital admissions data. It is unknown to what extent Indigenous Australians might be under-identified in private hospital admissions data. (For more information about Indigenous status data in the NHMD see Appendix B.)

In 2012–13, Indigenous Australians had much lower rates of private overnight hospital separations than other Australians for both same-day separations (17.3 and 72.1 separations per 1,000 respectively) and overnight separations (9.4 and 49.0 separations per 1,000 respectively) (Table 5.4).

Table 5.4: Same-day and overnight separations per 1,000 persons by Indigenous status, private overnight hospitals, 2012–13^(a)

	Indigenous Australians	Other Australians	Not reported	Total ^(b)
Same-day separations				
Separations	6,904	1,719,889	55,406	1,782,199
Separations per 1,000 population	17.3	72.1		73.3
Separation rate ratio	0.2	1.0		
Overnight separations				
Separations	3,732	1,162,055	29,186	1,194,973
Separations per 1,000 population	9.4	49.0		49.4
Separation rate ratio	0.2	1.0		
Total separations				
Separations	10,636	2,881,944	84,592	2,977,172
Separations per 1,000 population	26.7	121.1		122.8
Separation rate ratio	0.2	1.0		

(a) Separation rates by Indigenous status were directly age-standardised, using the projected Indigenous population (low series) as at 30 June 2012, based on the 2001 Census data. The populations used for calculating age-standardised separation rates by Indigenous status have different age groups compared with the populations used to calculate other age-standardised separation rates presented in this report. Therefore, the separation rates by Indigenous status are not directly comparable with the rates by remoteness of residence or socioeconomic status.

(b) Total includes separations for which the Indigenous status was not reported.

Source: NHMD.

How did patients access overnight private hospitals?

The **mode of admission** records the mechanism by which an admitted patient begins an episode of admitted patient care.

In 2012–13, 95% of all separations in private overnight hospitals had a mode of admission of *Other*, the term used to refer to all planned and unplanned admissions except transfers from other hospitals and statistical admissions, which occur when the care type changes (for example, from acute to subacute). *Admitted patient transferred from another hospital* was the next most common admission mode, accounting for 4% of all private overnight hospital separations (Table 5.5).

Table 5.5: All separations, by mode of admission, private overnight hospitals, 2012–13

Mode of admission	Same-day separations	Overnight separations	Total separations
Admitted patient transferred from another hospital	5,324	99,341	104,665
Statistical admission - episode type change ^(a)	731	19,913	20,644
Other ^(b)	1,764,273	1,069,225	2,833,498
Unknown	11,871	6,494	18,365
Total	1,782,199	1,194,973	2,977,172

(a) Statistical admission: care type change is where a new admitted patient episode is created as a result of a change in the clinical intent of care.

(b) *Other* is the term used to refer to all other planned and unplanned admissions.

Source: NHMD.

Why did people receive this care?

The reason that a patient receives admitted patient care can be described in terms of the principal diagnosis. (For more information on principal diagnoses and the ICD-10-AM classification, see Chapter 1.)

Different patterns of diagnoses can be seen in acute and sub-acute and non-acute care for patients in overnight hospitals. They have been presented separately in the following section. For more information on care types, see Chapter 1.

Acute care

In 2012–13, about 1 in 5 acute care private overnight hospital separations (507,000 separations) were for *Factors influencing health status and contact with health services* (this includes, for example, care involving dialysis and chemotherapy) (Table 5.6). About 13% of separations involved *Diseases of the digestive system* (350,000 separations), and 11% involved *Diseases of the musculoskeletal system and connective tissues* (292,000 separations).

Some types of principal diagnoses were much more likely to be associated with overnight separations. At least three-quarters of separations for *Injury, poisoning and certain other consequences of external causes* (75%), *Diseases of the respiratory system* (82%), *Pregnancy, childbirth and the puerperium* (84%), and *Certain conditions originating in the perinatal period* (97%) were overnight separations in 2012–13. In contrast, separations for *Mental and behavioural disorders*, *Diseases of the eye and adnexa*, and *Factors influencing health status and contact with health services* had a higher proportion of same-day separations (76%, 90% and 93%, respectively).

Table 5.6: Acute care separations, by principal diagnosis in ICD-10-AM chapters, private overnight hospitals, 2012–13

Principal diagnosis chapter		Same-day separations	Overnight separations	Total separations
A00–B99	Certain infectious and parasitic diseases	8,223	12,277	20,500
C00–D48	Neoplasms	141,980	104,583	246,563
D50–D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	24,056	9,631	33,687
E00–E90	Endocrine, nutritional and metabolic diseases	14,158	27,450	41,608
F00–F99	Mental and behavioural disorders	119,066	38,252	157,318
G00–G99	Diseases of the nervous system	32,254	69,133	101,387
H00–H59	Diseases of the eye and adnexa	84,990	9,668	94,658
H60–H95	Diseases of the ear and mastoid process	19,567	6,655	26,222
I00–I99	Diseases of the circulatory system	48,082	111,243	159,325
J00–J99	Diseases of the respiratory system	16,039	74,797	90,836
K00–K93	Diseases of the digestive system	244,475	105,483	349,958
L00–L99	Diseases of the skin and subcutaneous tissue	19,672	14,218	33,890
M00–M99	Diseases of the musculoskeletal system and connective tissue	115,467	176,035	291,502
N00–N99	Diseases of the genitourinary system	90,287	78,278	168,565
O00–O99	Pregnancy, childbirth and the puerperium	17,888	93,122	111,010
P00–P96	Certain conditions originating in the perinatal period	407	11,792	12,199
Q00–Q99	Congenital malformations, deformations and chromosomal abnormalities	5,336	4,340	9,676
R00–R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	101,380	61,825	163,205
S00–T98	Injury, poisoning and certain other consequences of external causes	25,728	78,815	104,543
Z00–Z99	Factors influencing health status and contact with health services	471,477	35,775	507,252
	Not reported	172	155	327
Total		1,600,704	1,123,527	2,724,231

Source: NHMD.

Most common acute care principal diagnoses

In 2012–13, the 20 most common specific principal diagnoses accounted for 33% of acute care separations in private overnight hospitals. The most common was *Other medical care* (almost 174,000 separations), which accounted for 6% of acute care separations (Table 5.7). This was also the most common specific principal diagnosis for acute care same-day separations (11% of acute same-day separations).

Table 5.7: Acute care separations for the 20 most common principal diagnoses in 3-character ICD-10-AM groupings, private overnight hospitals, 2012-13

Principal diagnosis		Same-day separations	Overnight separations	Total separations
Z51	Other medical care	173,561	291	173,852
Z49	Care involving dialysis	99,166	504	99,670
H26	Other cataract	58,694	4,558	63,252
G47	Sleep disorders	870	55,416	56,286
K01	Embedded and impacted teeth	48,840	777	49,617
Z45	Adjustment and management of implanted device	43,074	3,477	46,551
M23	Internal derangement of knee	36,640	9,783	46,423
C44	Other malignant neoplasms of skin	34,074	9,153	43,227
M17	Gonarthrosis (arthrosis of knee)	10,307	31,669	41,976
F32	Depressive episode	31,089	8,579	39,668
R10	Abdominal and pelvic pain	27,836	8,410	36,246
O82	Single delivery by caesarean section	25	34,044	34,069
D12	Benign neoplasm of major salivary glands	31,090	2,902	33,992
Z09	Follow-up examination after treatment for conditions other than malignant neoplasms	31,606	1,161	32,767
O80	Single spontaneous delivery	78	31,623	31,701
K21	Gastro-oesophageal reflux disease	27,889	2,031	29,920
Z12	Special screening examination for neoplasms	28,369	367	28,736
M54	Dorsalgia	17,266	9,264	26,530
Z08	Follow-up examination after treatment for malignant neoplasms	24,641	1,708	26,349
K92	Other diseases of digestive system	22,063	3,502	25,565
Other		853,526	904,308	1,757,834
Total^(a)		1,600,704	1,123,527	2,724,231

(a) Total includes acute separations for which an invalid or no principal diagnosis was reported.

Source: NHMD.

The top 20 principal diagnoses in overnight hospitals for 2012-13 were strongly driven by those diagnoses involving same-day separations, as is evident in Table 5.7. Table 5.8 shows the 20 most common principal diagnoses for overnight separations. Comparison of the 2 tables shows little overlap in diagnoses (the tables have only 4 codes in common), suggesting that there were differences in the types of conditions that were most commonly treated on an overnight basis compared with same-day.

In 2012-13, the most common principal diagnosis for overnight acute care separations in private overnight hospitals was *Sleep disorders* (5%), followed by *Single delivery by caesarean section* (3% of acute overnight separations) (Table 5.8).

Table 5.8: Overnight acute care separations for the 20 most common principal diagnoses in 3-character ICD-10-AM groupings, private overnight hospitals, 2012-13

Principal diagnosis		Separations
G47	Sleep disorders	55,416
O82	Single delivery by caesarean section	34,044
M17	Gonarthrosis (arthrosis of knee)	31,669
O80	Single spontaneous delivery	31,623
M75	Shoulder lesions	23,551
K40	Inguinal hernia	20,673
J35	Chronic diseases of tonsils and adenoids	20,260
K80	Cholelithiasis	18,795
M16	Coxarthrosis (arthrosis of hip)	17,965
I25	Chronic ischaemic heart disease	15,083
R07	Pain in throat and chest	13,435
I48	Paroxysmal tachycardia	13,307
I20	Angina pectoris	12,542
M51	Other intervertebral disc disorders	12,453
O81	Single delivery by forceps and vacuum extractor	12,360
E66	Obesity	12,055
J34	Other disorders of nose and nasal sinuses	11,698
C50	Malignant neoplasm of breast	10,989
I50	Heart failure	10,291
C61	Malignant neoplasm of prostate	10,241
Other		735,077
Total		1,123,527

Source: NHMD.

Sub-acute and non-acute care

Overall, 95% of sub-acute care and non-acute care separations (240,000 separations) in private overnight hospitals in 2012-13 had a principal diagnosis from the ICD-10-AM chapter *Factors influencing health status and contact with health services in private overnight hospitals in 2012-13* (AIHW 2014a). This chapter includes *Care involving the use of rehabilitation procedures*.

Rehabilitation care

Factors influencing health status and contact with health services was the most common principal diagnosis chapter for *Rehabilitation care* in 2012-13. This chapter includes *Care involving use of rehabilitation procedures*. For *Rehabilitation care*, as the principal diagnosis is required to be reported as *Care involving use of rehabilitation procedures*, the first additional diagnosis is usually the reason for the care.

The 20 most common first additional diagnoses reported for *Rehabilitation care* separations included 11 musculoskeletal conditions or injuries with *Gonarthrosis* (arthrosis of the knee) being the most common (Table 5.9).

Table 5.9: Separations for the 20 most common first additional diagnoses in 3-character ICD-10-AM groupings for *Rehabilitation care* separations, private overnight hospitals, 2012–13

First additional diagnosis		Same-day separations	Overnight separations	Total separations
M17	Gonarthrosis (arthrosis of the knee)	46,828	10,345	57,173
M16	Coxarthrosis (osteoarthritis of the hip joint)	17,729	5,477	23,206
Z96	Presence of other functional implants	7,388	1,175	8,563
M54	Dorsalgia (pain in the upper back)	6,237	1,942	8,179
S72	Fracture of femur (bone of the lower limb that extends from the hip to the knee)	4,284	3,487	7,771
M25	Other joint disorders, not elsewhere classified	4,971	1,578	6,549
M48	Other spondylopathies	3,292	1,912	5,204
T84	Complications of internal orthopaedic prosthetic devices, implants and grafts	3,437	1,494	4,931
I63	Cerebral infarction	3,532	1,106	4,638
M51	Other intervertebral disc disorders	3,102	1,323	4,425
S32	Fracture of lumbar spine and pelvis	2,263	1,756	4,019
R53	Malaise and fatigue	3,698	287	3,985
R29	Other symptoms and signs involving the nervous and musculoskeletal systems	1,957	1,048	3,005
S82	Fracture of lower leg, including ankle	1,953	1,008	2,961
R26	Abnormalities of gait and mobility	2,423	367	2,790
G20	Parkinson disease	2,032	421	2,453
I25	Chronic ischaemic heart disease	1,739	641	2,380
I89	Other noninfective disorders of lymphatic vessels and lymph nodes	2,128	67	2,195
M62	Other disorders of muscle	1,500	371	1,871
M19	Other arthrosis	1,303	416	1,719
Other		44,296	25,789	70,085
No additional diagnosis or not reported		9,958	46	10,004
Total		176,050	62,056	238,106

Source: NHMD.

Impairment groups

Data on rehabilitation care are submitted voluntarily by 88 private hospitals to the Australasian Rehabilitation Outcomes Collaboration. In 2012–13, the Collaboration had data for around 94% of overnight rehabilitation care separations in private hospitals (58,147 episodes of rehabilitation care). The data include impairment groups, which reflect the primary reason for the episode of rehabilitation care (AROC 2014b).

In 2012–13, the most common impairment groups included *Post orthopaedic surgery* (18,408 episodes of rehabilitation care), *Reconditioning* (that is, restoring functioning in the patient following surgery or illness) (10,864 episodes of rehabilitation care) and *Fractures* (6,740 episodes of rehabilitation care) (AROC 2014a).

Palliative care

Although around 6,000 separations in 2012–13 were recorded with a care type of *Palliative care* in private overnight hospitals, there were around 9,400 separations identified as providing some form of palliative care regardless of the care type specified. These separations are identified by either the assignment of the ICD-10-AM code Z51.5 *Palliative care* as an additional diagnosis, or by the assignment of the *Palliative care* type. The exact nature of the care provided for the separations that were not assigned the *Palliative care* type, but were assigned an additional diagnosis code of Z51.5, is unknown.

The most common principal diagnosis chapter reported for *Palliative care* separations in 2012–13 was *Neoplasms*. These accounted for 75% of *Palliative care* separations. The 5 most common neoplasm-related principal diagnoses are presented in Table 5.10, as are the top 5 non-neoplasm related principal diagnoses for *Palliative care*, which included heart failure and respiratory disorders.

Table 5.10: Palliative care separations, by 5 most common neoplasm-related and the 5 most common other principal diagnoses in 3-character ICD-10-AM groupings, private overnight hospitals, 2012–13

Principal Diagnosis		Same-day separations	Overnight separations	Total separations
Neoplasm related				
C34	Malignant neoplasm of bronchus and lung	150	727	877
C79	Secondary malignant neoplasm of other and unspecified sites	28	740	768
C78	Secondary malignant neoplasm of respiratory and digestive organs	17	589	606
C25	Malignant neoplasm of pancreas	48	381	429
C61	Malignant neoplasm of prostate	72	274	346
Other				
I50	Heart failure	6	278	284
N18	Chronic kidney disease	127	85	212
J18	Pneumonia, organism unspecified	6	152	158
J44	Other chronic obstructive pulmonary disease	n.p.	n.p.	129
K56	Paralytic ileus and intestinal obstruction without hernia	n.p.	n.p.	116

Source: NHMD.

How urgent was the care?

Table 5.11 includes information on urgency of admission and whether the separations were considered to be *Childbirth*, *Specialist mental health*, *Surgical*, *Medical* or *Other*. See the section ‘What care was provided?’ in Chapter 3 for more information on these broad categories of service.

In 2012–13, around 7% of separations were *Emergency* admissions, of which around three-quarters (73%) were for *Medical* care (Table 5.11). Most *Emergency* admissions were for overnight separations (90%). For *Non-emergency admissions*, almost two-thirds (65%) were for same-day separations.

What care was provided by private overnight hospitals?

The care that a patient received can be described in terms of the:

- broad category of service – *Childbirth*, *Specialist mental health*, *Medical* (not involving a procedure), *Surgical* (involving an operating room procedure) or *Other* (involving a non-operating room procedure, such as endoscopy)
- the intent of the care
- MDCs and AR-DRGs
- type of surgical or other procedure undertaken.

Broad category of service

In 2012–13, private overnight hospitals predominantly reported non-emergency admissions (Table 5.11). The type of care delivered differed between same-day and overnight separations. More same-day separations were *Medical* (40%) than any other service category, while half of all overnight separations were *Surgical* (50%). A large proportion of *Specialist mental health* care was provided to same-day patients (77%), while most *Emergency Medical* (92%) care was provided to overnight patients.

Table 5.11: Same-day and overnight separations by broad category of service and urgency of admission, private overnight hospitals, 2012–13

	Same-day separations	Overnight separations	Total separations
Childbirth	119	81,753	81,872
Specialist mental health	110,179	33,566	143,745
Emergency			
Surgical	4,906	34,462	39,368
Medical	10,916	136,733	147,649
Other	3,779	12,037	15,816
Non-emergency			
Surgical	494,714	558,195	1,052,909
Medical	702,271	297,655	999,926
Other	455,315	40,572	495,887
Total	1,782,199	1,194,973	2,977,172

Source: NHMD.

Care type

The **care type** describes the overall nature of a clinical service provided to an admitted patient during an episode of care. For more information on care type, see Chapter 1.

In 2012–13, there were 1.1 million overnight acute care separations in private overnight hospitals (92%), 251,000 separations for sub-acute care (8%) and 2,300 (<1%) separations for non-acute care (Table 5.12).

Table 5.12: Separations by care type and same-day/overnight status^(a), private overnight hospitals, 2012–13

Care type	Same-day separations	Overnight separations	Total separations
Acute care	1,600,704	1,123,527	2,724,231
Sub-acute care			
Rehabilitation	176,050	62,056	238,106
Palliative care	809	5,198	6,007
Geriatric evaluation and management	38	166	204
Psychogeriatric care	4,120	2,201	6,321
Maintenance care	477	1,822	2,299
Total	1,782,198	1,194,970	2,977,168

(a) Table excludes separations with a care type of *Other admitted care*, therefore totals in this table may not equal totals in other tables in this chapter.

Source: NHMD.

The majority of sub-acute care and non-acute care separations in 2012–13 involved same-day care. The most common type of sub-acute care was *Rehabilitation* care which accounted for 94% of sub-acute care and non-acute care in private overnight hospitals. In 2012–13, *Private acute Group A hospitals* accounted for 27% of all acute separations in overnight private hospitals. Of private overnight hospitals, *Rehabilitation hospitals* had the largest number of separations (126,000) for sub-acute care and non-acute care in 2012–13. They accounted for 49% of all private overnight hospital sub-acute care and non-acute care. The most common type of sub-acute care was *Rehabilitation* care (accounting for between 96% to 100% of sub-acute care and non-acute care separations) (Table 5.13).

Table 5.13: Separations by peer group and care type^(a), private overnight hospitals, 2012–13

	Acute care	Rehabilitation care	Palliative care	Geriatric Evaluation & Management	Psychogeriatric care	Maintenance care	Total
Private acute hospitals							
Group A	705,513	24,029	1,207	60	0	315	793,124
Group B	762,883	30,060	465	24	1	106	793,539
Group C	573,090	33,892	807	12	1	96	607,898
Group D	299,542	40,912	833	9	0	170	341,466
Specialist overnight hospitals							
Private psychiatric ^(b)	155,260	20	0	0	0	0	155,280
Sub-acute and non-acute hospitals							
Rehabilitation	4,675	126,412	179	28	0	0	131,294
Mixed sub-acute and non-acute	316	868	544	4	0	522	2,254
Other overnight hospitals^(c)							
	71,532	426	0	0	0	30	71,988
Total	2,572,811	256,619	4,035	137	2	1,239	2,834,843

(a) Table excludes separations with a care type of *Other admitted care*, therefore totals in this table may not equal totals in other tables in this chapter.

(b) 1 *Drug and alcohol hospital* has been combined with 27 *Private psychiatric hospitals* for confidentiality reasons.

(c) *Other overnight hospitals* includes 6 *Very small hospitals*, 16 *Other acute specialised hospitals* and 2 *Women's and children's hospitals*.

Source: PHDB.

Major diagnostic categories

This section presents information on acute care in private overnight hospitals as described by the 23 Major Diagnostic Categories (MDCs). For more information on AR-DRGs and MDCs, see Chapter 1.

Table 5.14: Acute care separations, by major diagnostic category, private overnight hospitals, 2012–13

Major Diagnostic Category		Same-day separations	Overnight separations	Total separations
Pre-MDC	Pre-MDC(tracheostomies, transplants, ECMO)	180	3,075	3,255
1	Diseases and disorders of the nervous system	35,076	33,472	68,548
2	Diseases and disorders of the eye	87,039	10,322	97,361
3	Diseases and disorders of the ear, nose, mouth and throat	119,250	66,873	186,123
4	Diseases and disorders of the respiratory system	7,934	97,276	105,210
5	Diseases and disorders of the circulatory system	42,668	124,997	167,665
6	Diseases and disorders of the digestive system	287,352	115,042	402,394
7	Diseases and disorders of the hepatobiliary system and pancreas	4,626	30,392	35,018
8	Diseases and disorders of the musculoskeletal system and connective tissue	137,557	225,742	363,299
9	Diseases and disorders of the skin, subcutaneous tissue and breast	87,337	55,111	142,448
10	Endocrine, nutritional and metabolic diseases and disorders	12,556	30,267	42,823
11	Diseases and disorders of the kidney and urinary tract	153,394	47,189	200,583
12	Diseases and disorders of the male reproductive system	36,625	24,312	60,937
13	Diseases and disorders of the female reproductive system	84,275	42,645	126,920
14	Pregnancy, childbirth and puerperium	20,159	94,547	114,706
15	Newborns and other neonates	801	17,675	18,476
16	Diseases and disorders of the blood and blood-forming organs, and immunological disorders	27,100	10,177	37,277
17	Neoplastic disorders (haematological and solid neoplasms)	185,595	11,083	196,678
18	Infectious and parasitic diseases	855	11,478	12,333
19	Mental diseases and disorders	94,463	30,060	124,523
20	Alcohol/drug use and alcohol/drug induced organic mental disorders	24,335	7,568	31,903
21	Injuries, poisoning and toxic effects of drugs	6,796	16,598	23,394
22	Burns	102	176	278
23	Factors influencing health status and other contacts with health services	143,431	15,084	158,515
	Error DRGs ^(a)	1,198	2,366	3,564
	Total	1,600,704	1,123,527	2,724,231

(a) An *Error DRG* is assigned to hospital records that contain clinically atypical or invalid information.

Source: NHMD.

In 2012–13, *Disorders of the digestive system* (15%) accounted for highest number of total acute care separations in private overnight hospitals, followed by *Diseases and disorders of the musculoskeletal system and connective tissue* (13%) (Table 5.14).

Disorders of the digestive system (18%) also accounted for the highest proportion of acute care same-day separations in 2012–13, followed by *Neoplastic disorders (haematological and solid neoplasms)* (12%) and *Diseases and disorders of the kidney and urinary tract* (10%). For overnight separations, the most common MDC was *Diseases and disorders of the musculoskeletal system and connective tissue* (20%), followed by *Diseases and disorders of the circulatory system* (11%) and *Diseases and disorders of the digestive system* (10%).

Most common AR-DRGs

In 2012–13 the 20 most common same-day AR-DRGs for accounted for 71% of all same-day acute separations (Table 5.15). By contrast, the 20 most common overnight AR-DRGs only accounted for 35% of all overnight acute separations (Table 5.16). *Sleep apnoea* was the most common AR-DRG for overnight acute separations and *Chemotherapy* was the most common AR-DRG for same-day acute separations.

Table 5.15: Same-day acute care separations, by 20 most common AR-DRGs version 6.0x, private overnight hospitals, 2012–13

AR-DRG	Same-day separations
R63Z Chemotherapy	172,758
G48C Colonoscopy, same-day	109,310
L61Z Haemodialysis	99,002
U60Z Mental health treatment, same-day, without ECT	88,646
Z40Z Endoscopy with diagnoses of other contacts with health services, same-day	75,482
G46C Complex gastroscopy, same-day	74,080
D40Z Dental extractions and restorations	69,971
C16Z Lens procedures	64,040
G47C Other gastroscopy, same-day	62,018
Z64B Other factors Influencing health status, same-day	59,271
I18Z Other knee procedures	53,319
J11Z Other skin, subcutaneous tissue and breast procedures	35,894
N07Z Other uterine and adnexa procedures for non-malignancy	32,492
L41Z Cystourethroscopy, same-day	28,597
G11Z Anal and stomal procedures	22,125
I68C Non-surgical spinal disorders, same-day	20,706
F42C Circulatory disorders without AMI with invasive cardiac investigative procedures, same-day	19,587
I30Z Hand procedures	19,245
V62B Alcohol use disorder and dependence, same-day	18,365
N10Z Diagnostic curettage or diagnostic hysteroscopy	18,039

Note: ECT—electroconvulsive therapy.

Source: NHMD.

Table 5.16: Overnight acute care separations, by 20 most common AR-DRGs version 6.0x, private overnight hospitals, 2012–13

AR-DRG	Overnight separations
E63Z Sleep apnoea	48,174
O60B Vaginal delivery without CSCC	34,821
I16Z Other Shoulder procedures	32,521
O01C Caesarean delivery without CSCC	29,665
G10B Hernia procedures without CC	27,871
I04B Knee replacement without CSCC	23,431
F42B Circulatory disorders without AMI with invasive cardiac investigative procedures without CSCC	21,916
D11Z Tonsillectomy and/or adenoidectomy	20,358
I03B Hip replacement without catastrophic CC	18,220
H08B Laparoscopic cholecystectomy without closed CDE without CS CC	17,293
I10B Other back and neck procedures without CSCC	13,899
U63B Major affective disorders age<70/ without CSCC	13,810
N04B Hysterectomy for non-malignancy without CSCC	12,897
D10Z Nasal procedures	11,469
I20Z Other foot procedures	11,332
D06Z Sinus and complex middle ear procedures	10,883
M02B Transurethral prostatectomy without CSCC	10,753
I13B Humerus, tibia, fibula and ankle procedures without CC	10,310
I18Z Other knee procedures	10,159
K04B Major procedures for obesity without CC	9,656

Note: CC—complications and comorbidities; CSCC—catastrophic or severe complications or comorbidities.

Source: NHMD.

Procedures

This section presents information on the procedures reported for acute care patients in private overnight hospitals. See Chapter 1 for a description of the ACHI classification system that is used to classify procedures.

Different types of procedures are performed for acute care and sub-acute and non-acute care patients in overnight hospitals. They have been presented separately in the following section. For more information on care types, see Chapter 1.

Acute care

In 2012–13, 6.5 million procedures were reported for acute care separations in private overnight hospitals, of which half (59%) were reported for same-day separations (Table 5.17). *Non-invasive, cognitive and other interventions* was the most common procedure chapter, and was reported for 84% of acute care separations. This chapter includes procedure blocks for *Cerebral anaesthesia*, *Generalised allied health interventions*, *Administration of pharmacotherapy*, *Conduction anaesthesia* and *Administration of blood and blood products*. The next most frequently

reported procedures were *Procedures on digestive system* (20%) and *Procedures on musculoskeletal system* (12%).

Table 5.17: Acute care separations with procedure(s) reported^(a), by ACHI chapter, private overnight hospitals, 2012–13

Procedure	Same-day separations	Overnight separations	Total separations	
1–86	Procedures on nervous system	45,284	51,826	97,110
110–129	Procedures on endocrine system	166	8,832	8,998
160–256	Procedures on eye and adnexa	83,841	9,595	93,436
300–333	Procedures on ear and mastoid process	21,274	9,602	30,876
370–422	Procedures on nose, mouth and pharynx	26,289	54,918	81,207
450–490	Dental services	76,012	3,427	79,439
520–570	Procedures on respiratory system	7,972	29,824	37,796
600–777	Procedures on cardiovascular system	39,174	89,455	128,629
800–817	Procedures on blood and blood-forming organs	5,291	17,637	22,928
850–1011	Procedures on digestive system	386,316	153,025	539,341
1040–1129	Procedures on urinary system	174,904	52,801	227,705
1160–1203	Procedures on male genital organs	36,794	28,119	64,913
1240–1299	Gynaecological procedures	92,693	43,940	136,633
1330–1347	Obstetric procedures	1,592	80,160	81,752
1360–1579	Procedures on musculoskeletal system	122,140	198,587	320,727
1600–1718	Dermatological and plastic procedures	91,730	54,829	146,559
1740–1759	Procedures on breast	11,184	21,951	33,135
1786–1799	Radiation oncology procedures	492	2,453	2,945
1820–1922	Non-invasive, cognitive and other interventions, n.e.c.	1,349,328	927,508	2,276,836
1940–2016	Imaging services	15,838	19,106	34,944
	Separations with one or more procedures reported	1,542,707	984,654	2,527,361
	Separations with no procedure reported	57,997	138,873	196,870
Total acute care separations		1,600,704	1,123,527	2,724,231
Total procedures reported for acute care separations^(b)		3,259,907	3,246,620	6,506,527

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

(b) Total procedures reported is all procedures (not separations).

Source: NHMD.

Most common acute care procedures

In 2012–13, the most common procedure block reported for acute care in private overnight hospitals was *Cerebral anaesthesia* (general anaesthesia), which was reported for 1.6 million separations, 60% of which were for same-day separations, reflecting the fact that it is a companion procedure for many other procedures. *Conduction anaesthesia* (local and regional anaesthesia) was more commonly used in overnight separations than same-day (Table 5.18).

The second most common procedure, *Generalised allied health interventions*, was reported for about 580,000 separations, of which 93% were overnight.

Table 5.18: Acute care separations with a procedure reported^(a) for the 20 most common ACHI procedure blocks, private overnight hospitals, 2012–13

Procedure block	Same-day separations	Overnight separations	Total separations
1910 Cerebral anaesthesia	982,625	654,135	1,636,760
1916 Generalised allied health interventions	30,133	398,509	428,642
1920 Administration of pharmacotherapy	204,620	26,882	231,502
1909 Conduction anaesthesia	60,650	130,841	191,491
911 Fiberoptic colonoscopy with excision	150,910	12,704	163,614
1008 Panendoscopy with excision	142,473	14,207	156,680
905 Fiberoptic colonoscopy	129,718	12,896	142,614
1060 Haemodialysis	98,987	1,857	100,844
1893 Administration of blood and blood products	32,825	57,773	90,598
1620 Excision of lesion(s) of skin and subcutaneous tissue	62,957	17,095	80,052
458 Surgical removal of tooth	63,966	2,874	66,840
1873 Psychological/psychosocial therapies	52,326	13,533	65,859
197 Extracapsular crystalline lens extraction by phacoemulsification	61,262	4,530	65,792
1089 Examination procedures on bladder	44,082	17,350	61,432
668 Coronary angiography	20,163	39,465	59,628
1265 Curettage and evacuation of uterus	48,789	7,260	56,049
1828 Sleep study	97	50,884	50,981
607 Examination procedures on ventricle	16,031	28,621	44,652
1517 Arthroscopic meniscectomy of knee with repair	34,227	5,574	39,801
412 Tonsillectomy and adenoidectomy	9,939	29,071	39,010

(a) A separation is counted once for the block if it has 1 or more procedures reported within the block.

Source: NHMD.

The 20 most common ACHI procedure blocks for overnight acute care separations for 2012–13 are presented in Table 5.19. Again, the procedure blocks *Cerebral anaesthesia* and *Generalised allied health interventions* were reported for the highest proportions of separations (62% and 49%, respectively).

Table 5.19: Overnight acute care separations with a procedure reported^(a) for the 20 most common ACHI procedure blocks, private overnight hospitals, 2012–13

Procedure block	Separations
1910 Cerebral anaesthesia	696,715
1916 Generalised allied health interventions	545,925
1909 Conduction anaesthesia	133,092
1893 Administration of blood and blood products	71,764
1828 Sleep study	51,578
668 Coronary angiography	41,095
1340 Caesarean section	36,306
1920 Administration of pharmacotherapy	32,369
412 Tonsillectomy and adenoidectomy	29,101
607 Examination procedures on ventricle	28,683
1333 Analgesia and anaesthesia during labour and delivery procedure	28,602
1518 Arthroplasty of knee	28,151
986 Division of abdominal adhesions	27,709
1915 Other client support interventions	24,905
1334 Medical or surgical induction of labour	24,226
1344 Postpartum suture	23,781
1620 Excision of lesion(s) of skin and subcutaneous tissue	23,521
49 Other incision procedures on spinal canal or spinal cord structures	22,954
1566 Excision procedures on other musculoskeletal sites	21,494
965 Cholecystectomy	21,149

(a) A separation is counted once for the block if it has 1 or more procedures reported within the block.

Source: NHMD.

Sub-acute and non-acute care

This section presents information on sub-acute care and non-acute care separations describing care by the type of procedure undertaken.

About 96% of procedures reported for sub-acute care and non-acute care separations in 2012–13 belonged to the ACHI procedure chapter *Non-invasive, cognitive and other interventions, not elsewhere classified* (Table 5.20). This chapter includes anaesthesia, allied health interventions (which includes physiotherapy and other rehabilitation-related procedures), dialysis and chemotherapy.

Table 5.20: Selected sub-acute and non-acute separations with a procedure^(a) reported, by same-day and overnight separations and ACHI chapter, private overnight hospitals, 2012–13

Procedure chapter		Same-day separations	Overnight separations	Total separations
1–86	Procedures on nervous system	3	260	263
850–1011	Procedures on digestive system	12	255	267
1040–1129	Procedures on urinary system	8	225	233
1360–1579	Procedures on musculoskeletal system	8	375	383
1600–1718	Dermatological and plastic procedures	41	278	319
1820–1922	Non-invasive, cognitive and other interventions, n.e.c.	173,354	68,271	241,625
	Separations with 1 or more procedures reported	173,365	68,337	241,702
	Separations with no procedure reported	8,129	3,106	11,235
Total sub- and non-acute care separations		181,494	71,443	252,937
Total procedures reported for sub-acute and non-acute care^(b)		358,318	209,284	567,602

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

(b) Total procedures reported is all procedures (not separations).

Source: NHMD.

Most common sub-acute and non-acute care procedures

In 2012–13, the most common procedure block was *Generalised allied health interventions* (92% of all sub-acute separations). Four of the 20 most common ACHI procedures involved skills training, 3 involved assessment and 2 involved counselling (Table 5.21).

Table 5.21: Sub-acute care and non-acute care separations with a procedure reported^(a) for the 20 most common ACHI procedure blocks, private overnight hospitals, 2012–13

Procedure block	Same-day separations	Overnight separations	Total separations
1916 Generalised allied health interventions	166,431	66,657	233,088
1880 Therapies using agents, not elsewhere classified	67,381	7,119	74,500
1876 Skills training in movement	36,367	2,582	38,949
1867 Counselling or education relating to personal care and other activities of daily/independent living	8,182	261	8,443
1873 Psychological/psychosocial therapies	3,875	1,249	5,124
1869 Other counselling or education	2,456	2,086	4,542
1877 Skills training in body system functions	3,158	274	3,432
1822 Assessment of personal care and other activities of daily/independent living	1,771	1,265	3,036
1915 Other client support interventions	5	2,157	2,162
1823 Mental, behavioural or psychosocial assessment	50	2,018	2,068
1824 Other assessment, consultation, interview, examination or evaluation	6	1,418	1,424
1893 Administration of blood and blood products	33	1,371	1,404
1908 Other therapeutic interventions	1,321	43	1,364
1910 Cerebral anaesthesia	369	823	1,192
1920 Administration of pharmacotherapy	92	662	754
1907 Electroconvulsive therapy	336	397	733
1552 Administration of agent into other musculoskeletal sites	4	264	268
1874 Skills training for voice, speech, fluency and communication	243	0	243
1875 Skills training in relation to learning, knowledge and cognition	167	2	169
1870 Interventions involving assistive or adaptive device, aid or equipment	3	122	125

(a) A separation is counted once for the block if it has one or more procedures reported within the block.

Source: NHMD.

How long did people stay?

There were 2.6 million acute care separations and 6.5 million acute care patient days in private overnight hospitals in 2012–13. On average, acute care patients in private overnight hospitals stayed for 2.5 days. Patients in *Mixed sub-acute and non-acute hospitals* had the longest average lengths of stay (8.1 days) and patients admitted to hospitals in *Private acute Group D hospitals* had the shortest average length of stay, on average 2.0 days (Table 5.22).

In 2012–13, patients admitted for sub-acute care and non-acute care stayed an average 4.9 days in private overnight hospitals. This varied depending on the type of hospital, ranging from 1.5 days in *Private psychiatric hospitals*, to 12.2 days in *Mixed sub-acute and non-acute hospitals* (Table 5.23).

Table 5.22: Admitted acute care separations, patient days and average length of stay by peer group, private overnight hospitals, 2012–13

	Separations	Patient days	ALOS	ALOS (excluding same-day)
Private acute hospitals				
Group A	705,513	1,993,393	2.8	4.8
Group B	762,878	1,889,363	2.5	4.2
Group C	573,090	1,183,623	2.1	3.8
Group D	299,543	604,465	2.0	4.3
Specialist overnight hospitals				
Private psychiatric ^(a)	155,260	599,957	3.9	19.1
Sub-acute and non-acute hospitals				
Rehabilitation	4,675	20,277	4.3	5.1
Mixed sub-acute and non-acute	316	2,570	8.1	8.2
Other ^(b)	71,532	148,104	2.1	3.5
Total (PHDB data)^(c)	2,572,811	6,441,752	2.5	4.7
Total (NHMD data)	2,724,231	6,760,321	2.5	4.6

(a) 1 Drug and alcohol hospital has been combined with 27 Private psychiatric hospitals for confidentiality reasons.

(b) Other includes 6 Very small hospitals, 16 Other acute specialised hospitals and 2 Women's and children's hospitals.

(c) Includes 6 separations for which ALOS could not be calculated.

Source: PHDB, NHMD. All data in this table are sourced from the PHDB except where specifically noted.

Table 5.23: Average length of stay (ALOS) for sub-acute care and non-acute care separations, by peer group, private overnight hospitals, 2012–13

	Separations	Patient days	ALOS	ALOS (excluding same-day)
Private acute hospitals				
Group A	25,611	159,111	6.2	15.7
Group B	30,656	116,880	3.8	13.8
Group C	34,808	146,348	4.2	13.4
Group D	41,924	160,069	3.8	15.2
Specialist overnight hospitals				
Psychiatric ^(a)	20	30	1.5	11.0
Rehabilitation	126,619	561,030	4.4	15.9
Mixed sub-acute and non-acute	1,938	23,676	12.2	16.2
Other ^(b)	456	7,572	16.6	18.0
Total (PHDB data)	262,032	1,174,716	4.5	15.2
Total (NHMD data)	252,937	1,246,336	4.9	14.9

(a) 1 Drug and alcohol hospital has been combined with 27 Private psychiatric hospitals for confidentiality reasons.

(b) Other includes 6 Very small hospitals, 16 Other acute specialised hospitals and 2 Women's and children's hospitals.

Source: PHDB, NHMD. All data in this table are sourced from the PHDB except where specifically noted.

How was the care completed?

The *mode of separation* records the status of the patient at the time of separation and, for some categories, the place to which the person was discharged or transferred.

Overall, 2012–13 most patients in private overnight hospitals in 2012–13 were assigned *Other* as mode of separation (95%) (Table 5.24). *Other* can include discharge to usual residence, to the patient's own accommodation, or to a welfare institution (including prisons, hostels and group homes providing primarily welfare services).

Table 5.24: All separations, by mode of separation, private overnight hospitals, 2012–13

Mode of separation	Same-day separations	Overnight separations	Total separations
Discharge/transfer to an(other) acute hospital	6,032	46,190	52,222
Discharge/transfer to a residential aged care service ^(a)	216	7,291	7,507
Discharge/transfer to an(other) psychiatric hospital	14	183	197
Discharge/transfer to other health care accommodation	44,192	19,990	64,182
Statistical discharge/type change	378	21,554	21,932
Left against medical advice/discharge at own risk	546	1,557	2,103
Statistical discharge from leave	116	123	239
Died	433	13,102	13,535
Other ^(b)	1,730,253	1,084,951	2,815,204
Not reported	19	32	51
Total	1,782,199	1,194,973	2,977,172

(a) The separation mode *Discharge/transfer to residential aged care service* excludes where this was the usual place of residence.

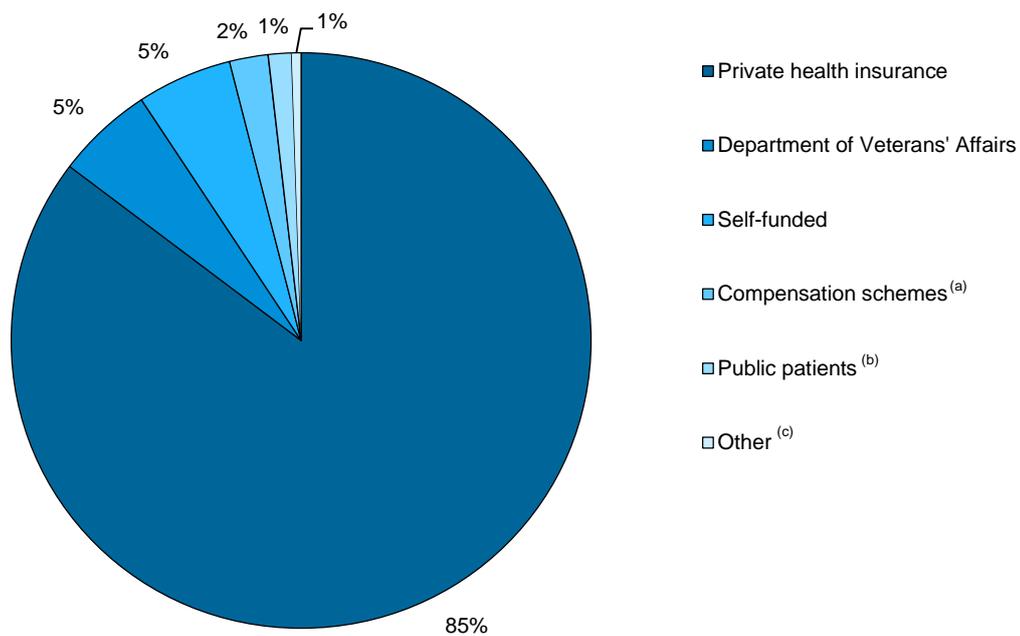
(b) The separation mode *Other* includes *Discharge to usual residence/own accommodation/welfare institution* (including prisons, hostels and group homes providing primarily welfare services).

Source: NHMD.

Who paid for the care?

The majority of care in private overnight hospitals was paid for by private health insurance (85%) in 2012–13 (Figure 5.9). Private health insurance was the top funder of both acute and sub-acute and non-acute care separations (86% and 82% respectively). DVA paid for a greater proportion of sub-acute and non-acute care (10%) than acute care (5%) (Table 5.25).

Tables E3 and E4 in Appendix E include supplementary data on funding sources for private separations in private overnight hospitals.



(a) *Compensation schemes* includes *Motor vehicle third party personal claims* and *Workers compensation*.

(b) *Public patients* includes separations for Medicare-eligible patients who were treated as public patients in a private hospital and separations with a funding source of *Reciprocal health care agreements* and *Other hospital or public authority* (with a public patient election status).

(c) *Other* includes separations with a funding source of *Other compensation*; *Department of Defence*; *Correctional facilities*; *Other hospital or public authority* (without a public patient election status); *Other*; *Health service budget—no charge raised due to hospital decision* (in private hospitals) and *Not reported*.

Source: NHMD.

Figure 5.9: Separations by source of funding, private overnight hospitals, 2012-13

Table 5.25: Separations by source of funding and care type, private overnight hospitals, 2012–13

	Same-day separations	Overnight separations	Total separations
Acute care			
Public patients ^(a)	29,895	4,611	34,506
Private health insurance	1,367,968	959,530	2,327,498
Self-funded	101,757	49,470	151,227
Workers compensation	23,685	27,655	51,340
Motor vehicle third party personal claim	2,090	2,532	4,622
Department of Veterans' Affairs	64,095	70,179	134,274
Other ^(b)	11,214	9,550	20,764
<i>Total acute care separations</i>	<i>1,600,704</i>	<i>1,123,527</i>	<i>2,724,231</i>
Sub- and non- acute care			
Public patients ^(a)	1,256	2,762	4,018
Private health insurance	153,308	53,539	206,847
Self-funded	3,524	2,292	5,816
Workers compensation	6,122	1,090	7,212
Motor vehicle third party personal claim	658	617	1,275
Department of Veterans' Affairs	15,725	10,758	26,483
Other ^(b)	901	385	1,286
<i>Total sub-acute and non-acute care separations</i>	<i>181,494</i>	<i>71,443</i>	<i>252,937</i>
Total separations^(c)	1,782,199	1,194,973	2,977,172

(a) *Public patients* includes separations for Medicare-eligible patients who were treated as public patients in a private hospital and separations with a funding source of *Reciprocal health care agreements* and *Other hospital or public authority* (with a public patient election status).

(b) *Other* includes separations with a funding source of *Other compensation; Department of Defence; Correctional facilities; Other hospital or public authority* (without a public patient election status); *Other; Health service budget—no charge raised due to hospital decision* (in private hospitals) and *Not reported*.

(c) Total separations includes those with a care type of *Other admitted patient care*.

Source: NHMD.

6 Areas for further work

The available national information about private hospitals includes a range of data on the activity of the private hospital sector, particularly in relation to admitted patients. There is also some information available on the overall characteristics of private hospitals, as presented in Chapter 2. Many private hospitals also submit additional data for voluntary reporting, such as rates of SAB infection and hand hygiene compliance rates. However, there are some gaps in the available data.

Data availability

Inconsistent and multiple data sources

Private hospital data are collected, analysed and disseminated through multiple collection arrangements including the AIHW's National Hospital Morbidity Database (NHMD), the ABS' Private Health Establishments Collection (PHEC) and the DoH's Private Hospital Data Bureau (PHDB) and Hospital Casemix Protocol (HCP). Details of the first 3 of these collections, which have been used as the main data sources for this report, are available in chapter 1.

The multiple arrangements for national private hospital data collation can result in inconsistencies among the collections and among the reports that are associated with them. Although there are some similarities and areas of consistency between the collections, there are also differences, in the scopes of the collection and in the data elements and definitions used, as outlined in Chapter 1.

The differing scopes of these collections (that is, all the hospitals that are intended to be included), and the differing coverage (that is, the hospitals that are actually included) can be problematic when attempts are made to use the different collections together, or to compare them. No information is available on the individual hospitals included in the PHEC, and there can be different mechanisms for defining and identifying hospitals from one collection to another.

As noted in chapter 1, the PHEC has coverage of all private health establishments in Australia. For 2012–13, the NHMD is estimated to include data from 91% of private hospitals and the PHDB is estimated to include data from 84% of private hospitals.

The PHEC includes data reported from 601 private health establishments and the PHDB includes data on 517 hospitals. In the NHMD 561 hospitals are designated as private hospitals (excluding those that mainly deliver public hospital services). The extent to which the differences in counts (between the PHEC and the other collections, in particular) represent different scopes and coverage, or different definitions and counting arrangements is not known. The differences between the NHMD and the PHDB probably mainly represent coverage differences, but they may not account for all the difference (Appendix A).

Data silos

The multiple collections of private hospital data have the additional effect of creating data silos, where different parts of the overall picture of private hospital sector are held separately across multiple agencies. For example, data on financial and establishment characteristics

(such as the number of beds and facilities available in a hospital) of private hospitals are collected through the PHEC. As these data are only available in summary through the *Private hospitals, Australia* publication, it can be difficult to link this information with activity data and so analyse relationships between financial and activity trends, whilst accommodating the commercial-in-confidence nature of the data.

That type of analysis would be important for the improved assessment of the relative performance of individual hospitals and across public and private hospital sectors. In a 2009 report of public and private hospitals, the Productivity Commission found inconsistencies and data gaps in existing information on hospital and medical costs. This made comparisons between the public and private sectors difficult, with the Productivity Commission noting that their estimates of hospital and medical costs should be considered experimental (Productivity Commission 2009).

In its report, the Productivity Commission also noted the barriers to linkage under the current arrangements. The Productivity Commission recommended that the privacy and confidentiality restrictions placed on the data should be reviewed to allow better data sharing across agencies (Productivity Commission 2009).

Gaps in national data collections

Hospital identification

Under NHMD data submission arrangements, private hospitals submit their admitted patient care data to the relevant state or territory health authority which then collates all public and private hospital data and submits it to the AIHW. For some jurisdictions, all private hospital data are submitted without individual hospital identifiers, making it impossible to identify individual private hospitals for that state or territory in the NHMD.

The lack of individual identifiers in the NHMD causes problems when reporting information about private hospitals, some of which are evident in this report. For example, the lack of identifiers makes it impossible to use the NHMD data for reporting peer group breakdowns for private hospitals. This has necessitated the use of the PHDB as an alternative data source despite its lower coverage. It also limits the capacity to link NHMD data with hospital-level data from other collections, such as the *MyHospitals* data.

It could be useful to investigate the barriers to having individual private hospital identifiers included in the NHMD with a view to establishing arrangements whereby the data could be included whilst maintaining the confidentiality of individual hospital data.

Non-admitted patient data

There is a paucity of data available nationally about the provision of non-admitted patient services by private hospitals, such as through emergency departments. Unlike for admitted patient activity, there is no nationally-agreed episode-level data collection for this activity.

Aggregate data (that is, total counts of selected types of non-admitted patient activity) are collected by the ABS through the PHEC. However, while these aggregate data are reported by the ABS in their annual *Private hospitals, Australia* publication, detailed data are not available, limiting their utility. Additionally, the way these data are counted (such as which types of interactions with a patient are included) is no longer consistent with that used for

public hospital non-admitted patient collections, making comparisons between the 2 sectors difficult.

There is little patient level data available on non-admitted patients in private hospitals. Data have been collected for the DoH's Hospital Casemix Protocol (HCP) since 2008–09, for activity covered by private health insurance. However, advice from the department is that for the most recent year (2012–13) data are not suitable for reporting.

The lack of non-admitted patient data also impacts the reporting of relevant performance indicators, such as the waiting time for emergency care in private hospital emergency departments; information which is available for most public hospital emergency departments.

Day hospital categorisation

Advice from the private hospital sector was that day hospitals could be usefully reported in 3 categories: stand-alone facility; stand-alone 23-hour facility (that is, a day hospital that is licenced to admit patients for up to 23 hours) and stand-alone facility attached to a medical practice. Data on this were sought by AIHW for this report but no data source that comprehensively identified 23-hour or medical practice-associated facilities was available. It is understood that the Australian Day Hospital Association is working with the ABS to capture these data through the PHEC.

Indigenous identification

The collection of the Indigenous status of patients by hospital providers is important for improving information on Aboriginal and Torres Strait Islander health. Under-identification of Indigenous status has serious implications for the provision of appropriate services for Aboriginal and Torres Strait Islander patients and makes accurate assessment of progress in 'closing the gap' difficult (AIHW 2013i).

As noted earlier in the report, the accuracy and completeness of Indigenous status identification in private hospitals data is unknown. The number of separations with no Indigenous status recorded has decreased over the last 10 years. However, the number of separations for which the patient's Indigenous status has been incorrectly recorded is unknown.

The 2013 study, *Indigenous identification in hospital separations data* (AIHW 2013g) recommended that a data quality study of Indigenous identification should be periodically conducted for public and private hospitals on a nationally coordinated basis, in order to assess data quality and generate comparable and up-to-date under-identification factors.

Performance indicators

Most hospital performance indicators used nationally in Australia are for public hospitals, and few performance indicators were considered acceptable or relevant for inclusion in this report for private hospitals.

Performance indicators are defined as statistics or other units of information that, directly or indirectly, reflect either the extent to which an anticipated outcome is achieved or the quality of the processes leading to that outcome (NHPC 2001).

The performance reporting context

Aspects of the performance of Australia's hospitals are regularly reported through a number of channels including the AIHW's annual *Australia Hospital Statistics* set of publications, the National Health Performance Authority's *MyHospitals* website, and the SCRGSP *Review of government service provision* report.

National performance reporting is accompanied by activities undertaken by health service providers to measure and monitor performance within their organisations to improve clinical outcomes and appropriateness of services. These activities are related to, but not considered to be, performance reporting, and in recent years have been supported by the Australian Commission on Safety and Quality in Health Care (ACSQHC). As part of its work to lead and coordinate improvements in safety and quality in health care across Australia, the Commission undertakes and facilitates the development of safety- and quality-related indicators for use in such local monitoring. For example, it has supported the development of core hospital based outcome indicators for overnight and day hospitals. Work at the Commission is also currently underway on developing indicators for hospital-associated mortality and healthcare associated infections. Work is also underway to implement a set of common questions across all state and territory patient experience surveys in public hospitals (ACSQHC 2014).

The performance indicator reporting in this report can be understood in the context of the National Health Performance Framework (NHPF). The NHPF was developed in 2001 by the National Health Performance Committee (NHPC) under the auspices of the Australian Health Ministers Advisory Committee. It is a structure to guide the understanding and evaluation of the health system, facilitating consideration of how well the health system or program is performing.

The NHPF has 3 domains: *Health Status, Determinants of Health* and *Health System Performance*. The *Health System Performance* domain is most directly relevant to the assessment of the provision of hospital services and includes a number of hospital-related performance indicators. Its 6 dimensions are: *Effectiveness, Safety, Responsiveness, Continuity of care, accessibility* and *Efficiency and sustainability* (AIHW 2014a).

Nationally agreed hospital performance indicators have also been developed in response to reporting requirements included in a number of national agreements, including the National Healthcare Agreement (NHA), hospitals-related National Partnership Agreements and the National Health Reform Agreement. The NHA specifies that private sector services will be included in reporting where relevant (COAG 2012).

The *Australian hospital statistics 2012–13* series of reports has reported on 6 hospital-related indicators from the NHPF and 9 hospital-related NHA performance indicators from the NHA. Table 6.1 lists these NHPF and NHA hospital-related indicators by their NHPF dimension.

Four performance indicators for private hospitals are included in this report, from 2 NHPF health system performance dimensions – *Safety* and *Efficiency and sustainability* (Table 6.1). There are no performance indicators available for public or private hospitals for 3 dimensions (*Effectiveness, Responsiveness* and *Continuity of care*). For the remaining dimension, *Accessibility*, there were no indicators available that were suitable for the private sector.

Table 6.1 National hospital performance indicators, by National Health Performance Framework dimension

Indicator	Related national indicator set		Reported in this publication
	NHA	NHPF	
Effectiveness			
No indicators available			
Safety			
Adverse events treated in hospitals		✓	✓
Unplanned/unexpected readmissions following selected surgical separations (same public hospital)	✓		
Healthcare associated infections	✓		✓
Falls resulting in patient harm in hospitals		✓	
Responsiveness			
No indicators available			
Continuity of care			
No indicators available			
Accessibility			
Rates of services: hospital procedures		✓	
Waiting time for emergency hospital care: proportion seen on time	✓		
Waiting time for emergency hospital care: proportion of emergency department presentations completed in 4 hours or less	✓		
Waiting times for elective surgery: waiting times in days (indicator procedure)	✓		
Admission to hospital from emergency department: proportion of emergency department presentations completed in 4 hours or less			
Admission to hospital from emergency department: length of emergency department stay at 90 th percentile			
Efficiency & sustainability			
Cost per casemix-adjusted separation for acute care episodes		✓	
Relative stay index		✓	✓
Average length of stay for selected AR-DRGS		✓	✓

Note: AR-DRG—Australian Refined Diagnosis Related Group; NHA—National Healthcare Agreement; NHPF—National Health Performance Framework.

Gaps for private hospitals

In some cases, private hospital performance is not reported due to the absence of nationally agreed performance indicators. For example, there is not an agreed approach for reporting waiting times for elective surgery in private hospitals.

There are also gaps in performance reporting for private hospitals due to the lack of available data for agreed indicators, including the following:

- Non-admitted patient-related indicators, such as the emergency department performance indicators on waiting times and time spent in the emergency department, could not be reported for private hospitals due to the absence of national data.
- The *Safety* indicator *Unplanned/unexpected readmissions following selected surgical separations* could not be calculated. The lack of private hospitals identifiers in the NHMD means that multiple separations for a single patient are unable to be linked in the dataset, making it impossible to identify which separations are readmissions following surgery. In addition, there are no routinely available mechanisms to identify readmissions to hospitals other than the hospital in which the surgery was performed.
- National data are not available for patient experience in private (and public) hospitals, although private hospital providers use a variety of feedback mechanisms (including online submission of feedback, Patient Liaison Officers and surveys of patient experience) and some private health insurance companies conduct surveys of the experience of their members, the results of which are shared with member hospitals and some information published online.

Concerns about the quality or completeness of the available data for agreed performance indicators have also led to gaps in private hospital performance reporting. For example, advice from the private hospital sector indicated concern about coded data from private hospitals being used for performance indicators, due to uncertainties about data collection methods, interpretations of the definitions and available resources to collect the data. After consultation, it was agreed that the indicator *Falls resulting in patient harm in hospitals* would not be included in this report because of these concerns. Data for private hospitals are reported for this indicator in *Australian hospital statistics*.

There were also gaps in performance reporting due to incomplete data. Two of the reported performance indicators – rates of hospital-related *Staphylococcus aureus* bacteraemia (SAB) and hand hygiene compliance – are based on data that are voluntarily supplied by private hospitals. This therefore presents a partial picture of the private sector as nothing is known of the rates of SAB infection or hand hygiene compliance in private hospitals that do not report to *MyHospitals* or Hand Hygiene Australia.

Last, a performance indicator may not be relevant when only applied to a single sector. *Rates of service: hospital procedures*, which is a measure of the accessibility of services, was reported for public and private hospitals in *Australian hospital statistics*. The indicator was not included in this report as this measure is not relevant when reported for a single sector.

Appendix A: Database quality statement summaries

This appendix includes data quality summaries and additional detailed information relevant to the data sources used in this report.

National Hospital Morbidity Database

The NHMD is a compilation of episode-level records from admitted patient morbidity data collection systems in Australian hospitals.

The data supplied are based on the National Minimum Data Set (NMDS) for admitted patient care and include demographic, administrative and length of stay data, as well as data on the diagnoses of the patients, the procedures they underwent in hospital and external causes of injury and poisoning.

The purpose of the NMDS for admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is separations for admitted patients in all public and private acute and psychiatric hospitals; free-standing day hospital facilities; and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not in scope but some are included.

The reference period for this data set is 2012–13. Records for 2012–13 are for hospital separations (discharges, transfers, deaths or changes in care type) in the period 1 July 2012 to 30 June 2013. Further information on the NHMD is available on METeOR at <http://meteor.aihw.gov.au/content/index.phtml/itemId/568730>.

Summary of key issues

- The NHMD is a comprehensive dataset that has records for all separations of admitted patients from essentially all public and most private hospitals in Australia.
- A record is included for each separation, but not for each patient, so patients who separated more than once in the year have more than 1 record in the NHMD.
- Private hospital records supplied by some states and territories are supplied under a single hospital establishment identifier. For these states and territories it is not possible to identify records for individual private hospitals.
- Hospitals may be re-categorised as public or private between or within years.
- There is apparent variation between states and territories in the use of statistical discharges and associated assignment of care types.
- There was variation between states and territories in the reporting of separations for *Newborns* (without qualified days).
- Data on state of separation should be interpreted with caution because of cross-border flows of patients. This is particularly the case for the Australian Capital Territory. In 2012–13, about 18% of separations for Australian Capital Territory hospitals were for patients who resided in New South Wales.

- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.
- Caution should be used in comparing diagnosis, procedure and external cause data over time, as the classifications and coding standards for those data can change over time. In particular, between 2009–10 and 2010–11, there were significant changes in the coding of diagnoses for diabetes and obstetrics and for imaging procedures. There were also significant changes made to coding practices for diabetes and related conditions for the 2012–13 year, resulting in increased counts for these conditions.

In 2012–13, an estimated 91% of private hospitals provided data to the NHMD (Table A1). The coverage of the NHMD and the PHDB did not match entirely, as approximately 13% of private hospitals provided data to the NHMD but not the PHDB and another 6% provided data to the PHDB but not the NHMD. Of all private hospitals in 2012–13, an estimated 3% did not provide data to either the NHMD or the PHDB. Complete information on the status of hospitals that did not provide data to either collection is not available and these estimates should be treated with caution.

Table A1: Proportion of hospitals^(a) providing data to the NHMD and the PHDB, 2012–13

	Provided data to the NHMD	Did not provide data to the NHMD	Total
Provided data to the PHDB	79%	6%	84%
Did not provide data to the PHDB	13%	3%	16%
Total	91%	9%	100%

(a) Proportions are estimates based on information provided by state and territory health authorities and the DoH.

Sources: NHMD, PHDB.

Quality of Indigenous status data

Previously, the AIHW has recommended that data on the Indigenous status of patients in private hospitals not be used for national reporting, as the quality of the data is unknown (AIHW 2013g). However, given the focus of this report on private hospitals and their patient characteristics, data on the Indigenous status of patients are reported here, while noting potential data quality issues.

Caution should be used in the interpretation of these data. The AIHW report, *Indigenous identification in hospital separations data: quality report* (AIHW 2013g) presented the latest findings on the quality of Indigenous identification in hospital separations data in Australia, based on studies conducted in public hospitals during 2011. The report found that nationally about 88% of Indigenous Australians were identified correctly in public hospital admissions data in the 2011–12 study period, and the true number of separations for Indigenous Australians was about 9% higher than reported.

The 2013 report noted that most of the under-identification of Indigenous Australian in public hospitals was due to patients' Indigenous status being incorrectly recorded rather than not reported. As in public hospitals, it is likely that separations for Indigenous Australians are under-reported in private hospital data.

Private hospitals data were not included in this study due to differences in 'governance, data collection and reporting arrangements'.

In 2012–13, there were about 136,500 separations in private hospitals where Indigenous status was not reported. The proportion of separations where Indigenous status was not reported was 4% in private hospitals, compared to 1% in public hospitals (AIHW 2014a).

Quality of the coded clinical data

The comparability of the coded diagnosis, procedure and external cause data can be affected by variations in the quality of the coding, the numbers of diagnoses and/or procedures reported and can also be influenced by state-specific coding standards.

The quality of coded diagnosis, procedure and external cause data can be assessed using coding audits in which, in general terms, selected records are independently recoded and the resulting codes compared with the codes originally assigned for the separation. There are no national standards for this auditing, so it is not possible to use information on coding audits to make quantitative assessments of data quality on a national basis.

Information on the quality and comparability of the coded data is available in Appendix A of *Australian hospital statistics 2012–13* (AIHW 2014a).

Condition onset flag data

The data element ‘Episode of admitted patient care – condition onset flag’ was mandated for national collection for the first time for the 2008–09 reporting period. Information on the data reported for Conditions onset flag for 2012–13 is included in Chapter 3.

Quality of the Condition onset flag data for 2012–13

In 2012–13, the coverage of COF data was 72% for private hospitals (Table A2). Data were missing for all private hospital records for New South Wales. Private hospital COF data were reported by the private hospital in the Northern Territory for the first time in 2012–13.

There was marked variation between states and territories in the overall proportion of records for which a condition was reported as arising during the episode of care. For private hospitals, the proportion ranged from 1.5% for Tasmania to 7.4% for Victoria. Differences in casemix between states and territories may account for some of this variation. However, this variation may indicate that there are differences in the allocation of COF values.

There was some variation among jurisdictions in the conditions reported as having onset during the episode of care.

The top 20 conditions reported as arising during the hospital stay provide support for the quality of the condition onset flag assignment (Table 3.17). The top 20 external causes of injury or poisoning reported as arising during the hospital stay also provide support for the quality of the condition onset flag assignment (Table 3.18).

Table A2: Proportion of separations with Condition onset flag reported^(a) (%), private hospitals, states and territories, 2012–13

State/territory	Proportion of separations (%)
New South Wales	0.0
Victoria	100.0
Queensland	100.0
Western Australia	100.0
South Australia	100.0
Tasmania	97.6
Australian Capital Territory	99.9
Northern Territory	100.0
Total	71.8

(a) The proportion of separations for which Condition onset flag was reported may include records where the flag was provided for some diagnoses and not for others.

Source: *Australian Hospital Statistics 2012–13* (AIHW 2014a).

Private hospital data bureau

Information for this section has been supplied by the DoH.

The PHDB is a compilation of episode-level records from admitted patient morbidity data collection systems in Australian hospitals declared as private by the DoH under the *Private Health Insurance Act 2007*.

The data supplied are based on specifications collated by the DoH and include demographic, administrative and length-of-stay data, as well as data on the diagnoses of the patients; the procedures they underwent in hospital; and charges applied by the hospital.

The reference period for this data set is 2012–13. The data set includes records for admitted patient separations between 1 July 2012 and 30 June 2013.

Summary of key issues

- The PHDB is a comprehensive dataset that has records for all separations of admitted patients from essentially all private hospitals in Australia.
- A record is included for each separation, not for each patient, so patients who were admitted more than once in the year have more than 1 record in the PHDB.
- PHDB data are supplied to the DoH on a monthly basis with each monthly file representing a private hospital's admitted patient separation records for that particular month. Whilst every endeavour is made to follow up hospitals that do not submit data for 1 or more months during a financial year, there exists a degree of non-compliance in PHDB. The 2012–13 estimate is approximately 1 month of non-supply per hospital, on average.
- The monthly files are validated using the DoH's CHECK-IT validation tool. Each record is checked against the edit rules outlined in the PHDB data specifications
<<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-casemix->

data-collections-about-HCP>. Files are rejected if more than 2% of records contain at least 1 error (that is, 'edit rule failure').

- As DoH accepts a 2% error threshold within each monthly submission of data, the final database used for reporting and analysis may include records with 1 or more errors.
- DoH creates a financial year reporting dataset approximately 6 months following the end of the financial year, by combining the individual monthly private hospital submissions. The majority of data quality checks are performed during the initial data load process via CHECK-IT however additional checks include an analysis of monthly reporting compliance (that is, whether hospitals submit data for each month of operation during a financial year), checks for faulty ICD-10-AM codes within the diagnosis code array, outlier charges, missing length of stay (a derived variable) and care type composition.
- The DoH also creates an 'inlier' dataset for PHDB Annual Report purposes. A truncation rule, suitable for use with asymmetrical distributions such as the PHDB charges, is applied at the AR-DRG level and values identified as outliers (high end only) are set to 'missing'.
- Private hospitals are identified in PHDB using an 8-character provider number. In a small number of cases, a provider number refers to more than 1 hospital.
- There was variation in the reporting of care type between PHDB and trends observed in the NHMD. Although overall the composition of records according to type of care is reasonably similar between NHMD and PHDB, PHDB does show a larger percentage of *Other admitted patient care* and within the *Rehabilitation care* care type, a different breakdown according to the 4 individual *Rehabilitation care* categories.
- There was variation in the reporting of services delivered to public patients. Hawkesbury hospital, for example, does not report public patient separations in the data supplied to PHDB although analysis of NHMD data for this hospital indicates public patients represent a majority of its total separations.
- There is an ongoing problem with the monthly files supplied to the department for 2 hospitals, resulting in an under-count of records in the database used for reporting. It is intended that this problem will be resolved when private hospitals commence submitting data to the DoH's Enterprise Data Warehouse during 2015.

In 2012–13, 84% of private hospitals provided data to the PHDB (Table A1). Of these, 6% provided data to the PHDB but not to the NHMD.

Private Health Establishments Collection

Information for this section has been supplied by the ABS.

The PHEC is an annual survey which collects information about the activities, staffing and finances of all private hospitals in Australia. The purpose of the collection is to provide statistics to support important decisions in policy development and planning in the delivery of health care.

The scope of the PHEC includes all private acute and psychiatric hospitals licensed by state and territory health authorities and all free-standing day hospital facilities approved by the

DoH, that operate for all or part of the reference year. This approach gives the best chance of ensuring 100% coverage.

Summary of data detail

- PHEC provides a measure of the contribution made by private acute hospitals and free-standing day hospitals to the total services provided by hospitals in Australia. It is important to clarify this contribution when making decisions about the overall capacity, quality and accessibility of the Australian health care system.
- Main data outputs are provided for:
 - facilities and specialised services, for Acute and Psychiatric hospitals whether they are for-profit or not-for-profit
 - available beds
 - type of centre for free-standing day hospitals
 - type of activities (patients separated and the number of patient days during the year)
 - procedures performed
 - morbidity data
 - staffing
 - finances.
- The data items and definitions are based on the National Health Data Dictionary produced by the AIHW and other classifications with the addition of data items requested by private hospital associations and health authorities.
- The locations of all private health establishments have been coded according to the ASGS. This coding is then used to present some elements of the data by selected geographic groupings. The selected groupings are state and territory, and further disaggregation called *Metro* and *Rural*.
- Data are first released 12 months after the end of the reference period, through the annual publication *Private hospitals, Australia* (4390.0).

Appendix B: Technical appendix

This appendix covers:

- private hospitals out of scope for the report
- definitions and classifications used
- the presentation of data in this report
- analysis methods.

Private hospitals out of scope for the report

Advice from state and territory health departments indicates that in 2012–13, 11 hospitals fitted the definition of private hospitals that predominantly provide public hospital services. Of these, 6 report their public contracted activity to the NHMD separately from their private hospital activity, and report only their private activity to the PHDB. For this report, only the private hospital activity is included, as ‘private hospitals’. The hospitals that submitted data under these arrangements are:

- Mater Adult Hospital, Queensland
- Mater Children’s Hospital, Queensland
- Mater Mother’s Hospital, Queensland
- Joondalup Health Campus, Western Australia
- Peel Health Campus, Western Australia
- McLaren Vale and Districts War Memorial Private Hospital, South Australia.

The remaining 5 private hospitals predominantly deliver public hospital services but their private activity and their public contracted activity is reported together, as relating to 1 hospital:

- Hawkesbury District Health Service, New South Wales
- Mildura Base Hospital, Victoria
- May Shaw District Nursing Centre, Tasmania
- Toosey Hospital, Tasmania
- Mersey Community Hospital, Tasmania.

In 2012–13 the proportion of separations that were for public patients in these hospitals ranged from 57% to 92%. These 5 hospitals have been excluded from all analyses using NHMD and PHDB data.

It is not known whether any or all of these hospitals are included in the ABS PHEC data.

Definitions and classifications

If not otherwise indicated, data elements were defined according to the definitions available on METeOR, the AIHW’s online metadata repository. In particular, data element definitions

for the Admitted Patient Care National Minimum Data Set (NMDS) 2012–13 are available at: <<http://meteor.aihw.gov.au/content/index.phtml/itemId/466132>>.

Data element definitions for analyses obtained from the ABS 2013 report: *Private hospitals, Australia, 2012–13* are available online at:

<<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4390.0Glossary12012-13>>.

Information on the following classifications is available in Chapter 1:

- Geographical classifications
 - Remoteness areas
- Socioeconomic status
- Classifications of clinical data
 - ICD-10-AM/ACHI
 - Diagnoses
 - Procedures
 - AR-DRG.

Estimated resident populations

All populations, except those used for analyses by Indigenous status, are based on the estimated resident population as at 30 June 2012 (at the beginning of the reporting period), based on the 2001 Census data.

For analyses by Indigenous status, the population projections based on the 2011 Census were not available at the time of the release of this report. Therefore, the ABS's Indigenous experimental estimates and projections for the projected Indigenous population (low series) as at 30 June 2012 (based on the 2001 Census data) were used.

Presentation of data

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

Suppression of data

The AIHW operates under a strict privacy regime which has its basis in Section 29 of the *Australian Institute of Health and Welfare Act 1987* (AIHW Act). Section 29 of the AIHW Act requires that confidentiality of data relating to persons (living and deceased) and organisations be maintained. The *Privacy Act 1988* governs confidentiality of information about living individuals.

The AIHW is committed to reporting that maximises the value of information released for users, while being statistically reliable and meeting legislative requirements described above.

Data (cells) in tables may be suppressed in order to maintain the privacy or confidentiality of a person or organisation, or because a proportion or other measure is related to a small number of events and may therefore not be reliable:

- Some data in this report have been suppressed to avoid attribute disclosure. The abbreviation 'n.p.' has been used in tables to denote these suppressions. For these tables, the totals include the suppressed information.
- The data for private hospitals in Tasmania, the Australian Capital Territory and the Northern Territory were not published separately for confidentiality reasons.
- In addition, data were suppressed for peer groups where there were:
 - fewer than 3 reporting units
 - 3 or more reporting units and 1 contributed more than 85% of the total separations, or
 - 3 or more reporting units and 2 contributed more than 90% of the total separations.

Admitted patient care data analyses

Standard admitted patient care data analyses

In this report, the counts of separations and patient days do not include separations for *Newborns* (without qualified days) or records for *Hospital boarders* or *Posthumous organ procurement*.

Standardised separation rate

Unless noted otherwise, population rates (separation rates) presented in this report are age-standardised, calculated using the direct standardisation method and 5-year age groups.

Separation rates by SA3, remoteness area and quintiles of socioeconomic disadvantage were directly age-standardised, using the estimated resident populations as at 30 June 2012. The estimated resident populations use a highest age group of 85 and over.

Separation rates by Indigenous status were directly age-standardised, using the projected Indigenous population (low series) as at 30 June 2012, based on the 2001 Census data. The population for other Australians was based on the estimated resident populations as at 30 June 2012. As the projected estimates use a highest age group of 65 and over, standardised rates calculated for analysis by Indigenous status are not directly comparable to the rates presented elsewhere.

Diagnoses tables

Most of the information about principal diagnoses in this report is presented using 2 methods of grouping records based on the ICD-10-AM disease classification:

- ICD-10-AM disease chapters – these 20 groups provide information aggregated at the ICD-10-AM chapter level
- 3-character ICD-10-AM groupings – 1,674 categories describe the diseases at a specific level. Detailed information is presented for the 20 groupings with the highest number of separations.

Procedures tables

For tables with counts of separations by groups (chapters or procedure blocks) of procedures, a separation 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 tables may not equal the sum of counts in the rows.

For data on the number of procedures (*Procedures reported* in tables 3.14, 4.12, 5.17, 5.20), all procedures are counted, even if more than 1 is reported for a separation.

The procedure information is presented using 2 methods of grouping procedures based on the ACHI procedure classification:

- ACHI procedure chapters – these 20 groups provide information aggregated at the ACHI chapter level
- ACHI procedure blocks – these 1,601 categories describe procedures at a specific level. Detailed information is presented for the 10 groups with the highest number of separations.

Broad category of service tables

Separations have been categorised as *Childbirth*, *Specialist mental health*, *Medical*, *Surgical* or *Other* based mainly on the AR-DRG recorded for the separation:

- *Childbirth*: separations for which the AR-DRG was associated with childbirth:
 - O01A *Caesarean delivery with catastrophic complication or comorbidity*
 - O01B *Caesarean delivery with severe complication or comorbidity*
 - O01C *Caesarean delivery without catastrophic or severe complication or comorbidity*
 - O02A *Vaginal delivery with operating room procedure with catastrophic or severe complication or comorbidity*
 - O02B *Vaginal delivery with operating room procedure without catastrophic or severe complication or comorbidity*
 - O60A *Vaginal delivery with catastrophic or severe complication or comorbidity*
 - O60B *Vaginal delivery without catastrophic or severe complication or comorbidity*
 - O60C *Vaginal delivery single uncomplicated without other condition*

This reporting does not include newborn care, but does include separations for childbirth for which specialised psychiatric care days were reported.

- *Specialist mental health*: separations for which at least 1 specialised psychiatric care day was reported. This reporting excludes separations for *Childbirth* that also reported specialised psychiatric care days.
- *Surgical*: separations for which the AR-DRG belonged to the *Surgical* partition (involving an operating room procedure), excluding separations for *Childbirth* and *Specialist mental health*.
- *Medical*: separations for which the AR-DRG belonged to the *Medical* partition (not involving an operating room procedure), excluding separations for *Childbirth* and *Specialist mental health*.

- *Other*: separations for which the AR-DRG did not belong to the *Surgical* or *Medical* partitions (involving a non-operating room procedure, such as endoscopy), excluding separations for *Childbirth* and *Specialist mental health*.

For this report, broad categories of service are presented for standard admitted patient care data analyses.

Data on geographical location

Data on geographical location in the NHMD is based on area of usual residence of patients. These data have been provided as state or territory and Statistical Area level 2 (SA2), a small area unit within the ABS's ASGS; and have been aggregated to remoteness areas.

Geographical location of hospital

The remoteness of private hospitals (by ABS Remoteness areas) was determined on the basis of its location. For this report, data were sourced from the 2012–13 PHDB data. Data on the remoteness area of hospitals are presented in Table 2.2. There were no private hospitals located in *Remote* or *Very Remote* areas in 2012–13.

Geographical location of usual residence of the patient

States and territories provided geographical data using SA2 codes, Statistical Local Areas and postcodes both for patients usually resident in the jurisdiction and for patients not usually resident in the jurisdiction.

The AIHW mapped the supplied area of residence data for each separation to remoteness area categories based on the ABS's ASGS Remoteness Structure 2011. This was undertaken on a probabilistic basis as necessary, using ABS concordance information describing the distribution of the population by remoteness areas and SA2s. Because of the probabilistic nature of this mapping, the remoteness area data for individual records may not be accurate; however, the overall distribution of records by geographical areas is considered useful.

Relative stay index analysis

Relative stay indexes (RSIs) have been identified as indicators of efficiency and are presented in Chapter 3. They are calculated as the number of 'observed patient days' for separations in selected AR-DRGs, divided by the number of 'expected patient days', standardised for casemix (based on national figures).

An RSI greater than 1.0 indicates that an average patient's length of stay is higher than expected given the casemix for the group of separations of interest. An RSI of less than 1.0 indicates that the length of stay was less than expected.

The standardisation for casemix (based on AR-DRG version 6.0x and the age of the patient for each separation) allows comparisons to be made that take into account variation in types of services provided; however, it does not take into account other influences on length of stay, such as Indigenous status or the remoteness area of the patient's residence or of the hospital.

Further information on relative stay index analysis is available in Appendix B of *Australian Hospital Statistics 2012–13* (AIHW 2014a).

Appendix C: Private hospital peer groups

This report presents data for the private hospital peer groups from the AIHW hospital peer group classification. The new AIHW peer grouping has been developed as a flexible and robust system for the categorisation of hospitals into peer groups:

- The peer groups are based on hospital characteristics according to available data and supplemented by stakeholder advice, and delineate groups of similar hospitals based on shared characteristics relating to the type and nature of services provided.
- The grouping is intended to be multi-purpose. The peer groups are not designed for any particular type of statistical analysis or performance reporting purpose.
- The grouping is intended to be stable over time. The individual groups have been defined by the type and nature of the services provided rather than by size-based characteristics, that can change over time in the absence of change in type of services.

Hospitals differ across a number of factors, including volume of activity, range of services delivered, type of care delivered and proportion of same-day separations. While AIHW hospital peer groups have been used to group public hospitals for reporting purposes since 1999, private hospital peer groups have only been included in the current classification.

Hospital peer groups used for this report

Technical information about the development of the peer groups will be available in the forthcoming AIHW publication *Australian hospital peer groups 2014*. The private hospital peer groups used in this report are outlined below.

Private acute hospitals

Private acute care hospitals are private hospitals that provide same day and overnight care; and largely acute medical and surgical care. The private acute hospitals have been divided into groups A, B, C and D as follows:

- *Private acute group A hospitals* are private acute hospitals that provide a 24 hour emergency service, an intensive care unit and other specialised services, such as coronary care, special care nursery, cardiac surgery and neurosurgery.
- *Private acute group B hospitals* are private acute hospitals that do not provide a 24 hour emergency service, but do provide an intensive care unit and other specialised services, such as coronary care, special care nursery, cardiac surgery and neurosurgery.
- *Private acute group C hospitals* are those private acute hospitals that do not provide emergency services or have an intensive care unit, but do provide specialised services in seven or more clinical specialities.
- *Private acute group D hospitals* are those private acute hospitals that do not provide emergency services or have an intensive care unit and do not provide specialised services in seven or more clinical specialities, but had 200 or more separations annually.

These private acute hospital groups are not equivalent to the public acute hospital groups A, B, C and D as reported in *Australian hospital peer groups 2014*.

Specialist overnight hospitals

Specialist overnight hospitals are hospitals that provide care on a same day and overnight basis to a specific target population or for a specific group of conditions. These hospitals exclude those that provide specialised care on a same day basis only. These hospitals include the following groups:

- *Women's and children's hospitals* specialise in the treatment and care of women and/or children. Given there are only 2 hospitals in this peer group, data for these hospitals has been reported in *Other overnight hospitals*.
- *Private psychiatric hospitals* are those that specialise in providing acute psychiatric care and/or treatment for people with a mental disorder or psychiatric disability and do not focus on children, adolescent, elderly or forensic populations. Some *Private psychiatric hospitals* also provide treatment of disorders relating to drug or alcohol use. The *Private psychiatric hospitals* are not comparable with the *Public acute psychiatric hospitals*.
- A *Drug and alcohol hospital* is a hospital that specialises in the treatment of disorders relating to drug or alcohol use. This group has only 1 private hospital and data for this hospital have been included in the *Private psychiatric hospitals* for confidentiality reasons.
- *Other acute specialised hospitals* are hospitals that specialise in a particular form of acute care, not grouped elsewhere. This group is too diverse to be a useful peer group for comparison and data for these hospitals has been reported in *Other overnight hospitals*.

Sub-acute and non-acute hospitals

Sub- and non-acute hospitals are hospitals that provide mostly sub- and non-acute care on a same day and overnight basis. They exclude those hospitals that provide care on a same day basis only. These hospitals include the following groups:

- *Private rehabilitation hospitals* are private hospitals that primarily provide rehabilitation and/or geriatric evaluation and management (GEM). The *Rehabilitation hospitals* in the private and public sectors are not comparable to each other.
- *Mixed sub-acute and non-acute hospitals* primarily provide a mixture of sub-acute (*Rehabilitation, Palliative care, Geriatric evaluation and management, Psychogeriatric care*) and non-acute (*Maintenance*) care.

Very small hospitals

Very small hospitals have few beds, a limited casemix and offer few admitted patient services. Most do not perform surgery. The *Very small hospitals* group is not considered suitable for comparison purposes due to the very low volumes of hospital activity. For this reason, data for private hospitals in this peer group have been included in *Other overnight hospitals*.

Day hospitals

Day hospitals are those hospitals where all or virtually all separations are same-day separations and, for private hospitals, where the hospital had a same-day licencing arrangement with the state or territory health department. There are 10 day hospital peer groups based on the provision of specific related procedures and 1 mixed procedure peer group as follows:

- A *Dialysis clinic* is a hospital that specialises in the provision of dialysis procedures on a same-day basis.
- An *Endoscopy centre* is a hospital that specialises in the provision of endoscopic procedures on a same-day basis.
- An *Eye surgery clinic* is a hospital that specialises in the provision of eye surgery on a same-day basis.
- A *Fertility clinic* is a hospital that specialises in the provision of fertility treatment (such as in vitro fertilisation) on a same-day basis.
- A *Haematology and oncology clinic* is a hospital that specialises in the provision of medical care on a same-day basis for patients affected by cancer and/or blood disorders.
- A *Hyperbaric treatment centre* is a hospital that specialises in the provision of hyperbaric oxygen therapy on a same-day basis. In this report, data for these hospitals have been included in *Other day hospitals* for confidentiality reasons.
- *Mixed day procedure hospitals* are day hospitals that rather than having a focus on any 1 specialty area, provide a variety of procedures on a same-day basis.
- An *Oral and maxillofacial procedure centre* is a hospital that specialises in the provision of procedures of oral and maxillofacial conditions on a same-day basis.
- A *Plastic and reconstructive surgery clinic* is a hospital that specialises in the provision of reconstructive and plastic surgery on a same-day basis.
- A *Reproductive health centre* is a hospital that specialises in the provision of abortion services on a same-day basis. In this report, data for these hospitals have been included in *Other day hospitals* for confidentiality reasons.
- A *Sleep centre* is a hospital that specialises in the diagnosis and management of sleep disorders, particularly sleep apnoea.

Unpeered hospitals

Unpeered hospitals are those day and overnight hospitals with unique characteristics that could not be assigned to one of the other peer groups. These hospitals do not form a peer group for comparison purposes due to the very diverse characteristics of the hospitals.

Appendix D: Private hospital licensing arrangements

This appendix outlines private hospital licencing arrangements of the states and territories, and arrangements through which the Australian Government declares hospitals to be private hospitals. This information is provided as a guide to the types of facilities included in data collections with scopes defined by these arrangements (see Chapter 1).

New South Wales

In New South Wales, private hospitals are licenced under the *Private Health Facilities Act 2007* and the *Private Health Facilities Regulation 2010*. The legislation defines a 'private health facility' as:

'...premises at which any person is admitted, provided with medical, surgical or other prescribed treatment and then discharged, or premises at which a person is provided with prescribed services or treatments, but it does not include:

- (a) an institution conducted by or on behalf of the State, or
- (b) a hospital or health service under the control of a public health organisation within the meaning of the *Health Services Act 1997*, or
- (c) a nursing home within the meaning of the *Public Health Act 2010*, or
- (d) premises of a class prescribed by the regulations for the purposes of this definition.'

Under the legislation, 18 classes of facilities are specified (including anaesthesia, cardiac surgery, chemotherapy, paediatric and rehabilitation) with associated standards which private hospitals are required to meet for each class. Hospitals can be licenced for more than 1 class. The legislation covers hospitals with patients who are:

- admitted for more than 24 hours
- not discharged on the same-day that they are admitted, but are not admitted for more than 24 hours
- admitted and discharged on the same-day.

Further information is available at www.health.nsw.gov.au/Hospitals/privatehealth/Pages/Licensing-of-Private-Health-Facilities.aspx.

Victoria

Private hospitals in Victoria are licenced under the *Health Services Act 1988* and the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013*. Under the legislation, a 'private hospital' means:

'...premises where persons are provided with health services of a prescribed kind or kinds and for which a charge is made and includes a privately-operated hospital but does not include—

- a public hospital or denominational hospital; or

a day procedure centre; or
a residential care service.'

A day procedure centre is defined as premises where:

- ' (a) a major activity carried on is the provision of health services of a prescribed kind or kinds and for which a charge is made; and
- (b) persons to whom treatment of that kind or those kinds is provided are reasonably expected to be discharged on the same date –

but does not include a public hospital, denominational hospital or private hospital.'

In Victoria, registration is required to provide certain types of health services:

- medical health services
- surgical health services
- speciality health services – including assisted reproductive treatment, mental health services, renal dialysis and intensive care.

Both overnight hospitals and day procedure centres are covered under the legislation. Further information is available at <www.health.vic.gov.au/privatehospitals/>.

Queensland

The regulation of private hospitals in Queensland occurs under the *Private Health Facilities Act 2009*. Under the legislation a private hospital includes all facilities at which health services are delivered to patients admitted and discharged not on the same-day, except where the hospital is:

- operated by the state, or
- a facility at which accommodation, and nursing or personal care, is given to persons who have a permanent need for the care (such as a nursing home or hostel).

A day hospital is a facility at which health services are provided to persons who are admitted to and discharged from the facility on the same-day, except where:

- a service has been provided to a person in an emergency, and
- it would be unreasonable, considering the circumstances of the person's health and wellbeing, to move the person to another health facility.

Day hospitals are considered private unless the facility is operated by the State. Further information is available at <<http://www.health.qld.gov.au/privatehealth/default.asp>>.

Western Australia

Licensing and monitoring of private hospitals in Western Australia is carried out under the authority of the *Hospitals and Health Services Act 1927* and the provisions of the *Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987* and the *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*. Western Australia licences private overnight hospitals separately to day hospitals. They fall into 4 classes:

- private day hospitals – class A (general anaesthesia)
- private day hospitals – class B (sedation)

- private day hospitals – class C (renal)
- private day hospitals – class D (psychiatric day hospitals)

Western Australia also issues a 23-hour licence to selected hospitals in class A, which allows these hospitals to admit patients for up to 23 hours where appropriate. Further information is available at

www.public.health.wa.gov.au/2/1350/2/licensing_of_private_healthcare_facilities.pm.

South Australia

South Australia licences private overnight hospitals under the *Health Care Act 2008* and *Health Care Regulations 2008*. Day hospitals are not required to hold a licence.

The Act defines the concept of a health service as:

- ‘(a) a service associated with:
 - (i) the promotion of health and well-being; or
 - (ii) the prevention of disease, illness or injury; or
 - (iii) intervention to address or manage disease, illness or injury; or
 - (iv) the management or treatment of disease, illness or injury; or
 - (v) rehabilitation or on-going care for persons who have suffered a disease, illness or injury; or
- (b) a paramedical or ambulance service; or
- (c) a residential aged care service; or
 - (c)(a) a research, pathology or diagnostic service associated with veterinary science; or
- (d) a service brought within the ambit of this definition by the regulations.’

The Act further defines a hospital to mean, according to the context:

- ‘(a) an entity (whether corporate or unincorporated and including a partnership or other structure) by which health services are provided, being health services that include services provided to persons on a live-in basis;
- (b) a site at which activities of an incorporated hospital are undertaken.’

However, a private hospital is then defined as ‘a hospital other than an incorporated hospital’. In effect, this means that day hospitals are not defined as a private hospital for the purposes of the South Australian legislation and so are not subject to the State’s private hospital licensing arrangements.

Copies of the *Health Care Act 2008* and *Health Care Regulations 2008* are available at www.legislation.sa.gov.au.

Tasmania

In Tasmania, private overnight and day hospitals are licenced under the *Health Service Establishments Act 2006* and the *Health Service Establishments Regulations 2011*. It defines private hospitals as

‘...premises at which any patient is provided with accommodation, medical, surgical or other treatment and with ancillary nursing care, for fee, gain or reward, but does not include:

- (a) an establishment conducted by or on behalf of the State; or
- (b) a day-procedure centre; or
- (c) a residential care service.’

Under the 2011 Act, health services are classified into 3 types:

- those requiring an admitted overnight hospital stay (type A)
- those usually requiring admitted treatments without an overnight stay (type B)
- those not usually requiring admitted treatment (type C).

Facilities that carry out type A services are licenced as private overnight hospitals and facilities that carry out only type B services are licenced as private day hospitals. Under the regulations, 12 classes of specialist service require specific authorisation, including cardiac surgery, intensive care and radiation therapy.

Copies of the *Health Service Establishments Act 2006* and the *Health Service Establishments Regulations 2011* can be accessed on the Australasian Legal Information Institute website at <www.austlii.edu.au>.

Northern Territory

Private hospitals in the Northern Territory are licenced under the *Private Hospitals Act 2011*. Under the Act, a private hospital:

- (1) ‘is premises that are fitted, furnished or staffed for the accommodation of persons for medical or surgical treatment for fee or reward.’
- (2) ‘includes premises for providing prescribed medical or surgical treatment for fee or reward.’

The definition explicitly excludes ‘hospitals conducted by the Territory’. It does not distinguish between overnight and day hospitals.

A copy of the *Private Hospitals Act 2011* can be accessed on the Australasian Legal Information Institute website at <www.austlii.edu.au>.

Australian Capital Territory

Licences in the Australian Capital Territory are issued under the ACT Health Care Facilities Code of Practice 2001, an enforceable Code of Practice under the *Public Health Act 1997*. The Code of Practice doesn’t specifically define private overnight or day hospitals; rather it defines health care facilities as

‘...premises where prescribed medical and dental procedures are carried out and/or premises in which overnight patient stays are provided prior to or after receiving medical treatment.’

Under the Code, prescribed medical and dental procedures are defined as those undertaken for medical or cosmetic reasons by a health care professional, and involves:

- the administration of a general, spinal, epidural or major regional block anaesthetic or intravenous sedative for the purpose of performing an elective procedure, but does not include mandibular blocks
- endoscopy
- dialysis, haemofiltration or haemoperfusion
- prolonged intravenous infusion of a single cytotoxic agent or sequential intravenous infusion of more than 1 cytotoxic agent
- cardiac catheterisation.

A copy of the ACT Health Care Facilities Code of Practice 2001 is available on the ACT Health website, <www.health.act.gov.au/publications/codes-of-practice/act-healthcare-facilities-code-of-practice-2001>.

Department of Health

In addition to state and territory licencing requirements, the DoH, under the *Private Health Insurance Act 2007*, must declare a public or private hospital in order for it to receive payment of health benefits from health insurers, following treatment of insured patients. There is no requirement for a hospital that does not wish to receive health benefits to be declared.

More information about the declaration of private hospitals by the Australian Government is available on the DoH website, <www.health.gov.au/>.

Appendix E: Supplementary tables

Appendix E contains more detailed information on funding source, principal diagnosis and procedures in private day and private overnight hospitals. Separations have been grouped by funding source to show:

- the 10 most common principal diagnoses in 3-character ICD-10-AM groupings
- the 10 most common ACHI procedure blocks.

Table E1: Separations for the 10 most common principal diagnoses in 3-character ICD-10-AM groupings, by funding source, private day hospitals, 2012-13

Principal diagnosis	Total separations
Public patients^(a)	
Z49 Care involving dialysis	74,153
Z51 Other medical care	1,059
H26 Other cataract	1,012
I25 Chronic ischaemic heart disease	447
I20 Angina pectoris	430
Z31 Procreative management (includes in-vitro fertilisation)	352
I21 Acute myocardial infarction	309
O04 Medical abortion	255
R07 Pain in throat and chest	206
H25 Senile cataract	179
Private health insurance	
Z51 Other medical care	61,530
Z49 Care involving dialysis	51,805
H26 Other cataract	48,410
Z31 Procreative management (includes in-vitro fertilisation)	33,464
H35 Other retinal disorders	31,142
C44 Other malignant neoplasms of skin	20,675
K21 Gastro-oesophageal reflux disease	15,051
Z12 Special screening examination for neoplasms	14,843
R10 Abdominal and pelvic pain	14,818
K01 Embedded and impacted teeth	14,777
Self-funded	
O04 Medical abortion	21,757
H26 Other cataract	10,714
Z31 Procreative management (includes in-vitro fertilisation)	7,133
R10 Abdominal and pelvic pain	5,515
K63 Other diseases of intestine	4,741
K29 Gastritis and duodenitis	4,494
K01 Embedded and impacted teeth	4,276
H35 Other retinal disorders	3,800
H25 Senile cataract	3,713
K21 Gastro-oesophageal reflux disease	3,707
Compensation schemes^(b)	
M54 Dorsalgia	1,027
M23 Internal derangement of knee	247

(continued)

Table E1 (continued): Separations for the 10 most common principal diagnoses in 3-character ICD-10-AM groupings, by funding source, private day hospitals, 2012-13

Principal diagnosis	Total separations
M46 Other inflammatory spondylopathies	238
G56 Mononeuropathies of upper limb	211
M79 Other soft tissue disorders, not elsewhere classified	155
Z47 Other orthopaedic follow-up care	107
L97 Ulcer of lower limb, not elsewhere classified	104
O04 Medical abortion	102
M75 Shoulder lesions	100
S61 Open wound of wrist and hand	95
Department of Veterans' Affairs	
H35 Other retinal disorders	5,236
Z49 Care involving dialysis	2,665
Z51 Other medical care	2,637
H26 Other cataract	2,256
C44 Other malignant neoplasms of skin	1,477
H25 Senile cataract	854
N18 Chronic kidney disease	496
H02 Other disorders of eyelid	457
L97 Ulcer of lower limb, not elsewhere classified	314
D12 Benign neoplasm of major salivary glands	312
Other^(c)	
Z51 Other medical care	721
Z49 Care involving dialysis	672
O04 Medical abortion	402
H26 Other cataract	344
K57 Diverticular disease of intestine	266
D12 Benign neoplasm of major salivary glands	242
K21 Gastro-oesophageal reflux disease	188
H52 Disorders of refraction and accommodation	179
F32 Depressive episode	146
I84 Haemorrhoids	139

(a) *Public patients* includes separations for Medicare-eligible patients who were treated as public patients in a private hospital and separations with a funding source of *Reciprocal health care agreements* and *Other hospital or public authority* (with a public patient election status).

(b) *Compensation schemes* includes *Motor vehicle third party personal claims* and *Workers compensation*.

(c) *Other* includes separations with a funding source of *Other compensation*, *Department of Defence*, *Correctional facilities*, *Other hospital or public authority* (without a public patient election status), *Other, No charge raised* (in private hospitals), and *Not reported*.

Source: NHMD.

Table E2: Separations for the 10 most common ACHI procedure blocks reported, by funding source, private day hospitals, 2012–13

Procedure block	Total separations
Public patients^(a)	
1060 Haemodialysis	72,988
1910 Cerebral anaesthesia	3,529
668 Coronary angiography	1,761
1063 Other interventions for renal dialysis	1,239
197 Extracapsular crystalline lens extraction by phacoemulsification	1,181
1920 Administration of pharmacotherapy	1,140
1909 Conduction anaesthesia	1,129
607 Examination procedure on ventricle	683
671 Transluminal coronary angioplasty with stenting	421
1297 Procedures for reproductive medicine	344
Private health insurance	
1910 Cerebral anaesthesia	328,743
911 Fiberoptic colonoscopy with excision	69,745
1920 Administration of pharmacotherapy	68,681
1008 Panendoscopy with excision	68,596
905 Fiberoptic colonoscopy	68,292
197 Extracapsular crystalline lens extraction by phacoemulsification	61,363
1060 Haemodialysis	56,521
1909 Conduction anaesthesia	42,059
1297 Procedures for reproductive medicine	33,158
209 Application, insertion or removal procedures on retina, choroid or posterior chamber	31,455
Self-funded	
1910 Cerebral anaesthesia	105,273
1265 Curettage and evacuation of uterus	23,125
1008 Panendoscopy with excision	19,169
911 Fiberoptic colonoscopy with excision	18,142
905 Fiberoptic colonoscopy	17,678
197 Extracapsular crystalline lens extraction by phacoemulsification	14,481
1909 Conduction anaesthesia	10,999
1005 Panendoscopy	9,568
1297 Procedures for reproductive medicine	7,134
1620 Excision of lesion(s) of skin and subcutaneous tissue	5,861
Compensation schemes^(b)	
1910 Cerebral anaesthesia	2,232
31 Application, insertion or removal procedures on vertebra or intervertebral disc	608
72 Percutaneous neurotomy of other peripheral nerve	454

(continued)

Table E2 (continued): Separations for the 10 most common ACHI procedure blocks reported, by funding source, private day hospitals, 2012–13

Procedure block		Total separations
63	Administration of anaesthetic agent around other peripheral nerve	431
1566	Excision procedures on other musculoskeletal sites	249
76	Relapse of carpal and tarsal tunnel	201
1909	Conduction anaesthesia	195
1517	Arthroscopic meniscectomy of knee with repair	195
33	Epidural infusion	169
1554	Other application, insertion or removal procedures on other musculoskeletal sites	144
Department of Veterans' Affairs		
1910	Cerebral anaesthesia	8,087
209	Application, insertion or removal procedures on retina, choroid or posterior chamber	4,979
1060	Haemodialysis	3,161
197	Extracapsular crystalline lens extraction by phacoemulsification	3,091
1920	Administration of pharmacotherapy	2,724
1909	Conduction anaesthesia	2,693
1620	Excision of lesion(s) of skin and subcutaneous tissue	2,027
1893	Administration of blood and blood products	1,186
911	Fibreoptic colonoscopy with excision	936
1008	Panendoscopy with excision	903
Other^(c)		
1910	Cerebral anaesthesia	3,224
911	Fibreoptic colonoscopy with excision	917
905	Fibreoptic colonoscopy	768
1060	Haemodialysis	653
1909	Conduction anaesthesia	638
1920	Administration of pharmacotherapy	575
1008	Panendoscopy with excision	569
197	Extracapsular crystalline lens extraction by phacoemulsification	445
1265	Curettage and evacuation of uterus	407
1005	Panendoscopy	322

(a) *Public patients* includes separations for Medicare-eligible patients who were treated as public patients in a private hospital and separations with a funding source of *Reciprocal health care agreements* and *Other hospital or public authority* (with a public patient election status).

(b) *Compensation schemes* includes *Motor vehicle third party personal claims* and *Workers compensation*.

(c) *Other* includes separations with a funding source of *Other compensation*, *Department of Defence*, *Correctional facilities*, *Other hospital or public authority* (without a public patient election status), *Other, No charge raised* (in private hospitals), and *Not reported*.

Source: NHMD.

Table E3: Separations for the 10 most common principal diagnoses in 3-character ICD-10-AM groupings, by funding source, overnight private hospitals, 2012–13

Principal diagnosis		Same-day separations	Overnight separations	Total separations
Public patients^(a)				
Z49	Care involving dialysis	16,490		16,490
Z51	Other medical care	2,900	6	2,906
H26	Other cataract	1,358	3	1,361
Z50	Care involving rehabilitation procedures	626	553	1,179
Z45	Adjustment and management of implanted device	1,138	3	1,141
N20	Calculus of kidney and ureter	489	48	537
C34	Malignant neoplasm of bronchus and lung	140	242	382
Z48	Other surgical follow-up care	7	374	381
Z75	Problems related to medical facilities and other health care	2	334	336
Z08	Follow-up examination after treatment for malignant neoplasms	318	6	324
Private health insurance				
Z50	Care involving rehabilitation procedures	148,792	49,051	197,843
Z51	Other medical care	159,911	244	160,155
Z49	Care involving dialysis	68,075	462	68,537
H26	Other cataract	45,532	3,588	49,120
G47	Sleep disorders	678	48,276	48,954
Z45	Adjustment and management of implanted device	39,555	2,889	42,444
K01	Embedded and impacted teeth	39,403	690	40,093
F32	Depressive episode	29,250	7,907	37,157
M23	Internal derangement of knee	28,789	7,731	36,520
M17	Gonarthrosis (arthrosis of knee)	8,361	27,767	36,128
Self-funded				
H26	Other cataract	8,703	171	8,874
K01	Embedded and impacted teeth	8,693	64	8,757
Z50	Care involving rehabilitation procedures	3,445	2,233	5,678
Z41	Procedures for purposes other than remedying health state	2,893	1,880	4,773
G47	Sleep disorders	85	3,929	4,014
M23	Internal derangement of knee	3,242	735	3,977
Z31	Procreative management (includes in-vitro fertilisation)	3,405	83	3,488
Z49	Care involving dialysis	3,213	11	3,224
Z51	Other medical care	3,146	13	3,159
K02	Dental caries	2,941	66	3,007
Compensation schemes^(b)				
Z50	Care involving rehabilitation procedures	6,774	1,661	8,435
M75	Shoulder lesions	353	5,351	5,704

(continued)

Table E3 (continued): Separations for the 10 most common principal diagnoses in 3-character ICD-10-AM groupings, by funding source, overnight private hospitals, 2012–13

Principal diagnosis		Same-day separations	Overnight separations	Total separations
M23	Internal derangement of knee	3,565	925	4,490
M54	Dorsalgia	2,519	982	3,501
F43	Reaction to severe stress, and adjustment disorders	1,836	351	2,187
K40	Inguinal hernia	332	1,844	2,176
M25	Other joint disorder, not elsewhere classified	826	1,321	2,147
G56	Mononeuropathies of upper limb	1,681	281	1,962
Z47	Other orthopaedic follow-up care	1,250	589	1,839
M17	Gonarthrosis (arthrosis of knee)	878	927	1,805
M51	Other intervertebral disc disorders	202	1,453	1,655
Department of Veterans' Affairs				
Z50	Care involving rehabilitation procedures	15,538	8,766	24,304
Z49	Care involving dialysis	11,165	26	11,191
F43	Reaction to severe stress, and adjustment disorders	7,147	743	7,890
Z51	Other medical care	6,590	26	6,616
C44	Other malignant neoplasms of skin	3,145	2,134	5,279
H26	Other cataract	2,992	715	3,707
I50	Heart failure	25	2,491	2,516
G47	Sleep disorders	10	2,354	2,364
M54	Dorsalgia	1,141	863	2,004
J44	Other chronic obstructive pulmonary disease	19	1,926	1,945
Other^(c)				
Z51	Other medical care	1,034	2	1,036
Z50	Care involving rehabilitation procedures	890	141	1,031
O80	Single spontaneous delivery	25	746	771
K01	Embedded and impacted teeth	636	11	647
M23	Internal derangement of knee	423	171	594
O82	Single delivery by caesarean section	4	515	519
G47	Sleep disorders	5	482	487
F43	Reaction to severe stress, and adjustment disorders	315	66	381
M54	Dorsalgia	268	94	362
M17	Gonarthrosis (arthrosis of knee)	137	205	342

(a) *Public patients* includes separations for Medicare-eligible patients who were treated as public patients in a private hospital and separations with a funding source of *Reciprocal health care agreements* and *Other hospital or public authority* (with a public patient election status).

(b) *Compensation schemes* includes *Motor vehicle third party personal claims* and *Workers compensation*.

(c) *Other* includes separations with a funding source of *Other compensation*, *Department of Defence*, *Correctional facilities*, *Other hospital or public authority* (without a public patient election status), *Other, No charge raised* (in private hospitals), and *Not reported*.

Source: NHMD

Table E4: Separations for the 10 most common ACHI procedure blocks reported, by funding source, private overnight hospitals, 2012–13

Procedure block	Same-day separations	Overnight separations	Total separations
Public patients^(a)			
1060 Haemodialysis	16,490	4	16,494
1910 Cerebral anaesthesia	6,528	1,973	8,501
1916 Generalised allied health interventions	602	3,062	3,664
1920 Administration of pharmacotherapy	3,332	61	3,393
197 Extracapsular crystalline lens extraction by phacoemulsification	1,471	8	1,479
1909 Conduction anaesthesia	975	399	1,374
1922 Other procedures related to pharmacotherapy	1,042	0	1,042
911 Fiberoptic colonoscopy with excision	980	45	1,025
1893 Administration of blood and blood products	460	371	831
1008 Panendoscopy with excision	780	31	811
Private health insurance			
1910 Cerebral anaesthesia	841,172	554,206	1,395,378
1916 Generalised allied health interventions	164,840	378,148	542,988
1920 Administration of pharmacotherapy	187,378	24,972	212,350
1909 Conduction anaesthesia	47,553	111,264	158,817
911 Fiberoptic colonoscopy with excision	136,488	10,684	147,172
1008 Panendoscopy with excision	127,649	12,168	139,817
905 Fiberoptic colonoscopy	119,245	10,925	130,170
1893 Administration of blood and blood products	29,105	50,038	79,143
1060 Haemodialysis	67,917	1,589	69,506
1880 Therapies using agents, not elsewhere classified	60,335	7,508	67,843
Self-funded			
1910 Cerebral anaesthesia	84,404	35,714	120,118
1916 Generalised allied health interventions	5,410	18,942	24,352
1909 Conduction anaesthesia	7,945	5,453	13,398
458 Surgical removal of tooth	11,146	243	11,389
1008 Panendoscopy with excision	10,096	336	10,432
911 Fiberoptic colonoscopy with excision	9,421	326	9,747
197 Extracapsular crystalline lens extraction by phacoemulsification	9,079	149	9,228
905 Fiberoptic colonoscopy	6,798	400	7,198
1920 Administration of pharmacotherapy	4,210	625	4,835
1265 Curettage and evacuation of uterus	3,932	307	4,239
Workers compensation^(b)			
1910 Cerebral anaesthesia	19,207	27,066	46,273

(continued)

Table E4 (continued): Separations for the 10 most common ACHI procedure blocks reported, by funding source, private overnight hospitals, 2012–13

Procedure block		Same-day separations	Overnight separations	Total separations
1916	Generalised allied health interventions	8,692	17,070	25,762
1909	Conduction anaesthesia	1,412	7,433	8,845
1566	Excision procedures on other musculoskeletal sites	1,231	3,010	4,241
1517	Arthroscopic meniscectomy of knee with repair	3,597	634	4,231
1880	Therapies using agents, not elsewhere classified	3,373	391	3,764
1405	Reconstruction procedures on shoulder	109	3,204	3,313
1873	Psychological/psychosocial therapies	2,779	530	3,309
1400	Other excision on shoulder	147	2,917	3,064
1554	Other application, insertion or removal procedures on other musculoskeletal sites	1,514	1,454	2,968
Department of Veterans' Affairs				
1916	Generalised allied health interventions	15,674	44,802	60,476
1910	Cerebral anaesthesia	24,994	30,333	55,327
1060	Haemodialysis	11,152	272	11,424
1920	Administration of pharmacotherapy	7,805	1,391	9,196
1893	Administration of blood and blood products	2,628	6,111	8,739
1909	Conduction anaesthesia	2,609	5,137	7,746
1620	Excision of lesion(s) of skin and subcutaneous tissue	4,257	2,998	7,255
911	Fibreoptic colonoscopy with excision	3,445	1,590	5,035
1008	Panendoscopy with excision	3,380	1,632	5,012
1876	Skills training in movement	4,068	498	4,566
Other^(c)				
1910	Cerebral anaesthesia	6,689	5,667	12,356
1916	Generalised allied health interventions	1,346	3,143	4,489
1920	Administration of pharmacotherapy	1,196	157	1,353
1909	Conduction anaesthesia	158	1,181	1,339
668	Coronary angiography	840	87	927
458	Surgical removal of tooth	711	29	740
1340	Caesarean section	4	543	547
1334	Medical or surgical induction of labour	7	510	517
911	Fibreoptic colonoscopy with excision	459	57	516
1828	Sleep study	3	493	496

(a) *Public patients* includes separations for Medicare-eligible patients who were treated as public patients in a private hospital and separations with a funding source of *Reciprocal health care agreements* and *Other hospital or public authority* (with a public patient election status).

(b) *Compensation schemes* includes *Motor vehicle third party personal claims* and *Workers compensation*.

(c) *Other* includes separations with a funding source of *Other compensation*, *Department of Defence*, *Correctional facilities*, *Other hospital or public authority* (without a Public patient election status), *Other, No charge raised* (in private hospitals), and *Not reported*.

Source: NHMD.

Glossary

Some definitions in the Glossary contain an identification number from METeOR. METeOR is Australia's central repository for health, community services and housing assistance metadata, or 'data about data'. METeOR can be viewed on the AIHW website at <www.aihw.gov.au>. Definitions of medical terms are based on those provided by the MedlinePlus Medical Dictionary (Merriam-Webster, Incorporated 2014) and Encyclopaedia (ADAM Inc. 2014).

Aboriginal or Torres Strait Islander: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.

acute: Coming on sharply and often brief, intense and severe.

acute care: Care in which the primary clinical purpose or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function
- perform diagnostic or therapeutic procedures. METeOR identifier: 270174.

additional diagnosis: A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment. METeOR identifier: 514271.

adenoidectomy: surgical removal of tissue found at the back of the nasal cavity, called adenoids.

admitted patient: 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). METeOR identifier: 268957.

adverse event: An incident in which harm resulted to a person receiving health care. They include infections, falls and other injuries, and reactions or complications due to surgery and other procedures, medical devices or medication, some of which may be preventable.

age standardisation: A set of techniques used to remove, as far as possible, the effects of differences in age when comparing two or more populations.

allied health professionals: Professionals working in audiology, dietetics and nutrition, hospital pharmacy, occupational therapy, orthoptics, orthotics and prosthetics, physiotherapy, podiatry, psychology, radiography, speech pathology and social work.

allied health services: Allied health services are provided by units and clinics for the treatment and counselling of patients. They mainly comprise physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy (ABS 2014b).

analgesic: Remedy that relieves or eliminates pain without loss of consciousness.

angiography: Production of a radiograph (for example, an X-ray) of the blood vessels after injection with a substance that is opaque to radiation. This provides a clearer view of the blood vessels in the radiograph.

anti-inflammatory: A substance that counteracts inflammation (a local response to cellular injury marked by dilation of fine blood vessels, increased number of white blood cells, redness, heat, pain, swelling and often loss of function).

antineoplastic agent: Agent that inhibits or prevents the growth and spread of neoplasms or malignant cells.

antipyretic: An agent which prevents, removes or relieves fever.

appendectomy: Surgical removal of the appendix.

arthrosis: A degenerative disease of a joint.

Australian Classification of Health Interventions (ACHI): ACHI was developed by the National Centre for Classification in Health. The 7th edition was used for the 2012–13 procedures data for admitted patients in Australian hospitals. See Chapter 1 for further information.

Australian Refined Diagnosis Related Groups (AR-DRGs): An Australian system of diagnosis related groups (DRGs). DRGs provide a clinically meaningful way of relating the number and type of patients treated in a hospital (that is, its casemix) to the resources required by the hospital. Each AR-DRG represents a class of patients with similar clinical conditions requiring similar hospital services. See Chapter 1 for further information.

available beds: Available beds are those immediately available (occupied and unoccupied) for the care of admitted patients as required. In the case of private Day hospital facilities, they include chairs, trolleys, recliners and cots and are used mainly for post-surgery recovery purposes only (ABS 2014b).

average length of stay (ALOS): The average number of patient days for admitted patient episodes. Patients admitted and separated on the same date are allocated a length of stay of 1 day.

benchmark: A standard or point of reference for measuring quality or performance.

care type: The care type defines the overall nature of a clinical service provided to an admitted patient during a separation (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care). METeOR identifier: 270174.

Admitted patient care consists of the following categories:

- acute care
- rehabilitation care
- palliative care
- geriatric evaluation and management
- psychogeriatric care
- maintenance care

- newborn care
- other admitted patient care.

Care other than admitted care include:

- posthumous organ procurement
- hospital boarder.

casemix: The range and types of patients (the mix of cases) treated by a hospital or other health service. Casemix classifications (such as AR-DRGs) provide a way of describing and comparing hospitals and other services for management purposes.

cataract: When the lens of the eye or its surrounding transparent membrane becomes cloudy, obstructing the passage of light. This can cause vision to become blurry.

cerebral anaesthesia: Includes general anaesthesia and sedation (according to ICD-10-AM). General anaesthesia is the loss of sensation across the entire body and loss of consciousness. Sedation induces a relaxed easy state, usually by use of sedatives.

cerebral infarction: Disruption of blood supply to the cerebrum (brain) resulting in dead or dying tissue. This is caused by obstruction due to embolism (blockage by abnormal, undissolved particle) or thrombosis (blood clot). A cerebral infarction is a type of stroke.

chemotherapy: The use of drugs (chemicals) to prevent or treat disease, with the term usually being applied to treatment for cancer rather than for other uses.

chronic: Persistent and long-lasting.

chronic obstructive pulmonary disease: A common lung disease which makes it difficult for a person to breathe. There are 2 main forms of COPD, chronic bronchitis, which involves a long-term cough with mucus, and emphysema, which involves destruction of the lungs over time (ADAM Inc. 2014).

congenital: Describes a condition existing at or dating from birth.

connective tissue: Tissue, usually of mesodermal origin, which supports, wraps around and binds together other tissues throughout the body in various forms, for example, as adipose tissue, tendons, ligaments, aponeuroses, cartilage and bone.

colonoscopy: Viewing of the large bowel (colon) using a long flexible tube (colonoscope) inserted through the anus.

comorbidity: When a person has 2 or more health problems at the same time.

complication: A secondary problem that arises from a disease, injury or treatment (such as surgery) that makes the patient's condition worse and treatment more complicated.

condition onset flag (COF): A means of differentiating those conditions which arise during, or arose before, an admitted patient hospitalisation. Having this information can provide an insight into the kinds of conditions patients already have when entering hospital and what arises during the hospitalisation. A better understanding of those conditions arising during the hospitalisation may inform prevention strategies, particularly in relation to complications of medical care. METeOR identifier: 496512.

conduction anaesthesia: Regional or local (limited to a specific area) loss of sensation.

consumer price index (CPI): A measure of changes, over time, in retail prices of a constant basket of goods and services representative of consumption expenditure by resident households in Australian metropolitan areas. It is used by the Reserve Bank of Australia as the official measure of inflation for evaluating monetary policy (ABS 2014a).

Department of Veterans' Affairs patient: A person whose charges for the hospital admission are met by the DVA. These patients include eligible veterans and war widows/widowers. The data are supplied by the states and territories and the eligibility to receive hospital treatment as a DVA patient may not necessarily have been confirmed by the DVA. METeOR identifier: 270092.

depressive episode: A period of low mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common (NCCH 2010).

dermatological: Relating to the branch of medicine concerned with the skin and its diseases.

diagnosis related group (DRG): A widely used casemix classification system used to classify admissions into groups with similar clinical conditions (related diagnoses) and similar resource usage. This allows the activity and performance of hospitals to be compared on a common basis. In Australian acute hospitals, AR-DRGs are used. METeOR identifier: 391295.

dialysis/haemodialysis: A process used to treat kidney failure. A machine is connected to the patient's bloodstream and then filters the blood externally to the body, removing water, excess substances and waste from the blood as well as regulating the levels of circulating chemicals. In doing this the machine takes on the role normally played by the kidneys.

elective surgery: Elective care in which the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians. METeOR identifier: 470208.

elective admissions involving surgery: Separation for which the urgency of admission was reported as elective (admission could be delayed by at least 24 hours) and where the assigned AR-DRG was surgical (excluding childbirth-related AR-DRGs).

endocrine: Refers to a system of glands that produce secretions, help to integrate and control metabolic activity, and include especially the pituitary, thyroid, parathyroid, adrenals, islets of Langerhans, ovaries and testes.

endoscopy: The viewing of internal parts of the body, such as the inside of the lower bowel (the colon) with a colonoscope.

enrolled nurses: Enrolled nurses are division 2 nurses who are registered with the Australian Health Practitioner Regulation Agency–Nursing and Midwifery Board of Australia. Includes general enrolled nurses and specialist enrolled nurses. METeOR identifier: 270497.

episode of care: The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type (see **care type** and **separation**). METeOR identifier: 268956.

error DRGs: AR-DRGs to which separations are grouped if their records contain clinically inconsistent or invalid information.

excision: Surgical removal or resection (as of a diseased part).

external cause: The environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect. METeOR identifier: 514295.

for profit/not for profit sector: 'Not for profit' hospitals are those which qualify as a non-profit organisation with either the Australian Taxation Office or the Australian Securities and Investments Commission. These are further categorised as Religious or charitable and Other (comprising bush nursing, community and memorial hospitals). All other hospitals are classed as For profit (ABS 2013b).

full-time equivalent (FTE) workforce or workload: A standard measure of the size of a workforce that takes into account both the number of workers and the hours that each works. For example, if a workforce comprises 2 people working full time 35 hours a week and 2 working half time, this is the same as 3 working full time – an FTE of 3.

funding source for hospital patient: The source of funds for an admitted patient episode or non-admitted patient service event. METeOR identifier: 472033.

gastroscopy: Viewing of the interior of the stomach using an endoscope.

geriatric evaluation and management: A type of sub-acute care which aims to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. METeOR identifier: 270174.

haemorrhage: Severe bleeding.

haemorrhoid: A mass of dilated veins in swollen tissue at the margin of the anus or nearby within the rectum, usually used in plural. Also called piles.

hepatobiliary system: A body system that includes the liver and bile, bile ducts and gallbladder.

hernia: A protrusion of an organ through connective tissue or through a wall of the cavity in which it is normally enclosed. Also called a rupture.

hospital: A health-care facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients. METeOR identifier: 268971.

hospitalisation: see **separation**.

hospital boarder: A person who is receiving food and/or accommodation at the hospital but for whom the hospital does not accept responsibility for treatment and/or care. METeOR identifier: 491557.

hyperbaric oxygen therapy: Treatment involving a special chamber to increase the amount of oxygen in the blood. This therapy speeds up the recovery of wounds, particularly those which are infected (ADAM Inc. 2014).

in vitro fertilisation: Fertilisation of an egg in a laboratory dish or test tube, so 1 or more of the fertilised eggs can be introduced into a female's uterus.

Index of Relative Socio-economic Disadvantage: One of the set of Socio-Economic Indexes for Areas for ranking the average socioeconomic conditions of the population in an area. It summarises attributes of the population such as low income, low educational attainment,

high unemployment and jobs in relatively unskilled occupations (ABS 2011a). For more information see Chapter 1.

Indigenous: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.

Indigenous status: A measure of whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin.

intensive care unit (ICU): A designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems. METeOR identifier: 327234.

International Classification of Diseases (ICD): The World Health Organization's internationally accepted classification of disease. The 10th revision (ICD-10) is currently in use. ICD-10-AM is the Australian modification of ICD-10, used for diagnoses recorded for patients admitted to hospitals. For more information see Chapter 1.

inter-hospital contracted care: Care for an admitted patient whose treatment and/or care is provided under an arrangement (either written or verbal) between a hospital purchaser of hospital care (contracting hospital) and a provider of an admitted service (contracted hospital) and for which the activity is recorded by both hospitals. METeOR identifier: 472024.

length of stay: The length of stay of an overnight patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting days the patient was on leave. A same-day patient is allocated a length of stay of 1 day. METeOR identifier: 269982.

maintenance care: Care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of maintenance care often require care over an indefinite period. Also called non-acute care. METeOR identifier: 270174.

Major Diagnostic Categories (MDCs): The category into which the patient's diagnosis and the associated AR-DRG falls. They correspond generally to the major organ systems of the body. METeOR identifier: 391298.

maxillofacial: Relating to the maxilla (jaw) and face.

medicament: A substance used for medical treatment.

metabolic disease: A disease or disorder that disrupts normal metabolic pathways. Includes diabetes.

mode of admission: The mechanism by which a person begins an episode of admitted patient care. METeOR identifier: 269976.

mode of separation: Status at separation of a person (discharge/transfer/death) and place to which a person is released (where applicable). METeOR identifier: 270094.

musculoskeletal: Refers to muscles and the skeleton.

neonate: A newborn infant, especially an infant less than 4 weeks old.

neoplasm: An abnormal ('neo', new) growth of tissue. Can be 'benign' (not a cancer) or 'malignant' (a cancer). Same as a tumour.

neoplastic: Relating to a neoplasm.

newborn care: Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission.

non-acute care: See **maintenance care**.

non-admitted patient: A patient who receives care from a recognised non-admitted patient service/ clinic of a hospital, including emergency departments and outpatient clinics.

obstetrics: A branch of medicine relating to childbirth, as well as any aspects of health preceding or subsequent to childbirth.

occasion of service: Any services provided to a non-admitted patient in a functional unit (for example, radiology) of the hospital. Each diagnostic test or simultaneous set of related diagnostic tests is counted as one occasion of service (ABS 2014a).

occupational therapy: Therapy based on engagement in meaningful activities of daily life (as self-care skills, education, work, or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.

oncology: Branch of medicine concerned with tumours.

other Australians: People who have stated that they are not of Aboriginal or Torres Strait Islander descent, and those for whom Indigenous status is unknown. Compare with non-Indigenous.

other admitted patient care: See care type.

outpatient: See **non-admitted patient**. METeOR identifier: 268973.

overnight-stay patient: A patient who, following a clinical decision, receives hospital treatment for a minimum of 1 night (that is, who is admitted to and separated from the hospital on different dates).

palliative care: A type of sub-acute care, in which the clinical intent or treatment goal is quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. METeOR identifier: 270174.

panendoscopy: The viewing of the upper gastro-intestinal tract (the pharynx, larynx, upper trachea, and oesophagus) with rigid and flexible endoscopes.

parasitic: Relating to the effects of parasites, that is, organisms which live in, with, or on another organism, usually to the detriment of the host.

patient days: The number of full or partial days of stay for patients who were admitted for an episode of patient care and who underwent separation during the reporting period. A patient who is admitted and separated on the same-day is allocated 1 patient day.

patient election status: Accommodation chargeable status elected by patient on admission. METeOR identifier: 326619. The categories are:

- public patient
- private patient.

patient revenue: Revenue received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges. METeOR identifier: 364797.

peer group: Groupings of hospitals into broadly similar groups in terms of characteristics.

performance indicators (of the health system): Statistics or other units of information that, directly or indirectly, reflect either the extent to which an anticipated outcome is achieved or the quality of the processes leading to that outcome (NHPC 2001).

pharmacotherapy: The treatment of disease with drugs.

plastic procedure: Procedure concerning the repair, restoration or improvement of lost, injured, defective or misshapen parts of the body primarily by transfer of tissue.

posthumous organ procurement: The procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

postpartum: Occurring in or following childbirth.

potentially preventable hospitalisation (selected): Hospital separations from a specified range of conditions where hospitalisation is considered to be largely preventable if timely and adequate care were provided through population health services, primary care and outpatient services. The PPH conditions are classified as vaccine-preventable, chronic and acute. The rate of PPHs is currently being used as an indicator of the effectiveness of a large part of the health system, other than hospital admitted patient care.

Pre-MDC (Pre-Major Diagnostic Category): AR-DRGs to which separations are grouped, regardless of their principal diagnoses, if they involve procedures that are particularly resource-intensive (transplants, tracheostomies or extra-corporeal membrane oxygenation without cardiac surgery).

principal diagnosis: The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment. METeOR identifier: 514273.

private hospital: A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Acute care and psychiatric hospitals (referred to in this report as 'overnight hospitals') are included, as are private free-standing day hospital facilities (referred to in this report as 'day hospitals').

private patient: Person admitted to a private hospital, or person admitted to a public hospital who decides to choose the doctor(s) who will treat them or to have private ward accommodation. This means they will be charged for medical services, food and accommodation.

procedure: A clinical intervention that is surgical in nature, carries a procedural risk, carries an anaesthetic risk, requires specialised training and/or requires special facilities or equipment available only in an acute care setting. METeOR identifier: 514040.

prosthetic: Relating to a prosthesis.

prosthesis: An artificial device to replace or enlarge a missing or impaired part of the body.

psychogeriatric care: A type of sub-acute care, in which the goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. METeOR identifier: 270174.

public hospital: A hospital controlled by a state or territory health authority. In Australia public hospitals offer free diagnostic services, treatment, care and accommodation to all Australians who need them.

public patient: A patient admitted to a public hospital who has agreed to be treated by doctors of the hospital's choice and to accept shared ward accommodation. This means that the patient is not charged.

puerperium: The period between childbirth and the return of the uterus to its normal size.

qualified days: The number of qualified days within newborn separations. Days within newborn separations are either qualified or unqualified. This definition includes all babies who are 9 days old or less. METeOR identifier: 268957 (Admitted patient). METeOR identifier: 270033 (Newborn qualification status). A newborn day is acute (qualified) when a newborn meets at least 1 of the following criteria:

- 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 Health Minister for the purpose of the provision of special care
- remains in hospital without its mother
- is admitted to the hospital without its mother.

reciprocal health care agreement: Patients who are overseas visitors from countries covered by Reciprocal Health Care Agreements. Australia has Reciprocal Health Care Agreements with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, Belgium, Slovenia, New Zealand and Ireland. The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital. METeOR identifier: 553314.

registered nurses: Registered nurses must be registered as division 1 nurses with the Australian Health Practitioner Regulation Agency–Nursing and Midwifery Board of Australia. METeOR identifier: 270500.

This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse and nurse educator. It may also include registered midwives (including pupil midwife). This category also includes nurses engaged in administrative

duties no matter what the extent of their engagement, for example, directors of nursing and assistant directors of nursing.

rehabilitation care: A type of sub-acute care, in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. METeOR identifier: 270174.

renal dialysis: See dialysis/haemodialysis

relative stay index (RSI): The actual number of patient days for acute care separations in selected AR-DRGs divided by the expected number of patient days adjusted for casemix. An RSI greater than 1 indicates that an average patient's length of stay is higher than would be expected given the jurisdiction's casemix distribution. An RSI of less than 1 indicates that the number of patient days used was less than would have been expected.

remoteness area: A classification of the remoteness of a location using the Australian Statistical Geography Standard Remoteness Structure (2011), based on the Accessibility /Remoteness Index of Australia (ARIA) which measures the remoteness of a point based on the physical road distance to the nearest urban centre. The categories are:

- Major cities
- Inner regional
- Outer regional
- Remote
- Very remote
- Migratory.

salary expenditure: Includes salaries and wages, payments to staff on paid leave, workers compensation leave and salaries paid to contract staff where the contract was for the supply of labour and where full-time equivalent staffing data were available.

same-day patient: An admitted patient who is admitted and separated on the same date. METeOR identifier: 327270.

self-funded: Separations in which the individual paid for the service themselves. METeOR identifier: 553314.

separation: An episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer to another facility, or death), or to a portion of a hospital stay beginning or ending in a change of type of care (such as from acute to rehabilitation). Other synonymous terms used in this report are hospitalisation and episode of care.

Separation also means the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care. METeOR identifier: 327268.

separation rate: The total number of separations for admitted patients divided by the total number of persons in the population under study. In this report, presented as a rate per 1,000 members of a population.

separation rate ratio: The separation rate for 1 population divided by the separation rate of another.

sleep apnoea: When a person repeatedly stops breathing during sleep. It has the same cause as snoring—reduced airflow at the back of the mouth—but is more extreme. More common in males and the obese, it leads to poorer mental functioning during the day and a greater risk of accidents.

socioeconomic status: An indication of how ‘well off’ a person or group is. In this report, socioeconomic status is reported using the Index of Relative Socio-economic Disadvantage, typically for 5 groups, from the most disadvantaged (worst off) to the least disadvantaged (best off).

specialised service: A facility or unit dedicated to the treatment or care of patients with particular conditions or characteristics, such as an intensive care unit. METeOR identifier: 269612.

subcutaneous: Being, living, used or made under the skin.

surgical procedure: A procedure used to define surgical AR-DRGs in version 6.0x (DoHA 2010).

systemic: Affecting the body as whole.

therapeutic: Relating to the treatment of disease providing relief or cure rather than, for example, a diagnostic process.

tonsillectomy: Surgical removal of the tonsils.

tracheostomy: A surgical procedure to create an opening into the trachea through the neck to allow the passage of air.

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- AIHW 2014 (forthcoming). Australian hospital peer groups 2014. Canberra: AIHW.
- AIHW 2014. Australian hospital statistics 2012–13. Health services series no. 54. Cat. no. HSE 145. Canberra: AIHW.
- AIHW 2014. Australia's hospitals at a glance 2012–13. Health services series no. 55. Cat. no. HSE 146. Canberra: AIHW.
- AIHW 2013. Australian hospital statistics 2012–13: *Staphylococcus aureus* bacteraemia in Australian public hospitals. Health services series 53. Cat. no. HSE 144. Canberra: AIHW.
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- AIHW 2013. Australian hospital statistics 2012–13: elective surgery waiting times. Health services series 51. Cat. no. HSE 140. Canberra: AIHW.
- AIHW 2013. Australian hospital statistics 2011–12. Health services series no. 50. Cat. no. HSE 134. Canberra: AIHW.
- AIHW 2012. Australian hospital statistics 2010–11. Health services series no. 43. Cat. no. HSE 117. Canberra: AIHW.
- AIHW 2011. Australian hospital statistics 2009–10. Health services series no. 40. Cat. no. HSE 107. Canberra: AIHW.
- AIHW 2010. Australian hospital statistics 2008–09. Health services series no. 34. Cat. no. HSE 84. Canberra: AIHW.

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Australian hospital statistics 2012–13: private hospitals is a new report in AIHW's series of summary reports describing the characteristics and activity of Australia's hospitals, focussed on the role of private hospitals in Australia.

In 2012–13, 41% of all separations occurred in private hospitals. From 2003–04 to 2012–13, the total number of private hospital separations increased by 46% from 2.6 million to 3.8 million. During this period, the number of same-day separations in private hospitals increased 60% from 1.7 million to 2.6 million separations and overnight separations increased 21% from 986,000 to 1.2 million.