Australian Department of Health and Ageing

Private Hospital Data Collection Review Final Report

October 2011
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The findings in this report are based on a qualitative study and the reported results reflect a perception of the Australian Department of Health and Ageing and other stakeholders consulted but only to the extent of the sample surveyed (being the Australian Department of Health and Ageing’s approved representative sample of stakeholders). Any projection to the wider health sector is influenced by the representativeness or otherwise of the views of the stakeholders consulted.

No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, stakeholders consulted as part of the review.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

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The findings in this report have been formed on the above basis.

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Executive Summary

The 2008 and 2010 health reforms will create a far more data reliant environment than currently exists. Further changes to those reforms, agreed to by the Council of Australian Governments (COAG) in 2011, have not altered this fact. Nationally, data will become essential for system design, financing and accountability. Thus far, implementation of data standardisation and expansion of patient level collections have focused on public hospitals, as they are the most critical to the reforms.

However, the reforms have implications also for the private sector. In particular, those reforms centred on accountability and transparency, make reference to the private sector and are likely to drive further development of private hospital data. Private hospitals themselves have expressed interest in participating in hospital reporting and some larger providers actively contributed to the recently launched myHospitals web site. Notwithstanding this interest, the private hospital sector has observed that such reporting incurs a cost to the hospitals and pointed to issues of the diverse range of reporting required of them; duplication of requirements among mandatory collections; and unnecessary complexity of data supply chains. If reporting was rationalised, data duplications removed and data supply chains streamlined, the reporting burden on private hospitals would be reduced and more active involvement in accountability and transparency activities would follow.

In this environment, the Australian Department of Health and Ageing (the Department) commissioned this Private Hospitals Data Collection Review (the Review) with the following objectives:

1. Increase the collection, management, and handling efficiency of private hospital data, so as to reduce data management burdens where possible;
2. To support increased comparability between the public and private sectors; and
3. Recommend a mechanism for creating and maintaining an authoritative list of private hospitals.

Term of reference 3 (an authoritative list of private hospitals) was overtaken by recent events relating to the national health reforms. In particular, the National Health Performance Authority (NHPA) will be required to report on hospitals and will have to decide what constitutes a private hospital for that purpose. This requirement effectively supersedes any mechanism that this Review might recommend.

Accordingly, although this Review considered recommendations relating to this term of reference, the Department has advised that those recommendations are no longer required. Nonetheless, the body of this report presents the options considered by the Review in relation to this term of reference. This information is presented in the hope it may be of value to NHPA and the Department in considering the NHPA requirements for such a list under the national health reforms.

To determine which data collections should be within scope of the Review, the following questions were asked of a set of identified data collections:

- Does this collection comprise data generated by and used by private hospitals and which ultimately ends up in the hands of the Commonwealth?
- Do the data from this collection end up in the hands of the Commonwealth agency, department or instrumentality? Such agencies include the Australian Institute of Health and
Welfare (AIHW), Australian Bureau of Statistics (ABS) and Federal Government departments.

- Is the collection one that the Department of Health and Ageing is likely to be able to influence?

As a result, the following collections were identified as being within scope:

- Hospital Casemix Protocol (HCP);
- Private Hospital Data Bureau (PHDB);
- National Admitted Patient Collection (APC);
- Private Health Establishments Collection (PHEC);
- National Hospital Cost Data Collection (NHCDC);
- National Perinatal Statistics Collection (NPSC); and
- Australian Cancer Database.

A number of additional national collections that involved private hospitals submission of data were considered but were deemed to be outside the scope of this Review. The primary reasons for excluding collections centred on whether the private hospitals' participation in the collections was imposed or otherwise mandatory and whether the Commonwealth, usually through the agency of the Department, was in a position to directly influence the operation of the collections.

As well as the existing collections identified as within scope, two areas of potential future national collection of data from private hospitals were identified and considered for inclusion. Data collection related to safety and quality indicators under the auspices of the Australian Commission for Safety and Quality in Health Care (ACSQHC) were seen to be within scope. Health workforce data, relating to the activities of Health Workforce Australia (HWA) was determined as out of scope. The latter decision was due to the HWA expressing its view that it had no plans for ongoing data collection involving private hospitals and felt it unlikely that this would change in the foreseeable future.

Hospital Casemix Protocol

The Private Health Insurance Act 2007 and its associated rules require private hospitals to provide HCP data to health insurers and insurers in turn are required to provide the HCP data, supplemented with additional data, to the Department. Private hospitals are required to submit data in accordance with data specifications published by the Department, in a fixed electronic file format.

In effect, a private hospital is required to prepare a separate file of episode level data for each insurer whose patients were treated in the given month and transmit each file separately to the relevant insurer. Where rehabilitation patients have been treated, a further file needs to be submitted to the relevant insurer(s).

Some streamlining is already achieved through the agency of the Australian Health Services Alliance (AHSA), which provides a bureau service for its members. This allows a private hospital to send the HCP files for those member funds to a single location – the AHSA.
The **Private Health Insurance Act 2007** requires HCP data be submitted for any and all admitted patient episodes where an insurance claim is lodged with an insurer. This requirement is imposed on all declared hospitals public and private. Under this Act both private and public hospitals may be declared. However, public hospitals provide a less complete HCP data set than private hospitals although the long-term aim is for public hospitals to move to full HCP provision.

**Private Hospital Data Bureau**

The **Private Health Insurance Act 2007** and its associated rules require private hospitals to provide PHDB data directly to the Department. Private hospitals are required to submit data in accordance with data specifications published by the Department, in a fixed, electronic file format. The Department maintains a list of PHDB eligible hospitals, which essentially is an amalgamation of the Department's list of declared hospitals and the AIHW list of hospitals that contribute to the APC.

The Department has developed a web browser based portal for submission of PHDB data. It actively encourages hospitals to use this portal for the submission of data as it is a secure process and makes it easier for hospitals to complete the data submission process.

**National Admitted Patient Collection**

The APC is a national collection of morbidity data comprising episode level data for all hospitals in Australia – public and private. This collection is managed and maintained by the AIHW and is also referred to as the National Hospital Morbidity Database.

The AIHW receives data annually from States and Territories. Each State or Territory supplies episode level data for the preceding financial year for all or most public and private hospitals within its jurisdiction. For the 2009-10 APC data submission process, data were not provided for 2 public hospitals, nor for private day hospital facilities in the NT or ACT, nor for 2 other private hospitals. In 2009-10, the extent of under counting of private hospital episodes in the APC was of the order of 3.3%.

The original submission of admitted episode level data by private hospitals to the various States and Territories takes place under different arrangements within each jurisdiction (see Table E-1).


Table E-1  Basis on which private hospitals provide admitted patient data, by State and Territory

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Basis for operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Required under legislation.</td>
</tr>
<tr>
<td>Victoria</td>
<td>Required under legislation.</td>
</tr>
<tr>
<td>Queensland</td>
<td>Required under legislation.</td>
</tr>
<tr>
<td>South Australia</td>
<td>Provided voluntarily.</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Required under legislation.</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Provided voluntarily.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Provided voluntarily.</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>Provided voluntarily.</td>
</tr>
</tbody>
</table>

Private Health Establishments Collection

The PHEC is operated and maintained by the ABS and operates annually, under the authority of the *Census and Statistics Act 1905*. That Act empowers the Commonwealth Statistician to direct private hospitals to contribute their data to the PHEC.

The scope of PHEC includes all private hospitals licensed by States and Territories and all free standing day hospitals approved by the Commonwealth. It includes data from each such facility relating to its ownership, basis for operation, accreditation, activities, staffing and finances.

The ABS has negotiated arrangements with States and Territories to streamline collection of part of the data required for PHEC. For consenting private hospitals, the ABS receives data on admitted patient activity for that private hospital directly from the relevant State or Territory. This arrangement means that the hospital does not need to extract and collate the necessary data from its own systems. Feedback from industry representatives and from States and Territories suggests that around 90% to 95% of all private hospitals provide their admitted data to PHEC in this way. Nonetheless, the remaining data sought by PHEC (financial, workforce etc.) are still required to be provided by the hospital itself.

The *Census and Statistics Act 1905* prevents the ABS from releasing PHEC data that might lead to the identification of individual private hospitals. Consequently, smaller jurisdictions’ data are aggregated in publications derived from PHEC. This constraint limits the utility of the PHEC data somewhat.

National Hospital Cost Data Collection

The NHCDC is managed by the Department. It is an annual collection of activity and cost data from public and private hospitals across Australia, which has been operating since 1996. NHCDC is essentially a voluntary collection. Public hospitals’ data are provided through the active co-ordination of each State and Territory health authority, while private hospitals’ data are provided directly by the hospitals themselves.

For the 2008-09 round, 169 private hospitals participated, comprising 59 free standing day hospitals and 110 other private hospitals. In terms of admitted episodes in private hospitals, the
2008-09 NHCDC accounted for 41% of episodes in free standing day hospitals and 71% of episodes in other private hospitals.

Data quality for the private hospitals’ component is variable, with significant caveats due to issues with inconsistent handling and reporting of costs, small AR-DRG volumes affecting estimates for free standing day hospitals and incomplete or inaccurate data affecting allocation of costs. In addition, private hospitals mostly lack the patient level feeder systems to capture consumption costs, thereby requiring estimation of hospitals’ costs through cost modelling, for the majority of private hospitals and free standing day hospitals.

Data can be submitted via a web based portal and the Department provides tools to carry out quality review of the data prior to its submission. For the 2008-09 round, a national co-ordinator also was appointed to facilitate the collection and review of the private hospitals’ data.

A review of the NHCDC and its processes was carried out in 2008 and the findings and recommendations from that review have guided and continue to guide the further development of the collection over time.

National Perinatal Statistics Collection

The NPSC is operated by the National Perinatal Statistics Unit, a collaborating unit with the AIHW based at the University of New South Wales. It collates data on pregnancy and childbirth, with State and Territory based units providing the data annually.

The processes for collection and reporting of the perinatal data are well-established. In most jurisdictions they have been operating for more than 20 years. Some streamlining at a local level is already evident.

Australian Cancer Database

The Australian Cancer Database (ACD) is managed and maintained by the Cancer and Screening Unit within the AIHW. That unit operates the ACD in collaboration with the Australasian Association of Cancer Registries (AACR), as part of the functions of the National Cancer Statistics Clearing House. The processes for collection and reporting of the cancer data are well-established. In most jurisdictions they have been operating for more than 30 years.

Safety and Quality Indicators

The ACSQHC was established in 2006 to develop a national framework for safety and quality in health care, together with an associated programme of work. Under the proposed national health reforms the ACSQHC has a larger responsibility to formulate and implement safety and quality standards, as well as to collect and disseminate information relating to safety and quality.

Currently, the ACSQHC has no intentions of pursuing new collections of data from hospitals in Australia. Rather, it holds the view that existing data collections, including those from private hospitals, are under-utilised in terms of routine generation and review of indicators of health care quality. Consequently, the ACSQHC aims to populate its safety and quality measures using existing data held in collections such as the APC.
The ACSQHC standards relating to safety and quality in health care will form the basis for future accreditation of hospitals in Australia, including private hospitals. Under this new accreditation system, private hospitals will be required to provide data on measures to accrediting bodies empowered to accredit hospitals under the standards. It is probable that the data provided by private hospitals to the accrediting organisations will also be required to be forwarded to the NHPA.

The new accreditation system was scheduled to begin from 1 July 2011 and to be implemented fully by 2015. During the implementation phase, hospitals will have a choice of accreditation under the old system or under the new, standards’ based system.

**Private hospital licensing**

Table E-2 summarises the private hospitals’ licensing requirements within the States and Territories. It does not cover statutory reporting obligations unrelated to the licensing arrangements, such as the requirements to report to cancer registries and perinatal statistics units.

It is clear that the concepts of private hospital and day hospital, while broadly similar across borders, differ substantially in terms of how they are specifically defined. The most extreme example of this is South Australia where the notion of a day hospital is not defined at all within the licensing arrangements.

There is also substantial variation in the range and nature of facility level details captured through licensing application and renewal processes. In particular, the information captured on service profiles varies significantly among jurisdictions.

The level of reporting and data submission expected of private hospitals also varies significantly among States and Territories. At one extreme, Queensland imposes significant reporting burdens across a range of operational areas. While at the other extreme South Australia imposes very little in the way of legislated reporting requirements.

No jurisdiction has a formal arrangement in place with the Department to provide the latter with updates to licence details for private hospitals and day facilities that they license. Informal arrangements operate for two jurisdictions.

**Table E-2 Summary of legislative requirements by State and Territory**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Facilities licensed</th>
<th>Service classes</th>
<th>Reporting requirements</th>
<th>Data provided to DoHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Private Hospitals, Day facilities</td>
<td>16 classes of service</td>
<td>Adverse Events, Root Cause Analysis, Regular audit, Admitted Patient Collection</td>
<td>No</td>
</tr>
</tbody>
</table>
### Issues and potential opportunities

There was a general acceptance that the processes for collecting cancer and perinatal data were largely independent of other processes and there were no opportunities for substantial streamlining in relation to those national collections.

The main concerns with respect to the NHCDC related to the issue of data quality, rather than to the burden associated with data preparation and submission. This partly reflects the voluntary nature of NHCDC participation for private hospitals.

A link to reporting burden arose in this context when considering how data quality might be improved for the private hospital component of the NHCDC. The main mechanism for

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Facilities licensed</th>
<th>Service classes</th>
<th>Reporting requirements</th>
<th>Data provided to DoHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>Private Hospitals  • Day facilities</td>
<td>15 classes of service</td>
<td>• Self-audit tool  • Episode level data  • Admitted Patient Collection</td>
<td>No</td>
</tr>
<tr>
<td>Queensland</td>
<td>Private Hospitals  • Day facilities</td>
<td>42 classes of service</td>
<td>• Sentinel events  • Root Cause Analysis  • Adverse outcome data on six monthly basis  • Self-audit tool  • Admitted Patient Collection</td>
<td>Informally</td>
</tr>
<tr>
<td>South Australia</td>
<td>Private Hospitals, excluding day facilities</td>
<td>6 classes of service</td>
<td>• Provision of documents for inspections</td>
<td>No</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Private Hospitals  • Day facilities (4 types)</td>
<td>34 classes of service</td>
<td>• Sentinel events  • Root Cause Analysis  • Mortality Review  • Inpatient statistics</td>
<td>Informally</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Private hospitals.  • Day hospitals</td>
<td>Three types of service, based on admitted status and overnight stay status</td>
<td>• Nil</td>
<td>No</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Private hospitals, including day hospitals</td>
<td>Unknown</td>
<td>• Unknown&lt;sup&gt;78&lt;/sup&gt;</td>
<td>No</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>Healthcare facilities, including public, private and day hospitals</td>
<td>10 types of service</td>
<td>• Notifiable incidents  • Annual report</td>
<td>No</td>
</tr>
</tbody>
</table>

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improving data quality was seen as being the capture of patient level cost or resource use data, through the implementation of “feeder systems”. However, stakeholders saw no intrinsic business case for a private hospital to invest the cost and effort to adopt such systems and modify their business processes to apply them.

There may be an opportunity to overcome some comparability issues through preparation of a series of experimental estimates’ reports, in addition to the usual NHCDC reports with their standard caveats. For example, one report may be on the pharmacy cost for private hospitals versus the pharmacy cost for public hospitals. The experimental estimate reports would build on the findings from the Productivity Commission Research Report into Public and Private Hospitals.

There is significant support for the PHEC and its modus operandi, principally from users of the data at sector level as well as from policy makers and planners. The ABS recently undertook a major review whose outcomes were implemented with the 2009-10 PHEC. Further changes will be implemented with a rolling out of the 2011-12 PHEC in August 2011.

The Department recently commissioned the AIHW to undertake a dataset specification development for a private hospital establishments’ collection that would correspond to the existing National Public Hospitals Establishment Dataset (NPHED) operated by the AIHW. In addition, the ABS and AIHW have commenced the work of aligning the NPHED and PHEC. The ABS has made changes to the PHEC collection form to better align the two collections.

Stakeholders generally were comfortable with the notion of AIHW operating as the collection agency for PHEC or an equivalent collection. The private hospital sector felt that the AIHW's governing legislation offers the same level of protection of the data as does that of the ABS. They and other stakeholders felt that the AIHW has in place well established and effective protocols for providing different levels of access to the data, while protecting privacy and confidentiality.

This support for the AIHW operating the PHEC or replacing it with a similar collection was qualified in the following ways:

• the range of data collected and definitions used would need to be maintained, so that the integrity of time series data is preserved;
• the coverage of private hospitals contributing to PHEC would need to be maintained or improved over the current high level achieved by the ABS;
• the ABS would need to have access to at least those aspects of the PHEC data required for national accounts and other reports relying on the PHEC data other than private hospitals Australia reports; and
• private hospitals would need to have control over the level of access provided to their individual data in a similar way to the protection that is currently afforded to States and Territories in relation to the APC. It may be possible to develop a standard agreement – analogous to the National Health Information Agreement – that could be used to effect such control.

Safety and quality reporting burden varies enormously across the private hospital sector in Australia. Some States and Territories impose significant reporting requirements specific to safety and quality while others impose very few.
In addition, health insurers impose their own requirements for reporting related to quality of care. This requirement is imposed through conditions inserted into contracts between private hospitals and health insurers. These requirements vary enormously in the specific data and supporting information sought and the frequency with which data are required.

The new accreditation arrangements are likely to be implemented across all hospitals and day facilities by January 2013. The ACSQHC is hopeful that this will lead to a greater sharing of common safety and quality data which will allow health insurers to reduce their demands for safety and quality reporting from private hospitals.

The details of national performance monitoring and reporting of safety and quality accreditation are, as yet, not determined. If there is to be a national collection, that may well fall to the NHPA.

This Review found that there is significant uncertainty about future data collection from private hospitals related to safety and quality. The ACSQHC and AIHW have recently undertaken a project to populate safety and quality indicators developed by the ACSQHC. Experience from this project highlights the following issues:

- ownership and custodianship of private hospital admitted patient data, which is provided to the APC by the jurisdictions, but "owned" and generated at source by private hospitals within differing jurisdictional arrangements;
- technical difficulties in identifying individual private hospitals within the APC, in order to generate nationally risk adjusted indicators through efficient central mechanisms; and
- the lag in achieving centrally collated, national data (somewhere between 5 and 17 months) for efficient and consistent central generation of a series of measures.

There is variety in the effort involved among hospitals in the process of extracting and providing data for the HCP, PHDB and APC. The variation largely related to issues of information systems’ capability, economies of scale and access to suitable information management skills.

A consistent view from stakeholders was that there is a subset of day hospitals that simply lack the scale and information systems to collect and provide the data sought by collections such as HCP, PHDB and APC. These day hospitals are often, but not always, small scale providers, whose data collection is limited to what is required to provide good clinical care and to manage the business aspect of the hospital. In some cases, these are day procedure centres providing services for which no insurance claims are made. As such, they may not be declared hospitals under the Commonwealth Private Health Insurance Act 2007, thereby not being subject to HCP and PHDB requirements.

The general view was that these admitted patient data collections themselves are warranted and that the range of data items collected should not be reduced. However, all stakeholders expressed concern over the fact that the HCP, PHDB, and the APC collect a significant set of common data items with common definitions and code sets. They also expressed concern over the substantial effort required to generate monthly extracts for these collections.

On a monthly basis a private hospital within any jurisdiction in Australia will submit a large amount of health data to insurers, State and Territory health authorities and the Department. Figure E-1 illustrates the processes for the submission of data to the APC – via jurisdictional admitted patient collections – and the HCP and PHDB collections.
Another issue with participating in these data collections is the validation of the monthly data submission. For example, in Victoria there are 403 different edits or “business rules”, violation of which may lead to rejection of submitted data. A rejection requires the hospital to check, correct and re-transmit that particular episode, which is not a simple task for the hospital. In addition insurers may have similar or different business rules to each other and to State health authorities. This means an episode of care may be accepted by an insurer but rejected by the State health authority.

**Figure E-1 Overview of HCP, PHDB and APC data submission processes**

![Diagram showing the data submission processes for HCP, PHDB, and APC]

The other main area of inefficiency in relation to these three data collections is the area of data overlap. Table E-3 summarises the key differences between the HCP and PHDB data specifications. Aside from these key differences, the two datasets capture essentially the same data items, with some minor differences in code sets.

Both the PHDB and the HCP require data to be submitted in a fixed field, ASCII file format. The specified format for the PHDB is different to that for the HCP, in spite of the fact that they have so many items in common.
Table E-3 Differences between the HCP and PHDB

<table>
<thead>
<tr>
<th>Field No or issue</th>
<th>HCP</th>
<th>PHDB</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Insurer Membership Identifier – valid value added</td>
<td>Insurer Membership Identifier – blank filled</td>
</tr>
<tr>
<td>2</td>
<td>Insurer identifier – the health fund registered three character code. Example: AHB - Defence Health AUF – Australian Unity Etc.</td>
<td>Payer Identifier – indicator of the type of funder of the episode: IH – Insured with Agreement with Hospital IN – Insured with no Agreement with Hospital SI – Self Insured WC – Worker’s Compensation TP – Third Party CP – Contracted to Public Sector CV – Department of Veterans’ Affairs patient DE – Department of Defence patient SE - Seaman OT - Other</td>
</tr>
<tr>
<td>3</td>
<td>Family Name</td>
<td>Family Name – Blank filled, as not required for reporting to DoHA</td>
</tr>
<tr>
<td>4</td>
<td>Given Name</td>
<td>Given Name – Blank filled, as not required for reporting to DoHA</td>
</tr>
</tbody>
</table>

There is a significant amount of overlap between the PHDB and APC (see Table E-4). Very few items included in the APC are not also included in the PHDB specification or able to be derived from PHDB items. There are a large number of items within the PHDB that are not available in the APC. By far the majority of these items relate to private hospitals’ charges and supporting information for different types of specialist care.

Table E-4 Relationship between PHDB and APC data items

<table>
<thead>
<tr>
<th>Items common to APC and PHDB</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items mappable from PHDB to APC</td>
<td>15</td>
</tr>
<tr>
<td>Items in PHDB and not in APC</td>
<td>43</td>
</tr>
<tr>
<td>Items in APC and not in PHDB</td>
<td>4</td>
</tr>
</tbody>
</table>

The other key difference between PHDB and APC data items is the fact that some States and Territories do not provide private hospital identifiers when submitting data for private hospitals within their jurisdiction. These jurisdictions maintain that the basis on which they collect and hold the private hospitals’ data is as custodians and that the data remain the property of the private hospitals. As such, they are not willing to provide the information that would allow individual private hospitals to be identified within the admitted episode data submitted to the APC.
These jurisdictions also are not willing to provide a data linkage field that would allow episodes from the same hospital to be identified as such, without explicitly identifying the hospital itself. This reflects the view that it would be possible, by comparing episode profiles for each hospital in the jurisdiction, to then identify individual hospitals.

Comparing the most recent complete year of data for PHDB and APC with the corresponding year’s data for PHEC shows that both PHDB and APC underenumerate numbers of private hospitals and of total admitted private hospital activity in Australia (see Table 8).

Some stakeholders pointed out that an opportunity exists to submit data via the ECLIPSE claiming system. ECLIPSE stands for \textit{Electronic Claim Lodgment and Information Processing Service Environment} and is an online claiming system developed by Medicare Australia (now part of the Australian Department of Human Services). It is used by private hospitals to lodge claims electronically with a health insurer and facilitates the checking of eligibility and payment of the claim by the insurer.

ECLIPSE contains within its file specification the HCP data specification, but this part of the record specification remains unused. In addition, the HCP specification within the ECLIPSE record has become outdated and no longer matches the current HCP specification.

According to Medicare Australia all health insurers are using ECLIPSE for online claiming and eligibility checking. One major health insurer informed this Review that around 50\% of its private hospital claims are handled using ECLIPSE. The DVA also indicated that around 50\% of claims from contracted hospitals and day procedure centres are handled using ECLIPSE.

Data suggest that around 19\% of insured private hospital episodes are claimed using ECLIPSE. As health insurers are actively pursuing further roll-out of ECLIPSE for managing claims lodged by private hospitals, this level of coverage will rise in the future.

The marketing of ECLIPSE as an online claiming solution has been the subject of a previous court case, brought by the distributor of a competing online claiming solution against Medicare Australia, alleging contravention of the \textit{Trade Practices Act}. That case was settled out of court in October 2009 and at present there is no competing solution in the marketplace. However, there remains a possibility that competing solutions for online claiming may enter the marketplace in the future.

Stakeholders identified the need to obtain information on privately insured patient stays in public hospitals as a high priority. An option was suggested, for the Department to work closely with a jurisdictional health department and an insurer to undertake a data linkage exercise, to test this as a means to fill this gap.

There have been issues with disconnection between data development and implementation of APC NMDS items, and operating constraints for the private hospital sector. This Review found the issues most likely have arisen because the data development and implementation processes largely have focused on the public sector and not adequately dealt with factors unique to the private sector.

There are 2 key factors that differentiate the private sector from the public, in terms of implementing changes to data standards and systems. The first is that costs of implementation for private hospitals and insurers need to be recovered through fees and charges and the second is that contractual arrangements dictate the data that private hospitals need to collect and report to insurers.
A recent issue with disconnection between implementation of changes in the code set for ICD-10 AM under the APC NMDS and the private hospital sector operating environment led to significant work for private hospitals and jurisdictional staff to develop a “work around” that allowed the hospitals to submit different data to different recipients. Risks of similar situations arising in the future would be reduced if there was greater involvement of private hospitals and insurers in national data development work and implementation planning.

**Recommendations**

This Review made a number of recommendations for future change, based on the findings contained in this report. Along with these recommendations, this Review has proposed an implementation timetable, whose key milestones are summarised in Table E-5.

From that consolidated timetable, it is clear that there is a significant workload involved in order to implement the full range of recommendations. Much of this workload falls to a few key actors. Principally, these are the Department, the Private Hospital Working Group (PHWG) and the HCP Working Group (HCPWG).

The ability to deliver on the recommended timetable is likely to be constrained by availability of adequate resources among these key actors. As such, this timetable may require revision as time progresses. Progress against the timetable should be reviewed regularly and milestones revised as necessary.

It must also be noted that the arena of hospital data collection and reporting is dynamic and more so at present, with the changes demanded by the recently agreed national health reforms. This fact is underlined by the supersession, by the establishment of the NHPA, of this Review’s term of reference relating to an authoritative list of private hospitals.

In light of this fluidity of environment, the recommendations of this Review and associated implementation plans should be routinely monitored and modified as circumstances change.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Undertake increased analysis of NHCDC information and develop a series of “experimental estimate” reports.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation</td>
<td>That the responsibility for the Private Health Establishments Collection be transferred to the Australian Institute of Health and Welfare.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>That CSV file format with field names in the first record be adopted as the standard file format for PHDB and HCP files. This recommendation covers all HCP files, including HCP1, HCP2 and AN-SNAP.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>That jurisdictions and private hospitals be approached to undertake a pilot test of a process for effecting a common file format for those data fields common to PHDB, HCP and the APC NMDS.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>That, subject to the above pilot succeeding, the successful model for common specification of common fields be rolled out to all private hospitals and all jurisdictions.</td>
</tr>
</tbody>
</table>
**Recommendation:** That the health insurance industry formally seek membership of NHISSC as an observer. This could be either as a permanent (observer) member or on an occasional basis, when issues specific to health insurers are to be considered.

**Recommendation:** That PHWG and HCPWG meet together at least once per year to discuss data related issues. This meeting should take place in the December quarter, to allow sufficient time for issues requiring implementation in the following financial year to be identified and considered.

**Recommendation:** That NHISSC be asked to develop a formal protocol for assessing business and related impacts of proposed changes to APC NMDS data items and associated metadata on the private hospital and health insurance sector.

**Recommendation:** That the ECLIPSE record specification be updated to permit transmission of HCP data according to the current HCP specification.

**Recommendation:** That the ECLIPSE record specification thereafter be maintained to ensure its capability to transmit HCP data remains current.

**Recommendation:** Investigate the feasibility of conducting a data linking exercise between a jurisdictional health department and insurers for improved HCP information.

### Table E-5 Implementation plan milestones and their timing

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Milestone</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSV format for PHDB and HCP</td>
<td>Agreed timetable for implementing CSV format for HCP and PHDB</td>
<td>October 2011</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Agreed cost and process for effecting ECLIPSE changes</td>
<td>December 2011</td>
</tr>
<tr>
<td>Health insurers and NHISSC</td>
<td>Write to Chair of NHISSC</td>
<td>December 2011</td>
</tr>
<tr>
<td>Joint HCPWG/PHWG meetings</td>
<td>Agreed format, business rules and timing for annual PHWG/HCPWG joint meeting</td>
<td>December 2011</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>In-principle agreement with at least one jurisdiction</td>
<td>December 2011</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Develop a detailed project plan. This will include developing a data set specification for use in a data linkage process</td>
<td>December 2011</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Milestone</td>
<td>Timing</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Arrange meeting with private health insurer to outline project and obtain participation consent. Provide the data set specification with the identifiers that will be required. Insurer to provide a sample dataset to use in linkage process</td>
<td>February 2012</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Arrange meeting with state health department. Organise to have data custodians and data linkage representatives from state health department. Specify the identifiers that will be supplied to the state health department</td>
<td>February 2012</td>
</tr>
<tr>
<td>Joint HCPWG/PHWG meetings</td>
<td>First PHWG/HCPWG joint meeting (items for discussion to include NHISSC private sector impact assessment protocol and protocol for regular communication between HCP and PHWG)</td>
<td>February/March 2012</td>
</tr>
<tr>
<td>PHEC transfer</td>
<td>Agreed project plan for transfer of PHEC, including timetable for final transfer</td>
<td>February/March 2012</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Agreed terms of ongoing arrangement</td>
<td>March 2012</td>
</tr>
<tr>
<td>Private hospital impact assessment protocol</td>
<td>Draft terms of reference for a protocol</td>
<td>March 2012</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>Agreed scope and objectives and operating parameters for the pilot with a jurisdiction(s)</td>
<td>April 2012</td>
</tr>
<tr>
<td>NHCDC experimental estimates</td>
<td>Develop draft reports for each of the selected areas</td>
<td>May 2012</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Agreed timetable for update and release of HCP capable ECLIPSE</td>
<td>May 2012</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Commence data exchange, linkage and analysis</td>
<td>May 2012</td>
</tr>
<tr>
<td>CSV format for PHDB and HCP</td>
<td>Implement new CSV file formats for HCP and for PHDB</td>
<td>June 2012</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Release of HCP capable ECLIPSE</td>
<td>June 2012</td>
</tr>
<tr>
<td>Private hospital impact assessment protocol</td>
<td>NHISSC agrees to final protocol</td>
<td>June 2012</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>In-principle agreement for involvement from private hospitals</td>
<td>July 2012</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Milestone</td>
<td>Timing</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Finalise data linkage exercise and prepare report. Identify issues and how process might work on larger scale</td>
<td>July 2012</td>
</tr>
<tr>
<td>NHCDC experimental estimates</td>
<td>Release report(s) for feedback and comment</td>
<td>August 2012</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>Agreed operating parameters and governance arrangements with partner hospitals</td>
<td>December 2012</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Report and consider expanded pilot results</td>
<td>March 2013</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>Report outcome of pilot test to NHISSC, HCPWG and PHWG</td>
<td>June 2013</td>
</tr>
<tr>
<td>Roll out new data transfer process to all jurisdictions</td>
<td>Agreed plan to roll out the new process to all jurisdictions and private hospitals</td>
<td>June 2013</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Commence work of rolling out pilot to other jurisdictions</td>
<td>July 2013</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Determination of need for annual update of ECLIPSE or not</td>
<td>September of the relevant year (2013 onwards)</td>
</tr>
<tr>
<td>PHEC transfer</td>
<td>PHEC transfer to AIHW completed</td>
<td>June 2014</td>
</tr>
<tr>
<td>Roll out new data transfer process to all jurisdictions</td>
<td>Rollout completed</td>
<td>June 2015</td>
</tr>
</tbody>
</table>
1 Purpose

This document forms the final report for the Private Hospitals Data Collection Review (the Review), which was commissioned by the Australian Department of Health and Ageing (the Department). The objectives of the Review are:

1. Increase the collection, management, and handling efficiency of private hospital data, so as to reduce data management burdens where possible;
2. To support increased comparability between the public and private sectors; and
3. Recommend a mechanism for creating and maintaining an authoritative list of private hospitals.

In commissioning the Review, the Department prescribed two streams of work to be undertaken by KPMG:

- current and proposed (where known) private hospital data collections and data supply chains from point of collection through to state and Commonwealth authorities and groups, and recommendations of options for streamlining (Work Stream 1); and
- public and private hospital service data and development of a feasible data convergence plan for public and private hospitals (Work Stream 2).

Work Stream 1 focused on objectives 1 and 3 listed above, while Work Stream 2 focused on objective 2. This report presents the findings and recommendations for both streams. It also includes a draft implementation plan for delivering those recommendations.

1.1 Project Background

The 2008 and 2010 health reforms will create a far more data reliant environment than currently exists. Further changes to those reforms, agreed to by the Council of Australian Governments (COAG) in 2011, have not altered this fact. Nationally, data will become essential for system design, financing and accountability. Thus far, implementation of data standardisation and expansion of patient level collections have focused on public hospitals, as they are the most critical to the reforms.

However, the reforms have implications also for the private sector. In particular, those reforms centred on accountability and transparency, make reference to the private sector and are likely to drive further development of private hospital data. In this context, it is noted that the 2008 National Healthcare Agreement\(^1\) includes indicators that apply equally to the private and public hospital sectors, as do those of the Australian Commission on Safety and Quality in Health Care (ACSQHC) indicators of patient and hospital level safety and quality. In addition, the National Health and Hospitals Network Agreement\(^2\) envisages that private hospitals will participate in the accountability and transparency reforms, including the hospital performance reports that will be prepared by the National Health Performance Authority (NHPA), at the hospital and hospital network levels.

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Private hospitals themselves have expressed interest in participating in hospital reporting and some larger providers actively contributed to the recently launched myHospitals web site (http://www.myhospitals.gov.au/). Notwithstanding this interest, private hospital managers, their peak bodies and other interested parties have observed that such reporting incurs a cost to the hospitals. They have pointed to issues of the diverse range of reporting required of them by the Commonwealth, States and Territories, representative groups and others; duplication of information among mandatory collections; and unnecessary complexity of data supply chains.

If reporting was rationalised, data duplications removed and data supply chains streamlined, the reporting burden on private hospitals would be reduced and more active involvement in accountability and transparency activities would follow.

1.2 Focus of the Review

1.2.1 Reducing Data Collection Burden

The focus for Work Stream 1 was on those collections where the data collected ultimately ends up in the hands of the Commonwealth or in the hands of a Commonwealth agency or instrumentality. Thus the focus was on data collections that are national in scope. In addition, this work stream focused on reduction in data collection burden but not in the range of data items collected, for those collections deemed to be within scope.

In considering the data collection burden, the Department asked KPMG to identify and review data collection processes both for those collections within scope and other collections operating at a local or state level. The purpose of this component of the Review was to gather a fuller picture of the overall data reporting burden borne by private hospitals. The Department recognised that the Review would not be able to make recommendations influencing the operations of those collections as lie outside the direct control and influence of the Commonwealth.

Nonetheless, it was expected that the Review might comment on relationships between those collections and reporting processes and those within scope of the Review.

1.2.2 Increased comparability of public and private sectors

The focus for Work Stream 2 was on the same collections as Work Stream 1 – where the data collected ultimately end up in the hands of the Commonwealth or in the hands of a Commonwealth agency or instrumentality. In considering these collections, this work stream focused on identifying where data are collected in both sectors and there are issues with the comparability of the data between sectors, or where (national) data are collected for the public sector and no comparable data are collected for the private sector.

In considering the comparability of data for the two sectors, the Department asked KPMG to identify how private sector data collections might be modified to move the private sector data closer (in terms of comparability) to public sector data.

This work stream focused on the comparability of data collected (nationally) from the two sectors and the ability to directly compare measures based on such data. In doing so, there is a question of the relevance of other aspects of comparability – those that relate to the rationale for wanting to compare public and private hospitals for a given measure and those that relate to confounders.
Confounders are factors that affect how measures should be interpreted or adjusted, such as the impact of the lower proportion of complex medical patients with multiple presenting co-morbidities in the private system, relative to the public system.

The other issues relate to fundamental issues of comparability between the two sectors. For example, there are fundamental differences in the operating models for public and private hospitals that affect whether meaningful comparisons of medical workforce can be made, using hospital level data.

Confounders are more strongly related to the interpretation of comparisons between the sectors, rather than to questions of (technical) comparability. As such, this review has focused on the more fundamental issues of comparability that affect the rationale for wanting to compare the two sectors, which have greater relevance to decisions to change existing data collection arrangements.

1.2.3 An authoritative list of private hospitals

Currently, the Department makes use of different lists of private hospitals for different purposes. In addition, there are other lists being used for purposes outside of the Department as well. With the advent of the national health reforms and the increased emphasis on performance measurement and reporting, it is important that private hospitals are well defined and that there is a common understanding of what health services should be included and which should be excluded when considering the performance of the private hospital sector.

Consequently, the Department had identified a need to rationalise the existing multiple lists and develop a mechanism for determining a single, authoritative list of private hospitals in Australia. That mechanism also should allow for ongoing maintenance of the list, at the least including processes to update information for existing hospitals, add information for new hospitals and to remove information for hospitals that cease to operate.

Therefore, this Review needed to consider the purposes to which such a list would be put, the existing lists of private hospitals - both at national and State or Territory levels – and available mechanisms for obtaining and maintaining the necessary data on private hospitals.

1.3 Methodology

Figure 1 summarises the approach to this Review. The process for deciding which private hospital data collections, data supply chains and reporting processes are within scope was agreed in project initiation. Broadly, the process consisted of asking the following questions in relation to identified data collections:

- Does this collection comprise data generated by and used by private hospitals and which ultimately ends up in the hands of the Commonwealth?
- Do the data from this collection end up in the hands of the Commonwealth agency, department or instrumentality? Such agencies include the Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS) and Federal Government departments.
- Is the collection one that the Department of Health and Ageing is likely to be able to influence?
Based on this clarification, the following collections were identified as warranting consideration for inclusion within scope of the Review:

- the National Hospital Cost Data Collection (NHCDC);
- the Hospital Casemix Protocol (HCP);
- the Private Hospital Data Bureau (PHDB);
- the ABS Private Health Establishments Collection (PHEC); and
- the AIHW Admitted Patient Collection National Minimum Data Set (APC).

Relevant collections implied by the work of the Australian Commission on Safety and Quality in Health Care (ACSQHC or the Commission) also were deemed to be within scope.

With respect to the NHCDC, the processes and systems for collecting the NHCDC data are not within the scope of this Review. The scope will be limited to identifying overlaps with other collections and collection processes and opportunities for streamlining other collection processes to reduce double handling and incompatible data.

Databases of claims for the medical component of private hospital care, held by the Department (Medicare Benefits Schedule claims) and by the Department of Veterans’ Affairs are out of scope.

Throughout the stakeholder consultation process in Work Stream 1 two other national collections were often mentioned by stakeholders. These collections were:

- Perinatal National Minimum Data Set; and
- Cancer registry data, collated by the National Cancer Statistics Clearing House (NCSCH) from state cancer registries.

Subsequently, these two collections were considered by the Review.
1.3.1 Work Stream 1

Following project initiation, there was a step to obtain and review documents relevant to the objectives for Work Stream 1. The types of documents reviewed include:

- Commonwealth, State and Territory legislation (Acts, Regulations and other legislative instruments);
- user manuals, guides, data dictionaries and other operational documents related to the data collections within scope (and those considered to be out of scope) for Work Stream 1;
- working documents provided by stakeholders, including some not publicly available and others that had been published;
- reports of previous reviews and of Government and non Government agencies; and
- submissions to previous reviews and Government sponsored inquiries.

In analysing this body of information for Work Stream 1, particular lines of enquiry were followed. These lines of enquiry and their relationship to each of the Review’s objectives relevant to Work Stream 1 are summarised in Table 1. This enquiry framework was applied with the focus on the data collections identified as within scope for this Review (see Chapter 2).
Table 1  Enquiry framework used in analysing and synthesising information gathered for Work Stream 1

<table>
<thead>
<tr>
<th>Objective</th>
<th>Focus of enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data collection streamlining</td>
<td>Identify the major concerns and issues with respect to reporting and data submission burden in the private hospital sector. Understand the processes associated with reporting and data submission by private hospitals. Identify areas of duplication, overlap or inefficiency. Identify potential opportunities for improvement.</td>
</tr>
<tr>
<td>An authoritative list of private hospitals</td>
<td>Identify the reasons for such a list. Identify existing lists and their use, within the Commonwealth. Develop a definition of “private hospital” suited to those purposes. Identify potential sources of information for populating such a list.</td>
</tr>
</tbody>
</table>

These documents were used to confirm the inclusion of the above data collections and also to identify other potential data collections for inclusion. In addition, the documents were reviewed for relevant information on those collections determined to be within scope of the Review.

Subsequently, consultations were undertaken with a wide range of stakeholders. These stakeholders included private hospitals and their representative bodies, health insurers and their representative bodies, State and Territory governments, representatives of national agencies and Departmental officers. The full list of stakeholders consulted is provided at 4.4.

Stakeholders were asked to provide their views and information relating to the data collections that should be within scope of the Review, other data collection and reporting burdens imposed on private hospitals, existing processes for data collection and opportunities for streamlining. Stakeholders were also asked about legislated and licensing requirements to which private hospitals are subject within different jurisdictions and their implications for both objective 1 and objective 3 of this Review.

Throughout the consultation process additional documentation was identified, obtained and reviewed to complement and supplement information obtained through the consultations themselves.

At the completion of the consultations and review of documentation, the full range of information found and reviewed was subject to analysis, synthesis and interpretation. Initial findings were tested selectively with stakeholders and with the Advisory Group formed by the Department for this Review. Potential recommendations were also tested in this way.

The last step in the process for Work Stream 1 was the drafting of the draft work stream report, which summarised the findings and presents the recommendations relating to the data collection streamlining objective and to the authoritative list objective for the Review.
1.3.2 Work Stream 2

Following project initiation the first step involved developing a comparison framework that stepped out how the collections within scope were going to be compared. The details of the comparison framework are discussed further below (see Comparison framework, page 8).

Next, there was a detailed, item by item comparison between data items listed in the APC and five of the private hospital collections within scope of the Review (HCP, PHDB, PHEC, Perinatal and Cancer collections).

The comparison was done using an Excel© spreadsheet. For each item by item comparison seven attributes were considered. Those attributes were:

1. Existence of same item in each collection (yes/no).
2. Naming congruence (yes/no).
3. Definition congruence (yes/no).
4. Domain congruence (yes/no).
5. Ability to map data items (yes/no).
6. Required for reporting (mandatory/optional).
7. Commentary on particular issues with the item.

The spreadsheet containing the results of this comparison has been provided to the Department separately from this report.

The next step involved obtaining and reviewing data collection manuals, survey forms and data set specifications relevant to the objectives for Work Stream 2. In this step the main reports where public and private hospital sectors are compared were reviewed. This included AIHW’s Australian Hospital Statistics and the Productivity Commission’s Public and Private Hospitals reports. The reason for this was that these reports had already highlighted a number of issues with comparing the public and private sectors.

Subsequently a workshop was run on 8 June 2011 with a number of stakeholders. These stakeholders included private hospitals and their representative bodies, health insurers and their representative bodies, representatives of AIHW and ABS and departmental officers. The full list of stakeholders consulted is provided in Appendix B.

Stakeholders were asked to provide their views and information relating to the data collections within scope of the review in relation to improving comparability between the public and private sectors. They were provided with three areas identified to improve comparability and to prioritise these options and also suggest possible convergence plans in these areas. Stakeholders were also asked to suggest other mechanisms to improve comparability between public and private sectors.

Discussions at the workshop often focussed on streamlining of data collections rather than improved comparability. Of the three areas identified to improve comparability stakeholders from private hospitals and insurers identified that obtaining data on private patient stays in public hospitals was the number one priority. The other areas of improving comparability were in terms of cost and reporting of private hospital establishment data in Australian Hospital Statistics publication.
For improving comparability in the domain of cost, stakeholders did not identify this as a priority. They stated that comparability within the sectors was more important than trying to achieve comparability across the public and private sectors. For improving the reporting of private hospital establishment data all stakeholders did not view the issue as a priority but they agreed that AIHW and ABS should continue to work together to resolve the issue.

At the completion of the workshop the full range of information found and reviewed was subject to analysis, synthesis and interpretation. The last step in the process for Work Stream 2 has been the drafting of this report, which summarises the findings and presents a feasible data convergence plan for data collections from public and private hospitals.

Different stakeholders see different potential benefits from increased capability to directly compare public and private hospitals on a range of performance measures. Governments, insurers and other purchasers of public and private hospital services have a strong interest in being able to compare treatment outcomes and treatment costs when devising policy or making purchasing choices. The hospitals themselves and their operators – both public and private – are interested in benchmarking their own performance against peers, to better understand the quality of their services and where they might improve that quality.

**Comparison framework**

In carrying out the detailed comparisons of collections, 6 dimensions for comparison were used:

- scope;
- definitions;
- counting rules;
- units of measurement;
- costs; and
- practicability of change.

Each of these dimensions is described further in the following sections.

**Scope of the Collection**

This dimension required consideration of the following attributes of the collection:

- defining the hospitals that contribute or are required to contribute data;
- the frequency of collection or data submission;
- the basis for participation, such as whether or not participation in the collection was required under legislation or under licensing conditions; and

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3 For example, self insured individuals purchase treatment as a private patient in public and private hospitals; the Department of Veterans’ Affairs purchases hospital services in both sectors; and State and Territory governments contract private hospitals to provide treatment for public patients.
• the area of hospital operations covered by the collection, such as admitted patient treatment or financial management or workforce.

Data Item Definitions

This dimension involves sourcing and detailing the various data dictionaries and collection manuals for each of the private hospital data collections. The collections within scope collect a large amount of personal, episode, establishment and financial information. These dictionaries and manuals were used for comparing all the items collected in the AIHW Admitted Patient Care NMDS to each of the private hospital collections (apart from the NHCDC).

This dimension involved sourcing the data dictionaries and collection manuals. These dictionaries were then used in the detailed item by item comparison between the AIHW Admitted Patient Care NMDS and the private hospital collections within scope.

Counting rules affecting data items

To compare the information collected it is important to understand the counting rules. This involves identifying what is the lowest level of information collected or the “statistical unit.” For example, the statistical unit for the AIHW Admitted Patient Care NMDS has a statistical unit defined as “Episodes of care for admitted patients” while the Cancer registry has a base statistical unit of a “tumour.”

This dimension identified the “statistical unit” of each collection.

Units of measurement, including code sets

There are a number of classifications that are quite particular to health collections. These include classifications such as ICD-10-AM, which refers to the Australian modification of the WHO ICD-10 base classification system. ICD-10-AM is a classification of diseases and health problems. Another classification is the Australian Classification of Health Interventions (ACHI) 5th edition. There is also the Australian Refined Diagnosis Related Groups (AR-DRGs), which is a patient classification system that provides a clinically meaningful way of relating the types of patients treated in a hospital to the resources required by the hospital.

Classifications as those listed above are subject to regular revisions and jurisdictions may not always be using the same version of these classifications. Occasionally jurisdictions may make slight modifications to these collections.

This dimension identified the main health classifications being used by each collection and which version of the classification the collection used (or if the collection accepted many versions).

Costs of collection and changes to collection

The data collections utilise a variety of collection methods. The ABS PHEC only collects information from private hospitals. This is done via both a survey that a private hospital responds to and a submission of data from the health department in the jurisdiction in which the private hospital is located. However the AIHW APC NMDS collects information from both public and private hospitals via the health department in each jurisdiction.
This dimension identified some of the main costs of the collection. The costs were not detailed in dollar amounts but by broadly identifying the main costs in terms of participating in the collection.

**Practicability of changing the collection**

Many of these data collections have been running for over a decade. For example, the ABS has been collecting data from private hospitals and jurisdictions for the PHEC since 1996-97. Not only do jurisdictional departments have established systems in place to supply private hospital data to these organisations they also have well established working relationships with ABS.

This dimension identified some of the barriers and enablers to changing the collection.
2 Current state summary

This chapter describes the current state of data collection from private hospitals in Australia, with a focus on those collections which end up in the hands of the Commonwealth agency. It identifies both current collections deemed to be within scope of this Review as well as some potential future collections that have implications for future reporting burden on Australia's private hospitals. Other national collections that were considered to be out of scope are also identified in this chapter.

This chapter also summarises the existing licensing arrangements in States and Territories and associated reporting requirements for private hospitals within those jurisdictions. It includes a section discussing issues raised by the Productivity Commission in its report on public and private hospitals, relating to availability and comparability of data from the two sectors.

The content in this chapter is based on the information obtained from consultations as well as from the document review. In addition, some of the work undertaken for Work Stream 2 has been used.

To identify inefficiencies and potential opportunities for streamlining of data collections from private hospitals, it was necessary to develop a consistent way of collecting and collating the information gathered about two collections within scope. Accordingly, a framework was developed and applied for this purpose. That framework is summarised in Table 2.

Table 2  Information gathering framework

<table>
<thead>
<tr>
<th>Area of interest</th>
<th>Nature of information sought</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of data collection</td>
<td></td>
</tr>
<tr>
<td>Timing of data collection</td>
<td>When did data collections start</td>
</tr>
<tr>
<td></td>
<td>How often are data submitted</td>
</tr>
<tr>
<td>Purpose of the collection</td>
<td>Rationale for the collection</td>
</tr>
<tr>
<td></td>
<td>Who gets the data</td>
</tr>
<tr>
<td>Scope of data collected</td>
<td>Kind(s) of data collected</td>
</tr>
<tr>
<td></td>
<td>Data items collected</td>
</tr>
<tr>
<td>Data submission requirements</td>
<td>Form and format of data submissions</td>
</tr>
<tr>
<td></td>
<td>Significance of reporting is</td>
</tr>
<tr>
<td></td>
<td>Duplication of data submitted to other data collections</td>
</tr>
<tr>
<td></td>
<td>Opportunity for streamlining</td>
</tr>
<tr>
<td>Data quality</td>
<td>Integrity and quality of the data</td>
</tr>
<tr>
<td></td>
<td>Missing data</td>
</tr>
<tr>
<td></td>
<td>Missing submissions</td>
</tr>
<tr>
<td>Data uses and applications</td>
<td>Existence of value-added products from this data collection that</td>
</tr>
<tr>
<td></td>
<td>are provided to or available to the private hospital(s)</td>
</tr>
<tr>
<td>Do the data from this collection get passed on to the</td>
<td>Which agency</td>
</tr>
<tr>
<td>Commonwealth</td>
<td>Process for transmission</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.1 **Existing national collections**

This section summarises and describes the national collections of private hospital data that were identified and considered for inclusion as part of the streamlining component of this Review. The following collections were identified as within scope for this Review:

- Hospital Casemix Protocol;
- Private Hospital Data Bureau;
- National Admitted Patient Collection;
- Private Health Establishments Collection;
- National Hospital Cost Data Collection;
- National Perinatal Statistics Collection; and
- National Cancer Registry.

These collections are described in more detail in the sections below.

The collections that have been excluded and the reasons for their exclusion are summarised in section 2.1.8.

### 2.1.1 Hospital Casemix Protocol

The HCP is mandated through Federal legislation. The *Private Health Insurance Act 2007* and its associated rules require private hospitals to provide HCP data to health insurers. Health insurers in turn are required to provide the HCP data, supplemented with additional data fields specific to their role as insurers, to the Department.

Private hospitals are required to submit data in accordance with data specifications published by the Department. Data are submitted electronically, in a fixed file format using the American Standard Code for Information Interchange (ASCII) standard. The data required include both admitted patient data and data related to non-admitted patient treatment.

For the admitted data, data are submitted monthly and a separate record is required for each admitted patient episode that ends in a given month. For non-admitted data, data are submitted on a quarterly basis, with a separate record for each non-admitted patient service.

If the hospital provides an insured patient with rehabilitation in an admitted setting, additional data relating to that rehabilitation episode need to be submitted in a different format, with an episode linkage identifier to allow the rehabilitation record to be linked to the corresponding admitted episode record.

In effect, a private hospital is required to prepare a separate file of episode level data for each insurer whose patients were treated in the given month and transmit each file separately to the relevant insurer. Where rehabilitation patients have been treated, a further file needs to be submitted to the relevant insurer(s).

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Some streamlining is already achieved through the agency of the Australian Health Services Alliance (AHSA), which provides a bureau service for its members. This allows a private hospital to send the HCP files for those member funds to a single location – the AHSA.

The range of data provided to insurers by private hospitals includes the name and other patient details, clinical details of the episode (including principal diagnosis, procedure and details of types of care provided), hospital charges and administrative details related to the episode. The insurer removes the patient name and adds data related to the benefits before forwarding the data to the Department.

The Private Health Insurance Act 2007 requires HCP data be submitted for any and all admitted patient episodes where an insurance claim is lodged with an insurer. This requirement is imposed on all declared hospitals. Under this Act both private and public hospitals may be declared. This means that both public and private hospitals are required to submit HCP data for insured patients to insurers, and that insurers are required to pass this on to the Department for both public and private hospital episodes.

However, the HCP admitted and rehabilitation data requirements are usually less onerous for public hospitals than for private hospitals. Historically, public hospitals usually do not have service contracts with insurance funds and so are able to claim only the default benefits for insured patients. As a result, public hospitals have only provided that subset of HCP data required to allow payment of default benefits, meaning that much of the detail of the patient episode is not provided. When the Private Health Insurance Act 2007 was drafted, States and Territories were not prepared to provide full HCP data for their public hospitals. Consequently, public hospitals continue to provide a less complete HCP data set to insurance funds, although the long-term aim is for public hospitals to move to full HCP provision.

In spite of the legislative requirement to submit HCP data, occasionally a hospital fails to provide the HCP data set to an insurer. In this situation the insurer is required to follow-up the hospital themselves. If this initial follow-up is unsuccessful, the insurer is required to advise the Department and is the Department's responsibility to further follow-up the hospital concerned. At present the Department is not actively following up these non-compliance situations.

The data are able to be used by insurers to analyse the range of conditions for which their members receive hospital services, the profile of services provided to their members by private hospitals, and the variation in charges and fees applied by different private hospitals.

The Department use the HCP data it receives to inform policy and planning in both the private hospital and private health insurance areas. It is also used as needed to brief the Minister or to respond to parliamentary questions.

In the past the Department prepared a CD of analysed HCP data that was distributed to hospitals, allowing hospitals to compare themselves with industry averages or benchmarks. This

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7 At the time of this Review, AHSA represented 27 insurance funds. Refer to https://www.ahsa.com.au/web/ for more information regarding AHSA and its members.
8 Section 121-5 of the Private Hospital Act 2007 states “A hospital is a facility for which a declaration under subsection (6) is in force.” and Section 121-6 states “The Minister may...declare that a facility is a hospital”. As such, a “declared hospital” is one that has been declared by the Minister under this Act.
product has been discontinued as the Department no longer has the resources available to produce this on a regular basis.

2.1.2 Private Hospital Data Bureau

The PHDB is mandated through Federal legislation. The *Private Health Insurance Act 2007* and its associated rules require private hospitals to provide PHDB data directly to the Department. Private hospitals are required to submit data in accordance with data specifications published by the Department. Data are submitted electronically, in a fixed, ASCII file format. The data required comprise episode data for all admitted patients.

Data are submitted monthly and a separate record is required for each admitted patient episode that ends in a given month. The range of data provided to the Department by private hospitals includes non-identifying patient details, clinical details of the episode (including principal diagnosis, procedure and details of types of care provided), and administrative details related to the episode.

The *Private Health Insurance Act 2007* requires PHDB data to be submitted for any and all admitted patient episodes within a declared private hospital. Consequently, PHDB data are not provided by public hospitals and are only provided by those private hospitals that are declared under the Act.

The Department maintains a list of PHDB eligible hospitals. This list essentially is an amalgamation of the Department's list of declared hospitals under the *Private Health Insurance Act 2007* and the Australian Institute of Health and Welfare's (AIHW) list of hospitals that contribute to the national admitted patient collection (APC).

In spite of the legislative requirement to submit PHDB data, occasionally a hospital fails to provide the PHDB data set to the Department. It is the Department's responsibility to follow-up the hospital concerned. At present, approximately 570 private hospitals submit data regularly to the PHDB. The PHDB is viewed as approximately 85% complete in its coverage. This is based on a comparison with data held in the APC maintained by the AIHW. However, this comparison is subject to uncertainty as some States and Territories do not separately identify which private hospitals submit data to the APC.

The Department has developed a web browser based portal for submission of PHDB data. It actively encourages hospitals to use this portal for the submission of data as it is a secure process and makes it easier for hospitals to complete the data submission process.

The Department uses the PHDB data for a wide range of purposes. These include analyses to inform policy and program development and evaluation. An annual report is produced which gets wide use within the industry as well as by researchers and others with an interest in the private hospital sector. The PHDB data is also used as needed to brief the Minister or to respond to parliamentary questions.

On occasion the Department also responds to requests from individual hospitals to analyse their own data for example, day surgeries have occasionally requested a comparison of their average

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10 *Private Health Insurance (Health Insurance Business) Rules 2010.*
theatre time with the national average for the peer day surgeries. However, these specific requests are often dealt with using the APC data given its greater coverage.

The data have been used recently for the development of private hospital profiles within the Department. This work is analogous to other work within the Department to develop public hospital profiles although the detail for the private hospital profiles is different to that for the public.

2.1.3 National Admitted Patient Collection

The APC is a national collection of morbidity data comprising episode level data for all hospitals in Australia – public and private. This collection is managed and maintained by the AIHW and is also referred to as the National Hospital Morbidity Database.

The AIHW receives data annually from States and Territories. Each State or Territory supplies episode level data for the preceding financial year for all or most public and private hospitals within its jurisdiction. For the 2009-10 APC data submission process, data were not provided for 2 public hospitals nor for private day hospital facilities in the NT or ACT nor for 2 other private hospitals. In 2009-10, the extent of under counting of private hospital episodes in the APC was of the order of 3.3%. This estimate was derived from a comparison between the numbers of private hospital episodes in the APC and those reported to the Australian Bureau of Statistics, through PHEC.

Data are supplied according to the National Minimum Data Set (NMDS) specification for admitted patient care. Each episode record contains non-identifying patient demographics, administrative data and clinical data specific to the episode.

The arrangement for provision of APC data to the AIHW is based on the National Health Information Agreement, under which the States And Territories agreed to provide the data. This agreement also covers the data standards and associated developmental work under which the APC operates.

However, the original submission of admitted episode level data by private hospitals to the various States and Territories takes place under different arrangements within each jurisdiction. In some jurisdictions, there is a legislative requirement for each private hospital to provide admitted episode data, sometimes as a condition of the licence. However, in other jurisdictions there is no such requirement and the arrangement under which private hospitals provide the data is essentially voluntary. Table 3 summarises the basis on which private hospitals provide admitted patient data for each of the States and Territories.

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14 [http://meteor.aihw.gov.au/content/index.phtml/itemId/182135](http://meteor.aihw.gov.au/content/index.phtml/itemId/182135)
Table 3  
**Basis on which private hospitals provide admitted patient data, by State and Territory.**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Basis for Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Required under legislation.</td>
</tr>
<tr>
<td>Victoria</td>
<td>Required under legislation.</td>
</tr>
<tr>
<td>Queensland</td>
<td>Required under legislation.</td>
</tr>
<tr>
<td>South Australia</td>
<td>Provided voluntarily.</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Required under legislation.</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Provided voluntarily.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>Provided voluntarily.</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>Provided voluntarily.</td>
</tr>
</tbody>
</table>

The APC data are used for a range of purposes. They are fundamental to a number of AIHW publications, such as the Australian Hospital Statistics series. A copy of the APC is also provided to the Department which uses it for a range of research, policy analysis, planning and policy development.

The APC is also a valuable resource for a range of other purposes and is fundamental to the development of consistent and comparable national performance measures. For example, it is used to populate various indicators of activity currently reported on the myHospitals website. In the future it will be used to generate performance measures under the National Health Care Agreement and the COAG health care reform process. It is also used extensively by researchers, commentators and policymakers across the Australian health sector.

2.1.4  
**Private Health Establishments Collection**

The PHEC is operated and maintained by the ABS. The collection has operated annually since 1991-92, with the exception of 2007-08 when budget measures caused it to be suspended during a period of review. Following detailed review, involving consultation with a range of users and the industry, the PHEC was reinstituted as an annual collection in 2008-09.

PHEC operates under the authority of the *Census and Statistics Act 1905*. That Act empowers the Commonwealth Statistician to direct private hospitals to contribute their data to the PHEC.

The scope of PHEC includes all private hospitals licensed by States and Territories and all free standing day hospitals approved by the Commonwealth. It includes data from each such facility relating to its ownership, basis for operation, accreditation, activities, staffing and finances.

The ABS has negotiated arrangements with States and Territories to streamline collection of part of the data required for PHEC. Subject to consent from the private hospital concerned, the ABS receives data on admitted patient activity for that private hospital directly from the relevant providers.

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*Private Hospitals, Australia, 2009-10*. ABS, 17 June 2011. Catalogue number 4390.0. Available at:  
State or Territory. This arrangement means that the hospital does not need to extract and collate the necessary data from its own systems. This arrangement works for those private hospitals that provide admitted patient data to their State or Territory and who choose to complete the authorisation for the release of health data. Feedback from industry representatives and from States and Territories suggests that around 90% to 95% of all private hospitals provide their admitted data to PHEC in this way. Nonetheless, the remaining data sought by PHEC are still required to be provided by the hospital itself.

The PHEC data are reported in summary form each year in the Private Hospitals, Australia series of annual publications. These publications are seen as extremely useful at an industry level, rather than at the individual hospital level. They are seen as providing a very good, possibly the most accurate, high level summary of treatment activity across the whole private hospital sector. They also provide the only publicly available summary data on the characteristics, financing and workforce of private hospitals.

The Census and Statistics Act 1905 prevents the ABS from releasing PHEC data that might lead to the identification of individual private hospitals. Consequently, smaller jurisdictions’ data are aggregated in publications derived from PHEC. For example, in the Private Hospitals, Australia publication Tasmania, Northern Territory and Australian Capital Territory results are combined. This constraint limits the utility of the PHEC data somewhat. However, it is possible to obtain more detailed analyses than those published through ad hoc requests to the ABS, provided the resulting tables do not lead to the identification of individual hospitals. This approach was adopted by the Productivity Commission in its research study into public and private hospitals in Australia19.

### 2.1.5 National Hospital Cost Data Collection

The National Hospital Cost Data Collection (NHCDC) is managed by the Department. It is an annual collection of activity and cost data from public and private hospitals across Australia, which has been operating since 1996. The most recently completed round of data collection was for the 2008-09 financial year. The report for that round was published in December 200920.

NHCDC is essentially a voluntary collection, involving collaboration among the Department, States and Territories, and private hospitals. Public hospitals’ data are provided through the active co-ordination of each State and Territory health authority, while private hospitals’ data are provided directly by the hospitals themselves.

For the 2008-09 round, 169 private hospitals participated, comprising 59 free standing day hospitals and 110 other private hospitals. In terms of admitted episodes in private hospitals, the 2008-09 NHCDC accounted for 41% of episodes in free standing day hospitals and 71% of episodes in other private hospitals.

The NHCDC aims to capture all private hospitals with 200 or more episodes in the year concerned21. It relies on the data captured through the PHDB to determine which hospitals are in scope for each year’s round of data collection, before approaching the hospitals themselves.

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21 The same activity threshold is also used for the public hospitals’ component of the NHCDC.
The NHCDC aims to collect cost and activity information for admitted episodes, non admitted services and emergency department services. The private hospitals’ component only covers admitted episodes. Data quality for the private hospitals’ component is variable, with significant caveats due to issues with inconsistent handling and reporting of costs, small AR-DRG volumes affecting estimates for free standing day hospitals and incomplete or inaccurate data affecting allocation of costs. In addition, private hospitals mostly lack the patient level feeder systems to capture consumption costs, thereby requiring estimation of hospitals’ costs through cost modelling, for the majority of private hospitals and free standing day hospitals.

Data can be submitted via a web based portal and the Department provides tools to carry out quality review of the data prior to its submission. For the 2008-09 round, a national co-ordinator also was appointed to facilitate the collection and review of the private hospitals’ data.

The admitted episodes’ component of the NHCDC produces reports on relative costs per episode by AR-DRG and by cost categories, as well as relative cost weights. These outputs are reported separately for public and private hospitals, and are produced for different subgroups of these hospitals. Time series comparisons are also produced, allowing some examination of variations in costs over time.

These outputs are used to inform casemix based funding models in various States and Territories, as well as in the development and implementation of Commonwealth policy. There is some use of the private sector results by hospitals to compare their cost structures with national averages. The Productivity Commission also made use of the NHCDC data in its research study into public and private hospitals. The Commission found it difficult to apply the data due to significant differences in data quality and approaches to costs’ classification and allocation between public and private hospitals.

A review of the NHCDC and its processes was carried out in 2008 and the findings and recommendations from that review have guided and continue to guide the further development of the collection over time.

2.1.6 National Perinatal Statistics Collection

The National Perinatal Statistics Collection (NPSC) is operated by the National Perinatal Statistics Unit (NPSU). This is a collaborating unit with the AIHW based at the University of New South Wales.

The NPSC collates data on pregnancy and childbirth, with State and Territory based units providing the data annually. The collected data conform to an NMDS for perinatal data. Individual States and Territories may collect a larger set of data than this NMDS, depending upon their local needs. Each State and Territory mandates reporting of birth related data to their respective maternal perinatal data collections, with the exception of the ACT. In most cases, the responsibility for providing the data lies with the attending midwife. Where there is no attending midwife and delivery takes place in a private hospital, the responsibility usually lies with the hospital.

22 Australian Refined Diagnosis Related Group classification (AR-DRG) is used for reporting
23 These cost categories are referred to as “cost buckets”.
The processes for collection and reporting of the perinatal data are well-established. In most jurisdictions they have been operating for more than 20 years. Some streamlining at a local level is already evident. For example, the ACT uses its admitted patient collection to obtain some birth related data is used in its perinatal collections.

The NPSC is used to report on a range of maternal and perinatal statistics. The annual Mothers and Babies report has been produced since 1991. It is also used for research purposes.

2.1.7 Australian Cancer Database

The Australian Cancer Database (ACD) is managed and maintained by the Cancer and Screening Unit within the AIHW. That unit operates the ACD in collaboration with the Australasian Association of Cancer Registries (AACR), as part of the functions of the National Cancer Statistics Clearing House (NCSCH)\(^{26}\).

The ACD collects data on incidence of new cases of cancer and on deaths due to cancers. NCSCH receives the data from State and Territory based cancer registries, on an annual basis, in accordance with a specified protocol\(^{27}\). That protocol lists the data items that are collected nationally, although States and Territory cancer registries usually collect a superset of this national data set.

Data are collected, collated and reported in terms of cases of cancer, rather than health care activities such as admission to hospital, non admitted treatment at a hospital or visits to community based health practitioners. As such, the State and Territory level processes involve collection and reconciliation of data from multiple sources – hospitals, medical specialists, pathologists, deaths’ data etcetera – to build individual cancer case records. It is these case records whose details that are summarised and submitted to the ACD. Each State and Territory has a legislative basis requiring health care providers to submit information to that jurisdiction’s registry, when a patient is diagnosed or treated for cancer.

The processes for collection and reporting of the cancer data are well-established. In most jurisdictions they have been operating for more than 30 years.

The data collected by the ACD is used for a range of reporting and research purposes, including the ongoing series of Australian Cancer Incidence and Mortality books\(^{28}\). The data are also available to researchers, subject to ethical and confidentiality requirements.

2.1.8 Existing collections excluded from consideration for streamlining.

In undertaking stakeholder interviews for this Review and in carrying out associated research, a number of additional national collections that involved private hospitals submission of data that were identified. These additional collections were considered but for the reasons outlined below, they were deemed to be outside the scope of this Review.

The primary reasons for excluding collections centred on whether the private hospitals' participation in the collections was imposed or otherwise mandatory and whether the Commonwealth, usually through the agency of the Department, was in a position to directly influence the operation of the collections.


National Joint Replacement Register

The National Joint Replacement Register was established in 1999 by the Australian Orthopaedic Association and continues to be operated by that Association today. The Register collects data from all hospitals undertaking joint replacement procedures throughout Australia.\(^{29}\)

The Register commenced operations in 1999 as a collection only from selected South Australian hospitals. Its scope was expanded gradually to include all Australian hospitals by 2003. The Association states the aims of the Register to be:

- to determine demographic and diagnostic characteristics of patients undergoing joint replacement surgery throughout Australia;
- to provide accurate information on the use of different types of prostheses in both primary and revision joint replacements;
- to evaluate the effectiveness of different types of joint replacement prostheses and surgical techniques at a national level;
- to compare the Australian joint replacement experience to that of other countries;
- to provide confidential data to individual surgeons and hospitals to audit their joint replacement surgery; and
- to educate Australian orthopaedic surgeons in the most effective prostheses and surgical techniques to achieve successful outcomes.

Data collected by the Register include limited patient demographics, diagnostic information and detailed data on the replacement procedure(s) performed and specific prostheses used. The Register produces annual reports and a number of supplementary reports on specific issues or with a specific research focus. The Association also undertake systematic review of the performance of prostheses based on the data held in the Register. The results of these reviews can be used by the Department to advise the Therapeutic Goods Administration on the listing of specific prostheses.

The National Joint Replacement Register, while funded by the Department through a levy on prostheses’ manufacturers and distributors,\(^{30}\) the Australian Orthopaedic Association operates the Register independently of the Commonwealth Government. The process of data collection also tends to operate through the agency of surgeons and nursing staff within hospitals. For these reasons, the National Joint Replacement Register was seen to be outside the scope of this Review.

Private Mental Health Alliance Centralised Data Management Service

The Private Mental Health Alliance (PMHA) is a peak industry body for private-sector mental health services in Australia.\(^{31}\) The Centralised Data Management Service (CDMS) is operated by the PMHA and collect data from participating private psychiatric hospitals on the clinical

\(^{29}\) [http://www.dmac.adelaide.edu.au/aoanjrr/about.jsp?section=hospitals]

\(^{30}\) [http://www.pmha.com.au/]

\(^{31}\) [http://www.pmha.com.au/]
status of patients before and after treatment. Hospitals’ participation in the CDMS is voluntary and currently around 40 hospitals participate\(^{32}\).

The principle purpose of the CDMS is to improve the quality and effectiveness of the services provided by private psychiatric hospitals. An annual statistical summary is produced from the data collected and hospitals are also provided with direct feedback on their performance relative to their peers.

The Service is jointly funded by the Australian Government, private health insurers and the participating hospitals themselves. It has operated since 2001 and stakeholders interviewed for this Review saw it as an exemplary model for successfully engaging the private hospital sector in providing data for performance monitoring and reporting purposes.

Nonetheless, given the voluntary nature of this collection and the fact that it is beyond the influence of the Department, the CDMS was seen as being outside the scope of this Review.

**Australasian Rehabilitation Outcomes Centre**

The Australasian Rehabilitation Outcomes Collaboration (AROC) was developed and is operated by the Centre for Health Services Development at the University of Wollongong. AROC collects and reports on data from the specialist medical rehabilitation sector\(^{33}\). The data are collected for a range of purposes, including national benchmarking, assessing efficacy of interventions, providing clinical and management information reports for stakeholders in the rehabilitation sector and annual reporting.

AROC obtains and holds data from both public and private hospitals. The collection is voluntary, with private hospitals subscribing to the AROC process on a voluntary basis. In return, they receive value added analytical outputs that allow them to assess their outcomes and performance against industry benchmarks.

Given the voluntary nature of AROC and the fact that the Commonwealth does not have direct influence over its operation, it was seen as outside the scope of this Review.

**Palliative Care Outcomes Collaboration**

The Palliative Care Outcomes Centre (PCOC) was developed and is operated by the Centre for Health Services Development at the University of Wollongong. PCOC collects and reports on data from palliative care service providers\(^{34}\). The data are collected to support national benchmarking and improvement of palliative care quality and outcomes. Data collection began from 2008 and for the period from July to December 2009, PCOC estimated that it captured data on 75 per cent or more of admitted, overnight stay palliative care episodes for most jurisdictions.

PCOC obtains and holds data from both public and private hospitals. The collection is voluntary, with private hospitals subscribing to the AROC process on a voluntary basis. In return, they receive value added analytical outputs that allow them to assess their outcomes and performance against industry benchmarks.

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Given the voluntary nature of PCOC and the fact that the Commonwealth does not have direct influence over its operation, it was seen as outside the scope of this Review.

**ANZICS Centre for Outcome and Resource Evaluation**

The Australian and New Zealand Intensive Care Society (ANZICS) maintains several data collections through its Centre for Outcome and Resource Evaluation (CORE). The three data collections maintained by CORE are the Adult Patient Database (APD), the Australian and New Zealand Paediatric Intensive Care Registry (ANZPIC), and the Critical Care Resources collection (CCR)\(^\text{35}\).

The principal aims of these collections are to provide a peer review mechanism for Australian and New Zealand intensive care units who participate, as well as a database for epidemiological and related research purposes and catalogue of intensive care resources. While participation in the CORE collections is open to all intensive care units in Australia and New Zealand, participation is voluntary.

Given the voluntary nature of the ANZICS CORE collections and the fact that the Commonwealth does not have direct influence over their operations, they were seen as outside the scope of this Review.

**ANZDATA**

The Australia and New Zealand Dialysis and Transplant Registry (ANZDATA) operates under the auspices of Kidney Health Australia and the Australia and New Zealand Society of Nephrology. It captures data on the incidence, prevalence and outcome of treatment for patients with end stage renal failure.

The Register captures data on patients treated at all dialysis and kidney transplant units throughout Australia and New Zealand\(^\text{36}\). As such, private hospitals and day centres providing dialysis services submit data to ANZDATA.

Contributing units submit data monthly for key events such as new patients, transplants and deaths. In addition, units submit an annual survey capturing a detailed cross-section of patient and treatment data for each patient actively receiving treatment.

ANZDATA produces an annual report based on the data collected. It also makes the data available for research and planning purposes and undertakes its own research.

Although participation in ANZDATA includes all dialysis and transplant units in Australia and New Zealand, participation is voluntary. Given this voluntary nature of participation and the fact that the Commonwealth does not have direct influence over ANZDATA and its operations, it was seen as outside the scope of this Review.


\(^{36}\) ANZDATA Registry Report 2010. Australia and New Zealand Dialysis and Transplant Registry Adelaide, South Australia.
2.2 Potential future national collections

As well as the existing collections which have been identified in the preceding section, two areas of potential future national collection of data from private hospitals were identified. The first of these related to safety and quality indicators and the second relates to health workforce. Each of these is discussed below.

2.2.1 Safety and Quality Indicators

The ACSQHC was established in 2006 to develop a national framework for safety and quality in health care, together with an associated programme of work. Under the proposed national health reforms the ACSQHC has a larger responsibility to formulate and implement safety and quality standards, as well as to collect and disseminate information relating to safety and quality.

Even if the reforms were not present, the Commission has a deep interest in the use of private hospital data for data-driven quality improvement. The second of three elements in its Australian Safety and Quality Framework for Health Care is *Driven by Information*. This element enacts the Commission’s view that timely review – at provider level – of a series of measures of safety and other elements of health care quality, within a sound clinical governance system, is an essential element of quality improvement.

 Nonetheless, the ACSQHC currently has no intentions of pursuing new collections of data from hospitals in Australia. Rather, it holds the view that existing data collections, including those from private hospitals, are under-utilised in terms of routine generation and review of indicators of health care quality. Consequently, the ACSQHC aims to populate its safety and quality measures using existing data held in collections such as the APC (see Section 2.1.3).

The ACSQHC has developed 10 standards relating to safety and quality in health care. These standards have been piloted in health services and the final standards are expected to be endorsed by the Australian Health Ministers' Conference (AHMC) during 2011. Once endorsed, the standards will form the basis for future accreditation of hospitals in Australia, including private hospitals.

Under this new accreditation system, private hospitals will be required to provide data on measures related to the 10 standards to accrediting bodies. There are 13 accrediting bodies that will be empowered to accredit hospitals under the standards. As stated above, the ACSQHC expects the data related to each of the measures to be able to be extracted from existing data collections.

It is probable that the data provided by private hospitals to the accrediting organisations will also be required to be forwarded to the NHPA.

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40 The NHPA is yet to be established, with enabling legislation passed by both houses of the Australian Parliament after the completion of this Review, on 20 September 2011 (*National Health Reform Amendment (National Health Performance Authority) Bill 2011*). The scope of data collections that the NHPA may initiate and their implications for future burdens on private hospitals are not yet determined. It is not clear whether the NHPA will
The new accreditation system is scheduled to begin from 1 July 2011 and to be implemented fully by 2015. During the implementation phase, hospitals will have a choice of accreditation under the current system or under the new standards’ based system.

In addition to the developmental work relating to the standards and accreditation, the ACSQHC has already developed a set of core, hospital level indicators for routine monitoring and reporting. From a private hospital perspective, these indicators “can be generated by jurisdictions or private hospital ownership groups, which hold the source data, and reported back to provider facilities”.

ACSQHC has also established principles for clinical quality registers, following a process of field testing, which involved six existing national clinical registries. Further work in this area is intended to produce “national arrangements... for Australian clinical quality registries” and to develop a plan for the necessary technical infrastructure to support such arrangements.

2.2.2 Workforce

Health Workforce Australia (HWA) is a Commonwealth statutory authority. It was established under the Health Workforce Australia Act 2009 with wide ranging responsibilities for the improvement of health workforce policy and planning in Australia. HWA reports to the Australian Health Ministers’ Conference (AHMC).

Part of HWA’s remit is to provide accurate information to support workforce policy development and planning. Since its establishment the HWA has commenced a number of activities involving the collection and collation of information on workforce within the Australian hospital sector. Some of those activities have involved requests to private hospitals to provide (workforce related) data to HWA.

In addition to these ad hoc data requests, HWA is responsible for the development of the National Health Workforce Statistical Resource. This resource is “a statistical database with two major components, the National Health Workforce Dataset (NHWDS) and the National Health Workforce Planning Tool (HWPT)”.

In light of these facts the HWA were approached to contribute to this Review. In particular, they were asked about the future prospects for ongoing data collection from private hospitals by the HWA. It is the view of the HWA that the NHWDS collection and reporting requirements in the future are likely to be served through data obtained from sources other than ongoing collection from private hospitals. The most recent experience of collecting data on clinical placements directly from private hospitals has proven burdensome and difficult, and HWA is actively pursuing alternative means to obtain this data in the future.
The HWPT is expected to rely on data from existing sources that do not require new or additional collection from private hospitals.

For these reasons, this Review did not consider potential future workforce collections as being relevant to the streamlining objective.

2.3 Private hospital licensing and data collection

This section summarises the licensing regimes for private hospitals in each State and Territory, as well as the Commonwealth legislative basis for declaring private hospitals. It focuses on the data reporting and submission requirements imposed by the different licensing arrangements.

The following sections provide detail of the licensing requirements for private hospitals for the Commonwealth, States and Territories.

2.3.1 Commonwealth private hospital declaration

A private hospital can be declared as such by the (delegate of the) Commonwealth Minister for Health and Ageing, under the Private Health Insurance Act 2007. Declaration enables a private hospital to receive payments of health benefits from health insurers, following treatment of insured patients.

The Department administers the declaration process. As part of that process, the Department collects the following information when a hospital is declared:

- facility name;
- ownership arrangements;
- name of Chief Executive Officer;
- date facility opened;
- address and contact details;
- geographic area;
- category of hospital\(^{45}\) (up to 5 categories);
- number of beds;
- type of hospital\(^{46}\);
- classes of clinical services offered by the hospital\(^{47}\);
- accreditation details;

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\(^{45}\) There are 5 categories: Private Hospital; Privatised Public Hospital; Hospital providing overnight treatment; Hospital providing overnight and day only treatment; Hospital providing day only treatment.

\(^{46}\) There are 7 types: For Profit; Religious; Charitable; Community; Memorial; Bush Nursing; Other/Not For Profit.

\(^{47}\) There are 42 classes: Addiction Dependency; Endoscopy; Neonatal Intensive Care Unit; Sleep Apnoea; AIDS/HIV; Epilepsy; Neurosurgical; Spinal; Burns; General Surgery; Obstetrics/Maternity; Surgical; Cardiac; Genetics; Oncology; Transplant; CCU; Geriatric Assessment Unit; Orthopaedics; Vascular; Chronic Disease Management; Gynaecology; Paediatric; Other Services (please list below); Day Surgery; High Dependency; Pain Management; Dental; Hospital in the Home; Palliative Care/ Hospice; Diabetes; Infectious Disease; Psychiatric; Dialysis; ICU; Rehabilitation; Ear Nose & Throat; IVF; Residential Aged Care Services; Emergency Department; Medical.
• whether the facility is co-located with a public hospital; and
• triage and emergency arrangements.

There is no obligation on the private hospital to update or maintain this information once it has been collected by the Department at hospital declaration.

The hospital declaration requirement and associated process also applies to public hospitals who wish to receive payments of health benefits for treating insured patients. However, there is no requirement to be declared under the Private Health Insurance Act 2007 for a hospital – either private or public – that does not wish to receive benefits’ payments.

All private hospitals declared under this Act are required to submit HCP data to health insurers (see Section 2.1.1) and are required to submit PHDB data to the Department (see Section 2.1.2).

2.3.2 New South Wales

Within NSW, private hospitals and day procedure centres must be licensed under the Private Health Facilities Act 2007 and the Private Health Facilities Regulation 2010. There are currently 18 prescribed classes of private health facilities. Licensing is overseen by the Private Hospital Unit within NSW Health.

The above legislation defines a private health facility in terms of the clinical nature of services provided by the facility. The range of clinical services that is prescribed as (potentially) being delivered by a private health facility is the same as the 18 service classes.

Schedule 1 of the Private Health Facilities Regulation 2010 outlines the standards with which private hospitals must comply. Section 21 outlines that private hospitals must report adverse events to the Department. Under section 42 of the Act, a root cause analysis team should also be appointed for any such reportable incident. The licensee has 30 days after being provided with an incident report by the root cause analysis team, to forward a copy of the report to the Director General.

In addition, the “licensee of a private health facility must conduct regular audits to ensure that the facility is complying with statutory requirements as well as the facility’s policies and procedures”.

Under the Act and Regulation, the Private Health Care Unit monitors and ensures compliance with licensing standards. This includes regular onsite visits, paper audits, telephone or written contact. After each audit, reports are made to facilities and the Unit conducts follow up work to ensure recommendations have been implemented.

Licensed private hospitals are also required to submit data monthly to the NSW Health Inpatient Statistics Collection (NSWISC), as specified in Policy Directive 2005/175. The data submitted...
by private hospitals to NSWISC forms the basis of the admitted patient data submitted by NSW Health to the AIHW for inclusion in the APC (see Section 2.1.3).

2.3.3 Victoria

The Department of Health is responsible for the regulation of private hospitals and day procedure centres under the Health Services Act 1988 and the Health Services (Private Hospitals and Day Procedure Centres) Regulations 2002. This legislation mandates the minimum requirements for the quality and safety of care delivered to patients in private hospitals and day procedure centres. A private hospital or day procedure centre cannot commence or continue operation and admission of patients unless the premises are registered under this legislation. Applications for renewal of registrations must be made three months in advance of expiry.

The above legislation defines a private hospital in terms of the services it provides and the fact that those services are provided for a charge. It also defines a day procedure centre in similar terms, with the additional criterion that patients "are reasonably expected to be admitted and discharged on the same date".

The Department’s Policy Instruments and Compliance Unit conducts regular on-site assessments of registered facilities. The inspection process begins with the proprietor completing a comprehensive self-assessment tool that incorporates legislative requirements, relevant professional standards, relevant guidelines, current best practice and occupational health and safety issues. The self-assessment tool is reviewed by the Policy Instruments and Compliance Unit prior to a scheduled inspection, the results of which are used to inform both the inspection plan and information gathering at the time of inspection.

Inspections of each registered private hospital and day procedure centre are undertaken at a minimum of once every two years. However, each facility is assessed against a risk-rated matrix and that matrix indicates whether more frequent regulatory inspections are required. Information collected through the inspection is used by the Department’s authorised officers to inform the Secretary on the standards of health care services provided against criteria set out in the above regulations. Results of the inspection are used to inform the Secretary of the Victorian Department of Health whether to renew a registration or whether to place additional conditions on the registration. As a standard, registrations remain valid for a period of two years.

As specified in the Health Services (Private Hospitals and Day Procedure Centres) Regulation 2002, private hospitals and day procedure centres are required to submit episode level data to the Department of Health in Victoria for every separation (completed admitted patient episode).

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54 The legislation requires a private hospital to provide one or more of medical health services, surgical health services or specialty health services. Specialty health services comprise one or more of artificial insemination; assisted reproductive treatment; cardiac services; emergency medicine; endoscopy; intensive care; mental health services; neonatal services; obstetrics; oncology (chemotherapy); oncology (radiation therapy); renal dialysis; and specialist rehabilitation services.
These data are stored in the Victorian Admitted Episode Dataset (VAED) and form the basis of the admitted patient data submitted by Victoria to the AIHW for inclusion in the APC (see Section 2.1.3).

External reporting of sentinel events is not mandated for the private hospital sector in Victoria. However, some private hospitals contribute data on quality and safety performance to state databases, including hospital-acquired infection data contributed to the Victorian Nosocomial Infection Surveillance System (VICNISS). This reporting commenced from 2009 and private hospitals participate on a voluntary basis.

2.3.4 Queensland

Private hospitals within Queensland are licensed under the *Private Health Facilities Act 1999* which “empowers the Chief Health Officer to make standards for the protection of the health and well being of patients receiving health services at private health facilities”\(^\text{57}\). Queensland has a Clinical Services Capability Framework for Licensed Private Health Facilities that specifies support services, staff profiles and minimum safety standards that should be met by private health facilities to ensure safe and appropriate supported clinical services\(^\text{58}\).

The above Act defines a *private hospital* and a *day hospital* separately. Both are defined as a facility that delivers health services, with a *health service* defined as “*a service provided to a person for maintaining, improving or restoring the person’s health and wellbeing*”. A *private hospital* is defined as a facility that provides health services to people who are admitted and discharged on separate days, and the facility is not a public hospital nor a nursing home, hostel or other residential nursing care facility. A *day hospital* is defined as a facility that provides health services to people who are admitted and discharged on the same day and which is not run by the State.

The *Private Health Facilities Act 1999* requires licensees of private health facilities to submit reports to the Chief Health Officer on a six monthly basis. The purposes of these reports are to:

- monitor the quality of health services provided at private health facilities;
- enable the State to give information to the Commonwealth or another State under agreements prescribed under section 147 of the Act; and
- monitor the general state of health of the public having regard to the types and numbers of health services provided at the facilities.

Reporting obligations include sentinel events (as defined by the Act) within 48 hours and for some events, a root cause analysis is required. On a six monthly basis, hospitals are also required to report adverse outcomes’ data. This is used by Queensland Health to identify any aspects of the health service provision that may require closer scrutiny and monitoring\(^\text{59}\).

A self-audit tool has been developed to allow hospitals to assess their individual compliance with the *Private Health Regulations*.


Additional reporting requirements are imposed on licensed private hospitals through the *Health Quality and Complaints Commission Act 2006*. Under this Act, the Health Quality and Complaints Commission (HQCC) has developed a set of 9 healthcare standards that apply to all licensed private hospitals and day hospitals in Queensland. These standards include an obligation to demonstrate improvement in quality of care via reporting against 89 indicators. The responses required for the indicators are a mixture of numbers and Yes/No responses.

There is scope for Queensland Health to share data reported the Chief Health Officer with the HQCC but only if the private hospital concerned provides its consent to do so.

In addition to these quality and safety reporting requirements, private hospitals in Queensland are required to provide data to the Queensland Health Admitted Patient Data Collection (QHAPDC) and to the Queensland Health Monthly Activity Collection (QHMAC). These requirements are mandated by the *Private Health Facilities Act 1999*. The data submitted by private hospitals to QHAPDC forms the basis of the admitted patient data submitted to Queensland Health to the AIHW for inclusion in the APC (see Section 2.1.3). The QHMAC data are used by Queensland Health to fulfil its reporting obligations under the Australian Healthcare Agreements.

As and when private hospitals and day facilities update their details, Queensland Health advises the Commonwealth Department of Health and Ageing of the changes.

### 2.3.5 South Australia

Within South Australia, the *Health Care Regulations 2008* and the *Health Care Act 2008* specify the regulations that govern the licensing of private hospitals. Day hospitals are not required to hold a licence.

The above Act defines the concept of a *health service* and then defines a *hospital* as an entity that provides health services including health services provided on a live-in basis. A *private hospital* is then defined as a hospital that is not incorporated under the Act itself. 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.

South Australia adopts a minimalist approach to private hospital licensing, with no routine data submission requirements imposed through the licensing arrangements. Nonetheless, all private hospitals (as defined by the above Act) and almost all private day hospitals in South Australia submit admitted episode data to the Integrated South Australian Activity Collection (ISAAC) on a monthly basis. This data submission is voluntary and has been taking place since the early 1990s. The data submitted by private hospitals and day hospitals to ISAAC forms the basis of the admitted patient data submitted by SA Health to the AIHW for inclusion in the APC (see Section 2.1.3).

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On an annual basis, licensed private hospitals are required to provide SA Health with an annual return, which incorporates data on selected establishment characteristics. The data required are outlined within Schedule Two of the Health Care Act 2008 and include facility name and address, ownership and management details, bed numbers, clinical services, changes in facilities offered, and changes in diagnostic equipment used. Under the terms of the license, private hospitals are subject to inspections.

2.3.6 Western Australia

Private hospitals and day hospitals are licensed within Western under the legislative framework provided by the Hospitals and Health Services Act 1927, the Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987, the Hospitals and Health Services (Day Hospital Facility) Determination 2005, and the Hospitals and Health Services (Day Hospital Facility) Determination (No. 2) 2005.

Under this legislation, a private hospital and a day hospital are defined separately. A hospital is defined as a “an institution for the reception and treatment of persons suffering from illness or injury, or in need of medical, surgical or dental treatment or assistance, and includes a maternity home or maternity hospital, day hospital facility, nursing home or nursing post”64. A private hospital is then defined as a hospital that is not a public hospital.

A day hospital is defined as premises that are separate from a hospital (as defined in the Hospitals and Health Services Act 1927), do not provide overnight accommodation, and provide one or more of a prescribed set of services. The services prescribed for day hospitals comprise:

- any procedure involving general, spinal or epidural anaesthetic65;
- any procedure performed under sedation, plexus blockade or Biers Block64;
- any procedure involving the invasion of a sterile body cavity64;
- peritoneal dialysis and haemodialysis for the treatment of end stage renal failure64; and
- multidisciplinary day programs for psychiatric treatment of patients with mental illness66.

In applying for a licence, applicants are requested to provide a range of establishment data that is entered into a central database within the Licensing Standards and Review Unit of WA Health. This includes; facility and licence applicant details; clinical specialties and number of beds. Under any licence that is subsequently granted, any changes to the standing data should be notified to the Unit within 24 hours.

The licence that is issued clearly stipulates the conditions under which it is granted. This includes the number of beds, classes of patients that can be treated, number and categories of staff. On an annual basis, each licensed facility is subject to an inspection before the licence is

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63 The return requires the private hospital to nominate whether the range of services provided has changed and specifically whether it operates any of coronary care unit; neonatal intensive care unit; intensive care unit; high dependency unit; renal dialysis; or rehabilitation.
67 Application for License under the Hospitals and Health Services Act 1927. Licensing Standards and Review Unit, Department of Health, Western Australia, 2009.
renewed. This includes verification of standing data and operations against the conditions of the licence. On renewal of the licence, WA Health provides the Commonwealth Department of Health and Ageing with a copy, which can be used to update the Department’s records.

Under the terms and conditions of private hospitals’ and day hospitals’ licences, licence holders must comply with WA Health policies. These include sentinel events68; critical incidents and mortality review69.

Licensed private hospitals and day hospitals also are required, under licence conditions, to submit data on admitted patients to the WA Hospital Morbidity Data System (HMDS)70. These data are required to be submitted monthly and form the basis for the data provided by WA Health to the AIHW for inclusion in the APC (see Section 2.1.3).

2.3.7 Tasmania

In Tasmania, private hospitals and private day hospitals are licensed under the Hospitals Act 1918. However, the Health Service Establishments Bill is currently before the Tasmanian Parliament and will repeal and replace the Hospitals Act 1918, once passed. This section presents the details of the licensing regime proposed under that Bill. The Bill itself specifies the requirements for licensing and arrangements for the safety, quality and standards imposed on services provided by private health establishments.

The Health Service Establishments Bill specifies the scope of services provided by private health establishments in terms of the clinical nature of the services and the need for supervision or specific delivery by a registered medical practitioner, a registered nurse with obstetric qualifications, a registered dental practitioner, or by a registered podiatrist. The Act then classifies such services into 3 types:

- Type A procedures – those requiring admitted overnight hospital stay;
- Type B procedures – those usually requiring admitted treatment without an overnight stay; and
- Type C procedures – those not usually requiring admitted treatment.

A facility where Type A procedures are undertaken for fee, gain or reward are required to be licensed as a private hospital under the above Bill, while a facility where Type B procedures are undertaken but no Type A procedures, is required to be licensed as a day procedure centre. The Secretary of the Tasmanian Department of Health and Human Services (DHHS) is also empowered to require a health establishment that does not deliver Type A nor Type B services to be licensed as either a private hospital or a day procedure centre, should considerations of public safety and service quality warrant so doing.

Once licensed, there are no explicit statutory reporting requirements for private hospitals, although the Health Service Establishments Bill empowers the Secretary of the DHHS to require licensed private hospitals and day procedure centres to provide “any information that...is required for the purposes of this Act”. It also allows for the making of regulations specifically to

require a licensee to submit “to the Secretary…a copy of the register of patients for the establishment”.

In effect, such a regulation would require private hospitals and day procedure centres to submit data to the DHHS admitted episode collection. Nonetheless, currently Tasmanian private hospitals and day hospitals do submit data to this collection, on a voluntary basis. These data form the basis for the data provided by DHHS to the AIHW for inclusion in the APC (see Section 2.1.3).

Establishment level data, such as bed numbers and theatre types, is collected by DHHS through the licence application and approval process, and is required to be updated as and when such details change. DHHS provides this information to the Commonwealth Department of Health and Ageing on an exception basis (that is, when there is a change to the licensee’s details).

2.3.8 Northern Territory

In NT, private hospitals are licensed under the Private Hospitals Act. This Act specifies the requirements for licensing and arrangements for the management and inspection of private hospitals.

The Private Hospitals Act defines a private hospital in terms of the provision of prescribed medical or surgical treatment for fee or reward. There is no separate definition or classification of a day hospital or similar concept. The Act describes prescribed medical or surgical treatment as involving high risk procedures that are prescribed by regulation. However, the necessary regulations are yet to be presented to the NT Parliament. Once licensed, there are no explicit statutory reporting requirements for private hospitals. However, the Chief Health Officer of NT Health is empowered to require a licensee to provide details of any birth or death that occurs in the private hospital.

The Private Hospitals Act requires annual inspection of each licensed private hospital. As a part of that inspection, the Act empowers the Chief Health Officer’s authorised inspector to inspect the “register of patients” that the hospital is required to maintain. This register contains patient, clinical and administrative data for each admitted patient episode.

Nonetheless, currently one NT private hospital submits data to the NT admitted episode collection, on a voluntary basis. No private day hospitals do so. These data form the basis for the data provided by NT Health to the AIHW for inclusion in the APC (see Section 2.1.3).

Establishment level data, such as bed numbers and theatre types, is collected by NT Health through the licence application and approval process, and is required to be updated as and when such details change.

2.3.9 Australian Capital Territory

In the ACT, private hospitals are licensed under the Public Health Act 1997. Under that Act, the operation of a private hospital is classified as a public health risk activity, requiring licensing. Private hospital licences are issued under the ACT Healthcare Facilities Code of Practice 2001, which is an enforceable code of practice under the Public Health Act 1997.

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71 The Private Hospitals Act was created by the passage of the Private Hospitals and Nursing Homes Amendment Act 2011, which passed through the NT Parliament on 3 May 2011 and commenced on 20 May 2011. The NT Legislative Assembly rose on 5 May 2011 and was scheduled to resume sitting on 23 June 2011.
The Code of Practice applies to all healthcare facilities, both public and private, that provide prescribed medical and dental procedures. The Code defines *prescribed medical and dental procedures* as comprising one or more of:

- administration of a general, spinal, epidural or major regional block anaesthetic or intravenous sedative for the purpose of performing an elective procedure, not including mandibular blocks;
- endoscopy;
- dialysis, haemofiltration or haemoperfusion;
- prolonged intravenous infusion of a single cytotoxic agent or sequential intravenous infusion of more than one cytotoxic agent; or
- cardiac catheterisation.

The Code also applies to all healthcare facilities that provide overnight accommodation to patients prior to or after medical treatment.

The concept of a *day hospital* is defined in the *Health Act 1997*, which defines a day hospital as a hospital where a person admitted for medical or surgical treatment is discharged on the same day.

This licensing framework does not require healthcare facilities to provide information to ACT Health, other than our requirement to notify ACT Health of serious incidents within 24 hours of their happening, and a requirement for producing a publicly available annual report.

Nonetheless, some ACT private hospitals voluntarily provide admitted episode data to ACT Health. Private day hospitals are the exception, with none of these providing data. These data form the basis for the data provided by NT Health to the AIHW for inclusion in the APC (see Section 2.1.3).

Similarly to South Australia, ACT adopts a "light touch" approach to private hospital licensing. Private hospital details are checked and updated as necessary on an annual basis, at around the time that the admitted episode data are due to be provided to the AIHW. The facility level details held by ACT health cover such things as facility ownership and contact details, range of clinical services offered, accreditation, held, and compliance with certain public health procedural requirements.

### 2.3.10 Summary

Table 4 summarises the licensing requirements within the States and Territories, in terms of the types of facilities that require licensing; the classes of service that each facility can be licensed to provide, reporting requirements determined by the licence, and whether or not the jurisdiction provides licence details to the Department. It does not cover statutory reporting obligations unrelated to the licensing arrangements, such as the requirements to report to cancer registries and perinatal statistics units.

Table 5 summarises the different approaches to defining private hospitals and Day hospitals within each State and Territory.

From the foregoing descriptions of licensing arrangements, it is clear that the concepts of private hospital and day hospital, while broadly similar across borders, differ substantially in
terms of how they are specifically defined. The most extreme example of this is South Australia where the notion of a day hospital is not defined at all within the licensing arrangements.

There is also substantial variation in the range and nature of facility level details captured through licensing application and renewal processes. In particular, the information captured on service profiles varies significantly among jurisdictions.

The level of reporting and data submission expected of private hospitals also varies significantly among States and Territories. At one extreme, Queensland imposes significant reporting burdens across a range of operational areas. While at the other extreme South Australia imposes very little in the way of legislated reporting requirements.

This variation is evident in terms of expectations around admitted episode data. Some jurisdictions require submission of admitted episode data from private hospitals and Day hospitals either as a condition of licence or as a statutory requirement. Others rely on voluntary submission of such data by the private sector.

No jurisdiction has a formal arrangement in place with the Commonwealth Department of Health and Ageing to provide the latter with updates to licence details for private hospitals and Day hospitals that they license. Informal arrangements operate for two jurisdictions.

Table 4  Summary of legislative requirements by State and Territory

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Facilities licensed</th>
<th>Service classes</th>
<th>Reporting requirements</th>
<th>Data provided to DoHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Private Hospitals</td>
<td>16 classes of service 73</td>
<td>• Adverse Events</td>
<td>No</td>
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<td></td>
<td>• Day facilities</td>
<td></td>
<td>• Root Cause Analysis</td>
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<td>• Regular audit</td>
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<td>• Admitted Patient Collection</td>
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<td>In addition, there</td>
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<td>are eighteen</td>
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<td></td>
<td>facilities 72</td>
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<tr>
<td>Victoria</td>
<td>Private Hospitals</td>
<td>15 classes of service 74</td>
<td>• Self-audit tool</td>
<td>No</td>
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<td></td>
<td>• Day facilities</td>
<td></td>
<td>• Episode level data</td>
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<td></td>
<td></td>
<td></td>
<td>• Admitted Patient Collection</td>
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</tbody>
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72 Anaesthesia; Cardiac catheterisation; Cardiac surgery; Chemotherapy; Emergency; Gastrointestinal Endoscopy; Intensive care; Interventional neuroradiology; Maternity; Medical; Mental health; Neonatal; Paediatric; Radiotherapy; Rapid detoxification; Rehabilitation; Renal dialysis; and Surgical.

73 Anaesthesia; Intensive care; Paediatric; Cardiac catheterisation; Interventional neuroradiology; Radiotherapy; Cardiac surgery; Maternity; Rapid opioid detoxification; Chemotherapy; Medical Rehabilitation; Emergency; Mental health; Renal dialysis; Gastrointestinal endoscopy; Neonatal; and Surgical. [http://www.health.nsw.gov.au/resources/hospitals/phc/pdf/app_lic_for_phf.pdf](http://www.health.nsw.gov.au/resources/hospitals/phc/pdf/app_lic_for_phf.pdf)

74 Medical health services; Surgical health services; Speciality health services for the provision of; Artificial insemination; Assisted reproductive treatment; Cardiac Services; Emergency Medicine; Endoscopy; Intensive Care; Mental Health; Neonatal Services; Obstetrics; Oncology (Chemotherapy); Oncology (Radiation Therapy); Renal Dialysis; and Specialist Rehabilitation. [http://docs.health.vic.gov.au/docs/doc/E62565B2EF1D4FB3CA25788700783BD5/FILE/Application%20kit%20for%20registration%20of%20private%20hospital%20or%20day%20procedure%20centre.pdf](http://docs.health.vic.gov.au/docs/doc/E62565B2EF1D4FB3CA25788700783BD5/FILE/Application%20kit%20for%20registration%20of%20private%20hospital%20or%20day%20procedure%20centre.pdf)
<table>
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<tr>
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<th>Service classes</th>
<th>Reporting requirements</th>
<th>Data provided to DoHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland</td>
<td>• Private Hospitals&lt;br&gt;• Day facilities</td>
<td>42 classes of service(^{75})</td>
<td>• Sentinel events&lt;br&gt;• Root Cause Analysis&lt;br&gt;• Adverse outcome data on six monthly basis&lt;br&gt;• Self-audit tool&lt;br&gt;• Admitted Patient Collection</td>
<td>Informally</td>
</tr>
<tr>
<td>South Australia</td>
<td>• Private Hospitals, excluding day facilities</td>
<td>6 classes of service(^{76})</td>
<td>• Provision of documents for inspections</td>
<td>No</td>
</tr>
<tr>
<td>Western Australia</td>
<td>• Private Hospitals&lt;br&gt;• Day facilities A-D&lt;br&gt;• Private nursing posts&lt;br&gt;• Private Psychiatric Nursing Hostels&lt;br&gt;• Private Nursing homes</td>
<td>34 classes of service(^{77})</td>
<td>• Sentinel events&lt;br&gt;• Root Cause Analysis&lt;br&gt;• Mortality Review&lt;br&gt;• Inpatient statistics</td>
<td>Informally</td>
</tr>
<tr>
<td>Tasmania</td>
<td>• Private hospitals.&lt;br&gt;• Day hospitals</td>
<td>Three types of service, based on admitted status and overnight stay status</td>
<td>• Nil</td>
<td>No</td>
</tr>
</tbody>
</table>

\(^{75}\) Cardiothoracic Surgery; Colorectal Surgery; Coronary Care; Drug & Alcohol; Ear Nose & Throat; Gastrointestinal Surgery; General Medicine; General Surgery; Gynaecology; High Dependency; Hepatobiliary/Pancreatic Surgery; Hospice; Intensive Care; Intensive Care Post-Operative; Maxillofacial Surgery; Mental Health; Mental Health – Secure; Neonatal Cots; Neurology; Neurosurgery; Obstetrics; Oncology; Oncology/Palliative Care; Ophthalmology; Orthopaedic; Otolaryngology Surgery; Paediatric Medicine; Paediatric Surgery; Palliative Care; Plastic & Reconstructive Surgery; Post Natal; Rehabilitation; Renal Medicine; Sleep Studies; Respiratory Medicine; Sub-Acute Medical; Thoracic Medicine; Thoracic Surgery; Unallocated; Urology; Vascular Surgery; Day Hospital Diagnostics; Day Hospital Primary Recovery and Day Hospital Treatment Bays. [http://www.health.qld.gov.au/privatehealth/docs/phf_application_forms.pdf](http://www.health.qld.gov.au/privatehealth/docs/phf_application_forms.pdf)

\(^{76}\) Coronary care unit; Neonatal intensive care unit; Intensive care unit; High dependency unit; Renal dialysis; Rehabilitation.

\(^{77}\) Department of Health Western Australia, Licensing and Standards Review Unit, License Application, Medicine – Cardiology; Dermatology; Emergency medicine; Gastroenterology; Hepatology; General Medicine; Gerontology; Infectious disease; Intensive care; Medical Oncology; Nephrology; Neurology; Nuclear Medicine; Obstetrics; Gynaecology; Ophthalmology; Paediatric Medicine; Palliative Medicine; Psychiatry; Rheumatology; Thoracic and sleep studies; Surgery – Cardiothoracic; colorectal; dental; Ear nose and Throat; General; Gynaecological; Neurosurgery; Oral/Maxillofacial; Major Orthopaedic; Minor Orthopaedic; Ophthalmic; Otolaryngology; Paediatric; Plastic; Urology; and Vascular.
### Table 5 How private hospitals are defined, by jurisdiction

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Private hospital</th>
<th>Day hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>Facility delivering one or more of a set of specific services</td>
<td>Facility delivering one or more of a set of specific clinical services, for a charge</td>
</tr>
<tr>
<td>Victoria</td>
<td>Facility delivering one or more of a set of specific clinical services, for a charge</td>
<td>Facility delivering one or more of a set of specific clinical services, for a charge. Patients are expected to be admitted and discharged on the same day</td>
</tr>
<tr>
<td>Queensland</td>
<td>Facility delivering health services (generically defined) to patients admitted and discharged on different days.</td>
<td>Facility delivering health services (generically defined) to patients admitted and discharged on the same day.</td>
</tr>
<tr>
<td>South Australia</td>
<td>Facility delivering health services (generically defined) to patients admitted overnight stay</td>
<td>Not defined</td>
</tr>
<tr>
<td>Western Australia</td>
<td>Facility providing medical, surgical or dental treatment that is not a public hospital</td>
<td>Facility separate to a hospital that provides one or more of a set of specific clinical services</td>
</tr>
<tr>
<td>Tasmania</td>
<td>Facility providing services requiring supervision of delivery by a registered health professional, to patients requiring admitted overnight stay</td>
<td>Facility providing services requiring supervision of delivery by a registered health professional, to patients expected to be admitted and discharged on the same day.</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>A facility providing prescribed medical or surgical services for a charge</td>
<td>Facility delivering one or more of a set of specific clinical services, for a charge, and where patients are admitted and discharged on the same day</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>Facility delivering one or more of a set of specific clinical services, for a charge</td>
<td>Facility delivering one or more of a set of specific clinical services, for a charge</td>
</tr>
</tbody>
</table>

78 Awaiting passage of regulations by NT Parliament.

79 *ACT Healthcare Facility Licence Application Form*. The 10 service types are Overnight stays prior to, or after receiving medical treatment; Administration of a general anaesthetic; Spinal anaesthetic; Epidural anaesthetic; Major regional block anaesthetic not including mandibular blocks; Intravenous sedative; Endoscopy; Dialysis, haemofiltration or haemoperfusion; Prolonged intravenous infusion of a single cytotoxic agent or sequential intravenous infusion of more than one cytotoxic agent; and Cardiac catheterisation.
2.4 Productivity Commission Findings

The Productivity Commission has been investigating the state of comparative reporting across the public and private hospital sector as part of a wide brief to report on “the relative performance of public and private hospitals, and related data issues.” The Commission has produced several reports and issues papers relevant to this report over the period from 2009 to the present (2011).

The relevance for this report is that the Productivity Commission has noted that ‘some data development will be needed in order to calculate ‘the efficient price’ for different services covered by the National Health and Hospitals Network Agreement (NHHNA)’. Now NHHNA has been formally agreed by all jurisdictions, the findings of the Productivity Commission and subsequent actions by the Department and other parties in response to those findings warrants some examination. The current state and implications for data development are examined in the sections below.

2.4.1 Existing Cost Data Sets - Inconsistent Collection Methods and Missing Information

The Productivity Commission Finding in its Report noted that:

“Existing datasets on hospital and medical costs are limited by inconsistent collection methods and missing information. The Commission has sought to address these limitations by drawing on various data sources and incorporating adjustments to make the data more comparable where possible, as well as noting data deficiencies where they exist. The resulting estimates of hospital and medical costs should be considered experimental.”

It is true that inconsistent collection methods and missing information limit the comparability and consequent utility of existing datasets on hospital and medical costs. Greater comparability could be achieved and some practical actions such as more effective data linkage are described in other parts of this report (Section 4). However it is important to note that private hospitals operate with different goals and in a different environment (where they are in competition with others) to the public sector. Issues to consider when contemplating changes to existing collections and processes to enhance comparability of public and private hospital data are:

- Private hospitals are reticent to make available data that may damage their commercial or negotiating position (with other hospitals and with insurers). Private hospitals making detailed costs’ data available is likely only to happen if the data are not published at a hospital level. This would mean such data would need to be provided in a manner that would preclude its publication on the myHospitals web site and protected it from access through Freedom of Information requests.

- There is no commercial business case for private hospitals to invest in the feeder systems and operational processes necessary to generate reliable, patient level costs’ data. Such systems exist in the public sector by virtue of past investment by governments whose objectives were to improve the efficiency of publicly funded hospital services at a system level. Adopting a similar approach to the private sector (that is, providing government funding to install feeder systems) creates an ongoing operating cost and does not address the

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80 Productivity Commission, Public and private hospitals (December 2009).
81 Ibid. Finding 5.1; p. 101.
data quality implications of the private hospitals’ view that they do not need the detailed costing data for their internal financial management.

- There are significant differences in business models between public and private hospitals that mean there are fundamental conceptual differences between the sectors. These differences include:
  - treatment of capital;
  - corporate overheads in the private sector vis-à-vis central departmental costs in the public sector (for example, how will local hospital network costs be viewed in the new system model?);
  - medical workforce is not a meaningful concept for private hospitals but is for public hospitals; and
  - the public system uses outpatient clinics as an extension of the hospital episode but in private sector this occurs in the community (in doctor’s rooms).

Each of these differences need to be closely examined to either find common measures and definitions, or to exclude these factors from any cost comparisons. The most viable course of action is to initiate a project to examine the cost components in public and private hospitals, whose objective would be to identify those cost components:

a) that are directly comparable and require no further consideration (for example, pharmaceutical costs);

b) where data development work will lead to meaningful comparisons (for example, nursing costs);

c) that are not meaningfully comparable between the sectors (for example, corporate overheads).

In the short term (12 months) costing comparisons could be drawn using only cost components in category a, in the medium term (3 years) work on cost components in category b would be added, while all those cost components in category c would be excluded.

- Private hospitals are not directly funded by government so the sector does not necessarily feel an obligation to report costs’ data based on accountability for public funding. Public funding to private hospitals is indirectly provided through the medium of private health insurance, effectively relying on health insurers to ensure that private hospital services are delivered efficiently. Insurers have access to a wide range of data on private hospital charges (based on claims received across the private hospital sector) and are seen by private hospitals as sophisticated purchasers of hospital services, well equipped to deliver on this role.

- Private hospitals are not signatories to the national health reform agreements. Several stakeholders made the point to this review that the process of national health reform has been one involving agreements among Federal, State and Territory Governments and that private hospitals have not entered into any of the national agreements. This leaves open the question of how private hospital compliance with the reporting expectations in those agreements will be delivered.
2.4.2 Private Hospital Reporting Methodologies

A second Productivity Commission Finding relating to the issues discussed above in 3.4.2 and which warrants further analysis is Finding 5.4. This finding is quoted below:

“A foreshadowed shift to nationally-consistent activity-based funding for public hospitals is expected to eventually lead to more robust cost data for the public sector. However, there remains considerable scope to improve the quality and consistency of hospital and medical cost data in Australia. In particular, there is a need for:

• private hospitals to report cost data using the same methodology as public hospitals, and to continue to have a high level of participation in the National Hospital Cost Data Collection, so that the data are reliable and can be disaggregated by sector, region, and size and type of facility

• items directly billed to private patients – such as some medical, diagnostics and medicines – to be linked with cost data reported by hospitals so that all costs associated with an episode of care are captured in a single collection

• reliable data on capital costs, hospital administration costs, head-office overheads, and the cost of medicines prescribed to hospital patients

• quantification of the additional FBT liability that for-profit hospitals incur by not having the FBT exemption that is available to other hospitals.”

Implementing this finding may require a strengthening of data-related provisions in the National Healthcare Agreement for public hospitals, and data reporting requirements for private hospitals. This would need to be informed by the project proposed in Section 2.4.1.

In proceeding down this path, governments will need to be conscious of the regulatory burden on reporting hospitals and, where possible, seek to limit it by avoiding duplication and inconsistency in reporting requirements, and by utilising cost-effective electronic reporting of data.

The most recent developments in this area are reflected in the recent National Health Reform Agreement (NHRA) among the Commonwealth, States and Territories to the national healthcare reforms. That agreement sets out the performance and accountability framework for hospitals and local hospital networks under the national reforms. The agreement specifies that private hospitals are to be included in “clear and transparent quarterly public reporting of the performance of every Local Hospital Network, the hospitals within it, every private hospital and every Medicare Local, through the new Hospital Performance Reports and Healthy Communities Reports”.

The NHRA clearly expects that private hospitals will be expected to report against financial performance standards, without specifying what those standards will be. The agreement also refers to reporting of “access to services, quality of service delivery, financial responsibility, …

82 Fringe Benefits Tax.
83 National Health Reform Agreement. August 2011.
86 Ibid. Clause C2, p44.
patient outcomes and patient experience"\(^{87}\) but it is not clear how much of this reporting will apply to private hospitals. For example, the NHRA specifically states there will be public reporting for public hospitals on "staffing, financial resources and performance outcomes and standards"\(^{88}\) but does not provide similar detail regarding private hospitals’ reporting.

The NHRA acknowledges the need to streamline data reporting obligations for all parties, including private hospitals, through use of existing data sources and supply paths "wherever possible"\(^{89}\). This is consistent with the recent resolution by the Australian Health Ministers’ Conference (AHMC) to establish a working group "to review opportunities to improve the effectiveness of health data reporting"\(^{90}\), with an emphasis on "the need to rationalise health data collections and reporting in the context of the national health reforms".

The responsibility for performance reporting under the NHRA will fall to the NHPA and the AHMC notes that any work to rationalise health data reporting will be undertaken with the NHPA. The NHPA will also be responsible for considering the issues affecting future comparability between public and private hospital sectors as discussed in this section.

2.4.3 Standardised Hospital Quality and Safety Reporting

A third Productivity Commission finding (Finding 6.1) relates to the need for a robust nationally-consistent data collection on hospital-acquired infections. While limited data indicates that private hospitals may have a lower rate of infections, it may be because of the differences in the populations being treated e.g. private hospitals are more likely to be treating a healthier population carrying out simpler procedures. The Commission goes on to say that a more definitive finding will require the development of data collections that enable risk differences between hospitals to be distinguished from genuine differences in performance.

The fact that a hospital is public or private is highly unlikely to be a causal factor for any differences in hospital acquired infection rates. Given that multiple factors are known to be involved (for example, age of the hospital and the extent of infection control education programs), a more productive course of action would be to set a target for a desired outcome (for example, that the rate of Staphylococcus aureus (including MRSA) bacteraemia be no more than 2.0 per 10,000 occupied bed days for acute care hospitals) and then measure achievement by each hospital of the outcome.

This Review found that this issue is to be addressed under the NHRA performance reporting framework. That framework will be enacted through the reporting requirements under the NHRA.

2.4.4 Including Private Hospital Quality and Safety Reporting in the NHPA

A related quality and safety issue that also warrants further analysis is the Productivity Commission Finding 6.2 that more action will be required to enable meaningful infection-rate comparisons between public and private hospitals. The Productivity Commission sees that an important step in this regard would be to include private hospitals in national reporting arrangements. As stated above, this is the intention under the NHRA, through the development of relevant standards by the ACSQHC and reporting against those standards through the agency of the NHPA.

\(^{87}\) Ibid. Clause C6, p44.  
\(^{88}\) Ibid. Clause C9, p45.  
\(^{89}\) Ibid. Clause C13, p45.  
\(^{90}\) AHMC Communiqué, 5 August 2011.
2.4.5 Limitations of the National Hospital Cost Data Collection

The Productivity Commission commented that while the NHCDC is the best available data source for the purpose of analysing costs, it does have major limitations. For example, “the NHCDC data provided to the Commission are from an unweighted sample, and so may not be representative of all hospitals; do not identify how the different tax treatment of for-profit and other hospitals affect costs; and exclude the asset value data required to calculate a user cost of capital”91.

Since the Productivity Commission made this comment, work has commenced in the update and refinement of hospital patient costing standards. Version 1.0 of the Australian Patient Costing Standards has been approved and published on the Department’s casemix web site. It is expected that these costing standards will be adopted in subsequent instances of the NHCDC. These updated costing standards will now provide consistency and greater transparency in the NHCDC.

As stated by the Commission, there are differences in the way hospitals measure costs they report to the NHCDC, which directly affects comparability between the two sectors. In particular, there is a mixture of hospitals who collect direct patient costs (principally public hospitals) and hospitals relying on modelled costs (most private hospitals). As referred to in Section 2.4.1, it is difficult to see this situation changing while private hospitals have no commercial incentive to invest in patient costing systems.

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91 Productivity Commission, Public and private hospitals. December 2009, pXL.
3 Identifying issues and potential solutions

This chapter summarises the findings from the analysis and synthesis of information gathered through the review of documentation and consultations with stakeholders. A wide range of stakeholders was approached, with most agreeing to participate in the Review. Some stakeholders were not able to be contacted or otherwise did not contribute to the Review. Nonetheless, the findings presented in this chapter are representative of all of the key sectors, organisations and agencies with major interests in the outcomes of this Review. The full list of stakeholders consulted is provided in 4.4 and Appendix B.

The detailed results of applying the comparison framework for Work Stream 2 are not included in this section but can be found in Appendix C. This comparative process identified and mapped the differences between the data collections, particularly in terms of what public hospitals were required to report and what private hospitals were required to report.

The main areas identified where changes could be made to improve comparability between public and private hospital data collections are:

- lack of HCP information for privately insured patient stays in public hospitals;
- alignment of AIHW National Public Hospital Establishments Database (NPHED) and ABS PHEC and reporting processes; and
- alignment of differences in public and private sector costs in NHCDC.

This section also summarises opportunities for streamlining collections, improving comparability of public and private hospitals, and for establishing a mechanism for maintaining an authoritative list of private hospitals.

3.1 Findings

Figure 2 and Figure 3 illustrate the data flows for private hospitals collectively and the data burden for an individual private hospital, with respect to the data collections within scope of this Review. They serve to highlight the reporting burden that these collections represent for the private hospital sector.
Figure 2  Overview of data collection landscape for private hospitals
On 8 June 2011 a workshop was held in Canberra to discuss private hospital and public hospital comparability (Work Stream 2). Workshop participants (see Appendix B) were sent a background information kit, which consisted of Section 3.2 and a summary of work to date. The workshop involved a discussion of the project, a background on work to date and also an in-depth discussion on identified areas for improved comparability between public and private hospital data.

Participants were asked what outcomes they wanted to see from the workshop. Participants identified that in relation to public and private hospital data collections they wanted:

- simplification;
- streamlining;
- wanted to make sure that the veracity of the data that is currently collected is not lost;
- decrease duplication;
- improve completeness of data;
- increase accuracy;
- decrease burden, and time taken to comply; and
- demonstration that there is value in the data that is being collected, and in conducting the review.

Many of these outcomes relate to streamlining (Work Stream 1 – such as simplification and streamlining) and not directly to the goal of improved comparability. Others are directly related...
to comparability (for example, completeness of data and accuracy). Within one workgroup at the workshop, participants were using “comparability” and “streamlining” interchangeably.

Importantly, a significant number of participants noted the inherent difficulty of comparing the two sectors and whether comparing the two sectors should be a priority. In making these observations, the threads of the discussion were that current levels of comparability are adequate for the stakeholders’ purposes; the effort involved in delivering comparability in some areas is not warranted; and the fundamental operating models for the two sectors make pursuing some comparisons pointless or render it impossible to resolve differences in counting rules.

3.1.1 Cancer data

There was a general acceptance that the processes for collecting cancer data were largely independent of other processes and there were no opportunities for substantial streamlining in relation to those national collections.

There is a standard, minimum data set defined by the ACD data items\(^{92}\). These items are provided for each cancer case (live case or cancer related death), by each State or Territory cancer registry. At the State or Territory level, case records are produced by collating and summarising data from multiple sources – pathologists, medical specialists, public hospitals, private hospitals and others. The range of data items required at this level is determined by legislation and supporting policy directions as is, to varying degrees, the process for submitting the data.

As a result, the range of data items required by each State and Territory usually exceeds the minimum national requirement. Large private hospital providers with hospitals operating in multiple jurisdictions are confronted with developing separate data extraction procedures for each jurisdiction.

However, the scope for standardising procedures and formats for submitting private hospitals’ data across States and Territories is limited, at best. This Review also notes those processes are not within the direct influence of the Department and the Commonwealth more generally.

3.1.2 Perinatal data

As with cancer data, there was a general acceptance that the processes for collecting perinatal data were largely independent of other processes and there were no opportunities for substantial streamlining in relation to the NPSC.

This observation must be qualified with the observation that it applies to the national level and does not apply to the same degree at the State and Territory level. There is variation among States and Territories in the data items required by perinatal statistics units at that level. In addition, there is variation in the level of information technology used in each jurisdiction. For example, some jurisdictions still use a paper based form for data submission to the perinatal collection.

There is a Perinatal National Minimum Data Set\(^{93}\). States and Territories collect additional data items beyond what is required for the Perinatal National Minimum Data Set. There is also variation in the forms used in different states for collecting perinatal data. Large private hospital

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providers with hospitals operating in multiple jurisdictions are confronted with developing separate data extraction procedures for each jurisdiction.

There may be a case for undertaking a comparative review of State and Territory perinatal reporting requirements and forms, with a view to identifying opportunities for reducing the variation among them. There may also be opportunities for States and Territories to share technological solutions developed locally, to make submission by large private hospital providers easier.

However, this Review notes that these are State and Territory level issues and beyond the direct influence of the Department and the Commonwealth more generally.

3.1.3 NHCDC

The purpose of the NHCDC is to produce benchmark data for use by hospitals so that they can compare their costs to other similar hospitals. The NHCDC also produces national cost weights for AR-DRGs and other statistics relevant for hospital service costing and planning.

The main concerns with respect to the NHCDC related to the issue of data quality, rather than to the burden associated with data preparation and submission. This partly reflects the voluntary nature of NHCDC participation for private hospitals.

A link to reporting burden arose in this context when considering how data quality might be improved for the private hospital component of the NHCDC. The main mechanism for improving data quality was seen as being capture of patient level cost or resource use data, through the implementation of “feeder systems”. However, stakeholders saw no intrinsic business case for a private hospital to invest the cost and effort to adopt such systems and modify their business processes to apply them.

There are a number of differences which prevent proper cost comparisons between private and public sectors. The key difference in the reporting of costs between public and private sector hospitals in the NHCDC:

- predominance of ‘cost modelling’ to produce cost estimates in the private sector, in comparison to ‘patient costing’ for the majority of public hospitals;
- treatment of teaching, training and research costs;
- differing admission practices within and between sectors;
- pharmacy costs for private hospitals;
- prostheses costs; and
- public and not-for-profit private hospitals are partially exempt from paying fringe-benefits tax (FBT) and are not required to pay payroll tax.94

Not only are there the above mentioned differences but the process of supplying data to the NHCDC process differs for public and private hospitals. The primary difference being that public hospitals submit their data to a State/Territory Health department officer to assess the data before it is sent on to the Department. Whereas private hospitals are required to undertake this quality assessment process themselves.

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94 Productivity Commission 2009, Public and Private Hospitals, Research Report, Canberra
3.1.4 PHEC

There is significant support for the PHEC and its modus operandi, principally from users of the data at sector level as well as from policy makers and planners. The ABS recently undertook a major review of the data items, the collection forms and the overall process for this collection. The outcomes of that review were implemented with the 2009-10 PHEC and further changes will be implemented with a rolling out of the 2011-12 PHEC in August 2011. The review and rolling out its changes represent a significant investment in PHEC for the ABS and the Department, who contributes to its funding.

One of the strengths of the current arrangements for PHEC is seen to be the protection afforded the private hospitals' data through the Census and Statistics Act 1905. Reinforcing this view, a number of private hospital stakeholders sought comfort regarding protection of their data's confidentiality during the PHEC review. However, while this is seen as a strength for protecting privacy and confidentiality of the data, it is also seen by other stakeholders as impeding the use of the data for important uses beyond PHEC reporting. In its enquiry into public and private hospitals, the Productivity Commission sought access to de-identified unit record data for PHEC. Although the analyses proposed by the Commission would not have led to the identification of individual hospitals, nonetheless access to the data at this level was not able to be provided.

Another strength of PHEC is seen as the existing arrangements for States and Territories to provide summarised activity data to the ABS on behalf of those private hospitals who have given consent for this to happen. This Review found that between 90% and 95% of private hospitals provide this consent and have this subset of the PHEC data provided in this way.

The following issue was identified with the Australian Hospital Statistics 2009-10 report, published by AIHW:

“Information on public hospital resources was sourced from the National Public Hospital Establishments Database (NPHED) (see Appendix 1). Some information on private hospital resources was sourced from the Australian Bureau of Statistics’ (ABS) Private Health Establishments Collection (PHEC) for 2008–09. For 2009–10, information on the number of private hospitals and private hospital beds was mainly provided by states and territories. The Department of Health and Ageing provided data on the number of Private free standing day hospital facilities and beds for jurisdictions where data were not available from states and territories (see Appendix 1). Private hospital expenditure and revenue information for 2009–10 was not available at the time of publication.”

This timeliness issue directly affects proper comparison of the public and private sectors at an establishment level.

The Department recently commissioned the AIHW to undertake a dataset specification development for a private hospital establishments' collection that would correspond to the existing National Public Hospitals Establishment Dataset operated by the AIHW.

In addition, the ABS and AIHW have commenced the work of aligning the NPHED and PHEC. The ABS has made changes to the PHEC collection form to better align the two collections and has piloted these changes. The AIHW have compared the items in the PHEC and NPHED to identify similarities and differences at the data item level.

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However this work focuses on obtaining private hospital establishment data for the Australian Hospital Statistics publication. It is about obtaining current hospital resources information. Currently that report uses PHEC data from the previous financial year for private hospitals, and uses NPHED data from the report’s financial year for public hospitals. That is, the 2009-10 AHS describes private hospitals in terms of PHEC data from 2008-09. Compounding this is the proximate timing of release of the AIHW's report and the ABS report from PHEC. Australian Hospital Statistics 2009-10 was released on 29 April 2010 while the PHEC output was released 7 weeks later, on 17 June 2010.

Stakeholders generally were comfortable with the notion of AIHW operating as the collection agency for PHEC or an equivalent collection. The private hospital sector felt that the AIHW's governing legislation offers the same level of protection of the data as does that of the ABS. They and other stakeholders felt that the AIHW has in place well established and effective protocols for providing different levels of access to the data, while protecting privacy and confidentiality.

This support for the AIHW operating the PHEC or replacing it with a similar collection was qualified in several ways, as follow:

- the range of data collected and definitions used would need to be maintained, so that the integrity of time series data was preserved;
- the coverage of private hospitals contributing to PHEC would need to be maintained or improved over the current high level achieved by the ABS;
- the ABS would need to have access to at least those aspects of the PHEC data required for national accounts and other reports relying on the PHEC data other than private hospitals Australia reports; and
- private hospitals would need to have control over the level of access provided to their individual data in a similar way to the protection is currently afforded States and Territories in relation to the APC. It may be possible to develop a standard agreement – analogous to the National Health Information Agreement – that could be used to effect such control.

### 3.1.5 Safety and quality data

Safety and quality reporting burden varies enormously across the private hospital sector in Australia. As discussed in Chapter 2 some States and Territories impose significant reporting requirements specific to safety and quality while others impose very few. In addition, health insurers impose their own requirements for reporting related to quality of care. This requirement is imposed through conditions inserted into contracts between private hospitals and health insurers.

The requirements of insurers, in relation to data and reporting for quality and safety related purposes vary enormously. There is variation in the specific data and supporting information requirement, in specifications for data items sought (for example, one insurer may require address as a single, free text field, while another requires it to be split into several fields) and the...
frequency with which data are required (for example, some require data quarterly while others require it monthly). A number of insurers also require an annual summary report to be provided by a private hospital. The level of detail and range of coverage required in this report also varies significantly with some insurers requiring only a page or two and others requiring up to 40 pages of information.

The new accreditation arrangements are likely to be implemented across all hospitals and day procedure services by January 2013. The ACSQHC is hopeful that this will lead to a greater sharing of common safety and quality data which will allow health insurers to reduce their demands for safety and quality reporting from private hospitals. At the least, the existence of national standards and indicators for safety and quality reporting will permit insurers to consider the standardisation of such reporting within their part of the industry.

The details of national performance monitoring and reporting of safety and quality accreditation are, as yet, not determined. It is unlikely that there will be a single national regulator for accreditation as State and Territory Health Departments will regulate the public sector and it is yet to be determined who will regulate the private sector. Whatever the detail of resolution, the regulators will receive accreditation outcome data from accrediting bodies on health services. If there is to be a national collection, that may well fall to the NHPA.

Representatives of the private hospital sector have been closely involved in the development of the accreditation reforms. Nonetheless, they are clear on the view that the private hospital sector has not been party to, nor is it a signatory to the national health care reforms and agreements that have been negotiated among Commonwealth, State and Territory governments.

This Review found that there is significant uncertainty about future data collection from private hospitals related to safety and quality. The ACSQHC and AIHW have recently undertaken a project to populate safety and quality indicators developed by the ACSQHC. This project required access to hospital level data in the APC. In order to provide this level of access, the AIHW approached private hospitals, through States and Territories, for their consent.

While hospitals generally were happy to provide their consent, States and Territories were prepared to provide their supporting consent only if they received copies of the results for each private hospital within a jurisdiction. Private hospitals were concerned that allowing this would lead to their individual data becoming subject to freedom of information legislation within States and Territories. They saw this as risking commercially sensitive information falling into the public arena. Consequently, they chose to withhold their consent.

This experience highlights the following issues:

- ownership and custodianship of private hospital admitted patient data, which is provided to the APC by the jurisdictions, but "owned" and generated at source by private hospitals with differing jurisdictional arrangements;
- technical difficulties in identifying individual private hospitals within the APC, in order to generate nationally risk adjusted indicators through efficient central mechanisms; and
- the lag in achieving centrally collated, national data (somewhere between 5 and 17 months) for efficient and consistent central generation of a series of measures.

It also suggests that the national reporting of private hospitals performance in other operational areas may be similarly difficult to implement.
In spite of these practical issues, the development of consistent and well-specified flows that support the generation of well designed measures will potentially provide insurers and other payers with a standard suite of well designed measures. In turn, this may create opportunities to reduce the burden for private hospitals of providing different reports – in terms of scope and presentation – to different insurers.

3.1.6 HCP, PHDB and APC

There is variety in the effort involved among hospitals in the process of extracting and providing data for the different collections in scope. The variation largely related to issues of information systems’ capability, economies of scale and access to suitable information management skills. Some stakeholders referred to “up to 4 days” of effort required to produce HCP and PHDB extractions while others stated that it required “the push of a button”.

A consistent view from stakeholders was that there is a subset of day hospitals that simply lack the scale and information systems to collect and provide the data sought by collections such as HCP, PHDB and APC. These day hospitals are often, but not always, small scale providers, whose data collection is limited to what is required to provide good clinical care and to manage the business aspect of the hospital. In some cases, these are day procedure centres providing services for which no insurance claims are made. As such, they may not be declared hospitals under the Commonwealth *Private Health Insurance Act 2007*, thereby not being subject to HCP and PHDB requirements.

**Overview of HCP, PHDB and APC data flows**

The general view was that the data collections themselves are warranted and that the range of data items collected should not be reduced. However, all stakeholders expressed concern over the fact that the HCP, PHDB, and the APC collect a significant set of common data items with common definitions and code sets. They also expressed concern over the substantial effort required to generate monthly extracts for these collections.

On a monthly basis a private hospital within any jurisdiction in Australia will submit a large amount of health data to insurers, State and Territory health authorities and the Department. Figure 4 illustrates the processes for the submission of data to the APC – via jurisdictional admitted patient collections – and the HCP and PHDB collections. The figure excludes the state based perinatal and cancer registry collections (see Section 3.1.1).

Figure 4 also does not illustrate another issue with participating in these data collections, which is the validation of the monthly data submission. This is where the private hospital receives an “edit report” or similar about their submission. This edit report will specify whether submitted episodes are either rejected, flagged as a warning or accepted based on the business rules of the organisation to which they are submitted.

For example, in Victoria there are 403 different edits or “business rules”. These edits are classified as rejection, fatal, warning and notifiable. Examples of these edits include where a hospital submits an invalid Medicare number (rejection) or a 14 year old is listed as being
married (warning). A rejection edit requires the hospital to check, correct and re-transmit that particular episode. This is not a simple task for the hospital.

In addition insurers may have similar or different business rules to each other and to State health authorities. This means an episode of care may be accepted by an insurer but rejected by the State health authority. Private hospitals also reported instances of insurers advising of rejected record is six months after the original data had been submitted. Understandably, it is much more difficult to go back and correct an error for record that is more than six months old. This was not an uncommon occurrence.

These difficulties are clearly more burdensome for those corporate private hospital providers who operate private hospitals in multiple jurisdictions than they are for individual private hospitals that operate in single jurisdictions. Nonetheless, they are the sources of significant inefficiency in the national private hospital data collection processes.

**Figure 4 Overview of HCP, PHDB and APC data submission processes**

![Diagram](image)

**Data overlap**

The other main area of inefficiency in relation to these three data collections is the area of data overlap. There are two main differences between the PHDB and the HCP. They are the scope of the collections and four data fields. A PHDB submission contains all private hospital

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97 It is important to note that this describes what happens only in Victoria, should a record fail validation check and be rejected. That is, only the rejected episode record need be resubmitted once it has been corrected. In Queensland, if a single episode record is rejected then the entire batch of records must be resubmitted once that error has been corrected.
separations while an HCP submission contains data only for insured patients for whom a benefit is being claimed.

Table 6 summarises the key differences between the HCP and PHDB data specifications. Aside from these key differences, the two datasets capture essentially the same data items, with some minor differences in code sets.

**Table 6 Differences between the HCP and PHDB**

<table>
<thead>
<tr>
<th>Field No or issue</th>
<th>HCP</th>
<th>PHDB</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Insurer Membership Identifier – valid value added</td>
<td>Insurer Membership Identifier – blank filled</td>
</tr>
<tr>
<td>2</td>
<td>Insurer identifier – the health fund registered three character code. Example: AHB - Defence Health AUF – Australian Unity Etc.</td>
<td>Payer Identifier – indicator of the type of funder of the episode: IH – Insured with Agreement with Hospital IN – Insured with no Agreement with Hospital SI – Self Insured WC – Worker’s Compensation TP – Third Party CP – Contracted to Public Sector CV – Department of Veterans’ Affairs patient DE – Department of Defence patient SE - Seaman OT - Other</td>
</tr>
<tr>
<td>3</td>
<td>Family Name</td>
<td>Family Name – Blank filled, as not required for reporting to DoHA</td>
</tr>
<tr>
<td>4</td>
<td>Given Name</td>
<td>Given Name – Blank filled, as not required for reporting to DoHA</td>
</tr>
</tbody>
</table>

Both the PHDB and the HCP require data to be submitted in a fixed field, ASCII file format. The specified format for the PHDB is different to that for the HCP, in spite of the fact that they have so many items in common.

The use of a fixed, ASCII format also means that when changes are made to the HCP or PHDB requirements then the process of modifying data extraction procedures is more difficult than would be the case if a more flexible data interchange format was used.

There is a significant amount of overlap between the PHDB and APC (see Table 7). Very few items included in the APC are not also included in the PHDB specification or able to be derived from PHDB items. For example, APC contains an Australian State or Territory identifier for the hospital, whereas PHDB contains a private hospital provider number that can be used to derive State or Territory for the hospital.

There are a large number of items within the PHDB that are not available in the APC. By far the majority of these items relate to private hospitals’ charges and supporting information for
different types of specialist care. For example, 3 of these items relating to Special Care Nursery – Special Care Nursery Charge, Special Care Nursery Days and Special Care Nursery Hours.

**Table 7  Relationship between PHDB and APC data items**

<table>
<thead>
<tr>
<th>Items common to APC and PHDB</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Items mappable from PHDB to APC</td>
<td>15</td>
</tr>
<tr>
<td>Items in PHDB and <strong>not</strong> in APC</td>
<td>43</td>
</tr>
<tr>
<td>Items in APC and <strong>not</strong> in PHDB</td>
<td>4</td>
</tr>
</tbody>
</table>

**Missing private hospital identifiers in APC**

The other key difference between PHDB and APC data items is the fact that some States and Territories do not provide private hospital identifiers when submitting data for private hospitals within their jurisdiction. These jurisdictions maintain that the basis on which they collect and hold the private hospitals’ data is as custodians and that the data remain the property of the private hospitals. As such, they are not willing to provide the information that would allow individual private hospitals to be identified within the admitted episode data submitted to the APC.

These jurisdictions also are not willing to provide a data linkage field that would allow episodes from the same hospital to be identified as such, without explicitly identifying the hospital itself. This reflects the view that it would be possible, by comparing episode profiles for each hospital in the jurisdiction, to then identify individual hospitals.

**Relative coverage**

Comparing the most recent complete year of data for PHDB and APC with the corresponding year’s data for PHEC shows that both PHDB and APC under enumerate numbers of private hospitals and of total admitted private hospital activity in Australia (see Table 8).

The PHDB applies only to private hospitals declared under the *Private Health Insurance Act 2007*, whereas APC and PHEC both aim to capture data from all licensed private hospitals in Australia. The differences between APC and PHEC coverage are due to private day hospitals in the ACT and NT not submitting data to the APC and to 2 other hospitals not providing data for 2009-10.
Table 8  Comparison of private hospitals and admitted patient separations covered for 2009-10: PHDB, APC and PHEC

<table>
<thead>
<tr>
<th>Data collection</th>
<th>2009-10 separations</th>
<th>2009-10 private hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHDB(^98)</td>
<td>2,599,163</td>
<td>Approximately 570</td>
</tr>
<tr>
<td>APC(^99)</td>
<td>3,461,715</td>
<td>573</td>
</tr>
<tr>
<td>PHEC(^100)</td>
<td>3,590,800</td>
<td>581</td>
</tr>
</tbody>
</table>

ECLIPSE

Some stakeholders pointed out that an opportunity exists to submit data via the ECLIPSE claiming system. ECLIPSE stands for Electronic Claim Lodgment and Information Processing Service Environment and is an online claiming system developed by Medicare Australia\(^101\). It is used by private hospitals to lodge claims electronically with a health insurer and facilitates the checking of eligibility and payment of the claim by the insurer.

ECLIPSE contains within its file specification the HCP data specification. This was originally included in 2006, when ECLIPSE was being considered as a mechanism for collecting HCP data. It has not become a tool for submission of HCP data, and so this part of the record specification remains unused. In addition, the HCP specification within the ECLIPSE record has become outdated and no longer matches the current HCP specification.

According to Medicare Australia all health insurers are using ECLIPSE for online claiming and eligibility checking. This does not mean that all insurers are using it for private hospital claiming, as ECLIPSE can also be used for online claiming of services delivered by other providers such as dentists, physiotherapists and medical specialists. It also does not mean that an insurer who is using ECLIPSE for private hospital claims is using it with all private hospitals with whom it deals. For example, one major health insurer informed this Review that around 50% of its private hospital claims are handled using ECLIPSE. The DVA also indicated that around 50% of claims from contracted hospitals and day procedure centres are handled using ECLIPSE.

Between May 2010 and April 2011, Medicare Australia processed approximately 588,000 in-hospital claims. While some of these claims may have been for hospitals other than private hospitals, it is likely that the majority related to private hospital episodes. Though some recently available data on hospital separations in Australia, this suggests that around 19% of insured

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private hospital episodes are claimed using ECLIPSE. Health insurers are actively pursuing further roll-out of ECLIPSE for managing claims lodged by private hospitals generally.

Any consideration of ECLIPSE as a preferred mechanism for collecting HCP data must consider issues of intellectual property and the possibility that other online claiming solutions may be preferred by insurers or private hospitals. The intellectual property inherent in ECLIPSE belongs to the Commonwealth, through Medicare Australia.

The marketing of ECLIPSE as an online claiming solution has been the subject of a previous court case, brought by the distributor of a competing online claiming solution against Medicare Australia, alleging contravention of the Trade Practices Act. A finding against Medicare Australia would have required a fee to be charged for use of ECLIPSE. That case was settled out of court in October 2009 and at present ECLIPSE remains freely available for use by insurers and hospitals. However, there remains a possibility that other competing solutions for online claiming may enter the marketplace in the future and this legal question to be revisited.

**HCP data for privately insured patient stays in public hospitals**

Workshop participants (see Appendix B) identified the need to obtain information on privately insured patient stays in public hospitals as top priority among the comparability issues. The clear consensus was that public hospitals should be providing this information; there has been continued growth in these separations from public hospitals (see Figure 5); and a plan needs to be devised to obtain this information.

An option was suggested at the workshop, to link AIHW inpatient data with insurers’ claims’ data. However, this approach was unlikely to succeed, as jurisdictions would be unlikely to provide the blanket permission required to use the AIHW data in this way, and the AIHW data lack the necessary identifiers to effect reliable linkage.

The preferred approach suggested by participants was for the Department to work closely with a jurisdictional health department and an insurer to undertake a data linkage exercise using episode and patient unit record numbers rather than just date of birth, gender, hospital, admission and separation dates.

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102 *Australian Hospital Statistics 2009-10*. AIHW. In 2009-10. There were 2,767,947 insured episodes and 199,732 DVA episodes in Australian private hospitals. The publication also indicated that private hospital activity had been growing at around 3.2% per annum leading into 2009-10.

103 From 1 July 2011, Medicare Australia will cease to exist as a separate agency and will become part of the Australian Department of Human Services. The intellectual property held by Medicare Australia will remain with the Commonwealth.

The following quote from the reporting requirements for HCP and PHDB highlights the issue with the lack of data for privately insured patient stays in public hospitals.

“It is also expected that hospitals will work toward providing health insurers with data that complies with the HCP. No timeframe has been set for public hospitals to provide health insurers with a complete HCP dataset as per the specifications. This recognizes the needs of both parties and allows additional time for hospitals to build a complete data provision capability, whilst continuing to provide existing base levels of data. DoHA expects public hospitals and health insurers to continue working towards providing the full HCP dataset.”

Table 9 highlights the number of privately insured patient stays in public hospitals. The Private Hospital Insurance Act 2007 requires HCP data be submitted for any and all admitted patient episodes where an insurance claim is lodged with an insurer. This requirement is imposed on all declared hospitals. Under this Act both private and public hospitals may be declared.

However, the HCP admitted and rehabilitation data requirements are usually less onerous for public hospitals than for private hospitals. Historically, public hospitals usually do not have service contracts with insurance funds and so are able to claim only the default benefits for insured patients. As a result, public hospitals have only provided that subset of HCP data required for payment of default benefits, meaning that much of the detail of the patient episode is not provided. When the Private Hospital Insurance Act 2007 was drafted, States and Territories were not prepared to agree to provide full HCP data for public hospitals. Consequently, public hospitals continue to provide a less complete HCP data set to health

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105 Section 121-5 of the Private Hospital Act 2007 states “A hospital is a facility for which a declaration under subsection (6) is in force.” and Section 121-6 states “The Minister may...declare that a facility is a hospital”. As such, a “declared hospital” is one that has been declared by the Minister under this Act.
insurance funds, although the long-term aim is for public hospitals to move to full HCP provision as noted in the quote above.

### Table 9  Separation by funding source

<table>
<thead>
<tr>
<th>Separation</th>
<th>Funding Source: Private health insurance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospital</td>
<td>501,819</td>
<td>15.3%</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>2,767,947</td>
<td>84.7%</td>
</tr>
<tr>
<td>Total</td>
<td>3,269,766</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

3.1.7 Governance of data development and implementation

There have been issues with disconnection between data development and implementation of APC NMDS items, and operating constraints for the private hospital sector. This Review found the issues most likely have arisen because the data development and implementation processes largely have focused on the public sector and not adequately dealt with factors unique to the private sector.

There are 2 key factors that differentiate the private sector from the public, in terms of implementing changes to data standards and systems. The first is that costs of implementation for private hospitals and insurers need to be recovered through fees and charges and the second is that contractual arrangements dictate the data that private hospitals need to collect and report to insurers.

Recently, an issue arose with disconnection between implementation of changes in the code set for ICD-10 AM under the APC NMDS and the private hospital sector operating environment. Private hospitals are bound to provide insurers with diagnostic and procedural information according to the AR-DRG versions, ICD versions or MBS codes specific in their contracts. When the most recent changes to ICD-10 AM were implemented, these led to AR-DRG changes for some patients. In turn, this would have resulted in reduced revenue for those patients under existing private hospital contracts.

As a result, significant work had to be carried out by private hospitals and by jurisdictional staff to develop a “work around” that allowed the hospitals to submit different data to different recipients. Finding ways to avoid the need for this sort of effort represents an opportunity for streamlining data collection from private hospitals.

Risks of similar situations arising in the future would be reduced if there was greater involvement of private hospitals and insurers in national data development work and implementation planning. Such involvement, particularly of insurers, would also place the sector on a more informed footing, which could allow greater consideration of data related

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106 Reporting Requirements for Hospital Casemix Protocol (HCP, HCP1 & HCP2), GT-Dental And Private Hospitals Data Bureau (PHDB).


issues when insurers and private hospitals are negotiating contract terms and conditions, further reducing risk of future problems.

3.1.8 An authoritative list of private hospitals

There are considered to be at least five lists of private hospitals in use within the Department and federal agencies:

- private hospitals declared under the *Private Health Insurance Act 2007*;
- private hospitals that submit data to the HCP collection;\(^{108}\)
- the AIHW list of private hospitals that contribute to the APC;
- the list of hospitals within local hospital networks;\(^{109}\) and
- a list of private hospitals that contributes to the myHospitals website.

The need for an authoritative list is re-inforced by the fact that the national health-care reforms herald greater transparency and visibility of hospital performance. As a consequence, there is an expectation that there will be monitoring and reporting of performance of hospitals in both public and private sectors.\(^{110}\) A fundamental prerequisite for such transparency is a common agreed understanding of what private hospitals are delivering services across Australia.

Departmental stakeholders agreed that any authoritative list should comprise those hospitals that are declared under the *Private Health Insurance Act 2007*.

When the private hospital is declared under that Act, the Department obtains a set of information about that hospital (see Section 2.3.1). The concern for the Department is that the information may change over time but the Department has no formal mechanism for updating hospitals' details when this happens. Consequently, changes in hospital name, profile of services or other key details are often out of date within its list of declared hospitals.

As discussed in Section 2.3, the Department does obtain updated hospital information from States and Territories on an informal basis. One possibility is that States and Territories may be willing to establish a formal arrangement for providing the Department with updated details for private hospitals. Indeed, Western Australia indicated that it would be happy to enter into such a formal arrangement. However, the variability of licensing regimes across jurisdictions and differences in things such as classifications of clinical service profiles means that this does not present a reliable means for keeping information in the Department's list of declared hospitals up-to-date.

This state of affairs is exacerbated by the fact that some jurisdictions do not license all declared private hospitals. For example, South Australia does not license day hospitals and so can provide no information on those hospitals.

This Review also found that there is no obvious mechanism provided in the *Private Health Insurance Act 2007* that would allow the department to demand private hospitals informed the Department when key details change.

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\(^{108}\) Note that this is a list that also includes public hospitals which submit data to the HCP collection.

\(^{109}\) Note that this is a list that includes both public hospitals and private hospitals within the hospital networks.

\(^{110}\) *National Health Reform Amendment (National Health Performance Authority) Bill 2011*. Parliament of Australia.
3.1.9 Other areas identified for improved comparability

Other areas identified in the workshop as potential avenues to improved comparability were the governance arrangements for the HCPWG and PHWG, as well as establishing a clearing house for data collection. The workshop’s participants felt these avenues, in the long term, would lead to improved comparability between the public and private sectors.

The issue of governance of the HCPWG and PHWG working groups primarily related to the fact that the two groups do not meet to consider matters of common interest. Participants suggested that at least once a year the groups should meet.

A clearing house for data would act as a recipient of data from public and private sectors. However there was not a great deal of detail suggested for this notion, nor for how it would lead to improved comparability between public and private sectors.

3.2 Potential areas for streamlining or improving comparability

3.2.1 Cancer data

There is no clear opportunity for streamlining the collection of national cancer data from private hospitals, nor for improving comparability in this area.

3.2.2 Perinatal data

There is no clear opportunity for streamlining the collection of perinatal cancer data from private hospitals, nor for improving comparability in this area.

3.2.3 NHCDC

There is no clear opportunity for streamlining the collection of NHCDC data from private hospitals.

There may be an opportunity to overcome some comparability issues through preparation of a series of experimental estimates’ reports, in addition to the usual NHCDC reports with their standard caveats. For example, one report may be on the pharmacy cost for private hospitals versus the pharmacy cost for public hospitals. The experimental estimate reports would build on the findings from the Productivity Commission Research Report into Public and Private Hospitals.

Benefits

• Increased use of and understanding of cost data and differences between sectors.
• Additional reports for the public and private sector (i.e. improved feedback loop).

Enablers

• Data is already collected and standardised.
• Building on work undertaken by Productivity Commission.
• Some stakeholders (state governments, media) are more interested in comparisons between sectors.
Barriers

- Additional work for the Department to create reports based on cost data.
- Achieving agreement on estimating cost areas (e.g. user cost of capital).
- Inappropriate use of experimental estimates.
- Some stakeholders (private hospitals) are more interested in comparisons within rather than between sectors.

Recommendation: Undertake increased analysis of NHCDC information and develop a series of “experimental estimate” reports.

3.2.4 Safety and quality data

There is significant uncertainty over the mechanisms that will operate for collation of safety and quality data at a national level. This Review finds that the expectations are that nationally mandated safety and quality indicators are expected to be able to be derived from currently collected data. However, the procedures and protocols for successfully doing this are yet to be proven, given the difficulties encountered in testing to date.

3.2.5 PHEC

The current processes and systems surrounding PHEC offer an opportunity for streamlining that would result in small savings in effort at the private hospital level and some reduction in effort at the State and Territory level. This opportunity would require the transfer of responsibility for PHEC from the ABS to the AIHW. Any benefits gained would require no additional investment or transfer effort for private hospitals themselves.

Figure 6 illustrates the current process for collecting the PHEC data, with the ABS operating the collection and States and Territories providing summary activity data on behalf of around 95% of all private hospitals.

Figure 7 illustrates the data flows under the proposed operating model for PHEC, with AIHW operating the collection. One key change in the flows is that summary activity data for all hospitals with data in the APC would be prepared in-house by the AIHW, with only those hospitals who do not submit data to the APC having to prepare and submit their own summary activity data. States and Territories would not need to summarise nor provide any data on behalf of private hospitals. Based on the private hospital coverage of APC (see Section 3.1.6), around 98% of private hospitals would have their data summarised by AIHW, with approximately 10 hospitals extracting and providing their own summary activity data.

The other key change in data flows is of course that all private hospitals would provide summary financial, workforce and other operating data to the AIHW instead of to the ABS.
Figure 6  Overview of current PHEC data flows

Figure 7  Overview of proposed new PHEC data flows
Benefits

The potential benefits from moving to this proposed model are:

- fewer private hospitals who need to extract and submit their own summary activity data;
- *Australian Hospital Statistics* reports could report public hospital and private hospital data for the same financial year;
- improved data for inclusion into *Australian Hospital Statistics* reports and their users;
- reduced effort on behalf of States and Territories; and
- greater flexibility in terms of access to de-identified PHEC data.

Enablers

There are several factors that would make it easier to move to the proposed model with AIHW assuming responsibility for the PHEC collection and reporting role:

- The AIHW has the legislative protections and track record to give confidence to private hospitals and their representatives that their data will remain secure and unable to be used in a potentially identifying fashion without individual hospitals’ consent.
- The ABS is likely to be amenable to a negotiated change in responsibility, subject to reasonable conditions. These conditions would include: confidence that any change would maintain the existing high participation rate in PHEC, by private hospitals, thereby maintaining the integrity of the PHEC time series; continuing access to the PHEC data that ABS requires for its non health related statistics, such as National Accounts reporting; and a transitional process that maximises the return on ABS investment in the review and re-engineering of the PHEC processes, forms and data items.
- The AIHW has the experience, systems and other infrastructure to be able to successfully take on the PHEC responsibility and deliver it successfully.
- The existing time frame for APC reporting would mean that PHEC reporting would be able to happen at least in line with current ABS time lines. By way of a comparison, each (financial) year’s *Australian Hospital Statistics* report is produced around 10 months after the relevant year’s end, while the corresponding *Private Hospitals, Australia* report is published around 11 months after the year’s end.

Barriers

There are significant barriers to this approach being practicable. These include:

- The APC does not contain unique hospital identifiers for private hospitals in some jurisdictions (see Section 3.1.6). Such identifiers need to be attached to APC episode records to allow data for each individual hospital to be summarised correctly. Without such identifiers, this proposed model will not work. The jurisdictions that currently do not provide hospital identifiers are likely to resist the necessary change to make this approach
work. This Review found that, even if private hospitals provided explicit consent for their APC data to be identified in this way, the jurisdictions would be unlikely to comply with this consent. This view existed even in those jurisdictions where admitted episode data are required as a condition of licence. In this case, the jurisdictions argue that they are responsible for the quality of the data and so will be seen as vicariously responsible for the quality of the summary results generated by AIHW but beyond the jurisdiction’s control.

This Review considered ways to circumvent this barrier. Possible ways to achieve this might be to effectively replace the APC at the national level with an improved PHDB. Achieving this would require a long term strategy to modify the PHDB to collect the core APC items, increase resources devoted to its operation and invest those resources in improving the coverage and quality of the data. This would need to succeed to the point where the revamped PHDB was adequate to generate the necessary summary activity data for most private hospitals. This option, if sufficiently successful, would have the additional benefit of eliminating the need for States and Territories to submit APC data to the AIHW for private hospitals.

This Review found that this option would most likely be more difficult to deliver than the preferred option of achieving collaboration with the States and Territories to provide hospital identifiers to the APC. Nevertheless, it remains as a long term alternative strategy.

- The AIHW does not have the same statutory power to compel private hospitals to provide PHEC data as the ABS does through the Census and Statistics Act 1905. This creates a risk of lowering the PHEC response rates for those sections of the PHEC relating to other than summary activity.
- AIHW timelines to release the Australian Hospital Statistics reports are generally getting shorter and private hospitals may have shorter amount of time to respond to PHEC.

Recommendation: That the responsibility for the Private Health Establishments Collection be transferred to the Australian Institute of Health and Welfare.

A transitional plan for delivering this recommendation is included in Chapter 4.

3.2.6 HCP, PHDB and APC

There are several options available to streamline the processes for one or more of these collections’ processes. Each of these is discussed below.

Option 1 Update the format of HCP and PHDB data interchange files

Currently each of the HCP and PHDB require data to be submitted using a collection specific, fixed field text file (see Section 3.1.6). This format makes the process of modifying file preparation software (by private hospitals) and file import software (insurers for HCP, the Department for PHDB) more difficult than it could be, when a change is required.

There are more flexible data interchange formats available, which are widely used and would simplify the processes of making changes to individual fields (names, data type), adding new fields and removing existing fields. The simplest such format to implement would be a comma separated values (CSV) text file. This is a standard format\(^{111}\) that is widely implemented and

\[^{111}\text{http://www.iana.org/assignments/media-types/text/index.html}\]
which most data management products are able to import or export without the need for software modification. The CSV file would consist of a header record that contains the names of the fields for the data and subsequent records would each contain one episode’s data.

Adopting this format for either HCP or PHDB would require further modification to record layouts beyond simply declaring a preferred CSV format. Both collections require a header record, which contains summary information and has a different format than the episode records that follow it in the file. The CSV file format does not allow for such an arrangement. However, it should be simple for file import and export procedures to be modified to output the header record’s fields as additional fields on each episode record rather than as a separate record at the beginning of the CSV file.

The more flexible file format also makes it practicable for a hospital to develop a single data extraction module for fields common to both HCP and PHDB. In effect, the private hospital extracts 3 files – one containing records with fields unique to HCP, one containing records with fields unique to PHDB and one containing records with fields common to both. The files would need to have a common field that allows them to be linked (an episode identifier). The PHDB file then would be created by linking the 2 relevant files and the HCP file analogously prepared. This would mean that private hospitals could reduce the effort required to modify PHDB and HCP data extraction software when future changes to fields common to both are made. Choosing to adopt this approach should be a decision left to private hospitals to make.

**Benefits**

- The order of fields within the CSV file’s records is not important, provided all fields are present for each record, the fields are in the same order throughout the file and the first record contains the names of the fields. This means that a private hospital can choose the most convenient order when outputting fields to the CSV file.
- Adding new fields to the collection becomes simpler. A new field can be added with less risk that the output file’s format will be corrupted through record layout errors.
- When a new field is added to the collection, it will not “break” the import procedures for recipients of the data if that field is erroneously specified or omitted altogether. This means that other fields in the file can be tested for validity independently of errors with the new field.
- When an existing field is removed from the collection, that variable simply needs to be omitted when exporting the file. No special effort needs to be made to adjust the variable ordering structure of the output file, other than excluding the field concerned.
- These last two benefits make further evolution of the collections more practicable.

**Enablers**

- CSV is widely implemented and used as a data interchange format and most data management software incorporates standard import and export capability for CSV files. This means that private hospitals’ and insurers’ software suppliers do not need to write and maintain modules for writing or reading the CSV files.
The changes required to export and import procedures should be relatively easy to implement successfully, requiring minimal effort.

**Barrier**

This requires every private hospital to change their data export procedure for each collection, every insurer to change their data import procedure (for HCP), every insurer to change their export procedure (for HCP) and the Department to change its import procedure for each collection.

While there is an initial cost for all parties in moving to this modus operandi, the benefits of making the change will accrue over time. Every time a change is required to the fields included in a collection, there will be a saving in the effort required to modify, test and implement data extraction and import routines. As such, there is value in pursuing a change to a more flexible format such as CSV, regardless of other changes being adopted or not.

There are also other format options available, that would provide similar flexibility, some of which allow greater functionality. For example, Extensible Markup Language (XML) is a standard file format specification for machine readable files. It provides a level of functionality that allows files to be read by a wide range of applications, not just data management software. Adoption of an XML format would open up possibilities for browser based manipulation of data files, among other possibilities.

However, there would be a significant cost to implementing and maintaining XML format specifications, in terms of developing the file specification, modifying software to produce the XML file and testing the software’s performance. It would require far more effort and time to implement such a solution than the benefits warrant. For this reason, the simpler, CSV option is preferred.

**Recommendation:** That CSV file format with field names in the first record be adopted as the standard file format for PHDB and HCP files. This recommendation covers all HCP files, including HCP1, HCP2 and AN-SNAP.

**Option 2  Modify the APC file formats at State and Territory level to match PHDB file formats for common fields**

The detailed comparison between the PHDB and the APC showed that there are many commonalities between the two collections. The APC is the minimum set of data elements agreed for mandatory collection and reporting at a national level about care provided to admitted patients in Australian hospitals. Jurisdictional health authorities specify what private hospitals must submit monthly in terms of patient care and they then supply this information to the AIHW in the APC format annually (see Section 2.1.3).

The PHDB has clinical, demographic, benefit and charge data for private hospital patient episodes nationally. In total there are 76 data items in each submission. The PHDB collects a large amount of patient and episode level benefit and charge information which is not within

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112 Extensible Markup Language (XML) 1.0 (Fifth Edition). World Wide Web Consortium (W3C). Available at: [http://www.w3.org/TR/REC-xml/](http://www.w3.org/TR/REC-xml/).
At present, each State and Territory specifies its own range of variables and file format for the admitted episode data that it collects from private hospitals. No two jurisdictions adopt the same file format nor do the file formats co-incide with PHDB or HCP format specifications, in terms of record layouts.

The consequences of this are that private hospitals currently have to maintain 3 separate data extraction procedures for admitted episode data across these 3 collections. Moreover, when a field common to all 3 collections is changed then the private hospital needs to change all 3 data extraction procedures separately. In the case of a large private hospital operator operating across multiple jurisdictions but with central data extraction procedures, the effort is considerably larger.113

As discussed above in relation to the CSV file format option for HCP and PHDB, this effort could be reduced to a single change requirement if HCP, PHDB and jurisdictional admitted episode collections shared a common file specification format, at least for that subset of fields common to all 3 collections.

However, the information that jurisdiction’s legislation dictate must be collected from private hospitals is often greater than the APC NMDS. This may not be a barrier though as many of the additional “state items” like coronary care unit days are already in the PHDB.

113 Note that although we refer to 3 collections there are actually 8 separately operated jurisdictional admitted episode collections.
 Nonetheless, there is value in exploring whether a change to allow common file format specification for selected data fields can be achieved. To do this would require one or more jurisdictions to agree to participate in a pilot process to test the approach. Similarly, one or more private hospitals would need to agree to participate in such a pilot test.

**Benefits**

- Potentially reduced effort required for private hospitals to prepare data extracts for HCP, PHDB and jurisdictional admitted episode collections.
- Reduced effort for private hospitals to modify data extraction procedures when a change occurs to a field common to 2 or more of the 3 collections.
- In jurisdictions where private hospitals experience difficulty meeting jurisdictional admitted episode data submission requirements, compliance with those requirements is likely to become easier and data quality to improve. This would have a consequential benefit for APC data quality at the national level, particularly as common fields include a number of APC NMDS agreed items.

**Enablers**

- If the above option of adopting CSV formats for PHDB and HCP is implemented, then it makes the process of delivering the common file specification substantially easier. It would simplify any changes to data extraction and import procedures for private hospitals and jurisdictions, respectively.

**Barriers**

- Agreement is needed for jurisdictions to modify their data collection formats and data import procedures for private hospitals.
- It may be that, for this approach to deliver worthwhile benefits, jurisdictions might have to agree to lose detail for some fields where they use supersets of APC NMDS agreed code sets.
- If the above CSV file format option is not successfully implemented, then an agreed HCP, PHDB and jurisdictional common data items’ format will be required, requiring much more effort to implement.
- A significant issue here is with the AR-DRG and ICD versions. While PHDB and HCP have a field for AR-DRG version, jurisdictions will generally only accept the current version as specified in the APC NMDS. A similar issue can arise with ICD codes for diagnoses. Private hospitals are bound to provide insurers with diagnostic and procedural information to insurers according to the AR-DRG versions, ICD versions or MBS codes specific in their contracts. For some insurers, these differ from currently mandated versions in the APC NMDS. This creates a disconnection between relevant code sets in HCP, PHDB and APC for some fields that are nominally common to all 3 collections.
- Protocols would be needed for delivering agreement between a larger range of stakeholders for future changes to items within PHDB, HCP and APC NMDS. Currently, APC NMDS and related data development is driven primarily by public sector needs. There is
representation of private hospitals in this process but this has only marginal influence on outcomes. The above issue with AR-DRG and ICD versions is a symptom of this situation, resolution of which will require meaningful consideration of implications for insurers and private hospitals when deciding how and when to implement changes to AR-DRG and ICD versions.

This will require finding a jurisdiction that would be willing to pilot such a process. A suitable jurisdiction may be Victoria as they have a well established data collection (Victorian Admitted Episodes Dataset) and expressed interest in such an option during this Review. NSW may also be interested in exploring this option, as they have just commenced a process of replacing their Inpatient Statistics Collection system for private health facilities.

The pilot would also involve selected private hospitals rather than a wholesale change for all private hospitals. A suitable model might be to seek the involvement of a corporate private hospital provider willing to participate. A corporate provider would have greater incentive to be involved, consistent with the greater benefits they could realise, and better infrastructure available to support its involvement.

Such a pilot study would need to operate under a governance and oversight arrangement involving the Department, the participating jurisdiction and the private hospital sector. NHISSC would also have an interest in the outcomes of the pilot.

If the pilot is successful then it would create pressure to roll out the approach out to other jurisdictions. This would arise as the benefits to private hospitals would be significant and the potential benefits to jurisdictional admitted episode collections and consequently to the APC also may be significant.

Even though PHDB and state based collections are run for each financial year this pilot preparatory work could commence immediately.

<table>
<thead>
<tr>
<th>Recommendation:</th>
<th>That jurisdictions and private hospitals be approached to undertake a pilot test of a process for effecting a common file format for those data fields common to PHDB, HCP and the APC NMDS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation:</td>
<td>That, subject to the above pilot succeeding, the successful model for common specification of common fields be rolled out to all private hospitals and all jurisdictions.</td>
</tr>
</tbody>
</table>

**Option 3  Modify governance arrangements for data development and implementation affecting private hospitals and insurers**

There have been issues with disconnection between data development and implementation of APC NMDS items, and operating constraints for the private hospital sector (see Section 3.1.7). In addition, this Review is recommending changes that require greater alignment of data sets and data collection processes for at least HCP, PHDB and the APC.

These recommendations will require active participation from private hospitals, health insurers, States and Territories, the Department, AIHW and ABS, to deliver successfully. Importantly, the level of involvement from these agencies will need to be maintained in the future, to minimise the risk that future changes to one or more of these collections re-introduce duplication, inefficiency or other problems.
At present, the HCP Working Group (HCPWG) is responsible for oversight of the HCP and comprises representation from insurers and Commonwealth Departments (DVA and the Department). The PHDB is maintained by the Department, with input from the Private Hospitals Working Group (PHWG) which comprises representation from private hospitals, AIHW, ABS and the Department. The APC NMDS is overseen by the National Health Information Standards and Statistics Committee (NHISSC), which comprises representation from States and Territories, the Commonwealth (the Department, DVA, Medicare Australia\textsuperscript{114}, ABS, AIHW), the National Health Chief Information Officers’ Forum (NHCIOF), the National e-Health Transition Authority (NeHTA) and APHA. The New Zealand Ministry of Health is accorded observer status\textsuperscript{115}.

Structures and protocols to improve communication among these 3 groups should be put in place. In addition, NHISSC should consider establishing a formal procedure for assessing impact of proposed changes to APC NMDS data items and metadata on the private hospital sector. That protocol should actively engage the HCPWG and PHWG and should extend beyond implementation requirements, feasibility and timetables to also include business impacts.

Such procedures could be established under the existing NHISSC business rules, which allow NHISSC to “appoint working groups where necessary”. Such working groups can include membership from outside of NHISSC, such as sector representatives and members of HCPWG and PHWG.

NHISSC also allows for informal observers to attend its meetings and, as noted above, the New Zealand Ministry of Health has been accorded formal observer status. It would be appropriate for the health insurance industry to seek the same observer status with NHISSC, to provide it with a means to contribute to discussions as needed and maintain timely awareness of national health data developments.

This Review finds also that regular meetings of HCPWG and PHWG, to consider joint data issues, should be scheduled. These meetings would provide opportunities to identify common concerns or opportunities with respect to the HCP, PHDB and APC nexus. They would also provide opportunities to discuss APC related issues and capture the full range of industry issues requiring consideration at NHISSC meetings.

**Benefits**

- Improved communication among key stakeholder groups in the management of national data development and implementation directly affecting the private hospital sector.
- Reduced risks of problems arising through inadequate consideration of implications of proposed changes for the business of private hospitals and insurers.
- Greater ownership of changes to HCP, PHDB and APC NMDS metadata and processes among private sector stakeholders.

\textsuperscript{114} From 1 July 2011, Medicare Australia will cease to exist and this role is expected to filled by a representative from the Commonwealth Department of Human Services.

Enablers

- The structures necessary to effect this option are in place and the proposed changes can be adopted within existing business rules.

- Representatives of private hospitals and insurers are keen for greater input into national data development and implementation activities. There is recognition that national performance monitoring processes will make use of the outputs from these activities and that it is important that the private sector’s view is adequately represented in decision making processes.

Barriers

- Engagement between insurers and private hospitals can be complicated by the fact that they often are in adversarial positions when negotiating contracts. This makes collaborative decision making more difficult.

Recommendation: That the health insurance industry formally seek membership of NHISSC as an observer. This could be either as a permanent (observer) member or on an occasional basis, when issues specific to health insurers are to be considered.

Recommendation: That PHWG and HCPWG meet at least once per year to discuss data related issues. This meeting should take place in the December quarter, to allow sufficient time for issues requiring implementation in the following financial year to be identified and considered.

Recommendation: That NHISSC be asked to develop a formal protocol for assessing business and related impacts of proposed changes to APC NMDS data items and associated metadata on the private hospital and health insurance sector.

Option 4 Central collection portal for PHDB and HCP data submission

The similarity between the PHDB and HCP has lead to suggestions that a central portal be established. Such a portal would receive a single file from a private hospital of all their separations for a given period. The private hospital would have access rights only to upload its own data.

This file would then be stored in a database accessible to the Department, DVA and other insurers through the same portal. The insurers would have access privileges allowing them to download only those records with their insurer identifier on them and only the HCP specific data from those records.

Insurers then would add their HCP specific information to the records.

The Department would have access rights allowing it to download only PHDB specific and HCP specific fields.

Figure 8 illustrates how such a portal would operate.
There are some prerequisites for such a portal to operate. First, a suitable entity to operate the portal would need to be identified or created and the necessary organisational infrastructure put into place. This would include ensuring adequate security protocols to protect confidentiality and privacy of the identified patient information that the portal would hold.

Second, PHDB and HCP file specifications would need to be replaced with a single file specification that would apply to all episode records. Private hospitals’ data extraction and submission procedures would need to be modified to accommodate the new format. Suitable governance and monitoring arrangements would need to be established as part of this step.

Third, the portal itself would need to be built and tested, before it could be implemented. Part of the functionality of the portal would need to be a data validation engine, which would automatically review a file of submitted data and generate an error report for the submitting hospital.

**Figure 8 Central collection portal for HCP and PHDB**

**Benefits**

- PHDB and HCP data would be generated and transmitted in a single file, for each private hospital. It would eliminate the need for separate files to be prepared for each insurer (HCP data) and for the Department (PHDB).
- HCP data would be downloaded in a single file, for each insurer. It would eliminate the need to obtain separate files from each private hospital.
- PHDB and HCP data would be able to be downloaded in a single file by the Department. It would eliminate the need to obtain separate files from each private hospital (PHDB) and from each insurer (HCP).

**Enabler**

- The Private Health Insurance Act 2007 provides the legislative framework to require private hospitals and insurers to submit their data via such a portal.
Barriers

- While the Private Health Insurance Act 2007 provides a legislative framework to require compliance, it does not provide a strong basis for enforcing compliance.
- There is no obvious entity that could fill the role of portal manager. No one agency or organisation appears sufficiently acceptable to all stakeholders, in terms of managing the privacy and confidentiality risks.
- There would be significant effort required for private hospitals and insurers to modify their data management procedures to comply with such a portal’s business processes.

Having considered the benefits, barriers and enablers, this Review finds that this option is unlikely to be achievable at this point in time. However, as PHDB, HCP and APC processes continue to evolve in the future, an opportunity may arise to reconsider whether a solution along these lines – entire or partial – will have become feasible.

Option 5 Using ECLIPSE for hospital to insurer HCP reporting

Consideration should be given to using ECLIPSE for transmission of HCP data by private hospitals to insurers. Currently, there is an outdated HCP specification within ECLIPSE (see Section 3.1.6. However, this part of the ECLIPSE record is not used by health insurers nor is it populated by private hospitals.

If this specification within the ECLIPSE record was updated to match the current HCP requirement, then private hospitals could populate these fields when preparing their ECLIPSE records and transmit their HCP data to insurers via the ECLIPSE record. This would integrate HCP data transmission into another business process, eliminating the need for a separate extraction and transmission process for HCP data.

Adopting an approach such as this would require establishment of an initial arrangement between the Department and Medicare Australia. There would also need to be an ongoing arrangement for maintaining the currency of the HCP specification as and when future changes will be made. Medicare Australia is amenable to such arrangements, on the basis that they are consistent with the policy directions it receives from the Australian Government and they are able to recover the costs of initial and subsequent changes.

At present, ECLIPSE is not used for all private hospital admitted episodes leading for which health insurers receive a claim (see Section 3.1.6). This means that transmission of HCP data by ECLIPSE cannot be implemented for all private hospitals and all health insurers at once.

Benefits

- Significant reduction in effort for private hospitals and insurers through elimination of an entire business process.

116 More correctly with the Commonwealth Department of Human Services, after 1 July 2011.
Enablers

- ECLIPSE has substantial market penetration, being used for around 19% of all private hospital admitted episode claims with health insurers. That market penetration will continue to grow as insurers increasingly engage private hospitals to change to ECLIPSE as the preferred method for claims’ lodgement.

- The outdated HCP specification within the current ECLIPSE record requires only small modifications to be brought up to date.

- Partial implementation of this approach is possible for a private hospital and a health insurer, and even partial implementation of this solution offers benefits to private hospitals and insurers. For example, if a private hospital uses ECLIPSE to lodge claims with half of the insurers with which it deals, it can eliminate half of the HCP data preparation and transmission burden by switching HCP data transmission to ECLIPSE for those insurers. Moreover, it can progressively reduce the burden further as it implements ECLIPSE with other insurers. A similar observation applies from the perspective of the health insurer receiving HCP data via ECLIPSE from some, but not all, private hospitals.

- For private hospitals who start using ECLIPSE in the future, implementing HCP transmission into ECLIPSE will be part of the overall ECLIPSE implementation and should require little additional effort or cost. Similarly for health insurers who move to receiving HCP data via ECLIPSE.

Barriers

- There is an implementation cost for a private hospital to move to HCP transmission via ECLIPSE, and for a health insurer to move to HCP receipt via ECLIPSE. This should effectively be a once only cost, as once the software module is developed to populate the HCP fields in ECLIPSE, it can be re-used each time a new insurer adopts ECLIPSE for claims’ lodgement. A similar observation applies to a health insurer receiving HCP data via ECLIPSE from some, but not all, hospitals.

- Medicare Australia will seek payment for costs associated with updating the HCP specification within ECLIPSE. Similarly, it will seek payment for future modifications to the specification. The Department should seek an arrangement whereby it pays only for work done and not for any “licence fee” type arrangement. In this context, it must be noted that the availability of up to date HCP transmission capability adds value to the ECLIPSE product.

- There is an unresolved legal question about the marketing model Medicare Australia uses for ECLIPSE (see Section 3.1.6). This question has not been tested in a court of law and so the risk remains that Medicare Australia may have to change its marketing model in the future. For example, ECLIPSE is currently marketed freely to users but could be forced to operate under a fee-based model. This would affect market penetration and potentially cause some users to cease using the product.

- There is a possibility that competing products may enter the marketplace and displace ECLIPSE. In this case, distributors of the competing products may or may not choose to include HCP data transmission as a product feature.
The above barriers suggest that it would be unwise to move to a model where ECLIPSE is the mandated medium for transmitting HCP data between private hospitals and insurers, in the short to medium term. However, there remains value in creating an environment in which private hospitals and insurers have a choice of using ECLIPSE for transmitting HCP data, particularly as the benefits of doing so can be large. For example, a corporate provider managing dozens of hospitals could achieve substantial savings.

The landscape with respect to market penetration and the risks identified above should be reviewed in the medium term to assess whether further changes in this regard are warranted.

**Recommendation:** That the ECLIPSE record specification be updated to permit transmission of HCP data according to the current HCP specification.

**Recommendation:** That the ECLIPSE record specification thereafter be maintained to ensure its capability to transmit HCP data remains current.

**Option 6** Pilot project to link claims’ data and inpatient data for private episodes in public hospitals

To obtain this missing information such as AR-DRG, diagnosis and procedure codes it may be possible to link the claim form and the data held by state health departments. Possible fields that could be used to link the two datasets include:

- Patient Unit Record Number/Episode Number/Hospital Record Number;
- Sex;
- Date of Birth;
- Hospital;
- Admission Date; and
- Separation Date.

This project could take the form of a pilot. It would require obtaining involvement from one insurer and one jurisdictional health department. The first stage would involve the Department meeting with an insurer and a jurisdiction health department to articulate the project. The Department would specify the reason for undertaking the linking, the benefits of undertaking the linking and the reporting and data distribution processes. A prior requirement would be to confirm the willingness of the AIHW to participate in such a pilot as an independent analyst and that there are no legislative nor other restrictions to prevent its participation.

The next step would involve the insurer extracting the agreed linking fields from their system. They would then supply this data to the jurisdiction health department. The jurisdiction health department would then attempt to link the insurer data to episodes in their system.

The jurisdictional health department would then report back on the results to stakeholders. The report would identify:

- the successful number of records linked and how many false matches were obtained;
- how long this data linking exercise takes;
• how long it would take if it were to involve linking data from multiple insurers; and
• how often this linking process could be undertaken (that is, monthly, quarterly or annually).

Information such as DRG and Principal Diagnosis could be supplied back to the insurer(s) by the jurisdictional health department in an agreed format. This would enable the insurer to load the data into their systems and undertake detailed comparisons (DRG level) between the public and private sector in terms of costs. It is likely this would be attractive to insurers but the validity of this view would be tested as part of the pilot.

The preferred plan for convergence focuses on obtaining HCP information from public hospitals on privately insured patient stays. Apart from charge information state and territory health departments already collect the same information that is specified in HCP from public hospitals.

**Table 11  Comparison of APC NMDS and HCP**

<table>
<thead>
<tr>
<th>Comparison</th>
<th><strong>APC NMDS vs. HCP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identical</td>
<td>18 items. Activity when injured, Additional diagnosis, Admission date, Care type, Date of birth, Inter-hospital contracted patient, Mental health legal status, Number of days of hospital-in-the-home care, Number of qualified days for newborns, Place of occurrence of external cause of injury (ICD-10-AM), Principal diagnosis, Procedure, Separation date, Sex, Total leave days, Total psychiatric care days, Urgency of admission</td>
</tr>
<tr>
<td>Mappable</td>
<td>15 items. Area of usual residence, Australian State/Territory, identifier (establishment), Condition onset flag, Diagnosis related group, Establishment number, Establishment sector, External cause, Hospital insurance status, Intended length of hospital stay, Major diagnostic category, Mode of admission, Mode of separation, Person identifier, Region code</td>
</tr>
<tr>
<td>In APC not HCP</td>
<td>4 items. Country of Birth, Indigenous Status, Funding source for hospital patient, Source of referral to public psychiatric hospital</td>
</tr>
<tr>
<td>In HCP not APC</td>
<td>43 items. Predominantly information about particular types of care information e.g. Coronary care unit charges, coronary care unit days etc.</td>
</tr>
</tbody>
</table>

If the States and Territories make available the information about episodes of care where privately insured patients elect to be treated as private patients in a public hospital, this will greatly improve comparability and transparency across the hospital system. It will enable more detailed comparative information to be made available about cost of stays by private patients whether they be in public or private hospitals.

The availability of such comparative information will contribute to creating a more competitive environment across both the public and private sectors, holding out the prospect, over time, of a more efficient hospital system as whole that will be better able to contain costs.

In a climate of increasing health costs, mostly due to an ageing population, it is essential to view the Australian hospital system as a whole and not as a disparate set of public and private hospitals that until now, have largely operated in isolation. If hospital services can be subject to greater competition, where jurisdictions may be able to outsource some procedures to private
hospitals, if safety and quality is not compromised, but the procedure is more cost effective, downward pressure on cost can be increased through greater competition.

Experience with State and Territory health authorities indicates they are open to developing a more competitive environment, but limitations in the ability to compare costs across the private and public hospital sectors have restricted this environment from developing. Allowing wider access to diagnosis and procedure information about private hospital patient stays in public hospitals would support greater efficiency across the whole Australian hospital system.

It is primarily the identical and mappable items for which insurers are interested in receiving information. More specifically the fields of:

- principal (and additional) diagnosis;
- procedure codes; and
- DRG.

If insurers have this information they can then compare stays between the public and private sectors. It also enables insurers to better help their members by potentially developing programs to assist their members in managing their conditions outside of the hospital setting.

The best approach to obtaining this information is for the Department to establish a project with a particular state or territory health department to undertake a data linkage exercise. This was identified as the best approach in the workshop. Outlined below are the prerequisites required to delivering the plan and the barriers, enablers and timeframes for undertaking this.

The prerequisites to delivering this option are identifying an insurer that would participate in this pilot process; identifying a jurisdiction to participate; and establishing governance and management structures for the project, across the Department, HCPWG and jurisdiction.

The choice of health department is a decision for the department. We suggest initial contact be made with the Victorian Department of Health to discuss this project as they have the most established admitted episode data collection (Victorian Admitted Episode Dataset – VAED). They also have a dedicated data linkage unit.

The choice of insurer is also a decision for the Department and we suggest contacting either Medibank Private or the Australian Health Services Alliance. In discussions with these stakeholders throughout Work Stream 1 both demonstrated a willingness to participate in a process to obtain information on privately insured stays in public hospitals. This was reinforced at the Work Stream 2 workshop.

**Benefits**

- Improved data for insurers.
- Insurers can compare public and private hospital stays.
- Collaboration between stakeholders.
- Increased use of private hospital data.
Enablers

- Data is already collected by jurisdiction health departments – this makes both the pilot and ongoing linkage easier.
- Some jurisdictional health departments have expressed a willingness to be involved in such a project – again making both the pilot and ongoing linkage easier.

Barriers

- Additional work for insurers through having to supply data.
- Additional work for jurisdictional health departments.
- Obtaining jurisdiction health department consent to participate in this project.
- Rolling out the pilot to all insurers would take time.
- Cost of data linkage – this is a barrier to be overcome for both the initial pilot and any ongoing linkage process.

Recommendation

Investigate the feasibility of conducting a data linking exercise between jurisdiction health department and insurers for improved HCP information.

3.3 A list of private hospitals

This term of reference has been overtaken by recent events relating to the national health reforms. In particular, NHPA will be required to report on hospitals and will have to decide what constitutes a private hospital in this context. This requirement effectively supersedes any mechanism that this Review might recommend.

Accordingly, although this Review considered recommendations relating to this term of reference, the Department has advised that those recommendations are no longer required. Nonetheless, this section presents the options considered by the Review, in relation to this term of reference. This information is presented in the hope it may be of value to NHPA and the Department in considering the NHPA requirements for such a list under the national health reforms.

An authoritative list of private hospitals will need to serve a number of purposes for the Department and the Commonwealth. These include:

- planning in relation to the nature and distribution of hospital services across Australia;
- policy analysis and development relating to hospital policy overall and to private hospitals specifically;
- ministerial briefings and advice;
- identifying hospitals within scope for different data collections; and
- identifying hospitals for performance monitoring and reporting, for national reforms as well as for ongoing health system oversight.
Most private hospitals in Australia are declared under the *Private Health Insurance Act 2007*. The exceptions are smaller clinics, nursing posts and hospitals that provide services to self insured people or otherwise without the need to lodge a claim with a health insurer.

In terms of coverage of the private hospital system for the above purposes, these non declared hospitals are marginal and unlikely to add significant capability to a list of private hospitals. Given their non declared status, it is difficult to identify some of these facilities. There is also no effective mechanism for the Department to obtain the desired details from these hospitals. This Review found no clear means by which a suitable such mechanism could feasibly be established and operate effectively.

When a hospital is declared, the Department obtains an initials set of hospital details (see Section 2.3.1). It is these items that the Department is most interested in keeping up to date.

The Department has developed a database internally for storing this information. That database holds the information collected at declaration and allows staff within the Department to access that data for review, update and reporting purposes. The database has been recently developed and is in the process of being implemented across the Department.

States and Territories collect some of the information that the Department needs for its authoritative list, from hospitals that they license within their respective jurisdictions. The process of declaration under the *Private Health Insurance Act 2007* requires that the declared hospital be licensed or otherwise approved to operate by the relevant State or Territory health authority. This means that States and Territories hold some of the information that the Department needs for most of the declared hospitals.

Moreover, the licence renewal processes in each State and Territory (usually annual) update that information locally. Some jurisdictions, such as Queensland, WA and Victoria, informally pass on updated information to the Department.

In some cases, such as classes of clinical services offered and category of hospital, the States and Territories classify hospitals differently than does the Department and than does each other. This limits the usefulness of some of the information somewhat. However, it does not render it useless as classes can sometimes be mapped successfully to Departmental classifications.

A significant gap at the State and Territory level is that South Australia does not license private day hospitals. Therefore, South Australia has no information that it can pass on to the department for this large subgroups of private hospitals in that State.

An ideal solution to the need for an authoritative list would be a single national list that was able to be shared by the Commonwealth and States and Territories.

**Option 1  Develop a portal for capturing, storing and managing private hospital details**

This option proposes the development of a web based portal for capturing, storing, reviewing and updating private hospitals’ details. The operating model for such a portal would be as follows:

- The Department supports and maintains the portal.
- The portal is accessible by the Department, other Commonwealth agencies, State and Territory health authorities and by private hospitals themselves.
• Access to the portal is secured with different access privileges for different users. A private hospital could access its own data only, for review and modification, with access to selected fields limited (such as declared hospital status, jurisdictional licence status). A State or Territory health authority could access data for all private hospitals within its jurisdiction, for review, modification and reporting, with access to selected fields limited (such as declaration status). The Department could access all private hospitals’ data, for review, modification and reporting, with access to all fields. Other Commonwealth agencies could access records for all private hospitals, for review and reporting purposes only and with selected fields barred from access.

• Private hospitals would automatically receive annual reminders (via email) to review and confirm or update their information via the portal.

Benefits

• This approach minimises the need for private hospitals to provide similar or the same information to more than one recipient.

• The process of updating is relatively simple, via a web based interface.

• It can be modified to issue more frequent reminders than annual, if it’s needed to provide greater confidence that the database is as up to date as practicable.

Enablers

• The Department has built its internal database, which could provide the underlying database structure needed to support such a portal.

• The risk of States and Territories and the Commonwealth using conflicting information regarding the numbers and profiles of private hospitals is virtually eliminated.

• Compliance with the necessary business processes would be relatively simple for all parties.

• State and Territory licensing requirements provide a legislative basis with sufficient power to enforce compliance from private hospitals.

Barriers

• While the Private Health Insurance Act 2007 provides a legislative framework to require compliance, it does not provide a strong basis for enforcing compliance. This will be an issue for those hospitals not subject to State or Territory licensing requirements.

• States and Territories would need to agree to modify their current processes and use the portal to collect the information that they need for licence management and renewal purposes. This would require them to be satisfied that security and access controls are sufficient to protect the data for private hospitals within their jurisdictions, as well as giving them sufficient access and control over data over which they currently exercise total control and ownership.
• There would be significant effort required to set up such a portal. Once set up, its maintenance and support would not be such a significant burden. However, user management and support would need to be provided.

A solution such as this portal is a long term proposition. At this early stage, it would be over engineering the solution to the problem of an authoritative list of private hospitals, and there would be a significant risk of failure. Nonetheless, it has several attractive qualities that mean it should not be dismissed totally. Rather, alternative approaches should be pursued in the short term, in a manner that does not prevent reconsidering the portal option in the medium to longer term.

**Option 2 Establish formal arrangements for exchange of private hospital details between the Department and individual States and Territories**

This Review found that at least one jurisdiction (WA) would be amenable to putting formal arrangements in place for sharing private hospitals’ licensing information with the Department. It is likely that other jurisdictions would also be amenable to entering into such arrangements.

The minimum arrangements would need to include the State or Territory advising the Department when a currently licensed private hospital’s details change. This would provide the Department with an opportunity to actively contact the hospital concerned and seek confirmation or updating of details held by the Department.

Additional elements to the partnership that should be pursued would be for the State or Territory to also pass onto the Department the updated details for the private hospital.

Where the Department becomes aware of a private hospital changing its details, then it could reciprocate by advising the relevant State or Territory health authority of the fact and providing any changed details it may have.

Entering into arrangements such as that described would not prevent consideration or implementation of the portal approach discussed above, at some future date. Indeed, it is more likely to foster a collaborative relationship between the Department and the jurisdictions, which could aid in setting up a portal. It would also offer an opportunity to identify business process issues that might affect the design and implementation of such a portal.

**Benefits**

• The Department would have more timely access to updated details for private hospitals whose licensing details change.

• States and Territories might likewise have access to more timely intelligence and details regarding changes relevant to private hospitals’ licences.

**Enablers**

• The Department’s private hospitals information area has good relationships with most States and Territories.

• For some jurisdictions, entering into such arrangements would simply be formalising an existing, informal practice.
• The risk of States and Territories and the Commonwealth using conflicting information regarding the numbers and profiles of private hospitals is reduced.

**Barriers**

• While the *Private Health Insurance Act 2007* provides a legislative framework to require compliance, it does not provide a strong basis for enforcing compliance.

• This option does not permit capture of information for those hospitals not subject to State or Territory licensing requirements.

**Option 3 Establish an internal database and annual process for updating private hospitals’ details**

As stated above, the Department has developed an internal database for the purposes of maintaining this authoritative list of private hospitals.

The current view within the Department is that relationships with private hospitals are generally agreeable and that private hospitals are likely to be amenable to being asked to confirm or update their licence details, from time to time. If a private hospital is provided with a copy of their current details, as known to the Department, the effort involved in checking and providing any updated information would be minimal.

This effort could be reduced further if the protocol for seeking an update from a private hospital took into account whether the private hospital concerned has had its details updated recently. This might have happened because the hospital contacted the Department itself when its details changed, or as a consequence of advice from a State or Territory health authority.

In considering how often private hospitals should be approached for confirmation of their details, an annual update is consistent with licensing renewal periods in most jurisdictions.

**Benefits**

• The Department would have more timely access to updated details for private hospitals whose licensing details change.

• The risk of States and Territories and the Commonwealth using conflicting information regarding the numbers and profiles of private hospitals is reduced.

**Enablers**

• The Department’s private hospitals information area has reasonable relationships with the private hospital sector.

**Barriers**

• While the *Private Health Insurance Act 2007* provides a legislative framework to require compliance, it does not provide a strong basis for enforcing compliance.
The Department needs to ensure its database captures the date of the most recent update or confirmation of the private hospital’s details. This should not be a difficult barrier to overcome.
4 Recommended implementation plan

This chapter summarises the implementation plan necessary to deliver the recommendations made in this report.

4.1 Private hospital data collection streamlining

This section summarises the milestones and broad timeline required to deliver on the streamlining recommendations made by this Review.

This is not intended to be a detailed project plan for each recommendation, but is intended to indicate the major steps and likely timing required.

4.1.1 Transfer of PHEC from ABS to AIHW

<table>
<thead>
<tr>
<th>Recommendation:</th>
<th>That the responsibility for the Private Health Establishments Collection be transferred to the Australian Institute of Health and Welfare.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Key agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish minimum service standards for transfer to be considered successful.</td>
<td>ABS, AIHW, DoHA, PHWG</td>
<td></td>
</tr>
<tr>
<td>Analyse current situation and probability of minimum requirements being met, including prerequisites for achieving success.</td>
<td>ABS, AIHW, DoHA, PHWG</td>
<td></td>
</tr>
<tr>
<td>Assess costs of achieving the transfer and ongoing costs of PHEC under AIHW's auspice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree to funding arrangements and develop budget bids.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop project plan for transfer.</td>
<td>ABS, AIHW, PHWG</td>
<td></td>
</tr>
<tr>
<td>Agreed project plan for transfer of PHEC, including timetable for final transfer.</td>
<td></td>
<td>February/March 2012</td>
</tr>
<tr>
<td>Implement project plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likely activities would include: developing service agreements (MoUs or similar for information sharing between ABS and AIHW), developing/adapting forms and procedures, communicating with private hospitals on plans and progress.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHEC transfer to AIHW completed.</td>
<td></td>
<td>June 2014</td>
</tr>
</tbody>
</table>
4.1.2 PHDB, HCP and APC data collection

**Recommendation:** That CSV file format with field names in the first record be adopted as the standard file format for PHDB and HCP files. This recommendation covers all HCP files, including HCP1, HCP2 and AN-SNAP.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider timing issues (including whether to wait for updates to HCP specification and PHDB specification).</td>
<td>HCPWG, PHWG, DoHA</td>
<td></td>
</tr>
<tr>
<td>Agreed timetable for implementing CSV format for HCP and PHDB.</td>
<td></td>
<td>October 2011</td>
</tr>
<tr>
<td>Inform private hospitals and insurers of plans and timetable for changes to HCP and PHDB specifications.</td>
<td>DoHA, HCPWG, PHWG</td>
<td></td>
</tr>
<tr>
<td>Inform public hospitals (States and Territories) of intentions to change HCP format specification and timetable.</td>
<td>DoHA, HCPWG, PHWG</td>
<td></td>
</tr>
<tr>
<td>Update DoHA procedures for accepting HCP and PHDB data to conform to the new file formats.</td>
<td>DoHA, HCPWG, PHWG</td>
<td></td>
</tr>
<tr>
<td>Implement new CSV file formats for HCP and for PHDB. At this point, implementation may be partial with some private hospitals continuing to submit data using the current file format. In reality, implementation will need to be phased in over a period of 6 to 12 months.</td>
<td></td>
<td>June 2012</td>
</tr>
</tbody>
</table>

**Recommendation:** That jurisdictions and private hospitals be approached to undertake a pilot test of a process for effecting a common file format for those data fields common to PHDB, HCP and the APC NMDS.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raise proposal with States and Territories, probably through NHISSC.</td>
<td>DoHA, NHISSC</td>
<td></td>
</tr>
<tr>
<td>In-principle agreement with at least one jurisdiction.</td>
<td></td>
<td>December 2011</td>
</tr>
<tr>
<td>Negotiate with interested jurisdiction(s), including scope and objectives of the pilot, governance and funding arrangements.</td>
<td>DoHA, Jurisdiction(s)</td>
<td></td>
</tr>
<tr>
<td>Activity or Milestone</td>
<td>Agents</td>
<td>Milestone timing</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Agreed scope and objectives and operating parameters for the pilot with a jurisdiction(s).</td>
<td>DoHA, Jurisdiction Partner(s), PHWG</td>
<td>April 2012</td>
</tr>
<tr>
<td>Identify candidate private hospitals or private hospital operators to invite into the pilot.</td>
<td>DoHA, Jurisdiction Partner(s), PHWG</td>
<td></td>
</tr>
<tr>
<td>In-principle agreement for involvement from private hospitals.</td>
<td>DoHA, Jurisdiction partner(s), Hospitals</td>
<td>July 2012</td>
</tr>
<tr>
<td>Negotiate with interested hospitals the operating parameters for their involvement.</td>
<td>DoHA, Jurisdiction partner(s), Hospitals</td>
<td></td>
</tr>
<tr>
<td>Agreed operating parameters and governance arrangements with partner hospitals.</td>
<td>DoHA, Jurisdiction Partner(s), Hospitals</td>
<td>December 2012</td>
</tr>
<tr>
<td>Develop file specifications, procedures and other operating requirements.</td>
<td>DoHA, Jurisdiction Partner(s), Hospitals, PHWG, HCPWG</td>
<td></td>
</tr>
<tr>
<td>Implement procedures.</td>
<td>DoHA, Jurisdiction partner(s), Hospitals</td>
<td></td>
</tr>
<tr>
<td>Assess results of pilot.</td>
<td>DoHA, Jurisdiction partner(s), Hospitals</td>
<td></td>
</tr>
<tr>
<td>Report outcome of pilot test to NHISSC, HCPWG and PHWG.</td>
<td>DoHA, Jurisdiction partner(s), Hospitals</td>
<td>June 2013</td>
</tr>
</tbody>
</table>

**Recommendation:** That, subject to the above pilot succeeding, the successful model for common specification of common fields be rolled out to all private hospitals and all jurisdictions.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use learning from pilot to develop the preferred model for the new data transfer process, taking into account any recent changes in APC, PHDB and HCP specifications.</td>
<td>DoHA, Partner jurisdiction(s), Partner hospitals</td>
<td></td>
</tr>
<tr>
<td>Use learning from pilot to develop a preferred method for a jurisdiction and its private hospitals to move to the new process.</td>
<td>DoHA, Partner jurisdiction(s), Partner hospitals</td>
<td></td>
</tr>
<tr>
<td>Identify pre requisites for successful transition and assess current state for each jurisdiction.</td>
<td>DoHA, Partner jurisdiction(s), Partner hospitals</td>
<td></td>
</tr>
<tr>
<td>Use results of above work to identify a preferred order for rolling out the new process to jurisdictions.</td>
<td>DoHA, HCPWG, PHWG, NHISSC</td>
<td></td>
</tr>
</tbody>
</table>
### 4.1.3 Governance of national data development activities

**Recommendation:** That the health insurance industry formally seek membership of NHISSC as an observer. This could be either as a permanent (observer) member or on an occasional basis, when issues specific to health insurers are to be considered.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiate with States and Territories to agree to move to the new process.</td>
<td>DoHA, HCPWG, PHWG, NHISSC</td>
<td></td>
</tr>
<tr>
<td>Agreed plan to roll out the new process to all jurisdictions and private hospitals.</td>
<td></td>
<td>June 2013</td>
</tr>
<tr>
<td>Rollout completed.</td>
<td></td>
<td>June 2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine the most suitable form of representation for the industry (e.g., selected HCP member, selected insurer, industry representative body).</td>
<td>HCPWG</td>
<td>December 2011</td>
</tr>
<tr>
<td>Write to Chair of NHISSC.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recommendation:** That PHWG and HCPWG meet together at least once per year to discuss data related issues. This meeting should take place in the December quarter, to allow sufficient time for issues requiring implementation in the following financial year to be identified and considered.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider primary objectives of a joint meeting, need for business rules and timing.</td>
<td>PHWG, HCPWG, DoHA</td>
<td></td>
</tr>
<tr>
<td>Agreed format, business rules and timing for annual joint meeting.</td>
<td></td>
<td>December 2011</td>
</tr>
<tr>
<td>First joint meeting (items for discussion to include NHISSC private sector impact assessment protocol and protocol for regular communication between HCP and PHWG).</td>
<td></td>
<td>February/March 2012</td>
</tr>
</tbody>
</table>
**Recommendation:** That NHISSC be asked to develop a formal protocol for assessing business and related impacts of proposed changes to APC NMDS data items and associated metadata on the private hospital and health insurance sector.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider needs of private sector (item for discussion at joint HCPWG/PHWG meeting).</td>
<td>PHWG, HCPWG, DoHA</td>
<td></td>
</tr>
<tr>
<td>Draft terms of reference for such a protocol.</td>
<td>PHWG, HCPWG, DoHA</td>
<td>March 2012</td>
</tr>
<tr>
<td>Put issue onto NHISSC agenda, with draft protocol as basis for discussion.</td>
<td>Private hospitals' representative on NHISSC</td>
<td></td>
</tr>
<tr>
<td>NHISSC agrees to final protocol.</td>
<td></td>
<td>June 2012</td>
</tr>
</tbody>
</table>

### 4.1.4 Making ECLIPSE capable of transmitting HCP data

**Recommendation:** That the ECLIPSE record specification be updated to permit transmission of HCP data according to the current HCP specification.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoHA enter into negotiations with Medicare Australia (DHS).</td>
<td>DoHA, DHS</td>
<td></td>
</tr>
<tr>
<td>Agreed cost and process for effecting changes.</td>
<td>DoHA, DHS</td>
<td>December 2011</td>
</tr>
<tr>
<td>Investigate feasibility issues.</td>
<td>DoHA, DHS</td>
<td></td>
</tr>
<tr>
<td>Consider timing issues (including whether to wait for updates to HCP specification, ECLIPSE change schedule).</td>
<td>DoHA, DHS, HCPWG</td>
<td></td>
</tr>
<tr>
<td>Agreed timetable for update and release of HCP capable ECLIPSE.</td>
<td></td>
<td>May 2012</td>
</tr>
<tr>
<td>Inform private hospitals and insurers of plans and timetable for HCP capable ECLIPSE.</td>
<td>DoHA, HCPWG, PHWG</td>
<td></td>
</tr>
<tr>
<td>Inform public hospitals (States and Territories) of intentions to change and opportunity available to provide full HCP data if they happen to use ECLIPSE for lodging claims.</td>
<td>DoHA</td>
<td></td>
</tr>
<tr>
<td>Software updates according to timetable.</td>
<td>DHS</td>
<td></td>
</tr>
<tr>
<td>Activity or Milestone</td>
<td>Agents</td>
<td>Milestone timing</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Release of HCP capable ECLIPSE.</td>
<td></td>
<td>June 2012</td>
</tr>
</tbody>
</table>

**Recommendation:** That the ECLIPSE record specification thereafter be maintained to ensure its capability to transmit HCP data remains current.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoHA enter into negotiations with Medicare Australia (DHS).</td>
<td>DoHA, DHS</td>
<td>March 2012</td>
</tr>
<tr>
<td><strong>Agreed terms of ongoing arrangement.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual review of HCP requirements within ECLIPSE.</td>
<td>DoHA, HCPWG, PHWG</td>
<td></td>
</tr>
<tr>
<td>Annual review of value of HCP capability within ECLIPSE.</td>
<td>DoHA, HCPWG, PHWG</td>
<td></td>
</tr>
<tr>
<td><strong>Determination of need for annual update of ECLIPSE or not.</strong></td>
<td></td>
<td>September of the relevant year (2013 onwards)</td>
</tr>
</tbody>
</table>

### 4.2 Private hospital and public hospital comparability

This section summarises the milestones and broad timeline required to deliver on the comparability recommendations made by this Review.

This is not intended to be a detailed project plan for each recommendation, but is intended to indicate the major steps and likely timing required.
4.2.1 Linkage of APC episodes’ data and insurance claims’ data

**Recommendation:** Investigate the feasibility of conducting a data linking exercise between a jurisdictional health department and insurers for improved HCP information.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a detailed project plan. This will include developing a data set specification for use in a data linkage process.</td>
<td>DoHA, HCPWG</td>
<td>December 2011</td>
</tr>
<tr>
<td>Arrange meeting with private health insurer to outline project and obtain participation consent. Provide the data set specification with the identifiers that will be required. Insurer to provide a sample dataset to use in linkage process.</td>
<td>DoHA, Insurers</td>
<td>February 2012</td>
</tr>
<tr>
<td>Arrange meeting with State and Territory Health Departments. Organise to have data custodians and data linkage representatives from a jurisdictional health department. Specify the identifiers that will be supplied to the jurisdictional health department.</td>
<td>DoHA, States</td>
<td>February 2012</td>
</tr>
<tr>
<td>Establish governance arrangements and data management protocols.</td>
<td>DoHA, Insurer, Jurisdiction</td>
<td></td>
</tr>
<tr>
<td><strong>Commence data exchange, linkage and analysis.</strong></td>
<td>Project team</td>
<td>May 2012</td>
</tr>
<tr>
<td><strong>Finalise data linkage exercise and prepare report. Identify issues and how process might work on larger scale.</strong></td>
<td></td>
<td>July 2012</td>
</tr>
<tr>
<td>Consider pilot results.</td>
<td>DoHA, HCPWG, Jurisdiction</td>
<td></td>
</tr>
<tr>
<td>Commence work on expanding beyond pilot to including all insurers that have members attending public hospitals in the jurisdiction.</td>
<td>DoHA, HCPWG, Jurisdiction</td>
<td></td>
</tr>
<tr>
<td>Identify data specification for insurers to submit data to pilot jurisdiction health department.</td>
<td>HCPWG</td>
<td></td>
</tr>
<tr>
<td>Link all privately insured patient stays in public hospitals within jurisdiction to all of the insurers’ members’ claims for public hospital stays in that jurisdiction.</td>
<td>Jurisdiction</td>
<td></td>
</tr>
<tr>
<td><strong>Report and consider expanded pilot results.</strong></td>
<td>DoHA, HCPWG, Jurisdiction</td>
<td>March 2013</td>
</tr>
<tr>
<td><strong>Commence work of rolling out pilot to other jurisdictions.</strong></td>
<td>DoHA, HCPWG, Jurisdictions</td>
<td>July 2013</td>
</tr>
</tbody>
</table>
4.2.2 NHCDC Experimental estimates’ reports

**Recommendation:** Undertake increased analysis of NHCDC information and develop a series of “experimental estimates” reports.

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Agents</th>
<th>Milestone timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine specific areas to use for first experimental estimates.</td>
<td>DoHA, PHWG</td>
<td></td>
</tr>
<tr>
<td>Develop draft reports for each of the selected areas.</td>
<td>DoHA</td>
<td>May 2012</td>
</tr>
<tr>
<td>Consider drafts and make decisions regarding release.</td>
<td>DoHA, PHWG</td>
<td></td>
</tr>
<tr>
<td>Release report(s) for feedback and comment.</td>
<td>DoHA</td>
<td>August 2012</td>
</tr>
</tbody>
</table>

4.3 The authoritative list of private hospitals

As discussed in Section 3.3, this term of reference has been overtaken by recent events relating to the national health reforms. Accordingly, although this review considered recommendations relating to this term of reference, the Department has advised that those recommendations are no longer required.

Given this fact, no timelines nor milestones are included here.

4.4 The consolidated implementation timetable

Table 12 summarises the timetables in the preceding sections and provides an overview of the milestones and their timing for each of the recommended areas of streamlining and comparability improvement.

This consolidated timeline is also summarised in Appendix E. This consolidation makes it clear that there is a significant workload involved in order to implement the full range of recommendations. Much of this workload falls to a few key actors. Principally, these are the Department, the PHWG and the HCPWG.

The ability to deliver on the recommended timetable is likely to be constrained by availability of adequate resources among these key actors. As such, this timetable may require revision as time progresses. Progress against the timetable should be reviewed regularly and milestones revised as necessary.

It must also be noted that the arena of hospital data collection and reporting is dynamic and more so at present, with the changes demanded by the recently agreed national health reforms. This fact is underlined by the supersession, by the establishment of the NHPA, of this Review’s term of reference relating to an authoritative list of private hospitals.

In light of this fluidity of environment, the recommendations of this Review and associated implementation plans should be routinely monitored and modified as circumstances change.
Table 12 Implementation plan milestones and their timing

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Milestone</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSV format for PHDB and HCP</td>
<td>Agreed timetable for implementing CSV format for HCP and PHDB.</td>
<td>October 2011</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Agreed cost and process for effecting ECLIPSE changes.</td>
<td>December 2011</td>
</tr>
<tr>
<td>Health insurers and NHISSC</td>
<td>Write to Chair of NHISSC.</td>
<td>December 2011</td>
</tr>
<tr>
<td>Joint HCPWG/PHWG meetings</td>
<td>Agreed format, business rules and timing for annual PHWG/HCPWG joint meeting.</td>
<td>December 2011</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>In-principle agreement with at least one jurisdiction.</td>
<td>December 2011</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Develop a detailed project plan. This will include developing a data set specification for use in a data linkage process.</td>
<td>December 2011</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Arrange meeting with private health insurer to outline project and obtain participation consent. Provide the data set specification with the identifiers that will be required. Insurer to provide a sample dataset to use in linkage process.</td>
<td>February 2012</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Arrange meeting with State and Territory Health Departments. Organise to have data custodians and data linkage representatives from a jurisdictional department. Specify the identifiers that will be supplied to the jurisdictional department.</td>
<td>February 2012</td>
</tr>
<tr>
<td>Joint HCPWG/PHWG meetings</td>
<td>First PHWG/HCPWG joint meeting (items for discussion to include NHISSC private sector impact assessment protocol and protocol for regular communication between HCP and PHWG).</td>
<td>February/March 2012</td>
</tr>
<tr>
<td>PHEC transfer</td>
<td>Agreed project plan for transfer of PHEC, including timetable for final transfer.</td>
<td>February/March 2012</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Agreed terms of ongoing arrangement.</td>
<td>March 2012</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Milestone</td>
<td>Timing</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>Agreed scope and objectives and operating parameters for the pilot with a jurisdiction(s).</td>
<td>April 2012</td>
</tr>
<tr>
<td>NHCDC experimental estimates</td>
<td>Develop draft reports for each of the selected areas.</td>
<td>May 2012</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Agreed timetable for update and release of HCP capable ECLIPSE.</td>
<td>May 2012</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Commence data exchange, linkage and analysis.</td>
<td>May 2012</td>
</tr>
<tr>
<td>CSV format for PHDB and HCP</td>
<td>Implement new CSV file formats for HCP and for PHDB.</td>
<td>June 2012</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Release of HCP capable ECLIPSE.</td>
<td>June 2012</td>
</tr>
<tr>
<td>Private hospital impact assessment protocol</td>
<td>NHISSC agrees to final protocol.</td>
<td>June 2012</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>In-principle agreement for involvement from private hospitals.</td>
<td>July 2012</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Finalise data linkage exercise and prepare report. Identify issues and how process might work on larger scale.</td>
<td>July 2012</td>
</tr>
<tr>
<td>NHCDC experimental estimates</td>
<td>Release report(s) for feedback and comment.</td>
<td>August 2012</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>Agreed operating parameters and governance arrangements with partner hospitals.</td>
<td>December 2012</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Report and consider expanded pilot results.</td>
<td>March 2013</td>
</tr>
<tr>
<td>Pilot of new data transfer process</td>
<td>Report outcome of pilot test to NHISSC, HCPWG and PHWG.</td>
<td>June 2013</td>
</tr>
<tr>
<td>Roll out new data transfer process to all jurisdictions</td>
<td>Agreed plan to roll out the new process to all jurisdictions and private hospitals.</td>
<td>June 2013</td>
</tr>
<tr>
<td>HCP data linkage for public hospitals</td>
<td>Commence work of rolling out pilot to other jurisdictions.</td>
<td>July 2013</td>
</tr>
<tr>
<td>HCP capable ECLIPSE</td>
<td>Determination of need for annual update of ECLIPSE or not.</td>
<td>September of the relevant year (2013 onwards)</td>
</tr>
<tr>
<td>PHEC transfer</td>
<td>PHEC transfer to AIHW completed.</td>
<td>June 2014</td>
</tr>
<tr>
<td>Roll out new data transfer process to all jurisdictions</td>
<td>Rollout completed.</td>
<td>June 2015</td>
</tr>
</tbody>
</table>
**Appendix A  Record of stakeholders’ consultations for Work Stream 1**

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>AJ Lanyon</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>Anneke Schneider</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>Bryan McLinden</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>Jane Boke</td>
<td>ACT Health</td>
</tr>
<tr>
<td>Julie Searle</td>
<td>ACT Health</td>
</tr>
<tr>
<td>Louise Edmonds</td>
<td>ACT Health</td>
</tr>
<tr>
<td>Alex Peng</td>
<td>Australian Health Insurance Association</td>
</tr>
<tr>
<td>Julian Lim</td>
<td>Australian Health Insurance Association</td>
</tr>
<tr>
<td>Mia Horrigan</td>
<td>Australian Health Insurance Association</td>
</tr>
<tr>
<td>Michael Armitage</td>
<td>Australian Health Insurance Association</td>
</tr>
<tr>
<td>Brett Henderson</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>Cheryl Harkins</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>George Bodilsen</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>Jenny Hargreaves</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>Kelly Cheng</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>Dr Barbara Carney</td>
<td>Australian Private Hospitals Association</td>
</tr>
<tr>
<td>George Neale</td>
<td>Australian Private Hospitals Association</td>
</tr>
<tr>
<td>Margaret Banks</td>
<td>Australian Commission for Safety and Quality in Health Care</td>
</tr>
<tr>
<td>Neville Board</td>
<td>Australian Commission for Safety and Quality in Health Care</td>
</tr>
<tr>
<td>Elizabeth Rankin</td>
<td>Australian Day Hospitals Association</td>
</tr>
<tr>
<td>Brenton Alexander</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>David Whelan</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Dr David Martin</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Frederick Beale</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Huibo Ji</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Kate Medwin</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Kelvin King</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Kerryn Wilde</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Louisa Wang</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Mark Thomann</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Organisation</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Patrick Henry</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Paul Burch</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Peter Callanan</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Ric Marshall</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Stephen Lewis</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Victoria Mowat</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Yana Steinebronn</td>
<td>Australian Department of Health and Ageing</td>
</tr>
<tr>
<td>Kate Steer</td>
<td>Australian Health Service Alliance</td>
</tr>
<tr>
<td>Nicolle Predl</td>
<td>Australian Health Service Alliance</td>
</tr>
<tr>
<td>Yolanda Webster</td>
<td>BUPA</td>
</tr>
<tr>
<td>Patrick Tobin</td>
<td>Catholic Health Australia</td>
</tr>
<tr>
<td>Kylie Keates</td>
<td>Catholic Negotiating Alliance</td>
</tr>
<tr>
<td>Mark Kaczmarek</td>
<td>Australian Department of Veterans’ Affairs</td>
</tr>
<tr>
<td>Anne Crouch</td>
<td>Eyetech Day Surgeries</td>
</tr>
<tr>
<td>Joan Cad</td>
<td>HAMBS</td>
</tr>
<tr>
<td>Sally Smith</td>
<td>HAMBS</td>
</tr>
<tr>
<td>Ian Crettenden</td>
<td>Health Workforce Australia</td>
</tr>
<tr>
<td>Michelle Dixon</td>
<td>Healthscope</td>
</tr>
<tr>
<td>Sallyanne Wiseman</td>
<td>Mater Health Services</td>
</tr>
<tr>
<td>Marissa Featherstone</td>
<td>MDHF</td>
</tr>
<tr>
<td>John Szakiel</td>
<td>Medibank Private</td>
</tr>
<tr>
<td>Jane Crowe</td>
<td>Medicare Australia</td>
</tr>
<tr>
<td>Sheldon White</td>
<td>Medicare Australia</td>
</tr>
<tr>
<td>Peter Brandt</td>
<td>NSW Department of Health</td>
</tr>
<tr>
<td>Lucy Fisher</td>
<td>Private Hospitals Association Queensland</td>
</tr>
<tr>
<td>Don Bahr</td>
<td>Queensland Health</td>
</tr>
<tr>
<td>Jim Snodgrass</td>
<td>Queensland Health</td>
</tr>
<tr>
<td>Lorraine Hooper</td>
<td>Queensland Health</td>
</tr>
<tr>
<td>Neil Gardner</td>
<td>Queensland Health</td>
</tr>
<tr>
<td>Mati Tabur</td>
<td>Ramsay Healthcare Pty. Ltd.</td>
</tr>
<tr>
<td>Vaughn Badaway</td>
<td>Ramsay Healthcare Pty. Ltd.</td>
</tr>
<tr>
<td>Dr Ron Somers</td>
<td>SA Health</td>
</tr>
<tr>
<td>Kym Piper</td>
<td>SA Health</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Organisation</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td>Maxine Menadue</td>
<td>SA Health</td>
</tr>
<tr>
<td>Paul Basso</td>
<td>SA Health</td>
</tr>
<tr>
<td>Kevin Ratcliffe</td>
<td>Tasmanian Department of Health and Human Services</td>
</tr>
<tr>
<td>Laurie Kinney</td>
<td>Tasmanian Department of Health and Human Services</td>
</tr>
<tr>
<td>Peter Mansfield</td>
<td>Tasmanian Department of Health and Human Services</td>
</tr>
<tr>
<td>Andrew Brown</td>
<td>Victorian Department of Health</td>
</tr>
<tr>
<td>Bruce Prosser</td>
<td>Victorian Department of Health</td>
</tr>
<tr>
<td>Kirsty Anderson</td>
<td>Victorian Department of Health</td>
</tr>
<tr>
<td>Mark Gill</td>
<td>Victorian Department of Health</td>
</tr>
<tr>
<td>Elisabeth Sallur</td>
<td>WA Health</td>
</tr>
<tr>
<td>Toni Satti</td>
<td>WA Health</td>
</tr>
</tbody>
</table>
### Appendix B  List of stakeholders consulted for Work Stream 2

Stakeholders consulted in Work Stream 2 workshop.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julian Lim</td>
<td>AHIA</td>
</tr>
<tr>
<td>Mia Horrigan</td>
<td>AHIA</td>
</tr>
<tr>
<td>Nicolle Predl</td>
<td>Australian Health Service Alliance (AHSA)</td>
</tr>
<tr>
<td>Kate Steer</td>
<td>Australian Health Service Alliance (AHSA)</td>
</tr>
<tr>
<td>David Martin</td>
<td>Department of Health and Ageing (DoHA)</td>
</tr>
<tr>
<td>Karen Chudleigh</td>
<td>Department of Health and Ageing (DoHA)</td>
</tr>
<tr>
<td>Peter Callanan</td>
<td>Department of Health and Ageing (DoHA)</td>
</tr>
<tr>
<td>Sally Smith</td>
<td>HAMBS</td>
</tr>
<tr>
<td>David Macqueen</td>
<td>Medibank Private (MBP)</td>
</tr>
<tr>
<td>John Robinson</td>
<td>Medibank Private (MBP)</td>
</tr>
<tr>
<td>Michelle Dixon</td>
<td>Healthscope</td>
</tr>
<tr>
<td>Kylie Keates</td>
<td>Catholic Negotiating Alliance</td>
</tr>
<tr>
<td>Patrick Tobin</td>
<td>Catholic Health Australia</td>
</tr>
<tr>
<td>Mati Tabur</td>
<td>Ramsay Health</td>
</tr>
<tr>
<td>Edmund Butler</td>
<td>Ramsay Health</td>
</tr>
<tr>
<td>Dr Barbara Carney</td>
<td>Australian Private Hospitals’ Association</td>
</tr>
<tr>
<td>George Neale</td>
<td>Australian Private Hospitals’ Association</td>
</tr>
<tr>
<td>George Bodilsen</td>
<td>AIHW</td>
</tr>
<tr>
<td>Cheryl Harkins</td>
<td>AIHW</td>
</tr>
<tr>
<td>Jenny Hargreaves</td>
<td>AIHW</td>
</tr>
<tr>
<td>Kelly Cheng</td>
<td>AIHW</td>
</tr>
<tr>
<td>Anneke Schmider</td>
<td>ABS</td>
</tr>
<tr>
<td>Brian McLinden</td>
<td>ABS</td>
</tr>
</tbody>
</table>
Appendix C  Comparison framework findings

C.1  HCP

C.1.1  HCP: Scope of the collection

The Hospital Casemix Protocol (HCP) data collection was established as part of the 1995 Private Health Insurance Reform legislation to monitor the deregulation of the private health industry.  The scope of the collection is for privately insured admitted patient episodes, whether they occur in a public or a private hospital. There are five data specifications within Hospital Casemix Protocol. They are HCP, HCP1, HCP2, GT-Dental and PHDB. The information flow varies among each specification. HCP involves data flowing from the Hospital to the Insurer, while HCP1 and HCP2 is data that flows from the Insurer to the Department (Note: GT-Dental is not within consideration here, while PHDB is discussed in more detail below).

The HCP data specification is the focus here as the flow of information for this specification is from the hospital to the insurer. Private hospitals supply this data monthly and should submit an episode within 42 days of patient discharge. The legislation that applies to HCP are:

- Private Health Insurance Act 2007 (the Act);
- Private Health Insurance (Health Insurance Business) Rules 2010;
- Private Health Insurance (Data Provision) Rules 2010.

Insurers do not currently receive any meaningful data on private patient episodes in public hospital (with the exception of Tasmania where the public hospitals use a management system that is widely used in the private sector). Just over 15 per cent of separations which are funded by private health insurance take place in a public hospital (See Table 4). There is no incentive for public hospitals to record and provide additional data (e.g. patient admission, separation date, procedure and diagnoses) as it won’t change the financial outcome for the public hospital.

<table>
<thead>
<tr>
<th>Separation</th>
<th>Funding Source: Private health insurance</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospital</td>
<td>501,819</td>
<td>15.3%</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>2,767,947</td>
<td>84.7%</td>
</tr>
<tr>
<td>Total</td>
<td>3,269,766</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

This lack of private patient stays in public hospitals is an issue for insurers as they cannot compare public and private hospital stays or understand the nature of the episode in the public hospital.

The Department expects public hospitals to continue to provide the information required by private health insurers to enable the payment of hospital benefits for insured patients (i.e. claiming benefits). As the reporting requirements for HCP and PHDB document states:

“It is also expected that hospitals will work toward providing health insurers with data that complies with the HCP. No timeframe has been set for public hospitals to provide health insurers with a complete HCP dataset as per the specifications. This recognises the needs of both parties and allows additional time for hospitals to build a complete data provision capability, whilst continuing to provide existing base levels of data. DoHA expects public hospitals and health insurers to continue working towards providing the full HCP dataset.”

C.1.2 HCP: Data item definitions

The HCP has clinical, demographic, benefit and charge data for privately-insured admitted-patient episodes nationally. In total there are 76 data items in each HCP submission. Of these 65 data items are collected in the episode record and 11 items for the header record. The HCP collects a large amount of patient and episode level benefit and charge information which is not within scope of the APC NMDS. These data items are defined in the HCP and PHDB manual. Summary comparisons between the data specifications for HCP and APC NMDS can be seen below in Table 5.

**Table 14  Comparison between APC NMDS and HCP**

<table>
<thead>
<tr>
<th>Comparison</th>
<th>APC NMDS vs. HCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identical</td>
<td>18 items. See spreadsheet for details.</td>
</tr>
<tr>
<td>Mappable</td>
<td>15 items. See spreadsheet for details.</td>
</tr>
<tr>
<td>In APC not HCP</td>
<td>4 items. Country of Birth, Indigenous Status, Funding source for hospital patient, Source of referral to public psychiatric hospital.</td>
</tr>
<tr>
<td>In HCP not APC</td>
<td>43 items.</td>
</tr>
</tbody>
</table>

C.1.3 HCP: Counting rules

The base statistical unit in the collection is the episode. However the HCP file submitted each month is split into a header and an episode record. The header record contains establishment level information like Provider Number and HCP version. The header record is often used to validate the submission as a whole. The episode contains information such as sex and admission time. The code sets used by HCP are ICD-10-AM version 7, ACHI version 6, AR-DRG (any version is accepted). The file format of HCP is a fixed width file, where the format is specified by column widths, pad character and left/right alignment.

HCP data is currently held as a ‘snapshot’ at the point at which the data is sent. This means that any later adjustments are not factored in to the dataset. In comparison to the APC NMDS, DRG changes generally trigger a data re-submission in state reporting. To improve comparability between APC NMDS and HCP, HCP would require a similar system to ensure data is complete and accurate.
C.1.4 HCP: Costing

It is difficult to fully cost the time and effort required to provide data for a collection such as HCP. The steps involved are generally extracting data each month from a patient administration system (PAS), checking the extract file, submitting the file for validation to insurers or organisations like AHSA and rectifying issues with the extract. Wholesale changes to a source system such as a Patient Administration System (PAS) or even PAS version upgrades can add a considerable cost to extracting and creating monthly data extracts be they HCP or a jurisdiction based collection.

C.1.5 HCP: Practicability of changing the collection

Changes to the HCP data collection do impose a burden on insurers (i.e. data recipients) and typically take six months to fully implement. For insurers or intermediary organisations like (AHSA) change may require negotiation and meetings with IT providers. In the past changes have been signed off by the Department in December for the beginning of the next financial year and this would need to continue.

The HCP is an established collection. The process of private hospitals extracting data from their systems on a monthly basis and submitting it will continue without a well laid out data convergence plan. The practicability of changing HCP, or any of the other collections, is discussed in more detail in Section 4.

C.1.6 PHDB: Scope

The Private Hospital Data Bureau (PHDB) data collection was established in 1997-98. The scope of the collection includes all private hospitals and day facilities. PHDB contains de-identified information on all private hospital separations, including patient demographics, hospital episode, clinical information (ICD-10-AM) and hospital charges for all patients in private hospitals.

The flow of information is from private hospitals to the Department. Private hospitals supply this data monthly and should submit an episode within 42 days (i.e. six weeks) of patient discharge. The legislation that applies to PHDB is the same as that for HCP, they are:

- the *Private Health Insurance Act 2007* (the Act);
- the *Private Health Insurance (Health Insurance Business) Rules 2010*;
- the *Private Health Insurance (Data Provision) Rules 2010*.

C.2 PHDB

C.2.1 PHDB: Data Item Definitions

The PHDB format is very similar to the HCP format. Both collections have 11 items in the header record and 65 items in the episode record. The header records collect 10 identical items, with the PHDB not collecting Insurer/Group Identifier. For the episode record the difference between PHDB and HCP is that HCP collects Insurer Membership Identifier, Insurer Identifier, Family Name and Given Name. For the field Insurer Identifier, which is a code that identifies the private health insurer PHDB collects Payer Identifier. Payer Identifier is an item that categorises the organisation that payed for the episode of care. Summary comparisons between the data specifications for PHDB and APC NMDS can be seen below in Table 6.
Table 15  Comparison between APC NMDS and PHDB

<table>
<thead>
<tr>
<th>Comparison</th>
<th>APC NMDS vs. PHDB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identical</td>
<td>18. See spreadsheet for details</td>
</tr>
<tr>
<td>Mappable</td>
<td>16. See spreadsheet for details</td>
</tr>
<tr>
<td>In APC not HCP</td>
<td>3 items. Country of Birth, Indigenous Status, Source of referral to public psychiatric hospital.</td>
</tr>
<tr>
<td>In HCP not APC</td>
<td>42. See spreadsheet for details</td>
</tr>
</tbody>
</table>

C.2.2   PHDB: Counting rules

Like HCP the base statistical unit in the collection is the episode. As mentioned though the PHDB file submitted each month is split into a header and an episode record. The header record contains establishment level information like Provider Number and ICD version. The header record is often used to validate the submission as a whole. The episode contains information such as sex and admission time. The code sets used by PHDB are ICD-10-AM version 7, ACHI version 6, AR-DRG (any version is accepted). The file format of PHDB is a fixed width file, where the format is specified by column widths, pad character and left/right alignment.

C.2.3   PHDB: Costing

It is difficult to fully cost the time and effort required for a private hospital to be a participant for a collection such as PHDB. The steps involved are generally extracting data each month from a patient administration system (PAS), checking the extract file, submitting the file for validation to the Department and liaising with the Department to rectify issues with the extract that the Department might discover. Wholesale changes to a PAS (or even PAS version upgrades) can add a lot of cost to extracting and creating monthly data extracts be they PHDB or a jurisdiction based collection.

C.2.4   PHDB: Practicability of changing the collection

The PHDB, like HCP, is an established collection. The process of private hospitals extracting data from their systems and submitting it on a monthly basis will continue without a well laid out data convergence plan. The practicability of changing PHDB, or any of the other collections, is discussed in more detail in Section 4.

C.3   Perinatal

C.3.1   Perinatal: Scope

The scope of this dataset includes all births at public and private hospitals but also those at birth centres and those within the community. National data on births are based on notifications to the perinatal data collection in each State and Territory. Midwives and other staff, using information obtained from mothers and from hospital or other records, complete notification forms for each birth in each jurisdiction. Information is included in the NPDC for all live births and stillbirths of at least 400 grams birth weight or at least 20 weeks gestation.
C.3.2 Perinatal: Data Item Definitions

Like the APC NMDS data flows from private hospitals to the State or Territory health department and then on to the AIHW. The specification for each State based perinatal collection is unique. The Perinatal NMDS for 2010-11 has 23 metadata items many of which are specific to the birth itself, for example, birth plurality (i.e. singleton, twins, triplets etc.).

The legislation that enables the collection of data for the Perinatal NMDS is the relevant state legislation. Agreement on the data items that should be included in the NMDS.

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Count of items between APC NMDS and Perinatal NMDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identical</td>
<td>10 – See spreadsheet for details</td>
</tr>
<tr>
<td>Mappable</td>
<td>Nil</td>
</tr>
<tr>
<td>In APC not perinatal</td>
<td>27 – See spreadsheet for details</td>
</tr>
<tr>
<td>In Perinatal not APC</td>
<td>13 – See spreadsheet for details</td>
</tr>
</tbody>
</table>

C.3.3 Perinatal: Counting Rules

The base statistical unit in the collection is the birth event. However information is also collected on the mother and the pregnancy.

C.3.4 Perinatal: Costing

It is difficult to fully cost the time and effort required for a private hospital to be a participant in the different jurisdiction based perinatal data collections. This is, because the collection methodology and content varies from jurisdiction to jurisdiction. For example, Victoria has only recently moved to electronic submissions (it was a paper based reporting method previously).

C.3.5 Perinatal: Practicability of changing the collection

The focus of each jurisdiction’s perinatal collection is local. That is, the jurisdiction collects and analyses information on and in relation to the health of mothers and babies in order to contribute to improvements in their health within that jurisdiction. For example, there are 23 metadata items in the NMDS but the Victorian Perinatal Data Collection consists of over 100 data items.121

To change the ongoing jurisdiction focussed collections would be difficult. In addition both public and private hospitals have to provide the same birth report i.e. data from private and public hospitals is comparable.

C.4 Cancer Registry

C.4.1 Cancer Registry: Scope

The AACR consists of the eight Australian State and Territory cancer registries, the New Zealand Cancer registry and the NCSCH at the AIHW. Cancer registration is an important and fundamental tool in cancer monitoring. Cancer is a notifiable disease in Australia and each State and Territory has a registry that assembles local information about new cases of cancers and about cancer deaths.

C.4.2 Cancer Registry: Data item definitions

Australian States and Territories are required by legislation to maintain a cancer registry of new cases of malignant cancer. Data are supplied to the registries from a range of sources. This includes private and public hospitals, pathology laboratories, radiotherapy centres and the relevant registry of births, deaths and marriages. The state and territory registries undertake a lot of data collation and cleansing prior to providing data to AIHW.

The data that both private and public hospitals are required to supply to the cancer registry within each jurisdiction is the same. However the data that hospitals must supply to the cancer registries is unique to that particular jurisdiction e.g. what a Victorian private hospital supplies to the Victorian Cancer Registry is not exactly the same (although it is similar) as what a Queensland private hospital supplies to the Queensland Cancer Registry. In addition the method of submission differs between jurisdictions, for example, electronic notifications can be submitted in some states and territories. Generally hospitals must supply the cancer notification within one month of the separation date.

<table>
<thead>
<tr>
<th>Table 17</th>
<th>Comparison between APC NMDS and Cancer Registry NMDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comparison</strong></td>
<td><strong>Count of items between APC NMDS and Cancer Registry NMDS</strong></td>
</tr>
<tr>
<td>Identical</td>
<td>6 – See spreadsheet for details</td>
</tr>
<tr>
<td>Mappable</td>
<td>Nil</td>
</tr>
<tr>
<td>In APC not Cancer Registry</td>
<td>31 – See spreadsheet for details</td>
</tr>
<tr>
<td>In Cancer Registry not APC</td>
<td>18 – See spreadsheet for details</td>
</tr>
</tbody>
</table>

C.4.3 Cancer Registry: Counting Rules

The base statistical unit in the collection is the tumour. Information is also collected on the patient though.

C.4.4 Cancer Registry: Costing

A considerable portion of the cost of maintaining a cancer registry is the work done within the jurisdiction itself. This is because the registry receives many individual notifications from different organisations (e.g. pathology and a private hospital notification). These individual notifications are then cleaned and linked together to create one tumour based record.

C.4.5 Cancer Registry: Practicability of changing the collection

The focus of each jurisdiction’s cancer registry is local. In addition data collected by the cancer registry is from a number of organisations, not just private hospitals. To change this collection would be difficult.

C.5 PHEC

C.5.1 PHEC: Scope

PHEC was first run by ABS in 1991-92. It is an annual survey which collects information about the activities, staffing and finances of all private hospitals in Australia. The survey is run annually although there was a break in the series in 2007-08 when the ABS did not collect data due to budgetary constraints.

The information flow for PHEC is more complex than the other collections. The information flow generally involves data being sent from private hospitals to the ABS and from state/territory health departments to the ABS on behalf of the private hospitals. This complex flow occurs when the private hospital has been sending data to the state or territory health department and they give permission for the state or territory health department to release the data. This data is supplied annually and the legislation that applies to PHEC is the Census and Statistics Act 1905, under which reporting is mandatory. ABS is also bound by that Act in that it cannot release the data supplied by individual private hospitals.

The comparable public hospital collection is the NPHED, which is compiled from data supplied by the State and Territory health authorities. The scope of this dataset is establishment-level data for public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans’ Affairs, and alcohol and drug treatment centres.

C.5.2 PHEC: Data Item Definitions

The PHEC is split into two forms. One form is for day surgeries while the other form is for acute and psychiatric hospitals. The surveys are almost identical with sections of the survey focussing on general information, hospital characteristics, activities, theatres and special facilities, staffing, finance and admitted patient data (health department can release this data if permission is given).

Part 6 and 7 of the two PHEC surveys collect admitted patient data. This section collects the total number of separations for various data items. For example, the funding source for patients is collected by number of separations. The code sets used by PHEC align with the National Health Data Dictionary. PHEC also collects number of separations for principal diagnosis (ICD-10-AM version 7), procedure (ACHI version 6) and major diagnostic category (AR-DRG).

C.5.3 PHEC: Counting Rules

Unlike HCP and PHDB, which has a statistical unit of the episode the base statistical unit is the private hospital for PHEC. Information is collected at this level but generally reported at the state/territory level.

C.5.4 PHEC: Costing

Costing the PHEC is difficult, however the Statistical Clearing House (SCH) provides some information as to the effort required to participate in PHEC. The SCH provides a central
clearance point for business surveys that are run, funded, or conducted on behalf of the Australian Government.\textsuperscript{123} PHEC went through a full review in 1997-98 and the average time to complete the survey was 672 minutes.\textsuperscript{124} The average time to complete the survey for the private hospitals is probably less than this now though, with the jurisdiction health departments supplying the admitted patient data.

The fact that PHEC collects information on the hospital, the facilities, staffing, finance and patients is a major contributor to the cost of the collection. To respond to each survey section would require accessing and analysing information from a number of databases/systems such as payroll systems and patient administration systems. Responsibility for obtaining and analysing this information to respond to the survey may be spread across a number of staff members within the hospital. This would also be a large part of the cost for private hospitals responding to ABS.

C.5.5 PHEC: Practicability of changing the collection

Recently the PHEC underwent a review.\textsuperscript{125} The review sought the views of stakeholders in relation to how they used the collection and how it might be improved. A key outcome for the review was to ensure the collection enables more valid comparisons between public and private hospitals. To achieve this, the ABS aimed to more closely align PHEC with the Public Hospitals NMDS.

ABS translated priority suggestions for change into statistical questions and included them in a revised PHEC form. During October - November 2010, the ABS tested the revised PHEC form with a range of private hospitals in Qld, Victoria and the ACT. This involved testing the new questions to determine if the information was able to be reported by hospitals and the relevance of the questions in a hospital context.\textsuperscript{126}

C.6 NHCDC

C.6.1 NHCDC Scope

The NHCDC was established in 1996-97. The purpose of the collection is to produce the national public and private sector cost weights for Australian Refined Diagnosis Related Group (AR-DRG) and associated analytical tables contained in the Cost Report. The data is used for outcomes measurement, performance information and policy development. It provides the health care industry with a nationally consistent method of classifying all types of patients, their treatment and associated costs.\textsuperscript{127}

For the private sector the NHCDC is the main vehicle by which relativities are developed to inform negotiations between private hospitals and health insurers. These standards will impact

\textsuperscript{124} \url{http://nss.gov.au/nss/home_NSF/84c014dd96ddf6cbca257118001dbbee/b8c00d55dee80c54ca25668ba007d993e?OpenDocument}, [Viewed 11/04/2011]
\textsuperscript{125} Correspondence with ABS.
\textsuperscript{126} \url{http://www.abs.gov.au/websitedbs/c311215.nsf/20564c23f3183fdaca25672100813ef1/39722f1c46cb8015ca2572f00163e92f?OpenDocument} [Viewed 06/04/2011]
on the results of the NHCDC in the private sector, recognising that to date the majority of private hospitals are costed using nationally derived service weights.\textsuperscript{128}

The scope of this data set is all public and private hospitals. Private day only facilities with less than 200 acute separations in the financial year are not within scope. The NHCDC is a voluntary collection so unlike HCP, PHDB and PHEC there is no legislation that underpins this collection. Data is supplied on an annual basis.

C.6.2 NHCDC: Data Item Definitions

Differences in reported costs between the two sectors result from factors such as different reporting practices and obligations, and admission practices. The key difference in the reporting of costs between public and private sector hospitals in the NHCDC:

- predominance of ‘cost modelling’ to produce cost estimates in the private sector, in comparison to ‘patient costing’ for the majority of public hospital.
- treatment of teaching, training and research costs.
- differing admission practices within and between sectors.
- pharmacy costs for private hospitals.
- prostheses costs.
- Public and not-for-profit private hospitals are partially exempt from paying fringe-benefits tax (FBT) and are not required to pay payroll tax.\textsuperscript{129}

Not only are there the above mentioned differences but the process of supplying data to the NHCDC process differs for public and private hospitals. The primary difference is that public hospitals submit their data to a State or Territory Health department officer to assess the data before it is sent on to the Department. However, private hospitals are required to undertake this quality assessment themselves.

C.6.3 NHCDC: Counting Rules

NHCDC is an annual collection of Australian hospital patient costing data. The purpose is to produce benchmark data for use by hospitals so that they can compare their costs to other similar hospitals. The NHCDC also produces national cost weights for AR-DRGs and other statistics relevant for hospital service costing and planning.

C.6.4 NHCDC: Costing

Hospitals voluntarily participate in the NHCDC. Private hospitals supply data at their own cost (and generally each private hospital submits its own data). The state or territory health department supplies public hospital data within their jurisdiction.

C.6.5 NHCDC: Practicability of changing the collection

NHCDC has been producing national hospital costing results since 1995-96 as a voluntary collection. The collection has been evolving since then, particularly in terms of hospital


\textsuperscript{129} Productivity Commission 2009, Public and Private Hospitals, Research Report, Canberra
participation. The NHCDC will need to continue to change though. In the National Partnership Agreement130 all jurisdictions agreed to the costing model being built on the NHCDC.

C.7 ACSQHC Safety and Quality Indicators

C.7.1 ACSQHC: Scope

The Commission recently commenced its official role as an independent, statutory authority, under the National Health and Hospitals Network Act 2011131. In that capacity, its key functions comprise:

- promoting, supporting and encouraging the implementation of initiatives relating to health care safety and quality;
- collection, analysis, interpretation and dissemination of information relating to health care safety and quality;
- publishing reports and papers relating to health care safety and quality;
- formulating reports and papers relating to health care safety and quality;
- formulating, promoting and supporting the implementation of standards, guidelines and indicators relating to health care safety and quality, as well as monitoring their implementation and impact;
- advising on national clinical standards;
- formulating model national schemes for the accreditation of organisations that provide health care services and relate to health care safety and quality;
- consulting and co-operating with other entities – including people, organisations and governments – on health care safety and quality; and
- promoting, supporting, encouraging, conducting and evaluating training programs and research for purposes connected with the performance of its functions.

The focus of national indicators of safety and quality program is to develop a process of routine review and action by health care providers. There is a subset of the safety and quality indicators, addressing hospital-level outcome indicators for supportive feedback and review at jurisdiction and facility level. These hospital-based outcome indicators can be generated by jurisdictions or private hospital ownership groups, which hold the source data, and reported back to provider facilities. The safety and quality value lies in developing the report-review-act cycle based on the routine supply of timely and targeted data back to hospitals. A number of jurisdictions are already undertaking a similar process with many of the same indicators.

There is no national legislation that forces private hospitals to participate in generating the hospital-based outcome indicators. In spite of this fact, it is important to note that representatives of the private sector have actively participated in the development and agreement of these indicators. Moreover, a number of private hospitals and operators of private hospitals have committed to the use of these core indicators.

130 National Partnership Agreement on Hospital and Health Workforce Reform, 2008
C.7.2  **ACSQHC: Data Item Definitions**

The core, hospital-based outcome indicators recommended for local generation and review are:

- Hospital standardised mortality ratio (HSMR).
- Death in low-mortality Diagnosis Related Groups (DRGs).
- In-hospital mortality rates for:
  - acute myocardial infarction (AMI).
  - heart failure.
  - Stroke.
  - fractured neck of femur.
  - pneumonia.
- Unplanned hospital re-admissions of patients discharged following management of:
  - AMI.
  - heart failure.
  - knee and hip replacements.
  - depression.
  - schizophrenia.
  - paediatric tonsillectomy and adenoidectomy.
- Healthcare associated Staphylococcus aureus (including MRSA) bacteraemia.
- Clostridium difficile infections.

There is a data dictionary available for Hospital Associated Infections. However the Commission does not collect information from private hospitals, it is intended to be used at a local level.

C.7.3  **ACSQHC: Counting Rules**

The National indicators of safety and quality are generated at whole of system and hospital level. As it is not a collection as such there is no base statistical unit.

C.7.4  **ACSQHC: Costing**

Costing the whole of system and hospital based outcome indicators, like all the other collections, is difficult. For private hospitals they must participate in the legislated jurisdiction based admitted patient collections (e.g. VAED). The indicators are then calculated by the Commission using the data that flows from private hospitals, to the jurisdictions and then onto the AIHW.

Creating the hospital based outcome indicators is not mandatory and so the cost of participation is a decision for the private hospital or private hospital group.
C.7.5  ACSQHC: Practicability of changing the collection

The commission’s indicators are not a collection as such. The indicators are either generated from existing collections (whole of system) or suggested that they be generated at the local level to improve safety and quality of patient care. In terms of improving comparability between public and private hospital data collections there is no need to change the commission’s indicators.
Appendix D  List of recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Text</th>
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<tbody>
<tr>
<td>Recommendation:</td>
<td>Undertake increased analysis of NHCDC information and develop a series of “experimental estimate” reports.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>That the responsibility for the Private Health Establishments Collection be transferred to the Australian Institute of Health and Welfare.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>That CSV file format with field names in the first record be adopted as the standard file format for PHDB and HCP files. This recommendation covers all HCP files, including HCP1, HCP2 and AN-SNAP.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>That jurisdictions and private hospitals be approached to undertake a pilot test of a process for effecting a common file format for those data fields common to PHDB, HCP and the APC NMDS.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>That, subject to the above pilot succeeding, the successful model for common specification of common fields be rolled out to all private hospitals and all jurisdictions.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>That the health insurance industry formally seek membership of NHISSC as an observer. This could be either as a permanent (observer) member or on an occasional basis, when issues specific to health insurers are to be considered.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>That PHWG and HCPWG meet together at least once per year to discuss data related issues. This meeting should take place in the December quarter, to allow sufficient time for issues requiring implementation in the following financial year to be identified and considered.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>That NHISSC be asked to develop a formal protocol for assessing business and related impacts of proposed changes to APC NMDS data items and associated metadata on the private hospital and health insurance sector.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>That the ECLIPSE record specification be updated to permit transmission of HCP data according to the current HCP specification.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>That the ECLIPSE record specification thereafter be maintained to ensure its capability to transmit HCP data remains current.</td>
</tr>
<tr>
<td>Recommendation:</td>
<td>Investigate the feasibility of conducting a data linking exercise between a jurisdictional health department and insurers for improved HCP information.</td>
</tr>
</tbody>
</table>
Appendix E  Consolidated implementation timetable
Appendix F  Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AACR</td>
<td>Australasian Association of Cancer Registries</td>
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<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<td>ACD</td>
<td>Australian Cancer Database</td>
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<tr>
<td>ACHI</td>
<td>Australian Classification of Health Interventions</td>
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<tr>
<td>ACSQHC</td>
<td>Australian Commission for Safety and Quality in Health Care</td>
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<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
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<tr>
<td>AHIA</td>
<td>Australian Health Insurance Association</td>
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<tr>
<td>AHMC</td>
<td>Australian Health Ministers’ Conference</td>
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<td>AHSA</td>
<td>Australian Health Services Alliance</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>AMI</td>
<td>acute myocardial infarction</td>
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<tr>
<td>AN-SNAP</td>
<td>Australian National Subacute and Nonacute Patient Classification System</td>
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<tr>
<td>ANZDATA</td>
<td>Australia and New Zealand Dialysis and Transplant Registry</td>
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<tr>
<td>ANZICS</td>
<td>Australian and New Zealand Intensive Care Society</td>
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<td>ANZPIC</td>
<td>Australian and New Zealand Patient Paediatric Intensive Care Registry</td>
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<tr>
<td>APC</td>
<td>Admitted Patient Collection</td>
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<tr>
<td>APD</td>
<td>Admitted Patient Dataset</td>
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<td>APHA</td>
<td>Australian Private Hospitals Association</td>
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<td>AR-DRG</td>
<td>Australian Refined Diagnosis Related Group</td>
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<td>AROC</td>
<td>Australasian Rehabilitation Outcomes Collaboration</td>
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<tr>
<td>ASCII</td>
<td>American Standard Code for Information Interchange</td>
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<tr>
<td>CCR</td>
<td>Critical Care Resources collection</td>
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<td>CDMS</td>
<td>Centralised Data Management Service</td>
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<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CORE</td>
<td>Centre for Outcome and Resource Evaluation</td>
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<tr>
<td>CSV</td>
<td>comma separated values</td>
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<td>DHHS</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>DHS</td>
<td>Australian Department of Human Services</td>
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<tr>
<td>DoHA</td>
<td>Australian Department of Health and Ageing</td>
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<tr>
<td>DRG</td>
<td>diagnosis related group</td>
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<td>DVA</td>
<td>Department of Veterans’ Affairs</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>ECLIPSE</td>
<td>Electronic Claim Lodgment and Information processing Service Environment</td>
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<td>FBT</td>
<td>Fringe Benefits Tax</td>
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<td>HCP</td>
<td>Hospital Casemix Protocol Working</td>
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<td>HCPWG</td>
<td>Hospital Casemix Protocol Working Group</td>
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<tr>
<td>HMDS</td>
<td>Hospital Morbidity Dataset</td>
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<td>HQCC</td>
<td>Health Quality and Complaints Commission</td>
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<tr>
<td>HSMR</td>
<td>hospital standardised mortality ratio</td>
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<td>HWA</td>
<td>Health Workforce Australia</td>
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<td>HWPT</td>
<td>Health Workforce Planning Tool</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>ICD-10-AM</td>
<td>International Classification of Diseases, Version 10, Australian Modification</td>
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<td>ISAAC</td>
<td>Integrated South Australian Activity Collection</td>
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<td>MBP</td>
<td>Medibank Private</td>
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<tr>
<td>MDHF</td>
<td>Mildura District Hospital Fund Limited</td>
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<td>MRSA</td>
<td>Methicillin resistant Staphylococcus aureus</td>
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<td>NCSCH</td>
<td>National Cancer Statistics Clearing House</td>
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<td>NHCDC</td>
<td>National Hospital Cost Data collection</td>
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<td>NHClFOF</td>
<td>National Health Chief Information Officers’ Forum</td>
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<td>NHNA</td>
<td>National Health and Hospitals Network Agreement</td>
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<td>NHISSC</td>
<td>National Health Information Standards and Statistics Committee</td>
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<td>NHPA</td>
<td>National Health Performance Authority</td>
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<td>NRHA</td>
<td>National Health Reform Agreement</td>
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<td>NMDS</td>
<td>National Minimum Dataset</td>
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<td>NPHED</td>
<td>National Public Hospital Establishments Collection</td>
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<td>NPSC</td>
<td>National Perinatal Statistics Collection</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>New South Wales Inpatient Statistics Collection</td>
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<td>NT</td>
<td>Northern Territory</td>
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<tr>
<td>PAS</td>
<td>Patient Administration System</td>
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<tr>
<td>PCOC</td>
<td>Palliative Care Outcomes Centre</td>
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<td>PHDB</td>
<td>Private Hospital Data Bureau</td>
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<tr>
<td>PHEC</td>
<td>Private Health Establishments Collection</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>PHWG</td>
<td>Private Hospital Working Group</td>
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<td>PMHA</td>
<td>Private Mental Health Alliance</td>
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<td>QHAPDC</td>
<td>Queensland Health Admitted Patient Data Collection</td>
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<td>QHMAC</td>
<td>Queensland Health Monthly Activity Collection</td>
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<td>SCH</td>
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<td>VAED</td>
<td>Victorian Admitted Episode Dataset</td>
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<td>VICNISS</td>
<td>Victorian Nosocomial Infection Surveillance System</td>
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<tr>
<td>WA</td>
<td>Western Australia</td>
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<tr>
<td>XML</td>
<td>Extensible Markup Language</td>
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