National Healthcare Agreement: PI 42-Intentional self-harm in hospitals, 2012 QS

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Identifying and definitional attributes

Metadata item type: Data Quality Statement

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Data quality

Data quality statement summary:

- The National Hospital Morbidity Database (NHMD) is a comprehensive data set that has records for all separations of admitted patients from essentially all public and private hospitals in Australia.
- Data on self-harm are recorded uniformly using the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM).
- The recorded number of separations involving intentional self-harm may be an underestimate as around 35 per cent of separations involving intentional self-harm did not have a code assigned for the place of occurrence. Underestimation and overestimation may also have occurred due to other limitations of the data.
- Comparability is affected by data not being adjusted for differences in casemix (for example, patient age).

Institutional environment: The Australian Institute of Health and Welfare (AIHW) has calculated this indicator.

The AIHW is an independent statutory authority within the Health and Ageing portfolio, which is accountable to the Parliament of Australia through the Minister for Health and Ageing. For further information see the AIHW website.

The data were supplied to the Institute by state and territory health authorities. The state and territory health authorities received these data from public and private hospitals. States and territories use these data for service planning, monitoring and internal and public reporting. Hospitals may be required to provide data to states and territories through a variety of administrative arrangements, contractual requirements or legislation.

States and territories supplied these data under the terms of the National Health Information Agreement (see link below).

www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788

Timeliness: The reference period for these data is 2009–10.

Accessibility: The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website include:

- *Australian hospital statistics* with associated Excel tables.
- interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).

Some data are also included on the MyHospitals website.

Interpretability: Supporting information on the quality and use of the NHMD are published annually in *Australian hospital statistics* (technical appendixes), available in hard copy or on the AIHW website. Readers are advised to note caveat information to ensure appropriate interpretation of the performance indicator. Supporting information includes discussion of coverage, completeness of coding, the quality of Indigenous data, and changes in service delivery that might affect interpretation of the published data. Metadata information for the NMDS for Admitted patient care is published in the AIHW's online metadata repository (METeOR) and the *National health data dictionary*.

Relevance:

The purpose of the NMDS for Admitted patient care is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NMDS is episodes of care for admitted patients in essentially all hospitals in Australia, including public and private acute and psychiatric hospitals, free-standing day hospital facilities, alcohol and drug treatment hospitals and dental hospitals. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories are not included. Hospitals specialising in ophthalmic aids and other specialised acute medical or surgical care are included.

The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments

The analyses by remoteness and socioeconomic status are based on the Statistical Local Area (SLA) of usual residence of the patient. The Socio-Economic Indexes for Areas (SEIFA) categories for socioeconomic status represent approximately the same proportion of the national population, but do not necessarily represent that proportion of the population in each state or territory (each SEIFA decile or quintile represents 10 per cent and 20 per cent respectively of the national population). The SEIFA scores for each SLA are derived from 2006 Census data and represent the attributes of the population in that SLA in 2006. To allocate a 2006 SEIFA score to 2009 SLAs (used for 2009–10 data), 2009 SLA boundaries are mapped backed to 2006 SLA boundaries. It is possible that the demographic profile of some areas may have changed between 2006 and 2009 due to changes in the socioeconomic status of the existing population, or changes to population size, thus potentially diminishing the accuracy of that area's SEIFA score over time. This is likely to impact most those quintiles in jurisdictions with a greater number of areas experiencing substantial population movement or renewal.

Separations are reported by jurisdiction of hospitalisation, regardless of the jurisdiction of usual residence. Hence, rates represent the number of separations for patients living in each remoteness area (regardless of their jurisdiction of residence) divided by the total number of separations for patients living in each remoteness area and hospitalised in the reporting jurisdiction.

Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.

Accuracy:

For 2009–10 almost all public hospitals provided data for the NHMD, with the exception of all separations for a mothercraft hospital in the Australian Capital Territory and about 2,400 separations for one public hospital in Western Australia.

The majority of private hospitals provided data, with the exception of the private day hospital facilities in the Australian Capital Territory and the Northern Territory. In addition, Western Australia was not able to provide about 10,600 separations for one private hospital.

States and territories are primarily responsible for the quality of the data they provide. However, the AIHW undertakes extensive validations on receipt of data. Data are checked for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked against data from other data sets. Potential errors are queried with jurisdictions, and corrections and resubmissions may be made in response to these edit queries. The AIHW does not adjust data to account for possible data errors or missing or incorrect values.

The specification for the indicator defines a separation involving self-harm as being one for which the place of occurrence is a Health service area. The Health service area as a place of occurrence is broader in scope than hospitals—it includes other health care settings such as day surgery centres or hospices. Hence, the numbers presented could be an overestimate as they may include separations involving intentional self-harm occurring in health service areas other than hospitals.

Around 35 per cent of all separations involving intentional self-harm did not have a code assigned for the place of occurrence. Consequently, the recorded number of separations involving intentional self-harm in hospital may be an underestimate.

For separations having multiple external causes, it is not possible to establish (from the NHMD) whether the nominated place of occurrence is associated with the intentional self-harm or with some other external cause. As a consequence, the count of separations may also be overestimated.

In the calculation of the indicator, separations with a principal diagnosis of an injury or poisoning have been excluded on the assumption that the self-harm occurred prior to admission to hospital. However, it is possible that some of these separations would have additionally involved self-harm that occurred in hospital.

The issue of whether a patient self-harms while on leave from hospital has not been addressed in the specification of the indicator.

Data on self-harm are recorded uniformly using the ICD-10-AM. Comparability is affected by data not being adjusted for differences in casemix (for example, patient age).

The Indigenous status data are of sufficient quality for statistical reporting for the following jurisdictions: New South Wales, Victoria, Queensland, South Australia and Western Australia (public and private hospitals) and Northern Territory (public hospitals only). National totals include these six jurisdictions only. Indigenous status data reported for Tasmania and Australian Capital Territory (public and private hospitals) should be interpreted with caution until further assessment of Indigenous identification is completed.

Cells have been suppressed to protect confidentiality where the presentation could identify a patient or a service provider or where rates are likely to be highly volatile, for example where the denominator is very small. The following rules were applied:

- Counts less than 3 were suppressed.
- Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1,000.
- Data for private hospitals in Tasmania, Australian Capital Territory and the Northern Territory were suppressed.

Coherence:

The information presented for this indicator is calculated using the same methodology as data published in *Australian hospital statistics 2009–10* and the *National healthcare agreement: performance report for 2009–10*.

The data can be meaningfully compared across reference periods for all jurisdictions except Tasmania. 2008–09 data for Tasmania does not include two private hospitals that were included in 2007–08 and 2009–10 data reported in the National Healthcare Agreement performance reports.

However, caution is required when analysing SEIFA over time for the reasons outlined above (see Relevance section). Methodological variations also exist in the application of SEIFA to various data sets and performance indicators. Any comparisons of the SEIFA analysis for this indicator with other related SEIFA analysis should be undertaken with careful consideration of the methods used, in particular the SEIFA index used and the approach taken to derive quintiles and deciles.

Relational attributes

Related metadata references:

Supersedes National Healthcare Agreement: PI 42: Intentional self-harm in hospitals, 2011 QS
Health, Superseded 04/12/2012

Indicators linked to this Data Quality statement:

National Healthcare Agreement: PI 42-Intentional self-harm in hospitals, 2012
Health, Retired 25/06/2013