

# National Healthcare Agreement: PI 22-Selected potentially preventable hospitalisations, 2012 QS

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## Identifying and definitional attributes

<b>Metadata item type:</b>	Data Quality Statement
<b>METEOR identifier:</b>	500465
<b>Registration status:</b>	<a href="#">Health</a> , Superseded 14/01/2015

## 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.
- Separations are reported by the jurisdiction of usual residence of the patient, not the jurisdiction of hospitalisation.
- Caution should be used in comparing 2007–08 data with later years as changes between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09 and 2009–10) and the associated Australian Coding Standards resulted in decreased reporting of additional diagnoses for diabetes, and increased reporting of gastroenteritis (chronic and acute categories, respectively, affected). These changes should also be taken into consideration in interpretation of these data against the National Healthcare Agreement performance benchmark for potentially preventable hospitalisations.
- In addition, interpretation of the related performance benchmark over time is problematic because the benchmark is specified as a proportion of separations rather than a population rate, and admission practices vary across jurisdictions and over time.
- The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.
- Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

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

The Institute 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).

[www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788](http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442472807&libID=6442472788)

**Timeliness:** The reference period for this data set is 2009–10.

<b>Accessibility:</b>	<p>The AIHW provides a variety of products that draw upon the NHMD. Published products available on the AIHW website are:</p> <ul style="list-style-type: none"> <li>• Australian hospital statistics with associated Excel tables.</li> <li>• interactive data cubes for Admitted patient care (for Principal diagnoses, Procedures and Diagnosis Related Groups).</li> </ul> <p>Some data are also included on the MyHospitals website.</p>
<b>Interpretability:</b>	<p>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 variation 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 <i>National health data dictionary</i>.</p>
<b>Relevance:</b>	<p>The purpose of the National Minimum Data Set (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.</p> <p>The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.</p> <p>The analyses by state and territory, remoteness and socioeconomic status are based on the Statistical Local Area (SLA) of usual residence of the patient, not the location of the hospital. Hence rates represent the number separations for patients living in each State or Territory, remoteness area or Socio-Economic Indexes for Areas (SEIFA) population group (regardless of the jurisdiction of the hospital they were admitted to) divided by the total number of people living in that remoteness area or SEIFA group in the State or Territory.</p> <p>The 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.</p> <p>Other Australians includes separations for non-Indigenous people and those for whom Indigenous status was not stated.</p>

**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 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.

Variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions.

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 rule was applied:

- Rates were suppressed where the numerator was less than 5 and/or the denominator was less than 1,000.

**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 2009–10.

However, caution should be used when comparing 2007–08 with later years due to changes between the ICD-10-AM 5th edition (used in 2007–08) and ICD-10-AM 6th edition (used in 2008–09 and 2009–10) and the associated Australian Coding Standards that resulted in:

- decreased reporting of additional diagnoses for diabetes
- increased reporting of diagnoses for dehydration and gastroenteritis.

In light of these comparability issues, supplementary data (as specified below) have also been supplied and may assist in the interpretation of time series. However it should be acknowledged that these data are not consistent with the original intent of the indicator.

- Diabetes complications (all diagnoses) and Dehydration and gastroenteritis excluded
- Diabetes complications (additional diagnoses only) and Dehydration and gastroenteritis excluded.

In addition, Tasmanian data are not comparable over time as 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.

Interpretation of the related performance benchmark over time is also problematic because the benchmark is specified as a proportion of separations rather than a population rate, and admission practices vary across jurisdictions and over time. Changes in a jurisdiction's denominator (separations) can artificially increase or decrease the results of the benchmark. Therefore the data provided in 2014–15 (and interim years) may not be directly comparable to the baseline data from which the target is based.

Caution is also 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 22-Selected potentially preventable hospitalisations, 2011 QS](#)  
[Health](#), Superseded 04/12/2012

Has been superseded by [National Healthcare Agreement: PI 18-Selected potentially preventable hospitalisations, 2013 QS](#)  
[Health](#), Superseded 14/01/2015

**Indicators linked to this Data Quality statement:**

[National Healthcare Agreement: PI 22-Selected potentially preventable hospitalisations, 2012](#)  
[Health](#), Superseded 25/06/2013