Episode of care—source of funding, patient funding source code NN

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Episode of care—source of funding, patient funding source code NN

Identifying and definitional attributes

Metadata item type:	Data Element
Short name:	Funding source for hospital patient
METEOR identifier:	649391
Registration status:	Health, Superseded 25/01/2018
Definition:	The source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code.
Context:	Admitted patient care. Hospital non-admitted patient care.

Data element concept attributes

Identifying and definitional attributes

Data element concept:	Episode of care—source of funding
METEOR identifier:	472038
Registration status:	Health, Superseded 06/12/2023 Tasmanian Health, Standard 05/09/2016
Definition:	The source of funds for an admitted patient episode or non-admitted patient service event.
Object class:	Episode of care
Property:	Source of funding

Value domain attributes

Identifying and definitional attributes

Value domain:	Patient funding source code NN
METEOR identifier:	649395
Registration status:	Health, Superseded 25/01/2018
Definition:	A code set representing the source of funds for a hospital patient.

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

	Value	Meaning
Permissible values:	01	Health service budget (not covered elsewhere)
	02	Health service budget (due to eligibility for Reciprocal Health Care Agreement)
	03	Health service budget (no charge raised due to hospital decision)

	04	Department of Veterans' Affairs
	05	Department of Defence
	06	Correctional facility
	07	Medicare Benefits Schedule
	08	Other hospital or public authority (contracted care)
	09	Private health insurance
	10	Worker's compensation
	11	Motor vehicle third party personal claim
	12	Other compensation (e.g. public liability, common law, medical negligence)
	13	Self-funded
	88	Other funding source
Supplementary values:	98	Not known

Collection and usage attributes

Guide for use:

CODE 01 Health service budget (not covered elsewhere)

Health service budget (not covered elsewhere) should be recorded as the funding source for Medicare eligible patients for whom there is no other funding arrangement.

CODE 02 Health service budget (due to eligibility for Reciprocal Health Care Agreement)

Patients who are overseas visitors from countries covered by Reciprocal Health Care Agreements.

Australia has Reciprocal Health Care Agreements with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, Belgium, Slovenia, New Zealand and Ireland. The Agreements provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

The Agreements with Finland, Italy, Malta, the Netherlands, Norway, Sweden, Belgium, Slovenia and the United Kingdom provide free care as a public patient in public hospitals, subsidised out-of-hospital medical treatment under Medicare, and subsidised medicines under the Pharmaceutical Benefits Scheme.

The Agreements with New Zealand and Ireland provide free care as a public patient in public hospitals and subsidised medicines under the Pharmaceutical Benefits Scheme, but do not cover out-of-hospital medical treatment.

Visitors from Italy and Malta are covered for a period of six months from the date of arrival in Australia only.

Visitors from Belgium, the Netherlands and Slovenia require their European Health Insurance card to enrol in Medicare. They are eligible for treatment in public hospitals until the expiry date indicated on the card, or to the length of their authorised stay in Australia if earlier.

Excludes: Overseas visitors who elect to be treated as private patients or under travel insurance.

CODE 03 Health service budget (no charge raised due to hospital decision)

Patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory. Also includes patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are for medical services bulk-billed to Medicare) and patients for whom a charge is raised but is subsequently

waived.

CODE 07 Medicare Benefits Schedule

Medicare eligible patients in scope of collection for whom services are billed to Medicare. Includes both bulk-billed patients and patients with out-of-pocket expenses. This value is not applicable for admitted patients.

CODE 08 Other hospital or public authority (contracted care)

Patients receiving treatment under contracted arrangements with another hospital (inter-hospital contracted patient) or a public authority (e.g. a state or territory government).

CODE 09 Private health insurance

Patients who are funded by private health insurance, including travel insurance for Medicare eligible patients. If patients receive any funding from private health insurance, choose Code 09, regardless of whether it is the majority source of funds.

Excludes: Overseas visitors for whom travel insurance is the major funding source.

CODE 13 Self-funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

CODE 88 Other funding source

This code includes overseas visitors for whom travel insurance is the major funding source.

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Data element attributes

Collection and usage attributes

Guide for use:

The source of funding should be assigned based on a best estimate of where the majority of funds come from, except for private health insurance, which should be assigned wherever there is a private health insurance contribution to the cost. This data element is not designed to capture information on out-of-pocket expenses to patients (for example, fees only partly covered by the Medicare Benefits Schedule).

If a charge is raised for accommodation or facility fees for the episode/service event, the intent of this data element is to collect information on who is expected to pay, provided that the charge would cover most of the expenditure that would be estimated for the episode/service event. If the charge raised would cover less than half of the expenditure, then the funding source that represents the majority of the expenditure should be reported.

If there is an expected funding source followed by a finalised actual funding source (for example, in relation to compensation claims), then the actual funding source known at the end of the reporting period should be recorded.

The expected funding source should be reported if the fee has not been paid but is not to be waived.

The major source of funding should be reported for nursing-home type patients.

Relational attributes

Related metadata references:

Supersedes Episode of care—source of funding, patient funding source code NN
Health, Superseded 05/10/2016

Has been superseded by Episode of care—source of funding, patient funding source code NN
Health, Superseded 20/10/2021

See also Appointment—principal source of funding, patient funding source code AAA
WA Health, Standard 24/04/2015

See also Appointment—principal source of funding, patient funding source code AAA
WA Health, Standard 19/03/2015

Implementation in Data Set Specifications:

Admitted patient care NMDS 2017-18
Health, Superseded 25/01/2018
Implementation start date: 01/07/2017
Implementation end date: 30/06/2018

Non-admitted patient care hospital aggregate NMDS 2017-18
Health, Superseded 25/01/2018
Implementation start date: 01/07/2017
Implementation end date: 30/06/2018

Non-admitted patient care Local Hospital Network aggregate NBEDS 2017-18
Health, Superseded 25/01/2018
Implementation start date: 01/07/2017
Implementation end date: 30/06/2018

Non-admitted patient NBEDS 2017-18
Health, Superseded 25/01/2018
Implementation start date: 01/07/2017
Implementation end date: 30/06/2018

Implementation in Indicators:

Used as Disaggregation

Australian Atlas of Healthcare Variation 2018: Number of thyroidectomy hospitalisations per 100,000 people aged 18 years and over, 2014-15 to 2016-17
Australian Commission on Safety and Quality in Health Care, Qualified 13/12/2018

Number of lumbar spinal fusion (excluding lumbar spinal decompression) hospitalisations per 100,000 people, aged 18 years and over, 2012-13 to 2014-15 and 2015-16 to 2017-18
Australian Commission on Safety and Quality in Health Care, Standard 27/04/2021