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## 5 PUBLIC ACUTE CARE HOSPITALS

### 5.1 Introduction

The public acute care hospitals performance data in this Report builds on the framework of performance indicators developed for the 1995 Report. The Steering Committee is working closely with the National Health Ministers' Benchmarking Working Group to develop a more complete set of performance indicators.

Since the 1995 Report, the information presented has improved. For example, the estimates of average cost per casemix-adjusted separation (that is, adjusted for the mix of cases) have incorporated more reliable data on admitted patient costs. Similarly, waiting times for elective surgery have been collected using a longer survey period to decrease the effect of seasonal patterns. However, significant data gaps remain, particularly on the quality and effectiveness of public acute care hospital services.

The lack of nationally comparable effectiveness information is being addressed. Over the next year, indicators measuring the quality of care in hospitals will be improved and indicators of health outcomes will continue to be developed.

### 5.2 Profile of the sector

The focus in this chapter is on the public acute care hospital component of the health sector. The Australian Institute of Health and Welfare (AIHW) defines acute care hospitals as:

Establishments which provide at least minimum medical surgical or obstetrical services for inpatient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing services as well as other necessary professional services. Most patients require a relatively short stay. (AIHW 1996, p23)

Most of the data presented relate to acute admitted patients, although non-acute admitted patients are also treated in acute care hospitals. Examples include some mental health and rehabilitation patients as well as long-stay nursing home type patients. Acute care hospitals also provide many ambulatory (non-admitted patient) services, including outpatient services and emergency services. Teaching and research activities also account for a portion of total expenditure for some hospitals.

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Some commonly used terms in the health sector are listed in Box 5.1. A more detailed and technical explanation is provided in the *National Health Data Dictionary* (NHDC 1995).

### **Box 5.1: Some common hospital terms**

**Acute care episode:** the majority of illnesses in hospitals, including providing treatment, performing surgery, relieving symptoms of illness and/or reducing the severity of the injury.

**Admitted patient:** a person who is formally admitted by a hospital.

**Ambulatory care:** services provided to non-admitted patients.

**Casemix-adjustment:** adjusting data on cases treated to account for the number and type of cases.

**Diagnosis Related Group (DRG):** a means of classifying hospital patients to provide a common basis for comparing factors such as cost-effectiveness and quality of care across hospitals; represents a class of patients with similar clinical conditions requiring similar hospital services.

**Length of stay:** calculated by subtracting the admission date from the separation date, minus leave days. Same-day patients are admitted and separated on the same day, and are attributed a length of stay of 1 day.

**Misadventure indicators:** a set of indicators that relate to the clinical process of care and can measure potential adverse outcomes of care. The misadventure indicators presented in this Report are pending the results of validity and reliability testing.

**Outpatients:** one class of non-admitted patients; patients who receive treatment from a hospital but do not require admission to hospital.

**Public hospitals:** those hospitals providing free treatment and accommodation to eligible persons who elect to be treated as public patients. In addition, public hospitals provide free non-admitted patient services and may provide treatment and accommodation services to private patients (although the latter services are chargeable).

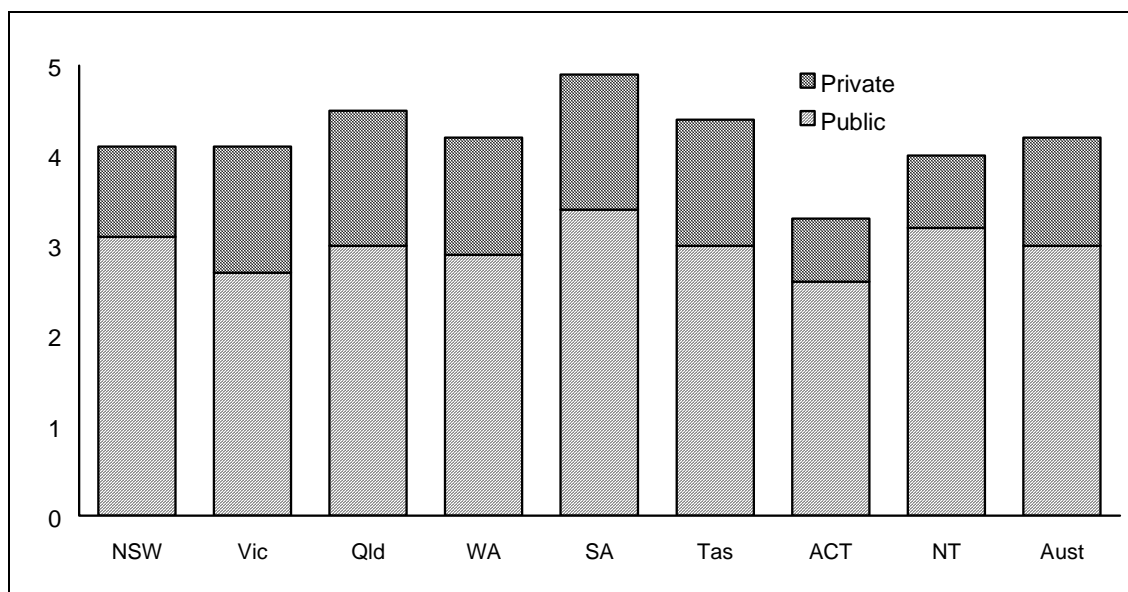
**Separation:** the discharge, transfer or death of a patient from hospital. The count of separations is similar to the count of admissions in acute hospitals.

*Source:* NHDC 1995

Total expenditure in public acute care hospitals amounted to \$10.2 billion in 1994–95. Government funding was split roughly equally between the Commonwealth and the State and Territory Governments.

In 1994–95 there were 1139 acute care hospitals in Australia, of which 686 were public. Across Australia there were 4.3 beds per 1000 population for public and private hospitals combined — virtually unchanged from 1993–94. SA recorded the highest public bed rate (3.4 beds per 1000 population) and the ACT the lowest (2.6 beds per 1000 population) (Figure 5.1).

Figure 5.1: Public and private<sup>1</sup> bed rates, 1994–95 (beds per 1000 population<sup>2</sup>)



1 Included private psychiatric hospitals and free-standing day hospital facilities.

2 Mid-point of June 1995 and June 1994 estimated resident populations.

Source: Table 5A.3

There were over 171 000 full-time equivalent staff in public acute care hospitals in Australia in 1994–95, compared to 167 902 in 1993–94. Nursing staff represented over 43 per cent of the staff.

There were almost 3.5 million separations in 1994–95 — an increase of 5.8 per cent from the previous year's level. More than 40 per cent of these separations were same-day separations (Table 5.1).

Table 5.1: Same day separations, 1994–95 (per cent of total separations)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Public acute hospitals	34.6	42.0	36.9	35.4	37.8	32.6	46.5	41.0	37.1
Private acute hospitals	53.3	49.8	43.2	57.3	33.7	35.9	50.7	31.1	48.3
<b>All acute hospitals</b>	<b>39.6</b>	<b>44.5</b>	<b>39.0</b>	<b>41.2</b>	<b>36.6</b>	<b>33.8</b>	<b>47.7</b>	<b>39.5</b>	<b>40.4</b>

Source: Table 5A.8

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The most common reasons for treatment in public acute care hospitals in 1994–95 (excluding same–day cases) were:

- normal delivery without complications (5.1 per cent of separations excluding same–day cases);
- newborn admission without significant operating room procedure, without problem (1.7 per cent);
- bronchitis and asthma, admitted patient younger than 50 years, without complications (1.5 per cent);
- lens procedure without vitrectomy, without complications (1.3 per cent);
- tonsillectomy and/or adenoidectomy (1.3 per cent); and
- heart failure and shock (1.3 per cent).

Including same–day cases, the six most common reasons for treatment were:

- renal dialysis (5.9 per cent of all separations);
- normal delivery without complications; (3.1 per cent);
- other gastroscopy for non–major digestive disease, without complications (2.9 per cent);
- chemotherapy (2.8 per cent);
- other colonoscopy without complications (2.6 per cent); and
- lens procedure without vitrectomy, without complications (1.5 per cent).

### **5.3 Recent developments in the sector**

Two important factors of change for public acute care hospitals were identified in the 1995 Report:

- the growing demand for the services provided; and
- the changing nature of hospital funding.

These developments continue to affect the work of public acute care hospitals in Australia and are taking place in an environment in which:

- patient numbers continue to increase;
- acute hospitals are consuming a declining share of the total health expenditure; and

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- many health services are increasingly being delivered by providers other than acute hospitals.

Factors influencing the increase in demand include falling private health insurance coverage, an ageing population and population growth. Admissions have increased over the past decade. The increase was largely accommodated by the declining length of stay made possible by advances in diagnostic technology, the development of minimally invasive surgical procedures, discharge planning, and acute services in the home.

In the ten years to 1993–94, the proportion of total recurrent health expenditure devoted to public and private acute hospitals had declined from 40 per cent to just over 35 per cent. Over the same period, expenditure on non-institutional health services (as a proportion of total recurrent expenditure) increased from 45 per cent to over 53 per cent (AIHW 1996).

Many health services are increasingly being delivered by providers other than acute hospitals. This reflects the view that the health of individuals can be improved if they receive a mix of services (such as long term care and a side range of post-acute services). The Coalition of Australian Governments (COAG) reforms discussed in Section 5.4 aim to ensure that the most appropriate form of care is provided to those in need.

## **5.4 COAG reforms**

In June 1996, COAG set broad directions for the reform of health and community services (COAG 1996), to shift the focus of health and community services from programs to people through a partnership between the Commonwealth and State and Territory Governments. This involves building a system that:

- provides quality care responsive to peoples' needs;
- provides incentives for preventative health and cost effective care;
- gives better value for tax payers' dollars;
- more clearly defines roles and responsibilities; and
- retains the benefits of universal access to basic health services through Medicare.

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## **5.5 Framework of performance indicators**

Although the framework presented here is similar to the one developed for the 1995 Report, refinements to the indicators are expected for the next Report (Figure 5.2). In particular, improvements are anticipated in two areas: quality of care and health outcome indicators and agreed ambulatory care indicators.

A description of all indicators is provided in Attachment 5A.

## **5.6 Future directions**

COAG has recognised that reliable performance information can help improve health outcomes:

Any new arrangements must not simply replace one lot of bureaucratic duplication with another. For example, in managing immunisation programmes, states would be clearly accountable for achieving target rates, jointly set, but have wide discretion about how they pursue the achievement of these, with national reporting on progress against the targets. (COAG 1996, p. 17).

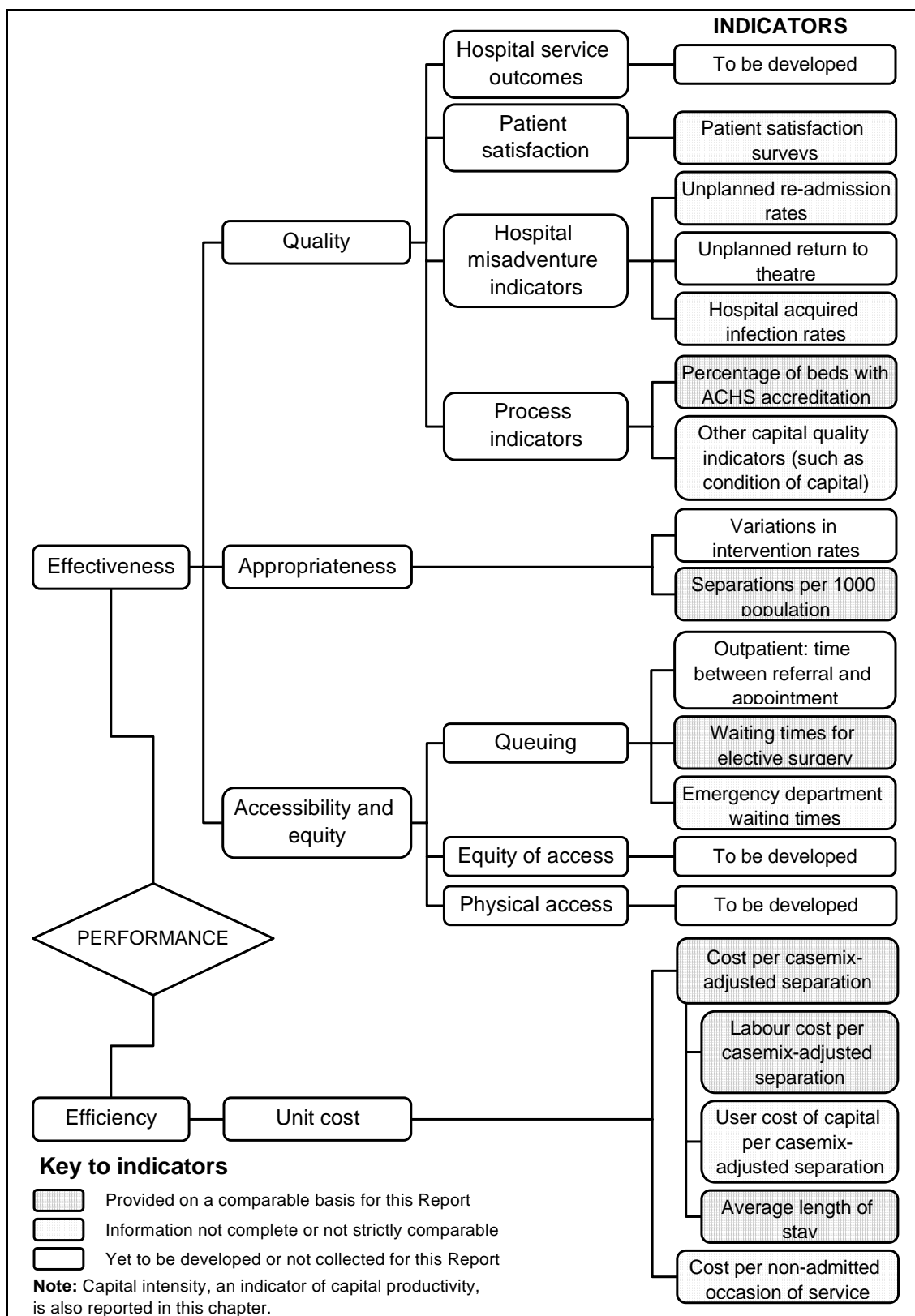
However, both the effectiveness and efficiency indicators reported in this chapter require further work before robust comparisons can be made. The work program includes:

- refining existing indicators;
- developing better quality of care indicators;
- developing indicators for ambulatory care; and
- broadening the scope of the Review.

### **5.6.1 Refining existing indicators**

There is still a need to refine the data. Most of this work involves collecting consistent and comparable data. Different asset valuation practices in the area of capital information, for example, make it difficult to compare performance across jurisdictions. Similarly, further work is required in the area of efficiency to improve estimates of costs for both admitted and non-admitted patient services.

Figure 5.2: Framework of indicators for public acute care hospitals



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### **5.6.2 Developing better quality of care indicators**

There was a lack of nationally comparable data on the quality of care in acute hospitals. This makes it difficult for policy makers and the community to assess the quality of care in acute hospitals across Australia. The only quality of care indicator for which nationally comparable data was available was the percentage of beds accredited by the Australian Council on Healthcare Standards (ACHS). However, the Steering Committee recognise that this indicator may not truly represent the quality of care of hospitals because accreditation of hospitals is a voluntary process and a low level of accreditation may reflect a low participation rate rather than poor quality.

The following projects should help to develop a national set of quality of care and outcome indicators for acute health care services:

- The Commonwealth Department of Health and Family Services, through the National Hospital Outcomes Program (NHOP) is working with the states and territories, and other stakeholders to develop a set of national indicators covering aspects of quality in hospitals such as access, effectiveness, appropriateness, patient safety, technical proficiency, consumer focus, coordination of care and efficiency;
- Another NHOP project has been commissioned to test the reliability and validity of the hospital misadventure indicators. The final report is due in the first half of 1997. Preliminary findings suggest that some of the misadventure indicators in the framework may need to be changed; and
- Commissioned as part of the NHOP, the final report of the consultancy looking into patient satisfaction surveys was completed in October 1995. It was noted in the report that the key issues of concern to consumers were: communication; being treated with respect; patient involvement in decision making; informed consent; privacy; and access to interpreters.

### **5.6.3 Developing indicators for ambulatory care**

Three indicators for ambulatory (non-admitted care) are in the framework but consistent definitions and robust data are not yet available. Work undertaken throughout 1996 has indicated that two indicators are likely to be developed for possible data collection in the second half of 1997:

- waiting times in emergency departments by triage category; and
- waiting times in emergency departments prior to admission.

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Possible additional potential indicators which require a longer lead time are:

- outpatient queuing time for appointment, by specialty;
- cost of treatment per weighted non–admitted occasion of service;
- outpatient activity, by specialty, per thousand of population; and
- patient feedback.

#### **5.6.4 Broadening the coverage of the Review**

The Steering Committee intends to expand the Report to cover other parts of the health sector. Consideration will be given to including community and public health in the next Report. Although the work program is yet to be determined, the Steering Committee is mindful of relevant exercises in the area.

### **5.7 Key performance results**

Although the quality of the data has improved for a number of indicators presented in this year’s Report, caution should be exercised when making comparisons between jurisdictions. The relative performance of a jurisdiction may be affected by factors beyond its control. Demographic factors such as age, sex, and ethnicity, for example, all affect the health status of the population. Geographic factors also affect the accessibility of hospital services to the hospital, and differences in the availability of services provided by private hospitals may affect the demand for public hospital services. Consequently, comparisons among jurisdictions are only valid where the data quality (in terms of consistency) is high.

#### **5.7.1 Quality**

A number of indicators were selected to measure the quality of care, including the percentage of public hospital beds accredited by the ACHS, patient satisfaction, the condition of capital, and hospital misadventures. Future reports can be expected to include a broader range of quality of care and health outcome indicators.

Despite some shortcomings as a quality indicator (Section 5.6.2), the percentage of beds accredited by the ACHS was selected as an indicator of quality because success in the ACHS program requires demonstrated adherence to quality assurance practices.

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The NT has not sought accreditation for its public hospitals. The majority of public beds in most other jurisdictions, however, were accredited by the ACHS as at June 30 1995 (Figure 5.3).

Figure 5.3: Public hospital beds accredited by the ACHS, 30 June 1995 (per cent)<sup>1</sup>



<sup>1</sup> Tasmanian and Victorian data as at 30 June 1996. The NT has not sought accreditation for its public hospitals.  
*Source:* Table 5A.15

Most jurisdictions were also able to provide some information on the quality of care at a system-wide level (Attachment 5A) but it is not comparable for several reasons including differences in the definitions used and data collection processes. The most notable results from the jurisdiction-level data were that:

- Victoria's unplanned readmissions to hospital were steady at around 10 per cent of the total number of patients treated;
- Western Australian patients ranked their hospital stay as 4.29 on a satisfaction scale of 1 to 5 in June 1996<sup>1</sup>;
- Emergency readmissions comprised around 7 per cent of all admissions to public hospitals in SA in 1995-96. A fifth of all emergency readmissions to public acute hospitals are represented by ten DRGs;
- Eighty seven per cent of patients in Tasmania were satisfied with the outcome of their hospital stay;

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<sup>1</sup> Where 1 is unsatisfied with the service and 5 is fully satisfied with the service.

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- Public hospitals in the ACT recorded low hospital acquired infection rates compared with the ACHS threshold; and
  - The rate of emergency readmission within 28 days for all hospitals in the NT averaged 6.8 per cent in 1994–95.

Another agreed indicator of quality is the condition of capital — measured by the ratio of depreciated replacement value (the current replacement cost of the asset less the accumulated depreciation) to replacement value (the current replacement cost of the asset). However, differences in asset valuation methods and incomplete information mean data for this indicator are not comparable.

Queensland recorded a ratio of depreciated replacement value to replacement value for their buildings of 0.88 while NSW recorded a ratio for equipment of 0.65. These relatively high ratios indicate newer or less depreciated assets.

### **5.7.2 Access**

#### *Waiting time for elective surgery*

Waiting times for elective surgery have been selected as an indicator of access. The data used to report on waiting times for elective surgery were obtained from a six month survey of Australian public hospitals in January to June 1995 (Moon 1996).<sup>2</sup>

The survey researcher noted the following difficulties in the implementation of the definitions of elective surgery affect the interpretation of the results presented in this Report (Moon 1996):

- *geographic factors*. Isolated hospitals may admit patients from waiting lists in an irregular pattern compared with other hospitals;
- *demographic factors*. Differences in the demography of populations could affect health status, potentially leading to different priorities and strategies for managing elective surgery waiting lists; and
- *cross-border flow*. Patients are usually treated in the closest hospital providing the required procedure so they may be placed on waiting lists in a State or Territory other than their place of residence.<sup>3</sup>

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<sup>2</sup> The numbers and attributes of patients admitted during the survey period may not be typical of patients admitted over a longer period of time.

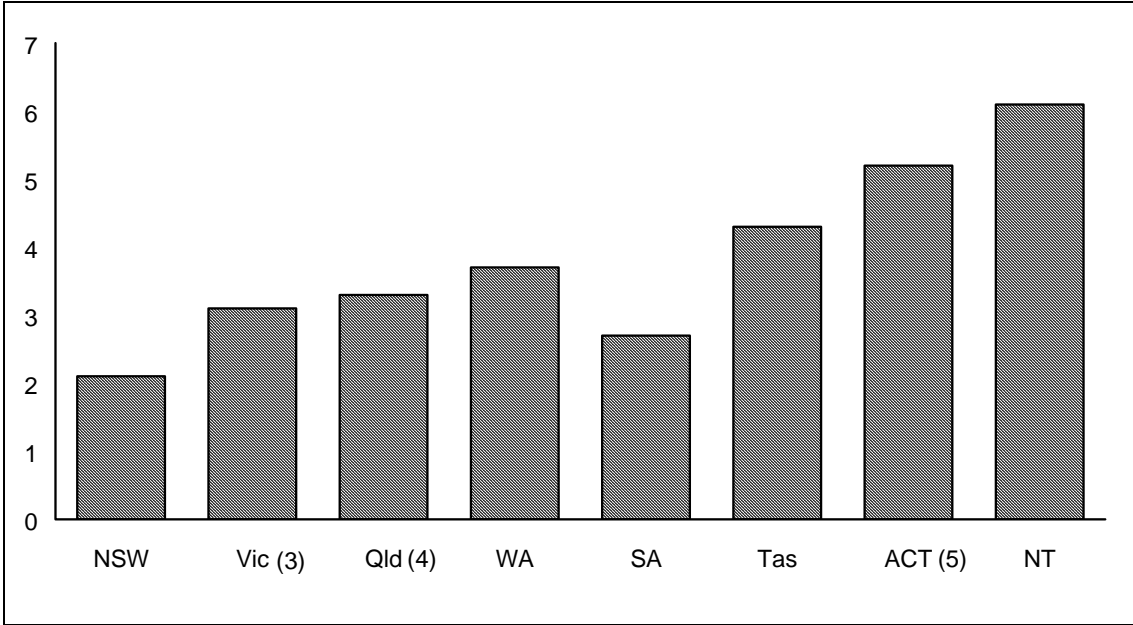
<sup>3</sup> In the ACT, for example, the major public hospital is a regional facility serving the south-east area of NSW.

Three sets of performance measures are reported under the broad heading of waiting times for elective surgery: clearance time; the proportion of patients waiting inappropriately at the time of survey; and the proportion of patients admitted after waiting inappropriately.

Clearance time is the length of time that it would take to provide services to all of those on the elective surgery waiting lists, assuming that the rate of servicing remained constant and that no patients were added to the list. It is a prospective measure of the capacity of the system to remove patients from waiting lists not the average waiting time.

During the survey period in 1995, NSW recorded the lowest clearance time (2.1 months) while the NT recorded the highest clearance time of 6.1 months. The national average was 2.7 months (Figure 5.4).

Figure 5.4: Clearance time for elective surgery, public acute care hospitals, 1995 (months)<sup>1,2</sup>



1 The survey period was January to June 1995. The numbers and attributes of patients admitted during this period may not be typical of patients admitted over a longer period of time.

2 The data covered all waiting list-related activity for most states and territories. Statistics presented for WA include teaching hospitals only. Statistics presented for Queensland derive from 10 hospitals which accounted for approximately 55 per cent of total separations.

3 To permit comparability with other estimates, data included 'booked' and 'unbooked' patients

4 Survey period differed from that used by other jurisdictions.

5 ACT data includes 'not ready for care' patients.

Source: Table 5A.17

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Additional waiting time data were also available on the proportion of patients waiting inappropriately at the time of the survey and the proportion of patients admitted after waiting inappropriately.<sup>4</sup> The data identified performance separately for category 1 patients — admission desirable within 30 days — and category 2 patients — admission desirable within 12 months.

There was a wide variation among jurisdictions in the proportions of both groups waiting longer than the desirable time (Box 5.2 and Figures 5.5 and 5.6).<sup>5</sup>

**Box 5.2: Waiting times for elective surgery for public acute care hospitals**

Key results from additional waiting time information collected by Moon (1996) were:

- 27 per cent of all category 1 patients in Australia at the time of survey had been waiting longer than 30 days. The proportion of patients so waiting ranged from 3 per cent in Victoria to 83 per cent in the NT (Figure 5.5);
- 11 per cent of all category 1 patients in Australia admitted from the elective surgery waiting list had been waiting over 30 days. The proportion of patients so waiting ranged from 3 per cent in Victoria to 21 per cent in the NT;
- 11 per cent of all category 2 patients in Australia at the time of survey had been waiting for longer than 12 months. The proportion of patients so waiting ranged from 5 per cent in NSW to 36 per cent in the NT (Figure 5.6); and
- 4 per cent of all category 2 patients in Australia admitted from the elective surgery waiting list had been waiting over 12 months. The proportion of patients so waiting ranged from 1 per cent in NSW to 22 per cent in SA.

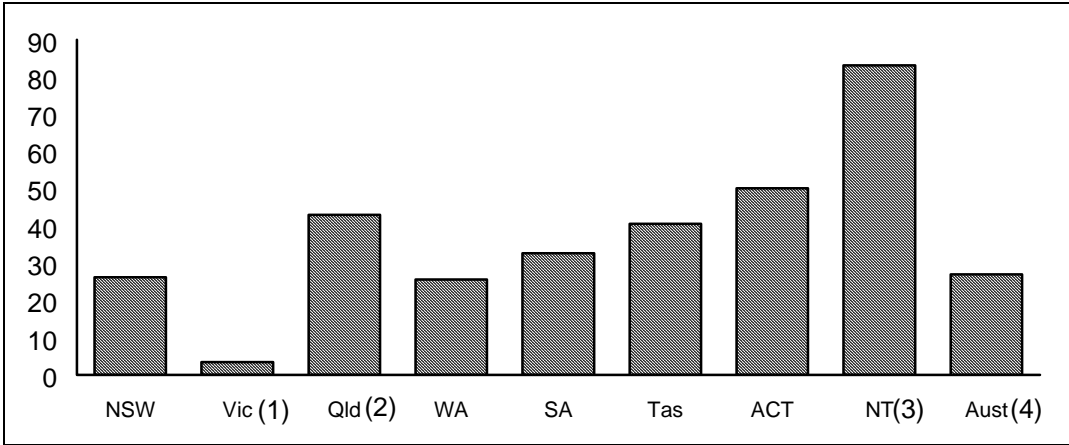
*Source:* Moon 1996

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<sup>4</sup> An inappropriate wait is one that is longer than appropriate for the urgency categorisation of the patient.

<sup>5</sup> Category 2 patients included semi-urgent patients (admission desirable within 90 days) and non-urgent patients, so 12 months was chosen as the threshold for inappropriate waits.

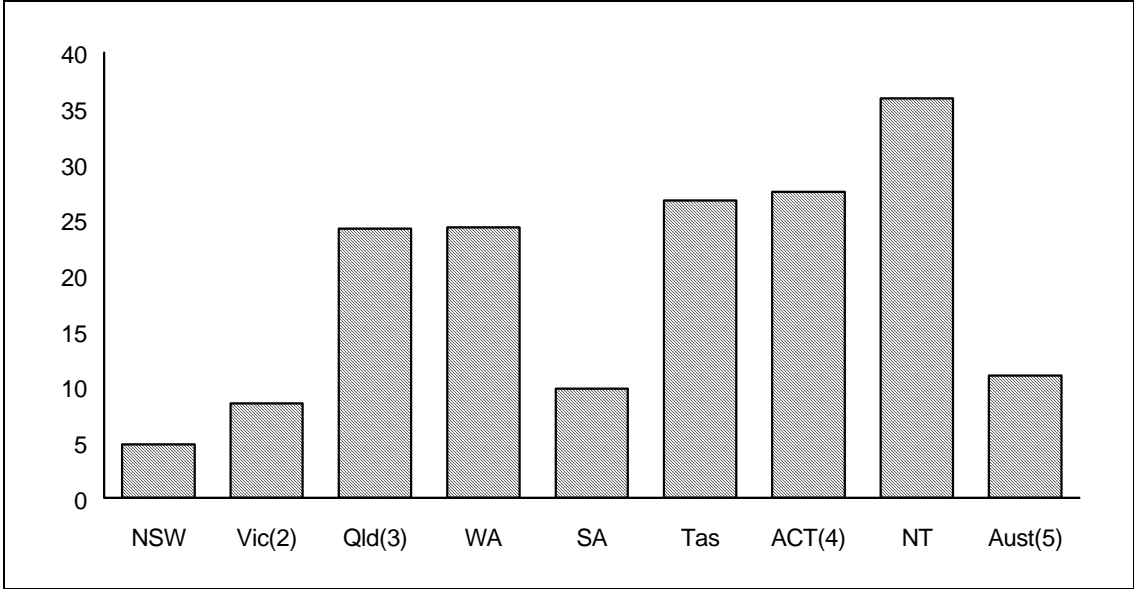
Figure 5.5: Category 1 elective surgery patients waiting longer than 30 days, January to June 1995 (per cent)



- 1 To permit comparability with other estimates, data included 'booked' and 'unbooked' patients.
- 2 Survey period differed from that used by other jurisdictions.
- 3 ACT data includes 'not ready for care' patients.
- 4 Excluded Queensland due to non-comparable survey period.

Source: Table 5A.18

Figure 5.6: Category 2 patients waiting longer than twelve months, January to June 1995 (per cent)<sup>1</sup>



- 1 Category 2 patients were those not classified as Category 1.
- 2 To permit comparability with other estimates, Victorian data included 'booked' and 'unbooked' patients.
- 3 Survey period differed from that used by other jurisdictions.
- 4 ACT data included 'not ready for care' patients.
- 5 Excluded Queensland due to non-comparable survey period.

Source: Table 5A.19

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### *Emergency department waiting times*

Three jurisdictions were able to provide waiting times for their emergency departments, but the results presented below are not comparable.

- NSW recorded an increase throughout 1994–95 in the percentage of patients seen within the recommended time, particularly for patients with the highest level of urgency. However, the percentage of patients seen within the recommended time for most levels of urgency declined between April and June 1996 (Table 5A.26);
- The proportion of patients seen within the recommended time in Victoria's emergency departments was steady throughout 1994–95; and
- Almost all category 1 and category 2 patients in Tasmania's emergency departments were seen within the recommended time.

### **5.7.3 Appropriateness**

Measuring the appropriateness of care is problematic. It involves examining where, what and how care should be provided.

Two indicators were selected to measure the appropriateness of care in public acute care hospitals: separations per 1000 population and variations in intervention rates. However, data for variations in intervention rates were not available for this Report.

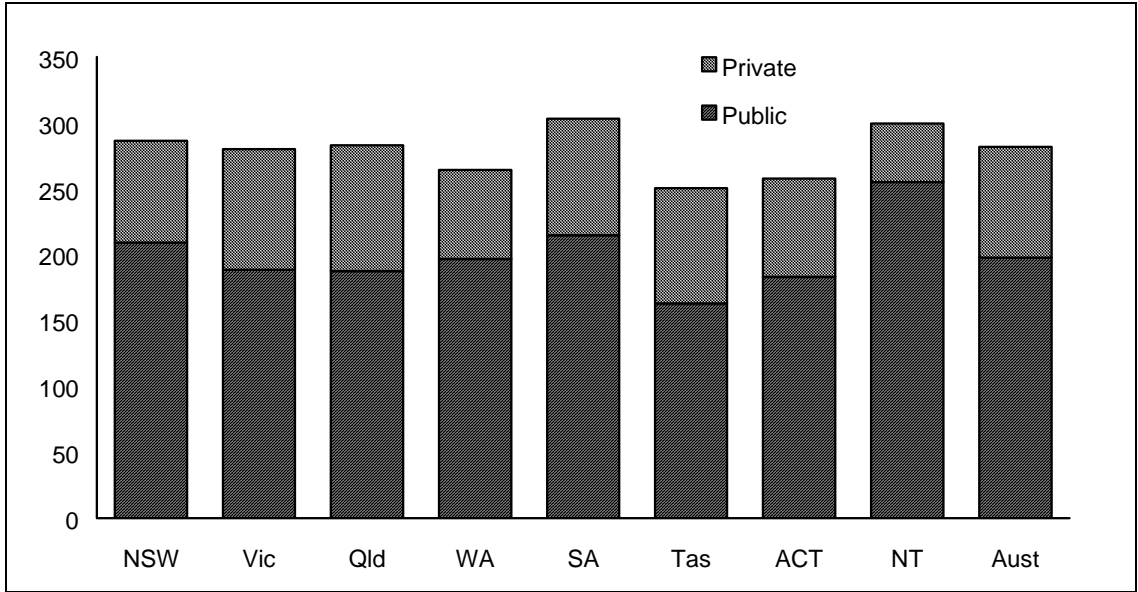
The level of acute care treatment across the population can be expressed as the total separations per 1000 population. This is included as an appropriateness indicator because it may highlight differences in the provision of hospital services among jurisdictions.

Total separations per 1000 population across Australia, from public and private hospitals rose from 258 separations to 282 separations between 1993–94 and 1994–95 (Figure 5.7).<sup>6</sup>

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<sup>6</sup> Changes in the number of separations could occur because of changes to coding or counting practices as well as changes in service provision.

Figure 5.7: Separation per 1000 population by type of hospital, 1994–95 (number)<sup>1</sup>



<sup>1</sup> This indicator was not standardised for population composition differences between states and territories, or for differences between states and territories in counting and reporting practices.

Source: Table 5A.20

### 5.7.4 Efficiency

Four indicators have been selected to measure the efficiency of public acute care hospitals in Australia. The key results from these indicators are presented below.

The Steering Committee is also exploring the use of other techniques such as data envelopment analysis (DEA) to measuring efficiency (Box 5.3).

#### *Cost per casemix-adjusted separation*

The efficiency data have been improved from the 1995 Report in that inpatient fractions are estimated in a more consistent manner. The inpatient fraction allows the expenditure associated with admitted patients to be separated from total hospital expenditure. Consequently, changes to the inpatient fraction could lead to variation in the cost per casemix-adjusted separation.<sup>7</sup>

<sup>7</sup> The inpatient fraction is the ratio of inpatient costs to total hospital costs and is generally estimated using existing management information. Where no inpatient fraction was available the inpatient costs as a proportion of total costs were derived using the Health and Allied

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**Box 5.3: DEA Case Study — Acute care hospitals in Victoria**

The Steering Committee is undertaking a case study using data envelopment analysis to assess the technical efficiency of a sample of hospitals in Victoria. The technique is discussed in Section 2.3.2.

The efficiency of the hospitals in the sample is being assessed in terms of their potential to increase their outputs while maintaining the same level of inputs. The inputs and outputs used in the case study are:

<b>Inputs</b>	<b>Outputs</b>
Full time equivalent medical staff	The number of patients, weighted by the expected resource intensity of caring for each patient and the severity of their illness
Full time equivalent non-medical staff	
Non-salary costs	The inverse of the unplanned readmission rate (to reflect the desirability of minimising the level of unplanned readmissions)

A full discussion of the DEA methodology, the case study and results will be contained in a paper being prepared by the Steering Committee.

Although the cost per casemix-adjusted separation should only deal with acute admitted patients, it was not always possible to separate out the costs of acute patients from all other admitted patients for all jurisdictions. However, non-acute admitted patients (such as mental health, rehabilitation, and nursing home type patients) account for less than 5 per cent of all admitted patients.<sup>8</sup>

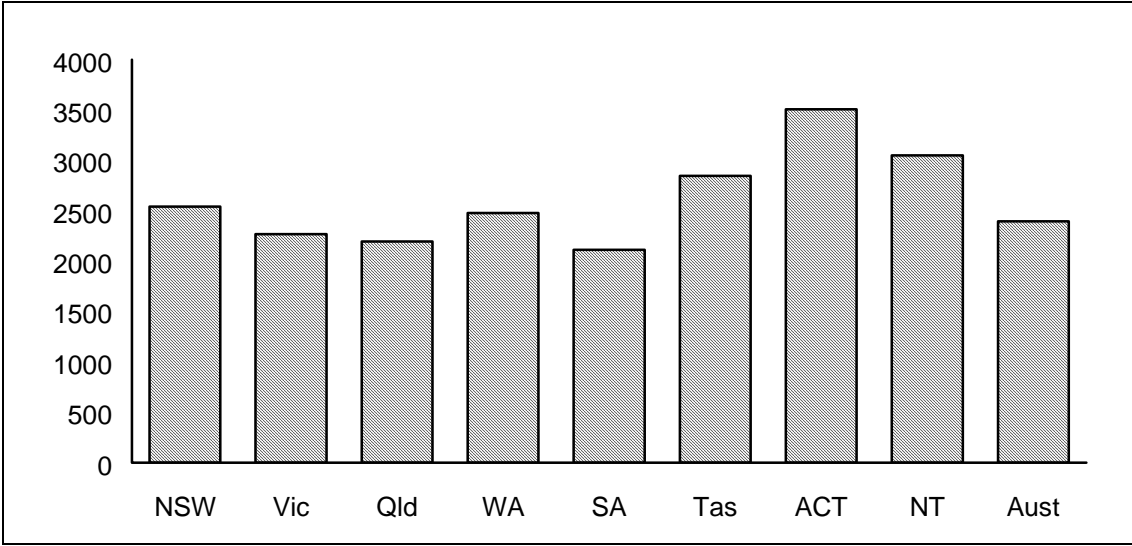
SA recorded the lowest cost per casemix-adjusted separation in 1994–95 (\$2113) while the ACT recorded the highest (\$3506). The national average was \$2396. In 1993–94, the average cost per casemix-adjusted separation across Australia was just over \$2300 (Figure 5.8). Estimates are based on a preliminary database, so caution should be exercised in interpreting the results.

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Services Advisory Council (HASAC) conversion rate which equates the cost of 5.753 non-inpatient services with the cost of one inpatient bed day. The HASAC method was used for Tasmania, the NT, and some hospitals in the ACT. The values reported for NSW, WA and Tasmania were estimated by the respective health authorities. It should be noted that there are reasons to question the applicability of the HASAC ratio and that the results are sensitive to the ratio used.

<sup>8</sup> Caution needs to be exercised with regard to separations information when comparing jurisdictions as there are differences in the reporting and counting rules used, particularly between those jurisdictions who funded their public hospitals on the basis of casemix information and those who did not.

Figure 5.8: Cost per casemix-adjusted separation for public acute care hospitals, 1994-95 (\$)



Source: Table 5A.22

*Cost per non-admitted patient occasion of service*

NSW and Queensland provided estimates of the cost per non-admitted patient occasion of service. They both estimated the average cost at \$62 per service.

*User cost of capital per casemix-adjusted separation*

A user cost of capital per casemix-adjusted separation (a measure of capital use) was calculated for buildings and equipment combined. However, the asset valuation data used were unreliable and so the user cost of capital could not be compared across jurisdictions. For example, Victoria recorded a user cost for buildings of \$246 per separation while WA recorded a user cost for equipment of \$57 per separation.<sup>9</sup>

*Average length of stay*

Average length of stay is also a significant factor determining the costs of hospital admitted patient episodes. The average length of stay for specific DRGs can be used both to predict cost and to determine relative efficiency. The average length of stay for the top five DRGs is shown in Table 5.2. As these estimates are based on an incomplete database, caution should be exercised in interpreting the results.

<sup>9</sup> Equipment assets in WA were valued at historical cost rather than replacement value.

Table 5.2: Average length of stay for the top 5 AN–DRGs — excluding same day cases — 1994–95 (days)<sup>1</sup>

<i>DRG</i>		<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>NT</i>	<i>ACT</i>	<i>Aust</i>
674	Vaginal delivery without complicating diagnosis									
	public	3.5	3.8	3.4	3.7	3.6	3.9	3.7	3.4	3.6
	private	5.3	5.8	5.2	5.4	5.7	4.8	na	na	5.4
	<b>total</b>	<b>3.8</b>	<b>4.3</b>	<b>3.9</b>	<b>4.2</b>	<b>4.1</b>	<b>4.2</b>	<b>na</b>	<b>na</b>	<b>4.0</b>
727	Neonate, admission weight > 2499g, without significant OR procedure, without problem									
	public	4.2	3.1	3.8	2.4	3.7	3.1	3.6	3.7	3.7
	private	5.5	2.9	4.7	3.6	6.1	3.7	na	na	5.5
	<b>total</b>	<b>4.7</b>	<b>3.0</b>	<b>3.9</b>	<b>2.6</b>	<b>4.4</b>	<b>3.3</b>	<b>na</b>	<b>na</b>	<b>4.1</b>
187	Bronchitis and asthma, age < 50, without complications									
	public	2.1	1.9	2.2	2.2	2.1	2.1	2.5	2.4	2.1
	private	2.0	2.2	2.4	2.9	2.4	2.0	na	na	2.3
	<b>total</b>	<b>2.1</b>	<b>1.9</b>	<b>2.2</b>	<b>2.2</b>	<b>2.1</b>	<b>2.1</b>	<b>na</b>	<b>na</b>	<b>2.1</b>
099	Lens procedure without vitrectomy, without complications									
	public	1.5	1.4	1.4	1.7	1.7	2.2	2.0	1.4	1.5
	private	1.3	1.5	1.5	1.5	1.8	1.5	na	na	1.5
	<b>total</b>	<b>1.4</b>	<b>1.5</b>	<b>1.5</b>	<b>1.6</b>	<b>1.8</b>	<b>1.6</b>	<b>na</b>	<b>na</b>	<b>1.5</b>
122	Tonsillectomy and/or adenoidectomy									
	public	1.8	1.3	1.3	1.5	1.5	2.0	1.3	1.3	1.5
	private	1.4	1.4	1.2	1.5	1.3	1.4	na	na	1.3
	<b>total</b>	<b>1.6</b>	<b>1.3</b>	<b>1.2</b>	<b>1.5</b>	<b>1.4</b>	<b>1.7</b>	<b>na</b>	<b>na</b>	<b>1.4</b>

na not available.

<sup>1</sup> Estimates were provided by DHFS using AN–DRG version 3.0 and trimmed using the inter–quartile range method.

Source: Table 5A.25

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