

The image features a dark purple background with a faint, architectural grid pattern. On the left side, there are three vertical bands of color: a thin purple line, a wider lime green band, and a wider dark green band. These bands have organic, wavy edges. Several thin white circles are scattered across the page, some overlapping the colored bands. The text is positioned on the right side of the page.

The state of our public hospitals,
June 2007 report

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www.health.gov.au/ahca

Additional hard copies of this report and accompanying fact sheets are available by emailing a request to

State.of.Our.Public.Hospitals@health.gov.au

or by writing to

State of Our Public Hospitals Report Request
Healthcare Services and Financing Branch
Australian Government Department of Health and Ageing
MDP 63
GPO Box 9848
Canberra City ACT 2601

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- to the state and territory health departments and hospital personnel who collected and provided the data used to produce this report
- to the Australian Institute of Health and Welfare for its assistance.



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Under the 2003–08 *Australian Health Care Agreements*, the Commonwealth Government is contributing an estimated \$42 billion to assist the states and territories in managing their public hospitals. Under these Agreements, all states and territories are required to continue to provide hospital services free of charge to eligible people who choose to be public patients.

Australians deserve detailed information on how well their public hospitals perform in relation to the quality, safety and timeliness of the services they provide.

Several states and territories are already meeting this demand for information. For example, Victoria's *Your Hospitals* report and Queensland's *Public Hospitals Performance Report* publish similar performance measures to those used in this report, but at an individual hospital level.

Both reports also provide indicators of patient satisfaction with the services they receive and some measures of safety and quality. For example, Queensland has published some detailed measures of clinical outcomes following a range of surgical, medical and other interventions. Victoria has also published analyses of how many hospital admissions may have been avoided through management of chronic and complex diseases by community services.

Internationally, this kind of reporting is well established and is a key driver of quality improvement in individual hospitals. In the United Kingdom, the annual *Good Hospital Guide* ranks all National Health Service acute care hospitals. In the United States, the annual *Best Hospitals* report ranks all US hospitals against a range of specialist services to establish an honour roll of the very best hospitals in the country. Both these reports are circulated by a national newspaper making them easily accessible to all health consumers.

An important question for Australia's health ministers is whether and to what extent we should expect all jurisdictions to commit to a similar level of transparency and accountability for individual hospitals. Critical to this discussion should be an assessment of the degree to which this kind of reporting leads to better hospital performance, better health outcomes for patients, and higher levels of patient satisfaction.

A handwritten signature in purple ink, appearing to read 'Tony Abbott'.

Tony Abbott MP
Minister for Health and Ageing



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OVERVIEW

Introduction to the report and its structure

Publishing this report annually is a responsibility of the Australian Government under the 2003–08 *Australian Health Care Agreements*. The report ensures that all governments are accountable for expenditure on public hospitals.

Each state and territory is accountable for the performance of its own public hospitals and for allocating funds to get the best health outcomes for patients. This report compares the performance of each state and territory on a range of key indicators.

The report shows public hospitals service trends and performance at state, territory and national levels and provides answers to frequently asked questions on Australia's public hospitals.

By providing a picture of the nation's public hospitals, the Australian Government aims to:

- increase community understanding about hospital sector performance
- show how this performance, and the sector itself, is changing
- stimulate improvement in performance and health outcomes for patients.

A snapshot of how each state or territory is performing against some key measures is summarised in this overview and presented in more detail elsewhere in the report. The fact sheets provided on each state and territory also provide some useful, local information.

Each year *The state of our public hospitals report* provides a more detailed picture of one aspect of hospital work. The first report released in 2004 focused on developments in public hospitals over the term of the previous 1998–2003 *Australian Health Care Agreements*. The 2005 report compared public and private hospitals, and the 2006 report focused on public hospitals in rural and remote areas of Australia. This report has a focus on the experiences of older Australians in hospitals.



This report has five parts

Part 1 answers big picture questions about all hospitals, including how many there are, what they do, how much they cost, and who works in them. It also provides a snapshot of what happens on a typical working day in public hospitals across Australia.

Part 2 looks at patients admitted to hospital and includes information about why they have been admitted, how many have been admitted and the average length of time they spend in hospital. Step-down care for people needing rehabilitation before leaving hospital is also described here.

Part 3 outlines all types of surgery carried out in public hospitals and focuses on the performance of public hospitals in providing elective surgery within recommended times. The types of surgery undertaken and the times people waited to get their surgery are detailed.

Part 4 is about public hospital services that are available for patients who are not admitted. It provides information about emergency department care and outpatient services.

Part 5 tells the story of older Australians in public and private hospitals by showing how people at different ages are using hospital services and the reasons why older Australians go to hospital. The anticipated impact of Australia's ageing population on hospitals in the future is also considered.

This report also has a brief **Appendix** which provides key definitions and information about the data used. Reference sources and websites with related information, including one for each state and territory's health department, are also included. For the first time, this 2007 report is accompanied by a technical reference guide to assist researchers and others understand how the statistical figures in this report were calculated. This reference guide is available with the on-line version of this report at www.health.gov.au/ahca.

The context of this report

State and territory governments provide public hospital services, free of charge, to public patients and are responsible for the day to day operations of public hospitals. The Australian Government provides substantial funds to the states and territories to support this activity through the *Australian Health Care Agreements*. States and territories also contribute their own funding (see Part 1).

Within the 2003–08 *Australian Health Care Agreements*, each state and territory agrees that the range of hospital services provided to public patients will be no less than that available on 1 July 1998. For this reason, the report often compares 2005–06 data with 1998–99 data.

As well as providing free services to public patients under Medicare principles, public hospitals also provide services to patients who are privately insured, or self-funded, and can choose their own doctor. A small number of patients seen in public hospitals are not eligible for Medicare (for example, overseas visitors) and may need to pay a direct fee for the health care they receive.

Although private hospitals are not covered by the *Australian Health Care Agreements*, what happens in these hospitals is important for the sector as a whole. As a result, this report includes some information on private hospitals.

Australian Health Care Agreements

The primary objective of the *Australian Health Care Agreements* is to secure access for the Australian community to public hospital services based on three principles:

1. Eligible persons are given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were (on 1 July 1998) provided by hospitals.
2. Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period.
3. Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographical location.

Full details of the *Australian Health Care Agreements* are available at www.health.gov.au/ahca.



State and territory public hospital performance reports

Each state and territory government maintains some level of regular performance reporting about its public hospital system. Unless otherwise noted each provides information about the performance of individual hospitals.

Victoria Your hospitals report (biannual release).

www.health.vic.gov.au/yourhospitals

Queensland Public Hospitals Performance Report (annual release and quarterly updates).

www.health.qld.gov.au/performance/default.asp

Tasmania Your Health and Human Services Progress Chart (quarterly release).

www.dhhs.tas.gov.au/agency/profile/performance.php

Australian Capital Territory ACT Health Public Services Performance Report (quarterly release).

www.health.act.gov.au (publications link)

New South Wales Hospital Information (annual release, which has information on the public hospital system, including a range of performance measures for individual hospitals).

www.health.nsw.gov.au/hospitalinfo

South Australia Some performance information is provided in its Annual Report.

www.health.sa.gov.au/Default.aspx?tabid=59

This website also includes a monthly report on elective surgery.

www.health.sa.gov.au/electivesurgery

Performance information is also published in the state's budget papers (see Budget Paper 4: Portfolio Statement, Volume 2).

www.treasury.sa.gov.au/dtf/budget/publications_and_downloads/current_budget.jsp?

Northern Territory Some performance information is provided in its Annual Report.

www.health.nt.gov.au/health/org_supp/public_affairs/anrep05_06/index.shtml

Western Australia Some performance information is provided in its Annual Report on different health service areas, but not individual hospitals.

www.health.wa.gov.au/publications/annual_reports.cfm

There is also a monthly elective surgery report for individual hospitals

www.health.wa.gov.au/ElectiveSurgery/waitinglist/index.cfm

and a report on emergency department services for individual hospitals.

www.health.wa.gov.au/publications/subject_index/e/emergency.cfm

Performance snapshot

PUBLIC HOSPITALS—average available beds per 1,000 weighted population, states and territories, 2005–06

Rank		Number	Change since 2004–05
1	Northern Territory	3.6	↓0.1
2	South Australia	2.8	↓0.1
3	New South Wales	2.7	↓0.2
4	Queensland	2.5	0
4	Tasmania	2.5	0
4	Western Australia	2.5	↓0.1
7	Australian Capital Territory	2.3	↑0.1
7	Victoria	2.3	0
Australia		2.6	0

PUBLIC HOSPITALS—percentage accredited, states and territories, 2005–06

Rank		%	Change since 2004–05
1	Australian Capital Territory	100	0
1	Northern Territory	100	0
1	Victoria	100	↑1
4	South Australia	94	0
5	Western Australia	86	↑12
5	Queensland	86	0
7	New South Wales	77	↓9
8	Tasmania	19	↓3
Australia		84	0

PUBLIC HOSPITAL SERVICES—state and territory government recurrent expenditure per person, weighted population, 2005–06

Rank		\$	Change since 2004–05
1	Northern Territory	1,407	↓21
2	Western Australia	894	↑24
3	Australian Capital Territory	865	↓42
4	Tasmania	806	↑77
5	New South Wales	669	↑21
6	Queensland	614	↑112
7	South Australia	597	↑14
8	Victoria	588	↑4
Australia		665	↑34

PUBLIC PATIENTS—number of admissions per 1,000 weighted population, states and territories, 2005–06

Rank		Number	Change since 2004–05
1	Northern Territory	512	↑34
2	Victoria	210	↑3
3	Western Australia	209	↓1
4	Australian Capital Territory	206	↑19
5	South Australia	192	↑3
6	Queensland	173	0
7	New South Wales	163	↑7
8	Tasmania	155	↑18
Australia		186	↑4





ELECTIVE SURGERY—percentage of admissions seen within the recommended time, states and territories, 2005–06

Rank		%	Change since 2004–05
1	Queensland	86	↓4
2	Victoria	84	↓2
3	South Australia	82	↓1
3	Western Australia	82	↓1
5	New South Wales	78	↑1
6	Northern Territory	73	↓4
7	Australian Capital Territory	70	↑2
8	Tasmania	68	↑2
Australia		81	↓1

ELECTIVE SURGERY—percentage of admissions that waited longer than one year, states and territories, 2005–06

Rank		%	Change since 2004–05
1	Queensland	2.1	↑0.3
2	South Australia	4.2	↑0.2
2	Western Australia	4.3	↑0.5
2	Victoria	4.5	↑0.5
5	New South Wales	5.4	↓1.5
6	Northern Territory	7.7	↑1.4
7	Tasmania	8.7	↓0.8
8	Australian Capital Territory	10.3	↑0.2
Australia		4.6	↓0.2

ELECTIVE SURGERY—median waiting time, all procedures, states and territories, 2005–06

Rank		Days	Change since 2004–05
1	Queensland	25	↑3
2	Western Australia	28	↑1
3	Northern Territory	30	↑1
4	Victoria	32	↑4
5	Tasmania	34	0
6	New South Wales	36	↑2
7	South Australia	38	↑3
8	Australian Capital Territory	61	↑16
Australia		32	↑3

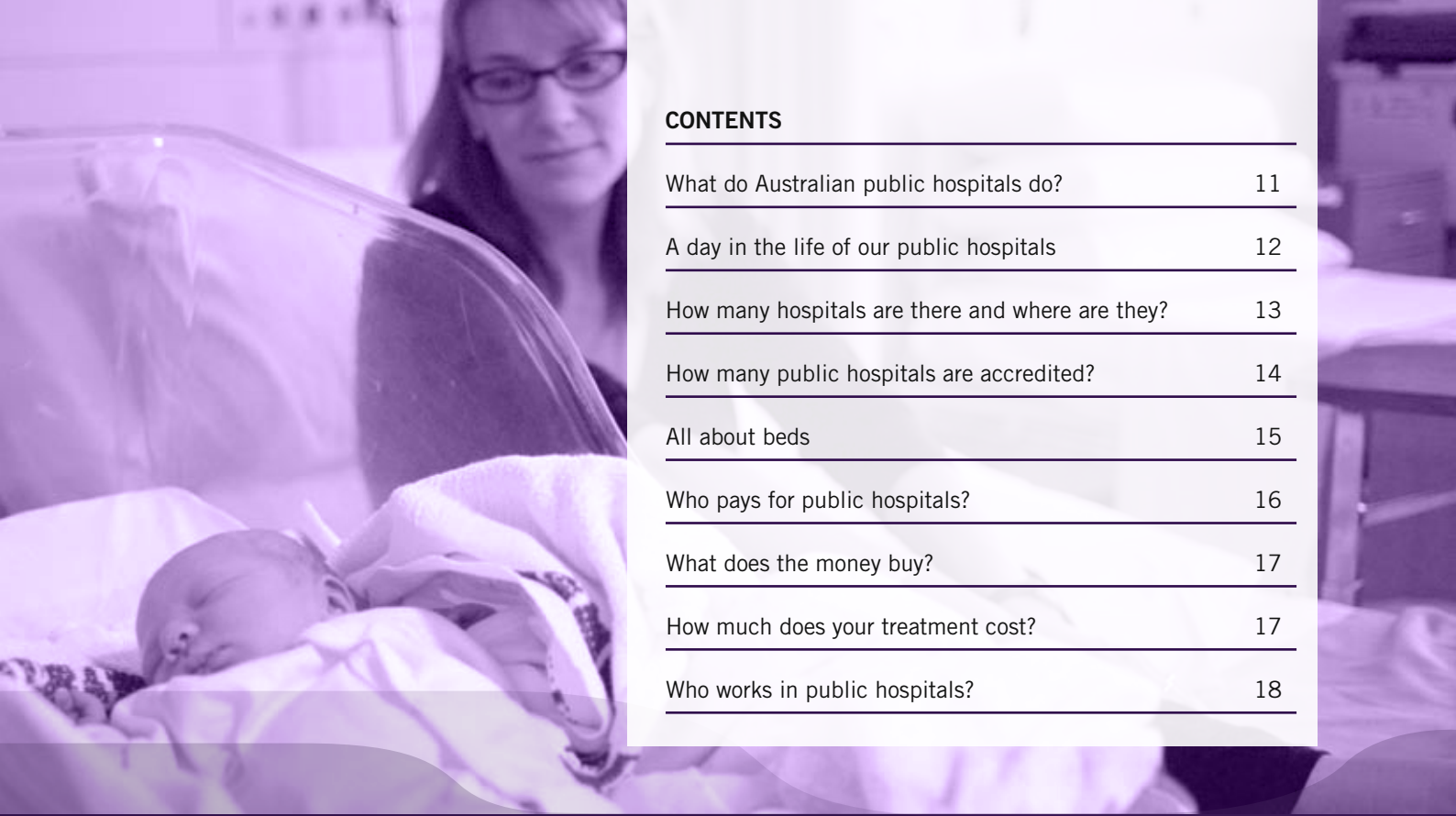
EMERGENCY DEPARTMENTS—percentage of people seen within the recommended time, states and territories, 2005–06

Rank		%	Change since 2004–05
1	Victoria	77	↓2
2	Western Australia	71	↑1
3	New South Wales	69	↑1
4	South Australia	62	↓1
4	Tasmania	62	↓6
6	Queensland	60	↑1
6	Northern Territory	60	↓2
8	Australian Capital Territory	52	↓6
Australia		69	0

EMERGENCY DEPARTMENTS—median waiting times for all patients, states and territories, 2005–06

Rank		Minutes	Change since 2004–05
1	Victoria	19	↑3
2	Western Australia	20	↓4
3	New South Wales	25	↓1
4	South Australia	27	0
5	Tasmania	28	↑4
6	Queensland	31	↓2
7	Northern Territory	35	↑2
8	Australian Capital Territory	46	↑6
Australia		24	↓1





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PART 1

THE 'WHAT, WHERE AND WHO' OF AUSTRALIA'S HOSPITALS

**AT A GLANCE IN 2005–06**

There were 755 public hospitals with 54,601 beds, which is four fewer hospitals and about 400 fewer beds than in 2004–05.

Eighty-four per cent of public hospitals were fully accredited, which accounted for 96 per cent of all public hospital beds.

There were about 2.6 public hospital beds per 1,000 weighted population.

More than one quarter of all expenditure on health care in Australia is spent on public hospitals.

Around 80 per cent of all hospital births occur in public hospitals.

The most common reason for admission to a public hospital was for renal dialysis with over 726,000 admissions costing more than \$352 million. In 2004–05, there were over 663,000 admissions for renal dialysis which cost about \$321 million.

Public hospitals employed the equivalent of 221,379 full time staff, an increase of 5 per cent from the previous year. Of these, 45 per cent were nurses and 10 per cent were salaried medical officers.



What do Australian public hospitals do?

Public hospitals provide a wide range of health services from urgent or life-saving treatments for accident or heart attack victims, to those designed to improve a patient's health or quality of life, such as hip replacements, palliative care, or rehabilitation.

Patients are admitted to public hospitals for many reasons including surgery, diagnostic tests, or treatment for severe medical conditions such as kidney failure or cancer.

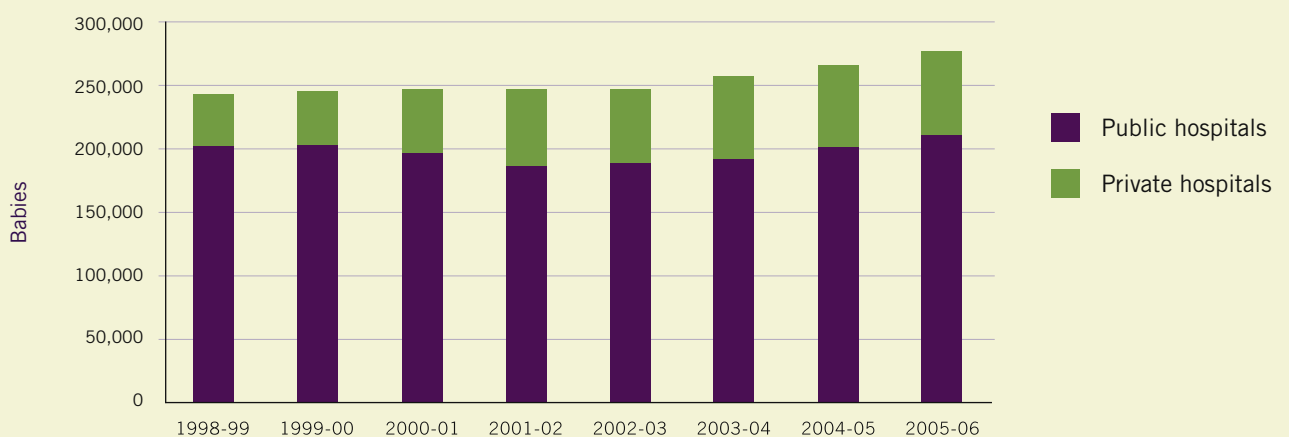
Patients also visit public hospital emergency departments for many reasons. Some require life-saving resuscitation, are experiencing severe pain or have a serious injury. Others may have less severe symptoms or injuries that are potentially serious (for example, a foreign body in the eye, a sprained ankle, a possible bone fracture, abdominal pain, or an earache). Patients receive treatment free-of-charge in the emergency department and some may subsequently be admitted to the hospital for further treatment.

Public hospitals also treat patients not requiring admission to a hospital in outpatient departments. These areas provide diverse services including diagnostic procedures, palliative care, dentistry, and rehabilitation services.

Public hospitals are also the principal locations for delivering Australia's next generation. Australia's public hospital maternity units account for up to 80 per cent of Australian babies born in all hospitals, including those born in a 'mini baby boom' shown in hospital statistics since 2002–03.



FIGURE 1.1 NEWBORNS—all hospitals, Australia, 1998–99 to 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by states and territories.

A day in the life of our public hospitals

To paint a picture of what happens on a typical working day in public hospitals across Australia, this is what happened on a randomly selected day, Thursday 16 March 2006.

In all public hospitals across the country:

- 15,756 patients were admitted and 15,906 patients discharged
- 614 babies were born.

Of the patients admitted for treatment:

- just over half (8,181) were discharged on the same day
- 944 had some form of acute heart problem
- 108 had pneumonia
- 86 had asthma
- 2,179 had renal dialysis
- 630 had emergency surgery
- 2,840 had elective surgery
- 53 had a hip or knee replacement
- 164 patients died.

At midnight there were 40,411 admitted patients staying overnight in public hospitals.

Of the estimated 12,767 patients who presented to emergency departments in larger public hospitals:

- 80 required resuscitation
- 5 died in an emergency department, and a further 2 were dead on arrival
- 3,819 were subsequently admitted to hospital.

On this day public hospital outpatient departments provided over 104,000 occasions of service.





How many hospitals are there and where are they?

At June 2006, Australia had 755 public hospitals and 536 private hospitals. Public hospitals included 736 acute hospitals and 19 psychiatric hospitals. The reduction in number since 2004–05 (when there were 759 public hospitals) is because of changes in the administrative reporting and amalgamation of hospitals.

Every public hospital is different. Public acute hospitals vary in size, in their range of services, their degree of specialisation, and the extent to which they engage in teaching and research. Public psychiatric hospitals are dedicated to providing specialised treatments for mental health patients, although these services are also provided by some public acute hospitals.

Private hospitals include day surgery centres (252), which provide specialised treatments such as gastroscopies and lens procedures on a day-only basis. All other private hospitals (284) deliver a wider range of services and provide for overnight stays.

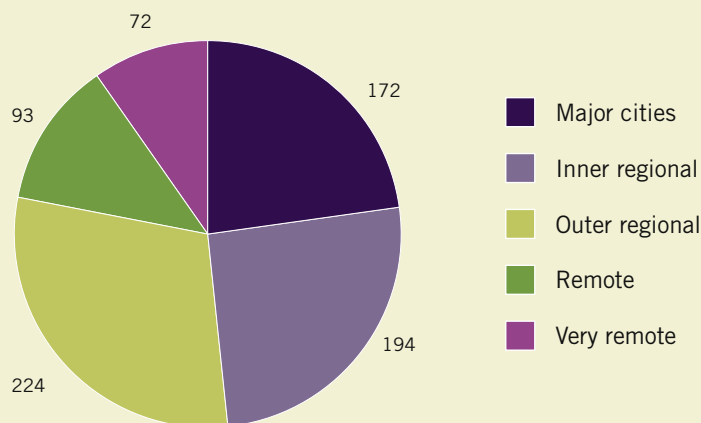
TABLE 1.1 ALL HOSPITALS—type of hospital, states and territories, 2005–06

	Public acute hospitals	Public psychiatric hospitals	Total public hospitals	Day surgeries	Private hospitals	Total private hospitals	Total hospitals
New South Wales	221	9	230	88	86	174	404
Victoria	142	1	143	66	79	145	288
Queensland	173	4	177	51	56	107	284
Western Australia	90	1	91	16	23	39	130
South Australia	78	1	79	23	31	54	133
Tasmania	24	3	27	2	5	7	34
Australian Capital Territory	3	0	3	5	3	8	11
Northern Territory	5	0	5	1	1	2	7
Australia	736	19	755	252	284	536	1,291

Source: Australian Institute of Health and Welfare (2007), *Australian hospital statistics 2005–06*

Across Australia, public hospitals can be found in major cities, many regional centres and in remote and very remote areas of the outback.

FIGURE 1.2 PUBLIC HOSPITALS—number by remoteness area, Australia 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

How many public hospitals are accredited?

Hospitals become accredited through a program of review and assessment such as those conducted by the Australian Council on Healthcare Standards, the Australian Quality Council, the Quality Improvement Council, or the International Organization for Standardization.

In 2005–06, 84 per cent of public hospitals in Australia were accredited. All public hospitals in the Australian Capital Territory, the Northern Territory and Victoria were accredited. All other states had not achieved accreditation for all their public hospitals. Tasmania had the lowest proportion of accredited public hospitals (19 per cent).

However, across the country, 96 per cent of public hospital beds are in accredited public hospitals. Although only five of Tasmania's 27 public hospitals are accredited, these hospitals account for 83 per cent of Tasmania's public hospital beds.

TABLE 1.2 PUBLIC HOSPITALS AND BEDS—number and percentage accredited, states and territories, 2005–06

Rank		Hospitals accredited		Beds accredited	
		Number	%	Number	%
1	Australian Capital Territory	3	100	714	100
1	Northern Territory	5	100	569	100
1	Victoria	143	100	12,273	100
4	South Australia	74	94	4,768	98
5	Queensland	153	86	9,811	97
5	Western Australia	78	86	4,764	96
7	New South Wales	176	77	18,332	93
8	Tasmania	5	19	1,080	83
	Australia	637	84	52,311	96

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

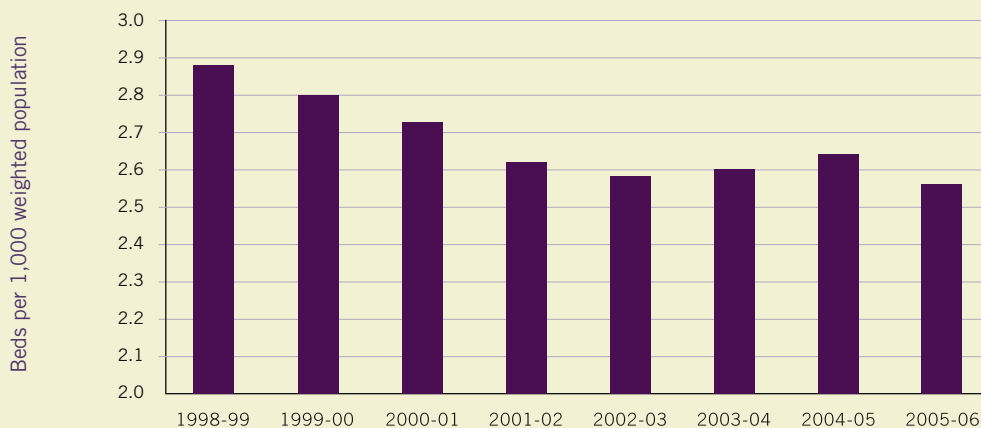


All about beds

The number of beds available for use is a basic measure of a hospital's capacity to deliver care for patients needing to stay overnight. It does not directly measure a hospital's capacity to provide other services such as hospital-in-the-home, emergency department or outpatient services.

A bed is considered immediately available for use if it is in a suitable location with sufficient nursing and other staff on hand to deliver effective care. In 2005–06, the number of available public hospital beds across Australia was 54,601 or about 2.6 per 1,000 weighted population.

FIGURE 1.3 PUBLIC HOSPITALS—average available beds per 1,000 weighted population, 1998–99 to 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

The number of beds per 1,000 weighted population in 2005–06 ranged from 3.6 in the Northern Territory to 2.3 in Victoria and the Australian Capital Territory.

Rank		2005–06	1998–99	
1	Northern Territory	3.6	4.2	1
2	South Australia	2.8	3.2	2
3	New South Wales	2.7	2.9	5
4	Queensland	2.5	3.2	2
4	Western Australia	2.5	3.1	4
4	Tasmania	2.5	2.4	8
7	Victoria	2.3	2.5	7
7	Australian Capital Territory	2.3	2.7	6
Australia		2.6	2.9	

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Who pays for public hospitals?

An estimated \$87.3 billion was spent on all health care in Australia in 2004–05, the latest year for which this figure is available. More than a quarter of this amount was spent on public hospitals.

Of the \$22.1 billion spent on public hospitals in 2004–05, the Australian Government spent \$9.8 billion, state, territory and local governments spent \$10.6 billion and private sources spent \$1.7 billion. Private sources include private health insurance and out-of-pocket payments by private and other patients.

The Australian Government's contribution includes the grants to the states and territories through the *Australian Health Care Agreements*, private health insurance rebates and the Department of Veterans' Affairs payments for treating veterans and their dependants.

Under the 2003–08 *Australian Health Care Agreements*, the Australian Government provides grants to the states and territories to help them provide free public hospital services to public patients. It will provide an estimated \$42 billion over the life of the Agreements. In 2005–06 it provided \$8.32 billion through the *Australian Health Care Agreements*.

The 2003–08 Agreements require each state and territory to increase funding for public hospitals to at least match the rate of growth of Australian Government funding provided under the Agreements. The states and territories exceeded this commitment in 2005–06. There has been a substantial increase in recurrent expenditure on public hospitals in all states and territories since 1998–99.

TABLE 1.4 PUBLIC HOSPITAL SERVICES—state and territory government recurrent expenditure per person, weighted population, 2005–06 (1998–99)

Rank		2005–06 (\$)	1998–99 (\$)	
1	Northern Territory	1,407	983	1
2	Western Australia	894	674	4
3	Australian Capital Territory	865	722	2
4	Tasmania	806	692	3
5	New South Wales	669	543	5
6	Queensland	614	408	8
7	South Australia	597	449	6
8	Victoria	588	418	7
	Australia	665	501	

Note: All figures are adjusted to 2005–06 dollars.

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

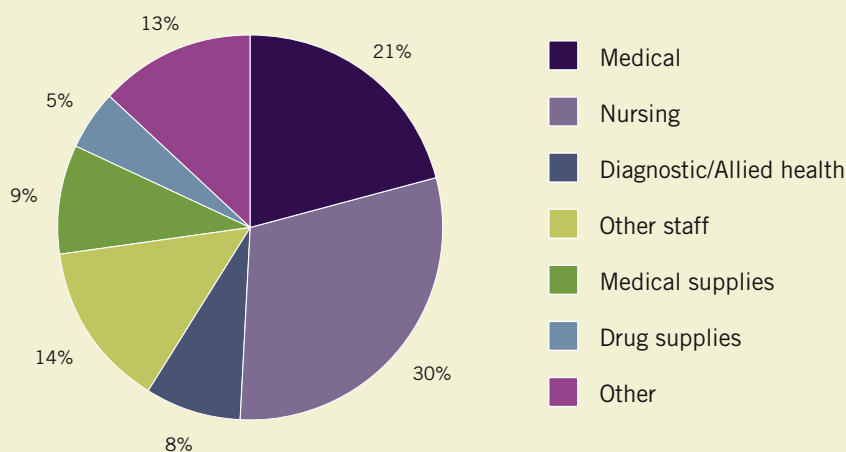




What does the money buy?

The cost of treating public hospital patients includes paying staff salaries and superannuation, fees for visiting medical practitioners, buying and operating increasingly sophisticated medical technology, buying daily supplies such as surgical dressings, and providing support services such as meals, cleaning, security, and computer systems. Salaries for medical practitioners account for 21 per cent and salaries for nurses 30 per cent of admitted patient costs.

FIGURE 1.4 PUBLIC HOSPITALS—distribution of spending, average total cost for an admitted patient (\$3,697), Australia, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

How much does your treatment cost?

The average cost for treating conditions depends on the complexity of treatment, the anaesthetics and drugs used, the level of care and time in hospital required and the surgical facilities needed.

Caring for patients with severe burns is the most expensive at about \$136,553 for each patient. Renal dialysis, provided to patients with temporary or permanent kidney failure, is at the lower end of the cost scale at \$485 per treatment. Renal dialysis replaces the function of the kidneys to remove waste products and excess fluids from the bloodstream, while maintaining the proper chemical balance of the blood. However, because each renal dialysis patient needs a number of services each week, the amount spent on the more than 720,000 public hospital dialysis admissions in 2005–06 was more than \$352 million, the highest total cost for any procedure provided in public hospitals. This does not include dialysis services provided to non-admitted patients in outpatient facilities. In contrast, the total cost of caring for patients with severe burns in 2005–06 (only 146 admissions) was slightly less than \$20 million.

TABLE 1.5 PUBLIC HOSPITALS—number of admissions and average cost, selected procedures, Australia, 2005–06

	Number	Average cost (\$)
Severe burns	146	136,553
Lung transplant	88	98,251
Hip replacement without complications	7,184	14,076
Uncomplicated caesarean	37,491	6,518
Uncomplicated birth	96,152	3,906
Same day chemotherapy	131,034	872
Same day renal dialysis	726,124	485

Source: Australian Government Department of Health and Ageing (2006), *National Hospital Cost Data Collection*.

Who works in public hospitals?

Nationally, the equivalent of 221,379 full-time staff were employed in all public hospitals in 2005–06. This is an increase of 26 per cent from 1998–99 and 5 per cent from 2004–05.

The equivalent of 22,858 full-time salaried medical officers were employed in public hospitals in 2005–06, an increase of 39 per cent from 1998–99. Salaried medical officers made up 10 per cent of the employed workforce in the public hospital sector. However, this statistic represents only part of the medical workforce. It does not include visiting medical specialists contracted by hospitals who are paid on a sessional or fee-for-service basis.

TABLE 1.6 PUBLIC HOSPITALS—average full-time equivalent staff, states and territories, 2005–06

	Salaried medical officers	Nurses	Diagnostic and other health professionals	Administrative and clerical staff	Personal care, domestic and other staff	Total
NSW	7,760	35,427	11,024	11,833	11,185	77,229
Vic	5,738	25,152	11,828	9,385	7,047	59,150
Qld	4,072	15,818	3,663	4,582	7,247	35,382
WA	2,118	8,727	2,459	3,303	3,827	20,434
SA	1,994	8,734	2,100	2,939	2,257	18,024
Tas	472	2,287	426	647	1,126	4,958
ACT	400	1,684	441	600	344	3,469
NT	304	1,179	291	415	544	2,733
Australia	22,858	99,008	32,232	33,704	33,577	221,379

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

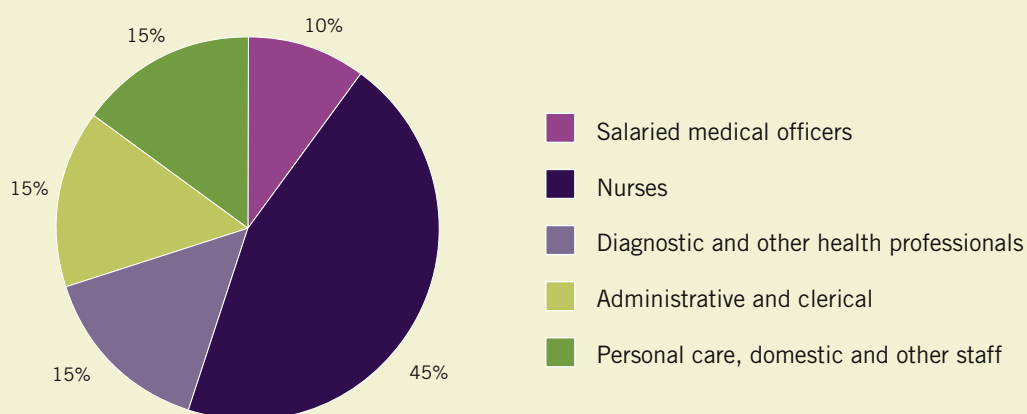


Nurses are the largest group of employed staff in public hospitals, making up 45 per cent of full-time equivalents. Since 1998–99, the number of equivalent full-time nurses in public hospitals increased by 26 per cent to 99,008 in 2005–06. In the states and territories that reported on the different types of nurses, registered nurses were the largest proportion of full-time equivalents.

In 2005–06, there were 32,232 full-time equivalent diagnostic and other health professionals employed in public hospitals, including radiographers, laboratory technicians, physiotherapists, occupational therapists, psychologists, and pharmacists. The number of full-time equivalent staff in this category increased by 42 per cent from 1998–99.

Administrative and clerical staff made up 15 per cent of full-time equivalent staff employed in public hospitals in 2005–06, an increase of 28 per cent since 1998–99. Staff employed in the personal care, domestic and other staff category made up 15 per cent of those employed in 2005–06, an increase of only 14 per cent from 1998–99. The provision of food and cleaning services through external contract arrangements may explain this relatively small increase, compared with other staffing categories.

FIGURE 1.5 PUBLIC HOSPITALS—average full-time equivalent staff by staffing categories, Australia, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.



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PART 2

THE 'INS' OF PUBLIC HOSPITALS



AT A GLANCE IN 2005–06

There were just under 4.5 million admissions to public hospitals, an increase of over 4.4 per cent since 2004–05.

Public hospitals accounted for 61 per cent of all patient admissions.

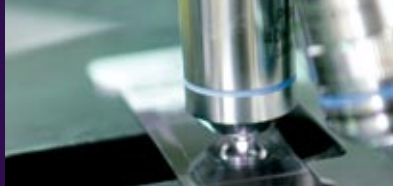
Eighty-seven per cent of public hospital admissions were public patients, 9 per cent were private patients and the remainder were a mix including veterans, defence personnel and patients under compensation arrangements.

Almost 4 million of all hospital admissions were public patients, an increase of almost 4.5 per cent since 2004–05.

Sixty-five per cent of public hospital admissions were for acute medical care and 18 per cent for surgery.

Half of all public hospital admissions were discharged on the same day.

There were over 153,000 patient admissions to hospital for rehabilitation care in 2005–06. About one third were public patients, almost half were private patients and the remainder were a mix including veterans, defence personnel and patients under compensation arrangements.

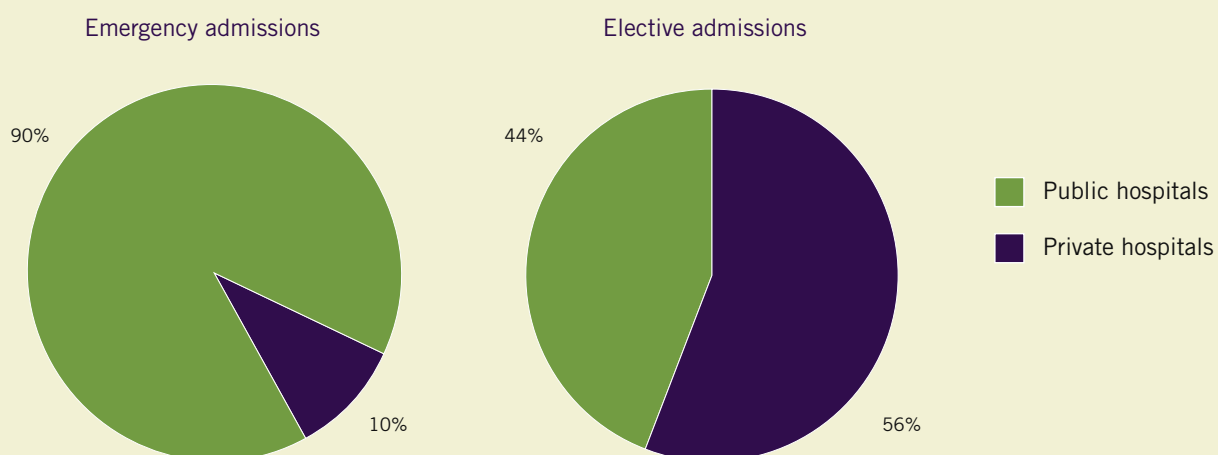


What's different about the roles played by public and private hospitals?

Public and private hospitals have different roles in the Australian health system. In 2005–06, 90 per cent of admissions identified as emergency interventions were in public hospitals. Emergency interventions generally need to be undertaken within 24 hours of the patient's first contact with a hospital.

In comparison, only 44 per cent of all hospital admissions identified as elective were in public hospitals. Elective interventions can be delayed for more than 24 hours without risk to the patient's life or body integrity.

FIGURE 2.1 ALL HOSPITAL ADMISSIONS—identified emergency and elective admissions, Australia, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

About 12 per cent of emergency admissions were for surgery in 2005–06, while about 40 per cent of elective admissions were for surgery.

Private hospitals managed 56 per cent of all hospital admissions for surgery (including emergency and elective surgery) in 2005–06.

How many patients are admitted to all hospitals?

In 2005–06, just under 4.5 million patients were admitted to public hospitals as public or private patients. This is an increase of nearly 16 per cent since 1998–99 and an increase of over 4.4 per cent since 2004–05, continuing the strong upward trend nationally since 2000–01. Over the same period, admissions to private hospitals also increased (by 52 per cent from 1998–99, though only by 3.8 per cent since 2004–05).

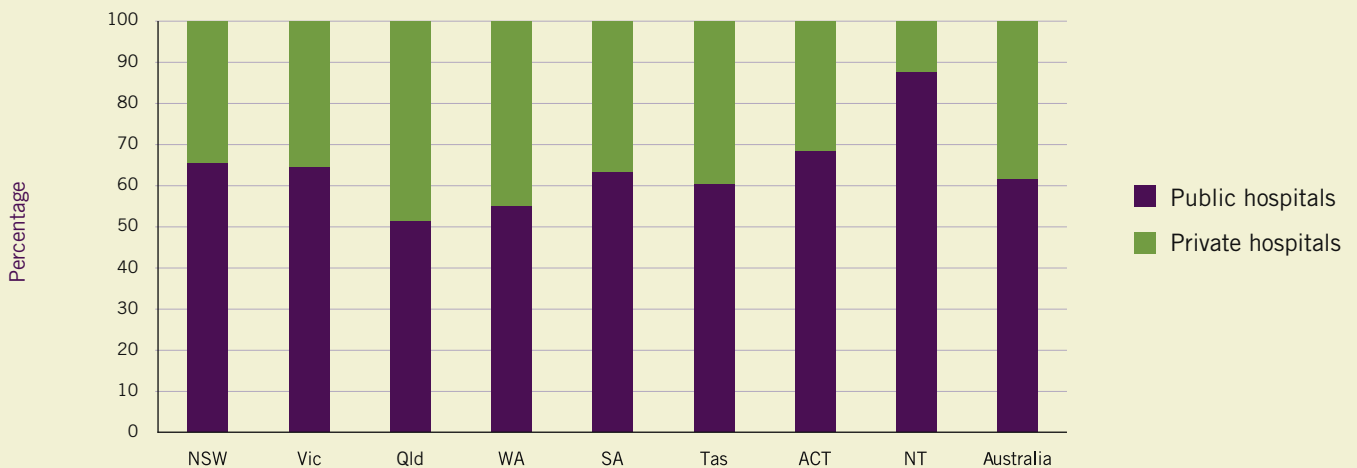
FIGURE 2.2 ALL HOSPITAL ADMISSIONS—number in each hospital sector, 1998–99 to 2005–06



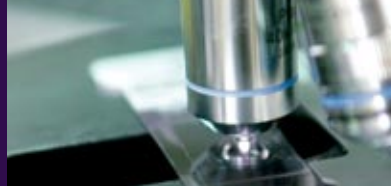
Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

In 2005–06 public hospital admissions were around 61 per cent of all hospital admissions. Across the states and territories, this figure varied from 51 per cent in Queensland to 87 per cent in the Northern Territory.

FIGURE 2.3 ALL HOSPITAL ADMISSIONS—proportion in each hospital sector, states and territories, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.



Over the time that public hospital admissions have grown, Australia's population has also grown, but at a slower rate (1.3 per cent). This means that, nationally, public hospital admissions per 1,000 weighted population have increased from 207 patients in 1998–99 to 210 patients in 2005–06. The Northern Territory had the highest admission rate in 1998–99 and in 2005–06 and continues to have a substantially higher rate (529 admissions per 1,000 weighted population). Victoria, the Australian Capital Territory and Tasmania also show an increase in the admission rate since 1998–99. This rate has dropped in South Australia, New South Wales, Western Australia and Queensland since 1998–99.

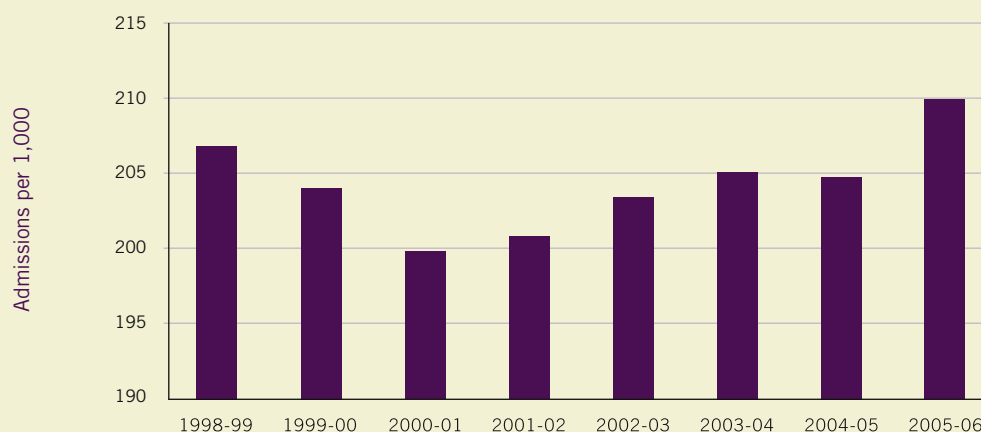
TABLE 2.1 PUBLIC HOSPITAL ADMISSIONS—number per 1,000 weighted population, states and territories, 2005–06 (1998–99)

Rank		2005–06	Change since 2004–05	1998–99	
1	Northern Territory	529	↑33	402	1
2	Victoria	239	↑5	207	5
3	Australian Capital Territory	235	↑23	219	3
4	South Australia	220	↑4	226	2
5	New South Wales	197	↑7	198	7
6	Western Australia	195	↑1	207	5
7	Queensland	186	↓1	212	4
8	Tasmania	179	↑12	168	8
	Australia	210	↑5	207	

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Figure 2.4 below shows how the national figure has changed between 1998–99 and 2005–06, initially dropping to a low of about 200 in 2000–01, and then climbing steadily since that time with the largest annual increase seen between 2004–05 and 2005–06.

FIGURE 2.4 PUBLIC HOSPITAL ADMISSIONS—number per 1,000 weighted population, Australia, 1998–99 to 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

How many public and private patients are admitted to public hospitals?

When people are admitted to a public hospital they are given the choice to be treated either as a public or private patient. This is a fundamental principle that state and territory governments have agreed to uphold through the *Australian Health Care Agreements*. Those who choose to be public patients receive, free of charge, all medical, allied health and pharmaceutical care. Private patients can choose their own doctor and ask for a private room. They are charged for their care by the hospital and treating doctors, and may recover all or some of their costs through private health insurance or choose to pay out of their own pocket.

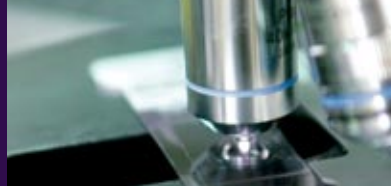
Australia has Reciprocal Health Care Agreements with a number of overseas countries. Patients from these countries may choose to be treated as public or private patients in Australian hospitals. Patients from countries without these agreements are treated as private patients.

In 2005–06, in addition to over 3.8 million public and over 400,000 private admissions, there were over 180,000 other admissions. These included patients whose care is paid for by other Australian Government agencies such as the Department of Veterans' Affairs or the Department of Defence. There are also patients whose care is paid through workers' compensation, third-party motor vehicle claims or other compensation arrangements.

TABLE 2.2 PUBLIC HOSPITAL ADMISSIONS—by patient type, states and territories, 2005–06

	Public patients %	Private patients %	Other patients %	Change in % of public patients since 2004–05
New South Wales	82	13	5	0
Victoria	88	8	4	0
Queensland	91	6	3	↑1
Western Australia	90	7	3	0
South Australia	87	8	5	0
Tasmania	82	12	6	0
Australian Capital Territory	88	7	5	0
Northern Territory	97	1	2	↑1
Australia	87	9	4	0

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.



How many public patients are admitted to all hospitals?

In 2005–06, there were almost 4 million public patient admissions to hospitals, which was 54 per cent of all admissions. Most public patient admissions were in public hospitals, although some public patients (almost 100,000) were treated in private hospitals under contract to state and territory governments. The number of public patient admissions to all hospitals rose by almost 4.5 per cent since 2004–05.

The Northern Territory had the highest proportion of public patient admissions (84 per cent).

TABLE 2.3 ALL HOSPITAL ADMISSIONS—percentage that are public patients, states and territories, 2005–06

	%	Change since 2004–05
New South Wales	54	↑1
Victoria	56	0
Queensland	48	0
Western Australia	59	↓1
South Australia	55	0
Tasmania	52	0
Australian Capital Territory	60	↑2
Northern Territory	84	0
Australia	54	0

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Nationally, the number of public patient admissions per 1,000 weighted population was higher in 2005–06 (186) than in 2004–05 (182).

TABLE 2.4 PUBLIC PATIENT ADMISSIONS—number per 1,000 weighted population, states and territories, 2005–06

Rank		2005–06	Change since 2004–05
1	Northern Territory	512	↑34
2	Victoria	210	↑3
3	Western Australia	209	↓1
4	Australian Capital Territory	206	↑19
5	South Australia	192	↑3
6	Queensland	173	0
7	New South Wales	163	↑7
8	Tasmania	155	↑18
	Australia	186	↑4

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Figure 2.5 shows how the national figure has changed between 1998–99 and 2005–06. Much like all public hospital admissions shown earlier in Figure 2.4, public patient admissions dropped to a low in 2000–01 and have climbed steadily since, with 2005–06 being the first year this measure has exceeded the 1998–99 figure.

FIGURE 2.5 PUBLIC PATIENT ADMISSIONS—number per 1,000 weighted population, Australia, 1998–99 to 2005–06

Note: The data definition of *public patient* for years before 2000–01 varies slightly from that used in later years.

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Why are people admitted to public hospitals?

People are admitted to public acute hospitals (apart from psychiatric hospitals) for one of five major reasons—acute medical care, acute medical procedures, surgery, maternity, or non-acute services. In 2005–06, about 70 per cent of public hospital expenditure was spent on admitted patient care.

Acute medical care includes patients admitted to hospital with a severe condition, such as kidney failure, a heart attack or cancer, which does not require immediate surgery. These patients are often treated with drugs or other care under specialist medical guidance. Around 65 per cent of patients admitted to public hospitals in 2005–06 received acute medical care.

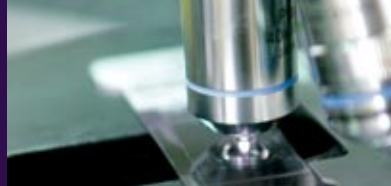
Acute medical procedures are typically undertaken with specialised equipment, usually do not require a general anaesthetic, and often require the patient to be in hospital for less than a day. Around 6 per cent of admissions in 2005–06 were for these kinds of procedures.

Patients requiring surgery accounted for almost 18 per cent of admissions during the same period.

Maternity services made up 8 per cent of admissions in 2005–06. Only mothers and unwell babies are included in the number of admissions for maternity services. Overall there were about 210,000 babies born in public hospitals in 2005–06. Most babies were not admitted and went home with their mothers.

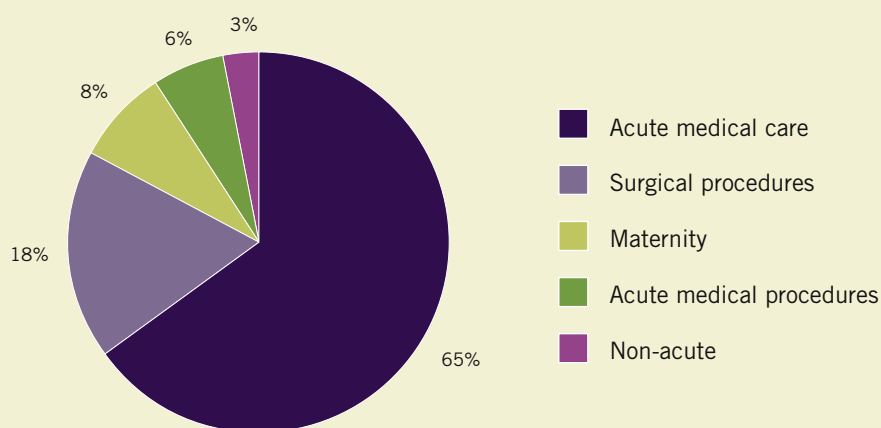
Non-acute services include rehabilitation (1.5 per cent), palliative care (0.5 per cent), geriatric evaluation management (0.3 per cent), psychogeriatric care (0.1 per cent) and maintenance care (0.4 per cent). In total, these types of non-acute care were just under 3 per cent of all public hospital admissions.

Between 1998–99 and 2005–06, admissions to public hospitals increased by nearly 16 per cent (606,000). Between 2004–05 and 2005–06, admissions increased by over 4.4 per cent (190,000 admissions). The increase is mainly accounted for by an increase in acute medical care admissions. These have increased by 23 per cent since 1998–99 and 7 per cent since 2004–05.



Since 1998–99, there has been a small increase in surgical procedures (1 per cent, 6,500 admissions) and a decrease in medical procedures (6 per cent, 19,000 admissions). Non-acute admissions increased by 5 per cent (6,200 admissions).

FIGURE 2.6 PUBLIC HOSPITAL ADMISSIONS—proportion of patients admitted in different categories, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

How long do patients stay in public hospitals?

Many patients in public hospitals, as well as private hospitals, are admitted and discharged on the same day. This may be for short duration procedures such as renal dialysis or colonoscopy. Most surgical lens procedures for cataract treatment can also be a same day admission.

TABLE 2.5 PUBLIC HOSPITAL ADMISSIONS—percentage which are same day, states and territories, 2005–06 (1998–99)

Rank		2005–06	1998–99	
1	Northern Territory	60	50	1
2	Victoria	56	48	3
3	Australian Capital Territory	55	50	1
4	Western Australia	51	45	5
5	Queensland	49	45	5
5	Tasmania	49	45	5
5	South Australia	49	48	3
8	New South Wales	44	41	8
	Australia	50	45	

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Nationally, half of all public hospital admissions were same day. Every state and territory had an increased proportion of same day admissions since 1998–99. New South Wales had the highest proportion of overnight admissions (56 per cent) in 2005–06.

In 2005–06, the average length of stay for all public hospital admissions was 3.7 days, but this includes all same day admissions. A more meaningful statistic is the average length of stay for those patients who stayed at least one night in hospital.

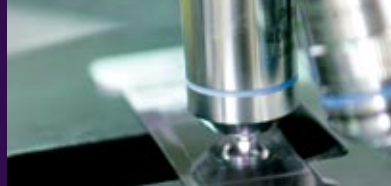
Rank		2005–06	1998–99	
1	Northern Territory	5.8	6.0	1
2	Queensland	6.2	7.0	6
3	Australian Capital Territory	6.3	6.4	2
4	Western Australia	6.4	6.4	2
5	Victoria	6.5	6.5	4
6	New South Wales	6.7	7.1	7
7	South Australia	7.2	6.6	5
8	Tasmania	7.3	8.2	8
Australia		6.6	6.8	

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Nationally, the average length of stay for patients who stayed overnight in hospital is 6.6 days, less than it was in 1998–99. In 2005–06, Tasmania had the longest average length of stay at 7.3 days. It also had the longest average length of stay in 1998–99. These calculations include length of stay for patients in psychiatric hospitals, which can average nearly 50 days. Previous editions of this report have excluded patients in psychiatric hospitals from this calculation. If this is done with 2005–06 data, the average length of stay (for acute care hospitals only) is 6.3 days.

Rank		%	Change since 2004–05
1	Victoria	3.04	↓0.08
2	South Australia	1.50	↓0.19
3	Australian Capital Territory	1.23	↓0.01
4	Northern Territory	0.56	↑0.23
5	Western Australia	0.31	↑0.20
6	Queensland	0.14	↓0.02
-	Tasmania	-	-
-	New South Wales	-	-
Australia		1.07	↓0.03

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.



Some hospitals provide care in a patient's home. Patients may choose this option if it is clinically appropriate and if there is adequate support at home. These patients are counted as admitted patients under the care of the treating hospital's doctors. Treatments for a wide range of conditions can be provided, the most common being intravenous antibiotic treatments and chemotherapy.

Only a small proportion of hospital admissions across Australia (just one per cent or 48,000) are hospital-in-the-home admissions. Victoria had the highest proportion of hospital-in-the-home admissions in 2005–06. New South Wales and Tasmania did not report hospital-in-the-home admissions.



THE FIVE MEDICAL AND OBSTETRIC CONDITIONS RESULTING IN THE HIGHEST NUMBER OF DAYS THAT PATIENTS SPENT IN HOSPITAL IN 2005–06 WERE:

- cardiology and interventional cardiology (317,707 admissions resulting in 1,024,527 days)
- respiratory problems (206,933 admissions resulting in 991,808 days)
- obstetrics (307,351 admissions resulting in 875,863 days)
- renal dialysis (725,927 admissions resulting in 726,212 days)
- neurology (143,243 admissions resulting in 612,670 days).

OVER THE SAME PERIOD, THE FOLLOWING AREAS OF SURGERY RECORDED THE HIGHEST NUMBER OF PATIENT DAYS:

- orthopaedics (253,429 admissions resulting in 1,029,840 days)
- neurosurgery (70,417 admissions resulting in 427,578 days)
- vascular surgery (40,122 admissions resulting in 302,658 days)
- upper gastrointestinal surgery (62,376 admissions resulting in 271,539 days)
- urology (119,431 admissions resulting in 262,782 days).

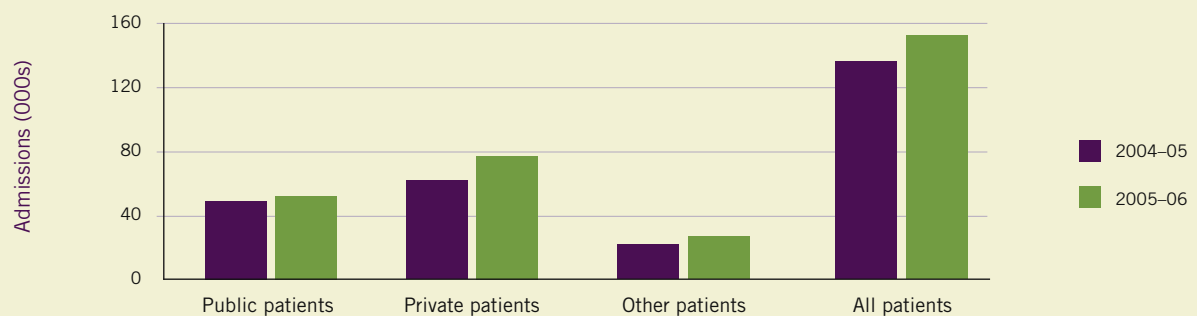
A focus on rehabilitation in hospital

Some patients are admitted to hospital to receive acute care, have a straightforward recovery period and can be discharged to return to their normal life relatively quickly. However, there are other patients who will need a period of rehabilitation before they can be discharged.

In 2005–06, there were over 153,000 admissions for rehabilitation and nearly 45 per cent of these were in public hospitals. This figure includes about 2,000 acute care admissions for rehabilitation, which may have involved rehabilitation following serious spinal or brain injuries. Most admissions were non-acute (around 151,000 admissions). Non-acute rehabilitation is most commonly needed by patients recovering from orthopaedic injuries (broken bones), but may also be needed after a stroke, a cardiac problem or other injuries. An episode of rehabilitation may immediately follow an episode of acute care, but is counted as a separate admission because of the change in the type of care the patient receives.

The number of rehabilitation admissions in all hospitals increased by nearly 17,000 from 2004–05, most of this increase being private patient admissions. A substantial proportion (11 per cent) of rehabilitation admissions are funded by the Department of Veterans' Affairs (incorporated in the *Other patients* category).

FIGURE 2.7 REHABILITATION—number of admissions, by patient type, all hospitals, Australia, 2004–05 to 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Around 21 per cent of rehabilitation admissions to all hospitals are same day only. Overnight stays for rehabilitation involve an average of 21.4 days, which is much longer than the average length of stay for all types of overnight admissions to public hospitals (6.6 days) or private hospitals (5.4 days).

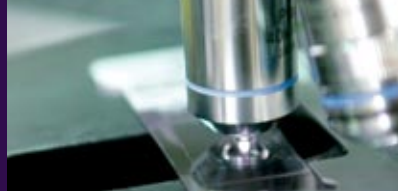
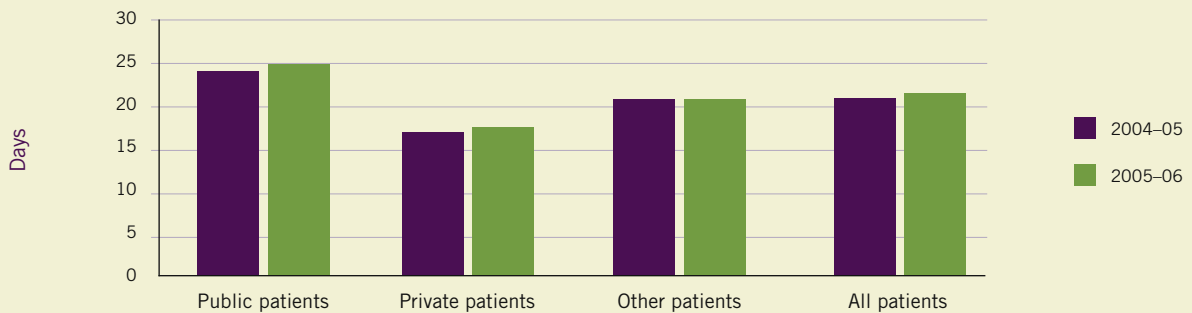


FIGURE 2.8 REHABILITATION—average length of stay, all hospitals, Australia, 2004–05 to 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

The need for rehabilitation generally increases for older patients, largely independent of the reason they were admitted to hospital. In 2005–06, over two-thirds of rehabilitation admissions involved patients over 65 years of age. Although over 50,000 rehabilitation admissions involved people aged between 0 and 64 years of age in 2005–06, this is less than three admissions per 1,000 people of those ages. In comparison, there were more than 71 admissions per 1,000 people aged 85 years or over.

The long length of stay associated with patients under 65 years of age is because of a small number of patients of younger ages receiving rehabilitation following a spinal or brain injury. These cases are associated with a very long stay in hospital.



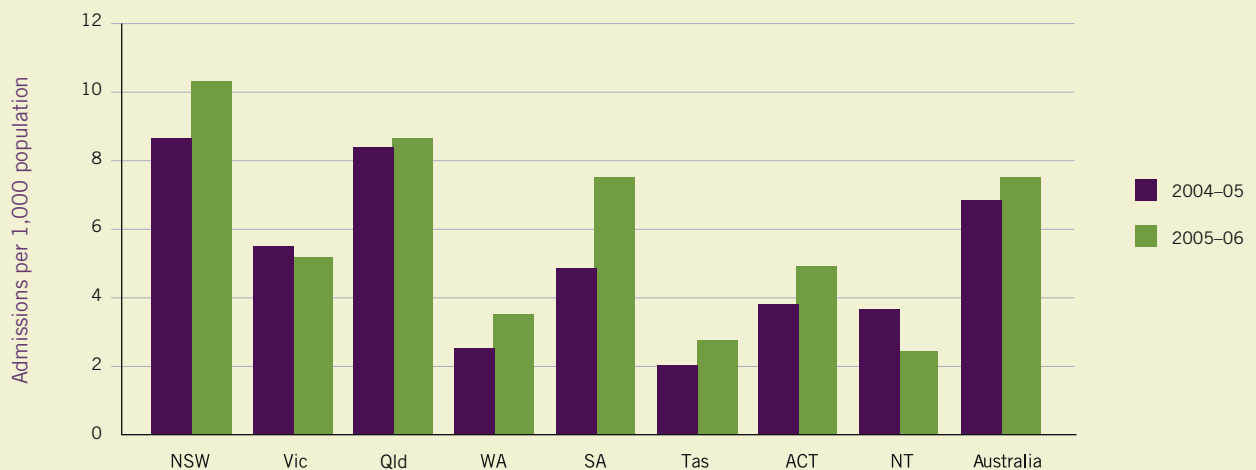
TABLE 2.8 REHABILITATION—admissions, average length of stay and admissions per 1,000 population by age group, all hospitals, Australia, 2005–06

Age group	Admissions	Average length of stay (days)	Admissions per 1,000 population	
			Change since 2004–05	
0–64 years	50,166	29.1	2.8	↑0.4
65–74 years	31,832	18.7	22.6	↑2.9
75–84 years	48,322	18.9	50.3	↑2.1
85 years and over	23,371	20.1	71.4	↑3.1
Total	153,691	21.4	7.5	↑0.7

Note: These figures are derived using unweighted population estimates.

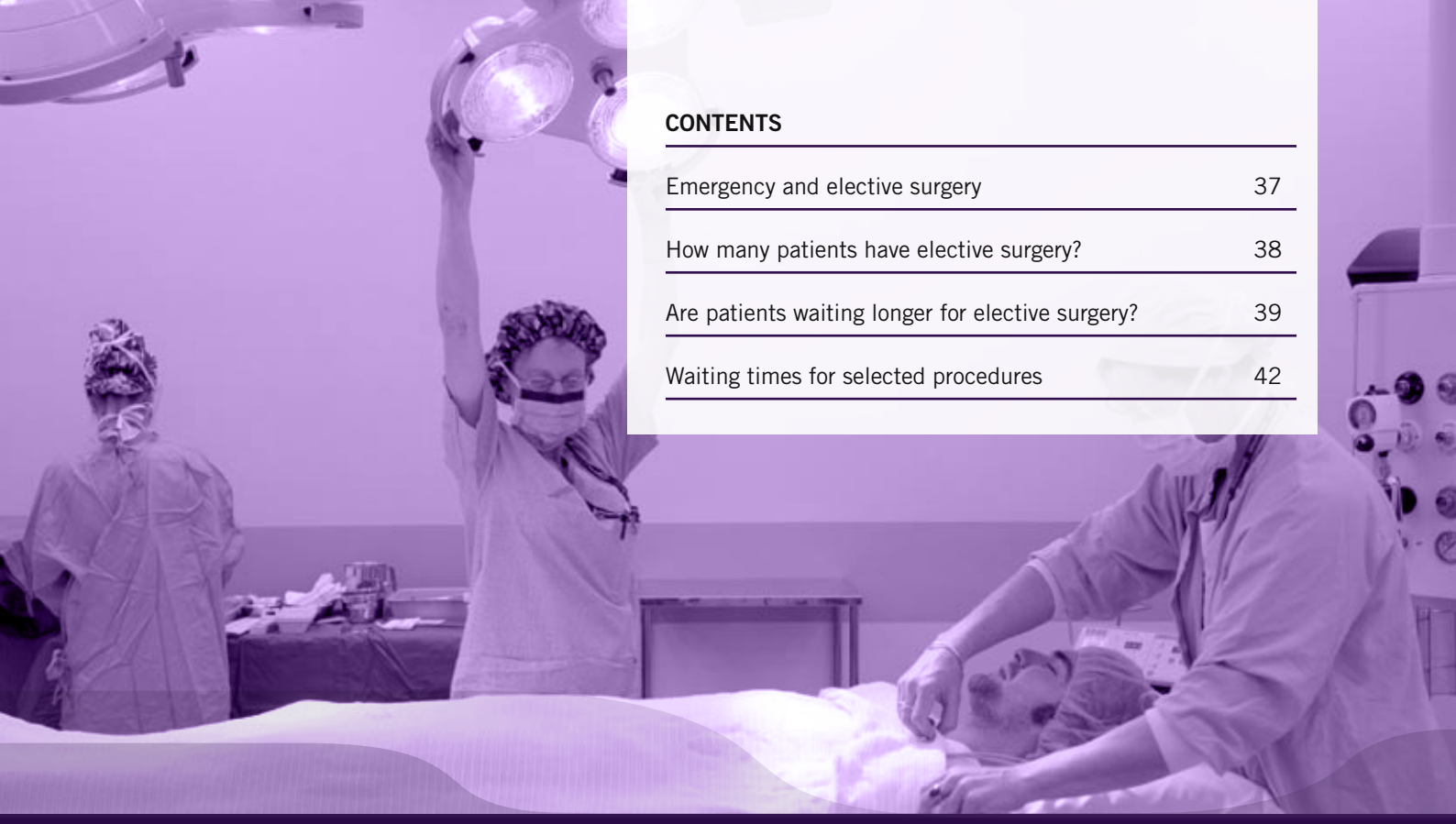
Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Under the 2003–08 *Australian Health Care Agreements*, all states and territories agreed to report on a range of step-down care performance indicators commencing in 2004–05. The rate of admission for rehabilitation in each state and territory is shown below. In 2005–06, New South Wales had the highest rate of admissions for rehabilitation and the Northern Territory had the lowest. The rate of admission for rehabilitation has increased nationally since 2004–05, though the rate declined slightly in Victoria and the Northern Territory.

FIGURE 2.9 REHABILITATION—admissions per 1,000 population, all hospitals, states and territories, 2004–05 and 2005–06

Note: These figures are derived using unweighted population estimates.

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.



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PART 3

SURGERY IN PUBLIC HOSPITALS

» **AT A GLANCE IN 2005–06**

Of the more than 2 million admissions for surgery in all hospitals, about 883,000 (44 per cent) were in public hospitals.

Twenty-three per cent of public hospital surgical admissions were emergency cases, needing to be undertaken within 24 hours.

More than 556,000 public patients were admitted from waiting lists for elective surgery, slightly more than in 2004–05.

Eighty-one per cent of elective surgery patients were seen within the recommended time for their procedure.

The median waiting time for all elective surgery procedures was 32 days.

Waiting times for some elective surgery procedures continued to exceed one year.



Emergency and elective surgery

In 2005–06, there were over 2 million admissions for surgical procedures in Australian hospitals with 44 per cent of these occurring in public hospitals (over 883,000 admissions).

About 71 per cent of public hospital surgical admissions were for elective surgery, meaning surgery that can be delayed for at least 24 hours. Public patient access to elective surgery is managed through waiting lists. These waiting lists are managed with the aim of ensuring patients are seen within a recommended time appropriate to the urgency of their condition.

Public hospitals also face the challenge of managing emergency surgery, which is surgery required to be performed within 24 hours to preserve life or body integrity. Around 207,000 or 23 per cent of public hospital surgical admissions in 2005–06 were for emergency procedures of this nature. The remaining 6 per cent of public hospital surgery is not categorised as emergency or elective, for example caesarean procedures.

Emergency surgery is performed when the patient's life or physical integrity is in direct jeopardy. Usually performed by surgeons specialising in emergency medicine, this surgery can be for many reasons but occurs most often in urgent or critical cases in response to trauma, cardiac events, poison episodes, brain injuries, and paediatric medicine.

Elective surgery is performed after a diagnosis based on a history of physical assessment of the patient and a range of laboratory test results. With emergency surgery, the surgeon may have less information about the patient than would ordinarily be required. The surgeon and theatre staff must work under very time-dependent conditions to save a patient's life and alleviate the condition they are treating.

Acute surgical emergencies include:

- invasive resuscitation for acute respiratory failure, including pulmonary embolism and pulmonary obstructions
- blunt and penetrating head, chest, abdomen injuries, mostly from automotive accidents
- severe burns
- cardiac events, including acute myocardial infarction
- cerebrovascular injuries, including severe stroke.

Much elective surgery is still urgent (such as coronary bypasses or gall bladder removals), or otherwise crucial to a person's wellbeing (such as total hip replacements or cataract extractions). Public hospitals generally provide elective surgery on the same day that a patient is admitted from a waiting list.

How many patients have elective surgery?

There were over 556,000 public patients admitted from elective surgery waiting lists in 2005–06.

This is more admissions than in 2004–05 (549,000) and continues a rising trend in recent years. The number of admissions in 2005–06 remained lower than in 1998–99 (565,000) which is prior to a range of private health insurance reforms introduced from 1999–2000 and an increase in private hospital use since those reforms.

Nationally, the number of elective surgery admissions per 1,000 weighted population was lower in 2005–06 than in 1998–99. However, the rate was higher in Tasmania and Western Australia and remained the same in the Australian Capital Territory.

As in 1998–99, the Northern Territory had the highest number of elective surgery admissions per 1,000 weighted population in 2005–06. South Australia had the lowest number. These figures must be interpreted with caution because not all public hospitals that perform elective surgery in Victoria, Queensland, Western Australia and South Australia provide data on elective surgery waiting times.

TABLE 3.1 ELECTIVE SURGERY—number of admissions per 1,000 weighted population, states and territories, 2005–06 (1998–99)

	2005–06	1998–99
New South Wales	28	35
Victoria	25	26
Queensland	26	35
Western Australia	24	23
South Australia	21	23
Tasmania	28	26
Australian Capital Territory	30	30
Northern Territory	36	41
Australia	26	30

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.





Are patients waiting longer for elective surgery?

Public patients requiring elective surgery are assigned to one of three categories of urgency.

CATEGORY 1

Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.

CATEGORY 2

Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly, or become an emergency.

CATEGORY 3

Admission at some time in the future for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly, and which does not have the potential to become an emergency. For the purposes of the *Australian Health Care Agreements*, Category 3 is reported on the basis that admission is desirable within 12 months.



Nationally, 34 per cent of public patient admissions for elective surgery were assigned to Category 1; 37 per cent to Category 2; and 29 per cent to Category 3 in 2005–06.

The states and territories had different proportions of admissions in each category. In New South Wales, Tasmania and the Northern Territory, the greatest proportion required admission within 30 days (Category 1). In Victoria, Queensland and the Australian Capital Territory, the greatest proportion required admission within 90 days (Category 2). In Western Australia and South Australia, the greatest proportion was in the least-urgent category (Category 3), with admission desirable within 12 months.

The capacity of hospitals in each state and territory to provide elective surgery to patients within the recommended time for each category is an important performance measure.

TABLE 3.2 ELECTIVE SURGERY—percentage of admissions in each category, states and territories, 2005–06

	Category 1	Category 2	Category 3
New South Wales	40	30	30
Victoria	22	47	31
Queensland	36	45	19
Western Australia	35	27	38
South Australia	34	27	39
Tasmania	44	34	22
Australian Capital Territory	30	46	24
Northern Territory	49	33	18
Australia	34	37	29

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Nationally, in 2005–06, 83 per cent of Category 1 patients were admitted within 30 days, 74 per cent of Category 2 patients within 90 days and 88 per cent of Category 3 patients within one year.

TABLE 3.3 ELECTIVE SURGERY—percentage of admissions seen within the recommended time, states and territories, 2005–06 (1998–99)

Rank		2005–06	1998–99	
1	Queensland	86	92	2
2	Victoria	84	91	3
3	South Australia	82	94	1
3	Western Australia	82	84	6
5	New South Wales	78	90	4
6	Northern Territory	73	90	4
7	Australian Capital Territory	70	73	8
8	Tasmania	68	75	7
	Australia	81	90	

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Nationally, 81 per cent of elective surgery admissions in all categories were seen within the recommended time in 2005–06. Queensland recorded the highest percentage (86 per cent) and Tasmania (68 per cent) recorded the lowest.

Overall national performance has decreased steadily from 1998–99 when 90 per cent of patients were admitted within the recommended time for their elective surgery category. The decrease in performance from 1998–99 has occurred in each state and territory, but most dramatically in the Northern Territory, New South Wales, and South Australia. The decrease was minor in Western Australia and in the Australian Capital Territory.



FIGURE 3.1 Elective surgery Category 1 patients admitted to public hospitals within the clinically appropriate time, state and territories, 2005–06

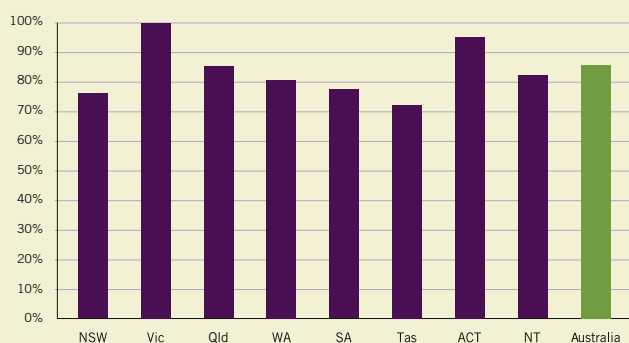


FIGURE 3.2 Elective surgery Category 2 patients admitted to public hospitals within the clinically appropriate time, state and territories, 2005–06

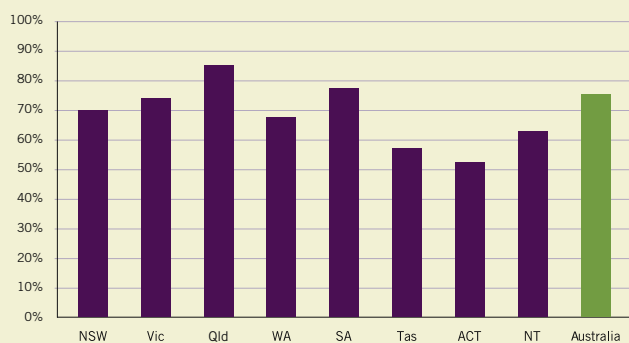
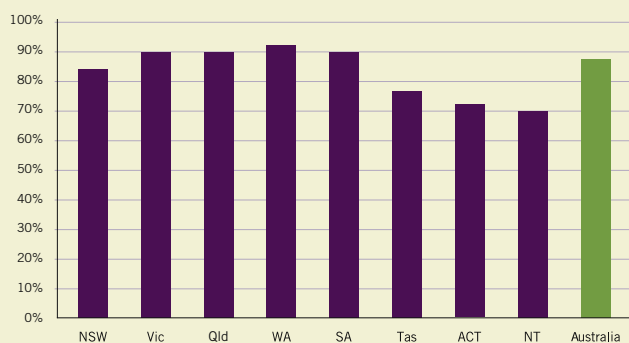


FIGURE 3.3 Elective surgery Category 3 patients admitted to public hospitals within the clinically appropriate time, state and territories, 2005–06



All states and territories, except New South Wales, South Australia and Tasmania, admitted more than 80 per cent of Category 1 patients for elective surgery within 30 days. The best performer was Victoria (100 per cent) – although it had the smallest proportion of patients in this category. Compared with the previous year, Victoria and Tasmania maintained their level of performance. The Australian Capital Territory has improved and other states and territories have dropped their level of performance. The percentage of patients seen within the recommended time in Category 1 in the Australian Capital Territory improved from 91 per cent in 2004–05 to 96 per cent in 2005–06.

Most states and territories admitted between 61 and 77 per cent of Category 2 patients within 90 days. Queensland, which had 45 per cent of its admissions in this category, admitted more than 80 per cent within the recommended time. The Australian Capital Territory was the worst performer, admitting only 52 per cent within the recommended time, although this is an increase in performance compared with the previous year (44 per cent).

Western Australia admitted more than 90 per cent of Category 3 patients within 12 months. The Northern Territory was the worst performer, admitting only 70 per cent within the 12 months.

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Waiting times for selected procedures

Waiting times for different procedures vary. Although elective surgery procedures considered urgent are dealt with quickly in public hospitals, less urgent procedures may be preceded by very long waits. Waiting times also vary widely across the states and territories. To evaluate state and territory performance on selected procedures, this report uses median waiting times (the time taken for 50 per cent of patients to be seen).

TABLE 3.4 ELECTIVE SURGERY—median waiting time (days), all procedures, states and territories, 2005–06 (2000–01)

Rank		2005–06	Change since 2004–05	2000–01	
1	Queensland	25	↑3	22	1
2	Western Australia	28	↑1	27	3
3	Northern Territory	30	↑1	25	2
4	Victoria	32	↑4	28	4
5	Tasmania	34	0	37	7
6	New South Wales	36	↑2	28	4
7	South Australia	38	↑3	34	6
8	Australian Capital Territory	61	↑16	44	8
Australia		32	↑3	27	

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Nationally, the median waiting time for public elective surgery patients was 32 days, 5 days longer than in 2000–01. The median waiting time in 2005–06 varied across the states and territories from a low of 25 days in Queensland to a high of 61 days in the Australian Capital Territory. In the Australian Capital Territory, the median waiting time rose by 17 days overall since 2000–01, with a rise of 16 days since 2004–05.

In 2005–06, some patients were admitted for elective surgery after waiting for more than a year. For example, of the fifteen selected surgical procedures reported on, 20 per cent or more of admissions for septoplasty (a surgical procedure to correct the septum, the separation between the nostrils), total knee replacement and varicose vein procedures waited more than a year.

TABLE 3.5 ELECTIVE SURGERY—number and percentage of admissions that waited longer than one year, states and territories, 2005–06

Procedure		NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia
Cataract extraction	Per cent	10.5	0.8	4.2	5.9	4.5	50.8	22.7	21.6	7.5
	Number	2,121	90	239	230	102	361	242	80	3,465
Total hip replacement	Per cent	16.0	13.0	3.3	9.2	14.9	32.2	16.8	8.3	13.3
	Number	461	241	39	51	78	93	32	2	997
Total knee replacement	Per cent	29.1	18.6	6.4	20.0	26.0	41.0	29.6	22.2	23.1
	Number	1,507	368	108	136	171	110	87	4	2,491
Myringoplasty	Per cent	26.7	9.4	10.2	10.4	10.0	38.9	61.1	45.7	16.3
	Number	137	39	39	17	23	7	11	16	289
Septoplasty	Per cent	32.9	14.7	19.0	16.2	20.1	43.8	41.8	19.4	22.4
	Number	497	266	92	32	38	7	23	7	962
Other	Per cent	3.6	4.3	1.8	3.7	3.5	5.3	7.2	6.4	3.5
	Number	6,132	4,985	1,746	1,627	1,107	734	537	332	17,200
Total	Per cent	5.4	4.5	2.1	4.3	4.2	8.7	10.3	7.7	4.6
	Number	10,855	5,989	2,263	2,093	1,519	1,312	932	441	25,404

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.



FIGURE 3.4 Median waiting times (days) for cholecystectomy, states and territories, 2005–06

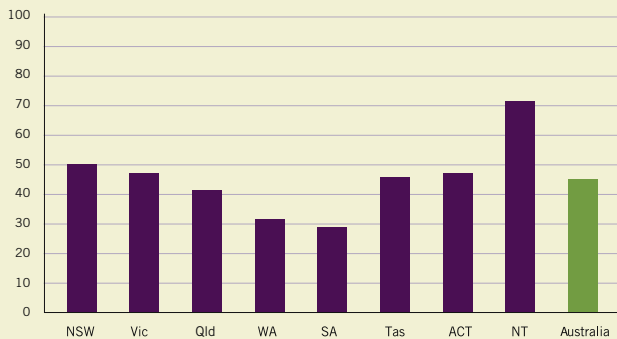


FIGURE 3.5 Median waiting times (days) for myringotomy, states and territories, 2005–06

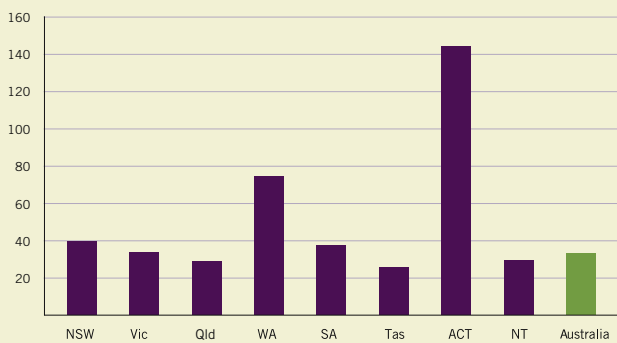
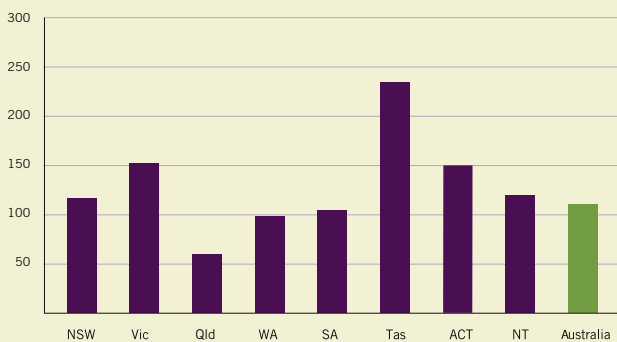


FIGURE 3.6 Median waiting times (days) for total hip replacement, states and territories, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

The longest median waiting time experienced by patients in the Australian Capital Territory. Of 18 patients in the ACT with a median waiting time of 631 days for myringoplasty (surgical repair of a perforated eardrum with a tissue graft), two patients waited for 1,000 days. Across Australia, 16 per cent of admissions for myringoplasty (289 cases) were preceded by waits longer than one year.

Nationally, the surgical procedure with the largest proportion of admissions (23 per cent) waiting more than a year was a total knee replacement. More than 60 per cent of those people were waiting for admission to a New South Wales hospital.

Although only 8 per cent of people waiting for a cataract procedure were waiting longer than a year, this was nearly 3,500 people. More than 60 per cent were waiting for admission to a New South Wales hospital. Tasmanian patients had a median waiting time for cataract procedures of over one year (389 days).

The median waiting time for cholecystectomy (removal of the gall bladder) varied from 29 days in South Australia to 71 days in the Northern Territory.

A myringotomy procedure is a tiny incision in the eardrum to drain fluid often combined with the insertion of a small plastic ear tube (a tympanostomy tube). The Australian Capital Territory stood out as having a substantially higher median waiting time (144 days) for this procedure. Tasmania had the lowest median waiting time (23 days).

For total hip replacements, Tasmania stood out with a substantially higher median waiting time (238 days). Queensland achieved the lowest waiting time (61 days).



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PART 4

THE 'OUTS' OF PUBLIC HOSPITALS

» AT A GLANCE IN 2005–06

There were nearly 4.8 million emergency presentations to emergency departments in larger hospitals, an increase of approximately 420,000 since 2004–05.

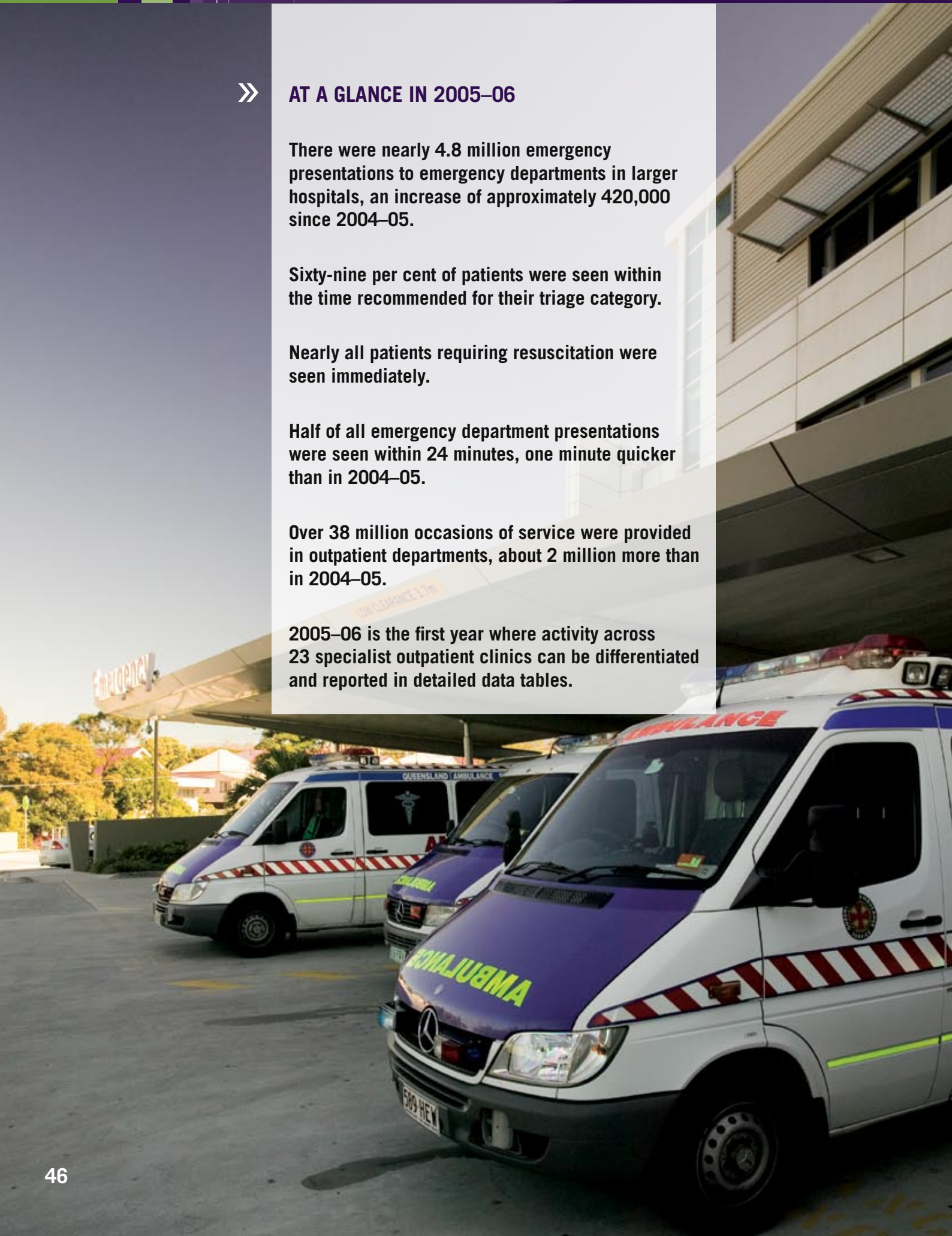
Sixty-nine per cent of patients were seen within the time recommended for their triage category.

Nearly all patients requiring resuscitation were seen immediately.

Half of all emergency department presentations were seen within 24 minutes, one minute quicker than in 2004–05.

Over 38 million occasions of service were provided in outpatient departments, about 2 million more than in 2004–05.

2005–06 is the first year where activity across 23 specialist outpatient clinics can be differentiated and reported in detailed data tables.





Emergency departments

A new national data collection for emergency departments in public hospitals was introduced in 2003–04. Data are primarily supplied by larger hospitals only, although some states and territories are beginning to provide data from smaller hospitals in their jurisdiction.

The Australian Institute of Health and Welfare estimates that the national collection captured information from 78 per cent of all emergency occasions of service in 2005–06, up from 75 per cent in 2003–04. Due to the changing nature of the data collection's coverage, the information presented for emergency departments in this report should be interpreted with caution.

When it is an emergency

Hospital emergency departments are set up to deal with medical emergencies that are life threatening or could cause serious disability. For many reasons, emergency departments also treat other needs, but the priority is to handle urgent medical needs. Patients arriving at an emergency department are assigned to one of five triage categories, as defined by the Australasian College of Emergency Medicine. For each category, the College has set a maximum time by which patients should be seen by a nurse or doctor for treatment. Under the triage system, patients assigned to a more urgent triage category are treated first.

Emergency department triage categories

Triage category 1, Resuscitation: need for patients to be seen immediately. Patients in this category are critically ill and require immediate attention. Most arrive at the emergency department by ambulance and may already be receiving emergency life support. This category includes patients whose blood pressure may be dangerously low, who have serious breathing difficulties, or who may be unresponsive following a head injury or drug overdose.

Triage category 2, Emergency: need for patients to be seen within 10 minutes. Patients in this category are probably suffering from a critical illness or very severe pain. This category includes patients who are suffering from serious chest pain likely to be related to a heart attack, who have difficulty breathing, or who have severe fractures.

Triage category 3, Urgent: need for patients to be seen within 30 minutes. Patients in this category could be suffering from severe illness, head injuries, major bleeding from cuts, major fractures, persistent vomiting, or dehydration.

Triage category 4, Semi-urgent: need for patients to be seen within 60 minutes. Patients in this category usually have less severe symptoms or injuries, although their condition may be serious. This category includes patients with mild bleeding, a foreign body in the eye, possible bone fractures, abdominal pain, migraine, or earache.

Triage category 5, Non-urgent: need for patients to be seen within 120 minutes. Patients in this category usually have minor illnesses or symptoms that may have been present for more than a week. Patients with stable chronic conditions who are experiencing minor complicating symptoms are also included.

How many patients attend emergency departments?

In 2005–06, there were more than 6.3 million accident and emergency occasions of service in all hospitals. Almost 4.8 million were presentations to emergency departments in larger hospitals for which waiting times are recorded. This excludes presentations involving pre-planned attendance for routine or follow-up care.

The increase in emergency presentations partly resulted from an increased number of hospitals reporting, but nonetheless incorporates a real increase in use of emergency departments in 2005–06.

TABLE 4.1 EMERGENCY DEPARTMENTS—number of presentations, states and territories, 2005–06

	2005–06 (000s)	Change since 2004–05 (000s)
New South Wales	1,672	↑201
Victoria	1,200	↑90
Queensland	816	↑34
Western Australia	420	↑44
South Australia	329	↑24
Tasmania	110	↑12
Australian Capital Territory	99	↑9
Northern Territory	111	↑6
Australia	4,757	↑420

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Nationally, there were 223 presentations to emergency departments per 1,000 weighted population in 2005–06, a large increase over the figure of 208 recorded in 2004–05. The Northern Territory stood out with the highest number. In the Northern Territory there are relatively fewer general practitioners and a greater reliance on public hospitals for all aspects of health care. The Australian Capital Territory had the next highest rate of emergency department presentations and South Australia the lowest.

TABLE 4.2 EMERGENCY DEPARTMENTS—number of presentations per 1,000 weighted population, states and territories, 2005–06

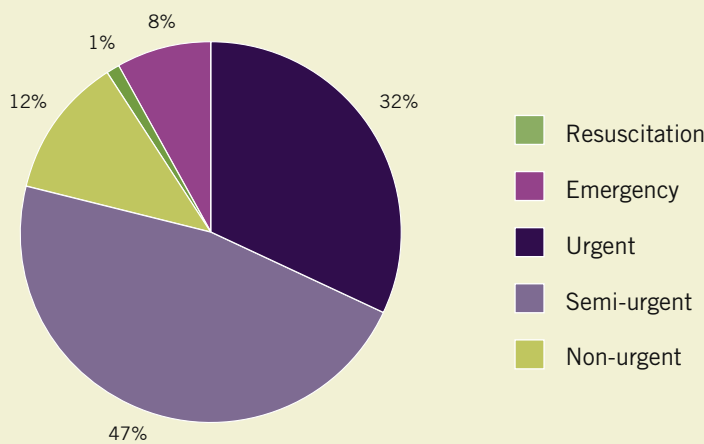
	2005–06	Change since 2004–05
New South Wales	232	↑24
Victoria	225	↑12
Queensland	202	↑3
Western Australia	208	↑17
South Australia	192	↑12
Tasmania	208	↑20
Australian Capital Territory	322	↑21
Northern Territory	705	↑21
Australia	223	↑15

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.



Nationally, only a small proportion of all presentations were in the two highest triage categories: 1 per cent in category 1, Resuscitation, and 8 per cent in category 2, Emergency. Most were in triage categories 3, Urgent (32 per cent), or 4, Semi-urgent (47 per cent). Only 12 per cent of attendances were in category 5, Non-urgent. There has been little change in these proportions since 2003–04 when the national emergency department data collection was established.

FIGURE 4.1 EMERGENCY DEPARTMENTS—presentations, by triage category, Australia, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

How long do patients wait to be seen?

Nationally, 69 per cent of patients were seen within the time recommended for their triage category in 2005–06. Victoria performed the best with 77 per cent of patients seen within the recommended time. The Australian Capital Territory, at 52 per cent, was the poorest performer.

TABLE 4.3 EMERGENCY DEPARTMENTS—percentage of people seen within the recommended time, states and territories, 2005–06

Rank		%	Change since 2004–05
1	Victoria	77	↓2
2	Western Australia	71	↑1
3	New South Wales	69	↑1
4	South Australia	62	↓1
4	Tasmania	62	↓6
6	Queensland	60	↑1
6	Northern Territory	60	↓2
8	Australian Capital Territory	52	↓6
Australia		69	0

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Nationally, half of emergency department presentations were seen within 24 minutes. The average time varied among the states and territories, ranging from 19 minutes in Victoria to 46 minutes in the Australian Capital Territory.

TABLE 4.4 EMERGENCY DEPARTMENTS—median waiting times for all patients, states and territories, 2005–06

Rank		Minutes	Change since 2004–05
1	Victoria	19	↑3
2	Western Australia	20	↓4
3	New South Wales	25	↓1
4	South Australia	27	0
5	Tasmania	28	↑4
6	Queensland	31	↓2
7	Northern Territory	35	↑2
8	Australian Capital Territory	46	↑6
	Australia	24	↓1

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.





FIGURE 4.2 Proportion of Category 1 (Resuscitation) emergency patients seen within recommended time (immediately), by state and territory, 2005–06

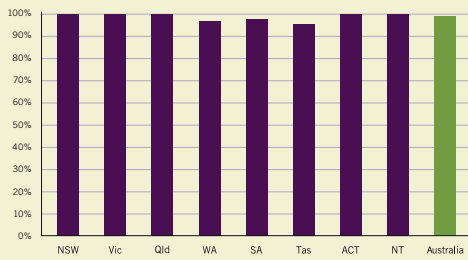


FIGURE 4.3 Proportion of Category 2 (Emergency) emergency patients seen within recommended time (10 minutes), by state and territory, 2005–06

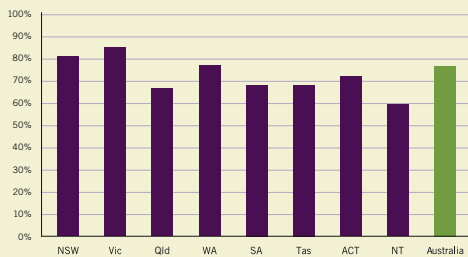


FIGURE 4.4 Proportion of Category 3 (Urgent) emergency patients seen within recommended time (30 minutes), by state and territory, 2005–06

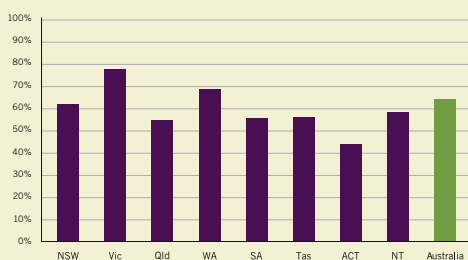


FIGURE 4.5 Proportion of Category 4 (Semi-urgent) emergency patients seen within recommended time (1 hour), by state and territory, 2005–06

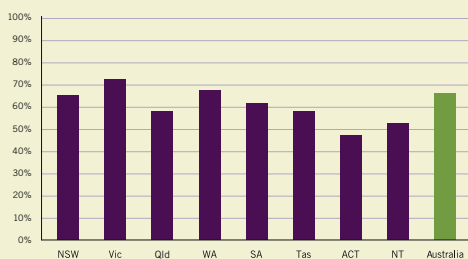
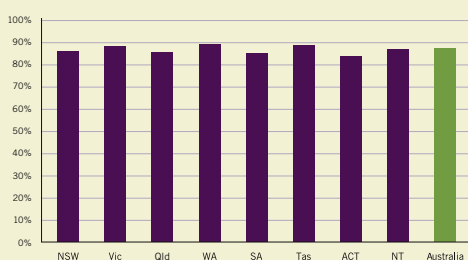


FIGURE 4.6 Proportion of Category 5 (Non-urgent) emergency patients seen within recommended time (2 hours), by state and territory, 2005–06



Nationally, 99.5 per cent of patients in triage category 1, Resuscitation, were seen immediately in 2005–06. There was little variation among the states and territories in this regard.

Tasmania had the lowest percentage of patients (95 per cent) seen within the recommended time (immediately).

Nationally, 77 per cent of patients in triage category 2, Emergency, were seen within the recommended time of ten minutes. Performance varied across the country, with Victoria performing best and the Northern Territory performing poorest. New South Wales, the Australian Capital Territory and Western Australia improved on their performance since 2004–05, but all other states showed some decline.

Nationally, 64 per cent of patients in triage category 3, Urgent, were seen within the recommended time of 30 minutes. New South Wales, Western Australia and Queensland improved on their performance since 2004–05. The Australian Capital Territory continued to be the worst performer, dropping further from 50 per cent in 2004–05 to 44 per cent in 2005–06. Tasmania also showed a significant decline from 67 per cent to 57 per cent over this period.

Nationally, 65 per cent of patients in triage category 4, Semi-urgent, were seen within the recommended time of one hour. New South Wales, Queensland and Western Australia all improved slightly since 2004–05. The Australian Capital Territory also continued to be the worst performer in this category, dropping from 52 per cent in 2004–05 to 47 per cent in 2005–06.



Nationally, 87 per cent of patients in triage category 5, Non-urgent, were seen within the recommended time of two hours in 2005–06, with little variation among the states and territories. The Australian Capital Territory remained the worst performer at 84 per cent, but this figure improved from 83 per cent in 2004–05.

Where do patients go after the emergency department?

TABLE 4.5 EMERGENCY DEPARTMENTS—percentage by departure status, states and territories, 2005–06

	Admitted or referred	Not admitted	Did not wait or left at own risk	Not reported
New South Wales	31	62	7	0
Victoria	33	62	5	0
Queensland	23	68	9	0
Western Australia	26	71	3	0
South Australia	32	63	4	1
Tasmania	27	66	7	0
Australian Capital Territory	26	66	8	0
Northern Territory	25	66	9	0
Australia	29	65	6	0

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Around two-thirds of patients treated in the emergency departments either did not need further treatment or only required follow-up care provided by outpatient services, general practitioners or other health professionals. Less than one-third were admitted to the same or another hospital. Victoria admitted the highest proportion of emergency department patients, while Queensland admitted the lowest.

A small proportion (6 per cent) did not wait for treatment. A smaller proportion (slightly over 0.1 per cent) were reported as dead on arrival or died in the emergency department. However, this statistic may not be completely reliable because New South Wales has reported no deaths in this data collection in any year since 2003–04.



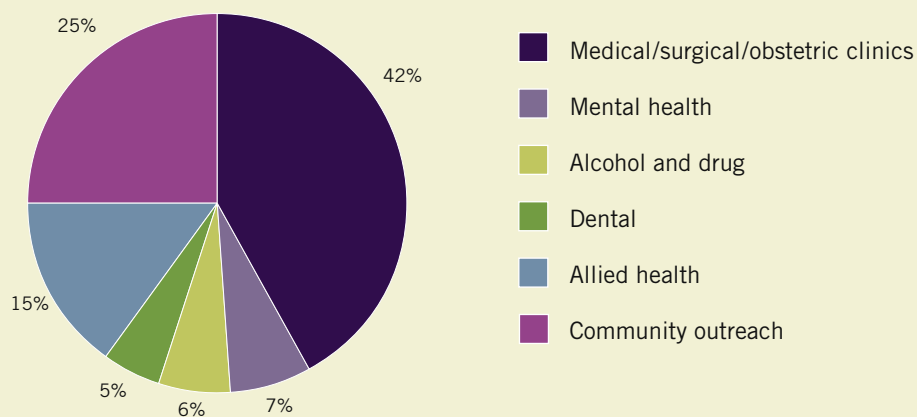
An inside view on outpatient services

Outpatient services are provided by public hospitals either at the hospital, in clinics at another site, or in community settings. Outpatients do not need to stay in hospital overnight and are usually not admitted to hospital.

Public hospitals provide a wide range of outpatient services, including those that focus on:

- the medical management of chronic conditions, such as pain management, asthma, dementia and epilepsy
- pre- and post-surgery checks and follow-ups
- obstetrics (treating and caring for women during pregnancy)
- allied health services, such as occupational therapy, physiotherapy, cardiac rehabilitation, and nutritional counselling
- dental services
- mental health services
- community outreach programs—services provided away from the hospital in places such as schools, community clinics and private homes
- diagnosis, such as imaging (for example, magnetic resonance imaging or computerised tomography scans) and laboratory testing (for example, blood tests).

FIGURE 4.7 OUTPATIENT SERVICES—types, excluding diagnostic imaging and pharmacy, Australia, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

The way hospitals deliver patient care changes over time and with new medical technologies. Some treatments that previously required admission to hospital are now provided in outpatient clinics.

A wide range of health professionals work in outpatient clinics, including doctors, medical specialists, nurses, dentists, physiotherapists, speech pathologists, podiatrists, psychologists and occupational therapists. Increasingly, admitted patients are discharged from hospital with a multidisciplinary care plan to enable effective follow-up care from other health professionals, either in outpatient departments or in the community.



How many outpatient services do public hospitals provide?

Outpatient services are generally measured by counting occasions of services. Each examination, consultation, treatment or other service, counts as one occasion of service. In some cases, a set of related tests, such as those carried out on a single blood sample, also count as one occasion of service. Information provided by the states and territories does not allow determination of how many patients were seen in outpatient departments each year.

In 2005–06, there was a raw count of more than 38 million outpatient occasions of service in public hospitals, almost 2 million more than in 2004–05. However, in 2005–06, a new national outpatient care data collection commenced. This requires all states and territories to report against 23 specific types of clinical service provided to individuals and groups. Group occasions of service are commonly patient education sessions, such as pre-natal classes for expecting mothers. Detailed tables of individual and group occasions of service reported by each state and territory are provided at the end of this section.

Outpatient services are provided by large and small public hospitals. The new data collection also allows easier identification of outpatient activity in different types of public hospitals.



TABLE 4.6 OUTPATIENT SERVICES—individual and group occasions of service by hospital peer group, states and territories, 2005–06

Occasions of service	NSW (000s)	Vic (000s)	Qld (000s)	WA (000s)	SA (000s)	Tas (000s)	ACT (000s)	NT (000s)	Australia (000s)	%
For individuals										
Principal referral, women's and children's hospitals	3,763	1,754	2,004	724	754	413	162	93	9,667	84.8
Large metro and rural hospitals	656	512	266	86	147	-	40	-	1,708	15
Other hospitals	14	-	-	-	12	-	-	-	24	0.2
Total	4,433	2,266	2,270	810	913	413	202	93	11,399	100
For groups										
Principal referral, women's and children's hospitals	43	4	6	43	10	-	3	-	110	85.4
Large metro and rural hospitals	8	3	2	4	1.8	-	-	-	18	13.9
Other hospitals	1	-	-	-	0.2	-	-	-	1	0.7
Total	52	7	8	47	12	-	3	-	129	100

Note: Western Australia data represent the number of individuals who attended group sessions rather than the number of group sessions.

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Although this new data collection helps to show more about what outpatient departments do, the Australian Government is working with all states and territories to develop a data collection of the number of patients seen, what they are seen for and how long they wait to be seen.



TABLE 4.7 OUTPATIENT SERVICES—individual occasions of service by clinic types, selected hospitals, states and territories, 2005–06

Individual occasions of service	NSW (000s)	Vic (000s)	Qld (000s)	WA (000s)	SA (000s)	Tas (000s)	ACT (000s)	NT (000s)	Australia (000s)	Per cent
01 Allied health	645	772	390	288	193	90	25	11	2,414	20.8
02 Dental	336	65	138	3	11	1	-	-	555	4.9
03 Gynaecology	53	49	68	8	29	13	4	4	228	2.0
04 Obstetrics	680	275	279	39	102	47	45	15	1,481	12.9
05 Cardiology	72	37	86	24	24	13	13	2	271	2.3
06 Endocrinology	146	44	63	24	28	28	7	0.2	341	2.9
07 Oncology	209	157	153	46	24	54	29	1	673	5.8
08 Respiratory	104	18	49	12	31	4	8	0.5	227	2.0
09 Gastroenterology	17	20	26	8	15	0.8	5	-	92	0.8
10 Medical	1,180	194	332	160	170	47	17	15	2,116	19.8
11 General practice/primary care	141	-	18	0.8	-	-	-	-	159	1.4
12 Paediatric	77	14	26	4	20	15	8	4	168	1.4
13 Endoscopy	11	-	11	1	-	1	2	1	27	0.2
14 Plastic surgery	28	75	26	28	21	3	3	0.7	184	1.6
15 Urology	21	39	33	8	14	2	1	0.5	119	1.0
16 Orthopaedic	272	143	220	56	56	16	9	11	782	6.6
17 Ophthalmology	130	95	61	43	52	8	0.04	8	398	3.4
18 Ear, nose and throat	27	41	35	15	18	2	1	4	143	1.2
19 Pre-admission pre-anaesthesia	142	88	111	12	35	16	13	6	423	3.7
20 Chemotherapy	61	-	15	-	-	10	7	-	93	0.8
21 Dialysis	9	-	-	2	-	-	-	3	14	0.2
22 Surgery	63	129	120	26	66	41	4	8	456	4.0
23 Paediatric surgery	9	12	9	0.2	4	-	1	0.1	36	0.3
Total	4,433	2,266	2,270	810	913	413	202	93	11,399	100.0
Group occasions of service	NSW (000s)	Vic (000s)	Qld (000s)	WA (000s)	SA (000s)	Tas (000s)	ACT (000s)	NT (000s)	Australia (000s)	Per cent
01 Allied health	16	7	5	47	5	-	2	-	83	63.9
04 Obstetrics	4	-	2	-	2	-	0.6	-	7	5.7
10 Medical	24	-	0.4	-	2	-	0.3	-	26	20.3
Other clinic types	8	-	0.6	-	3	-	0.1	-	13	9.9
Total	52	7	8	47	12	-	3	-	129	100.0

Note: Western Australia data represent the number of individuals who attended group sessions rather than the number of group sessions.

Source: Australian Government Department of Health and Ageing, Australian Health Care Agreement data reported by the states and territories.



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PART 5

OLDER AUSTRALIANS IN HOSPITAL



AT A GLANCE IN 2005–06

Thirty-five per cent of all hospital admissions and 47 per cent of occupied bed days were for people aged 65 years and over.

Overnight patients aged 65 years and over averaged 8.6 days per hospital stay. Those aged over 85 years averaged 10.6 days.

Six per cent of all public hospital admissions for people aged 65 years and over were for non-acute care, including rehabilitation and geriatric evaluation management.

A range of services are available to assist older Australians return home after a hospital stay, including outpatient and community services, and the Transition Care Program.

In 2005–06, people aged 65 years and over represented 13.2 per cent of Australia's population. This proportion is expected to increase to 25 per cent by 2047.

This demographic change is expected to raise Australian Government expenditure on hospitals and health services by 80 per cent in real terms, up to 2.2 per cent of Australia's gross domestic product, by 2047. This forecast includes a component of ongoing investment in new health care technologies.

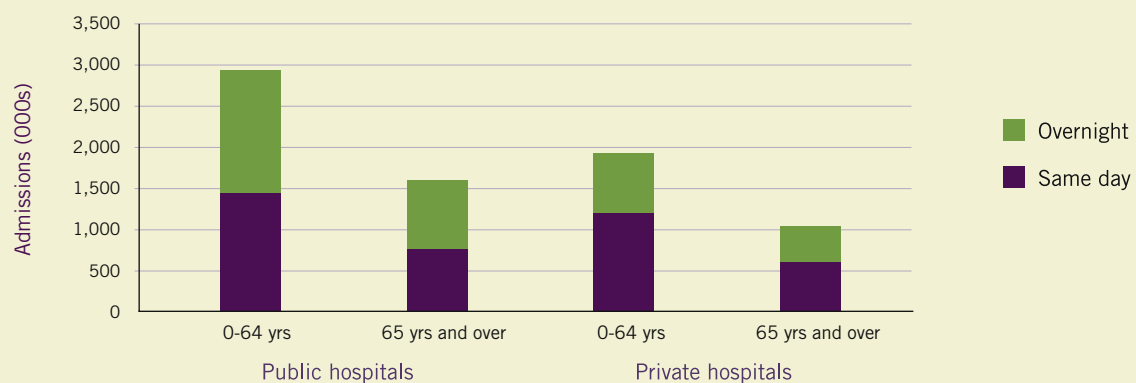


How does hospital care differ for older Australians?

Older Australians have a higher rate of admission to hospitals than the general population. They are admitted for a different mix of reasons and their stay in hospital is generally longer.

In 2005–06, admissions of Australians aged 65 years or over represented 35 per cent of all hospital admissions and 47 per cent of all occupied bed days, while comprising only 13.2 per cent of Australia’s population. The split of admissions between public and private hospitals for older Australians was about the same as that of the general population, with 61 per cent being in public hospitals.

FIGURE 5.1 ALL HOSPITALS—admissions to public and private hospitals by age group, Australia, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

The proportion of same day admissions is higher for people aged from 65 years to 74 years. For example, while 50 per cent of all public hospital admissions were same day, 59 per cent of admissions for patients aged 65 to 74 years were same day. However, the proportion of same day admissions declines in older age groups. Only 26 per cent of public hospital admissions for people over 85 years of age were same day.

People 65 years and over staying overnight in hospital had an average stay of 8.6 days, compared with an average of 6.2 days for all Australians. The average length of stay was even higher in oldest age groups, being more than 10.6 days for people aged 85 years or more.

The reasons for increasing length of stay for older people include slower recovery from treatment and a greater likelihood of carrying co-morbidities or health problems other than the one for which they were admitted.

	0-64 yrs	65-74 yrs	75-84 yrs	85 yrs and over	65 yrs and over	All ages
Private hospitals (days)	4.1	5.6	7.7	9.9	7.4	5.4
Public hospitals (days)	5.2	7.7	9.5	11.0	9.2	6.6
Total	4.8	7.0	8.8	10.6	8.6	6.2

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

The funding formula used by the Australian Government to determine annual payments to the states and territories under the *Australian Health Care Agreements* corrects for the relatively high number of hospital services provided to older people.

Why are older Australians admitted to public hospitals?

Renal dialysis, cardiology and respiratory medicine and orthopaedics are the most common reasons that older people are admitted to public hospitals. People aged over 65 years represent a particularly high proportion of patients admitted for ophthalmology, which commonly involves surgical lens procedures for cataract treatment.

TABLE 5.2 PUBLIC HOSPITALS—profile of common acute care hospital services provided for older Australians, 2005–06

	People aged 0-64 yrs	People aged 65 yrs and over	65 yrs and over (%)
Renal dialysis	375,414	350,513	48%
Cardiology	112,939	144,678	56%
Respiratory medicine	113,465	93,469	45%
Orthopaedics	175,043	78,388	31%
Gastroenterology	104,698	70,951	40%
Neurology	85,974	57,270	40%
Ophthalmology	28,273	56,581	67%
Chemotherapy	79,477	51,504	39%

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Older Australians and elective surgery

People over the age of 65 comprised 28 per cent of public hospital admissions for emergency surgery and 28 per cent for elective surgery in 2005–06. The median waiting time for all elective surgery in public hospitals was higher in the 65–84 years age groups than for the general population. This is influenced by the relatively long waits for joint replacement and cataract treatment that are commonly required by older people.

TABLE 5.3 ELECTIVE SURGERY—median waiting times and long waits, by age group, Australia, 2005–06

	0-64 yrs	65-74 yrs	75-84 yrs	85 yrs and over	All ages
Median waiting time (days)	30	35	35	28	32
Waited longer than 365 days (%)	4.1	5.2	4.7	3.2	4.6

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.



The top five types of elective surgery for older Australians in 2005–06 are shown below.

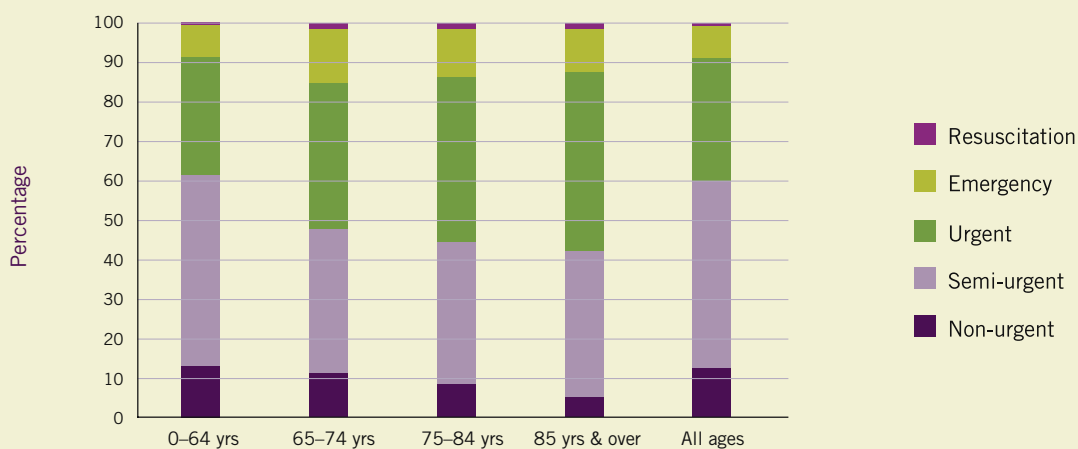
Rank	Procedure	Number
1	Lens procedures (same day)	42,067
2	Other skin, subcutaneous tissue and breast procedures	12,804
3	Knee replacement and reattachment	8,136
4	Inguinal and femoral hernia procedures	5,444
5	Transurethral procedures (without complications)	5,131

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Older Australians and emergency departments

Older Australians have a higher overall rate of presentation to emergency departments than other age groups. They also require more urgent attention than other age groups, being over 30 per cent of people in the two highest triage categories (*Resuscitation* and *Emergency*).

FIGURE 5.2 EMERGENCY DEPARTMENTS—presentations, by triage category, by age group, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

More than 50 per cent of the older people presenting to an emergency department are admitted to the same hospital, or referred to another, compared with 22 per cent of people under 65 years of age.

	Admitted or referred	Not admitted	Did not wait or left at own risk
0-64 yrs (%)	23	70	7
65-74 yrs (%)	51	46	3
75-84 yrs (%)	62	36	2
85 yrs and over (%)	67	32	1
All ages	29	65	6

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Preparing for discharge or further care

Six per cent of all public hospital admissions for people aged 65 years or more are for non-acute care, compared with only one per cent of admissions for people less than 65 years of age. Older Australians are the highest users of rehabilitation care prior to discharge. A hospital may also provide geriatric evaluation management, specifically for older people. This service comprises a functional assessment to give guidance to a patient and family members regarding the patient's best options for follow-up care after discharge.

Public hospitals also play an important role in providing longer-term maintenance care for patients who are unable to return to their home or may not be able to access a suitable placement in an aged care facility.

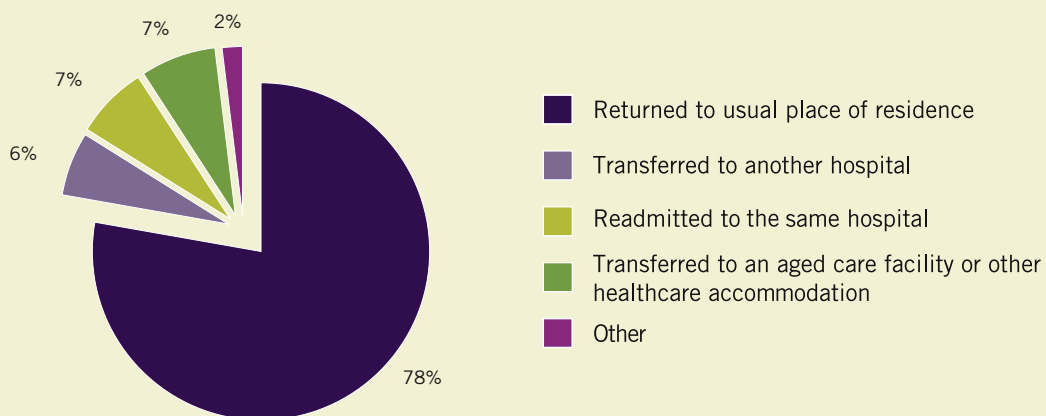
TABLE 5.6 PUBLIC HOSPITALS—non-acute care admissions, by age group, Australia, 2005–06

	0-64 yrs admissions	65 yrs and over admissions	65 yrs and over (%)
Rehabilitation	19,942	48,501	71%
Palliative care	5,924	14,418	71%
Geriatric evaluation and management	947	12,968	93%
Psychogeriatric care	336	4,247	93%
Maintenance care	3,016	16,734	85%
Total	30,165	96,868	76%

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

Patients being prepared for discharge following an admission for acute care may receive a period of 'step-down care' comprising either rehabilitation or geriatric evaluation management. In 2005–06, 78 per cent of rehabilitation and geriatric evaluation management admissions resulted in the patient returning home or to their usual place of residence, which may be an aged care facility for some.

FIGURE 5.3 REHABILITATION AND GERIATRIC EVALUATION MANAGEMENT—admissions of patients aged 65 years and over, by mode of separation, public hospitals, Australia, 2005–06



Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.



After discharge, public hospitals may provide follow-up care in outpatient departments or community outreach services for older Australians. These services are largely incorporated in the two busiest clinics (*medical and allied health*) measured under the new outpatient care data collection described in Part 4 of this report.

The Australian and state and territory governments are collaborating on initiatives to improve the care of long-stay older patients in public hospitals and their access to appropriate long-term care options. Under the Improving Care for Older Patients in Public Hospitals initiative, the Australian Government will provide a total of \$150 million over four years to the states and territories to implement a range of initiatives that will complement existing programs in each jurisdiction. In urban areas, the initiative will focus on reducing unnecessary admissions, improving admitted patient services, and improving the transition to appropriate long-term care. In rural areas, the focus will also be on improving the flexibility and capacity of rural hospitals to provide more age-friendly services. This program builds on a number of other recent initiatives including:

- the Pathways Home Program, that provides funding to the states and territories to improve their rehabilitation and step-down services; and
- the Transition Care Program.

The Transition Care Program

The Australian and state and territory governments are seeking to help more older Australians return home after their hospital stay through the Transition Care Program. The program is jointly funded by the Australian Government and the state and territory governments and was announced in the 2004–05 Australian Government Budget.

The program is designed to help older people leaving hospital to return home rather than inappropriately enter residential care. Transition care provides older people with a package of services that includes low-intensity therapy (such as physiotherapy, occupational therapy and social work), case management, as well as nursing support, personal care or both. It helps older people complete their recovery and optimise their functional capacity, while they or their family or carer consider long-term care arrangements.

Transition care can be provided in either a home-like residential setting or in the community. In the community setting, transition care is usually provided in the older person's home.

Transition care can be provided for a maximum of 12 weeks with a possible extension of another six weeks. It is estimated that the average period of care will be eight weeks.

When the program is fully established with 2,000 operational places, it will assist up to 13,000 older Australians each year. The Australian Government has met its target of allocating 2,000 transition care places by June 2007.

TABLE 5.7 TRANSITION CARE PROGRAM—allocated placements, states and territories, 2004–05 to 2006–07

	2004–05 places	2005–06 places	2006–07 places	Total places
New South Wales	173	377	153	703
Victoria	150	226	126	502
Queensland	106	167	78	351
Western Australia	50	50	60	160
South Australia	90	31	55	176
Tasmania	20	32	5	57
Australian Capital Territory	10	25	0	35
Northern Territory	0	0	16	16
Australia	599	908	493	2,000

Source: Australian Government Department of Health and Ageing.

What about the future?

In 1998–99 and 2005–06, the rate of public hospital admissions of people younger than 65 is the same at 163 admissions per 1,000 population. In both years, the rate of hospital admissions was higher in older age groups, up to 686 admissions per 1,000 population aged over 85 years in 2005–06. Also, in the older groups, the rate of hospital admissions increased from 1998–99 to 2005–06.

Occupied bed days per 1,000 population has declined for all age groups since 1998–99, although older age groups continue to have the greatest rate of bed day occupation.

TABLE 5.8 PUBLIC HOSPITALS—admissions and occupied bed days per 1,000 population, by age group, Australia, 1998–99 and 2005–06

	Admissions		Occupied bed days	
	2005–06	1998–99	2005–06	1998–99
0–64 yrs	163	163	506	544
65–74 yrs	487	451	1,839	2,087
75 yrs and over	686	572	4,204	4,539
All ages	218	205	831	865

Note: These figures are derived using unweighted population estimates.

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.





In 2005–06, about 38 per cent of public hospital expenditure was spent on care for admitted patients aged 65 years and over. As the proportion of the Australian population aged 65 years and over increases, it is expected that the cost of maintaining public hospital services will also increase.

TABLE 5.9 PUBLIC HOSPITALS—recurrent expenditure per person on admitted patients, by age group, Australia, 2005–06

	0-64 yrs (\$)	65-74 yrs (\$)	75-84 yrs (\$)	85 yrs and over (\$)	65 yrs and over (\$)	All ages (\$)
New South Wales	643	1,934	3,087	3,868	2,588	910
Victoria	639	1,889	3,051	3,687	2,529	896
Queensland	532	1,606	2,488	2,943	2,065	719
Western Australia	561	1,781	2,955	3,600	2,390	778
South Australia	571	1,649	2,513	2,977	2,145	811
Tasmania	575	1,830	2,802	3,251	2,338	833
Australian Capital Territory	642	2,919	4,871	5,802	3,899	959
Northern Territory	1,050	4,245	7,803	6,214	5,319	1,255
Australia	609	1,843	2,934	3,564	2,441	851

Note: These figures are derived using unweighted population estimates.

Source: Australian Government Department of Health and Ageing, *Australian Health Care Agreement* data reported by the states and territories.

An intergenerational report (IGR) is produced by the Australian Government every five years to assess the sustainability of government policies over the next 40 years. The second report (IGR2), released in 2007, forecasts that Australia's population will grow to 28.5 million by 2047 and 25 per cent of the population will be over 65 years of age. This will partly be a result of the average life expectancy increasing by seven years for men (to 86 years) and women (to 90 years). The ageing of the population will particularly quicken from 2010 when the bulk of the post-war baby boom generation begins passing 65 years of age.

IGR2 states that Australian Government health expenditure will almost double over the next 40 years. The cost of hospitals and health services (being principally the costs of public hospitals, private health insurance rebates and hospital care for veterans) will increase by 80 per cent in real terms to 2.2 per cent of Gross Domestic Product (GDP) in 2047. This projected increase is not just a result of demographic change but also reflects a continued investment in new technology.

Although hospitals and health services are currently the largest component of Australian Government health expenditure, it is expected that this will be overtaken by costs to the Pharmaceutical Benefits Scheme, which will rise to 3.8 per cent of GDP by 2047.

The costs of residential and community aged care services will rise to 1.8 per cent of GDP.



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APPENDIX

A note about data

This report uses five data collections provided to the Australian Government Department of Health and Ageing by the states and territories under the *Australian Health Care Agreements*. They are:

1. Admitted patient care
2. Public hospitals establishments
3. Emergency departments
4. Outpatient care
5. Elective surgery waiting times.

The collections were provided to the Department by 31 December 2006. Amendments and corrections to the data were accepted up to 31 March 2007.

This report also uses data from other sources. Data sources are identified in the figures and tables included in this report and other sources are listed in full later in this appendix.

In general, comparisons between the states and territories and over time should be treated cautiously because the methods used to collect data in the states and territories can differ. This is particularly the case for the emergency departments data collection because the number of hospitals reporting data has been increasing from year to year.

Elective surgery waiting times data are collected for all elective surgery admissions by urgency category and for 15 selected elective surgical procedures, a number of which have been noted in this report. The 15 selected procedures only represent about 33 per cent of all admissions with waiting times data. Unless otherwise specified, waiting times data, including breakdowns by urgency category, are calculated from all admissions with waiting times data.

A note about admissions

The state of our public hospitals report series has adopted the term 'admission' to describe an episode of care for an admitted patient. It has the same technical meaning as the term 'separation', which is used in other reports such as the *Australian hospital statistics* series.

Within one reporting year there may be multiple admissions involving the same person, particularly for recurring procedures such as renal dialysis. This report makes statements about the frequency of patients presenting to hospitals without meaning to imply they are all different individuals. This principle also applies to statements made about emergency department presentations.

To be consistent with other national reports on hospital usage, including the *Australian hospital statistics* series, babies who were born in hospitals but required only routine care are not included in admissions data.

A record of an admission is only created at the time the admission ends. Hence a small proportion of 2005–06 admissions that extended past 30 June 2006 are not included in data reported for the 2005–06 period.



A note about non-admitted services

All states and territories provided 2005–06 data on activity in emergency and outpatient departments. In these areas, care is provided to people without them first being admitted to the hospital.

The emergency departments data collection currently covers larger hospitals, which are expected to have specialised facilities and staff dedicated to delivering emergency care. The data collection does not currently capture all emergency services that may be provided in smaller public hospitals. The Australian Government is working with the states and territories to steadily increase the scope and coverage of the collection. This report uses the term ‘presentation’ to describe an episode of care delivered to an individual in an emergency department.

The outpatient care data collection is also currently limited to data collected from larger hospitals. This data collection does not currently have the capacity to provide information about the episodes of care delivered to individuals in outpatient departments. It only contains data describing the level of activity in different areas of care provided by outpatient departments. This report uses the term ‘occasions of service’ to describe discrete outpatient service activities. The Australian Government is working with the states and territories to create a data collection with comprehensive records of outpatient care episodes.

A note about population

The estimated residential Australian population increased from 19.1 million in December 1998 to 20.5 million in December 2005.

The weighted population figures used in this report take into account the variation in hospital usage by different age groups and sexes. This can make comparisons between the states and territories, and comparisons over time, more meaningful where age and sex distribution vary.

The weighted population grew from 18.9 million to 21.3 million from December 1998 to December 2005. Changes in the weighted population of each state and territory varied over this period. As shown in Table A.1, the largest changes were in Queensland and Western Australia.

TABLE A.1 WEIGHTED POPULATION—percentage change by state and territory, 1998–99 to 2005–06

	Weighted population 2005–06 (million)	Growth since 1998–99 weighted population (%)
New South Wales	7.2	12.7
Victoria	5.3	13.5
Queensland	4.0	20.5
Western Australia	2.0	17.1
South Australia	1.7	9.6
Tasmania	0.5	10.1
Australian Capital Territory	0.3	15.3
Northern Territory	0.2	15.9
Australia	21.3	14.4

Source: 2003–08 *Australian Health Care Agreements*

Some tables in this report draw comparisons between different age groups. In those instances, the population data are unweighted. Also, the formula used to calculate weighted populations for the 2003–08 *Australian Health Care Agreements* was different from that used for the 1998–2003 *Agreements*. Some statistics reported in earlier editions of *The state of our public hospitals report* were re-calculated for this report.

A number of tables and figures in this report list the states and territories in a standard order, which is not intended to imply any ranking of performance. Table A.1 is an example of this standard order. The order is based on population size, where New South Wales has the highest and the Northern Territory has the lowest.

Australian standard geographical classification

This report used the Australian standard geographical classification—remoteness area (ASGC–RA) to examine where public hospitals were located and where patients lived. This classification categorises areas as *major cities*, *inner regional*, *outer regional*, *remote* and *very remote*, based on distance from different types of service centres.



How this year's report differs from earlier editions

The first edition of *The state of our public hospitals report* was released in June 2004.

The original scope of the report was to publish information provided by the states and territories against an agreed set of performance indicators established under the *Australian Health Care Agreements*. However, the calculation methods under the Agreements differ slightly from other published sources of hospital statistics. To avoid inconsistency in national reporting on hospitals, a number of calculation methods have been modified:

- Since *The state of our public hospitals, June 2006 report*, counts of admissions have excluded babies born in hospital and requiring only routine care.
- In *The state of our public hospitals, June 2007 report*, calculations of admissions are primarily determined by site of treating hospital rather than patient residence.
- In *The state of our public hospitals, June 2007 report*, calculations of emergency department statistics include presentations where the type of visit was not reported. Previously these were excluded.
- In *The state of our public hospitals, June 2007 report*, calculations of elective surgery waiting time exclude patients who required admission from the waiting list for emergency surgery. Previously these were included.

Some statistics reported in earlier editions of *The state of our public hospitals report* were re-calculated for this report.

Comparisons with *Australian hospital statistics 2005–06*

Some of the information in this report may differ slightly from that published by the Australian Institute of Health and Welfare (AIHW) in *Australian hospital statistics 2005–06*.

Both reports draw on the same data collections provided by the states and territories. The AIHW and the Department of Health and Ageing collaborated in managing corrections and updates to these collections until the time of publication of *Australian hospital statistics 2005–06*. However, each report contains some minor differences in the way different statistics are calculated.

Both reports use much the same approach to count all patients receiving care in public or private hospitals. Both reports also use much the same approach to distinguish public patients. However, in this report, private patients are more narrowly defined than in *Australian hospital statistics 2005–06*.

This report's definition includes patients who are self-funded and patients whose care is funded by private health insurance. It excludes patients whose care is funded by other sources such as the Department of Veterans' Affairs. In this report, those patients are incorporated within an *Other* category. The glossary at the end of this section contains more detail on definition of patient type.

Statistics based on populations are also different because this report mainly used the *Australian Health Care Agreements'* weighted population, while *Australian hospital statistics 2005–06* used estimated residential populations, directly age standardised where possible.

There are also minor differences in the analysis methods used, including the treatment of missing values, the groupings of categories (for example, non-admitted occasions of service) and the inclusion or exclusion of records based on specific criteria (for example, the patient's departure status from emergency departments).

Published sources used in developing this report

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Australian Institute of Health and Welfare (2001) *Waiting times for elective surgery in Australia 1998–99*, AIHW, Canberra

Health Data Standards Committee (2006) *National health data dictionary (Version 13)*, AIHW, Canberra

Simmonds, F. and Stevermuer, T. (2007) *The Australasian Rehabilitation Outcomes Centre annual report: The state of rehabilitation in Australia*. Aust. Health Rev. 2007: 31 Suppl.1:S31-S53.



Useful websites

Australian Government

Department of Health and Ageing www.health.gov.au

Australian Institute of Health and Welfare www.aihw.gov.au

Australian Commission on Safety and Quality in Health Care www.safetyandquality.org

National Health Data Dictionary www.aihw.gov.au/content/index/phtml/itemID/182137

State and territory health departments

Australian Capital Territory www.health.act.gov.au

New South Wales www.health.nsw.gov.au

Northern Territory www.nt.gov.au/health

Queensland www.health.qld.gov.au

South Australia www.health.sa.gov.au

Tasmania www.dhhs.tas.gov.au

Victoria www.dhs.vic.gov.au

Western Australia www.health.wa.gov.au

Hospital performance reports in other countries

USA - *Best Hospitals* report www.usnews.com/usnews/health/best-hospitals/tophosp.htm

United Kingdom – *Dr Foster's Good Hospital Guide* www.drfooster.co.uk

Australian electronic health (eHealth) resources

Health*Insite* www.healthinsite.gov.au

Health*Insite* is an Australian Government initiative providing a wide range of up-to-date and quality assessed health information for Australian consumers. It covers important health topics such as diabetes, cancer, mental health and asthma.

Health*Connect* www.healthconnect.gov.au

Health*Connect* is a joint Australian, State and Territory Government initiative to develop a national health information network for all Australians.

Australian Indigenous Health*InfoNet*: www.healthinonet.ecu.edu.au

Health*InfoNet* aims to contribute to the health of Australia's Indigenous people by making relevant, high quality information and statistics easily accessible to everyone.

GLOSSARY

This glossary attempts to provide a 'plain English' explanation of the following terms used in this report. Readers seeking more robust technical definitions should refer to the *National health data dictionary*.

Admission refers to a completed episode of hospital care which begins when a patient is admitted to a hospital. It ends when the patient is discharged from the hospital, is transferred to another hospital, changes their type of care, or dies. In this report, the term is intended to have the same meaning as the term separation used in other statistical reports. Admissions may be same day or overnight admissions. Newborn babies requiring only routine care, episodes of posthumous organ procurement and hospital boarders are excluded from counts of admissions in this report.

Average length of stay is the total number of days for all admissions divided by the number of admissions.

Care type defines the type of service provided to an admitted patient during an episode of care. The main types are:

1. acute care, comprising surgical and acute medical services
2. rehabilitation
3. palliative care
4. geriatric evaluation and management
5. psychogeriatric care
6. maintenance care
7. newborn care
8. other admitted patient care (care which does not meet any of the above categories)
9. posthumous organ procurement
10. hospital boarders (generally well family members staying overnight with an admitted patient).

Care types in group 9 and 10 are excluded from counts of admissions in this report. Well newborns requiring only routine care are also excluded from admission counts. Note that where a patient's care type changes (for example, from acute care to rehabilitation), this is generally counted as a new admission, although the patient may not physically move from the hospital.

Elective surgery is any form of surgery that a patient's doctor or health professional believes to be necessary but which can be delayed by at least 24 hours.

Elective surgery waiting time is the time from the date a patient was added to the procedure's waiting list to the date the patient was admitted for the same procedure, less any time the patient was not ready for care.



Emergency department waiting time is the time from when a patient presents to the emergency department to the time treatment begins.

Hospital types: Two types of hospitals are used in this report:

1. private hospitals are privately owned and operated institutions. The term includes acute care hospitals, psychiatric hospitals and free-standing day surgeries.
2. public hospitals are hospitals controlled by a state or territory health authority. The term includes acute care and psychiatric hospitals.

Hospital-in-the-home is the provision of care to admitted patients at their homes as a substitute for hospital accommodation.

Occasion of service is a measure of service activity for outpatient facilities. Each discrete service activity, for example, each test or set of related tests, each consultation, or each treatment, counts as one occasion of service.

Patient type: Three categories of patient type are used in this report. The choice of category is determined primarily by the source of funding for the patient's care and secondarily by reference to the patient's recorded election status (public or private):

1. **Public** patients are those who are eligible for Medicare and elect to receive hospital services as a public patient in accordance with the *Australian Health Care Agreements*. A small proportion of public patients are treated in private hospitals (for example, under contractual arrangements managed by state and territory governments). Public services are generally free of charge.
2. **Private** patients are those who pay for their hospital expenses by private health insurance and/or their own funds. Private patients may be treated in public or private hospitals.
3. **Other** patients are those who do not meet the definition of either public or private patients. This category includes patients whose hospital expenses are paid for by the Department of Veterans' Affairs, the Department of Defence or compensation arrangements. This category also includes patients from correctional facilities. Any patient admission record with unknown funding source will be included here unless the patient's election status is clearly identified as public or private. Patients in this category may be treated in public or private hospitals.

Presentation (emergency department) refers to a non-admitted completed episode of care provided in a dedicated emergency department. A presentation commences when a person is assigned a triage category and may then involve a waiting period before the person is seen by an emergency clinician. It ends when the person leaves the emergency department (for example, to home or transferred to another facility or is admitted to hospital), or if the person dies.

Recurrent expenditure is expenditure on goods and services that are ongoing, for example, expenditure on wages and salaries, medical and pharmaceutical supplies, and domestic services.

Triage category is used to indicate the urgency of a patient's need for medical and nursing care in an emergency department. Patients are placed in one of five categories on the National Triage Scale by an experienced nurse or medical practitioner.

Weighted population is a measure of the population of a state, territory or Australia adjusted to account for demographic differences in age and sex. This weighting enables fairer comparisons between jurisdictions, or over time, where variation in demographic differences may affect those comparisons.



Technical reference guide

For the first time, this 2007 report is accompanied by a technical reference guide to assist researchers and others understand how the statistical figures in this report were calculated. This reference guide contains considerably more detail on calculation methods than is included in this brief Appendix.

The technical reference guide is available with the on-line version of this report at:

www.health.gov.au/ahca



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