

Australian hospital statistics 2004–05

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Foreword

Australian hospital statistics 2004–05 continues the Australian Institute of Health and Welfare's comprehensive annual reporting on Australia's hospitals. Detailed information is presented on hospital care and hospitals in 2004–05, as are summaries of changes over time, and comparisons between public and private hospitals.

This year, improvements have been made to the presentation of data on care provided in emergency departments in public hospitals. Information on median waiting times and lengths of time waited at the 90th percentile are presented, in addition to information on the proportion of patients seen on time. Graphs on emergency department episodes by time of day show for the first time that, nationally, highest numbers of patients present at emergency departments between 8am and 12 noon.

Another innovation this year reflects our drive to improve the quality of Indigenous status in the data—thus providing a stronger evidence base for policy makers to use. Information on hospitalisation rates for Indigenous patients is presented only for those states and territories for which the quality of the Indigenous status data was considered to be adequate. This follows an AIHW study in 2005 in which a detailed assessment of the quality of the data was made, and analysis guidelines were developed that take it into account.

An enhancement has also been made to the statistics presented on the cost per casemix-adjusted separation, a statistic that has been used for a number of years as an indicator of efficiency in public hospitals. For the first time, estimates of the cost per casemix-adjusted separation have been made both with and without depreciation included for most states and territories.

Timeliness is an important quality for statistical reports and, once again this year, publication is within 11 months of the end of the reference period. We thank the contributions of state and territory health authority data providers that allow this report to become available in such a timely manner.

The Institute will continue to work with the data providers and the Australian Hospital Statistics Advisory Committee to maintain timeliness, and to improve the quality and usefulness of this report. Comments from readers are always welcome.

Penny Allbon

Director

May 2006

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- Ken Tallis (AIHW) (Chair)
- John Agland (New South Wales Health Department)
- Paul Basso (South Australian Department of Health)
- Paul Collins (Private Health Insurance Administration Council)
- Sue Cornes (Queensland Health)
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Abbreviations

ABS	Australian Bureau of Statistics	NHCDC	National Hospital Cost Data Collection
ACT	Australian Capital Territory	NHDC	National Health Data Committee
AIHW	Australian Institute of Health and Welfare	NHMBWG	National Health Ministers' Benchmarking Working Group
ALOS	Average length of stay	NHPA	National Health Priority Area
AMI	Acute myocardial infarction	NHPC	National Health Performance Committee
AR-DRG	Australian Refined Diagnosis Related Group	n.p.	Not published
ave	Average	NSSRG	Non-specialist service related group
behav.	Behavioural	NSW	New South Wales
CABG	Coronary artery bypass graft	NT	Northern Territory
Cat.	Catastrophic	OECD	Organisation for Economic Co-operation and Development
CC	Complication and/or comorbidity	op.	Operation
CDE	Common duct exploration	O.R.	Operating room
COPD	Chronic obstructive pulmonary disease	PICQ	Performance Indicators for Coding Quality
dis.	Diseases	PPH	Potentially preventable hospitalisation
DHAC	Department of Health and Aged Care	proc(s)	Procedure(s)
DoHA	Department of Health and Ageing	Qld	Queensland
DRG	Diagnosis Related Group	RRMA	Rural, Remote and Metropolitan Area
ECMO	Extracorporeal membrane oxygenation	RSI	Relative stay index
ECT	Electroconvulsive therapy	SA	South Australia
exp.	Exposure to	SCRGSP	Steering Committee for the Review of Government Service Provision
FTE	Full-time equivalent	SEIFA	Socio-Economic Indexes for Areas
HASAC	Health and Allied Services Advisory Council	sep.	Separation
HIV	Human immunodeficiency virus	sev	Severe
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification	SLA	Statistical Local Area
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification	SRG	Service Related Group
IFRAC	Admitted patient fraction	SRR	Standardised separation rate ratio
inv.	Involving	SSRG	Specialised service related group
mal.	Malignant	Tas	Tasmania
MDC	Major Diagnostic Category	URI	Upper respiratory tract infection
mis	Misadventure	Vic	Victoria
n.a.	Not available	VMO	Visiting medical officer
NCCH	National Centre for Classification in Health	W	With
n.e.c.	Not elsewhere classified	W/O	Without
		WA	Western Australia
		..	Not applicable

Hospitals at a glance

Australian hospital statistics 2004–05 provides a twelfth year of comprehensive annual statistical reporting by the Australian Institute of Health and Welfare on the characteristics and activity of Australian hospitals. This section provides a summary of the report's information on Australian hospitals. It illustrates changes in hospital activity over time and some differences between hospitals in the public and private sectors.

More information on how to interpret the data is provided in the relevant chapter quoted in each subsection. More information about the terms used is in the glossary. Hospitals included in this report include public acute care and psychiatric hospitals, private free-standing day hospital facilities and other private hospitals (including psychiatric hospitals).

Admitted patient separations and patient days

Separations and patient days provide useful ways to measure how many admitted patients are treated in hospitals. See *Chapter 2*.

Changes between 2003–04 and 2004–05

- There were 7,018,850 separations and 23,828,612 patient days in 2004–05, compared with 6,841,225 separations and 23,583,303 patient days in 2003–04.
- Between 2003–04 and 2004–05, separations increased by 1.8% for public acute hospitals and by 4.4% for private hospitals after adjusting for coverage change and a Tasmanian hospital being recategorised from the private sector to the public sector.
- With the same adjustments, separations increased by 1.7% for public patients and by 3.9% for private patients, and separations for which private health insurance was reported as the funding source increased by 5.3%.
- With the same adjustments, the number of patient days increased by 1.4% in public acute hospitals and by 0.9% in private hospitals.
- Between 2003–04 and 2004–05 (with the same adjustments) the number of same

same day separations increased by 2.0% in public acute hospitals and by 6.1% in private hospitals and overnight separations increased by 1.5% and 1.6% respectively.

Changes between 1995–96 and 2004–05

- Between 1995–96 and 2004–05, separations from all hospitals increased by 35.7% (not adjusted for coverage change). Separations increased by 19.5% in public acute hospitals and by 73.8% in private hospitals (including free-standing day hospital facilities).
- Over the same period, the number of patient days in public acute hospitals increased by 2.0%, and for private hospitals they increased markedly (up by 21.6%).
- Separations per 1,000 population increased by 3.5% for public acute hospitals and by 51.3% for private hospitals between 1995–96 and 2004–05 (Figure 1).
- Over the same period, patient days per 1,000 population decreased by 15.3% for public acute hospitals and by 0.6% for private hospitals (Figure 2).
- For stand alone public psychiatric hospitals, separations per 1,000 population fell by 28.8% between 1996–97 and 2004–05 and there was a

47.6% fall in patient days per 1,000 population. This accompanied a fall in the number of public psychiatric hospitals (see below).

- In 1995–96, 69.0% of separations and 69.4% of patient days in acute care hospitals were in public acute hospitals. By 2004–05, these percentages had fallen to 60.7% and 66.6%, respectively, showing a shift in hospital use from public acute to private hospitals during this period.

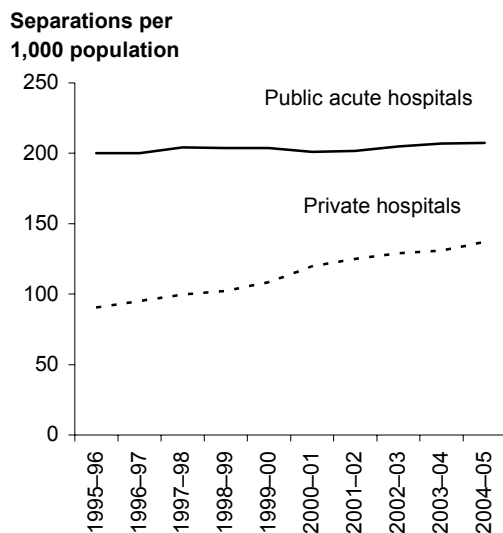


Figure 1: Separations per 1,000 population, public acute and private hospitals, Australia, 1995–96 to 2004–05

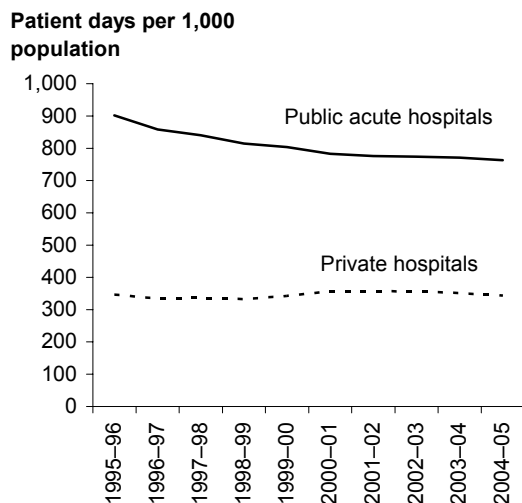


Figure 2: Patient days per 1,000 population, public acute and private hospitals, Australia, 1995–96 to 2004–05

Length of stay

The proportion of separations that are same day is increasing, and the average length of stay in hospitals is decreasing. See *Chapter 2*.

- The proportion of same day separations increased between 1995–96 (42.4%) and 2004–05 (54.8%).
- The number of same day separations increased by 3.7% between 2003–04 and 2004–05 compared with a 1.3% increase in overnight separations. Same day separations increased by 2.1% in public hospitals and by 5.7% in private hospitals.
- The average length of stay in hospitals was 3.4 days in both 2003–04 and 2004–05.
- The average length of stay decreased 20.9% between 1995–96 and 2004–05, from 4.3 days to 3.4 days. The average length of private hospital stays decreased to 2.6 days, and that for public acute hospital stays decreased to 3.7 days (Figure 3).

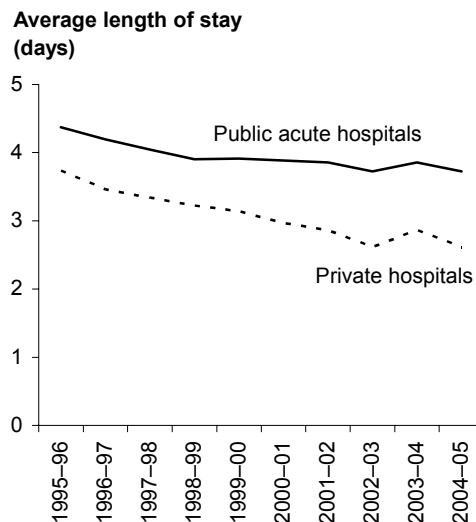


Figure 3: Average length of stay, public acute and private hospitals, Australia, 1995–96 to 2004–05

- Average lengths of stay have remained relatively constant over this period for patients staying at least one night. They were 6.4 days in public acute

hospitals and 5.4 days in private hospitals in 2004–05 (Figure 4).

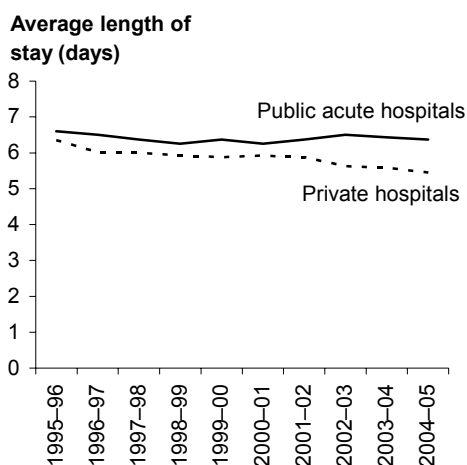
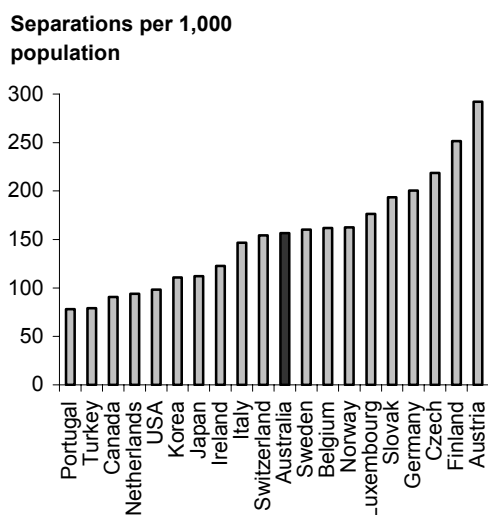


Figure 4: Average length of stay for overnight separations, public acute and private hospitals, Australia, 1995–96 to 2004–05

International comparisons

- The number of overnight separations per 1,000 population in Australia for 2002–03 was in the middle of the range reported by other OECD countries for recent years (Figure 5, OECD 2004).



Note: Data for Canada, the USA, Belgium, Germany and Austria are for 2001–02.

Figure 5: Overnight separations per 1,000 population, Australia and selected OECD countries, 2002–03

- Comparability of international separation rates is likely to be affected

by differences in definitions of hospitals and in admission practices.

Age group and sex

Females accounted for more separations than did males. See *Chapter 8*.

- In 2004–05, there were 3,726,032 separations for females compared with 3,292,736 separations for males, 53.1% and 46.9% of separations respectively.
- Overall, in 2004–05 there were 366.7 separations per 1,000 population for females, compared with 327.6 separations per 1,000 population for males (Figure 6).

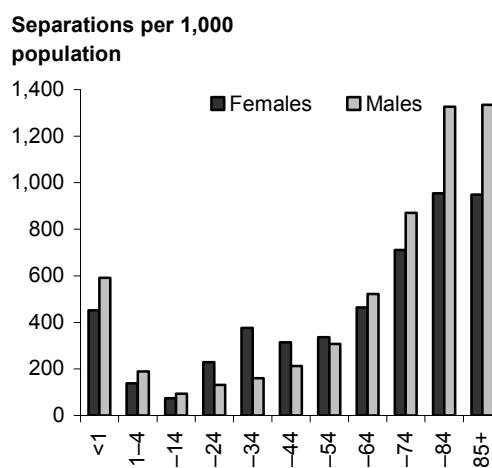


Figure 6: Separations per 1,000 population, by age group and sex, Australia, 2004–05

- The differences in the separation rates for males and females varied between age groups. There were more separations per 1,000 population for females than for males in all age groups between 15 and 54 years (which include child-bearing ages for women). Males had higher separation rates than females in all age groups less than 15 years old and 55 years and over.
- Separations for both males and females increased between 2000–01 and 2004–05. These increases were very marked for both females and males aged 55 and over. Most notably, separations increased by 26.7% for females aged 55–64 years and by 36.1%

for males aged 85 years and over (Figure 7).

- Separations of persons aged 0–4 years decreased over this period for both males and females.

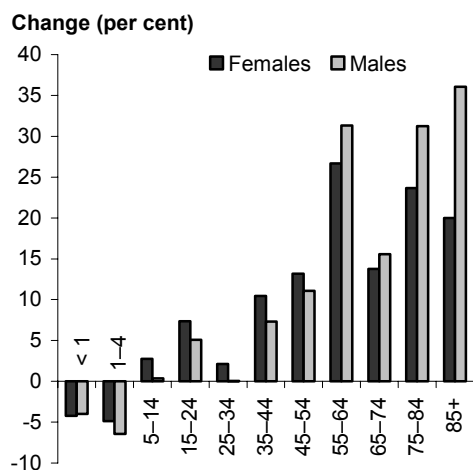


Figure 7: Change in the number of separations (per cent), by age group and sex, Australia, 2000-01 to 2004-05

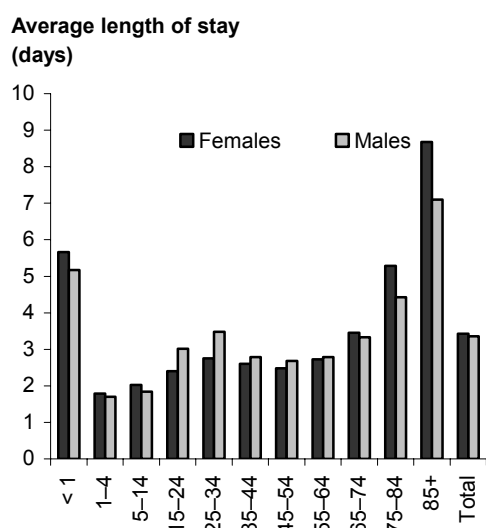


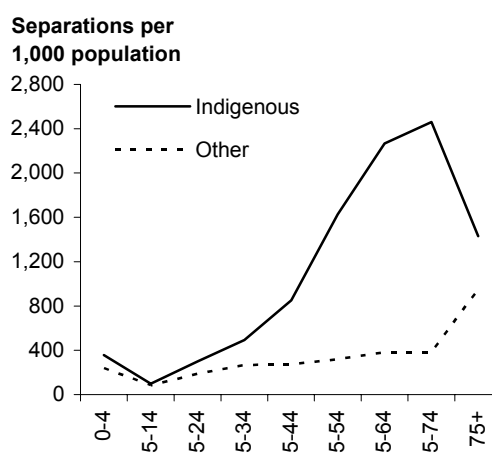
Figure 8: Average length of stay, by age group and sex, Australia, 2004-05

- The average length of stay did not vary greatly between males and females, being around 3.4 days for both. Females aged either less than 15 years or 65 years and over had longer average lengths of stay than males in those age groups (Figure 8).

Persons identifying as Indigenous

Indigenous people, that is, those identifying as being of Aboriginal and/or Torres Strait Islander origin, had higher separation rates in 2004–05 than other persons. See *Chapter 8*.

- In 2004–05, the age-specific separation rate for Indigenous persons (593.8 per 1,000 population) was about double the rate for other persons (316.4 per 1,000 population). It was higher for all age groups, particularly for age groups 35–44 years and over (Figure 9).



Notes
 1. Other includes both non-Indigenous and not stated/inadequately described separations.
 2. This figure includes data only for Queensland, Western Australia, South Australia and the Northern Territory (public hospitals only).

Figure 9: Separations per 1,000 population, by Indigenous status and age group, Australia, 2004-05

Remoteness Areas

Remoteness Area categories divide Australia into areas depending on distances from population centres. See *Chapter 8*.

- The number of separations per 1,000 population varied by Remoteness Area. Overall, separation rates were highest in very remote and lowest in inner regional areas.
- Separation rates for public hospitals were highest for patients living in very remote areas (411.3 separations per 1,000 population) and lowest for

patients living in major cities (195.7 separations per 1,000 population).

- Separation rates for private hospitals were highest for patients living in major cities (146.9 separations per 1,000 population) and lowest for patients living in very remote areas (46.9 separations per 1,000 population).

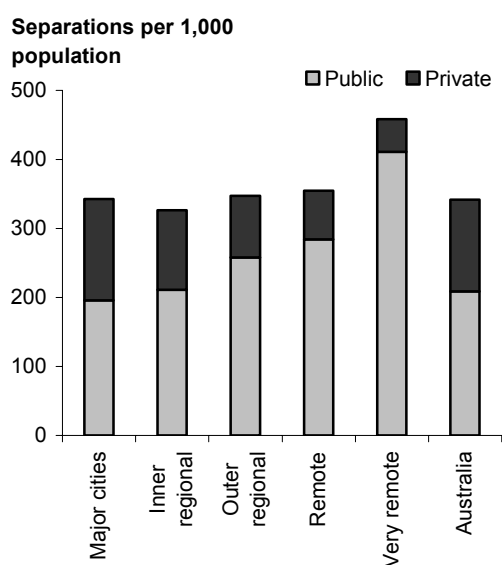


Figure 10: Separations per 1,000 population, by Remoteness Area of usual residence and hospital sector, Australia, 2004-05

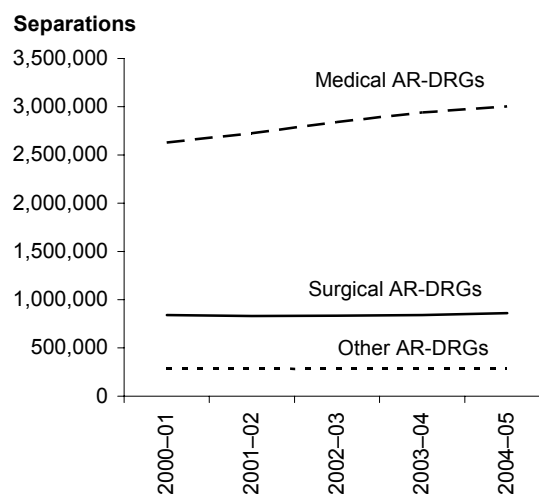
- Overall, remote areas had higher separation rates for public hospitals than major cities and regional areas. In contrast, major cities had higher separation rates for private hospitals than regional and remote areas.

Overall type of care

Separations are allocated to Australian Refined Diagnosis Related Groups (AR-DRGs) which can be used to describe whether the overall care was medical, surgical or other. Other care includes endoscopies. See *Chapter 12*.

- In public hospitals, separations with medical AR-DRGs increased by 14.3% between 2000-01 and 2004-05. Separations with surgical AR-DRGs increased by 2.2% and other AR-DRGs

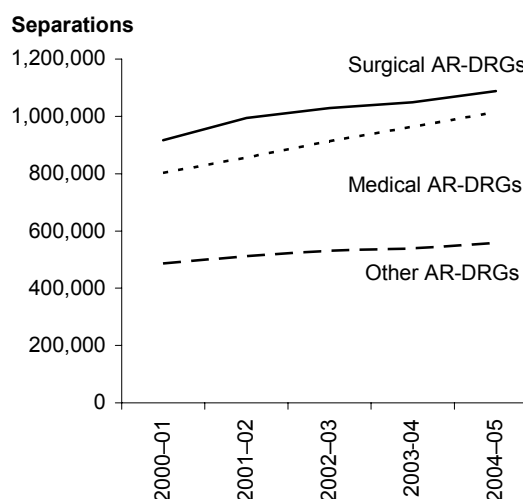
decreased by 2.6% in the same period (Figure 11).



Note: AR-DRG version 5.1 was used for data in 2004-05.

Figure 11: Separations for medical, surgical and other AR-DRGs version 5.0/5.1, public hospitals, Australia, 2000-01 to 2004-05

- In private hospitals, separations with medical AR-DRGs increased by 26.2%, those with surgical AR-DRGs increased by 18.6% and those with other AR-DRGs increased by 14.8% (Figure 12).



Note: AR-DRG version 5.1 was used for data from 2004-05.

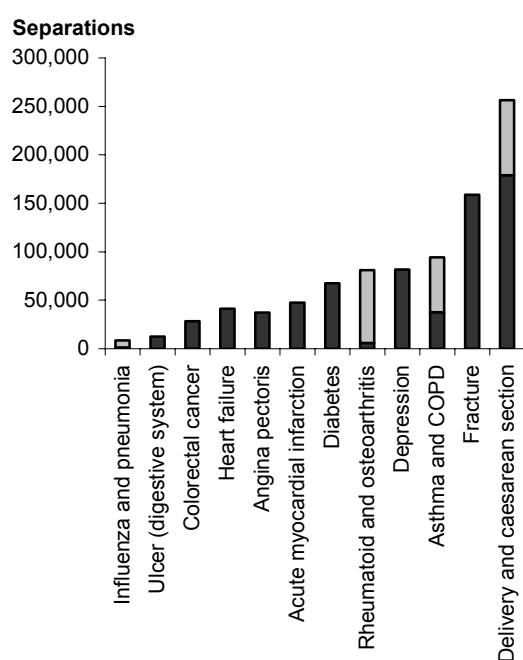
Figure 12: Separations for medical, surgical and other AR-DRGs version 5.0/5.1, private hospitals, Australia, 2000-01 to 2004-05

Conditions treated

The conditions (diseases or injuries and poisonings) treated in hospitals are classified using the *International statistical*

classification of disease and related health problems, 10th revision, Australian Modification (ICD-10-AM). Using this classification, each separation is allocated a principal diagnosis which is the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care. See *Chapter 9*.

- Overall, 37.8% of separations in 2004–05 had a principal diagnosis that derived from one of five ICD-10-AM chapters: Diseases of the digestive system; Neoplasms; Diseases of the circulatory system; Pregnancy, childbirth and the puerperium; and Injury and poisoning.



Note: Columns with two categories of principal diagnosis are indicated using two shadings.

Figure 13: Separations, by selected principal diagnosis, Australia, 2004–05

- The National Health Priority Areas (NHPAs) initiatives focus on chronic diseases that have a significant health burden. They are: asthma, cancer control, cardiovascular health, diabetes, injury prevention and control, mental health, and arthritis and musculoskeletal conditions.

- In 2004–05 the NHPAs were represented by some high-volume diagnoses. There were 158,854 separations with a principal diagnosis of fracture; 37,461 separations with a principal diagnosis of asthma and 56,788 with chronic obstructive pulmonary disease (COPD); 81,011 separations with a principal diagnosis of arthritis; 37,250 separations with a principal diagnosis of angina pectoris; and 67,656 separations with a principal diagnosis of diabetes (Figure 13).

Selected potentially preventable hospitalisations

The selected potentially preventable hospitalisations presented in this report are hospitalisations thought to be avoidable if timely and adequate non-hospital care is provided. Both acute and chronic conditions are represented. Rates for potentially preventable hospitalisations are potential indicators of the effectiveness of non-hospital care. See *Chapter 4*.

- Overall, the selected potentially preventable hospitalisations represented 9.4% of all separations in 2004–05.
- Overall, the number of separations per 1,000 population for the selected potentially preventable hospitalisations increased by an average of 1.8% per year between 2000–01 and 2004–05.
- Some diseases can be prevented by vaccination. The number of separations per 1,000 population for these diseases decreased by an average of 3.9% per year between 2000–01 and 2004–05 (Figure 14).

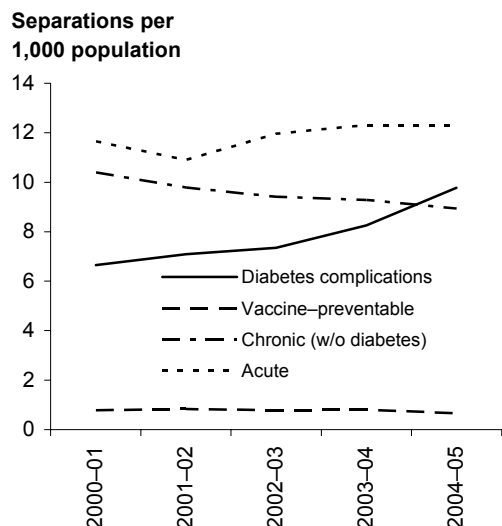


Figure 14: Selected potentially preventable hospitalisations per 1,000 population, Australia, 2000-01 to 2004-05

- For chronic conditions, excluding diabetes, potentially preventable hospitalisations per 1,000 population decreased by an average of 3.7% per year between 2000-01 and 2004-05.
- For diabetes complications, potentially preventable hospitalisations per 1,000 population increased by an average of 10.1% per year between 2000-01 and 2004-05.
- For acute conditions, potentially preventable hospitalisations fluctuated around 12 separations per 1,000 population between 2000-01 and 2004-05.

Procedures undertaken

A procedure can be surgical or non-surgical and can treat or diagnose a condition or be of a patient support nature such as anaesthesia. See *Chapter 10*.

- One or more procedures were reported for 81.2% of the separations in Australian hospitals in 2004-05.
- Overall, 55.6% of separations that reported a procedure occurred in the public sector, and 44.4% occurred in the private sector. Overall, 74.2% of separations from the public sector

recorded a procedure compared with 92.2% in the private sector.

- Separations in 2004-05 for selected high-volume procedures and selected procedures that can be electively performed are shown in Figure 15.

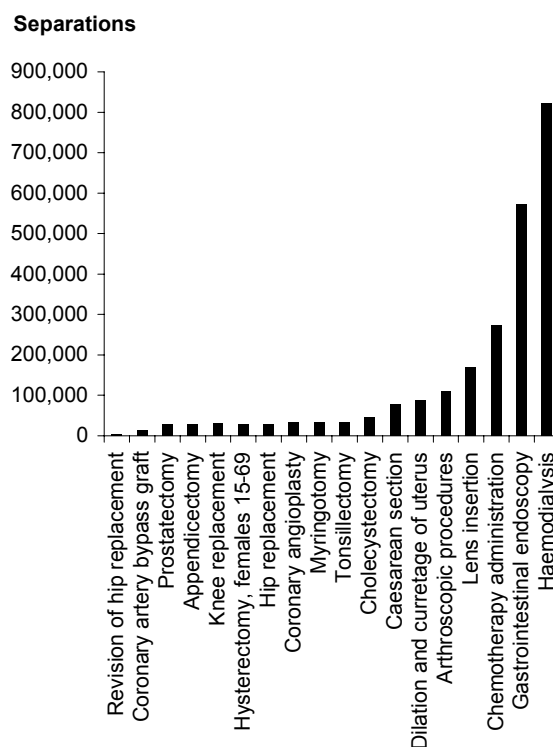


Figure 15: Separations with selected procedures, Australia, 2004-05

- In 2004-05, high volume procedures included *Haemodialysis* (822,133 separations), *Gastrointestinal endoscopy* (573,057 separations), *Chemotherapy administration* (273,500 separations), *Lens insertion* (170,021 separations) and *Arthroscopic procedures* (119,347 separations).
- Some procedures are being increasingly undertaken in the private sector, such as coronary artery bypass graft and coronary angioplasty.
- The number of separations for coronary artery bypass graft and coronary angioplasty increased by 23.6% between 2000-01 and 2004-05. They increased by 28.3% in the private sector and by 19.8% in the public sector.

- In 2004–05, 54.1% of the separations with a coronary artery bypass graft or coronary angioplasty were in the public sector and 45.9% were in the private sector (25,948 and 22,016 respectively), compared with 55.8% and 44.2% in 2000–01 (21,656 and 17,162 respectively) (Figure 16).

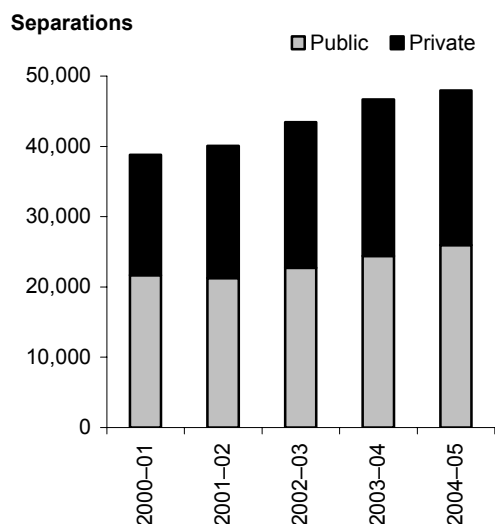


Figure 16: Separations for coronary artery bypass graft and coronary angioplasty by hospital sector, Australia, 2000–01 to 2004–05

Waiting times for elective surgery in public hospitals

The median waiting time for elective surgery in public hospitals in 2004–05 was 29 days. See *Chapter 6*.

- Ophthalmology, orthopaedic surgery, and ear, nose and throat surgery were the surgical specialties with the longest median waiting times (66, 48 and 37 days respectively) in 2004–05 (Figure 17).
- All other surgical specialties had a median waiting time of less than 30 days. Cardio-thoracic surgery had the shortest median waiting time (11 days).

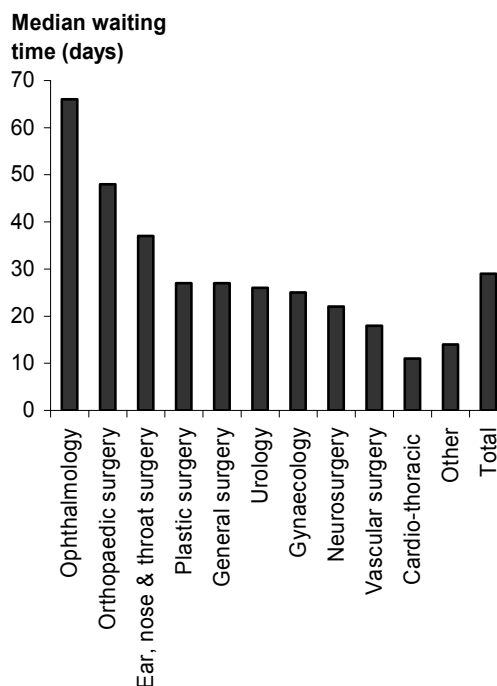


Figure 17: Public hospital median waiting time, by specialty of surgeon, Australia, 2004–05

Emergency department care in public hospitals

About 5.9 million accident and emergency occasions of service were provided in public hospitals in 2004–05 (see *Chapter 5*).

- Data on triage category, waiting times, patient age group and sex were available for about 76% of accident and emergency occasions of service, mainly those delivered in emergency departments in *Principal referral and specialist women’s and children’s hospitals* and *Large hospitals*.
- A higher proportion of patients were seen on time (as defined in *Chapter 5*) in *Large hospitals* than in *Principal referral and specialist women’s and children’s hospitals*. In *Large hospitals*, 73% of emergency department occasions of service were seen on time, with 99% of patients who were assigned a triage category of *Resuscitation* seen on time.

- In *Principal referral and specialist women's and children's hospitals*, 65% of emergency department occasions of service were seen on time, with 100% of patients who were assigned a triage category of *Resuscitation* seen on time.
- In *Large hospitals*, 69% of *Urgent* patients were seen on time compared with 61% in *Principal referral and specialist women's and children's hospitals* (Figure 18).

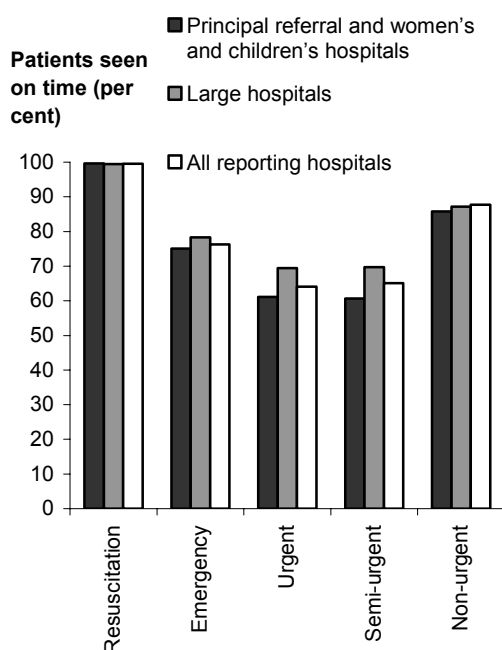


Figure 18: Public hospital emergency department occasions of service seen on time (per cent), by triage category and public hospital peer group, Australia, 2004-05

- Males accounted for more emergency department occasions of service than females. There were more occasions of service for males than females in all age groups except for patients aged 75 years and over.
- Persons aged 15-24 years accounted for the largest number of emergency department occasions of service (698,266, 15.4%) (Figure 19).

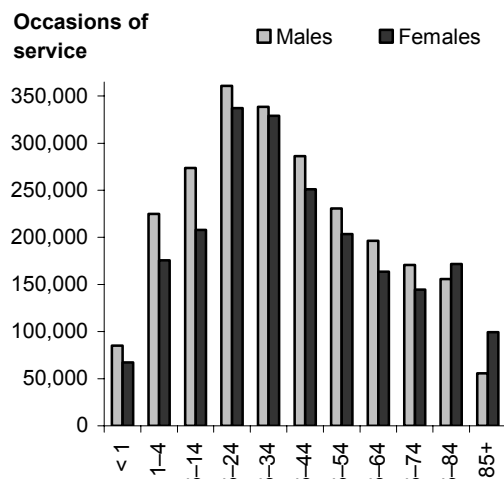


Figure 19: Emergency department occasions of service, by age group and sex, Australia, 2004-05

Australian hospitals

Overall, the number of hospitals in Australia has increased over time. See *Chapter 2*.

- There were 1,293 hospitals in Australia in 2004-05.
- There were 759 public acute hospitals and 20 public psychiatric hospitals.
- There were 244 private free-standing day hospital facilities and 290 other private hospitals.
- There has been a marked increase in the number of private free-standing day hospital facilities, from 140 in 1995-96 to 244 in 2004-05.
- The number of public psychiatric hospitals decreased from 26 facilities in 1995-96 to 20 facilities in 2004-05.

Available beds

The number of available beds is a better indicator of the availability of hospital services than is the number of hospitals because hospital sizes vary considerably. However, comparability of hospital bed numbers can be affected by the casemix of hospitals with differing proportions of

beds being available for specialised and more general purposes. See *Chapter 2*.

- In 2004–05, there were 82,100 available beds in Australia.
- There were 52,626 available beds in public acute hospitals and 2,487 in public psychiatric hospitals.
- There were an estimated 1,833 available beds in private free-standing day hospital facilities and 25,155 in other private hospitals.
- There was a 1.7% reduction in available beds from 83,538 in 1995–96 to 82,100 in 2004–05, an average decrease of 0.2% annually.
- The number of available beds in public acute hospitals decreased by an average of 0.7% annually, from 55,891 in 1995–96 to 52,626 in 2004–05 (Figure 20).

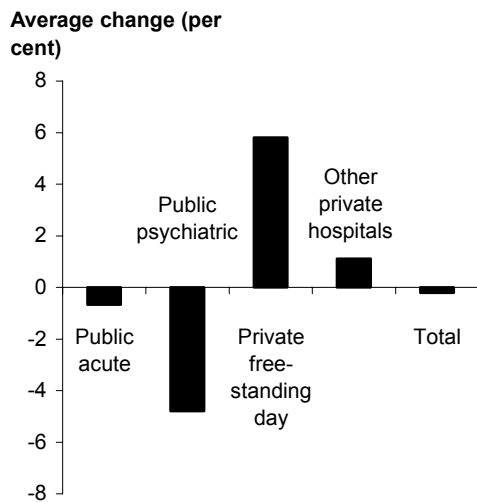


Figure 20: Average annual change in the number of available beds, by type of hospital, Australia, 1995–96 to 2004–05

- The number of available beds/chairs in private free-standing day hospital facilities increased by an average of 6.7% annually between 1995–96 and 2004–05 (from 1,023 to 1,833).

Staff in Australian public hospitals

Staff numbers in public acute and public psychiatric hospitals have grown over time (Figure 21). See *Chapter 3*.

- The number of full-time equivalent staff increased by an average of 1.4% annually between 1995–96 (184,494) and 2004–05 (211,645). The number of salaried medical officers increased by an average of 4.8% annually over this period (from 13,361 to 21,394) and the number of nurses increased by an annual average of 1.6% (from 80,570 to 93,992).

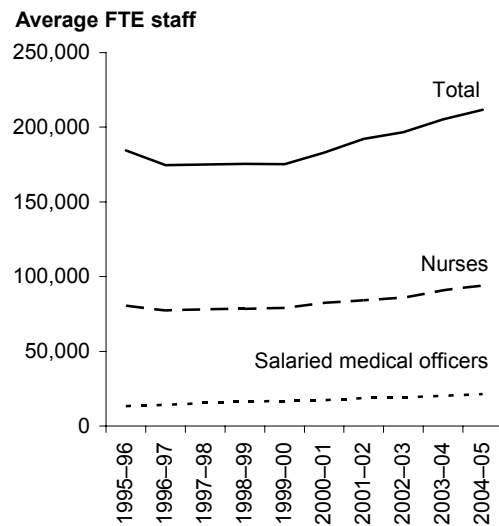


Figure 21: Average full-time equivalent staff, public hospitals, Australia, 1995–96 to 2004–05

Recurrent expenditure on public hospitals

Recurrent expenditure is expenditure on goods and services that are consumed during the year, for example, salaries. See *Chapter 3*.

- Recurrent expenditure on public acute and public psychiatric hospitals was \$21,758 million in 2004–05. After adjusting for inflation, this represented an increase of 4.9% compared with 2003–04.

- The largest share of this expenditure was for salary payments, which accounted for 61.7% (\$13,428 million) of recurrent expenditure (Figure 22).
- The major non-salary recurrent expenses in the public sector were for medical and surgical supplies, administrative expenses and drug supplies.

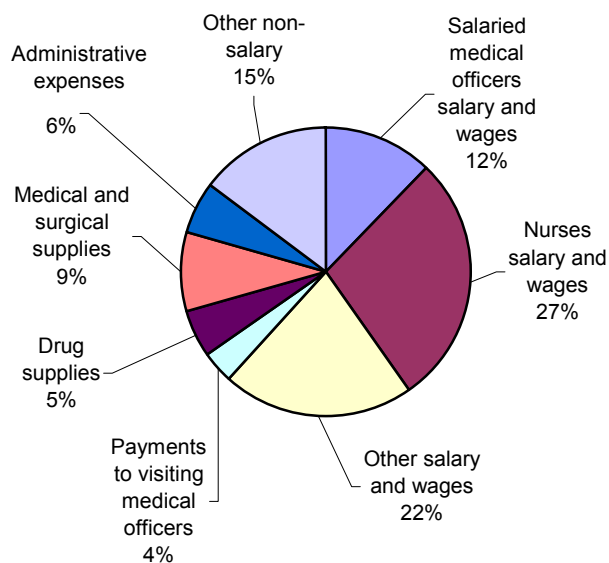


Figure 22: Recurrent expenditure, public hospitals, Australia, 2004-05

Recurrent expenditure (cost) for providing care in public hospitals

The average recurrent expenditure per casemix-adjusted separation is regarded as a measure of efficiency. See *Chapter 4*.

- The average recurrent cost of providing care per casemix-adjusted separation in public hospitals increased from \$2,987 in 2000-01 to \$3,410 in 2004-05 (not adjusted for inflation).
- This represents a total increase of 20.3% in this period, an average increase of 4.7% annually (Figure 23).
- In 2004-05 the average cost comprised \$1,789 for non-medical labour expenditure, \$646 for medical labour expenditure and \$975 for other recurrent expenditure. Other recurrent expenditure costs include domestic services; repairs and maintenance; administration and medical, drug and food supplies.

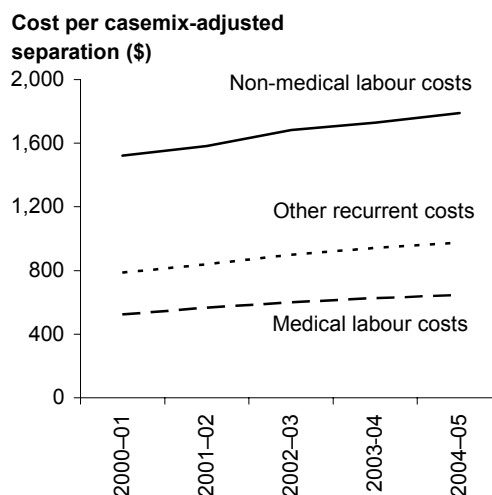


Figure 23: Cost per casemix adjusted separation, Australia, 2000-01 to 2004-05