Australian hospital statistics 2005–06

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Foreword

Australian hospital statistics brings together every year an authoritative suite of statistics and information about what is happening within the public and private sectors of Australia's hospital system. It is the product of co-operation between all state and territory health authorities and the Australian Government, collated and analysed by the AIHW. The Institute's independence and expertise underpins our role in publishing this information for the use of policy makers, service providers and the general public.

We strive to make the information as policy relevant and user-friendly as possible. Where appropriate we make comparisons between jurisdictions, areas of residence, and Indigenous and other persons. We also include comparisons over time of hospital activity.

As might be expected, this report demonstrates that the growth in activity and expenditure within Australia's hospitals is continuing, with the strongest activity growth occurring within public acute hospitals. Same-day separations remain on the increase, with public hospitals picking up a larger part of the same-day increase. The length of stay for overnight cases remains fairly constant.

The rate of hospitalisation for Aboriginal and Torres Strait Islander peoples is double that for other persons. Similarly the rate of hospitalisation for people who live in very remote areas of Australia is double that for people living in major cities.

The growing burden of disease attributable to chronic conditions is reflected in part by increased separation rates for selected chronic diseases. For example, the separation rate for complications of diabetes has increased by an average of 8.6% per year between 2001–02 and 2005–06.

The report also shows that the National Health Priority Areas were represented by high numbers of separations for some diagnoses, and records a notable growth in coronary artery bypass graft and coronary angioplasty, in both the public and private sectors.

This year the information on performance has been considerably improved, with the provision of time series information against the performance indicators in Chapter 4 and improvements in the tables to make the information more accessible to readers.

Accompanying this report is a suite of additional statistical information on our website. This includes interactive online data cubes from hospital databases. The report itself can also be accessed from the website.

Timely reporting of this information involves a chain of responsibilities, from hospital clinicians and administrative staff through state and territory authorities to the AIHW's database and analysis teams. We continue to strive for timely reporting and to improve the quality and usefulness of the report. We welcome comments from readers.

Penny Allbon

Director

May 2007

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- Jenny Hargreaves (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
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ALOS	Average length of stay
AMI	Acute myocardial infarction
AR-DRG	Australian Refined Diagnosis Related Group
ave	Average
behav.	Behavioural
Cat.	Catastrophic
CC	Complication and/or comorbidity
COPD	Chronic obstructive pulmonary disease
dis.	Diseases
DHAC	Department of Health and Aged Care
DoHA	Department of Health and Ageing
DRG	Diagnosis Related Group
ECMO	Extracorporeal membrane oxygenation
ECT	Electroconvulsive therapy
ESWT	Elective surgery waiting times
exp.	Exposure to
FTE	Full-time equivalent
HASAC	Health and Allied Services Advisory Council
HDSC	Health Data Standards Committee
HIV	Human immunodeficiency virus
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
IFRAC	Admitted patient fraction
inv.	Involving
mal.	Malignant
MDC	Major Diagnostic Category
mis	Misadventure
n.a.	Not available
NNAPEDCD	National Non-admitted Patient Emergency Department Care Database
NCCH	National Centre for Classification in Health
n.e.c.	Not elsewhere classified
NHCDC	National Hospital Cost Data Collection
NHDC	National Health Data Committee
NHMBWG	National Health Ministers' Benchmarking Working Group
NHMD	National Hospital Morbidity Database
NHPA	National Health Priority Area
NHPC	National Health Performance Committee
NOCD	National Outpatient Care Database
NPHED	National Public Hospital Establishments Database
n.p.	Not published
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Co-operation and Development
op.	Operation
O.R.	Operating room
PICQ	Performance Indicators for Coding Quality
PPH	Potentially preventable hospitalisation
proc(s)	Procedure(s)
Qld	Queensland
RRMA	Rural, Remote and Metropolitan Area
RSI	Relative stay index
SA	South Australia
SCRGSP	Steering Committee for the Review of Government Service Provision
SEIFA	Socio-Economic Indexes for Areas
sep.	Separation

sev	Severe
SLA	Statistical local area
SRG	Service related group
SRR	Standardised separation rate ratio
Tas	Tasmania
Vic	Victoria
VMO	Visiting medical officer
W	With
W/O	Without
WA	Western Australia
. .	Not applicable

Summary

Australian hospital statistics 2005–06 is the thirteenth annual report on the characteristics and activity of Australia's hospitals. Hospitals included in the report include public acute care and psychiatric hospitals, public non-acute hospitals, private free-standing day hospital facilities and other private hospitals.

This report describes information on a variety of aspects of Australia's hospital services, including admitted patient care, elective surgery waiting times, non-admitted emergency department care, outpatient care, and public hospital expenditure and resources.

Admitted patient care

During 2005–06, there were 7.3 million separations from Australian hospitals accounting for over 24.3 million patient days, compared to 7.0 million separations and 23.8 million patient days in 2004–05. The majority of separations (61%) and patient days (67%) were from public acute hospitals. Most separations were for same-day care (55%). The average length of stay for all hospitals has decreased by 21.4% between 1996–97 and 2005–06 from 4.2 days to 3.3 days. In 2005–06 for public acute hospitals, the average length of stay was 3.7 days; in private hospitals it was 2.6 days.

In 2005–06, 37.4% of separations had a principal diagnosis that derived from one of five groups of conditions: *Diseases of the digestive system*; *Neoplasms*; *Diseases of the circulatory system*; *Pregnancy, childbirth and the puerperium*; and *Injury and poisoning*. The National Health Priority Areas were represented by some high-volume diagnoses. There were over 164,000 separations with a principal diagnosis of fracture; almost 38,000 separations with a principal diagnosis of asthma; and over 57,000 with chronic obstructive pulmonary disease. There were almost 85,000 separations with a principal diagnosis of arthritis and almost 78,000 with a principal diagnosis of angina pectoris.

Females accounted for 53% of hospital separations with a separation rate of 377 per 1,000 compared to 338 per 1,000 for males. Indigenous Australians had high rates of hospitalisation with a separation rate of 623 per 1,000 population compared to 360 per 1,000 for other persons (noting that the Indigenous status data need improvement).

Waiting times for elective surgery

In 2005–06, there were almost 557,000 admissions for elective surgery reported to the National Elective Surgery Waiting Times Data Collection. The median waiting time for elective surgery in public hospitals was 32 days. *Cardio-thoracic surgery* had the shortest median waiting time (12 days); *Ophthalmology* had the longest median waiting time (69 days). Approximately 4.6% of people admitted for elective surgery from the elective surgery waiting lists had waited more than 365 days.

Emergency department care

In 2005–06, there were approximately 6.3 million accident and emergency department occasions of service provided in Australia's public hospitals. Of those occasions of service for

which triage category and waiting times data are available (approximately 4.9 million presentations), 69% were seen within the time specified as appropriate for their triage category. In *Principal referral and Specialist women and children's hospitals*, the proportion seen on time was 65%, in *Large hospitals* the proportion was 73%.

Outpatient activity

Excluding services in emergency departments, there were approximately 38 million non-admitted patient occasions of service in public hospitals during 2005–06. Approximately 15 million of these occasions of service were in outpatient clinics. Of those outpatient episodes for which clinic-level information was available (approximately 11.4 million episodes), 2.4 million were occasions of service in *Allied health* clinics, and 2.1 million were in *Medical* clinics. Records were also provided for approximately 129,000 group occasions of service. Approximately 83,000 of these group sessions occurred in *Allied health* clinics.

Hospital resources and expenditure

In 2005–06, Australia had 736 public acute hospitals, 19 public psychiatric hospitals, 252 private free-standing day hospital facilities and 284 other private hospitals. In 2005–06, there were almost 82,000 available hospital beds in Australia, with almost 55,000 available beds in public acute and psychiatric hospitals and over 27,000 available beds in private hospitals. The number of available beds in public acute hospitals decreased by an average of 0.3% annually, and the number of available beds/chairs in private free-standing day hospital facilities increased by an average of 6.0% annually, between 1996–97 and 2005–06.

The number of full-time equivalent staff in public acute and public psychiatric hospitals increased by an average of 2.7% between 1996–97 (174,695) and 2005–06 (221,379). The number of salaried medical officers increased by an average of 5.4% per year over that period (from 14,210 full time equivalents to 22,858).

Recurrent expenditure on public acute and public psychiatric hospitals was $23,991 million in 2005–06, 5.6% greater than expenditure in 2004–05 after adjusting for inflation. *Salary payments* accounted for 62.1% of total recurrent expenditure in 2005–06, and *Medical and surgical supplies* accounted for 9% of total recurrent expenditure. The average cost per separation was $3,698 excluding depreciation and $3,839 including depreciation.

Hospitals at a glance

Australian hospital statistics 2005–06 provides a thirteenth year of comprehensive annual statistical reporting by the Australian Institute of Health and Welfare on the characteristics and activity of Australian hospitals. A summary of the report's information on Australian hospitals is presented below. 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 2004–05 and 2005–06

- There were 7,311,983 separations and 24,330,653 patient days in 2005–06, compared with 7,018,850 separations and 23,828,612 patient days in 2004–05.
- Separations increased by 4.5% for public acute hospitals and by 3.3% for private hospitals after adjusting for coverage changes.
- With the same adjustments, separations increased by 4.3% for public patients and by 3.7% for private patients, and separations for which private health insurance was reported as the funding source increased by 4.2%.
- With the same adjustments, the number of patient days increased by 2.8% in public acute hospitals and by 1.8% in private hospitals.
- With the same adjustments for coverage changes, the number of same-day separations increased by 5.6% in public acute hospitals and by 4.1% in private hospitals and overnight separations increased by 3.4% and 1.8% respectively.

Changes between 1996–97 and 2005–06

- Separations from all hospitals increased by 37.3% (not adjusted for coverage change). Separations increased by 22.8% in public acute hospitals and by 68.9% in private hospitals (including free-standing day hospital facilities).

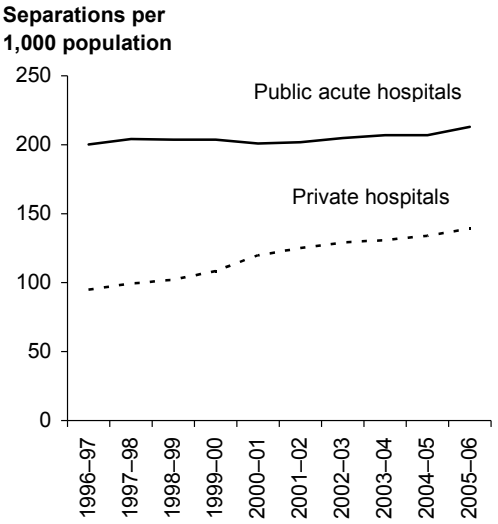


Figure 1: Separations per 1,000 population, public acute and private hospitals, Australia, 1996–97 to 2005–06

- Separations per 1,000 population increased by 6.4% for public acute hospitals and by 46.6% for private hospitals (Figure 1).

- The number of patient days in public acute hospitals increased by 7.2%.For private hospitals patient days increased by 25.8%.
- Patient days per 1,000 population decreased by 10.5% for public acute hospitals and increased by 2.7% for private hospitals (Figure 2).
- For stand-alone public psychiatric hospitals, separations per 1,000 population fell by 36.7% and there was a 57.8% fall in patient days per 1,000 population. This accompanied a fall in the number of public psychiatric hospitals.

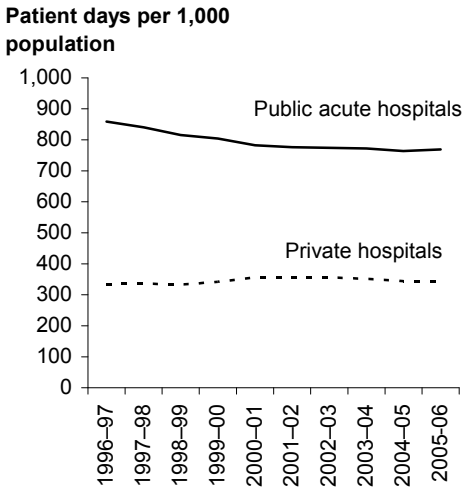


Figure 2: Patient days per 1,000 population, public acute and private hospitals, Australia, 1996–97 to 2005–06

- In 1996–97, 68.0% of separations and 68.1% of patient days in acute care hospitals were in public acute hospitals. By 2005–06, these percentages had fallen to 60.9% and 67.1%, respectively, showing a shift in hospital use from public acute to private hospitals overall, during this period.

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 1996–97 (44.7%) and 2005–06 (55.3%).
- The number of same-day separations increased by 5.1% between 2004–05 and 2005–06 compared with a 3.1% increase in overnight separations. Same-day separations increased by 5.5% in public hospitals and by 4.6% in private hospitals.
- The average length of stay in hospitals was 3.4 days in 2004–05 and 3.3 days 2005–06.
- The average length of stay decreased by 21.4% between 1996–97 and 2005–06, from 4.2 days to 3.3 days. The average length of private hospital stays decreased to 2.6 days, and that of public acute hospital stays decreased to 3.7 days (Figure 3).

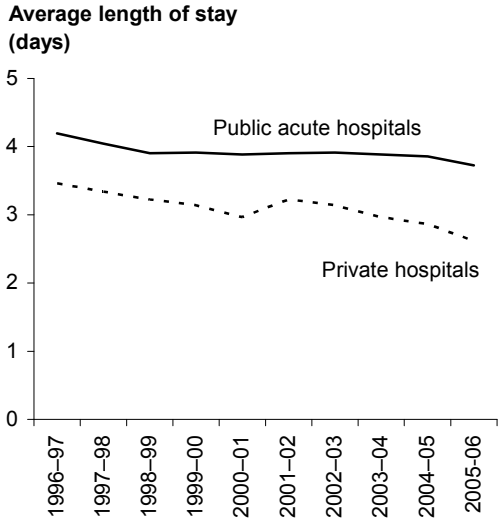


Figure 3: Average length of stay, public acute and private hospitals, Australia, 1996–97 to 2005–06

- Average lengths of stay have remained relatively constant over this period for patients staying at least one night. They were 6.3 days in public acute hospitals and 5.4 days in private hospitals in 2005–06 (Figure 4).

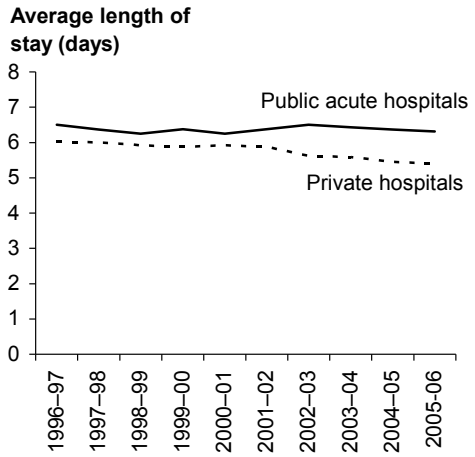
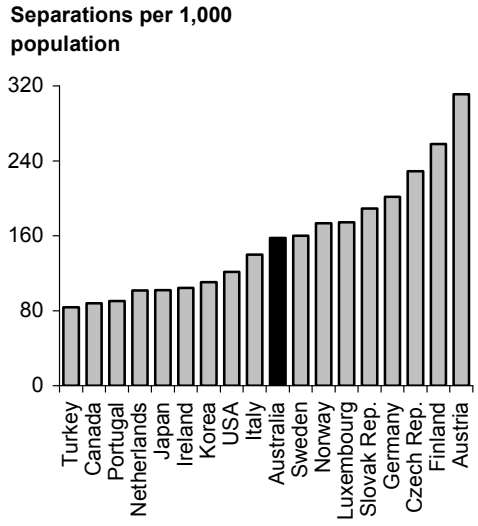


Figure 4: Average length of stay for overnight separations, public acute and private hospitals, Australia, 1996–97 to 2005–06

International comparisons



Abbreviation: Reb.—republic.

Notes:

1. Data for Canada, Japan, Italy, the USA and Germany are for 2002–03.
2. Data for OECD countries vary in collection periods, from financial year, fiscal year and calendar year.

Figure 5: Overnight separations per 1,000 population, Australia, 2004–05 and selected OECD countries

- The number of overnight separations per 1,000 population in Australia for 2003–04 was in the middle of the range reported by other OECD countries for recent years (Figure 5, OECD 2006).
- Comparability of international separation rates is likely to be affected by differences in definitions of hospitals, collection periods and in admission practices.

Age group and sex

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

- In 2005–06, there were 3,873,645 separations for females compared with 3,438,248 separations for males, 53.0% and 47.0% of separations respectively.
- Overall, in 2005–06 there were 376.8 separations per 1,000 population for females, compared with 338.0 separations per 1,000 population for males (Figure 6).

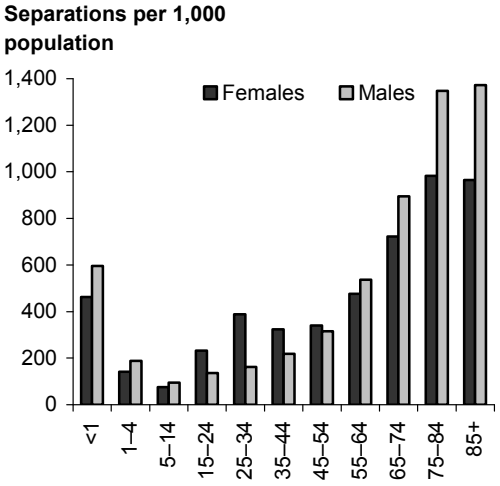


Figure 6: Separations per 1,000 population, by age group and sex, Australia, 2005–06

- 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 2001–02 and 2005–06. These increases were very marked for both females and males aged 55 and over. Most notably, separations increased by 26.0% for females aged 55–64 years and by 42.2% for males aged 85 years and over (Figure 7).
- Separations of persons aged 1–4 years decreased over this period for both males and females.

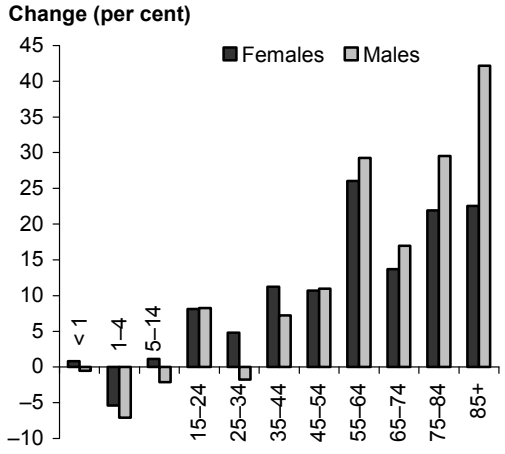


Figure 7: Change in the number of separations (per cent), by age group and sex, Australia, 2001–02 to 2005–06

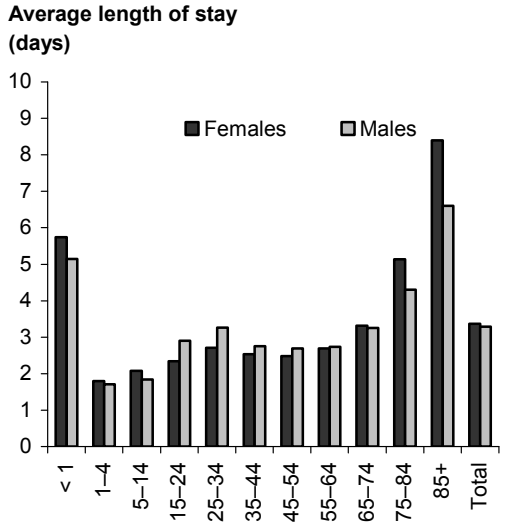


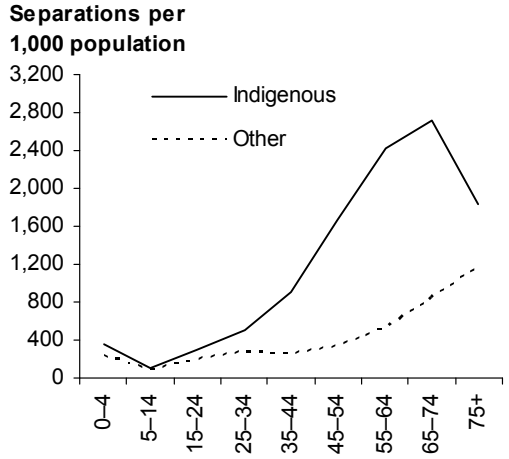
Figure 8: Average length of stay, by age group and sex, Australia, 2005–06

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

Aboriginal and/or Torres Strait Islander peoples

Those identifying as being of Aboriginal and/or Torres Strait Islander origin, had higher separation rates in 2005–06 than other persons. See *Chapter 8*.

- In 2005–06, the crude separation rate for Indigenous persons (623.1 per 1,000 population) was about double the rate for other persons (360.1 per 1,000 population). It was higher for all age groups, particularly for ages 35 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, 2005–06

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 (453.8 separations per 1,000 population) and lowest for patients living in major cities (200.1 separations per 1,000 population).
- Separation rates for private hospitals were highest for patients living in major cities (148.6 separations per 1,000 population) and lowest for patients living in very remote areas (51.2 separations per 1,000 population).
- 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.

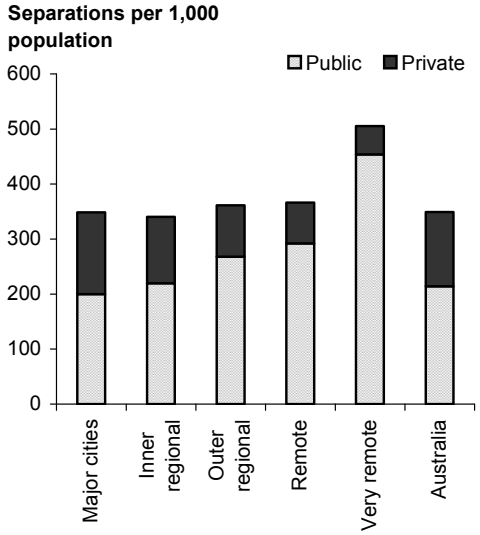
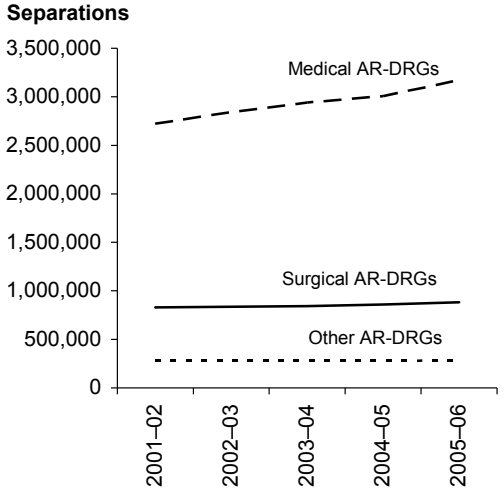


Figure 10: Separations per 1,000 population, by Remoteness Area of usual residence and hospital sector, Australia, 2005–06

Overall type of care

Separations were 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*.

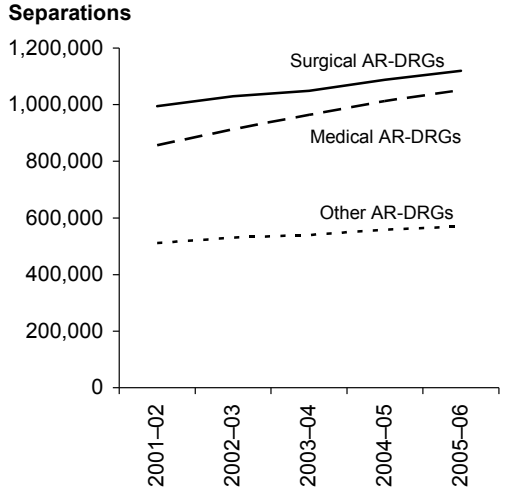
- In public acute hospitals, separations with *Medical AR-DRGs* increased by 16.5% between 2001–02 and 2005–06. Separations with *Surgical AR-DRGs* increased by 6.3% and *Other AR-DRGs* increased by less than 0.1% in the same period (Figure 11).



Note: AR-DRG version 5.0 was used for data in 2005–06.

Figure 11: Separations for medical, surgical and other AR-DRGs version 5.0, public hospitals, Australia, 2001–02 to 2005–06

- In private hospitals, separations with *Medical AR-DRGs* increased by 22.8%, those with *Surgical AR-DRGs* increased by 12.6% and those with *Other AR-DRGs* increased by 11.4% (Figure 12).



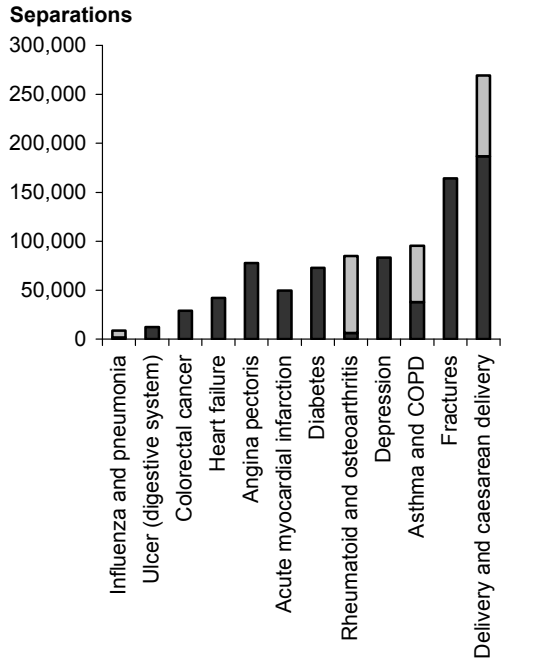
Note: AR–DRG version 5.0 was used for data from 2005–06.

Figure 12: Separations for medical, surgical and other AR-DRGs version 5.0, private hospitals, Australia, 2001–02 to 2005–06

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, 37.4% of separations in 2005–06 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.
- 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 2005–06, the NHPAs were represented by some high-volume diagnoses. There were 164,360 separations with a principal diagnosis of fracture; 37,930 with a principal diagnosis of asthma and 57,538 with a principal diagnosis of chronic obstructive pulmonary disease (COPD); 84,999 with a principal diagnosis of arthritis; 77,582 with a principal diagnosis of angina pectoris; and 72,745 with a principal diagnosis of diabetes (Figure 13).



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

Figure 13: Separations, by selected principal diagnosis, Australia, 2005–06

Selected potentially preventable hospitalisations

The selected potentially preventable hospitalisations presented in this report are 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*.

- Selected potentially preventable hospitalisations represented 9.3% of all separations in 2005–06.
- Overall, the number of separations per 1,000 population for the selected potentially preventable hospitalisations increased by an average of 2.9% per year between 2001–02 and 2005–06.
- Some diseases can be prevented by vaccination. The number of separations per 1,000 population for these diseases decreased by an average of 5.7% per year between 2001–02 and 2005–06 (Figure 14).

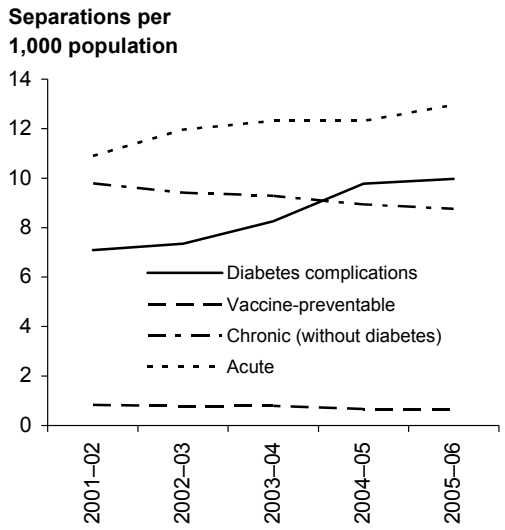


Figure 14: Selected potentially preventable hospitalisations per 1,000 population, Australia, 2001–02 to 2005–06

- For chronic conditions, excluding diabetes, potentially preventable hospitalisations per 1,000 population decreased by an average of 2.8% per year between 2001–02 and 2005–06.
- For diabetes complications, potentially preventable hospitalisations per 1,000 population increased by an average of 8.6% per year between 2001–02 and 2005–06.
- For acute conditions, potentially preventable hospitalisations per 1,000 population increased by an average of 4.2% per year between 2001–02 and 2005–06.

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 81.5% of the separations in Australian hospitals in 2005–06.
- Overall, 55.8% of separations that reported a procedure occurred in the public sector. Overall, 74.5% of separations from the public sector recorded a procedure compared with 92.5% in the private sector.

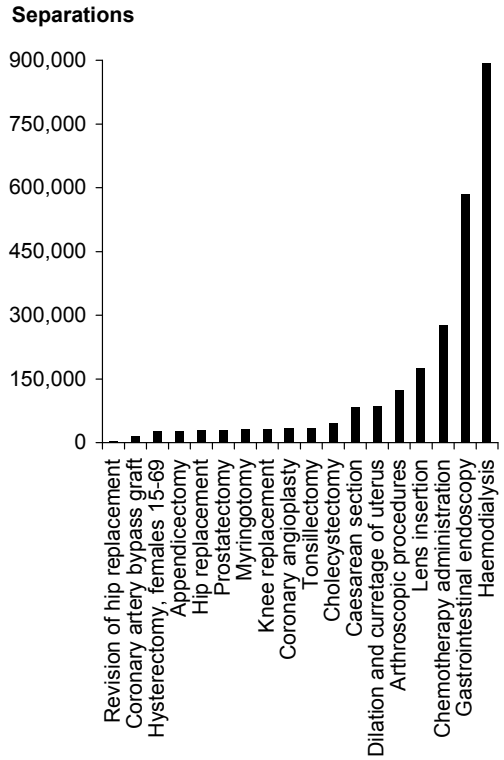


Figure 15: Separations with selected procedures, Australia, 2005–06

- Separations in 2005–06 for selected high-volume procedures and selected procedures that can be electively performed are shown in Figure 15.
- In 2005–06, high-volume procedures included *Haemodialysis* (892,847

separations), *Gastrointestinal endoscopy* (584,569 separations), *Chemotherapy administration* (277,570 separations), *Lens insertion* (175,631 separations) and *Arthroscopic procedures* (124,700 separations).

- The number of separations for coronary artery bypass graft and coronary angioplasty increased by 22.0% between 2001–02 and 2005–06. They increased by 17.9% in the private sector and by 25.7% in the public sector.
- In 2005–06, 54.7% of the separations with a coronary artery bypass graft or coronary angioplasty were in the public sector and 45.3% were in the private sector (26,745 and 22,182 respectively), compared with 53.1% and 46.9% in 2001–02 (21,285 and 18,809 respectively) (Figure 16).

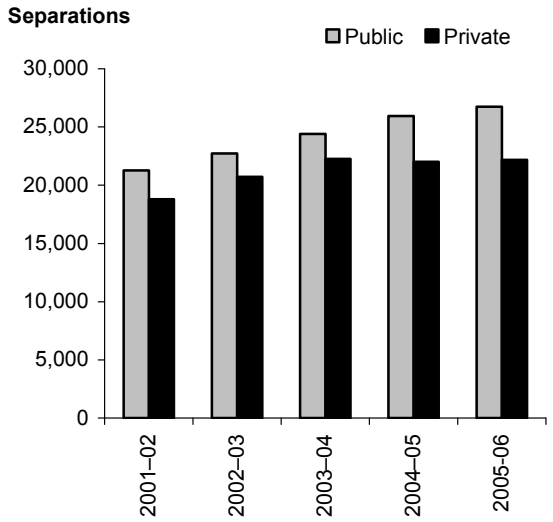


Figure 16: Separations for coronary artery bypass graft and coronary angioplasty by hospital sector, Australia, 2001–02 to 2005–06

Waiting times for elective surgery in public hospitals

The median waiting time for elective surgery in public hospitals in 2005–06 was 32 days. See *Chapter 6*.

- Ophthalmology, orthopaedic surgery, and ear, nose and throat surgery were the surgical specialties with the longest median waiting times (69, 54 and 47 days respectively) in 2005–06 (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 (12 days).

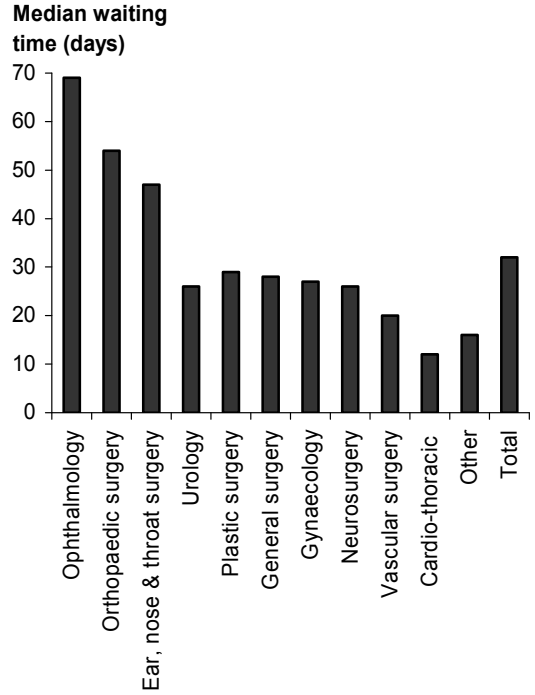


Figure 17: Public hospital median waiting time, by specialty of surgeon, Australia, 2005–06

Emergency department care in public hospitals

About 6.3 million accident and emergency occasions of service were provided in public hospitals in 2005–06. See *Chapter 5*.

- Data on triage category, waiting times, patient age group and sex were available for about 78% 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 hospit*als.
- 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*, 70% of *Urgent* patients were seen on time compared with 60% in *Principal referral and Specialist women's and children's hospitals* (Figure 18).

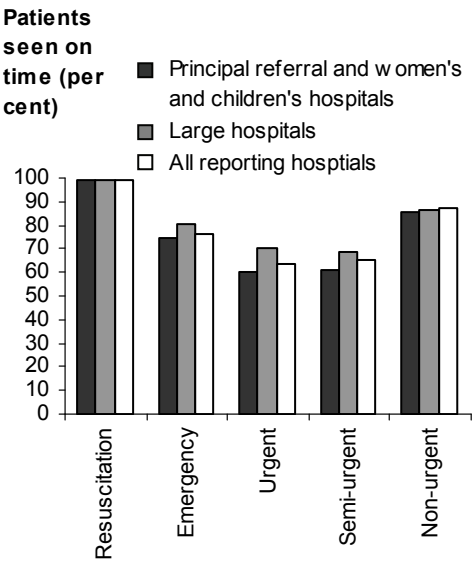


Figure 18: Public hospital emergency department occasions of service seen on time (per cent), by triage category and public hospital peer group, Australia, 2005–06

- Persons aged 15–24 years accounted for the largest number of emergency department occasions of service (767,153, 15.6%) (Figure 19).

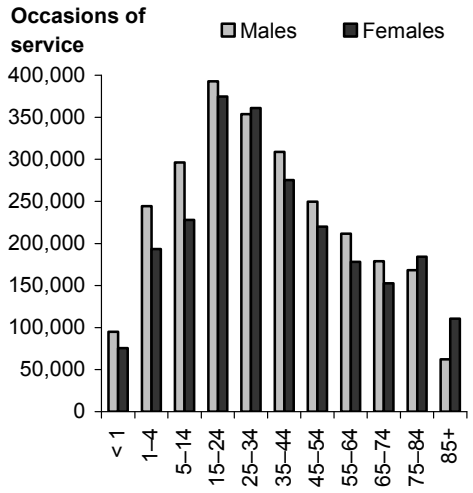


Figure 19: Emergency department occasions of service, by age group and sex, Australia, 2005–06

Non-admitted patient care in public hospitals

About 44.7 million non-admitted patient occasions of service were provided by public hospitals in 2005–06. (See *Chapter 2*).

- Almost 15 million of these occasions of service were delivered in specialist outpatient clinics and data on the type of outpatient clinic, the number of individual and group occasions of service were available for about 76% of these (See *Chapter 5*).
- *Allied health* and *Medical* were the outpatient clinics with the highest number of occasions of service reported (See *Chapter 5*).

Australian hospitals

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

- There were 1,291 hospitals in Australia in 2005–06.
- There were 736 public acute hospitals and 19 public psychiatric hospitals.

- There were 252 private free-standing day hospital facilities and 284 other private hospitals.
- There has been an increase in the number of public acute hospitals, from 724 in 2001–02 to 736 in 2005–06.
- The number of public psychiatric hospitals decreased from 22 facilities in 2001–02 to 19 facilities in 2005–06.

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 2005–06, there were 81,818 available beds in Australia.
- There were 52,236 available beds in public acute hospitals and 2,366 in public psychiatric hospitals.
- There were an estimated 1,965 available beds in private free-standing day hospital facilities and 25,252 in other private hospitals.
- There was a 1.0% increase in available beds from 80,966 in 1996–97 to 81,818 in 2005–06, an average increase of 0.1% annually.
- The number of available beds in public acute hospitals decreased by an average of 0.3% annually, from 53,478 in 1996–97 to 52,236 in 2005–06 (Figure 20).
- The number of available beds/chairs in private free-standing day hospital facilities increased by an average of 6.0% annually between 1996–97 and 2005–06 (from 1,163 to 1,965).

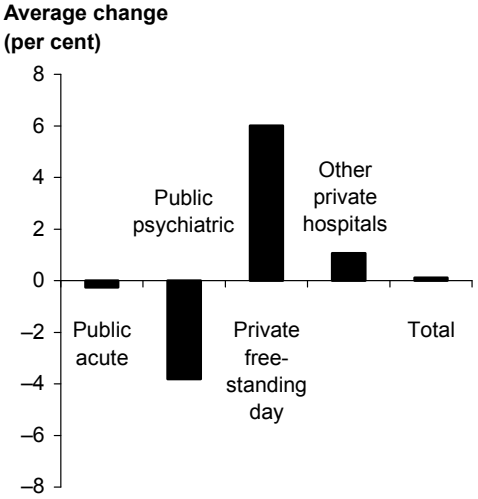


Figure 20: Average annual change in the number of available beds, by type of hospital, Australia, 1996–97 to 2005–06

Staff in Australian public hospitals

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

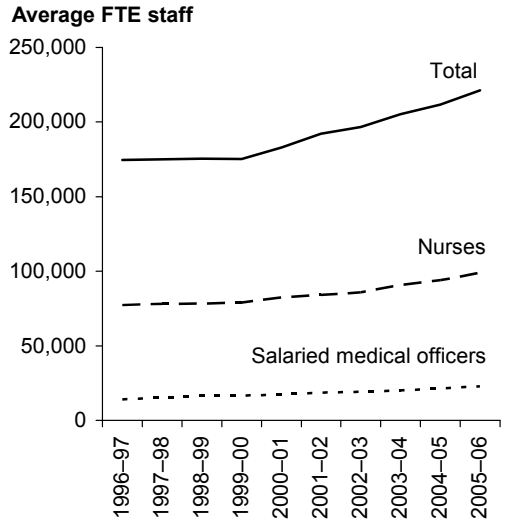


Figure 21: Average full-time equivalent staff, public hospitals, Australia, 1996–97 to 2005–06

- The number of full-time equivalent staff increased by an average of 2.7% annually between 1996–97 (174,695) and 2005–06 (221,379). The number of salaried medical officers increased by an average of 5.4% annually over this

period (from 14,210 to 22,858), and the number of nurses increased by an annual average of 2.8% (from 77,390 to 99,008).

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 $23,991 million in 2005–06. After adjusting for inflation, this represented an increase of 5.6% compared with 2004–05.
- The largest share of this expenditure was for salary payments, which accounted for 62% ($14,888 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.

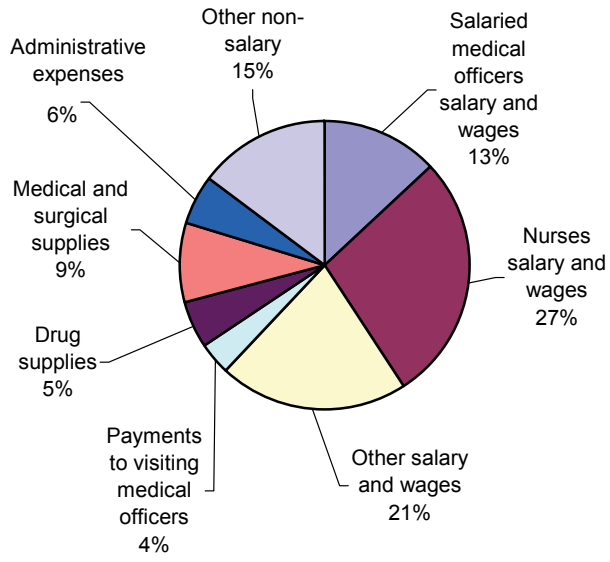


Figure 22: Recurrent expenditure, public hospitals, Australia, 2005–06

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 $3,004 in 2001–02 to $3,698 in 2005–06 (not adjusted for inflation).
- This represents a total increase of 23.1% in this period, an average increase of 5.3% annually (Figure 23).
- In 2005–06 the average cost comprised $1,921 for non-medical labour expenditure, $745 for medical labour expenditure and $1,032 for other recurrent expenditure. Other recurrent expenditure costs include domestic services; repairs and maintenance; administration, and medical, drug and food supplies.

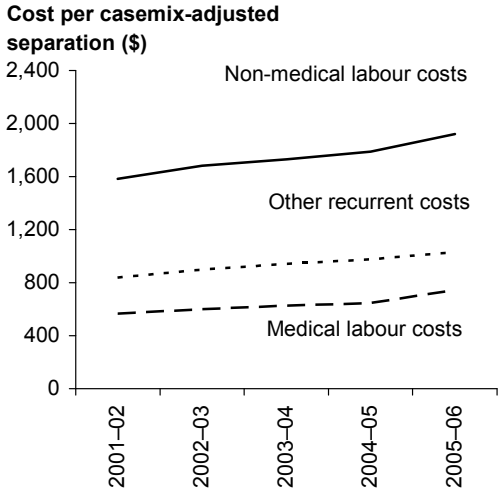


Figure 23: Cost per casemix-adjusted separation, Australia, 2001–02 to 2005–06