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Australian Institute of Health and Welfare

Board Chair

Hon. Peter Collins, AM, QC

Director

Penny Allbon

Any enquiries about or comments on this publication should be directed to:

George Bodilsen (hospital statistics): Telephone (02) 6244 1157

Katrina Burgess (patient statistics): Telephone (02) 6244 1215

Australian Institute of Health and Welfare

GPO Box 570

Canberra ACT 2601

Email: hospitaldata@aihw.gov.au

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Foreword

I am pleased to present *Australian hospital statistics 2007–08*, an authoritative report that provides a comprehensive range of statistics and information about public and private hospitals.

The publication is produced with the cooperation and advice of state and territory health authorities, the Australian Government, and other stakeholders. While based on jurisdictional data, it reflects the AIHW's expertise in applying impartial analysis to the raw data from jurisdictions, to produce information and analysis that informs the community and policy makers.

This year, new features of the report include the incorporation of the revised National Health Performance Framework to present hospital performance indicators. The revised framework was agreed by AHMAC's National Health Information Standards and Statistics Committee in 2008 and simplifies the consideration of the performance of health services.

As previously, the report includes a range of hospital performance indicators, many of them endorsed by AHMAC. The report indicates which of the indicators are in the new National Healthcare Agreement, such as selected potentially preventable hospitalisations, rates of services provided by public and private hospitals, waiting times for elective surgery and emergency department care, and the cost per casemix-adjusted separation.

Another innovation this year has been to report a wider range of information than previously on access to elective surgery. Statistics are presented on access to both publicly and privately funded elective surgery, and on access by various population groups. These new measures show that, in 2007–08, public elective surgical admissions increased with increasing socioeconomic disadvantage, and that Aboriginal and Torres Strait Islander persons had higher median waiting times for elective surgery than other Australians.

Finally, the report previews data on the timing of onset of conditions treated in hospital. Conditions reported as having onset after admission can be regarded as a measure of the safety and quality of health care. We will aim to present comprehensive statistics using these data next year, when they are available for all states and territories.

The AIHW strives to deliver useful information as soon as it possibly can. The complex pathway of data flows through recording, coding, collating, validating and analysing on its way from hospital bed to an AIHW report. This whole process is under review within all areas of the health system as a result of the push from the Council of Australian Governments for speedier information. It is my determined desire that next year's information will be reported earlier and in a variety of formats to reflect the various needs at all levels of government and the community.

Penny Allbon

Director

June 2009

Acknowledgments

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The AIHW's Australian Hospital Statistics Advisory Committee has also been of great assistance to this project. Members of the Committee are:

- Jenny Hargreaves (AIHW) (Chair)
- John Agland (New South Wales Health Department)
- Paul Basso (South Australian Department of Health)
- Josephine Beer (Victorian Department of Human Services)
- Eui-Soo Choi (New South Wales Health Department)
- Paul Collins (Private Health Insurance Administration Council)
- Sue Cornes (Queensland Health)
- Louise Edmonds (Australian Capital Territory Department of Health)
- Gary Inglis (Northern Territory Department of Health and Community Services)
- Jiten Mangal (Commonwealth Grants Commission)
- Peter Mansfield (Tasmanian Department of Health and Human Services)
- Peter Menzel (Australian Government Department of Health and Ageing)
- George Neale (Australian Private Hospitals Association Limited)
- Tara Pritchard (Australian Bureau of Statistics)
- Elisabeth Sallur (Western Australian Department of Health)
- Paul Tridgell (Australian Healthcare and Hospitals Association)
- Marla Tun (National Centre for Classification in Health)

Within the AIHW, the report was prepared by George Bodilsen, Katrina Burgess, Brett Henderson, Moira Hewitt, Tony Mole, Duane Riley and Katie Williams. Geoff Davis assisted in database management. Cecilia Burke and John Steggall coordinated the publication process.

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Abbreviations

ABS	Australian Bureau of Statistics	NHISSC	National Health Information Standards and Statistics Committee
ACHI	Australian Classification of Health Interventions	NHMBWG	National Health Ministers' Benchmarking Working Group
ACT	Australian Capital Territory	NHMD	National Hospital Morbidity Database
AHMAC	Australian Health Ministers' Advisory Council	NHPA	National Health Priority Area
AIHW	Australian Institute of Health and Welfare	NHPC	National Health Performance Committee
ALOS	Average length of stay	NMDS	National minimum data set
AR-DRG	Australian Refined Diagnosis Related Group	NNAPEDCD	National Non-admitted Patient Emergency Department Care Database
Cat.	Catastrophic	NOCD	National Outpatient Care Database
CC	Complication and/or comorbidity	n.p.	Not published
DoHA	Department of Health and Ageing	NPHEd	National Public Hospital Establishments Database
DRG	Diagnosis Related Group	NSW	New South Wales
exp.	Expense	NT	Northern Territory
FTE	Full-time equivalent	OECD	Organisation for Economic Co-operation and Development
HASAC	Health and Allied Services Advisory Council	PICQ	Performance Indicators for Coding Quality
HDSC	Health Data Standards Committee	PPH	Potentially preventable hospitalisation
HIV	Human immunodeficiency virus	Qld	Queensland
ICD-9-CM	International classification of diseases, 9th Revision, Clinical modification	RRMA	Rural, Remote and Metropolitan Area
ICD-10-AM	International statistical classification of diseases and related health problems, 10th revision, Australian modification	RSI	Relative stay index
IFRAC	Admitted patient fraction	SA	South Australia
MDC	Major Diagnostic Category	SCRGSP	Steering Committee for the Review of Government Service Provision
n.a.	Not available	SEIFA	Socio-Economic Indexes for Areas
NAPEDC	Non-admitted patient emergency department care	SLA	Statistical local area
NCCH	National Centre for Classification in Health	SRG	Service related group
n.e.c.	Not elsewhere classified	SRR	Standardised separation rate ratio
NESWTDC	National Elective Surgery Waiting Times Data Collection	Tas	Tasmania
..	Not applicable	Vic	Victoria
NHCDC	National Hospital Cost Data Collection	VMO	Visiting medical officer
NHDC	National Health Data Committee	WA	Western Australia.

Summary

Hospitals are a vital and highly visible part of Australia's health system. What services do our hospitals provide? How do public and private hospitals compare? How quickly are hospitals providing emergency department services or elective surgery? How much do our hospitals cost?

Australian hospital statistics 2007–08 helps to answer questions such as these.

Services provided

Public hospital emergency department presentations are increasing at a faster rate than other hospital services.

- Public hospitals dealt with more than 7 million presentations to emergency departments in 2007–08, and there was an increase of about 4.9% each year since 2003–04.
- Our hospitals handled about 7.9 million admissions in 2007–08, and there was an increase of about 3.6% each year since 2003–04.
- Public hospitals provided about 41 million services through outpatients departments in 2007–08, and there was an increase of about 2.4% each year since 2003–04.

Public and private hospitals

Public and private hospitals have different service profiles.

- Medical care accounted for 74% of public hospital admissions in 2007–08, and increased in volume by 16% from 2003–04 to 2007–08, more than the increase in surgical care (9%). In private hospitals, surgical care accounted for 41% of admissions in 2007–08, and both surgical and medical care increased in volume by 18% from 2003–04 to 2007–08.
- An increasing proportion of admissions over the years have been for same-day care – 50% in public hospitals in 2007–08, and 66% in private hospitals.

Who waits, how long?

Waiting times and admission rates are used to judge the accessibility of hospital services.

- For people going to public hospital emergency departments, 100% of the most urgent cases were seen on time and 69% overall – about the same as in recent years.
- The median waiting time for elective surgery in public hospitals was 34 days, up from 28 days in 2003–04. The proportion of people waiting over a year (3%) was lower than the 4% for the few years before.
- People living outside major cities, those with lower socioeconomic status and especially Indigenous Australians had higher rates of public elective surgical admissions than their counterparts. People living in major cities and those with higher socioeconomic status had relatively high rates of private elective surgical admissions.

Costs

Expenditure on hospitals rose more quickly than inflation.

- Recurrent expenditure on Australia's public hospitals was \$29 billion in 2007–08. The 6% rise from 2006–07 expenditure (adjusted for inflation) was similar to previous years.

Hospitals at a glance

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*.

Overall

In 2007–08, there were over 7.9 million separations from Australian hospitals.

- 60% of separations were in public hospitals (4.7 million separations) and half of these were same-day separations.
- 40% of separations were in private hospitals (3.1 million) and two-thirds of these were same-day separations (Figure 1).

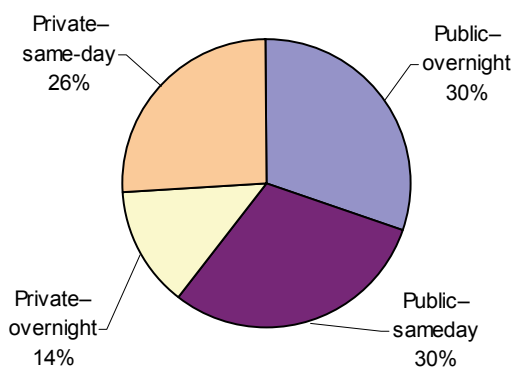


Figure 1: Proportion of separations by hospital sector and same-day/overnight status, Australia, 2007–08

Changes between 2006–07 and 2007–08

- There were 7.9 million separations and 25.6 million patient days in 2007–08, compared with 7.6 million separations and 24.9 patient days in 2006–07.
- Separations increased by 1.8% for public acute hospitals and by 6.4% for private hospitals (not adjusted for reporting changes).

- Same-day separations increased by 1.3% in public acute hospitals and by 8.2% in private hospitals. Overnight separations increased by 2.2% and 3.1% respectively.
- Patient days increased by 2.0% in public acute hospitals and by 4.3% in private hospitals.
- Overall, public patient separations increased by 1.9%, private patient separations increased by 5.4%, and separations for private patients funded by private health insurance increased by 6.7%.

Changes between 1998–99 and 2007–08

- Overall, between 1998–99 and 2007–08, separations increased by 37.3% (not adjusted for coverage and reporting changes).
- Separations increased by 23.1% in public acute hospitals and by 66.9% in private hospitals (including free-standing day hospital facilities).
- Separations per 1,000 persons increased by 5.2% for public acute hospitals and by 39.6% for private hospitals (Figure 2).

Separations per 1,000 population

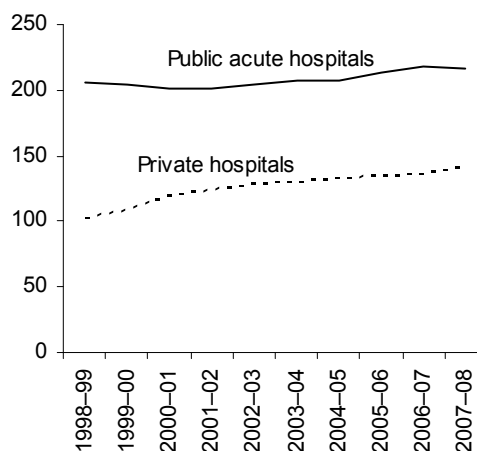


Figure 2: Separations per 1,000 population, public acute and private hospitals, Australia, 1998–99 to 2007–08

- The number of patient days in public acute hospitals increased by 13.5%. For private hospitals, patient days increased by 29.1%.
- Patient days per 1,000 persons decreased by 5.8% for public acute hospitals and increased by 5.4% for private hospitals, with most of this change occurring between 1998–99 and 2001–02 (Figure 3).

Patient days per 1,000 population

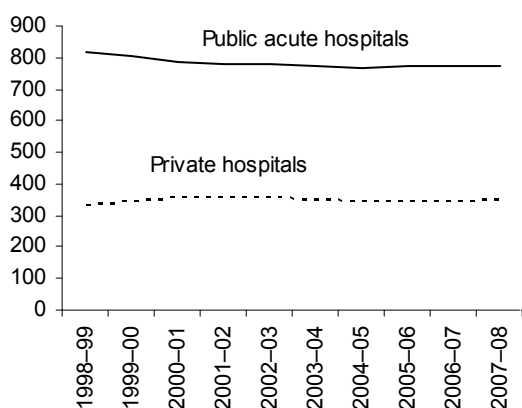


Figure 3: Patient days per 1,000 population, public acute and private hospitals, Australia, 1998–99 to 2007–08

- For stand-alone public psychiatric hospitals, separations per 1,000 persons fell by 15.2% and there was a 23.5% fall in patient days per 1,000 persons.
- In 1998–99, 69.1% of separations and 66.9% of patient days were in public acute hospitals. By 2007–08, the public acute hospital share of separations had fallen to 60.1% and the proportion of patient days was 66.8%.

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 1998–99 (47.9%) and 2007–08 (56.3%).

- The number of same-day separations increased by 4.4% between 2006–07 and 2007–08 compared with a 2.5% increase in overnight separations.
- The average length of stay (including same-day separations) in hospitals was 3.3 days in 2006–07 and 2007–08.
- The average length of stay decreased by 16.3% between 1998–99 and 2007–08, from 3.9 days to 3.3 days.
- The average length of private hospital stays decreased by 22.6% from 3.2 days in 1998–99 to 2.5 days in 2007–08, and public acute hospital stays decreased 7.7% from 3.9 days to 3.6 days (Figure 4).

Average length of stay (days)

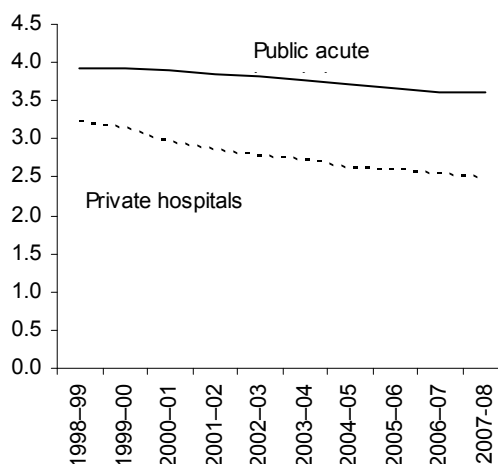


Figure 4: Average length of stay, public acute and private hospitals, Australia, 1998–99 to 2007–08

- Between 1998–99 and 2007–08, for patients staying at least one night:
 - average length of stay varied between 6.2 days and 6.5 days for public acute hospitals
 - average length of stay decreased from 5.9 days in 1998–99 to 5.4 days in 2007–08 for private hospitals (Figure 5).

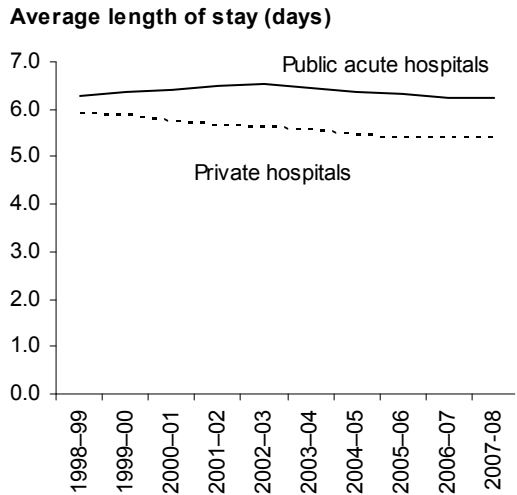
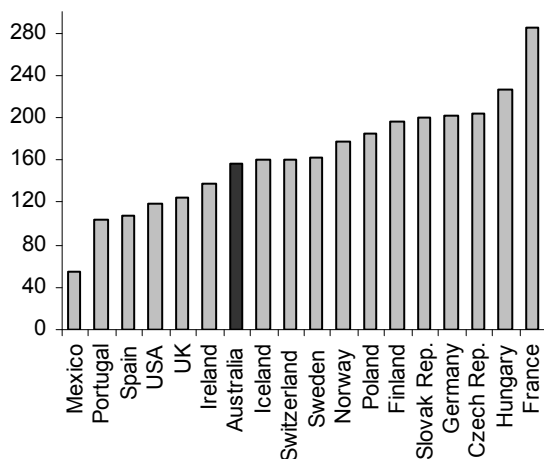


Figure 5: Average length of stay for overnight separations, public acute and private hospitals, Australia, 1998-99 to 2007-08

International comparisons

- The number of overnight separations per 1,000 persons in Australia for 2007-08 was in the middle of the range reported by other OECD countries for recent years (Figure 6, OECD 2008).

Separation per 1,000 population



Abbreviation: Rep.—Republic.

Note: Data for OECD countries vary in collection periods, from financial year, fiscal year and calendar year. Data are for 2006 except for Australia (2007-08) and the USA (2005).

Figure 6: Overnight separations per 1,000 population, Australia, 2007-08 and selected OECD countries (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 2007-08, there were over 4.1 million separations for females (393 per 1,000 persons) compared with 3.7 million separations for males (348.8 per 1,000 persons), 52.7% and 47.3% of separations respectively (Figure 7).

Separations per 1,000 population

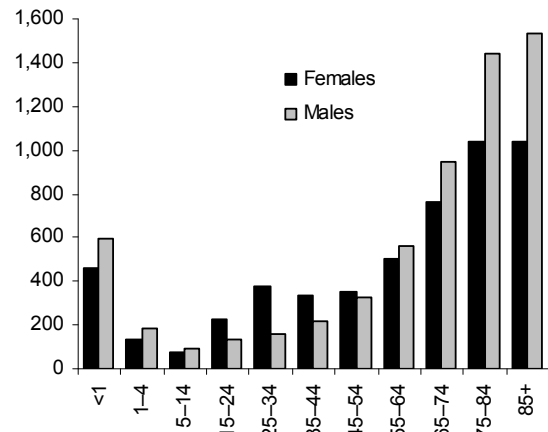


Figure 7: Separations per 1,000 population, by age group and sex, Australia, 2007-08

- Separation rates were higher 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 other age groups.
- Separations increased for both males and females between 2003-04 and 2007-08. These increases were very marked for both males and females aged 55 and over (Figure 8).

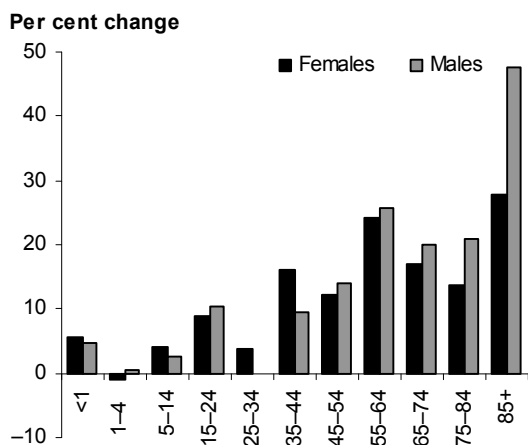


Figure 8: Change in the number of separations (per cent), by age group and sex, Australia, 2003-04 to 2007-08

- Most notably, separations increased by 47.6% for males aged 85 years and over and by 24.2% for females aged 55-64 years.
- Separations of persons aged 1-4 years decreased slightly over this period for females and were stable for males.
- Overall, the average length of stay did not vary greatly between males and females, being around 3.3 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 9).

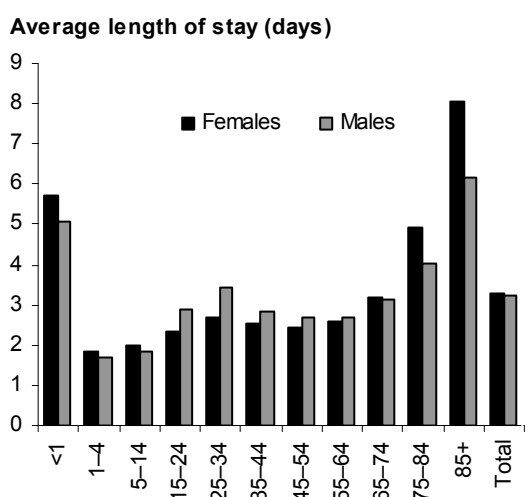
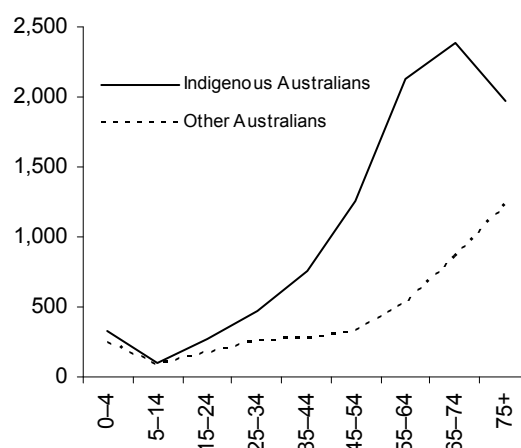


Figure 9: Average length of stay, by age group and sex, Australia, 2007-08

Persons identifying as Indigenous

Indigenous Australians, that is, those identifying as being of Aboriginal and/or Torres Strait Islander origin, had higher separation rates in 2007-08 than other persons. See *Chapter 8*.

Separations per 1,000 population



Notes

1. Other Australians includes both non-Indigenous and not stated/inadequately described separations.
2. This figure includes data for New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory.

Figure 10: Separations per 1,000 population, by Indigenous status and age group, Australia, 2007-08

- In 2007-08, the age-standardised separation rate for *Indigenous Australians* (915.8 per 1,000 persons) was about two and a half times the rate for *Other Australians* (356.8 per 1,000 persons). The rates for *Indigenous Australians* were higher for all age groups (Figure 10).

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 persons varied by remoteness area. Overall, separation rates were highest in *Very remote* and lowest in *Inner regional* areas (Figure 11).

- For public hospitals, separation rates were highest for patients living in *Very remote* areas and lowest for patients living in *Major cities* (432.6 and 201.2 separations per 1,000 persons, respectively).
- For private hospitals, separation rates were highest for patients living in *Major cities* and lowest for patients living in *Very remote* areas (160.2 and 84.1 separations per 1,000 persons respectively).

Separations per 1,000 population

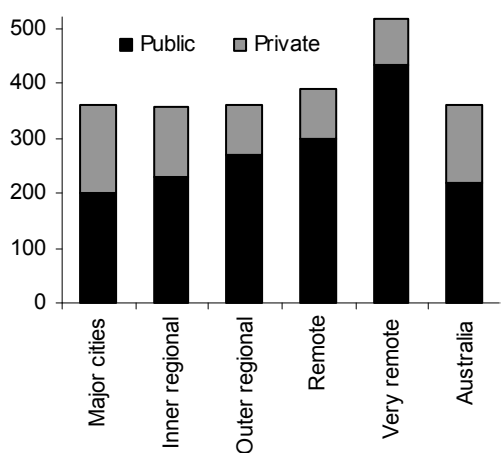


Figure 11: Separations per 1,000 population, by remoteness area of usual residence and hospital sector, Australia, 2007-08

Overall type of care

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

- In public hospitals, between 2003-04 and 2007-08, separations increased for:
 - *Medical AR-DRGs* (15.6%)
 - *Surgical AR-DRGs* (9.2%) and
 - *Other AR-DRGs* (3.9%) (Figure 12).

Separations ('000)

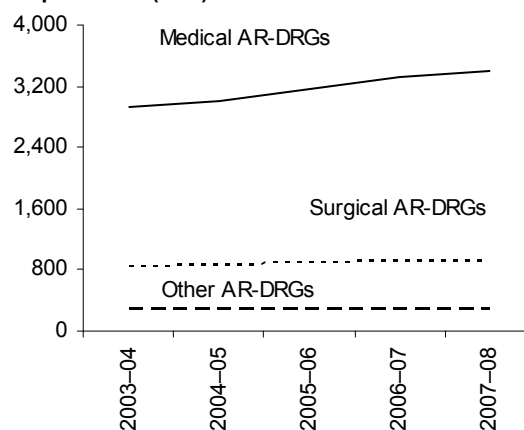


Figure 12: Separations for *Medical, Surgical and Other AR-DRGs* version 5.1, public hospitals, Australia, 2003-04 to 2007-08

- In private hospitals, over the same period, separations increased for:
 - *Medical AR-DRGs* and *Surgical AR-DRGs* (17.5%) and
 - *Other AR-DRGs* (17.7%) (Figure 13).

Separations ('000)

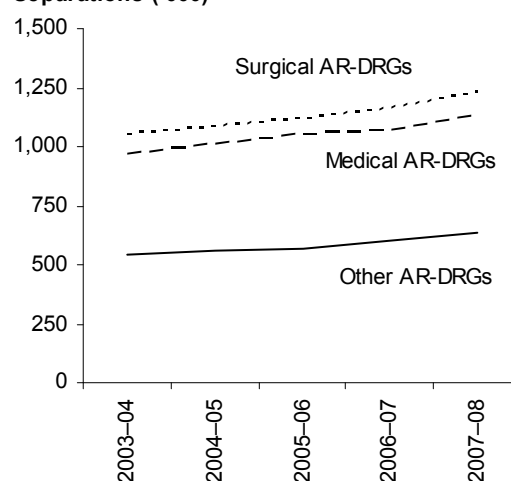


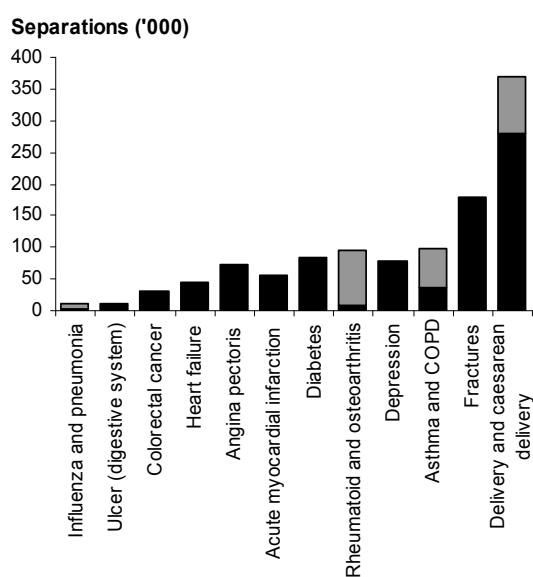
Figure 13: Separations for *Medical, Surgical and Other AR-DRGs* version 5.1, private hospitals, Australia, 2003-04 to 2007-08

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). 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, 36.6% of separations in 2007–08 had a principal diagnosis from one of five ICD-10-AM chapters:
 - *Diseases of the digestive system*
 - *Neoplasms*
 - *Diseases of the circulatory system*
 - *Pregnancy, childbirth and the puerperium*
 - *Injury and poisoning.*
- The National Health Priority Area (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.



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

Figure 14: Separations, by selected principal diagnosis, Australia, 2007–08

- In 2007–08, the NHPAs were represented by some high-volume diagnoses, with principal diagnoses of:
 - fractures (179,000 separations)
 - asthma (38,000)

- chronic obstructive pulmonary disease (COPD) (59,000)
- arthritis (86,000)
- angina pectoris (72,000)
- diabetes mellitus (83,000) (Figure 14).

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. They are therefore potential indicators of the effectiveness of non-hospital care. Both acute and chronic conditions are represented. See *Chapter 4*.

- Selected potentially preventable hospitalisations represented 9.3% of all separations in 2007–08.
- Overall, the number of separations per 1,000 persons for the selected potentially preventable hospitalisations increased by an average of 2.0% per year between 2003–04 and 2007–08.
- For chronic conditions, excluding diabetes, potentially preventable hospitalisations per 1,000 persons rose with increasing remoteness ranging from 9.1 in *Major cities* to 19.1 in *Very remote* regions (Figure 15).
- This pattern was also evident for acute conditions, where potentially preventable hospitalisations per 1,000 persons rose with increasing remoteness from 12.5 in *Major cities* to 29.3 in regions classed as *Very remote*.
- For diabetes complications, potentially preventable hospitalisations per 1,000 persons were markedly higher in *Remote* areas than in other areas.

Separations per 1,000 population

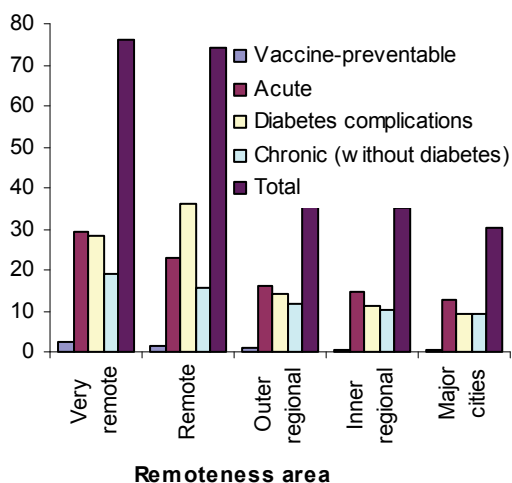


Figure 15: Selected potentially preventable hospitalisations per 1,000 population, by remoteness area of usual residence, Australia, 2007-08

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 83% of separations in Australian hospitals in 2007-08.
- Over 93% of separations from private hospitals recorded a procedure, compared with 76% from public hospitals.
- Overall, 55% of separations that reported a procedure occurred in the public sector.

Separations in 2007-08 for selected high-volume procedures and selected procedures that can be electively performed are shown in Figure 16.

- In 2007-08, high-volume procedures included
 - *Haemodialysis* (1.0 million)
 - *Gastrointestinal endoscopy* (631,000)
 - *Chemotherapy administration* (260,000)
 - *Lens insertion* (190,000) and
 - *Arthroscopic procedures* (137,000).

Separations ('000)

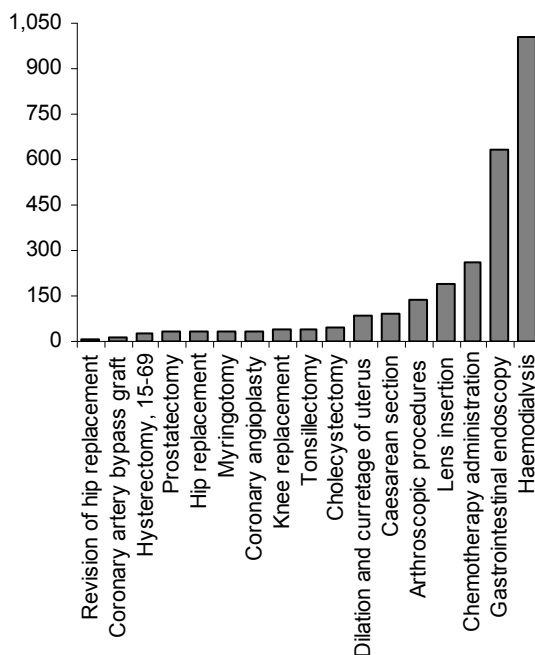


Figure 16: Separations, by selected procedure, Australia, 2007-08

- The number of separations for *Lens insertion* increased overall by 21.3% from 156,000 in 2003-04 to 190,000 in 2007-08 (Figure 17).
- Approximately 70% of *Lens insertions* were performed in private hospitals.
- Separations for *Lens insertion* increased by 21.7% in the private sector and by 20.4% in the public sector over this period.

Separations

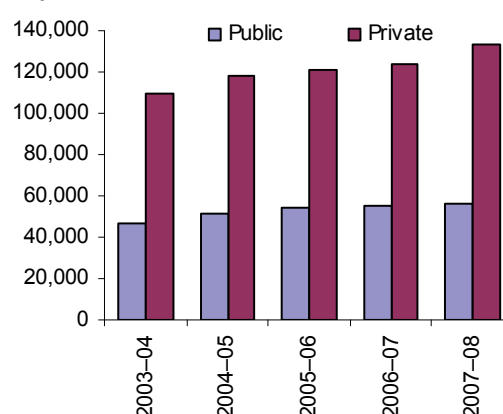


Figure 17: Separations for *Lens insertion*, by hospital sector, Australia, 2003-04 to 2007-08

Elective surgical separations

There were over 1.7 million elective surgical separations in 2007–08, 619,000 in the public sector and 1.1 million in the private sector. See *Chapter 6*.

There was some variation in the rates of access to both private and public elective surgical separations by socioeconomic status.

- The rate of private elective surgical separations was highest for those in the *Most advantaged* quintile (69 per 1,000 persons) and decreased with socioeconomic status to 38 per 1,000 persons for the *Most disadvantaged* quintile (Figure 18).

Separations per 1,000 persons

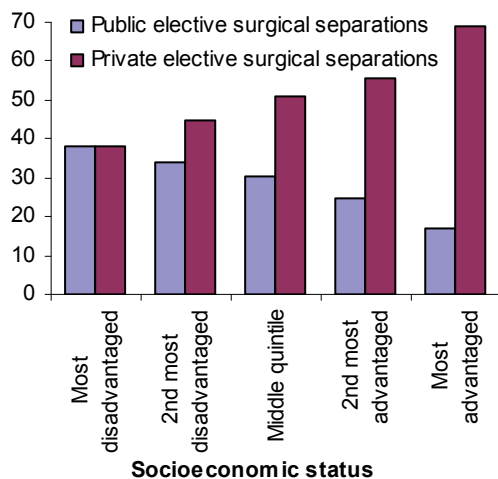


Figure 18: Separations per 1,000 for public and private elective surgical separations, by quintile of socioeconomic advantage/disadvantage, 2007–08

- In contrast, the rate of public elective surgical separations was lowest for those in the *Most advantaged* quintile (17 per 1,000) and highest for those *Most disadvantaged* quintile (38 per 1,000).

Waiting times for elective surgery in public hospitals

The median waiting time for elective surgery in public hospitals in 2007–08 was 34 days. This compared with a median

waiting time of 32 days in 2006–07. See *Chapter 6*.

Median waiting time (days)

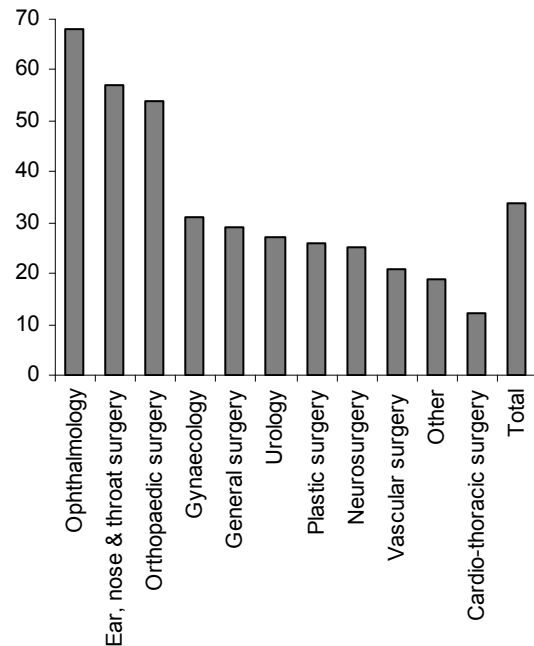


Figure 19: Public hospital median waiting time, by specialty of surgeon, Australia, 2007–08

- *Ophthalmology*, *Ear, nose and throat surgery* and *Orthopaedic surgery* were the surgical specialties with the longest median waiting times (68, 57, and 54 days respectively) in 2007–08 (Figure 19).
- *Cardio-thoracic surgery* had the shortest median waiting time (12 days).

Emergency department care in public hospitals

There were about 7.1 million accident and emergency presentations to public hospitals in 2007–08. See *Chapter 5*.

- Data on triage category, waiting times, patient's age group and sex were available for about 78% of these, mainly those presentations to emergency departments in *Principal referral* and *Specialist women's and children's hospitals* and *Large hospitals*.

- In 2007–08, about 23% of patients arrived by ambulance, but this varied by triage category, ranging from 84% of *Resuscitation* patients to 4% of *Non-urgent* patients (Figure 20).

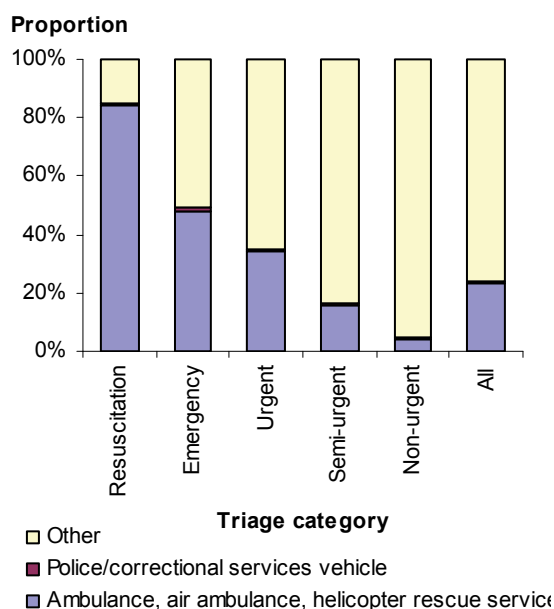


Figure 20: Public hospital emergency department presentations, by triage category and arrival mode, 2007–08

- 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 patients were seen on time, with 100% of *Resuscitation* patients seen on time.
- In *Principal referral and Specialist women’s and children’s hospitals*, 65% of patients were seen on time, with 100% of *Resuscitation* patients seen on time.

Non-admitted patient care in public hospitals

Excluding accident and emergency services, there were about 41.2 million non-admitted patient occasions of service provided by public hospitals in 2007–08. See *Chapter 2*.

- Of these, more than 16.4 million were delivered in specialist outpatient

clinics with the chief contributors being in *Allied health* and *Dental*. See *Chapter 5*.

- *Pharmacy, Pathology and Radiology & organ imaging* made up a further 16.2 million individual non-admitted patient occasions of service.
- There were 429,000 group session occasions of service, with *Mental Health, Alcohol & Drug* and *Community health* accounting for 27% of group sessions.
- Public psychiatric hospitals delivered over 149,000 occasions of service, including both individual and group sessions.

Australian hospitals

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

- In 2007–08, there were 1,314 hospitals in Australia, with:
 - 742 public acute hospitals
 - 20 public psychiatric hospitals
 - 272 private free-standing day hospital facilities and
 - 280 other private hospitals.
- The number of public acute hospitals has remained relatively stable since 2003–04.
- The number of private hospitals increased from 525 facilities in 2003–04 to 552 facilities in 2007–08.

Available beds

As hospital sizes vary considerably, the number of available beds is a better indicator of the availability of hospital services than is the number of hospitals. 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*.

- The number of available beds in Australia increased by 5.0% between 1998–99 (80,200 beds) and 2007–08 (84,235 beds), an annual average increase of 0.5%.
- In 2007–08, the available beds were:
 - 54,137 in public acute hospitals
 - 2,330 in public psychiatric hospitals
 - 2,151 in private free-standing day hospital facilities and
 - 25,617 in other private hospitals.
- The number of available beds in public acute hospitals increased by an average of 0.6% annually, from 51,423 in 1998–99 to 54,137 in 2007–08 (Figure 21).
- The number of available beds/chairs in private free-standing day hospital facilities rose by an average of 4.4% annually between 1998–99 and 2007–08 (from 1,460 to 2,151).

Average change (per cent)

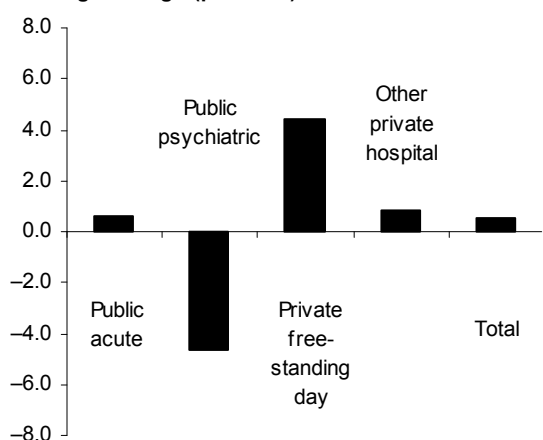


Figure 21: Average annual change in the number of available beds, by type of hospital, Australia, 1998–99 to 2007–08

Staff in Australian public hospitals

Staff numbers (See *Chapter 3*) in public acute and public psychiatric hospitals have grown over time (Figure 22).

- The number of full-time equivalent staff increased by an average of 3.6%

annually between 1998–99 (175,535) and 2007–08 (240,344).

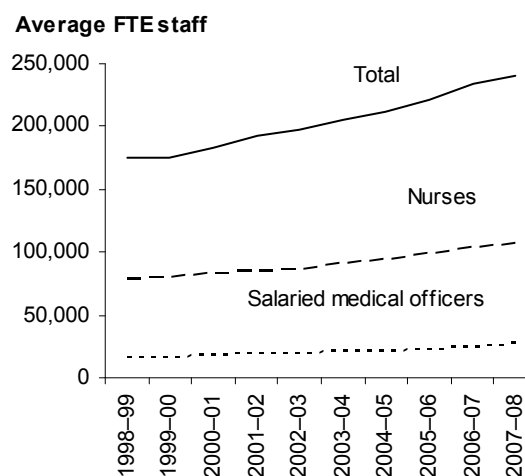


Figure 22: Average full-time equivalent staff, public hospitals, Australia, 1998–99 to 2007–08

- The number of salaried medical officers increased by an average of 5.7% annually over this period (from 16,458 to 26,996), and the number of nurses increased by an annual average of 3.5% (from 78,319 to 107,089).

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*.

- In 2007–08, recurrent expenditure on public acute and public psychiatric hospitals was \$28,908 million (excluding depreciation). After adjusting for inflation, this represented an increase of 6.1% compared with 2006–07.
- About 62% of this expenditure was for salary payments (\$17,935 million) (Figure 23).
- The major non-salary recurrent expenses in the public sector were for medical and surgical supplies, administrative expenses and drug supplies.

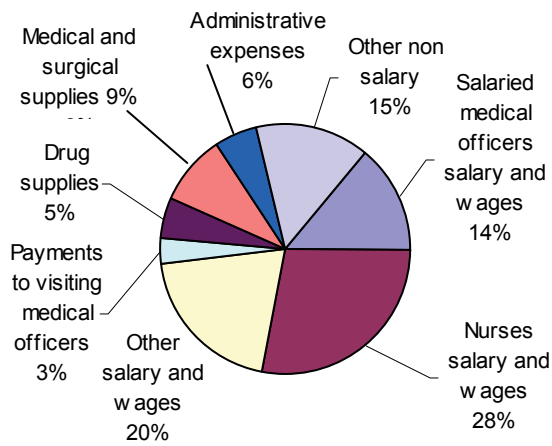


Figure 23: Recurrent expenditure, public hospitals, Australia, 2007-08

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 \$3,293 in 2003-04 to \$4,232 in 2007-08 (not adjusted for inflation).
- This represents a total increase of 28.8% in this period, an average increase of 6.5% annually (Figure 24).

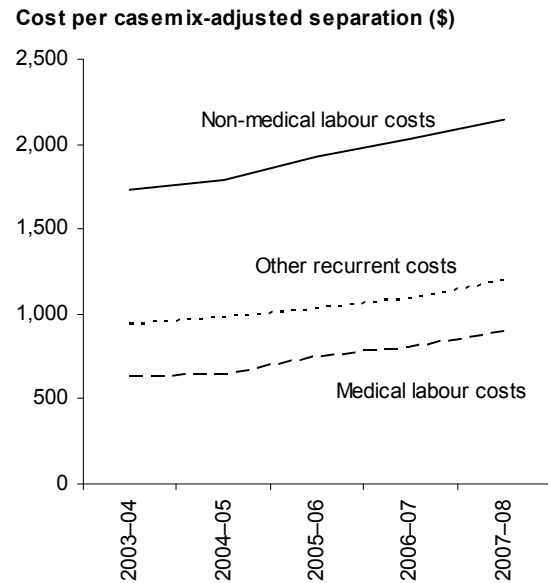


Figure 24: Cost per casemix-adjusted separation, Australia, 2003-04 to 2007-08

- In 2007-08 the average cost comprised:
 - \$2,140 for non-medical labour expenditure,
 - \$894 for medical labour expenditure and
 - \$1,197 for other recurrent expenditure.

Other recurrent expenditure costs include domestic services; repairs and maintenance; administration; and medical, drug and food supplies.

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 are public acute care and psychiatric hospitals, private free-standing day hospital facilities and other private hospitals (including psychiatric hospitals).