
4A HEALTH ATTACHMENT

Definitions for the descriptors and indicators in this attachment are in Section 4A.4. Unsourced information has been obtained from Commonwealth, State or Territory Governments.

4A.1 Jurisdictions' comments

Commonwealth Government comments

National Public Health Partnership

“ In public health there have been some major achievements, notably the progress towards the National Public Health Partnership. This is a development initiated by the Council of Australian Governments (COAG) and agreed to by Health Ministers. The work program accompanying the Partnership is aimed at better coordinating and integrating national public health strategies and strengthening the public health infrastructure and capacity, including the national public health information base and public health performance indicators and benchmarks.

1997–98 and 1998–99 Public Health Outcome Funding Agreements

The Public Health Outcome Funding Agreements (PHOFAs) are two year bilateral funding agreements between the Commonwealth Government and each State and Territory Government. They broadband (or pool) the Specific Purpose Payments (SPPs) to the States and Territories for eight public health program areas, which constitutes all Commonwealth funding to the States and Territories for public health. The decision to broadband the SPPs for public health was initiated by COAG and is being progressed by Health Ministers.

The PHOFAs place a high priority on the achievement of national public health priority outcomes, while allowing States and Territories flexibility in determining how resources will be deployed, in order to achieve these outcomes. The Commonwealth has negotiated a set of performance indicators with each State and Territory for monitoring the PHOFAs. These indicators are a subset of the total information required to monitor public health in Australia.

Acute Care Sector

Work has been continuing under the National Hospital Outcomes Program on developing and testing performance indicators. One project recently completed tested the reliability and validity of four hospital wide quality of care indicators. These were the rates of emergency patient hospital readmissions within 28 days of separation; unplanned return to the operating room; post-operative wound infection; and hospital acquired bacteraemia.

The results of this project have shown that the rates of the above indicators do not appear to be appropriate for use as external measure of the quality of care provided by hospitals. Current activity in developing performance indicators for public acute care hospitals includes focusing on indicators of quality of care, access, productivity and patient safety.

New South Wales Government comments

During 1995–96 NSW released the Government Vision for Health, a strategic framework which articulated its goals of better health for people, equity of access to comprehensive health services, and improving the service quality. The framework themes *Caring for Health* provided subsequent direction for NSW Health.

To improve health, public health initiatives ranged from control of infectious diseases to strategies aimed at reducing falls in the elderly. Pilot projects commenced to improve the quality and effectiveness of clinical care, particularly in National Priority Areas of cardiovascular disease, cancer, injury, mental health and diabetes. The importance of evidence-based best practice guidelines linked to increased monitoring was stressed.

NSW Health worked closely with the Aboriginal community to develop an Aboriginal Partnership Agreement which set the policy framework for the delivery of services.

During 1995–96, NSW focused on reducing waiting lists and times. By the end of the year the elective surgery list had reduced by 12 per cent after being 50 per cent of its March 1995 value in December 1995 (all comparisons adjusted for transfers). Further, between June 1995 and June 1996, the number of surgical and medical patients waiting more than 12 months fell by 56 per cent and the number of patients waiting between 6 and 12 months fell by 40 per cent. Also during this time, the average waiting time (combined medical and surgical) fell by nine days (from 1.2 months to 0.9 months) and the average time on the list fell by almost three weeks (from 3.1 months to 2.5 months).

The cost per acute casemix-adjusted separation has been estimated by NSW to be \$2556 or \$2441 without depreciation (*NSW Public Hospitals Comparison Data Book 1995–96*, NSW Health 1997). This cost explicitly excludes sub- and non-acute patients. The methodology differs in some significant ways from that adopted by the Institute.

The reported costs per casemix-adjusted separation are not strictly comparable across the jurisdictions. First, the inpatient fraction is calculated inconsistently within and across jurisdictions. Second, the existing methodology has included from NSW a substantial portion of sub- and non-acute services which would artificially inflate costs. Also, in the treatment of private medical costs, it has been assumed that the high costs of treatment of public patients by visiting medical officers in NSW implies high costs for the private medical costs. This is yet to be shown to be the case. Finally NSW, unlike other jurisdictions, includes in the cost of hospitals the cost of Area Health Service administration. This would also inflate the reported costs.

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Victoria Government comments

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Victoria strongly supports the comparisons of overall performance and key performance ingredients between states and with the best practitioners world wide. While it is acknowledged that many of the indicators in this collection need further development as they often highlight differences in state administrations, funding mechanisms and service provision rather than best practice, they do provide a useful starting point for further analysis.

It is important to recognise that the organisational structure and types of services delivered from public hospitals varies across jurisdictions. Hospitals in small states tend to concentrate on the provision of acute services, while larger states tend to provide a wider range of services. For example, in Victoria all metropolitan and most large rural hospitals now provide a range of services including acute, aged care and mental and community health.

This makes interstate comparisons difficult from three perspectives. First Victorian hospitals are independent entities. All input costs are fully allocated at this level, unlike some states where some health costs are absorbed by state agencies other than public hospitals. Second, Victorian hospitals tend to be larger with their activities spread over a number of campuses, while the majority of their interstate peers operate from stand-alone sites. Third, they provide a range of sub-acute services such as planned geriatric respite, rehabilitation, palliative care, designated psychiatric and psychogeriatric and non-acute nursing home type; none of which are adequately measured by acute output measures. Victoria supports the development of appropriate sub-acute output measures and their identification, comparison and exclusion from acute costs. The significance of these indicators is apparent as most jurisdictions are moving towards funding defined outputs in some form.

In Victoria, a funder/purchaser/provider model was introduced for acute services in 1993–94. Currently the Department of Human Services purchases around 95 per cent (in dollar terms) of its hospital services according to output/price criteria. While the best known and developed of these is casemix funding for acute inpatients, aged care, mental health and outpatients services (from 1997–98) are also funded in this way. The purchase price and outcome levels are set at benchmark levels as determined by Government and the Department. While services are mostly provided through independently governed and managed public hospitals, Government is committed to the principles of National Competition Policy and will progressively purchase more services via a contestable process where prices are set by the tender. Clearly performance comparisons between states must include services provided by both the private and public sectors.

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Queensland Government comments

“ Queensland Health operates in a distinctive environment of a resident population dispersed over large areas. Queensland's hospitals respond to needs of local populations, many of which are in rural and remote areas. In addition, significant indigenous communities are found at many remote sites, posing particular challenges to Queensland's public health system.

Queensland Health now has 38 fully operational District Health Services plus the Mater Hospitals Service operating under its own Board. With access to advice on local priorities from their District Health Councils composed of local people, each District now concentrates on providing health services and patient care close to where people live and work.

Management of health services was substantially upgraded by the introduction of Service Agreements between Corporate Office and Districts. Agreements specify hospital and other services to be provided in a District matched to a realistic budget and appropriate performance reporting requirements.

Queensland Health focuses on the basics of health care delivery. While remaining within budget, more people are being treated, delays are being reduced, and access expanded. For example, at the end of 1996–97, only 2.4 per cent of Category 1 patients had been waiting longer than 30 days for elective surgery.

In 1997–98, there will be more doctors, nurses, allied health and medical technical staff so that approximately two out of every three staff are health professionals and almost nine out of ten staff overall are providing services to the people of Queensland.

In addition to enhancing an array of inpatient and ambulatory services, Queensland is making transitional care a priority, ensuring that people using Queensland Health facilities receive adequate and appropriate information and support before and after their treatment.

Quality will not be traded off. Queensland Health's new quality policy requiring externally assessed systems will be implemented. An additional 28 hospitals (approximately 33 per cent of available beds) are preparing for ACHS accreditation before July 1998.

Finally, a major thrust to renew and expand Queensland's health infrastructure will see total capital expenditure increase by over 90 per cent to just under \$570 million in 1997–98 covering over 70 major projects, half of these in rural areas.

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Western Australia Government comments

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WA recognises the importance of assessing public health system performance. In line with this, the Commissioner of Health established the Key Performance Indicators Working Party (KPIWP) in 1996, whose initial task involved addressing performance issues in public hospitals. In 1997, its scope broadened to include Public and Community health and Mental health.

The State KPIWP developed a core suite of hospital performance indicators for use in 1996–97. At the same time, it recognised that these indicators needed to be reviewed and refined periodically if they are to keep abreast of changing practices in the delivery of health services.

As is the case of state performance measures, the suite of indicators included in the *Report on Government Services 1998* should be used with caution. In particular, valid comparisons across jurisdictions may be limited by the nature of some indicators. As well as differentially changing practices, it has been found that some measures of performance work well within institutions, perhaps, across time. But, because of differing methods of data capture or definition, the same measures cannot be used to make broader comparisons.

In 1996–97 WA developed a three dimensional Health Program Model which encourages a shift of focus from counting inputs to identifying outputs and outcomes. The axes of the model consist of health condition groups, levels of intervention and client demographics. There are 10 health condition groups and three intervention levels. Details of age, gender, geographic location, aboriginality and socio-economic status inform the demographic dimension.

The WA public health system has been undergoing some changes in management structure. Currently, admitted patient acute care services are delivered in hospitals which are part of Health Services. A Health Service is made up of one or more hospitals, Community Health and Public Health facilities under the management of a single general manager. There are 22 Health Services in the State, one in the Metropolitan area and 21 in the country. In 1997–98, all 15 public hospitals in Metropolitan Perth were brought under the management of the Metropolitan Health Service Board. The 21 rural Health Services also include more than one facility.

Casemix has been used to inform admitted patient service agreements between the Health Department and hospitals/Health Services since 1993–94. In 1996–97, the State initiated a Budget Reform process that culminated in an operational strategy for balancing inputs and outputs. Fundamental to this strategy were a revised program model for all of health and a funding

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model that differentiated between central and exceptional episodes of admitted patient care. These models were implemented in July 1997.

South Australia Government comments

“ An ageing population with increasing numbers of people with chronic illness, a growing emphasis on better health outcomes for consumers, increasing service demands on hospitals and rising health care costs have led to consideration of reforms in SA in the financing, planning and provision of health and community services to move the SA health system to a coordinated approach to care delivery. The decision to adopt a system-wide coordinated model of health care has arisen as a result of the decision to develop an outcomes-focused health system. Historically the health system has focused on the supply of health services as a goal rather than on the needs and requirements of individual consumers and the population at large. Coordinated care is one approach to facilitating health service provision to achieve better health outcomes for South Australians.

A number of trials of coordinated care have been funded to investigate approaches to coordinating care for people with complex health needs or chronic conditions. SA HealthPlus and Care 21 have been funded as Coordinated Care Trials: both are sponsored by the Department of Health and Family Services. These trials are being undertaken and evaluated to assess particular models of coordinated care for groups of people with chronic conditions and/or complex health needs. The SA HealthPlus trial will involve a number of populations with a range of health and other needs using a model of coordinated care which emphasises population health gain through a focus on consumer need as the starting point for the delivery of care. The participating providers in the trial will aim to manage individual consumer needs across primary, secondary and tertiary sectors on the health and community services system using evidence based, individualised care planning. The pooling of Commonwealth and State funds and the enrolment of consumers are other important elements of the SA HealthPlus trial. Care 21 is available to people age 65 years and over (or 55 years or over if Aboriginal), living in one of the outer northern Adelaide suburbs, and who use or need services to support them in their home.

In addition to this focus, the SA Health Commission is trialing the development and establishment of infrastructure necessary to support a broad system-wide coordinated care approach in SA which moves beyond the care of those with chronic and/or complex health conditions. This infrastructure includes financial, administration and information needs. As such, it has greater

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significance than if it were solely a trial of a particular model of coordinated care.

Tasmania Government comments

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The combination of a highly ruralised low level population base, relative social and economic disadvantage of the population generally, low health status, rising community expectations about ready access to high quality (and expensive) medical treatment, and isolation all serve to present Tasmania with a substantially higher cost of providing public acute care, and public and community health services.

To further enhance opportunities to optimise the planning, coordination, efficiency and quality of services and to position the Agency to provide integrated services across the health care system responsive to the needs of local communities, Tasmania has recently restructured its Department of Health and Community Services from a regional to a statewide service.

Particular initiatives which support this development include:

- a coordinated care trial 'Care Works' linking services to individual needs;
- Telehealth project which introduces technology to achieve of shift of effort away from centralised facilities towards community based care and support;
- the development of a Rural Health Unit in conjunction with the University of Tasmania to examine needs and models of care in rural communities;
- a new Public Health Act which is a leader in public health legislation in Australia; and
- community integration for people with significant disabilities or mental illnesses.

Tasmania supports the broader view of performance of the health care sector, and recognition of the interrelationships which exist between providers and services. The development of performance indicators to make effective comparisons between hospitals and jurisdictions continues, in concert with improvements to the quality of information currently collected and reported. At this stage it should be noted that in comparing data:

- during 1995–96 Tasmania was not accounting for changes in episodes of care in measures of hospital activity (separations, weighted separations) which means that activity is underestimated by around 10 per cent in comparison to those states currently reporting on an episode of care basis; and
- valid comparisons of hospitals operating in a casemix environment will not be possible until 1997–98.

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Australian Capital Territory Government comments

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The ACT maintains its support for the comparative reporting of state and territory data where it can provide useful indicators of the performance of the public hospital system. Comparative interpretation of the data needs to be qualified and where possible understood in terms of the differences in state administration, funding and service provision.

1995–96 marks the commencement of a period of major change in the administration and purchasing of the ACT health services including the preparation for the introduction of purchaser/provider arrangements, full accrual accounting, casemix funding and a clinical service team approach to hospital care management. These changes were designed both to enhance the effectiveness of services and to improve efficiency and accountability. ACT data for 1995–96 needs to be viewed in the context of a system that had been acknowledged as high cost but one where active control measures were being progressed.

In general terms, the 1995–96 data presents some indication that the ACT is being successful in containing expenditure, increasing activity levels and maintaining a quality focus. While there is clearly room for improvement the extent that this is possible needs to be assessed against pressures applying to small scale jurisdictions. In particular the provision of a comprehensive range of services, many at tertiary levels, with comparatively low volumes foregoes the achievement of some economies of scale. Additionally, higher than average input costs aligned largely to the historical characteristics of the ACT's health workforce place limits on rapid movement towards a national average price.

In line with the purchaser/provider model the ACT, from 1996–97 onwards, has developed a purchasing strategy based on volume, price and quality. Contestability is being developed within the limits of the ACT's relatively small provider base. The ACT is also moving towards increasing provider participation in integrated and coordinated care service provision. In 1997–98, for instance, the ACT Government has begun a large coordinated care trial involving a joint partnership with the ACT Division of General Practitioners. The ACT supports moves to include both the public and private sectors in performance comparisons and to develop relevant national measures relating to outcome effectiveness.

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Northern Territory Government comments

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Territory Health Services (THS) provides acute and non-acute care to a population of approximately 181 000 spread over the fourth largest jurisdiction in Australia. Of that population, 27 per cent are Aboriginal or Torres Strait Islander (ATSI) with a higher morbidity rate than the non-ATSI population.

There are five major centres spread across the NT comprising approximately half of the NT. The balance of the population is scattered in small communities of between 30 and 1500 people, often quite distant from population centres.

THS has increased the range of services provided in its acute care hospitals by aggressively recruiting specialist doctors. Since the last Report, 12 specialist medical practitioners were recruited to NT hospitals. All but one are engaged in direct patient treatment. This recruitment was aided by the establishment of the NT Clinical School attached to the Menzies School of Health Research.

Over the last two years THS has invested heavily in information technology which has enabled better reporting of health statistical, management and quality data for use both within the department and for reporting purposes.

The NT supports the reporting of performance measures of government service provision and the comparison of performance across jurisdictions as benchmarking tools. However, any valid comparisons across jurisdictions can only be made where the performance measures used are collected in exactly the same way in each jurisdiction. In many of the tables presented in this Report, different states and territories have collected information using different methods. When examining this Report the following factors affecting service delivery in the NT should be noted:

- the small number of hospitals and small population result preclude the same economies of scale available to the more populous states;
- there are a larger number of unproductive costs associated with health service delivery in the NT, including the provision of accommodation, recreational leave fares, extra leave, higher recruitment and relocation costs and affiliated facilities support costs;
- there are increased costs in the freight components for drugs, equipment and food to NT hospitals; and

- due to the dispersed nature of the NT population, there are higher patient travel costs relating to inter-hospital transfers.

For the above reasons and given that the data used in this Report relates to the financial year 1995–96, great care should be taken when attempting to compare service provision between jurisdictions both then and at this time.

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4A.2 All jurisdictions' data

4A.2.1 Descriptors

Table 4A.1: Hospitals, 1995–96 (number)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Public	173	115	144	87	75	15	2	5	616
Private ^a	91	104	50	23	42	10	2	1	323
Free-standing day hospital facilities ^b	73	23	17	10	10	2	5	0	140
Total	337	242	211	120	127	27	9	6	1 079

a Included private psychiatric hospitals.

b Private hospitals providing care on a same-day basis.

Sources: AIHW unpublished; ABS Cat. No. 4390.0

Table 4A.2: Recurrent expenditure, 1995–96

	<i>Units</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Public										
Total	\$m	4 316	2 628	1 723	991	871	274	214	130	11 147
Expenditure per person	\$	702	581	520	567	590	579	702	735	614
Private ^a	\$m	803 ^b	815	574	277	255 ^c	101	na	na	2 904
All hospitals	\$m	5 119	3 443	2 297	1 268	1 126	375	214	130	14 050

na not available

a Included recurrent expenditure for free-standing day hospitals in Australia column only.

b Included data for ACT.

c Included data for NT.

Sources: AIHW unpublished; ABS Cat. No. 4390.0

Table 4A.3: Separations from public acute care hospitals, 1995–96

	<i>Units</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total separations	'000	1 210	897	632	352	317	72	56	46	3 582
Same-day separations	%	37.3	43.4	39.5	38.2	39.9	37.0	46.6	43.3	39.7
Non-admitted occasions of service ^a	'000	15 011	7 426	5 949	2 730	2 224	608	386	305	34 639

a Data referred to non-admitted occasions of service from all public hospitals.

Sources: AIHW 1997a; AIHW unpublished

Table 4A.4: Top 10 AN–DRGs by volume (including same-day cases) in public hospitals, 1995–96

<i>AN–DRG</i>	<i>Description</i>	<i>Separations</i>	<i>Per cent of total separations</i>
572	Admit for renal dialysis	310 513	8.6
780	Chemotherapy	122 066	3.4
674	Vaginal delivery without complications	112 753	3.1
332	Other Gastroscopy for non-major digestive disease without complications	68 776	1.9
335	Other Colonoscopy without complications	47 997	1.3
187	Bronchitis and asthma age <50 without complications	44 153	1.2
683	Abortion with D&C, Aspiration curettage or Hysterotomy	39 049	1.1
484	Other skin, subcutaneous tissue and breast procedures	37 262	1.0
686	Other antenatal with moderate or no complications	36 739	1.0
252	Heart failure and shock	32 700	0.9

Source: AIHW 1997a

Table 4A.5: Top 10 AN-DRGs by volume (excluding same-day cases) in public hospitals, 1995-96

<i>AN-DRG</i>	<i>Description</i>	<i>Separations</i>	<i>Per cent of total separations</i>
674	Vaginal delivery without complicating diagnosis	109 695	5.0
187	Bronchitis and asthma age <50 without complications	38 840	1.8
941	Rehabilitation	32 092	1.5
252	Heart failure and shock	30 776	1.4
177	Chronic obstructive airways disease	28 485	1.3
727	Neonate admission weight >2499g without significant OR procedure without problems	25 118	1.2
686	Other antenatal with moderate or no complications	24 372	1.1
122	Tonsillectomy and/or adenoidectomy	21 960	1.0
347	Abdominal pain or mesenteric adenitis without complications	21 528	1.0
261	Chest pain	20 517	0.9

Source: AIHW 1997a

Table 4A.6: Government expenditure on public and community health, 1989-90 to 1994-95

	<i>Government expenditure (current dollars) (\$'000)</i>	<i>Percentage change on previous year (constant 1989-90 dollars) (%)</i>
1989-90	1 454	—
1990-91	1 345	-13.7
1991-92	1 356	-4.0
1992-93	1 594	14.9
1993-94	1 770	9.8
1994-95	1 819	2.6

— not applicable

Source: AIHW 1997b

4A.2.2 Effectiveness

Table 4A.7: Hospital acquired infection, 1995–96 (per cent)

	<i>NS</i> <i>W</i>	<i>Vic^a</i>	<i>Qld^a</i>	<i>WA^b</i>	<i>SA</i>	<i>Tas^c</i>	<i>ACT</i>	<i>NT^a</i>	<i>Aust</i>
Post-operative wound (clean)									
Teaching/Metro	na	na	na	na	na	2.1	na	na	na
Non-teaching/Metro	na	na	na	0.9	na	na	na	na	na
Non-teaching/Non-metro	na	na	na	3.0	na	na	na	na	na
Metro	na	na	na	na	na	na	0.8	na	na
Non-metro	na	na	na	na	na	na	na	na	na
All hospitals	na	2.4	1.9	2.4	na	na	na	na	na
Post-operative wound (contaminated)									
Teaching/Metro	na	na	na	3.4	na	4.5	na	na	na
Non-teaching/Metro	na	na	na	1.8	na	na	na	na	na
Non-teaching/Non-metro	na	na	na	9.3	na	na	na	na	na
Metro	na	na	na	na	na	na	0.8	na	na
Non-metro	na	na	na	na	na	na	na	na	na
All hospitals	na	5.9	1.8	3.5	na	na	na	na	na
Hospital-acquired bacteraemia									
Teaching/Metro	na	na	na	0.6	na	0.2	na	na	na
Non-teaching/Metro	na	na	na	0.2	na	na	na	na	na
Non-teaching/Non-metro	na	na	na	0.2	na	na	na	na	na
Metro	na	na	na	na	na	na	0.2	na	na
Non-metro	na	na	na	na	na	na	na	na	na
All hospitals	na	0.5	0.2	0.5	na	na	na	na	na

na not available

a These data were collected and published by the ACHS, and were based on 12 hospitals.

b State figures for WA were computed as a weighted average.

c The definitions for clean and contaminated infections vary from those of the ACHS.

Table 4A.8: Emergency readmission, 1995–96

	<i>NSW</i>	<i>Vic^a</i>	<i>Qld^b</i>	<i>WA^c</i>	<i>SA</i>	<i>Tas^d</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Emergency patient readmission rate (per cent)									
Teaching/Metro	na	na	na	3.0	6.4	1.1	na	na	na
Non-teaching/ Non-metro	na	na	na	5.3	na	3.3	na	na	na
Other metro	na	na	na	na	6.8	na	4.2	na	na
Country	na	na	na	na	7.8	na	na	na	na
All hospitals	na	0.1	2.8	3.8	na	na	na	na	na
Emergency patient readmissions (number)	na	na	na	na	na	na	1 683	2 227	na

na not available

a The unplanned readmission rate in Victoria represented the percentage (10 per cent) of patients who within 28 days were readmitted to the same hospital/campus without the medical practitioner having a plan or intention to re-admit the patient. The measure does not take account of whether it is for the same or unrelated matter.

b These data were collected by the ACHS for accredited facilities for unplanned hospital readmissions.

c The total figure for WA was computed as a weighted average.

d Rates were calculated as per the ACHS' hospital-wide clinical indicator.

Table 4A.9: Separations, 1995–96 (number per 1000 people)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
1995–96	203. 8	192. 5	191. 4	192. 8	220. 2	152. 8	186. 1	254. 3	197. 8

Source: AIHW unpublished

Table 4A.10: Public hospital beds accredited by the ACHS, 30 June 1996 (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT^a</i>	<i>Aust</i>
30 June 1996	59.9	76.8	43.9	65.7	70.0	85.9	100. 0	0.0	62.4

na not available

a The NT has not sought accreditation for its public acute care hospitals.

Source: ACHS unpublished

Table 4A.11: Emergency department patients admitted within the recommended time period, 1995–96 (per cent)^a

	<i>NS W</i>	<i>Vic</i>	<i>Qld</i>	<i>WA^b</i>	<i>SA</i>	<i>Tas^c</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Resuscitation (Immediate)									
Metro Teaching	89	na	na	na	na	na	na	na	na
Metro Non-teaching	84	na	na	na	na	na	na	na	na
Non-metro/ Non-teaching	90	na	na	na	na	na	na	na	na
All hospitals	88	100	na	100	na	99	na	na	na
Emergency (10 minutes)									
Metro Teaching	54	na	na	na	na	na	na	na	na
Metro Non-teaching	67	na	na	na	na	na	na	na	na
Non-metro/ Non-teaching	80	na	na	na	na	na	na	na	na
All hospitals	67	78	na	na	na	98	na	na	na
Urgent (30 minutes)									
Metro Teaching	54	na	na	na	na	na	na	na	na
Metro Non-teaching	68	na	na	na	na	na	na	na	na
Non-metro/ Non-teaching	79	na	na	na	na	na	na	na	na
All hospitals	67	77	na	na	na	74	na	na	na
Semi-urgent (60 minutes)									
Metro Teaching	63	na	na	na	na	na	na	na	na
Metro Non-teaching	74	na	na	na	na	na	na	na	na
Non-metro/ Non-teaching	83	na	na	na	na	na	na	na	na
All hospitals	73	na	na	66	na	73	na	na	na
Non-urgent (120 minutes)									
Metro Teaching	90	na	na	na	na	na	na	na	na
Metro Non-teaching	92	na	na	na	na	na	na	na	na
Non-metro/ Non-teaching	95	na	na	na	na	na	na	na	na
All hospitals	92	na	na	90	na	92	na	na	na

na not available

a Time periods recommended by the Australasian College of Emergency Medicine.

b Data for one hospital over a six month period.

c Data for one hospital.

4A.2.3 Efficiency

Table 4A.12: Recurrent cost for public acute care hospitals, 1995–96

	<i>Units</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Total separations	'000	1 210	897	632	352	317	72	56	46	3 582
Average case weight		1.00	1.02	0.95	0.98	1.02	0.99	0.91	0.67	0.99
Casemix-adjusted separations ^a	'000	1 213	918	601	346	322	72	50	31	3 551
Total recurrent expenditure	\$m	4 316	2 628	1 723	991	871	274	214	130	11 147
Inpatient fraction ^b	%	0.76	0.75	0.79	0.80	0.79	0.73	0.77	0.78	0.77
Public patient proportion ^c	%	0.78	0.82	0.89	0.84	0.80	0.81	0.84	0.95	0.81
Recurrent cost per casemix-adjusted separation										
<i>Non medical labour costs</i>										
Nursing	\$	755	633	679	613	614	802	865	992	669
Diagnostic/ allied health	\$	246	197	158	176	159	204	295	296	205
Administrative	\$	223	169	133	189	167	183	282	190	185
Other staff	\$	281	185	264	324	168	337	167	319	247
Superannuation ^d	\$	121	95	120	103	115	170	60	103	103
Total	\$	1 627	1 279	1 354	1 405	1 223	1 696	1 670	1 900	1 430
<i>Medical labour costs</i>										
Public patients										
Salaried/ sessional staff	\$	224	250	249	178	200	317	337	398	234
VMO payments	\$	219	92	73	140	148	32	349	142	145
Private patients (estimated) ^e	\$	127	77	40	59	86	82	129	28	86
Total^f	\$	570	419	362	377	433	431	816	568	464
Total labour costs	\$	2 197	1 698	1 716	1 782	1 656	2 127	2 486	2 468	1 894

(cont.)

Table 4A.12: Recurrent cost for public acute care hospitals, 1995–96 (cont.)

	<i>Units</i>	<i>NS</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Other recurrent costs</i>										
Domestic services	\$	62	66	73	110	67	69	104	51	70
Repairs/ maintenance	\$	79	53	52	115	87	51	58	63	71
Medical supplies	\$	179	136	186	159	169	223	275	168	168
Drug supplies	\$	109	96	120	116	96	108	136	151	106
Food supplies	\$	37	27	27	30	24	25	49	46	31
Administration	\$	123	109	119	75	143	153	150	207	117
Other	\$	91	76	17	57	23	135	209	298	70
Total	\$	680	563	592	662	610	763	979	983	635
Total recurrent hospital costs	\$	2 877	2 261	2 309	2 443	2 266	2 890	3 466	3 451	2 529

a Casemix-adjusted separations were the product of separations and the average case weight.

b Inpatient fractions were estimated using the HASAC method for the ACT, the NT and some hospitals in Tasmania.

c Public patient bed-days as a proportion of total bed-days. For Tasmania, the national average was used as a substitute.

d In WA and the NT the major superannuation scheme was funded by Treasury and the hospitals did not contribute; the national average was used as a substitute for these jurisdictions.

e Estimate based on the difference between total medical labour costs and public patient medical labour costs.

f Estimated total medical costs calculated as the sum of salary/sessional and VMO payments divided by public patient proportion. This was an estimate of the medical costs for all non-public patients, including private, compensable and ineligible.

Source: AIHW unpublished

Table 4A.13: Indicative estimates of the cost of capital per casemix-adjusted separation for public acute care hospitals, 1995–96^a

	<i>Units</i>	<i>NSW^b</i>	<i>Vic^c</i>	<i>Qld</i>	<i>WA^d</i>	<i>SA^e</i>	<i>Tas^f</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Buildings</i>										
Depreciated replacement value	\$m	3 883	4 100	na	1 061	938	274	na	na	na
Opportunity cost ^g	\$m	272	287	na	74	66	19	na	na	na
Depreciation	\$m	125	na	na	33	31	na	9	na	na
Casemix-adjusted separations	'000	1 213	918	601	346	322	72	50	31	3 551
User charge per separation	\$	327	na	na	310	301	na	na	na	na
<i>Equipment</i>										
Depreciated replacement value	\$m	793	na	na	121	132	na	na	na	na
Opportunity cost ^g	\$m	56	na	na	8	9	na	na	na	na
Depreciation	\$m	114	na	na	20	26	na	5	na	na
Casemix-adjusted separations	'000	1 213	918	601	346	322	72	50	31	3 551
User charge per separation	\$	139	na	na	83	108	na	na	na	na

na not available

a These data were not based on nationally consistent definitions or methodologies and can be considered indicative only.

b These data excluded assets of institutions that are covered under the third and fourth Schedules of the Public Hospitals Act (mainly religious and charitable hospitals).

c Valuations of land, buildings and equipment were brought to account at either historical costs, transfer value, their certified value Director's valuation or at cost. Depreciation was applied to fixed assets with values in excess of \$1000 in accordance with their estimated useful life using either the straight line or diminishing value method. Replacement value represented the total cost of replacing the facilities in exactly the same area and the same functional division of space. This was a gross figure with no account taken of depreciation or the value of land. Depreciated replacement value could not be disaggregated and was presented as a total for buildings and equipment. Included valuations of land and buildings owned by religious and charitable hospitals.

d These data included information on recognised facilities as listed in the Medicare Agreement 1993 to 1998. The annual depreciated replacement value was estimated.

e Some data were unaudited. Total depreciation for buildings assumed an average life of 50 years and total depreciation for equipment assumed an average depreciation was 8.52 per cent of gross or average life was 11.7 years.

f These data excluded one hospital which was leased.

g Calculated as replacement depreciated value by 7 per cent.

Source: AIHW unpublished

Table 4A.14: Cost per non-admitted patient occasion of service, 1995–96 (\$)

	<i>NSW^a</i>	<i>Vic^b</i>	<i>Qld^c</i>	<i>WA</i>	<i>SA^d</i>	<i>Tas^f</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Teaching	na	86.03	73.84	na	na ^e	na	na	na	na
Non-teaching	na	na	49.69	na	na	na	na	na	na
Metropolitan	na	na	87.75	na	71.04	na	na	na	na
Allied health	na	na	na	na	47.73	na	na	na	na
Medical	na	na	na	na	76.77	na	na	na	na
Obstetrics and gynaecology	na	na	na	na	48.59	na	na	na	na
Paediatrics	na	na	na	na	55.07	na	na	na	na
Radiology	na	na	na	na	69.78	na	na	na	na
Surgical	na	na	na	na	39.90	na	na	na	na
Psychiatry	na	na	na	na	72.33	na	na	na	na
Accident and emergency	na	na	na	na	128.35	na	na	na	na
Radiotherapy	na	na	na	na	103.20	na	na	na	na
Dental	na	na	na	na	61.43	na	na	na	na
Groups	na	na	na	na	78.33	na	na	na	na
Non-metropolitan	na	na	52.97	na	23.00	na	na	na	na

na not available

a See Table 4A.18 for NSW data.

b The figure for Victoria was the average cost per encounter based on analysis of two month's activity and cost data from the six largest teaching hospitals. Under the Victorian Ambulatory Classification System (VACS) the funded unit was the encounter which encompassed the clinical visit and all ancillary services (including imaging, pathology and pharmacy) provided to the patient within a 30 day 'window' either side of the clinic visit.

c No breakdown by service type was available for Queensland.

d Figures provided for metropolitan hospitals were funding rates or prices per non-admitted patient occasion of service. Figures for non-metropolitan hospitals were average cost per occasion of service. There was no distinction between Teaching and Non-teaching hospitals for the purpose of funding.

e Average funding rate or price per occasion of service.

f Tasmania did not use this performance measure.

Table 4A.15: Average length of stay for the top 10 AN-DRGs —
excluding same day cases, 1995–96 (days)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<i>Vaginal delivery without complication diagnosis</i>									
Public	3.23	3.42	3.72	3.29	3.45	3.57	3.63	3.46	3.45
Private	4.94	5.26	na	5.24	5.08	4.43	5.73	5.55	5.34
Total	3.55	3.72	na	3.75	3.88	3.96	4.16	3.88	3.86
<i>Rehabilitation</i>									
Public	19.60	18.02	16.05	19.40	16.08	20.61	20.54	21.72	19.11
Private	na	17.58	na	19.80	19.18	14.27	19.14	17.88	18.67
Total	na	18.04	na	19.50	17.45	19.75	19.91	21.55	19.01
<i>Bronchitis and asthma age <50 without complications</i>									
Public	2.32	2.10	2.54	2.14	2.23	2.13	1.85	2.10	2.08
Private	3.14	2.06	na	2.34	2.95	2.20	2.17	2.50	2.33
Total	2.33	2.10	na	2.17	2.26	2.14	1.87	2.12	2.09
<i>Heart failure and shock</i>									
Public	7.23	6.83	5.94	6.17	5.97	7.62	6.31	6.19	6.46
Private	8.13	8.55	na	7.21	7.68	7.24	8.12	8.37	7.90
Total	7.31	6.98	na	6.43	6.30	7.51	6.75	6.42	6.71
<i>Tonsillectomy and/or adenoidectomy</i>									
Public	1.42	1.66	1.15	1.21	1.43	1.76	1.27	1.47	1.42
Private	1.19	1.32	na	1.12	1.39	1.37	1.32	1.28	1.29
Total	1.34	1.52	na	1.17	1.41	1.52	1.29	1.40	1.37
<i>Cholecystectomy without common duct exploration</i>									
Public	3.24	2.99	3.31	2.50	2.74	3.24	2.87	3.25	2.89
Private	3.48	2.90	na	2.65	3.15	2.95	3.05	3.03	2.93
Total	3.32	2.96	na	2.56	2.89	3.08	2.94	3.17	2.90
<i>Neonate admission weight > 2499 g without significant OR procedure without problems</i>									
Public	3.53	3.73	3.35	2.88	2.43	3.14	4.41	4.05	3.63
Private	5.31	5.35	na	4.19	3.06	3.74	2.59	6.15	4.95
Total	4.37	4.33	na	3.11	2.53	3.46	3.99	4.47	4.02

(cont.)

Table 4A.15: Average length of stay for the top 10 AN-DRGs —
excluding same day cases, 1995–96 (days) (cont.)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<i>Chronic obstructive airways disease</i>									
Public	7.85	6.93	6.06	6.30	6.30	7.45	5.71	6.50	6.53
Private	9.33	8.49	na	8.04	7.81	8.13	8.20	8.90	8.21
Total	8.07	7.04	na	6.76	6.61	7.63	6.34	6.88	6.81
<i>Lens procedure without vitrectomy and without complications</i>									
Public	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Private	1.00	1.00	na	1.00	1.00	1.00	1.00	1.00	1.00
Total	1.00	1.00	na	1.00	1.00	1.00	1.00	1.00	1.00
<i>Inguinal and femoral hernia procedures age >9</i>									
Public	2.10	2.67	2.06	1.96	2.33	2.50	2.15	2.44	2.36
Private	2.50	2.69	na	2.07	2.73	2.45	2.44	2.54	2.48
Total	2.34	2.68	na	2.02	2.52	2.46	2.30	2.49	2.42

na not available

— not applicable

Source: DHFS unpublished

Table 4A.16: Average length of stay for the top 10 AN-DRGs —
excluding same day cases, 1994-95 (days)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<i>Vaginal delivery without complicating diagnosis</i>									
Public	3.5	3.8	3.4	3.7	3.6	3.9	3.7	3.4	3.6
Private	5.3	5.8	5.2	5.4	5.7	4.8	na	na	5.4
Total	3.8	4.3	3.9	4.2	4.1	4.2	na	na	4.0
<i>Neonate admission weight > 2499g without significant OR procedure without problem</i>									
Public	4.2	3.1	3.8	2.4	3.7	3.1	3.6	3.7	3.7
Private	5.5	2.9	4.7	3.6	6.1	3.7	na	na	5.5
Total	4.7	3.0	3.9	2.6	4.4	3.3	na	na	4.1
<i>Bronchitis and asthma age < 50 without complications</i>									
Public	2.1	1.9	2.2	2.2	2.1	2.1	2.5	2.4	2.1
Private	2.0	2.2	2.4	2.9	2.4	2.0	na	na	2.3
Total	2.1	1.9	2.2	2.2	2.1	2.1	na	na	2.1
<i>Lens procedure without vitrectomy without complications</i>									
Public	1.5	1.4	1.4	1.7	1.7	2.2	2.0	1.4	1.5
Private	1.3	1.5	1.5	1.5	1.8	1.5	na	na	1.5
Total	1.4	1.5	1.5	1.6	1.8	1.6	na	na	1.5
<i>Tonsillectomy and/or adenoidectomy</i>									
Public	1.8	1.3	1.3	1.5	1.5	2.0	1.3	1.3	1.5
Private	1.4	1.4	1.2	1.5	1.3	1.4	na	na	1.3
Total	1.6	1.3	1.2	1.5	1.4	1.7	na	na	1.4
<i>Heart failure and shock</i>									
Public	7.3	6.6	6.4	6.3	6.6	7.1	6.4	8.0	6.8
Private	9.4	8.6	7.6	8.0	9.0	8.1	na	na	8.4
Total	7.4	7.0	6.7	6.6	6.9	7.2	na	na	7.1
<i>Cholecystectomy without common duct exploration</i>									
Public	3.6	3.3	2.9	3.3	3.9	3.3	3.8	3.7	3.4
Private	3.1	3.4	3.0	3.4	3.4	3.1	na	na	3.2
Total	3.5	3.3	2.9	3.4	3.7	3.2	na	na	3.3

(cont.)

Table 4A.16: Average length of stay for the top 10 AN-DRGs — excluding same day cases, 1994–95 (days) (cont.)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
<i>Medical back problems age <75 years without complications</i>									
Public	4.3	3.9	3.7	3.7	4.0	4.0	4.1	4.8	4.0
Private	4.4	4.0	3.3	3.0	3.1	3.8	na	na	3.7
Total	4.3	3.9	3.5	3.4	3.7	3.8	na	na	3.9
<i>Chronic obstructive airways disease</i>									
Public	7.2	5.8	6.6	6.5	6.8	7.6	5.7	7.2	6.7
Private	8.6	8.4	8.1	8.5	8.1	8.2	na	na	8.3
Total	7.3	6.3	6.9	6.9	7.0	7.7	na	na	7.0
<i>Hernia procedures except inguinal and femoral age > 9 years</i>									
Public	3.1	2.4	2.1	2.7	2.8	2.6	2.4	2.6	2.6
Private	2.9	2.6	2.2	3.3	2.8	2.9	na	na	2.7
Total	3.0	2.5	2.2	3.0	2.8	2.8	na	na	2.7

na not available

Source: DHFS unpublished

Table 4A.17: Average length of stay, 1993–94 to 1995–96 (days)

	<i>Including same-day cases</i>			<i>Excluding same-day cases</i>		
	<i>Public</i>	<i>Private</i>	<i>Total</i>	<i>Public</i>	<i>Private</i>	<i>Total</i>
1993–94	5.1	3.9	4.8	7.3	6.1	7.0
1994–95	4.8	3.7	4.5	7.0	6.0	6.8
1995–96	4.6	3.7	4.5	7.0	6.4	7.1

Source: AIHW 1997a

4A.3 Single jurisdiction data

4A.3.1 New South Wales

Table 4A.18: Cost per non-admitted patient occasion of service, 1995–96 (\$)

	<i>Emergency</i>	<i>Primary and community based</i>	<i>Outpatient</i>
Principal referral	69	80	79
Paediatric	101	29	141
Major metropolitan referral	62	64	35
Major non-metropolitan referral	60	44	84
District metropolitan	44	43	53
District non-metropolitan	57	53	72
Community acute	63	47	44
Ungrouped acute	63	48	45
<i>NSW Acute Summary</i>	<i>59</i>	<i>54</i>	<i>70</i>

4A.3.2 Western Australia

Table 4A.19: Patient satisfaction index, June 1996^a

	<i>Teaching</i>	<i>Non-teaching</i>	<i>All public hospitals</i>
As at June 1996	4.20	4.37	4.29

a Satisfaction is computed as an index out of 5.00, where 1.00 is unsatisfied and 5.00 is fully satisfied.

4A.4 Definitions and explanatory notes

Table 4A.20: Performance indicators — public acute care hospitals

<i>Indicator</i>	<i>Definition</i>
Efficiency	
User cost of capital per casemix-adjusted separation	Depreciation + opportunity cost / casemix-adjusted separation.
Labour cost per casemix-adjusted separations	Salary and wages * Inpatient fraction + VMO payments / case weighted separations.
Cost per casemix-adjusted separation	(Recurrent expenditure) * Inpatient fraction / total separations * the average case weight.
Cost of treatment per non-admitted patient	(Recurrent expenditure) * (1 - inpatient fraction) / total non-admitted patient separations.
Average length of stay (ALOS)	The ALOS is equal to the arithmetic mean of the length of stay for all patient episodes. Estimated by dividing total occupied bed days by total episodes
Total replacement value per casemix-adjusted separation	Total replacement value/casemix-adjusted separation.
Real expenditure	Actual expenditure adjusted for changes in prices. Adjustments are made using the GDP(E) price deflator, and expressed in terms of final year prices.
Effectiveness	
<i>Quality</i>	
Percentage of facilities accredited with the ACHS	The ratio of accredited beds to all hospital beds in the jurisdiction.
Condition of capital	Ratio of depreciated replacement value to total replacement value.
Rate of emergency patient readmission within 28 days	Number of emergency patient readmissions within 28 days of separation / the total number of admissions excluding deaths.
Rate of unplanned return to operating room	Number of separations with one or more unplanned visits to an operating room subsequent to a previous procedure during the same admission / total number of separations where one or more procedures were performed.

(cont.)

Table 4A.20 Performance indicators — public acute care hospitals
(cont.)

<i>Indicator</i>	<i>Definition</i>
Rate of post-operative wound infection	Number of patients having evidence of wound infection on or after the fifth post-operative day following clean (contaminated) surgery / number of patients undergoing clean (contaminated) surgery with a post-operative length of stay equal to or greater than five days.
Rate of hospital acquired bacteraemia	Number of separated patients who acquired bacteraemia during a hospital stay / number of separations with a length of stay equal to or greater than two days.
Patient satisfaction	No agreed definitions currently exist for this indicator.
<i>Appropriateness</i>	
Variations in intervention rates	Number of separations for selected procedures / 1000 persons
Separations per 1000 population	Total number of separations / 1000 persons.
<i>Access</i>	
Waiting times for elective surgery	Two indicators are reported: – proportion of patients waiting inappropriately at census; and – proportion of patients admitted after waiting inappropriately.
Accident and emergency waiting times	No agreed definitions currently exist for this indicator.
Outpatient waiting times	No agreed definitions currently exist for this indicator.

