
5A PUBLIC ACUTE CARE HOSPITALS

Definitions for the descriptors and indicators in this attachment are in Section 5A.4. Unsourced information has been obtained from Commonwealth, State or Territory Governments.

5A.1 Jurisdiction comments

Commonwealth Government comments

“ The Commonwealth is putting a much greater emphasis on monitoring and reporting of performance than it has ever done before. This interest in performance extends over areas of efficiency, productivity, quality and approach and appropriateness of services and a range of access issues.

The Commonwealth has in place some major initiatives under the National Hospitals Outcomes Program (NHOP) to develop and test indicators relating to quality of care and health outcomes. NHOP has undertaken a review of local and international health outcomes and quality of care indicators, to provide the foundation for the development and implementation of nationally consistent indicators. Collaborative work is proceeding between the Commonwealth, State, and Territory Governments and other health systems stakeholders. A national workshop for experts in the area was held in November 1996 and a number of expert groups have been formed to advise on the development and testing of a range of national quality and outcome indicators over the next 12 to 18 months.

NHOP is also testing the reliability and validity of four national hospital wide quality of care indicators. These are rates of:

- unplanned readmission to hospital;
- unplanned return to operating room;
- post-operative wound infection; and
- hospital acquired bacteraemia.

Testing the validity of indicators is an essential activity. On the face of it, for example, the unplanned return to the operating room seems an appropriate indicator of quality of care. But early results of the NHOP study have shown that it may not be a valid national indicator of quality of care for comparing hospitals. Rather, it would appear to have more practical use for surgeons at the local level who wish to use it to review and improve their individual practice. The message in this is that we need to be careful about the use of the data, and how it is to assist us to promote high quality, appropriate care.

Another major focus of the Commonwealth Government is on the development of indicators to measure consumer perception of health care. These will relate both to customer participation in the planning and delivery of services and consumer feedback on performance of the health care system.

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New South Wales Government comments

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It still does not appear to be the case that interstate comparisons of expenditure are valid, that is whether the same definitions are used to define the relevant data items. For example, recurrent expenditures for the same state and the same year are different according to different sources.

NSW appears to have the most inclusive accounting system of all the states, as a result of the introduction of a comprehensive accrual accounting system. NSW includes all costs and this does not seem to be the case for the other States. This, of course, would tend to overestimate the unit inpatient costs for NSW.

For example, factors which may make NSW appear more expensive than other states are the inclusion in HUCS data (in hospital expenditures) of administrative overhead costs such as all Area Health Service costs and Community Health expenditures.

The number of teaching hospitals (10) attributed to NSW may be an underestimate because of the strict definitions used in NSW concerning Principal Referral Hospitals. This would flow on to the sections comparing expenditure in states and territories and would have the effect of making NSW teaching hospitals appear more expensive and non-teaching hospitals appear less expensive.

During 1994–95 considerable resources were devoted to improving access to elective inpatients. Waiting time performance benchmarks were set for Area Health Services and funds provided as an incentive to attain these benchmarks. This led to NSW being able to maintain clearance times at low levels and to reduce the number of patients waiting inappropriately.

NSW has the highest proportion of Category 1 patients of all states and territories. This is probably due to the fact that NSW does not have a 90-day clinical urgency category and doctors classify many patients who may be able to wait (say) six weeks into Category 1 whereas in other states these patients would be classified as Category 2. This inflation of Category 1 in NSW then artificially inflates the number of patients waiting inappropriately.

NSW has improved its performance with respect to prompt treatment of the more urgent emergency department patients. This has been largely due to a waiting time reduction scheme implemented during the year. The actual levels of performance in Categories 1 and 2 are understated because a large proportion of data entry for these patients is undertaken retrospectively.

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Victoria Government comments

Victoria continues to be at the forefront in the development of output based funding systems. A new ambulatory classification and funding system has been introduced in six major hospitals representing 33 per cent of all outpatient services. Further standardisation of acute hospital activity data will enhance capacity to measure performance.

Melbourne's 36 previously independent public hospitals have been aggregated into 6 health care networks each with a single board of governance. These metropolitan health care networks have been established to achieve greater service and agency coordination and to develop new service models. At the same time integration of rural services is being promoted through the Healthlinks program.

A range of initiatives has been developed to promote quality:

- an Acute Health Quality Committee has been established to advise the Minister and the Department of Human Services on quality, including the development of performance indicators;
- an Infection Control Task Force in collaboration with public acute hospitals, will review infection monitoring and control procedures and develop a strategy for best practice;
- stage 3 of the patient satisfaction survey will be conducted early in 1997. The survey will involve all public acute hospitals in Victoria and in the order of 12 000 patients will be surveyed;
- five pilot projects are designed to identify systems of delivery of acute care which minimise the risk of occurrence of preventable adverse clinical events and to develop measurable performance indicators for the management of clinical risk; and,
- the Health Complaints project is developing software that can provide hospitals and the Health Services Commissioner with the means to implement standardised system wide complaints reporting and analysis.

In assessing the comparative performance of Victoria's hospitals in relation to waiting lists it is important to note the significantly smaller proportion of urgent (category 1) patients in Victoria whose wait has exceeded the 'ideal' waiting time of 30 days. This demonstrates the success of Victoria's approach to waiting list management in achieving prioritisation of patients according to clinical need.

Queensland Government comments



Queensland Health operated in the distinctive environment of the substantially dispersed population over large areas, with many regional centres across the State. Queensland hospitals must respond to needs of local populations within a context of significant rurality and remoteness. Indigenous populations of varying size are found at many remote sites, posing particular challenges to the state public health systems.

The Department has undergone restructuring in the last year and there is now an explicit separation of the role and funder, purchaser and provider. A new Corporate Office contains separate funder and purchaser elements, while thirty nine new Districts which replaced thirteen Regional Offices have a provider role. The new structure will deliver micro economic reforms allowing increased access to hospital services.

Quality in service delivery is a high priority for Queensland, and in accord with this focus, Queensland Health now actively supports public hospitals seeking ACHS accreditation status. The number of public hospital beds accredited over the last year has doubled and continues to increase rapidly.

Queensland has established systems to report accurate and comprehensive data on waiting times for elective surgery. While this report indicates 43 per cent of Category 1 patients waited longer than 30 days, this figure (at the end of 1995) has fallen to less than 5 per cent waiting longer than 30 days as at the end of 1996. The success of the 'Surgery on time' program has enabled Queensland patients higher quality care because of its reduction in inappropriate waiting times.

Casemix-adjusted data continue to demonstrate that Queensland operates in a very cost effective manner, having the second lowest cost per casemix adjusted separation in Australia. Queensland Health has moved to casemix funding of its public hospitals (as of 1 January 1995) and continues to extend benchmarking into new treatment areas, including rehabilitation, palliative care and ambulatory care which will become effective in January 1997.

Caution must be exercised in interpreting data in this Report on the condition of capital stock. While the Report suggests Queensland has high quality buildings and equipment, there exists a need to rebuild and replace much of the stock which has resulted in a \$2 billion capital works program over ten years.

On a number of performance indicators taken together, Queensland is surpassing national benchmarks. High quality services with low waiting times delivered at low unit cost characterise the Queensland public hospital system.



Western Australia Government comments

“ The geography of WA presents significant challenges in the provision of health services to all residents with equity and efficiency. There is a concentration of population in a single metropolitan area with the remainder being widely dispersed in much smaller, rural and remote centres. It is nevertheless useful for this State to participate in national comparisons of performance to enhance the context for continual improvement.

Considerable improvements are required to information systems to enable data capture and analysis for performance measurement. This is particularly relevant in the area of outpatient activity and emergency department services. A new system of recording emergency department activity has been trialed at one teaching hospital and will be implemented throughout the metropolitan area, and selected country hospitals in early 1997. WA is just completing the reengineering of the morbidity database, with record linkage, which will allow much more meaningful and thorough examination of health services and outcomes.

A suite of key performance indicators are being defined for WA hospitals. These indicators should provide useful information at the hospital level (ie Board, CEO and General Manager), as well as providing performance information to the Health Department of Western Australia, the Government and the public. These indicators are being developed using a framework similar to the one adopted by the National Health Ministers' Benchmarking Working Group, and used in the Steering Committee Report.

This Report indicates that, in 1994–95, WA achieved a satisfactory level of performance, compared to national averages. The State aims to improve its performance, particularly in the management of waiting lists for elective surgery. A *Waiting List Management Strategy* has been developed which will assist the State to reduce both the number of people waiting for care, and the average waiting time on the lists. This will be undertaken in conjunction with development of a new program structure, focussed on health conditions.

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South Australia Government comments

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The data shown for SA reflects the first year of funding of hospital services using a casemix approach.

Over this period the public hospital system has been forced with an increased number of admissions. Despite this additional pressure on the system, cost per separation (both adjusted and unadjusted) have remained among the lowest in Australia.

Work has continued in monitoring aspects of quality of care such as the rate of readmissions and waiting times for non-urgent elective surgery. Further work is continuing toward developing an approach to measure patient satisfaction. In addition, trials of the Rand Medical Outcome Study Short Form 36 have continued to be supported in a number of areas within the health system.

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Tasmania Government comments

During 1994–95 the Department of Community and Health Service’s planning process required acute care programs to contribute to a business plan which includes performance indicators and agreed targets.

Tasmania’s relatively dispersed (60 per cent of residents live outside the capital city) population introduced economies of scale disadvantages compared to larger jurisdictions. This presents particular challenges to Tasmanian hospitals to provide services which meet both community expectation and its capacity to pay.

Particular caution should be exercised in examining information presented on average costs. During 1994–95 Tasmania was not accounting for changes in episodes of care in measures of hospital activity (separations, weighted separations) which means that activity is understated compared to the other states. Tasmania had not undertaken any studies to apportion acute inpatient costs — these have been estimated in the Report.

These factors can have considerable influence on the calculation of average cost separation. Tasmania commenced implementing episodes of care coding during 1996 and a methodology to calculate the inpatient fraction for Tasmanian hospitals will be developed and implemented during 1997.

When examining information on average length of stay the impact that implementation of episodes of care coding has on this performance indicator should also be taken into account.

Tasmania is continuing to implement Casemix in public hospitals and a casemix funding model will be introduced on 1 July 1997. Based on experience on other states this will have considerable impact on measures of activity and resources use and on performance indicators outlined in this report.

The quality of care in Tasmania continues to be high. Hospital consistently met target for quality of care performance measures during 1994–95. Consumer feedback surveys confirm that a large proportion of patients are satisfied with the care they received. All major Tasmanian public hospitals have current accreditation with the Australian Council on Health Care Standards.

During 1996–97 Tasmania’s three major hospitals have been brought together into an integrated service called Hospitals’ Service. This will provide opportunities to enhance the planning, coordination and efficiency of services.

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Australian Capital Territory Government comments

The most telling aspect of this chapter are the indicators concerning the relative efficiency of the ACT public hospital system. The indicators support the findings of a number of other reviews in recent years which have found that the ACT public hospital system is far more costly than the national average. In assessing this the following factors need to be considered:

- the ACT is unique in a number of aspects. The size of the ACT relative to other jurisdictions means that there is a likelihood that some economies of scale are foregone in providing a comprehensive range of acute services at comparatively low volumes. It is perhaps notable that again the three smallest jurisdictions experience the highest unit cost of treating patients;
- the ACT is a uniquely urban jurisdiction in that all of its hospital services are provided in a metropolitan setting. It is well recognised that the provision of acute services in metropolitan hospitals is more expensive than in rural facilities;
- the ACT became self-governing in 1989. Prior to that time the management of the public hospital system was the responsibility of the Commonwealth Government. The usual direct linkage between decisions affecting the resourcing of the hospitals and state revenues and outputs produced, was not in place until that occurred; and
- the ACT public hospital system is unusual in that a large proportion of its clients reside in another jurisdiction. More than 20 per cent of inpatients and about 14 per cent of non-inpatients reside in the south east region of NSW. As a referral centre it is reasonable to expect that the Territory's hospitals treat cases which are on average more expensive.

The effects of these factors are apparent in the efficiency indicators contained in this Report. Reform of the ACT health system to bring its cost structures more in line with the national average is a high priority of the Government.

The Government has also targeted improvements to waiting list management as a high priority. There has been a significant improvement in the number of Category 1 patients waiting longer than 30 days for treatment; as of November 1996 only 1.5 per cent of these patients were waiting longer than the clinically-desirable period.

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Northern Territory Government comments

“ The results of this report indicate the difficulties faced by the NT Government in providing health services to a population of 171 440 scattered over an area of 1 346 000 square kilometres. Of this population almost half live outside an urban area. As a result many of the services normally provided by a hospital in an urban setting are provided by community based health centres both government and non-government.

A large proportion of the population of the NT has a higher morbidity rate than the general Australian population (Plant, Condon and Durling 1995) Consequently a large proportion of patients arrive at a hospital with complicating conditions superimposed on the principle condition for which they were admitted. The result is longer than the national Average Length Of Stay or many conditions and a greater chance of infections and complications as a result of preexisting morbidity.

Unplanned readmissions to hospital within 28 days of discharge includes readmissions of patients for both the same or similar AN-DRG and those who were readmitted for a totally different reason.

Waiting times for elective surgery shown in this report reflect the relative scarcity of specialist medical officers in the NT, three out of the five NT hospitals have no specialist medical officers on their staff so are reliant on the availability of visiting specialists. Also no account is taken in the figures provided for those Territorians who have elective surgery provided in other States using the Patients Assistance Travel Scheme. Account should also be taken of the large variations in percentages reported with minor changes in number of patients treated due to the small numbers involved.

At the time of the data collection the desirability of seeking accreditation for Territory public hospitals was decided at the institutional level.

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5A.2 All jurisdictions data

5A.2.1 Descriptive data

The following notes apply to the descriptive data presented below:

- The number of Victorian teaching hospitals is different to that reported last time due to changes in the way teaching hospitals were identified;
- In Victoria, the major repatriation hospital merged into the public hospital system on 1 January 1995; and
- As part of the National Mental Health Strategy there has been a reduction of 883 beds in psychiatric hospitals between July 1993 and June 1995. As a result some additional beds may have been opened in acute hospitals over this period.

Table 5A.1: Hospitals, 1994–95 (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									
-Teaching	10	16	8	5	6	3	1	2	52
-Non-teaching	176	109	174	84	75	14	2	3	637
-Total public	186	125	182	89	81	17	3	5	686
Private ¹	92	111	52	22	39	9	2	1	328
Free-standing day hospital facilities ²	71	23	11	8	7	1	4	na	125
Total	349	259	245	119	127	27	9	6	1 139

na not available.

1 Includes private psychiatric hospitals.

2 Private hospitals providing care on a same-day basis only.

Sources: AIHW unpublished; ABS Cat. No. 4390.0

Table 5A.2: Available beds, 1994–95 (number)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Public									
-Teaching	6 124	6 508	3 171	2 371	2 021	1 113	584	438	22 331
-Non-teaching	12 469	5 736	6 635	2 576	2 964	316	193	110	30 999
-Total public	18 594	12 245	9 806	4 947	4 985	1 429	777	548	53 330
Private ¹	6 049	6 075	4 783	2 198	2 247	658	220	140	23 309
Total acute beds	24 603	18 320	14 589	7 145	7 232	2 087	997	688	76 639

1 Includes beds for free-standing day hospitals in Australian column only.

Sources: AIHW unpublished; ABS Cat. No. 4390.0

Table 5A.3: Public and private beds per 1000 population, 1994–95 (number)¹

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Public	3.1	2.7	3.0	2.9	3.4	3.0	2.6	3.2	3.0
Private ²	1.0	1.4	1.5	1.3	1.5	1.4	0.7	0.8	1.3
Total acute hospitals	4.1	4.1	4.5	4.2	4.9	4.4	3.3	4.0	4.3

1 Population estimated as mid-point of June 1995 and June 1994 estimated resident population.

2 Includes private psychiatric hospitals and free-standing day hospital facilities.

Sources: AIHW unpublished; ABS Cat. No. 3101.0; ABS Cat. No. 4390.0

Table 5A.4: Total recurrent expenditure, 1994–95 (\$millions)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Public									
-Teaching	1 732	1 571	680	604	537	228	160	105	5 617
-Non-teaching	2 145	847	908	275	294	35	39	20	4 563
-Total	3 877	2 419	1 588	879	831	263	199	125	10 180
Private ¹	718 ²	722	488	252	239 ³	83	na	na	2 573
Total acute	4 595	3 141	2 075	1 131	1 070	346	na	na	12 753

na not available

1 As reported in *Private Hospitals Australia, 1994–95*, ABS Cat. No. 4390.0.

2 Included data for ACT

3 Included data for NT.

Sources: AIHW unpublished; ABS Cat. No. 4390.0

Table 5A.5: Total recurrent expenditure per 1000 population, 1994–95
(\$'000)

	<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	637	539	491	512	565	555	657	726	567
Private	112 ¹	161	151	147	146 ²	177	na	na	143
Total acute hospitals	750	700	641	659	710	732	na	na	711

na not available

1 Included data for ACT

2 Included data for NT.

Sources: AIHW unpublished; ABS Cat. No. 4390.0

Table 5A.6: Staffing levels in public hospitals, 1994–95 (FTEs)

	<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>
<i>Teaching</i>									
Salaried medical officers	2 843	2 539	995	1 206	1 001	289	202	146	9 221
Nursing staff	10 654	9 713	5 000	3 827	3 933	1 784	1 067	737	36 715
Other	13 563	11 788	5 915	5 678	4 519	1 842	1 208	1 519	46 032
Total	27 060	24 040	11 910	10 711	9 453	3 915	2 477	2 402	91 967
<i>Non-teaching</i>									
Salaried medical officers	1 614	493	1 103	111	180	3	28	14	3 545
Nursing staff	16 656	7 102	7 797	2 843	2 895	338	295	70	37 995
Other	17 209	6 695	7 453	2 889	2 680	307	245	120	37 598
Total	35 478	14 289	16 353	5 842	5 755	648	568	204	79 138
<i>Total</i>									
Salaried medical officers	4 457	3 031	2 098	1 317	1 181	292	231	160	12 766
Nursing staff	27 310	16 815	12 797	6 670	6 828	2 122	1 362	807	74 710
Other	30 771	18 483	13 368	8 567	7 199	2 149	1 453	1 639	83 629
Total	62 538	38 329	28 263	16 553	15 208	4 563	3 046	2 605	171 105

Source: AIHW unpublished

Table 5A.7: Total separations, 1994–95 ('000)

	<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 acute care hospitals	1 215	845	604	337	316	77	55	42	3 491
Private acute hospitals	468	409	309	115	129	41	22	8	1 501
Total separations	1 683	1 254	913	452	445	118	78	49	4 993

Source: DHFS unpublished

Table 5A.8: Same day separations, 1994–95 (per cent of total separations)

	<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 acute hospitals	34.6	42.0	36.9	35.4	37.8	32.6	46.5	41.0	37.1
Private acute hospitals	53.3	49.8	43.2	57.3	33.7	35.9	50.7	31.1	48.3
All acute hospitals	39.6	44.5	39.0	41.2	36.6	33.8	47.7	39.5	40.4

Sources: AIHW unpublished, DHFS unpublished; ABS Cat. No. 4390.0

Table 5A.9: Occupied bed days, 1994–95 ('000)

	<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 acute care hospitals	5 537	3 581	2 684	1 431	1 594	418	239	196	15 680
Private acute hospitals	1 469	1 560	1 182	433	546	149	59	24	5 422
Total separations	7 006	5 141	3 866	1 864	2 140	568	297	220	21 102

Source: DHFS unpublished

Table 5A.10: Average occupancy rate, 1994–95 (per cent of capacity)

	<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	81.6	80.1	75.0	79.3	87.6	80.2	84.2	97.8	80.6
Private	66.5	70.4	67.7	54.0	66.5	62.1	73.1	47.1	63.7
Total acute hospitals	77.9	76.9	72.6	71.5	81.1	74.5	81.7	87.5	75.4

Sources: AIHW unpublished, ABS Cat. No. 4390.0

Table 5A.11: Non-admitted patient occasions of service, 1994–95 ('000)

	<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 acute care hospitals	12 360	6 699	6 332	3 373	2 314	635	396	287	32 395
Private acute hospitals	na	na	na	na	na	na	na	na	1 084
Total	na	na	na	na	na	na	na	na	33 479

na not available

Source: DHFS unpublished

Table 5A.12: Top 10 AN–DRGs by volume (including same–day cases) public and private acute hospitals, 1994–95¹

<i>Rank</i>	<i>AN–DRG</i>	<i>Description</i>	<i>Separations</i>	<i>Per cent of total separations</i>
1	572	Admit for renal dialysis	285 173	5.9
2	674	Vaginal delivery without complicating diagnosis	151 144	3.1
3	332	Other gastroscopy for non–major digestive disease without complications	142 251	2.9
4	780	Chemotherapy	137 306	2.8
5	335	Other colonoscopy without complications	124 673	2.6
6	099	Lens procedure without vitrectomy without complications	72 159	1.5
7	683	Abortion with D&C aspiration curettage or hysterotomy	68 549	1.4
8	128	Dental extraction and restoration	67 249	1.4
9	421	Knee procedures	63 744	1.3
10	484	Other skin subcutaneous tissue and breast procedures	59 848	1.2

1 Estimates provided by DHFS using AN–DRG version 3. These estimates are based on an incomplete database so caution should be exercised in interpreting the results

Source: DHFS unpublished

Table 5A.13: Top 10 AN-DRGs by volume (excluding same-day cases) public and private acute hospitals, 1994-95¹

<i>Rank</i>	<i>AN-DRG</i>	<i>Description</i>	<i>Separations</i>	<i>Per cent of total separations</i>
1	674	Vaginal delivery without complicating diagnosis	149 299	5.1
2	727	Neonate admission weight > 2499g without significant OR procedure without problem	49 060	1.7
3	187	Bronchitis and asthma age < 50 without complications	42 565	1.5
4	099	Lens procedure without vitrectomy without complications	37 700	1.3
5	122	Tonsillectomy and/or adenoidectomy	37 468	1.3
6	252	Heart failure and shock	37 312	1.3
7	367	Cholecystectomy without common duct exploration	35 180	1.2
8	455	Medical back problems age < 75 without complications	34 482	1.2
9	177	Chronic obstructive airways disease	33 018	1.1
10	320	Hernia procedures except inguinal and femoral age > 9	32 163	1.1

1 Estimates provided by DHFS using AN-DRG version 3. These estimates are based on an incomplete database so caution should be exercised in interpreting the results

Source: DHFS unpublished

Table 5A.14: Indicative estimates for value of assets for public acute care hospitals, 1994–95 (\$ millions)¹

	NSW ²	Vic ³	Qld ⁴	WA ⁵	SA ⁶	Tas	ACT ⁷	NT	Aust
<i>Total replacement value</i>									
Buildings	4 527	3 924	4 000	2 044	1 950	313	na	na	na
Equipment	1 099	na	750	228	262	90	na	na	na
<i>Depreciated replacement value</i>									
Buildings	3 809	2 126	3 500	1 070	605	225	275	na	na
Equipment	712	na	na	115	na	42	na	na	na

na not available

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

2 Plant and equipment are reported as the one asset class in NSW. Due to the size of NSW and the complexity of introducing accrual accounting it was decided that asset revaluations would be performed in a staged approach. Subsequent to the introduction of accrual accounting five-yearly revaluations have now been conducted in 50 per cent of the metropolitan area. Opening valuations reported to/by the Department were generally reported at values net of depreciation and therefore do not disclose the true replacement value involved. Users of the data provided are therefore cautioned that building comparisons with other States will provide a distorted picture of the NSW position and will suggest a greater remaining life of assets than will be reported in other States. This aspect of reporting will be improved progressively in NSW Health as each revaluation performed will separately restate the gross value of the assets and the accumulated depreciation thereon. This process will be complete by the year 2000–01.

3 Data are only available on building values. Actual values rather than estimates have been reported for hospitals not included in the 1993–94 Victorian hospitals survey. The sources for this data are reports prepared for each hospital either by private valuers or the Office of the Valuer General. For hospitals included in the survey the depreciated replacement cost reported is based on the published replacement cost figure rather than on data from valuation reports produced for financial reporting purposes. The survey figures are based on differential construction costs for each functional area and are considered to be more accurate than a flat rate/m². Replacement costs for 30 June 1995 were calculated as the replacement cost at 30 June 1994 indexed by 3.75 per cent equal to estimated BPI movement across the period. Depreciation was calculated at 3.00 per cent of replacement cost being the average rate for buildings as a whole (as estimated for the 1993–94 Survey).

4 Valuations for hospital buildings exclude land but include buildings leased to other entities for the operation of hospital services. Depreciation cannot be determined at this stage. However all buildings and land are currently being valued with information available by 28/1/97. Valuations are being undertaken using a Condition Based Index (as opposed to finance straight line depreciation) and Deprival Value Depreciation/Replacement). A review of equipment is currently being undertaken and equipment values replacement to 2000–01 will be finalised by January 1997. The Asset Management Unit is currently developing methodologies relating to Maintenance Planning and Management Functionality Index and Facility Condition Index with a view to valuing assets. It is estimated that off-site residences owned by Queensland Health are currently valued at around \$50 million plus \$120 million for furniture and fittings.

(cont.)

Table 5A.14 Indicative estimates for value of assets for public acute care hospitals, 1994–95 (\$millions)¹ (cont.)

5 The data includes all hospitals as listed in the schedule supporting the Medicare Agreement. As a result Nursing Posts are included in the 1994–95 data. The Nursing Posts figures were not included in the 1993/94 information. The information is sourced from unaudited figures as used to satisfy the whole of government reporting requirements in 1995. Building RCV calculations include equipment that is integral to the building structure; these are assets that are attached to the structure of the building and cannot easily be moved for example air-conditioning plant lift structures boilers and other large mounted equipment. The value of this integral equipment is not separable. As per the Treasurer’s Instructions assets are recognised in accordance with the Australian Accounting Standards and internal policies. These do not require additional valuation methods to be applied to equipment. This approach has been accepted by external auditors. Equipment assets generally have a limited useful life and a high turnover rate therefore the historical cost methodology is seen as an up-to-date representation of the value of equipment. Current asset management systems do not facilitate subsequent revaluations of equipment assets.

6 Notes and data from 1993–94 Report. SA provided estimates of the total replacement value of all buildings and equipment based on values provided by the SA Audit Commission which estimated that 75 per cent of the total assets value is represented by building assets including plant. The estimates assume that the vast majority of assets are related to hospitals. Estimates of the depreciated replacement value of buildings were based on the results of a recent valuation exercise showing that the depreciated value was 31 per cent of the total value. A useful life of 50 years was used for buildings to determine depreciation. Due to the difficulties in estimating the useful life and residual value of equipment no estimates of depreciated value or depreciation were provided.

7 Buildings are revalued every three years. The values reported date from 1993–1995 and have not been indexed. Additions and deletions for the Canberra Hospital have not been able to be identified at this time. Buildings have not been valued at total replacement value at June 1995. Equipment is valued at cost not replacement value.

5A.2.2 Effectiveness indicators

Table 5A.15: Public hospital beds accredited by the ACHS, 30 June 1995 (per cent)

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas¹</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Public	76	83	48	76	71	87	100	na	na
Private	na	72	77	75	81	66	100	na	na
Total	na	na	58	76	74	79	100	na	na

na not available

¹ As at 30 June 1996

Source: ACHS unpublished

Table 5A.16: Condition of capital for public acute care hospitals, 1994–95 (ratio)¹

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i> ²	<i>SA</i> ³	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Buildings	0.84	0.54	0.88	0.52	0.31	0.72	na	na	na
Equipment	0.65	na	na	0.50	na	0.47	na	na	na

na not available

1 Ratio of depreciated replacement value to total replacement value

2 Equipment assets in WA are valued at historical cost rather than replacement value.

3 1993–94 figures.

Table 5A.17: Clearance time for elective surgery by clinical specialty for public acute care hospitals, 1995 (months)¹

	<i>NSW</i>	<i>Vic</i> ²	<i>Qld</i> ³	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i> ⁴
Cardio-thoracic surgery	1.1	1.2	2.1	0.6	1.0	2.3	0.6	na	1.1
Ear nose and throat	3.6	3.5	6.5	6.4	4.2	5.8	3.9	10.3	4.0
General surgery	1.6	2.8	2.9	2.9	2.3	3.1	6.7	6.6	2.2
Gynaecology	1.5	1.9	3.1	1.1	1.8	3.6	3.2	3.8	1.8
Neurosurgery	0.8	2.1	2.7	0.8	0.6	7.0	2.7	na	1.3
Ophthalmology	3.9	3.5	4.3	4.3	1.6	3.8	3.9	5.8	3.6
Orthopaedic surgery	3.3	4.7	4.5	6.6	4.5	7.1	7.9	12.6	4.2
Plastic surgery	2.0	5.1	2.8	5.1	3.2	6.5	6.3	3.8	3.8
Urology	2.0	3.2	2.8	4.4	2.4	6.9	7.4	1.7	2.9
Vascular surgery	1.7	4.2	2.4	1.8	1.3	3.7	7.2	na	2.5
Other	0.4	2.5	1.6	1.7	0.0	0.3	6.6	na	1.0
All patients	2.1	3.1	3.3	3.7	2.7	4.3	5.2	6.1	2.7

na not available

1 Clearance time is a prospective measure of the capacity of the system to remove patients from waiting lists. It should not be considered as the average waiting time. The survey period was six months — the numbers and attributes of patients admitted during this period may not be typical of patients admitted over a longer period of time. Categorisation of patients by clinical urgency was implemented to varying degrees and with variable consistency. For most States and Territories the data cover all waiting list-related activity: statistics presented for WA include teaching hospitals only; statistics presented for Queensland derive from 10 hospitals accounting for approximately 55 per cent of total separations.

2 To permit comparability with other State estimates Victorian data include 'booked' and 'unbooked' patients.

3 Queensland survey period differed from that used by other jurisdictions.

4 Excludes Queensland due to non-comparable survey period.

Source: Moon 1996

Table 5A.18: Waiting times for category 1 elective surgery patients¹ in public acute care hospitals, 1995 (per cent)²

	NSW	Vic ³	Qld	WA	SA	Tas	ACT	NT	Aust ⁴
<i>Proportion of patients waiting over 30 days at census by clinical specialty</i>									
Cardio-thoracic surgery	21	5	24	0	15	0	0	na	14
Ear nose and throat	32	15	50	0	43	67	46	71	33
General surgery	21	0	34	0	19	29	50	79	22
Gynaecology	19	2	29	0	22	46	52	90	22
Neurosurgery	13	0	60	0	9	22	na	na	11
Ophthalmology	27	0	81	0	6	80	0	na	26
Orthopaedic surgery	42	0	65	50	58	59	33	100	42
Plastic surgery	43	0	29	26	63	43	28	na	38
Urology	22	4	42	43	28	45	63	na	27
Vascular surgery	19	7	67	na	17	50	50	na	19
Other	15	0	33	25	na	0	na	na	15
All patients	26	3	43	26	33	41	50	83	27
<i>Proportion of patients admitted after waiting over 30 days by clinical specialty</i>									
Cardio-thoracic surgery	18	0	21	1	10	2	na	na	11
Ear nose and throat	15	9	19	9	13	19	na	28	13
General surgery	10	3	16	1	9	12	na	19	9
Gynaecology	12	2	20	0	13	16	na	18	11
Neurosurgery	7	2	42	2	7	0	na	na	6
Ophthalmology	15	0	27	4	7	4	na	na	12
Orthopaedic surgery	17	4	23	11	17	35	na	50	15
Plastic surgery	16	9	23	5	14	21	na	0	13
Urology	17	2	35	24	14	32	na	na	14
Vascular surgery	12	2	22	0	10	47	na	na	9
Other	3	0	11	9	na	3	na	na	2
All patients	12	3	19	7	11	17	na	21	11

na not available

1 Category 1 patients are those for whom admission is desirable within 30 days.

2 Generally based on a survey period of six months — this period may not be typical. For most state and territories the data covered all waiting list-related activity: statistics for WA included teaching hospitals only; statistics presented for Queensland were derived from 10 hospital accounting for approximately 55 per cent of total separations for October and November 1995 only.

3 To permit comparability with other State estimates Victorian data included 'booked' and 'unbooked' patients.

4 Excludes Queensland due to non-comparable survey period.

Source: Moon 1996

Table 5A.19: Waiting times for category 2 elective surgery patients¹ in public acute care hospitals, 1995 (per cent)²

	NSW	Vic ³	Qld	WA	SA	Tas	ACT	NT	Aust ⁴
<i>Proportion of patients waiting over 12 months at census by clinical specialty</i>									
Cardio-thoracic surgery	1	5	8	6	1	3	0	na	3
Ear nose and throat	8	10	47	33	12	49	21	55	16
General surgery	2	9	15	18	5	24	28	34	10
Gynaecology	1	2	13	1	5	22	14	30	5
Neurosurgery	2	5	15	3	3	40	18	na	8
Ophthalmology	3	4	24	18	1	13	11	21	5
Orthopaedic surgery	7	9	24	18	9	19	28	38	11
Plastic surgery	13	19	44	35	19	40	46	33	23
Urology	4	8	21	32	19	30	45	8	15
Vascular surgery	16	22	41	27	4	30	58	na	22
Other	2	6	6	13	na	44	8	na	7
All patients	5	9	24	24	10	27	28	36	11
<i>Proportion of patients admitted after waiting over 12 months by clinical speciality)</i>									
Cardio-thoracic surgery	0	1	5	0	0	12	na	na	1
Ear nose and throat	3	3	28	14	9	24	na	18	6
General surgery	1	4	3	4	3	16	na	7	3
Gynaecology	0	2	2	0	2	14	na	5	2
Neurosurgery	0	1	3	0	0	26	na	na	1
Ophthalmology	3	2	12	6	1	29	na	9	3
Orthopaedic surgery	3	9	10	12	5	57	na	6	8
Plastic surgery	1	21	9	6	5	29	na	17	10
Urology	1	5	8	3	3	22	na	5	4
Vascular surgery	2	5	5	3	5	31	na	na	4
Other	0	2	2	2	0	3	na	na	1
All patients	1	4	7	5	4	22	na	8	4

na not available

1 Category 2 patients are those not classified as Category 1

2 Generally based on a survey period of six months — this period may not be typical. For most state and territories the data covered all waiting list-related activity: statistics for WA included teaching hospitals only; statistics presented for Queensland were derived from 10 hospital accounting for approximately 55 per cent of total separations for October and November 1995 only.

3 To permit comparability with other State estimates Victorian data included 'booked' and 'unbooked' patients.

4 Excludes Queensland due to non-comparable survey period.

Source: Moon 1996

Table 5A.20: Separations per 1000 population by type of hospital, 1994–95 (number¹)

	<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	209.2	188.5	187.4	184.3	214.7	163.2	183.1	255.1	197.9
Private	77.1	91.5	95.6	67.2	88.6	87.3	74.5	44.5	83.9
Total acute hospitals	286.3	280.0	282.9	251.5	303.3	250.5	257.6	299.6	281.9

1 This indicator was not standardised for population composition differences between states and territories, or for differences between states and territories in counting and reporting practices.

Sources: AIHW unpublished, DHFS unpublished, WA unpublished, ABS Cat. No. 3101.0

5A.2.3 Efficiency indicators

Table 5A.21: Recurrent costs per separation for public acute care hospitals (unadjusted), 1994–95¹

	<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	1 215	845	604	337	316	77	55	42	3 491
Total recurrent expenditure	\$m	3 877	2 419	1 588	879	831	263	199	125	10 180
Inpatient fraction ²	%	74.9	77.5	75.4	81.4	79.8	79.0	78.2	79.8	76.8
Public patient proportion ³	%	77.2	76.8	87.1	83.9	85.0	81.3	80.3	94.5	80.1
<i>Non medical labour costs</i>										
Nursing	\$	711	632	612	627	625	841	757	716	663
Diagnostic/allied health	\$	222	194	146	187	157	195	281	207	193
Administrative	\$	191	169	117	179	158	135	236	140	167
Other staff	\$	245	195	249	270	179	334	155	302	231
Superannuation ⁴	\$	98	115	98	22	102	136	49	0	95
Total	\$	1 466	1 305	1 223	1 285	1 221	1 641	1 478	1 364	1 349
<i>Medical labour costs</i>										
Public patients										
Salaried/sessional staff	\$	183	240	209	252	194	209	295	285	212
VMO payments	\$	196	93	68	116	148	138	292	95	136
Private patients (estimated) ⁵	\$	112	101	41	71	60	80	144	22	86
Total	\$	491	434	319	439	402	427	731	403	434
Total labour costs	\$	1 957	1 739	1 542	1 724	1 623	2 068	2 209	1 767	1 783

(cont.)

Table 5A.21: Recurrent costs per separation for public acute care hospitals (unadjusted), 1994–95¹ (cont.)

	<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>
<i>Other recurrent costs</i>										
Domestic services	\$	45	70	69	109	68	93	91	53	65
Repairs/maintenance	\$	68	55	50	107	78	79	48	51	66
Medical supplies	\$	143	135	155	135	135	223	232	94	144
Drug supplies	\$	99	97	98	108	90	140	109	78	99
Food supplies	\$	36	27	26	30	26	26	46	32	30
Administration	\$	98	125	82	70	125	146	109	147	103
Other	\$	105	92	19	51	21	23	177	212	75
Total other	\$	593	602	498	609	543	731	812	667	582
Total recurrent costs	\$	2 551	2 340	2 039	2 332	2 167	2 798	3 022	2 434	2 366

1 Costs have not been adjusted for casemix. These estimates are based on a preliminary database so caution should be exercised in interpreting the results.

2 Inpatient fractions have been estimated using the HASAC method for Tasmanian, NT and some hospitals in NSW and ACT. The value for WA was estimated by WA Health. The value reported for NSW in the 1995 Report was likely to have been an underestimate resulting in an underestimate of the cost per separation.

3 Public patient bed-days as a proportion of total bed-days.

4 In WA and NT the major superannuation scheme is funded by Treasury and the hospitals do not contribute.

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

Source: AIHW unpublished

Table 5A.22: Cost per casemix-adjusted separation for public acute hospitals, 1994–95

	<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	1 215	845	604	337	316	77	55	42	3 491
Average case weight ¹		1.00	1.03	0.93	0.94	1.03	0.98	0.86	0.80	0.99
Units of care ²	'000	1 219	872	561	317	324	76	48	33	3 447
Total recurrent expenditure	\$m	3 877	2 419	1 588	879	831	263	199	125	10 180
Inpatient fraction ³	%	74.9	77.5	75.4	81.4	79.8	79.0	78.2	79.8	76.8
Public patient proportion ⁴	%	77.2	76.8	87.1	83.9	85.0	81.3	80.3	94.5	80.1
<i>Non medical labour costs</i>										
Nursing	\$	708	613	659	666	609	856	879	896	671
Diagnostic/allied health	\$	221	188	158	199	153	199	326	259	195
Administrative	\$	190	164	126	190	154	137	274	176	170
Other staff	\$	244	189	268	286	175	340	180	378	234
Superannuation ⁵	\$	98	111	106	24	100	138	56	0	96
Total	\$	1 461	1 265	1 316	1 365	1 191	1 669	1 716	1 709	1 366
<i>Medical labour costs</i>										
Public patients										
Salaried/sessional staff	\$	182	232	225	268	189	213	342	358	215
VMO payments	\$	195	90	74	123	144	140	339	120	138
Private patients (estimated) ⁶	\$	112	98	44	75	59	81	168	28	87
Total	\$	490	420	343	466	392	434	849	505	440
Total labour costs	\$	1 951	1 685	1 659	1 831	1 583	2 103	2 565	2 214	1 806
<i>Other recurrent cost</i>										
Domestic services	\$	44	68	74	116	66	95	105	66	66
Repairs/maintenance	\$	68	53	53	113	76	80	56	64	66
Medical supplies	\$	142	131	167	143	132	227	269	117	146
Drug supplies	\$	98	94	105	115	87	142	126	98	100
Food supplies	\$	36	26	28	32	25	27	54	41	31
Administration	\$	98	121	88	74	122	148	126	184	105
Other	\$	105	90	21	54	21	24	206	266	76
Total other	\$	591	583	536	646	529	743	942	836	590
Total recurrent hospital costs	\$	2 542	2 269	2 195	2 478	2 113	2 846	3 506	3 050	2 396

1 Estimates provided by DHFS using AN-DRG version 3. These estimates are based on a preliminary database so caution should be exercised in interpreting the results.

(cont.)

Table 5A.22: Cost per casemix-adjusted separation for public acute hospitals, 1994–95 (cont.)

2 Units of care is the product of separations and average case weight.

3 Inpatient fractions have been estimated using the HASAC method for Tasmania, NT and some hospitals in NSW and ACT. The value for WA was estimated by WA Health. It is likely that the value reported for NSW in the 1995 Report was an underestimate resulting in an underestimate of the cost per separation.

4 Public patient bed-days as a proportion of total bed-days.

5 In WA and the NT the major superannuation scheme is funded by Treasury and the hospitals do not contribute.

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

Sources: AIHW unpublished, DHFS unpublished

Table 5A.23: Indicative estimates of the cost of capital per casemix adjusted separation for public acute care hospitals, 1994–95¹

	<i>Units</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA²</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
<i>Buildings</i>										
Depreciated replacement value	\$m	3 809	2 126	3 500	1 070	605	225	275	na	na
Opportunity cost ³	\$m	267	149	245	75	42	16	19	na	na
Depreciation	\$m	121	66	na	32	39	18	7	na	na
Casemix-adjusted separations	'000	1 219	872	561	317	309	76	48	na	na
User charge per separation		318	246	na	337	263	443	553	na	na
<i>Equipment</i>										
Depreciated replacement value	\$m	712	na	na	115	na	42	na	na	na
Opportunity cost ³	\$m	50	na	na	8	na	3	na	na	na
Depreciation	\$m	87	na	na	10	na	32	5	na	na
Casemix-adjusted separations	'000	1 219	na	na	317	na	76	na	na	na
User charge per separation		113	na	na	57	na	465	na	na	na

na not available

1 These data are not based on nationally consistent definitions or methodologies and can be considered indicative only. (see notes to Table 5A.14).

2 1993–94 figures.

3 Calculated as replacement depreciated value by 7 per cent.

Table 5A.24: Indicative estimates of capital use, 1994–95 (\$ per separation)¹

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i> ²	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Buildings	3 712	4 502	7 128	6 448	6 314	4 126	na	na	na
Equipment	901	na	1 336	720	849	1 186	na	na	na

na not available

1 Capital intensity is total replacement value/separations. These data are not based on nationally consistent definitions or methodologies and can be considered indicative only (see Descriptive data; Table 5A.14 for asset value calculation note).

2 1993–94 figures

Table 5A.25: Average length of stay for the top 10 AN–DRGs — excluding same day cases, 1994–95 (days)¹

<i>DRG</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>NT</i>	<i>ACT</i>	<i>Aust</i>
<i>674 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>727 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>187 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>099 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>122 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

(cont.)

Table 5A.25: Average length of stay for the top 10 AN-DRGs —
excluding same day cases, 1994–95 (days)¹ (cont.)

DRG	NSW	Vic	Qld	WA	SA	Tas	NT	ACT	Aust
<i>252 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>367 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
<i>455 Medical back problems age < 75 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>177 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>320 Hernia procedures except inguinal and femoral age > 9</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
Additional 5 AN-DRGs including same-day cases ²									
1	572	Admit for renal dialysis							
2	332	Other gastroscopy for non-major digestive disease without complications							
3	780	Chemotherapy							
4	335	Other colonoscopy without complications							
5	099	Lens procedure without vitrectomy without complications							

na not available

1 Estimates provided by DHFS using AN-DRG version 3.0; data trimmed using inter-quartile range method. These estimates are based on an incomplete database so caution should be exercised in interpreting the results.

2 These AN-DRGs would be included in the list of top 20 codes if same-day cases were included. The average length of stay for these codes (including same-day cases) is 1.0 days for public and private hospitals across all jurisdictions.

Source: DHFS unpublished

5A.3 Single jurisdiction data

5A.3.1 New South Wales

NSW was able to provide data on both waiting times for their emergency departments and their cost per non-inpatient occasion of service. The results of a patient satisfaction survey conducted in 1993–94 were presented in the Report on Government Service Provision 1995.

Waiting times for emergency departments

Data was provided on the number of patients classified according to need treated within ideal times in NSW emergency departments.

Table 5A.26: NSW patients seen within recommended time in emergency departments, 1995–96 (per cent)

<i>Date</i>	<i>Level of urgency</i>				
	2 minutes	10 minutes	30 minutes	1 hour	2 hours
July 1995	74.22	48.83	53.72	65.19	88.63
Aug 1995	74.21	52.04	54.10	64.11	88.37
Sept 1995	73.56	53.70	58.64	70.47	91.36
Oct 1995	74.27	55.87	60.47	71.74	92.47
Nov 1995	80.19	55.74	60.08	71.65	93.13
Dec 1995	86.26	62.29	63.57	71.99	91.34
Jan 1996	82.84	60.56	61.59	72.01	92.08
Feb 1996	84.76	60.82	61.68	71.43	92.56
Mar 1996	82.69	62.61	62.60	71.46	92.45
April 1996	86.34	68.98	71.28	74.07	89.22
May 1996	92.08	53.58	55.12	64.79	86.89
June 1996	85.57	51.93	49.34	56.97	81.53

Source: NSW unpublished

Cost per non-admitted patient occasion of service

The NSW Health Department estimated their cost per non inpatient occasion of service at \$62.

5A.3.2 Victoria

Victoria provided data on unplanned readmissions to hospital and waiting times for their emergency departments. The results of a patient satisfaction survey conducted in 1995 were presented in the Report on Government Service Provision 1995.

Unplanned readmissions to hospital

The indicator of unplanned readmissions for further treatment of the same or a related condition is still being developed. Currently the indicator includes readmissions for chronic conditions and for unrelated conditions. The indicator does not include unplanned readmissions for the same condition to a different hospital.

Table 5A.27: Victoria unplanned readmissions to hospital, 1995–96

	<i>Units</i>	<i>June 1995 quarter</i>	<i>Sept 1995 quarter</i>	<i>Dec 1995 quarter</i>	<i>Mar 1996 quarter</i>
Total patients readmitted to hospital	No.	53 955	57 437	58 514	57 859
Total patients with unplanned readmission within 28 days of initial discharge	No.	17 969	19 174	19 684	19 349
Unplanned readmission as a proportion of total patients treated	%	9.6	10.1	10.2	10.3

Source: Department of Human Services Victoria various years

Waiting times for emergency departments

The Victorian Department of Human Services was also able to provide data on the number of patients classified according to need who are treated within ideal times in the emergency departments of hospitals participating in the Emergency Services Enhancement Program.

Table 5A.28: Victoria percentage of patients seen within ideal time in emergency departments, 1995–96^{1,2,3}

	<i>Sept 1995 quarter</i>	<i>Dec 1995 quarter</i>	<i>Mar 1996 quarter</i>
Category 1	100	100	100
Category 2	81	82	79
Category 3	75	77	73

1 Waiting times are calculated as the time between presentation at the emergency department and the commencement of treatment. The following Australasian College for Emergency Medicine patient categories and recommended treatment times are used:

Category 1: Resuscitation case requiring immediate treatment.

Category 2: Emergency case requiring treatment within 10 minutes.

Category 3: Urgent case requiring treatment within 90 minutes.

2 Variations in waiting times may reflect delays in clerical data entry rather than delays in clinical response.

3 Percentages are unweighted averages of individual hospitals.

Source: Department of Human Services Victoria various years

5A.3.3 Queensland

Queensland was able to provide data on the cost of non-admitted patient occasions of service. By 1996-97 data should also be available on waiting times for accident and emergency.

Cost per non-admitted patient occasion of service

The average cost per non-admitted patient occasion of service in Queensland for 1994–95 was \$62.

5A.3.4 Western Australia

WA provided the results of a State-wide survey of public hospitals held in June 1996.

Table 5A.29: WA patient satisfaction results, 1996¹

	<i>Tertiary</i>	<i>Secondary</i>	<i>All hospitals</i>
Overall satisfaction index (maximum 5.00)	4.20	4.37	4.29

1 Based on 2 140 responses.

Source: WA unpublished

5A.3.5 South Australia

SA provided data on unplanned readmissions to hospital by type of hospital and by diagnostic related group.

Unplanned readmissions to hospital

Emergency readmissions comprised 7 per cent of admissions to SA public hospitals. Over 19 per cent of readmissions are represented by ten diagnostic related groups.

Table 5A.30: SA emergency readmissions by hospital, 1995–96 (per cent)

	<i>Sept 1995 quarter</i>	<i>Dec 1995 quarter</i>	<i>Mar 1996 quarter</i>
Metro acute	6.8	6.4	6.5
Country acute	7.7	7.6	7.8
<i>Total acute</i>	<i>7.0</i>	<i>6.7</i>	<i>6.8</i>
Psychiatric	15.3	15.2	17.5
Total	7.1	6.8	7.0

Source: SA unpublished

Table 5A.31: SA top 10 DRG of emergency readmissions in public acute hospitals, March quarter 1996 (number and proportion of total readmissions)

<i>DRG (Version 3)</i>	<i>Number</i>	<i>Per cent</i>
Vaginal delivery without complicating diagnosis	160	3.2
Heart failure and shock	150	3.0
Chronic obstructive airways disease	97	2.0
Oesophagitis gastroenteritis and other miscellaneous digestive disorders > 74 or (10-74 w cc)	96	1.9
Other antenatal admission with moderate or no complicating diagnosis	93	1.9
Postpartum & post abortion diagnosis without operating room procedure	76	1.5
Complications of treatment age < 60 or without cc	75	1.5
Personality disorders & acute reactions	71	1.4
Major affective disorders	70	1.4
Abdominal pain or mesenteric adenitis w/o cc	63	1.3
Total	951	19.1

Source: SA unpublished

5A.3.6 Tasmania

Tasmania provided data on accident and emergency waiting times and the results of a patient satisfaction survey conducted in November 1995.

Accident and emergency waiting times

Accident and emergency waiting times were provided by level of need for the Royal Hobart Hospital.

Table 5A.32: Tasmania proportion of patients attended within ACHS recommended times, 1995–96

<i>Level of need</i>	<i>Patients attended within recommended time</i>
Category 1 (immediate)	99
Category 2 (10 minutes)	98
Category 3 (30 minutes)	74
Category 4 (60 minutes)	73
Category 5 (120 minutes)	92

Source: Tasmania unpublished

Patient satisfaction

Table 5A.33: Tasmania selected patient satisfaction results, 1995¹ (per cent)

<i>Variable</i>	<i>Excellent</i>	<i>Very good</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>	<i>na</i>
<i>General indicators</i>						
Hospital quality	42	36	16	3	4	0
Outcome of hospital stay	32	38	17	6	1	6
Hospital image	25	38	17	11	7	2
<i>Care treatment and communication</i>						
Consideration of needs	49	31	13	5	2	0
Coordination of care	52	27	14	5	3	0
Ease of getting information	39	35	15	7	2	2
Instructions	40	34	15	7	4	1
Informing family and friends	32	31	25	5	4	4
<i>Staff</i>						
Doctors — skills	47	27	14	5	2	5
Doctors — information and communication	42	27	16	6	5	4
Doctors — coordination	42	23	18	7	4	8
Nurses — skills	58	31	5	5	2	0
Nurses — information and communication	48	36	6	7	2	2
<i>Comfort/meals</i>						
Privacy	25	35	15	10	6	9
Condition of room	38	38	13	7	1	4
Restful atmosphere	22	28	27	16	7	0
Supplies and furnishings	27	35	26	7	2	3
Meals	14	23	27	22	11	3

1 Based on 173 responses from 2 sites in November 1995.

Source: Tasmania unpublished

5A.3.7 Australian Capital Territory

The ACT provided 1995–96 data for hospital acquired infections. A wide range of misadventure rates for ACT hospitals as well as the results of a 1995 patient satisfaction survey were presented in the Report on Government Service Provision 1995.

Hospital acquired infection rates

Table 5A.34: ACT hospital acquired infection rates, June 1995 to May 1996 (per cent)

	<i>Rate of clean operative wound infection</i>	<i>Rate of contaminated operative wound infection</i>	<i>Rate of patients who acquire bacteraemia 48 hours after admission</i>
June 1995	3.49	0.87	0.35
July 1995	1.05	1.05	0.22
August 1995	1.32	1.32	0.12
September 1995	1.49	1.98	0.05
October 1995	2.16	0.87	0.18
November 1995	0.45	2.27	0.00
December 1995	1.45	1.45	0.00
January 1996	0.00	0.00	0.48
February 1996	0.58	0.00	0.28
March 1996	0.45	0.45	0.05
April 1996	2.94	0.00	0.00
May 1996	3.45	2.16	0.60
Average	1.57	1.04	0.19

Source: ACT unpublished

5A.3.8 Northern Territory

NT provided emergency readmission rates for all NT hospitals.

Unplanned readmission to hospital

Table 5A.35: NT emergency readmissions within 28 days, 1995–96
(number and proportion of total emergency readmissions)

	<i>Number</i>	<i>Per cent</i>
July 1995	148	6.33
August 1995	135	5.38
September 1995	152	6.55
October 1995	185	7.90
November 1995	173	7.41
December 1995	174	7.58
January 1996	204	9.42
February 1996	147	6.38
March 1996	164	6.84
April 1996	146	6.35
May 1996	161	6.31
June 1996	122	5.22

Source: NT unpublished

5A.4 Definitions and explanatory notes

Table 5A.36: Definition and explanation of the performance indicators

<i>Category / Indicator</i>	<i>Definition</i>	<i>Explanation</i>
Efficiency		
User cost of capital per casemix adjusted separation	Depreciation + Opportunity cost/ casemix adjusted separation.	This indicator takes into account the user cost of capital. It is the sum of depreciation and opportunity cost of all hospital assets excluding land.
Labour cost per casemix adjusted separations	Salary and wages * Inpatient fraction + VMO payments / case weighted separations.	Measures the labour component per casemix adjusted separation
Cost per casemix adjusted separation	(Recurrent expenditure) * Inpatient fraction / total separations * the average case weight.	Deals with the recurrent costs associated with acute admitted patients (inpatients)
Cost of treatment per non-admitted patient	(Recurrent expenditure) * (1 - inpatient fraction) / total non-admitted patient separations.	Measures the costs associated with non-admitted patients
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	Length of stay can be used as a predictor of cost. Comparing ALOS for similar services across two or more providers is a simple way of evaluating relative efficiency.
Total replacement value per casemix adjusted separation	Total replacement value/casemix adjusted separation.	A measure of capital intensity

(cont.)

Table 5A.36: Definition and explanation of the performance indicators
(cont.)

<i>Category / Indicator</i>	<i>Definition</i>	<i>Explanation</i>
Effectiveness		
<i>Quality</i>		
Percentage of facilities accredited with the ACHS	The ratio of accredited beds to all hospital beds in the jurisdiction.	This indicator is a proxy general measure of the quality of care processes.
Condition of capital	Ratio of depreciated replacement value to total replacement value.	A way of illustrating the age/condition of hospital assets excluding land.
Rate of emergency patient re-admission within 28 days	Number of emergency patient readmissions within 28 days of separation/ total number of admissions excluding deaths.	Refers to admission to the same hospital. Restricting the scope to emergency patients will help filter out unplanned re-admissions that may not have been unexpected such as for some chronic illnesses.
Rate of unplanned return to operating room	Number of separations with one or more unplanned visit to an operating room subsequent to a previous procedure during the same admission / total number of separations where one or more procedures were performed.	Attempts to capture all visits to an operating room subsequent to complications arising from any procedure/operation whether or not it was performed in an operating room.
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 5 days.	Attempts to measure hospital acquired infection rates.
Rate of hospital acquired bacteraemia	Number of separated patients who acquire bacteraemia during a hospital stay / number of separations with length of stay of ≥ 2 days.	As above.
Patient satisfaction	No agreed definitions currently exist for this indicator.	

(cont.)

Table 5A.36: Definition and explanation of the performance indicators
(cont.)

<i>Category / Indicator</i>	<i>Definition</i>	<i>Explanation</i>
<i>Appropriateness</i>		
Variations in intervention rates	Number of separations for selected procedures/1000 persons.	This indicator attempts to measure the appropriateness of care in-so-far as variations in intervention rates for a small geographic area reflect the collective decisions of medical practitioners who refer patients for surgical treatment in hospital.
Separations per 1 000 population	Total number of separations/1000 persons.	
<i>Access</i>		
Waiting times for elective surgery	Three indicators are reported: - clearance times; - proportion of patients waiting inappropriately at census; and - proportion of patients admitted after waiting inappropriately.	A definition of clearance times is provided as a note in Table 5A.18.
Accident and emergency waiting times	No national definition exists for this indicator.	Development projects in this field are currently being undertaken some of which are sponsored by the Health Service Outcomes Branch of the Commonwealth Department of Health and Family Services.
Outpatient waiting times	No national definition exists for this indicator.	Development projects in this field are currently being undertaken some of which are sponsored by the Health Service Outcomes Branch of the Commonwealth Department of Health and Family Services.