# 12 Public hospitals

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| Attachment tables |
| Attachment tables are identified in references throughout this chapter by a ‘12A’ prefix (for example, table 12A.1) and are available from the website at www.pc.gov.au/rogs/2018. |
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This chapter reports on the performance of State and Territory public hospitals.

Further information on the Report on Government Services including other reported service areas, the glossary and list of abbreviations is available at www.pc.gov.au/rogs/2018.

## 12.1 Profile of public hospitals

Public hospitals provide a range of services, including:

* acute care services to admitted patients
* subacute and non-acute services to admitted patients (for example, rehabilitation, palliative care and long stay maintenance care)
* emergency, outpatient and other services to non-admitted patients
* mental health services, including services provided to admitted patients by designated psychiatric/psychogeriatric units
* public health services
* teaching and research activities.

This chapter focuses on services (acute, subacute and non-acute) provided to admitted patients and services provided to non-admitted patients in public hospitals. These services comprise the bulk of public hospital activity.

In some instances, data for stand-alone psychiatric hospitals are included in this chapter. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in the ‘Mental health management’ chapter of this Report (chapter 13).

### Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was $61.4 billion in 2015-16 (table 12A.1), with 91.8 per cent funded by the Australian, State and Territory governments and 8.2 per cent funded by non-government sources (including depreciation) (AIHW 2017b).

Government real recurrent expenditure (all sources) on public hospitals per person was $2550.9 in 2015-16; an increase from $2366.0 in 2014-15 (table 12A.2).

### Size and scope of sector

#### Hospitals

In 2015-16, Australia had 701 public hospitals – 3 more than 2014-15 (table 12A.3). Although 68.8 per cent of hospitals had 50 or fewer beds (figure 12.1), these smaller hospitals represented only 14.0 per cent of total available beds (table 12A.3).

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| Figure 12.1 Public hospitals, by size, 2015-16**a, b** |
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| More details can be found within the text surrounding this image. |

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| a See table 12A.3 for detailed footnotes and caveats. b The ACT did not have hospitals with 10 or fewer beds or more than 50 to 100 beds. The NT did not have hospitals with 10 or fewer beds. |
| *Source*: AIHW (2017), *Hospital resources 2015-16: Australian hospital statistics,* Health services series no. 78. Cat. no. HSE 190; table 12A.3. |
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#### Hospital beds

There were 60 957 available beds for admitted patients in public hospitals in 2015-16, equivalent to 2.6 beds per 1000 people (tables 12A.3–4). The concept of an available bed is becoming less important in the overall context of hospital activity, particularly given the increasing significance of same day hospitalisations and hospital-in-the-home (AIHW 2011). Nationally, the number of beds available per 1000 people increased as remoteness increased (table 12A.4).

#### Admitted patient care

There were approximately 6.3 million separations from public (non-psychiatric) hospitals in 2015-16, of which just over half were same day patients (table 12A.5). Nationally, this translates into 246.9 separations per 1000 people (figure 12.2). Acute care separations accounted for the majority of separations from public hospitals (table 12A.10).

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| Figure 12.2 Separation rates in public (non-psychiatric) hospitals**a** |
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| More details can be found within the text surrounding this image. |

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| a See table 12A.6 for detailed footnotes and caveats. |
| *Source*: AIHW (various years), *Australian Hospital Statistics*, Health Services Series, Cat. nos HSE 134 and 145; AIHW (various years), *Admitted patient care: Australian hospital statistics,* Health services series Cat. nos. HSE 156, 172 and 185; table 12A.6. |
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Variations in admission rates can reflect different practices in classifying patients as either admitted same day patients or non-admitted outpatients. The extent of differences in classification practices can be inferred from the variation in the proportion of same day separations across jurisdictions for certain conditions or treatments. This is particularly true of medical separations, where there was significant variation across jurisdictions in the proportion of same day medical separations in 2015-16 (table 12A.7).

In 2015-16, on an age-standardised basis, public hospital separation rates for Aboriginal and Torres Strait Islander Australians were markedly higher than the corresponding rates for all Australians. For private hospital separations, rates were higher for all Australians compared to Aboriginal and Torres Strait Islander Australians (though separations are lower for private hospitals compared to public hospitals) (table 12A.8).

#### Non-admitted patient services

Non-admitted patient services include outpatient services, which may be provided on an individual or group basis, and emergency department services. A total of 32.3 million individual service events were provided to outpatients in public hospitals in 2015‑16 and around 1.1 million group service events (table 12A.11). Differing admission practices across states and territories lead to variation among jurisdictions in the services reported (AIHW 2017c). There were 7.5 million presentations to emergency departments in 2015-16 (table 12A.12).

#### Staff

In 2015-16, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (figure 12.3). Comparing data on FTE staff across jurisdictions should be undertaken with care, as these data are affected by jurisdictional differences in the recording and classification of staff.

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| Figure 12.3 Average FTE staff per 1000 people, public hospital services, 2015-16**a** |
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| More details can be found within the text surrounding this image. |

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| a See table 12A.9 for detailed footnotes and caveats. |
| *Source*: AIHW (2017), *Hospital resources 2015-16: Australian hospital statistics*. Health services series no. 78. Cat. no. HSE 190; ABS (unpublished), Australian Demographic Statistics, December Quarter 2015, Cat. no. 3101.0; table 12A.9. |
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## 12.2 Framework of performance indicators for public hospitals

Performance is reported against objectives that are common to public hospitals in all jurisdictions (box 12.1).

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| Box 12.1 Objectives for public hospitals |
| Public hospitals aim to alleviate or manage illness and the effects of injury by providing acute, non and sub-acute care along with emergency and outpatient care that is:* timely and accessible to all
* appropriate and responsive to the needs of individuals throughout their lifespan and communities
* high quality and safe
* well co-ordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required
* sustainable.

Governments aim for public hospital services to meet these objectives in an equitable and efficient manner. |
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The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of public hospital services (figure 12.4).

The performance indicator framework shows which data are complete and comparable in the 2018 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability, data completeness and information on data quality from a Report-wide perspective. In addition to section 12.1, the Report’s Statistical context chapter (chapter 2) contains data that may assist in interpreting the performance indicators presented in this chapter. Chapters 1 and 2 are available from the website at www.pc.gov.au/rogs/2018.

Improvements to performance reporting for public hospital services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

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| Figure 12.4 Public hospitals performance indicator framework |
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| More details can be found within the text surrounding this image. |

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## 12.3 Key performance indicator results for public hospitals

Different delivery contexts, locations and types of client can affect the equity, effectiveness and efficiency of health services.

### Outputs

Outputs are the services delivered (while outcomes are the impact of these services on the status of an individual or group) (see chapter 1). Output information is also critical for equitable, efficient and effective management of government services.

### Equity

#### Access — Equity of access by special needs groups

‘Equity of access by special needs groups’ is an indicator of governments’ objective to provide hospital services in an equitable manner (box 12.2).

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| Box 12.2 Equity of access by special needs groups |
| ‘Equity of access by special needs groups’ is measured for the special needs group of people living in remote and very remote areas and is defined as the percentage of people who delayed going to hospital due to distance from hospital, by region.Similar rates across regions can indicate equity of access to hospital services across regions.Data are not yet available for reporting against this measure. |
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### Effectiveness

#### Access — Emergency department waiting times

‘Emergency department waiting times’ is an indicator of governments’ objective to provide timely and accessible services to all (box 12.3).

| Box 12.3 Emergency department waiting times |
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| ‘Emergency department waiting times’ is defined by the following two measures:* Emergency department waiting times by triage category, defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand. The benchmarks, set according to triage category, are as follows:
* triage category 1: need for resuscitation — patients seen immediately
* triage category 2: emergency — patients seen within 10 minutes
* triage category 3: urgent — patients seen within 30 minutes
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| Box 12.3 (continued) |
| * triage category 4: semi-urgent — patients seen within 60 minutes
* triage category 5: non-urgent — patients seen within 120 minutes.
* Proportion of patients staying for four hours or less, is defined as the percentage of presentations to public hospital emergency departments where the time from presentation to admission, transfer or discharge is less than or equal to four hours. It is a measure of the duration of the emergency department service rather than a waiting time for emergency department care.

High or increasing proportions for both measures is desirable.Data reported for both measures are:* comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
* complete (subject to caveats) for the current reporting period. All required 2016-17 data are available for all jurisdictions.
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##### Emergency department waiting times by triage category

Nationally in 2016-17, all patients in triage category 1 were seen within the clinically appropriate timeframe. For all triage categories combined, around three-quarters of patients were seen within triage category timeframes (table 12.1). The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage and clinical practices — in particular, the allocation of cases to urgency categories. The proportion of patients in each triage category who were subsequently admitted can indicate the comparability of triage categorisations across jurisdictions and thus the comparability of the waiting times data (table 12A.13).

Emergency department waiting times by hospital peer group, Indigenous status, remoteness and socioeconomic status for public hospitals are reported in the attachment
(tables 12A.14–17).

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| Table 12.1 Proportion of emergency department patients seen within triage category timeframes, public hospitals, 2016-17**a** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Triage category | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
|  1 — Resuscitation | 100 | 100 | 100 | 100 | 100 | 100 | 99 | 100 | 100 |
|  2 — Emergency | 81 | 77 | 72 | 80 | 67 | 75 | 77 | 66 | 77 |
|  3 — Urgent | 76 | 70 | 60 | 50 | 52 | 57 | 50 | 55 | 66 |
|  4 — Semi-urgent | 81 | 73 | 74 | 65 | 69 | 65 | 63 | 58 | 74 |
|  5 — Non-urgent | 94 | 89 | 94 | 92 | 92 | 89 | 91 | 88 | 92 |
|  **Total** | **81** | **73** | **69** | **64** | **64** | **65** | **62** | **61** | **73** |

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| a See box 12.3 and table 12A.13 for detailed definitions, footnotes and caveats.  |
| *Source*: AIHW (2017), *Emergency department care 2016-17: Australian hospital statistics*. Health services series no. 80. Cat. no. HSE 194; table 12A.13. |
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##### Proportion of patients staying for four hours or less

The proportion of patients staying for four hours or less in an emergency department has increased from 67.3 per cent in 2012-13 to 72.0 per cent in 2016-17 (figure 12.5).

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| Figure 12.5 Length of stay for emergency department care, proportion of patients staying for four hours or less**a, b** |
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| More details can be found within the text surrounding this image. |

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| a See box 12.3 and table 12A.18 for detailed definitions, footnotes and caveats. b Data were not available for the ACT for 2015-16 and have not been included in the Australian total for that year. |
| *Source*: AIHW (various years), *Emergency department care: Australian hospital statistics*. Health services series no. 52, 58, 65, 72 and 80 Cat. no. HSE 142, 153, 168, 182 and 194; table 12A.18. |
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#### Access — Waiting times for admitted patient services

‘Waiting times for admitted patient services’ is an indicator of governments’ objective to provide timely and accessible services to all (box 12.4).

| Box 12.4 Waiting times for admitted patient services |
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| ‘Waiting times for admitted patient services’ is defined by the following three measures:* Overall elective surgery waiting times
* Elective surgery waiting times by clinical urgency category
* Presentations to emergency departments with a length of stay of 4 hours or less ending in admission.
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| Box 12.4 (continued) |
| Data reported for these three measures are:* comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
* complete (subject to caveats) for the current reporting period. All required 2016-17 data are available for all jurisdictions.

Overall elective surgery waiting times‘Overall elective surgery waiting times’ are calculated by comparing the date patients are added to a waiting list with the date they were admitted. Days on which the patient was not ready for care are excluded. ‘Overall waiting times’ are presented as the number of days within which 50 per cent of patients are admitted and the number of days within which 90 per cent of patients are admitted. Patients on waiting lists who were not subsequently admitted to hospital are excluded.For overall elective surgery waiting times, a low or decreasing number of days waited are desirable. Comparisons across jurisdictions should be made with caution, due to differences in clinical practices and classification of patients across Australia. The measures are also affected by variations across jurisdictions in the method used to calculate waiting times for patients who transferred from a waiting list managed by one hospital to a waiting list managed by another hospital, with the time waited on the first list included in the waiting time reported in NSW, WA, SA and the NT. This approach can have the effect of increasing the apparent waiting times for admissions in these jurisdictions compared with other jurisdictions (AIHW 2017a).Elective surgery waiting times by clinical urgency category‘Elective surgery waiting times by clinical urgency category’ reports the proportion of patients who were admitted from waiting lists after an extended wait. In general, at the time of being placed on the public hospital waiting list, a clinical assessment is made of the urgency with which the patient requires elective surgery. The clinical urgency categories are: * Category 1 — procedures that are clinically indicated within 30 days
* Category 2 — procedures that are clinically indicated within 90 days
* Category 3 — procedures that are clinically indicated within 365 days.

The term ‘extended wait’ is used for patients in the categories 1, 2 and 3 waiting longer than specified times (30 days, 90 days and 365 days respectively).For elective surgery waiting times by clinical urgency category, a low or decreasing proportion of patients who have experienced extended waits at admission is desirable. However, variation in the way patients are classified to urgency categories should be considered. Rather than comparing jurisdictions, the results for individual jurisdictions should be viewed in the context of the proportions of patients assigned to each of the three urgency categories.Presentations to emergency departments with a length of stay of 4 hours or less ending in admission‘Presentations to emergency departments with a length of stay of 4 hours or less ending in admission’ is defined as the percentage of presentations to public hospital emergency departments where the time from presentation to admission to hospital is less than or equal to four hours.A high or increasing proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission is desirable. |
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##### Overall elective surgery waiting times

Nationally in 2016-17, 50 per cent of patients were admitted within 38 days and 90 per cent of patients were admitted within 258 days (figure 12.6 and table 12A.19). Data are available on elective surgery waiting times by hospital peer group and indicator procedure, Indigenous status, remoteness and socioeconomic status (tables 12A.19–22).

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| Figure 12.6 Waiting times for elective surgery, public hospitals**a, b** |
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| Days waited at the 50th percentile  More details can be found within the text surrounding this image. |
| Days waited at the 90th percentile  More details can be found within the text surrounding this image. |

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| a See box 12.4 and table 12A.19 for detailed definitions, footnotes and caveats. b Data were not available for the ACT for 2015-16 and have not been included in the Australian total for that year.*Source*: AIHW (various years), *Elective surgery waiting times: Australian hospital statistics,* Cat. nos. HSE 140, 151, 166, 183 and 197; table 12A.19. |
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##### Elective surgery waiting times by clinical urgency category

Elective surgery waiting times by urgency category not only provide an indication of the extent to which patients are seen within a clinically desirable time (table 12.2), but also draw attention to the variation in the way in which patients are classified across jurisdictions. Jurisdictional differences in the classification of patients by urgency category in 2016-17 are shown in tables 12A.23. The proportions of patients on waiting lists who already had an extended wait at the date of assessment are reported in tables 12A.24–31.

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| Table 12.2 Patients admitted from waiting lists with extended waits, by clinical urgency category, 2016-17 (per cent)**a** |
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|  | Category 1 | Category 2 | Category 3 | Total |
| New South Wales |  |
|  Total | 0.2 | 2.4 | 3.6 | 2.4 |
| Victoria |  |
|  Total | – | 19.8 | 5.7 | 10.6 |
| Queensland |  |
|  Total | 2.2 | 3.9 | 1.5 | 2.7 |
| Western Australia |  |  |  |  |
|  Total | 10.8 | 12.5 | 3.2 | 8.1 |
| South Australia |  |  |  |  |
|  Total | 11.5 | 12.5 | 4.9 | 9.4 |
| Tasmania |  |  |  |  |
|  Total | 20.7 | 38.4 | 20.2 | 27.1 |
| Australian Capital Territory |  |
|  Total | 8.6 | 19.1 | 11.8 | 13.4 |
| Northern Territory |  |
|  Total | 4.3 | 20.7 | 18.3 | 14.4 |

 |
| a See box 12.4 and tables 12A.24–31 for detailed definitions, footnotes and caveats. – Nil or rounded to zero. |
| *Source*: AIHW (unpublished) National Elective Surgery Waiting Times Data Collection; tables 12A.24, 12A.25, 12A.26, 12A.27, 12A.28, 12A.29, 12A.30 and 12A.31. |
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##### Emergency department presentations with stay of 4 hours or less ending in admission

Nationally in 2016-17, almost half of those who presented to an emergency department and were admitted, waited 4 hours or less to be admitted to a public hospital (table 12.3).

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| Table 12.3 Proportion of emergency department presentations with a length of stay 4 hours or less ending in admission, 2016-17**a** |
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| Triage category | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
|  1 — Resuscitation | 50 | 59 | 57 | 65 | 59 | 51 | 65 | 48 | 56 |
|  2 — Emergency | 44 | 55 | 55 | 56 | 44 | 31 | 57 | 33 | 50 |
|  3 — Urgent | 41 | 53 | 54 | 45 | 38 | 22 | 46 | 31 | 47 |
|  4 — Semi-urgent | 48 | 57 | 57 | 48 | 46 | 26 | 55 | 32 | 51 |
|  5 — Non-urgent | 67 | 68 | 67 | 58 | 70 | 41 | 61 | 33 | 64 |
|  **Total** | **44** | **55** | **55** | **49** | **43** | **26** | **51** | **32** | **49** |

 |
| a See box 12.4 and table 12A.32 for detailed definitions, footnotes and caveats.  |
| *Source*: AIHW (2017), *Emergency department care 2016-17: Australian hospital statistics*. Health services series no. 80. Cat. no. HSE 194; table 12A.32. |
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#### Access — Accessibility

‘Accessibility’ is an indicator of government’s objective to provide timely and accessible services to all (box 12.5).

| Box 12.5 Accessibility |
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| ‘Accessibility’ is defined as the number of specialist hospital services per 1000 people, by remoteness.High or increasing rates can indicate improved access to hospital services. Low availability of specialist hospital services by remoteness can be associated with an increase in distance travelled and waiting times.Data are not yet available for reporting against this measure. |
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#### Appropriateness — Appropriateness of hospital services

‘Appropriateness of hospital services’ is an indicator of government’s objective to provide care that is appropriate and responsive to the needs of individuals throughout their lifespan and communities (box 12.6).

| Box 12.6 Appropriateness of hospital services  |
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| ‘Appropriateness of hospital services’ comprises many factors with one measure currently identified; ‘prescribing of antibiotics in hospitals’ is defined as the percentage of prescriptions for antibiotics in hospitals where prescribing was noncompliant with guidelines.Low and decreasing prescribing of antibiotics that is inappropriate is desirable.Data are not yet available for reporting against this measure. |
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#### Quality — Safety — Accreditation

‘Accreditation’ is an indicator of governments’ objective to provide public hospital services that are high quality and safe (box 12.7).

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| Box 12.7 Accreditation |
| ‘Accreditation’ is defined by the proportion of hospitals accredited to the National Safety and Quality Health Service standards. The standards are:* Governance for safety and quality in health service organisations
* Partnering with consumers
* Preventing and controlling healthcare associated infections
* Medication safety
* Patient identification and procedure matching
* Clinical handover
* Blood and blood products
* Preventing and managing pressure injuries
* Recognising and responding to clinical deterioration in acute health care
* Preventing falls and harm from falls.

A high or increasing rate of accreditation is desirable. However, it is not possible to draw conclusions about the quality of care in those hospitals that are not accredited to all standards. Data reported for this measure are:* comparable (subject to caveats) across jurisdictions
* incomplete for the current reporting period. Data for 2016 were not available.
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Data for 2016 were not available for this Report. Data for 2015 are reported in table 12A.33 and show that of the 698 public hospitals, 93 per cent had been assessed as at 30 June 2015.

#### Quality — Safety — Adverse events in public hospitals

‘Adverse events in public hospitals’ is an indicator of governments’ objective to provide public hospital services that are high quality and safe (box 12.8). Sentinel events, which are a subset of adverse events that result in death or very serious harm to the patient, are reported as a separate output indicator.

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| Box 12.8 Adverse events in public hospitals |
| ‘Adverse events in public hospitals’ is defined by the following three measures: * Selected healthcare-associated infections
* Adverse events treated in hospitals
* Falls resulting in patient harm in hospitals.

Selected healthcare-associated infections ‘Selected healthcare-associated infections’ is the number of *Staphylococcus aureus* (including Methicillin-resistant *Staphylococcus aureus* [MRSA]) bacteraemia (SAB) patient episodes associated with public hospitals (admitted and non-admitted patients), expressed as a rate per 10 000 patient days for public hospitals. A patient episode of SAB is defined as a positive blood culture for SAB. Only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.SAB is considered to be healthcare-associated if the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, or if the first positive blood culture is collected less than or equal to 48 hours after admission to hospital and the patient episode of SAB meets at least one of the following criteria: * SAB is a complication of the presence of an indwelling medical device
* SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
* SAB was diagnosed within 48 hours of a related invasive instrumentation or incision
* SAB is associated with neutropenia contributed to by cytotoxic therapy. Neutropenia is defined as at least two separate calendar days with values of absolute neutrophil count (ANC) or total white blood cell count <500 cell/mm3 (0.5 × 109/L) on or within a seven-day time period which includes the date the positive blood specimen was collected (Day 1), the three calendar days before and the three calendar days after.

Cases where a known previous positive test has been obtained within the last 14 days are excluded. Patient days for unqualified newborns, hospital boarders and posthumous organ procurement are excluded.A low or decreasing rate of selected healthcare-associated infections is desirable. (continued next page) |
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| Box 12.8 (continued) |
| Data reported for this measure are:* comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
* complete (subject to caveats) for the current reporting period. All required 2016-17 data are available for all jurisdictions.

Adverse events treated in hospitals‘Adverse events treated in hospitals’ are incidents in which harm resulted to a person during hospitalisation and are measured by separations that had an adverse event (including infections, falls resulting in injuries and problems with medication and medical devices) that occurred during hospitalisation. Hospital separations data include information on diagnoses and place of occurrence that can indicate that an adverse event was treated and/or occurred during the hospitalisation, but some adverse events are not identifiable using these codes.Low or decreasing adverse events treated in hospitals is desirable.Data reported for this measure are:* comparable (subject to caveats) across jurisdictions and over time
* complete (subject to caveats) for the current reporting period. All required 2015-16 data are available for all jurisdictions.

Falls resulting in patient harm in hospitals‘Falls resulting in patient harm in hospitals’ is defined as the number of separations with an external cause code for fall and a place of occurrence of health service area, expressed as a rate per 1000 hospital separations. It is not possible to determine if the place of occurrence was a public hospital, only that it was a health service area.A low or decreasing rate of falls resulting in patient harm in hospitals is desirable.Data reported for this measure are: * comparable (subject to caveats) across jurisdictions and over time
* complete (subject to caveats) for the current reporting period. All required 2015-16 data are available for all jurisdictions.
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##### Selected healthcare-associated infections

Selected healthcare-associated infections per 10 000 patient days is reported in figure 12.7.

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| Figure 12.7 Selected healthcare-associated infections, public hospitals**a** |
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| More details can be found within the text surrounding this image. |

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| a See box 12.8 and table 12A.34 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW 2017 *Staphylococcus aureus bacteraemia in Australian hospitals 2016-17; Australian hospital statistics*. Health services series; table 12A.34. |
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##### Adverse events treated in hospitals

Nationally in 2015-16, 6.6 per cent of separations in public hospitals had an adverse event reported during hospitalisation (table 12.4). Results by category (diagnosis, external cause and place of occurrence (of the injury or poisoning)) are in table 12A.35.

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| Table 12.4 Separations with an adverse event per 100 separations, public hospitals, 2015-16**a** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aust |
| Total |  6.8 |  6.2 |  6.4 |  7.2 |  7.3 |  8.0 |  7.3 |  3.4 |  6.6 |

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| a See box 12.8 and table 12A.35 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished), National Hospital Morbidity Database; table 12A.35. |
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##### Falls resulting in patient harm in hospitals

Falls resulting in patient harm per 1000 hospital separations varied across states and territories in 2015-16 (figure 12.8). Data are reported by Indigenous status and remoteness in table 12A.36.

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| Figure 12.8 Separations for falls resulting in patient harm in public hospitals, 2015-16**a** |
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| More details can be found within the text surrounding this image. |

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| a See box 12.8 and table 12A.36 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (2017), *Admitted patient care 2015-16: Australian hospital statistics*. Health services series no. 75. Cat. no. HSE 185; table 12A.36. |
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#### Quality — Safety — Sentinel events

‘Sentinel events’ is an indicator of governments’ objective to deliver public hospital services that are high quality and safe (box 12.9). Sentinel events are a subset of adverse events that result in death or very serious harm to the patient. Adverse events are reported as a separate output indicator.

| Box 12.9 Sentinel events |
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| ‘Sentinel events’ is defined as the number of reported adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient. Sentinel events occur relatively infrequently and are independent of a patient’s condition. Australian health ministers have agreed on a national core set of sentinel events for which all public hospitals are required to provide data. The eight agreed core sentinel events are: 1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.
2. Suicide of a patient in an inpatient unit.
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
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| Box 12.9 (continued) |
| 1. Intravascular gas embolism resulting in death or neurological damage.
2. Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.
3. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
4. Maternal death associated with pregnancy, birth or the puerperium.
5. Infant discharged to the wrong family.

A low or decreasing number of sentinel events is desirable. Over time, an increase in the number of sentinel events reported might reflect improvements in incident reporting mechanisms and organisational cultural change, rather than an increase in the frequency of such events. However, trends need to be monitored to establish whether this is the underlying reason.Data reported for this measure are:* comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
* complete (subject to caveats) for the current reporting period. All required 2015-16 data are available for all jurisdictions.
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Sentinel event programs have been implemented by all State and Territory governments. The purpose of these programs is to facilitate a safe environment for patients by reducing the frequency of these events. The programs are not punitive, and are designed to facilitate self-reporting of errors so that the underlying causes of the events can be examined, and action taken to reduce the risk of these events re-occurring.

Numbers of sentinel events for 2015-16 are reported below. As larger states and territories will tend to have more sentinel events than smaller jurisdictions, the numbers of separations are also presented to provide context.

In 2015-16:

* in NSW public hospitals there were 34 sentinel events (table 12A.37) compared to around 1.9 million separations (table 12A.5)
* in Victorian public hospitals there were 16 sentinel events (table 12A.38) compared to around 1.7 million separations (table 12A.5)
* in Queensland public hospitals there were 15 sentinel events (table 12A.39) compared to around 1.3 million separations (table 12A.5)
* in WA public hospitals there were 5 sentinel events (table 12A.40) compared to around 631 000 separations (table 12A.5)
* in SA public hospitals there were 11 sentinel events (table 12A.41) compared to around 439 000 separations (table 12A.5)
* in Tasmanian public hospitals there were no reported sentinel events (table 12A.42) compared to around 123 000 separations (table 12A.5)
* in ACT public hospitals there was 1 reported sentinel event (table 12A.43) compared to around 108 000 separations (table 12A.5)
* in NT public hospitals there were no reported sentinel events (table 12A.44) compared to around 148 000 separations (table 12A.5).

Data for 2011-12 to 2015-16 are reported in tables 12A.37–44, along with disaggregation by the type of sentinel event. Australian totals are reported in table 12A.45 and show that in 2015-16 there was a total of 82 sentinel events — the lowest number over the 5 years of data in this Report.

#### Quality — Responsiveness — Patient satisfaction

‘Patient satisfaction’ provides a proxy measure of governments’ objective to deliver services that are responsive to individuals throughout their lifespan and communities (box 12.10).

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| Box 12.10 Patient satisfaction |
| ‘Patient satisfaction’ is defined by the following six measures for the purposes of this report: * Proportion of people who went to an emergency department in the last 12 months reporting that the emergency department doctors, specialists or nurses ‘always’ or ‘often’:
* listened carefully to them
* showed respect to them
* spent enough time with them
* Proportion of people who were admitted to hospital in the last 12 months reporting that the hospital doctors, specialists or nurses ‘always’ or ‘often’:
* listened carefully to them
* showed respect to them
* spent enough time with them.

A high or increasing proportion of patients who were satisfied is desirable, as it suggests the hospital care was of high quality and better met the expectations and needs of patients. Data reported for these measures are:* comparable (subject to caveats) across jurisdictions and over time
* complete (subject to caveats) for the current reporting period. All required 2016-17 data are available for all jurisdictions.

The Patient Experience Survey does not include people living in discrete Indigenous communities and very remote areas, which affects the comparability of the NT results. |
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Patient satisfaction surveys are different from other sources of hospital quality data because they provide information on hospital quality from the patient’s perspective. Surveys can be useful for obtaining information on patient views of both clinical and non-clinical hospital care (such as whether patients feel they were treated with respect and provided with appropriate information regarding their treatment).

In 2016-17, nationally for all measures, the satisfaction rate was above 80 per cent, with satisfaction generally higher for nurses compared to doctors/specialists and hospitals compared to Emergency departments. To assist interpretation of these results, associated relative standard errors and confidence intervals are reported in attachment
tables 12A.46–49.

#### Quality — Continuity — Continuity of care

‘Continuity of care’ is an indicator of government’s objective to provide care that is well co-ordinated to ensure continuity of care where more than one service type, and/or ongoing service provision is required (box 12.11).

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| Box 12.11 Continuity of care |
| ‘Continuity of care’ can be measured in three different ways: relational continuity, management continuity and informational continuity. For this indicator, the management concept is measured and is defined as the number of hospital patients with complex needs for which a discharge plan is provided within 5 days of discharge divided by all hospital patients with complex care needs expressed as a rate per 1000 separations.High or increasing rates of discharge plans provided to patients with complex care needs within 5 days is desirable. While it is desirable for discharge plans to be provided to patients, the indicator does not provide any information on whether the discharge plan was carried out or whether it was effective in improving patient outcomes.Data are not yet available for reporting against this measure. |
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#### Quality — Continuity — Selected unplanned hospital readmission rates

‘Selected unplanned hospital readmission rates’ is an indicator of governments’ objective to provide public hospital services that are of high quality and well-coordinated to ensure continuity of care (box 12.12).

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| Box 12.12 Selected unplanned hospital readmission rates |
| ‘Selected unplanned hospital readmission rates’ is defined as the rate at which patients unexpectedly return to the same hospital within 28 days for further treatment where the original admission involved one of a selected set of procedures, and the readmission is identified as a post-operative complication. It is expressed as a rate per 1000 separations in which one of the selected surgical procedures was performed. The indicator is an underestimate of all possible unplanned/unexpected readmissions.The selected surgical procedures are knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendectomy. Unplanned readmissions are those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned.Low or decreasing rates of unplanned readmissions are desirable. Conversely, high or increasing rates suggest the quality of care provided by hospitals, or post-discharge care or planning, should be examined, because there may be scope for improvement.Data reported for this measure are:* comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
* complete (subject to caveats) for the current reporting period. All required 2015-16 data are available for all jurisdictions.
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Selected unplanned hospital readmission rates in public hospitals are reported in table 12.5. Of the selected surgical procedures, readmission rates are highest nationally, and for most jurisdictions, for tonsillectomy and adenoidectomy.

| Table 12.5 Selected unplanned hospital readmission rates per 1000 separations, by selected surgical procedure, 2015-16**a** |
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|  | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Total |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Knee replacement | 19.5 | 19.3 | 31.4 | 23.3 | 27.5 | 36.4 | 9.4 | 55.6 | 23.1 |
| Hip replacement | 17.3 | 19.1 | 20.0 | 21.9 | 20.9 | 39.0 | – | 23.8 | 19.2 |
| Tonsillectomy andAdenoidectomy | 27.1 | 23.9 | 56.7 | 53.7 | 52.3 | 46.0 | 30.6 | 85.7 | 34.7 |
| Hysterectomy | 38.3 | 25.9 | 35.0 | 42.9 | 33.6 | 36.3 | 48.8 | 51.5 | 33.4 |
| Prostatectomy | 23.6 | 20.7 | 42.3 | 40.4 | 29.2 | 10.5 | 27.8 | 37.0 | 26.5 |
| Cataract surgery | 2.7 | 2.8 | 4.6 | 1.6 | 2.6 | 8.8 | 2.0 | 6.6 | 3.2 |
| Appendectomy | 18.8 | 19.3 | 20.2 | 32.5 | 34.1 | 35.0 | 12.2 | 43.3 | 20.9 |

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| a See box 12.12 and table 12A.50 for detailed definitions, footnotes and caveats. – Nil or rounded to zero. |
| *Source*: AIHW National Hospital Morbidity Database; WA Health (unpublished); table 12A.50. |
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Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, if post-discharge planning was inadequate, or for reasons outside the control of the hospital (for example poor post-discharge care). Selected unplanned hospital readmission rates are reported by hospital peer group, Indigenous status, remoteness and socioeconomic status in table 12A.51.

#### Sustainability — Workforce sustainability

‘Workforce sustainability’ is an indicator of governments’ objective to provide sustainable public hospital services (box 12.13).

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| Box 12.13 Workforce sustainability |
| ‘Workforce sustainability’ reports age profiles for nurse (including midwives) and medical practitioner workforces. It shows the proportions of registered nurses and medical practitioners in ten year age brackets, by jurisdiction and by region.High or increasing proportions of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement is desirable. All nurses (including midwives) and medical practitioners in the workforce are included in these measures, as crude indicators of the potential respective workforces for public hospitals. These measures are not a substitute for a full workforce analysis that allows for migration, trends in full-time work and expected demand increases. They can, however, indicate that further attention should be given to workforce sustainability for public hospitals.Data reported for this measure are:* comparable (subject to caveats) across jurisdictions and over time
* complete (subject to caveats) for the current reporting period. All required 2016 data are available for all jurisdictions.
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Nationally in 2016, 17.6 per cent of the medical practitioner workforce and 12.0 per cent of the nursing workforce were aged 60 years and over (figures 12.9 and 12.10), reflecting a gradual increase from 2007 for nurses (table 12A.52) and from 2009 for medical practitioners (table 12A.54). State and territory data are available in tables 12A.53 (nursing) and 12A.55 (medical practitioner).

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| Figure 12.9 Nursing workforce (includes midwives), by age group, 2016**a** |
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| More details can be found within the text surrounding this image. |

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| a See box 12.13 and table 12A.53 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished) National Health Workforce Data Set; table 12A.53. |
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| Figure 12.10 Medical practitioner workforce, by age group, 2016**a** |
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| More details can be found within the text surrounding this image. |

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| a See box 12.13 and table 12A.55 for detailed definitions, footnotes and caveats. |
| *Source*: AIHW (unpublished) National Health Workforce Data Set; table 12A.55. |
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### Efficiency

#### Cost per admitted patient separation

‘Cost per admitted patient separation’ is an indicator of governments’ objective to deliver services in an efficient manner (box 12.14).

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| Box 12.14 Cost per admitted patient separation |
| ‘Cost per admitted patient separation’ is defined by the following two measures:* Recurrent cost per weighted separation
* Capital cost per weighted separation.

A low or decreasing recurrent cost per weighted separation or capital cost per weighted separation can reflect more efficient service delivery in public hospitals. However, this indicator needs to be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness.Recurrent cost per weighted separation‘Recurrent cost per weighted separation’ is the average cost of providing care for an admitted patient (overnight stay or same day) adjusted for casemix. Casemix adjustment takes account of variation in the relative complexity of the patient’s clinical condition and of the hospital services provided, but not other influences on length of stay. Data reported for this measure are:* comparable (subject to caveats) across jurisdictions
* complete (subject to caveats) for the current reporting period. All required 2015-16 data are available for all jurisdictions.

Capital cost per weighted separation‘Capital cost per weighted separation’ is calculated as the user cost of capital (calculated as 8 per cent of the value of non-current physical assets including buildings and equipment but excluding land) plus depreciation, divided by the number of weighted separations. This measure allows the full cost of hospital services to be considered. Depreciation is defined as the cost of consuming an asset’s services. It is measured by the reduction in value of an asset over the financial year. The user cost of capital is the opportunity cost of the capital invested in an asset, and is equivalent to the return foregone from not using the funds to deliver other services or to retire debt. Interest payments represent a user cost of capital, so are deducted from capital costs to avoid double counting.Data reported for this measure are:* comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions
* complete (subject to caveats) for the current reporting period. All required 2015-16 data are available for all jurisdictions.
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##### Recurrent cost per weighted separation

Nationally in 2015-16, the recurrent cost per weighted separation was $5199 (figure 12.11).

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| Figure 12.11 Recurrent cost per weighted separation, 2015-16**a** |
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| More details can be found within the text surrounding this image. |

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| a See box 12.14 and table 12A.56 for detailed definitions, footnotes and caveats. |
| *Source*: IHPA (unpublished) National Hospital Cost Data Collection; table 12A.56. |
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Data on the average cost per admitted patient separation are available on the subset of presentations that are acute emergency department presentations (table 12A.58).

The ‘Relative stay index’ can provide useful context for interpreting the cost per separation indicator as the length of stay per separation can influence cost. The relative stay index is defined as the actual number of acute care patient days divided by the expected number of acute care patient days, adjusted for casemix. The relative stay index for Australia for all hospitals (public and private) is one. A relative stay index greater than one indicates that average length of patient stay is higher than expected given the jurisdiction’s casemix distribution. A relative stay index of less than one indicates that the number of bed days used was less than expected. The relative stay index for public hospitals is reported in table 12A.59.

##### Capital cost per weighted separation

Costs associated with non-current physical assets are important components of the total costs of many services delivered by government agencies. Capital costs are reported in table 12A.57.

The Steering Committee’s approach is to report the full costs of a service where they are available. Where the full costs of a service cannot be accurately measured, the Steering Committee seeks to report estimated costs that are comparable (chapter 1 has further information on this approach). Where differences in comparability remain, the differences are documented. A number of issues remain to improve further the quality of these estimates.

#### Recurrent cost per non-admitted patient

‘Recurrent cost per non-admitted patient’ is an indicator of governments’ objective to deliver services in an efficient manner (box 12.15).

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| Box 12.15 Recurrent cost per non-admitted patient |
| ‘Recurrent cost per non-admitted patient’ is defined by the following two measures:* Average cost per non-admitted acute emergency department presentation
* Average cost per non-admitted service event.

A low or decreasing recurrent cost per non-admitted patient can reflect more efficient service delivery in public hospitals. However, this indicator should be viewed in the context of the set of performance indicators as a whole, as decreasing cost could also be associated with decreasing quality and effectiveness. This indicator does not adjust for the complexity of service.Data reported for both measures are:* comparable (subject to caveats) across jurisdictions
* complete (subject to caveats) for the current reporting period. All required 2015-16 data are available for all jurisdictions.
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Nationally in 2015-16, the average cost per non-admitted emergency department presentation was $515 (ranging across jurisdiction from $408 to $619) and per non-admitted service event was $303 (ranging across jurisdictions from $223 to $627) (figure 12.12).

| Figure 12.12 Recurrent cost per non-admitted patient, 2015-16**a** |
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| More details can be found within the text surrounding this image. |
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| a See box 12.15 and tables 12A.60–61 for detailed definitions, footnotes and caveats. |
| *Source*: IHPA (unpublished) National Hospital Cost Data Collection; tables 12A.60–61. |
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### Outcomes

#### Outcomes are the impact of services on the status of an individual or group (see chapter 1).

#### Mortality in hospitals

‘Mortality in hospitals’ is an indicator of governments’ objective to alleviate or manage illness and the effects of injury (box 12.16).

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| Box 12.16 Mortality in hospitals |
| ‘Mortality in hospitals’ is defined as death in low-mortality diagnostic related groups expressed as a rate.Low or decreasing rates of mortality in hospitals indicate more successful management of illness and the effects of injury. Data are not yet available for reporting against this measure. |
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## 12.4 Definitions of key terms

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| **Accreditation** | Professional recognition awarded to hospitals and other healthcare facilities that meet defined industry standards. Public hospitals can seek accreditation through the Australian Council on Healthcare Standards Evaluation and Quality Improvement Program, the Australian Quality Council (now known as Business Excellence Australia), the Quality Improvement Council, the International Organisation for Standardization 9000 Quality Management System or other equivalent programs. |
| **Acute care** | Clinical services provided to admitted patients, including managing labour, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. |
| **Admitted patient** | A patient who undergoes a hospital’s admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person’s home (for hospital-in-the-home patients). |
| **Allied health (non‑admitted)** | Occasions of service to non-admitted patients at units/clinics providing treatment/counselling to patients. These include units providing physiotherapy, speech therapy, family planning, dietary advice, optometry and occupational therapy. |
| **AR-DRG** | Australian Refined Diagnosis Related Group - a patient classification system that hospitals use to match their patient services (hospital procedures and diagnoses) with their resource needs. AR-DRG version 6.0x is based on the ICD-10-AM classification. |
| **Casemix adjusted** | Adjustment of data on cases treated to account for the number and type of cases. Cases are sorted by AR‑DRG into categories of patients with similar clinical conditions and requiring similar hospital services. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions. |
| **Casemix adjusted separations** | The number of separations adjusted to account for differences across hospitals in the complexity of episodes of care. |
| **Community health services** | Health services for individuals and groups delivered in a community setting, rather than via hospitals or private facilities. |
| **Comparability** | Data are considered comparable if (subject to caveats) they can be used to inform an assessment of comparative performance. Typically, data are considered comparable when they are collected in the same way and in accordance with the same definitions. For comparable indicators or measures, significant differences in reported results allow an assessment of differences in performance, rather than being the result of anomalies in the data. |
| **Completeness** | Data are considered complete if all required data are available for all jurisdictions that provide the service. |
| **Cost of capital** | The return foregone on the next best investment, estimated at a rate of 8 per cent of the depreciated replacement value of buildings, equipment and land. Also called the ‘opportunity cost’ of capital. |
| **Elective surgery waiting times** | Elective surgery waiting times are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted for the awaited procedure. Days on which the patient was not ready for care are excluded.  |
| **Emergency department waiting time to commencement of clinical care** | The time elapsed for each patient from presentation to the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) to the commencement of service by a treating medical officer or nurse. |
| **Emergency department waiting times to admission** | The time elapsed for each patient from presentation to the emergency department to admission to hospital. |
| **ICD-10-AM** | The Australian modification of the International Standard Classification of Diseases and Related Health Conditions. This is the current classification of diagnoses in Australia. |
| **Hospital boarder** | A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. |
| **Length of stay** | The period from admission to separation less any days spent away from the hospital (leave days). |
| **Medicare** | Australian Government funding of private medical and optometrical services (under the Medicare Benefits Schedule). Sometimes defined to include other forms of Australian Government funding such as subsidisation of selected pharmaceuticals (under the Pharmaceutical Benefits Scheme) and public hospital funding (under the Australian Health Care Agreements), which provides public hospital services free of charge to public patients. |
| **Mortality rate** | The number of deaths per 100 000 people. |
| **Newborn qualification status** | A newborn qualification status is assigned to each patient day within a newborn episode of care.A newborn patient day is qualified if the infant meets at least one of the following criteria:* is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient,
* is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care,
* is admitted to, or remains in hospital without its mother.

A newborn patient day is unqualified if the infant does not meet any of the above criteria.The day on which a change in qualification status occurs is counted as a day of the new qualification status.If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day. |
| **Nursing workforce** | Registered and enrolled nurses who are employed in nursing, on extended leave or looking for work in nursing. |
| **Medical practitioner workforce** | Registered medical practitioners who are employed as medical practitioners, on extended leave or looking for work as a medical practitioner. |
| **Non-acute care** | Includes maintenance care and newborn care (where the newborn does not require acute care). |
| **Non-admitted occasions of service** | Occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service establishment. Services can include emergency department visits, outpatient services (such as pathology, radiology and imaging, and allied health services, including speech therapy and family planning) and other services to non-admitted patients. Hospital non-admitted occasions of service are not yet recorded consistently across states and territories, and relative differences in the complexity of services provided are not yet documented. |
| **Non-admitted patient** | A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service. |
| **Public hospital** | A hospital that provides free treatment and accommodation to eligible admitted persons who elect to be treated as public patients. It also provides free services to eligible non-admitted patients and can provide (and charge for) treatment and accommodation services to private patients. Charges to non-admitted patients and admitted patients on discharge can be levied in accordance with the Australian Health Care Agreements (for example, aids and appliances). |
| **Real expenditure** | Actual expenditure adjusted for changes in prices. |
| **Relative stay index** | The actual number of patient days for acute care separations in selected AR–DRGs divided by the expected number of patient days adjusted for casemix. Includes acute care separations only. Excludes: patients who died or were transferred within 2 days of admission, or separations with length of stay greater than 120 days, AR-DRGs which are for ‘rehabilitation’, AR‑DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), AR-DRGs which have a length of stay component in the definition, and error AR-DRGs. |
| **Same day patients** | A patient whose admission date is the same as the separation date. |
| **Sentinel events** | Adverse events that cause serious harm to patients and that have the potential to undermine public confidence in the healthcare system. |
| **Separation** | A total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change in the type of care for an admitted patient (for example, from acute to rehabilitation). Includes admitted patients who receive same day procedures (for example, renal dialysis). |
| **Service event** | An interaction between one or more health-care provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in dated entry in the patient’s medical record. |
| **Subacute care** | Specialised multidisciplinary care in which the primary need for care is optimisation of the patient’s functioning and quality of life. A person’s functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction.Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care. |
| **Triage category** | The urgency of the patient’s need for medical and nursing care:category 1 — resuscitation (immediate within seconds)category 2 — emergency (within 10 minutes)category 3 — urgent (within 30 minutes)category 4 — semi-urgent (within 60 minutes)category 5 — non-urgent (within 120 minutes). |
| **Urgency category for elective surgery** | Category 1 patients — admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it can become an emergency. Category 2 patients — admission within 90 days is desirable for a condition that is causing some pain, dysfunction or disability, but that is not likely to deteriorate quickly or become an emergency.Category 3 patients — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency. |

## 12.5 References

AIHW (Australian Institute of Health and Welfare) 2011, *Australian Hospital Statistics 2009-10*, Health Services Series No. 40, Cat. no. HSE 107 AIHW, Canberra.

—— 2017a, *Elective surgery waiting times 2016–17: Australian hospital statistics,* Health services series no. 83. Cat. no. HSE 197 AIHW, Canberra.

—— 2017b, *Health expenditure Australia 2015–16,* Health and Welfare Expenditure Series No. 58, Cat. no. HWE 68 Canberra, AIHW.

—— 2017c, *Non-admitted patient care 2015–16: Australian hospital statistics*, Health services series no. 76. Cat. no. HSE 188 AIHW, Canberra.