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# 10 Public hospitals

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### **Attachment tables**

Attachment tables are identified in references throughout this Indigenous Compendium by an 'A' suffix (for example, in this chapter, table 10A.3). As the data are directly sourced from the 2010 Report, the Compendium also notes where the original table, figure or text in the 2010 Report can be found. For example, where the Compendium refers to '2010 Report, p. 10.15' this is page 15 of chapter 10 of the 2010 Report, and '2010 Report, table 10A.2' is attachment table 2 of attachment 10A of the 2010 Report. A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at ([www.pc.gov.au/gsp](http://www.pc.gov.au/gsp)).

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Public hospitals are important providers of government funded health services in Australia. A key objective of government is to provide public hospital services to ensure the population has access to cost-effective health services, based on clinical need and within clinically appropriate times, regardless of geographic location. Public hospitals provide a range of services, including:

- acute care services to admitted patients
- sub-acute 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 provided to admitted patients and emergency services provided to non-admitted patients in public hospitals (see *Report on Government Services 2010* (2010 Report), chapter 10). These services comprise the bulk of public hospital activity and, in the case of services to admitted patients, have the most reliable data available. Data in the chapter include sub-acute and non-acute care services.

In some instances, stand-alone psychiatric hospitals are included in this chapter (see 2010 Report, chapter 10), although their role is diminishing in accordance with the National Mental Health Strategy. Under the strategy, the provision of psychiatric treatment is shifting away from specialised psychiatric hospitals to mainstream public hospitals and the community sector. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in the mental health section of the 'Health management' chapter (reported in 2010 Report, chapter 12).

Some common health terms relating to hospitals are defined in box 10.1.

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## Box 10.1 Some common terms relating to hospitals

### *Patients*

**admitted patient:** a patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients can receive acute, sub-acute or non-acute care services.

**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.

### *Types of care*

Classification of care depends on the principal clinical intent of the care received.

**acute care:** clinical services provided to admitted or non-admitted patients, including managing childbirth, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.

**sub-acute and non-acute care:** clinical services provided to patients suffering from chronic illnesses or recovering from such illnesses. Services include rehabilitation, planned geriatric care, palliative care, geriatric care evaluation and management, and services for nursing home type patients. Clinical services delivered by designated psychogeriatric units, designated rehabilitation units and mothercraft services are considered non-acute.

### *Hospital outputs*

**separation:** an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Admitted patients who receive same day procedures (for example, renal dialysis) are included in separation statistics.

**casemix-adjusted separations:** the number of separations adjusted to account for differences across hospitals in the complexity of their episodes of care. Casemix adjustment is an important step to achieving comparable measures of efficiency across hospitals and jurisdictions.

**non-admitted occasion 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.

(Continued on next page)

## Box 10.1 (Continued)

### **Other common health terms**

**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 5.1 is based on the ICD-10-AM classification.

**ICD-10-AM (the Australian modification of the International Standard Classification of Diseases and Related Health Problems):** the current classification of diagnoses and procedures.

Source: AIHW (2006, 2008); NCCH (2008).

## **Indigenous data in the Public hospitals chapter**

The Public hospitals chapter in the 2010 Report contains the following data items on Indigenous people:

- separations by hospital sector of patient, 2007-08
- separations per 1000 people
- separations with a procedure recorded, selected principal diagnoses, July 2006–June 2008 (per cent)
- separations with a procedure recorded, July 2006–June 2008 (per cent)
- separations with a procedure recorded, by remoteness, July 2006–June 2008 (per cent)
- perinatal, neonatal and fetal deaths, 2003–2007.

## **Separation rates for Indigenous patients**

The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. The AIHW (2005) report *Improving the Quality of Indigenous Identification in Hospital Separations Data* found that Indigenous patient data was of acceptable quality for analytical purposes only for Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National E Health Information Principal Committee (NEHIPC) has approved NSW and Victorian Indigenous patient data as acceptable in quality for analytical purposes, from the 2004-05 reference year. Efforts to improve Indigenous identification across states and territories are ongoing.

The available data are not necessarily representative of other jurisdictions. Also because of improvements in data quality over time, caution should be used in time series analysis of the data.

In 2007-08, separations for Indigenous people accounted for around 3.6 per cent of total separations and 5.5 per cent of separations in public hospitals in NSW, Victoria, Queensland, WA, SA and the NT combined (table 10.1). Indigenous people made up only around 2.2 per cent of the population in these jurisdictions (table AA.3 and 2010 Report, table AA.2). Most separations involving Indigenous patients (92.9 per cent) in these jurisdictions occurred in public hospitals (table 10.1).

**Table 10.1 Separations, by Indigenous status of patient and hospital sector, 2007-08<sup>a, b</sup>**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total <sup>c</sup>
Public hospital separations ('000)									
Indigenous	53.1	12.4	64.9	42.7	17.3	2.6	1.9	61.6	252.0
Non-Indigenous	1 399.2	1 327.1	749.6	415.5	339.2	91.2	77.7	28.7	4 259.3
Not reported	14.4	11.8	17.5	–	11.8	2.4	1.6	–	55.4
Total	1 466.7	1 351.2	832.0	458.2	368.3	96.3	81.1	90.3	4 566.7
Private hospital separations ('000)									
Indigenous	1.1	0.6	4.4	12.1	1.1	np	np	np	19.3
Non-Indigenous	843.1	791.5	701.8	313.3	228.2	np	np	np	2 877.9
Not reported	13.8	10.1	74.1	–	14.3	np	np	np	112.3
Total	857.9	802.3	780.3	325.4	243.6	np	np	np	3 009.5
Indigenous separations as proportion of total separations (%)									
Public hospitals	3.6	0.9	7.8	9.3	4.7	2.7	2.3	68.2	5.5
Private hospitals	0.1	0.1	0.6	3.7	0.5	np	np	np	0.6
All hospitals	2.3	0.6	4.3	7.0	3.0	np	np	np	3.6
Separations in public hospitals as a proportion of separations in all hospitals (%)									
Indigenous	98.1	95.2	93.6	77.9	94.0	np	np	np	92.9
Non-Indigenous	62.4	62.6	51.6	57.0	59.8	np	np	np	59.7

<sup>a</sup> Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. <sup>b</sup> Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions. The AIHW advised that only data for NSW, Victoria, Queensland, WA, SA and the NT are considered to be acceptable for the purpose of analysis. Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions. <sup>c</sup> The total includes data only for NSW, Victoria, Queensland, WA and SA for private hospitals and all hospitals. – Nil or rounded to zero. np Not published.

Source: AIHW (2009), *Australian Hospital Statistics 2007-08*, Health Services Series No. 33, Cat no. HSE 71; table 10A.1; 2009 Report, table 10.1, p. 10.13.

In 2007-08, on an age standardised basis, 807.7 public hospital separations (including same day separations) for Indigenous patients were reported per 1000 Indigenous people in NSW, Victoria, Queensland, WA, SA and the NT combined

(table 10.2). This rate was markedly higher than the corresponding rate of 217.6 per 1000 for these jurisdictions' combined total population (table 10.2). Incomplete identification of Indigenous people limits the validity of comparisons over time, as well as across jurisdictions.

**Table 10.2 Estimates of public hospital separations per 1000 people, by Indigenous status of patient<sup>a, b</sup>**

	NSW <sup>c</sup>	Vic	Qld <sup>c</sup>	WA <sup>c, d</sup>	SA <sup>c</sup>	Tas	ACT	NT <sup>c</sup>	Total <sup>e</sup>
2003-04									
Indigenous	np	np	710.9	789.3	853.9	np	np	1286.2	np
Total population	np	np	189.3	191.0	235.9	np	np	428.9	np
2004-05									
Indigenous	np	np	733.6	821.5	822.2	np	np	1 441.0	907.0
Total population	np	np	188.1	195.2	225.3	np	np	456.2	205.2
2005-06									
Indigenous	495.6	np	745.4	845.2	875.0	np	np	1 548.0	792.1
Total population	204.7	np	188.5	198.8	229.7	np	np	491.4	205.7
2006-07									
Indigenous	528.0	624.3	756.7	876.5	929.3	np	np	1 584.8	787.5
Total population	205.9	246.6	218.7	218.1	232.6	np	np	480.6	218.7
2007-08									
Indigenous	550.5	629.8	785.7	869.4	908.9	np	np	1 670.6	807.7
Total population	202.8	247.8	195.7	215.1	216.4	np	np	486.4	217.6

<sup>a</sup> The rates are directly age standardised to the Australian population at 30 June 2001. <sup>b</sup> Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions and time. <sup>c</sup> AIHW advice on data of acceptable quality limits reporting across jurisdictions for various years. Data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality and changes in hospitalisation rates for Indigenous people over time that can be partly due to improved identification. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions. <sup>d</sup> Data for WA from 2006-07 include separations for public patients at Joondalup and Peel Health Campuses. Separations for these patients are not included in previous years. <sup>e</sup> Total rates include data for Queensland, WA, SA, and the NT for all years, and from 2005-06 include NSW and from 2006-07 include Victoria. Total rates before 2005-06 are not comparable with the 2005-06 total and total rates before 2006-07 are not comparable with the 2006-07 total. np Not published.

Source: AIHW (unpublished), National Hospital Morbidity Database; table 10A.2; 2010 Report, table 10.2, p. 10.14.

## Separations with a procedure recorded for Indigenous patients

While Indigenous Australians are more likely to be hospitalised than non-Indigenous Australians, they are less likely to undergo procedures while in hospital. The underlying reasons for this are not well understood and are likely to reflect a range of factors, including, for example, clinical judgements about the appropriateness of treatment by procedure, patient preferences and concerns, and distance from appropriate facilities (AHMAC 2006). Other factors are also likely to

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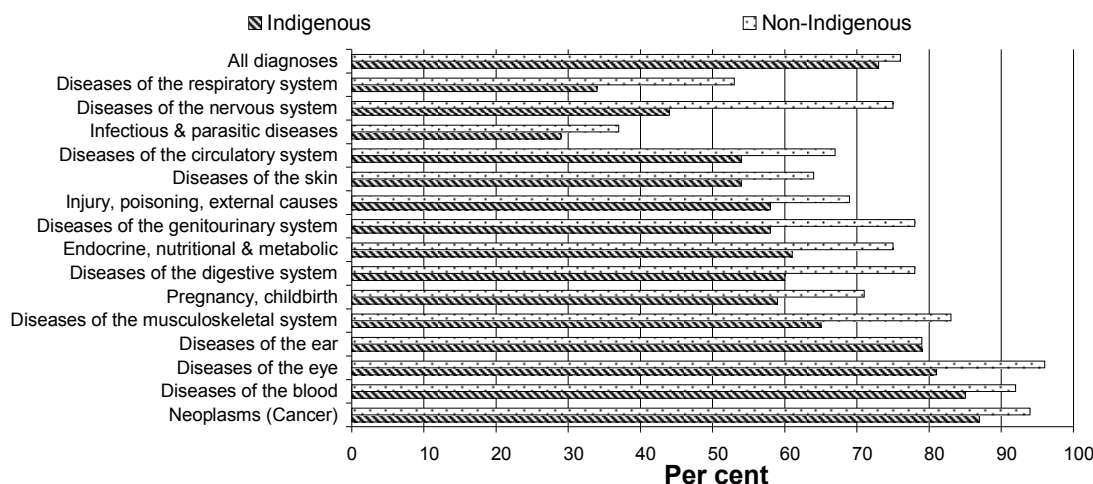
affect the data, including those relating to variations in casemix, comorbidities and stage at presentation.

Data for NSW, Victoria, Queensland, WA, SA and NT public hospitals for separations with a procedure recorded by principal diagnosis are presented in figure 10.1. Separations with a procedure recorded both by jurisdiction and by remoteness are presented in figures 10.2 and 10.3, and include data for all patients treated in public hospitals and public patients treated in private hospitals. Private hospital data are not published for the NT, but the extent to which public patients are treated in private hospitals in that jurisdiction is limited.

In the period July 2006–June 2008, excluding care involving dialysis, consistently lower proportions of separations with a procedure were recorded for Indigenous patients compared with non-Indigenous patients in almost all categories of principal diagnosis (figure 10.1). The differences can be observed across all jurisdictions for which data are available (figure 10.2). While remoteness is associated with progressively reduced rates of separation with a procedure recorded for all patients, differences were more pronounced for Indigenous patients (figure 10.3).

Care involving dialysis accounts for the greatest number of Indigenous separations, with end-stage renal disease requiring frequent dialysis treatments, often several times per week. The alternative to dialysis is a kidney transplant. Indigenous people have very high levels of end-stage renal disease as a consequence of high rates of diabetes, hypertension and related illnesses. In addition, few Indigenous people receive kidney transplants (AHMAC 2006). Without the exclusion of dialysis the result would overestimate the numbers of Indigenous people being treated by procedure for other conditions.

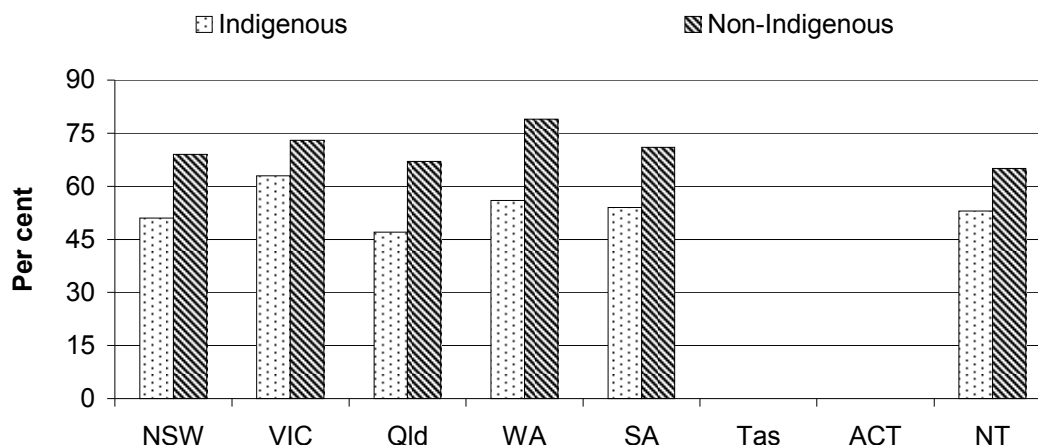
**Figure 10.1 Separations with a procedure recorded by principal diagnosis, by Indigenous status of patient, July 2006–June 2008<sup>a, b</sup>**



<sup>a</sup> Includes patients treated in public hospitals and public patients treated in private hospitals in NSW, Victoria, Queensland, WA, SA and NT. <sup>b</sup> 'All diagnoses' excludes care involving dialysis.

Source: AIHW (unpublished), National Hospital Morbidity Database; table 10A.3; 2010 Report, figure 10.9, p. 10.15.

**Figure 10.2 Separations with a procedure recorded, by Indigenous status of patient, July 2006–June 2008<sup>a, b, c</sup>**

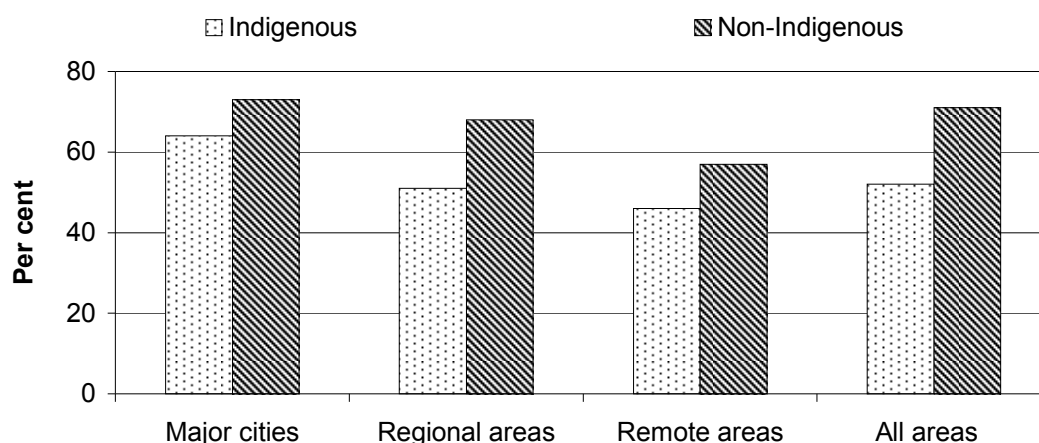


<sup>a</sup> Includes all patients treated in public hospitals and public patients treated in private hospitals. Private hospital data for NT were not available therefore results for NT include public hospital data only. <sup>b</sup> The AIHW advised that only data for NSW, Victoria, Queensland, WA, SA and the NT are considered to be acceptable for the purpose of analysis. Nevertheless, data for these jurisdictions should be interpreted with caution as there are jurisdictional differences in data quality. In addition, these jurisdictions are not necessarily representative of the excluded jurisdictions. <sup>c</sup> 'All diagnoses' excludes care involving dialysis.

Source: AIHW (unpublished), National Hospital Morbidity Database, table 10A.4; 2010 Report, figure 10.10, p. 10.16.



Figure 10.3 **Separations with a procedure recorded, by Indigenous status of patient and remoteness, July 2006–June 2008<sup>a, b</sup>**



<sup>a</sup> Includes all patients treated in public hospitals and public patients treated in private hospitals in NSW, Victoria, Queensland, WA, SA and NT. Private hospital data for NT were not available therefore results for NT include public hospital data only. <sup>b</sup> 'All diagnoses' excludes care involving dialysis.

Source: AIHW (unpublished), National Hospital Morbidity Database, table 10A.5; 2010 Report, figure 10.11, p. 10.16.

## Framework of performance indicators for public hospitals

Data for Indigenous people are reported for a subset of the performance indicators for public hospitals in the 2010 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 10.4. The performance indicator framework shows which data are comparable in the 2010 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

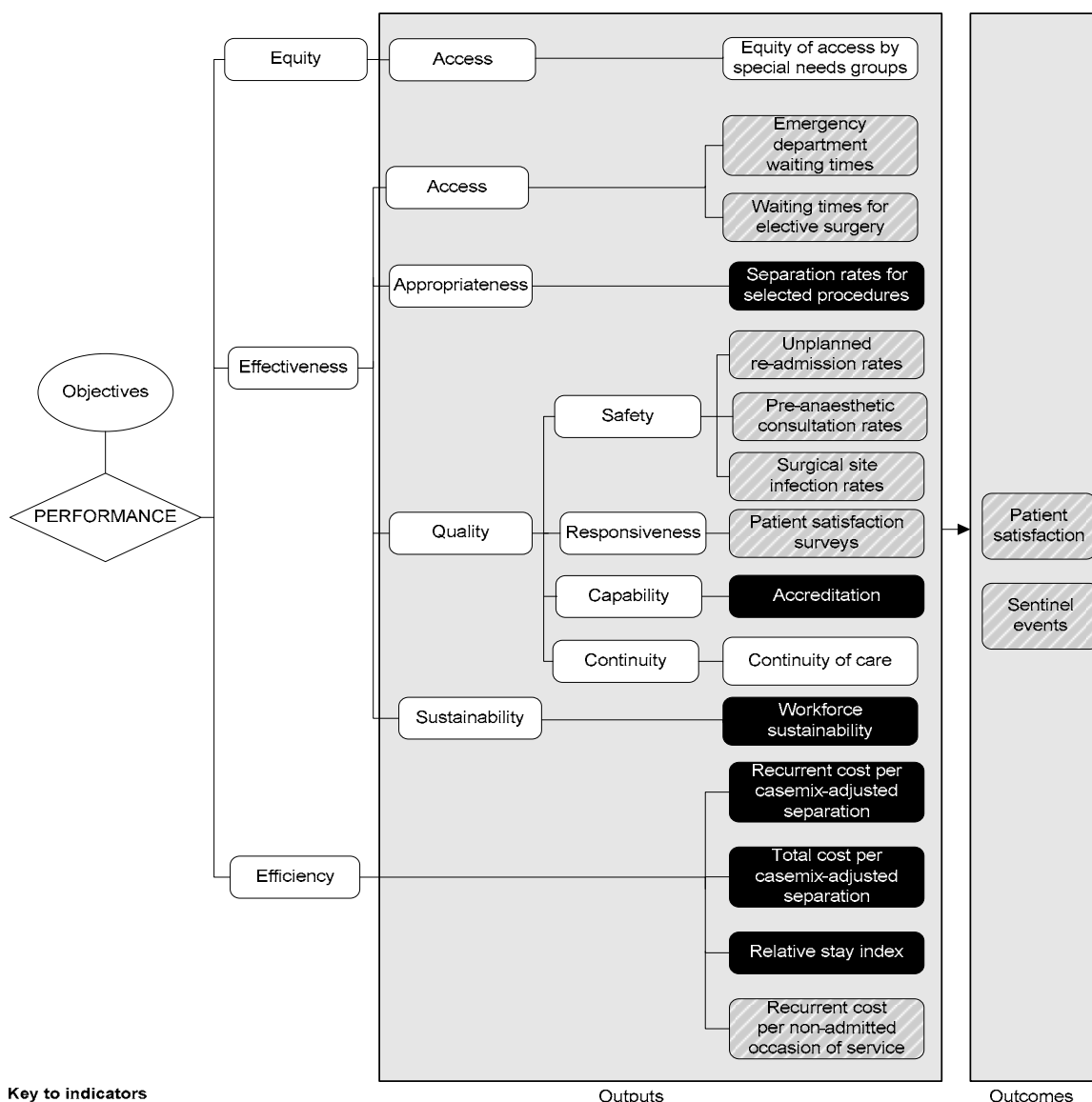
The Council of Australian Governments (COAG) has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services, (2010 Report, chapter 1 provides more detail on reforms to federal financial relations). The National Healthcare Agreement covers the area of health, while the National Indigenous Reform Agreement (NIRA) establishes specific outcomes for reducing the level of

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disadvantage experienced by Indigenous Australians. The agreements include sets of performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council.

The measurement details of relevant National Agreement reporting were under development at the time of preparing this Report. It is anticipated that the performance indicator results reported in this chapter will be revised to align with the performance indicators in the National Agreements for the 2011 Report.

Figure 10.4 Performance indicators for public hospitals



**Key to indicators**

- Text** Data for these indicators comparable, subject to caveats to each chart or table
- Text** Data for these indicators not complete or not directly comparable
- Text** These indicators yet to be developed or data not collected for this Report

Source: 2010 Report, figure 10.13, p. 10.23.

### Equity of access by special needs groups

‘Equity of access by special needs groups’ is an indicator of governments’ objective to provide accessible services (box 10.2).

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**Box 10.2 Equity of access by special needs groups**

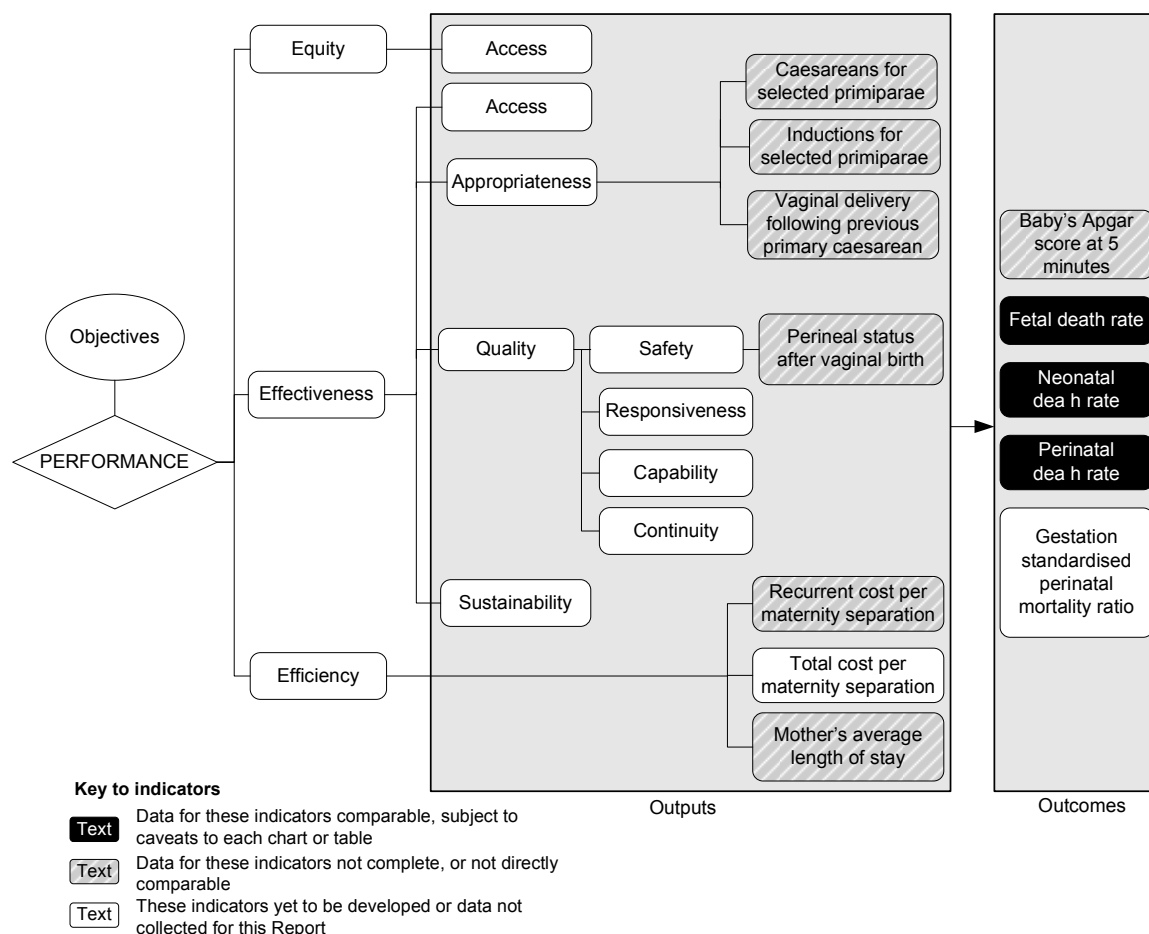
'Equity of access by special needs groups' measures the performance of agencies providing services for three identified special needs groups: Indigenous people; people living in communities outside the capital cities (that is, people living in other metropolitan areas, or rural and remote communities); and people from a non-English speaking background.

'Equity of access by special needs groups' has been identified as a key area for development in future Reports.

**Framework of performance indicators for maternity services**

Data for Indigenous people are reported for a subset of the performance indicators for maternity services in the 2010 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 10.5. The performance indicator framework shows which data are comparable in the 2010 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Figure 10.5 Performance indicators for maternity services



Source: 2010 Report, figure 10.25, p. 10.73.

## Fetal death rate

'Fetal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.3).

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### **Box 10.3 Fetal death rate**

Fetal death (stillbirth) is the birth of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Fetal deaths by definition include only infants weighing at least 400 grams or of a gestational age of at least 20 weeks.

'Fetal death rate' is reported as an indicator because maternity services for admitted patients have some potential to reduce the likelihood of fetal deaths. However, this potential is limited and other factors (such as the health of mothers and the progress of pregnancy before hospital admission) are also important.

The 'fetal death rate' is calculated as the number of fetal deaths divided by the total number of births (live births and fetal deaths combined), by State or Territory of usual residence of the mother. The rate of fetal deaths is expressed per 1000 total births. This indicator is also reported by the Indigenous status of the mother.

Low fetal death rates can indicate high quality maternity services. In jurisdictions where the number of fetal deaths is low, small annual fluctuations in the number affect the annual rate of fetal deaths.

Differences in the 'fetal death rate' between jurisdictions are likely to be due to factors outside the control of maternity services for admitted patients. To the extent that the health system influences fetal death rates, the health services that can have an influence include outpatient services, general practice services and maternity services.

Data reported for this indicator are comparable.

Fetal deaths rates by the Indigenous status of the mother are shown in figure 10.6.

### **Neonatal death rate**

'Neonatal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.4).

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#### **Box 10.4 Neonatal death rate**

Neonatal death is the death of a live born infant within 28 days of birth (see 2010 Report, section 10.8 for a definition of a live birth). As for fetal deaths, a range of factors contribute to neonatal deaths. However, the influence of maternity services for admitted patients is greater for neonatal deaths than for fetal deaths, through the management of labour and the care of sick and premature babies.

The 'neonatal death rate' is calculated as the number of neonatal deaths divided by the number of live births registered. The rate of neonatal deaths is expressed per 1000 live births, by State or Territory of usual residence of the mother. This indicator is also reported by the Indigenous status of the mother.

Low 'neonatal death rates' can indicate high quality maternity services. The rate tends to be higher among premature babies, so a lower neonatal death rate can also indicate a lower percentage of pre-term births.

Data reported for this indicator are comparable.

Neonatal death rates by the Indigenous status of the mother are shown in figure 10.6.

#### **Perinatal death rate**

'Perinatal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.5).

#### **Box 10.5 Perinatal death rate**

A perinatal death is a fetal or neonatal death (boxes 10.3 and 10.4).

The 'perinatal death rate' is calculated as the number of perinatal deaths divided by the total number of births (live births registered and fetal deaths combined) in each jurisdiction. It is expressed per 1000 total births. This indicator is also reported by the Indigenous status of the mother.

The caveats that apply to fetal and neonatal death rates also apply to perinatal death rates.

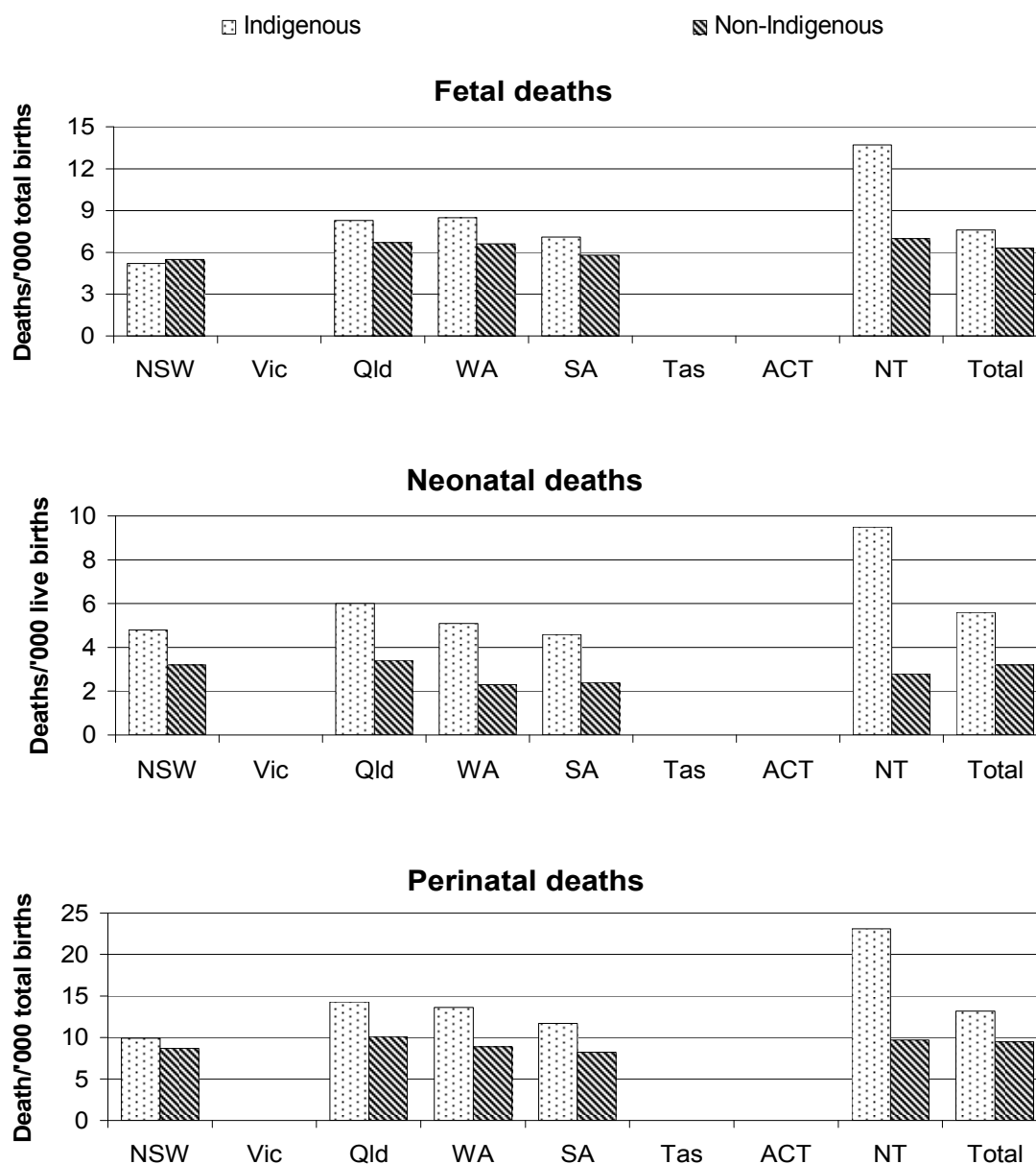
Data reported for this indicator are comparable.

Perinatal death rates by the Indigenous status of the mother are shown in figure 10.6.

Fetal, neonatal and perinatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. Data for other

jurisdictions are not included due to small numbers or poor coverage rates (ABS 2004). In those jurisdictions for which data are available, the fetal, neonatal and perinatal death rates for Indigenous people are generally higher than those for non-Indigenous people (figure 10.6).

**Figure 10.6 Fetal, neonatal and perinatal deaths, by Indigenous status of mother 2003–2007<sup>a</sup>**



<sup>a</sup> The total relates to those jurisdictions for which data are published. Data are not available for other jurisdictions.

Source: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 10A.6; 2010 Report, figure 10.34, p. 10.90.



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## **Future directions in performance reporting**

Priorities for future reporting on public hospitals and maternity services include improving the comprehensiveness of reporting by filling in gaps in the performance indicator frameworks. Important gaps in reporting for public hospitals include indicators of equity of access to services for special needs groups (particularly Indigenous people), and indicators of continuity of care. Gaps in the maternity services framework include equity of access, effectiveness of access, three aspects of quality — responsiveness, capability and continuity — and the effectiveness subdimension of sustainability.

### *COAG developments*

#### *Report on Government Services alignment with National Agreement reporting*

It is anticipated that future editions of the Health chapters and preface will align with applicable National Agreement indicators, including the NIRA. Further alignment between the Report and National Agreement indicators, and other reporting changes, might result from future developments in National Agreement and National Partnership reporting.

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## Attachment tables

Attachment tables for data within this chapter are contained in the attachment to the Compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 10A.3 is table 3 in the Public hospitals attachment). Attachment tables are on the Review website ([www.pc.gov.au/gsp](http://www.pc.gov.au/gsp)). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Compendium). The tables included in the attachment are listed below.

- Table 10A.1** Separations by hospital sector and Indigenous status of patient, 2007-08
- Table 10A.2** Separations per 1000 people, by Indigenous status of patient (number)
- Table 10A.3** Separations with a procedure recorded, selected principal diagnoses, by Indigenous status of patient, July 2006 – June 2008 (per cent)
- Table 10A.4** Separations with a procedure recorded, by Indigenous status of patient, July 2006 – June 2008 (per cent)
- Table 10A.5** Separations with a procedure recorded, by Indigenous status of patient and remoteness, July 2006 – June 2008 (per cent)
- Table 10A.6** Perinatal, neonatal and fetal deaths, 2003–2007

## References

- ABS (Australian Bureau of Statistics) 2004, *Deaths, Australia 2003*, Cat. no. 3302.0, Canberra.
- AHMAC (Australian Health Ministers' Advisory Council) 2006, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2006*, AHMAC, Canberra.
- AIHW (Australian Institute of Health and Welfare) 2005, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, AIHW Cat. no. HSE 101, Canberra.
- 2006, *Australian Hospital Statistics*, Cat. nos HSE 11, 14, 41 and 71, AIHW, Canberra.
- 2008 METeOR AIUHW Metadata Online Registry <http://meteor.aihw.gov.au/content/index.phtml/itemId/181162> (accessed 12 November 2008).
- NCCH (National Centre for Classification in Health) 2008, *The International Statistical Classification of Diseases and Related Health Problems, 10th Revision*, Australian Modification, 6<sup>th</sup> edition (ICD-10-AM), Sydney.