Report on Government Services 2020

PART E, SECTION 12: PRESENTATION REVISED ON 25 JUNE 2020, RELEASED ON 31 JANUARY 2020

12 Public hospitals

The presentation of this section has been updated since its release on 31 January 2020.

This section is presented in a new online format. Dynamic data visualisations replace the static chapter format used in previous editions. Machine readable data are also available for download. A guide is available on accessing information in the new format.

This section reports on the performance of governments in providing public hospitals, with a focus on acute care services.

The **Indicator Results** tab uses data from the data tables to provide information on the performance for each indicator in the **Indicator Framework.** The same data are also available in CSV format.

Skip to downloadable Public hospitals data tables and supporting material

Context

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 coordinated 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.

Service overview

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 section 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 section. The performance of psychiatric hospitals and psychiatric units of public hospitals is examined more closely in the 'Mental health management' section of this Report (section 13).

Funding

Total recurrent expenditure on public hospitals (excluding depreciation) was $67.2 billion in 2017-18 (table 12A.1), with 91 per cent funded by the Australian, State and Territory governments and 9 per cent funded by non-government sources (including depreciation) (AIHW 2019b).

Government real recurrent expenditure (all sources) on public hospitals per person was $2706 in 2017-18; an increase on 2016-17 ($2673, table 12A.2).

Size and scope of the sector

Hospitals

In 2017-18, Australia had 693 public hospitals – 2 fewer than 2016-17 (table 12A.3). Although 68.3 per cent of hospitals had 50 or fewer beds (figure 12.1), these smaller hospitals represented only 13.1 per cent of total available beds (table 12A.3).

Select year
(applies to both table 12.1 and figure 12.1):
2017-18

more than 100 beds
more than 50 to 100 beds
more than 10 to 50 beds
10 or fewer beds

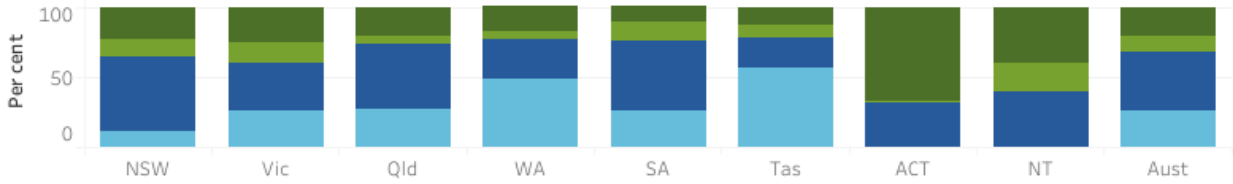
Table 12.1 **Public hospitals (including psychiatric hospitals), Available beds, 2017-18**
by jurisdiction

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
no.	21,253	14,820	12,243	5,947	4,608	1,340	1,078	954	62,243

Source: table 12A.3

In 2017-18, Australia had 693 public hospitals – 2 fewer than 2016-17. Although 68.3 per cent of hospitals had 50 or fewer beds, these smaller hospitals represented only 13.1 per cent of total available beds (table 12A.3).

Figure 12.1 **Public hospitals (including psychiatric hospitals), 2017-18 (a)**
by jurisdiction, by Hospital size



Source: table 12A.3

(a) 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.

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

Hospital beds

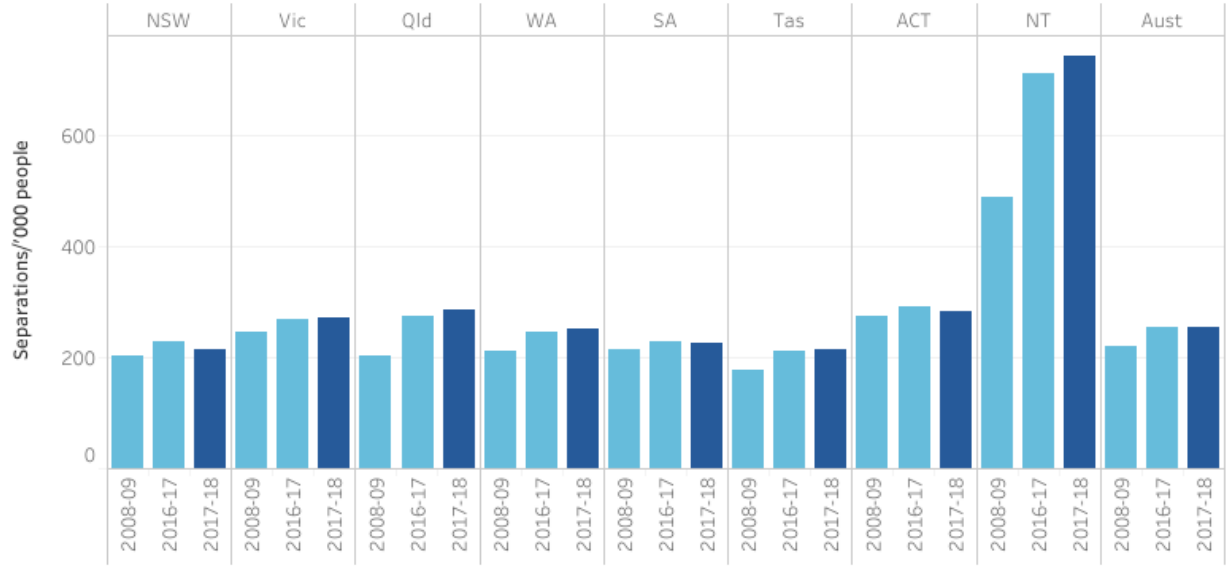
There were 62 243 available beds for admitted patients in public hospitals in 2017-18, equivalent to 2.6 beds per 1000 people (tables 12A.3–4). The concept of an available bed is becoming less important in the overall context of hospital activity, particularly given the increasing significance of same 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 6.7 million separations from public (non-psychiatric) hospitals in 2017-18, of which just over half were same day patients (table 12A.5). Nationally, this equates to 253.9 separations per 1000 people (figure 12.2). Acute care separations accounted for 94.0 per cent of separations from public hospitals (table 12A.10).

Select year(s):
Multiple values

Figure 12.2 **Separations, Per 1000 population, Public acute hospitals** by jurisdiction, by year



Source: table 12A.6

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

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 2017-18 (table 12A.7).

In 2017-18, 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 37.7 million individual service events were provided to outpatients in public hospitals in 2017-18 and around 1.3 million group service events (table 12A.11). Differing admission practices across states and territories lead to variation among jurisdictions in the services reported (AIHW 2019d). There were 8.0 million presentations to emergency departments in 2017-18 (table 12A.12).

Staff

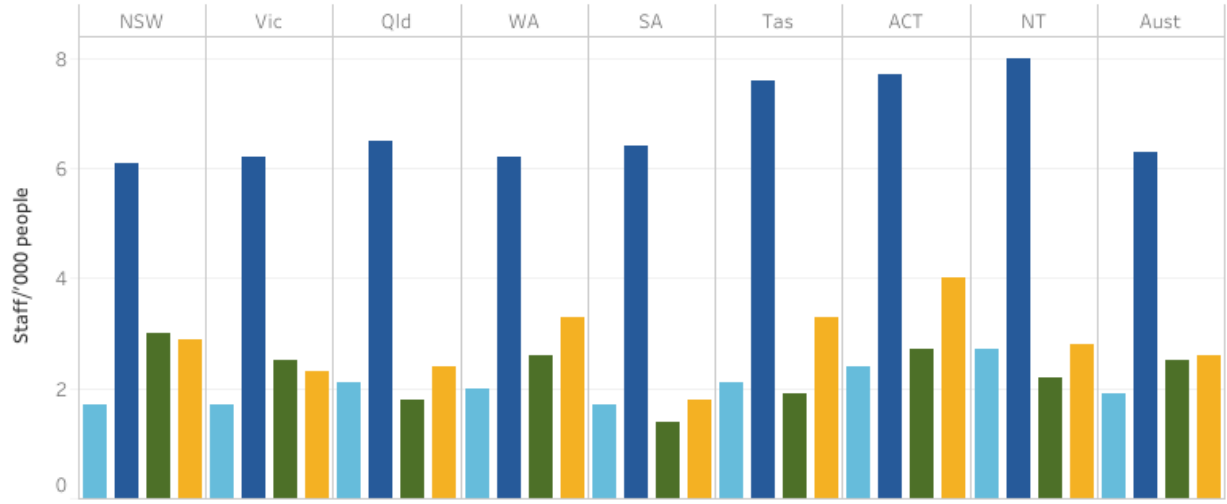
In 2017-18, nurses comprised the single largest group of full time equivalent (FTE) staff employed in public hospitals (figure 12.3). Comparing data on FTE staff across jurisdictions should be undertaken with care, as these data are affected by jurisdictional differences in the recording and classification of staff.

Select year:
2017-18

Salaried medical officers
Nurses
Diagnostic and allied health
Administrative and clerical

Figure 12.3 **Average full time equivalent (FTE) Per 1000 population, Public hospitals (including psychiatric hospitals), 2017-18**

by jurisdiction, by staff



Source: table 12A.9

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

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References

Australian Commission on Safety and Quality in Health Care (ACSQHC) 2018, *Annual Report 2017-18* , ACSQHC, Sydney.

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

—— 2019a, *Elective surgery waiting times 2018-19: Australian hospital statistics* , AIHW, Canberra, https://www.aihw.gov.au/reports-data/myhospitals/sectors/elective-surgery (accessed 11 December 2019).

—— 2019b, *Health expenditure Australia 2017-18* , Health and Welfare Expenditure Series No. 65, Cat. no. HWE 77 AIHW, Canberra.

—— 2019c, *Hospital resources 2017-18: Australian hospital statistics* , Health services series, AIHW, Canberra, https://www.aihw.gov.au/reports/hospitals/hospital-resources-2017-18-ahs/data (accessed 15 October 2019).

—— 2019d, *Non-admitted patient care 2017-18: Australian hospital statistics* , Health services series, AIHW, Canberra, https://www.aihw.gov.au/reports/hospitals/non-admitted-patient-care-2017-18-ahs/contents/at-a-glance (accessed 15 October 2019).

Indicator Framework

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of public hospital services.

The performance indicator framework shows which data are complete and comparable in this Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Section 1 discusses data comparability and completeness from a Report-wide perspective. In addition to the service area's Profile information, the Report's statistical context (section 2) contains data that may assist in interpreting the performance indicators presented in this section.

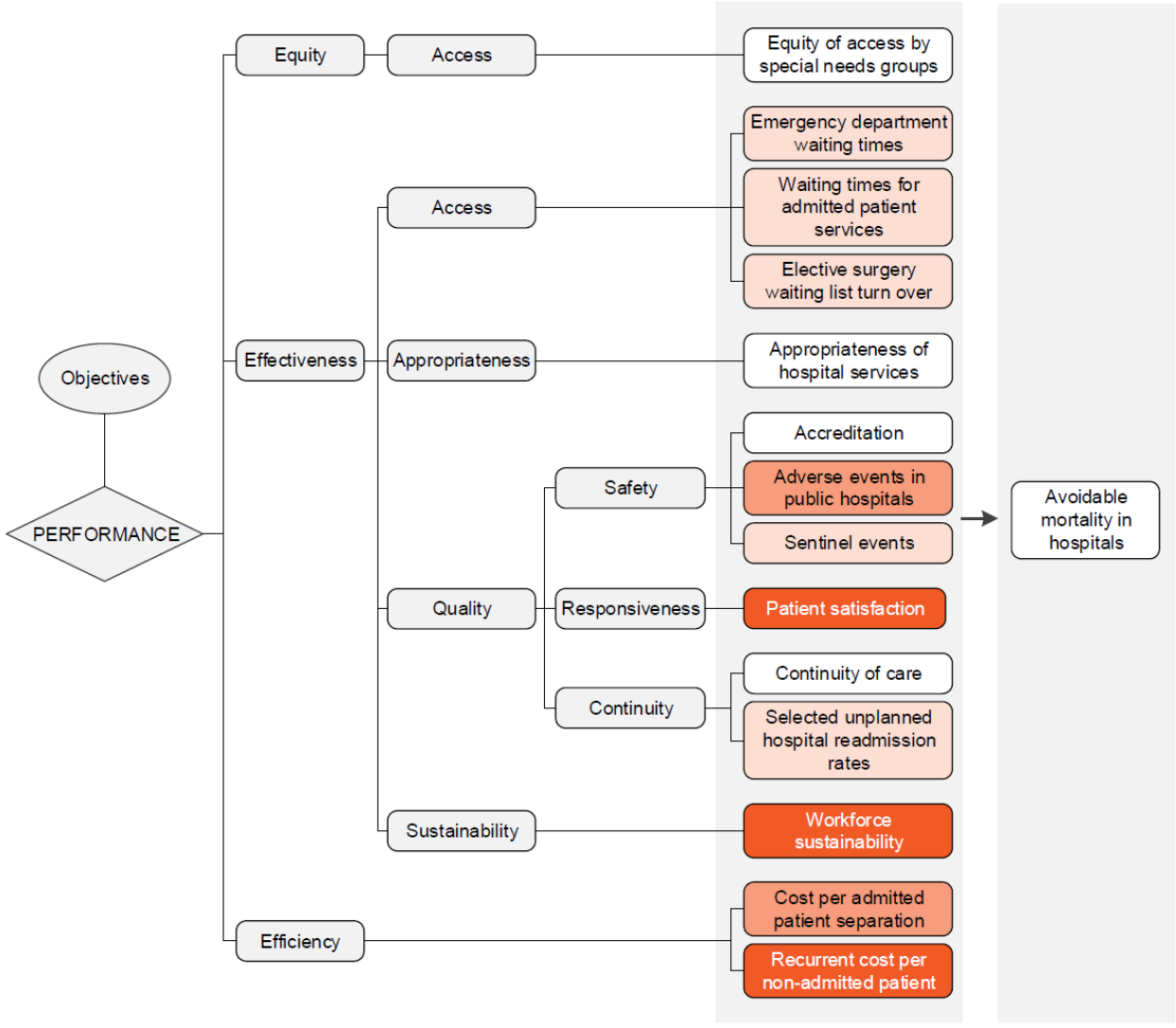
Improvements to performance reporting for public hospital services are ongoing and include identifying data sources to fill gaps in reporting for performance indicators and measures, and improving the comparability and completeness of data.

Outputs

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

Outcomes

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



Key to indicators*

Text	Most recent data for all measures are comparable and complete
Text	Most recent data for at least one measure are comparable and complete
Text	Most recent data for all measures are either not comparable and/or not complete
Text	No data reported and/or no measures yet developed

* A description of the comparability and completeness of each measure is provided in indicator interpretation boxes within the section

Indicator Results

An overview of the public hospital services performance indicator results are presented. Different delivery contexts, locations and types of clients can affect the equity, effectiveness and efficiency of public hospital services.

Information to assist the interpretation of these data can be found in the public hospital services supporting interpretative material and data tables. Data tables are identified by a ‘12A’ prefix (for example, table 12A.1).

All data are available for download as an excel spreadsheet and as a CSV dataset — refer to Download supporting material. Specific data used in figures can be downloaded by clicking in the figure area, navigating to the bottom of the visualisation to the grey toolbar, clicking on the 'Download' icon and selecting 'Data' from the menu. Selecting 'PDF' or 'Powerpoint' from the 'Download' menu will download a static view of the performance indicator results.

Equity of access by special needs groups is an indicator of governments' objective to provide hospital services in an equitable manner.

***Measure*:** The percentage of people who delayed going to hospital due to distance from hospital, by region.

***Guidance*:** Similar rates across regions can indicate equity of access to hospital services across regions.

Data are not yet available for reporting against this indicator.

Emergency department waiting times is an indicator of governments' objective to provide timely and accessible services to all. It is defined by two measures.

Measure 1: Emergency department waiting times by triage category — the proportion of patients seen within the benchmarks set by the Australasian Triage Scale.
Measure 2: Proportion of patients staying for four hours or less — 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.

Guidance: High or increasing proportions for both measures is desirable.

Data are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.

Data are complete (subject to caveats) for the current reporting period.

Select year(s) (applies to table 12.2):
(Multiple values)

Table 12.2 Measure 1: **Emergency department waiting times, All public hospitals (per cent)** by jurisdiction, by triage category timeframes, by year

		NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1 - Resuscitation	2018-19	100	100	100	100	100	100	100	100	100
	2017-18	100	100	100	100	100	100	100	100	100
	2013-14	100	100	100	100	100	100	100	100	100
	2009-10	100	100	99	99	100	99	100	100	100
2 - Emergency	2018-19	79	75	72	78	60	72	74	67	75
	2017-18	81	76	72	81	63	71	77	63	76
	2013-14	83	84	80	86	74	85	83	61	82
	2009-10	82	80	77	71	78	71	83	63	78
3 - Urgent	2018-19	74	66	61	48	46	56	32	54	63
	2017-18	76	68	59	50	48	56	37	49	64
	2013-14	76	73	67	58	65	66	50	51	70
	2009-10	70	71	60	55	63	52	57	49	65
4 - Semi-urgent	2018-19	79	72	75	64	65	64	47	65	73
	2017-18	80	72	73	65	66	66	48	56	73
	2013-14	80	71	75	71	77	71	57	53	75
	2009-10	73	67	66	64	63	63	56	51	68
5 - Non-urgent	2018-19	93	89	93	91	89	85	83	92	91
	2017-18	94	89	93	92	89	89	81	87	92
	2013-14	94	88	92	94	92	90	86	89	92
	2009-10	89	85	89	92	85	88	77	91	88
Total excluding unknown triage category	2018-19	78	71	69	63	58	64	46	64	71
	2017-18	80	72	68	64	60	66	49	57	72
	2013-14	81	75	73	70	73	72	61	57	75
	2009-10	75	72	66	64	67	63	62	56	70

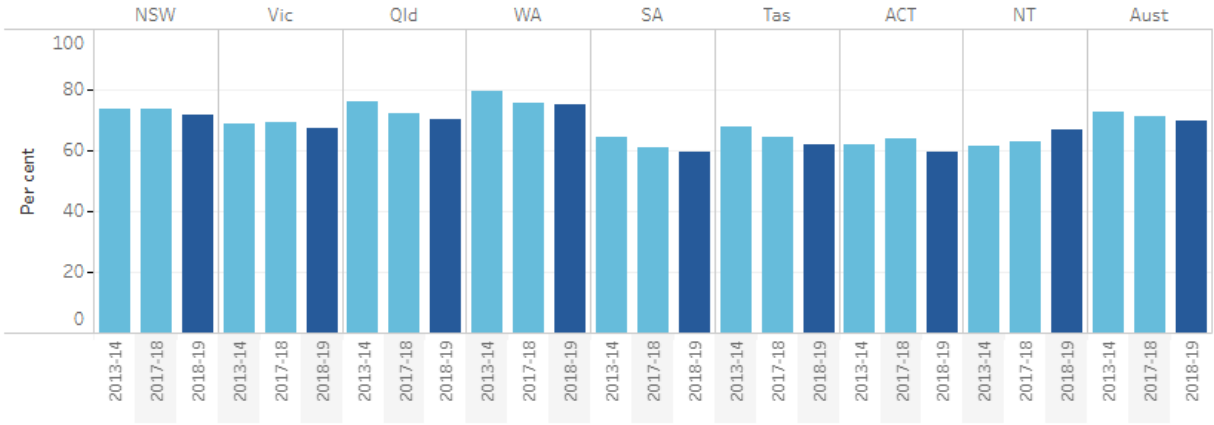
Source: table 12A.13
na Not available.

Nationally in 2018-19, all patients in triage category 1 were seen within the clinically appropriate timeframe. For all triage categories combined, an estimated 71 per cent of patients were seen within triage category timeframes.

Select year(s) (applies to figure 12.4):

(Multiple values)

Figure 12.4 Measure 2: **Patients staying for four hours or less, ED stay length is within four hours (a)** by jurisdiction, by year



Source: table 12A.18

(a) Data were not available for the ACT for 2015-16 and have not been included in the Australian total for that year.

The proportion of patients staying for four hours or less in an emergency department was 69.6 per cent in 2018-19; down from 73.2 per cent in 2014-15 and 2015-16.

Waiting times for admitted patient services is an indicator of governments' objective to provide timely and accessible services to all. It is defined by three measures.

Measure 1: Overall elective surgery waiting times — 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.
Measure 2: Elective surgery waiting times by clinical urgency category — the proportion of patients who were admitted from waiting lists after an extended wait.
Measure 3: Presentations to emergency departments with a length of stay of 4 hours or less ending in admission — the proportion of presentations to public hospital emergency departments where the time from presentation to admission to hospital is less than or equal to 4 hours.

Guidance: A low or decreasing number of days waited are desirable (measure 1). A low or decreasing proportion of patients who have experienced extended waits at admission is desirable (measure 2). 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 (measure 3).

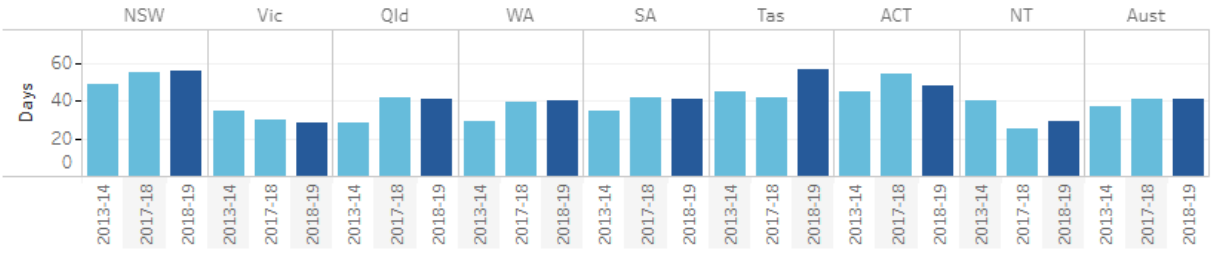
Data are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.

Data are complete (subject to caveats) for the current reporting period.

Select year(s) (applies to figure 12.5):
(Multiple values)

Select percentile:
50th percentile
90th percentile

Figure 12.5 Measure 1: **Elective surgery: waiting times, All public hospitals, 50th percentile** by jurisdiction, by year



Source: table 12A.19

Nationally in 2018-19, 50 per cent of patients were admitted within 41 days and 90 per cent of patients were admitted within 279 days. 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).

Select year (applies to table 12.3a):
2018-19

Table 12.3a Measure 2: **Patients admitted from waiting lists with extended waits, 2018-19**
by jurisdiction, by clinical urgency category (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Category 1 (>30 days)	0.1	–	3.6	14.0	9.6	28.2	3.8	4.4
Category 2 (>90 days)	3.0	18.0	7.7	16.2	17.1	56.9	24.7	12.5
Category 3 (>12 months)	4.3	3.9	5.2	7.1	8.3	33.6	21.9	7.4
All patients	3.0	9.1	5.7	11.9	12.0	39.6	17.4	8.3

Source: tables 12A.24-12A.31
– Nil or rounded to zero. **na** Not available.

Jurisdictional differences in the classification of patients by urgency category are shown. 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.

Select year (applies to table 12.3b):
2018-19

Table 12.3b Measure 3: **Emergency department presentations, ED stay length is within four hours ending in admission, All public hospitals, 2018-19**
by jurisdiction, by triage category (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
1 - Resuscitation	47	55	54	66	54	52	50	42	53
2 - Emergency	42	52	55	57	45	33	42	36	49
3 - Urgent	38	50	52	47	35	25	31	34	44
4 - Semi-urgent	44	52	55	50	43	26	35	37	48
5 - Non-urgent	64	65	66	59	61	39	43	46	62
Total	41	51	53	51	40	27	35	35	47

Source: table 12A.32
na Not available.

Nationally in 2018-19, 47 per cent of people who presented to an emergency department and were admitted, waited 4 hours or less to be admitted to a public hospital.

Elective surgery waiting list turn over is an indicator of governments' objective to provide timely and accessible services to all.

Measure: The number of additions to, and removals from, public hospital elective surgery waiting lists. It is measured by dividing the number of people removed from public hospital elective surgery waiting lists during the reference year by the number of people added to public hospital elective surgery waiting lists during the same year, multiplied by 100.

Guidance: A higher and increasing per cent of patient turn over is desirable as it indicates the public hospital system is keeping pace with demand for elective surgery.

- Data are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year(s):
(Multiple values)

Table 12.4 **Elective surgery waiting list turn over**
by jurisdiction, by year

		Additions to public hospital elective surgery waiting lists	Removals following admission for surgery	Turn over
		no.	no.	%
NSW	2018-19	263,338	229,851	87.3
	2017-18	256,665	226,499	88.2
	2013-14	246,461	216,675	87.9
Vic	2018-19	230,043	198,517	86.3
	2017-18	228,672	200,380	87.6
	2013-14	187,038	170,314	91.1
Qld	2018-19	177,414	142,358	80.2
	2017-18	171,364	140,935	82.2
	2013-14	145,260	127,494	87.8
WA	2018-19	103,472	88,673	85.7
	2017-18	102,562	85,804	83.7
	2013-14	102,141	86,882	85.1
SA	2018-19	70,112	58,835	83.9
	2017-18	67,081	56,477	84.2
	2013-14	71,416	62,968	88.2
Tas	2018-19	22,157	17,858	80.6
	2017-18	22,050	17,564	79.7
	2013-14	18,849	15,315	81.3
ACT	2018-19	16,355	14,017	85.7
	2017-18	15,306	13,340	87.2
	2013-14	13,848	11,781	85.1
NT	2018-19	10,140	8,027	79.2
	2017-18	10,233	7,779	76.0
	2013-14	9,388	7,594	80.9
Aust	2018-19	893,031	758,136	84.9
	2017-18	873,933	748,778	85.7
	2013-14	794,401	699,023	88.0

Source: table 12A.33

Nationally in 2018-19, 893 031 people were added to public hospital elective surgery waiting lists, while 758 136 people were removed following admission for surgery, resulting in a national public hospital elective surgery waiting list turn over of 84.9 per cent.

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.

***Measure*:** Yet to be defined.

This indicator has been identified for development and future reporting.

Accreditation is an indicator of government's objective to provide public hospital services that are high quality and safe.

***Measure*:** 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.

***Guidance*:** 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 are not available for reporting against this indicator.

Data for 2018 were not available for this Report, and have not been available since the 2017 Report. The AIHW (2019c) provides some information on the number of hospitals accredited to various accreditation standards, but no longer produces a proportion of all public hospitals that are accredited due to data quality concerns (data for 2015 are in table 12A.34). In future reports, this indicator will be reported as a proportion of all public hospitals that are accredited, subject to the identification of a suitable data source.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) reports some summary accreditation data based on its National Safety and Quality Health Service Standards (NSQHSS) accreditation program. All hospitals and day procedure services are required to implement the NSQHSS. Health service organisations have to demonstrate they meet all of the requirements in the NSQHSS to achieve accreditation.

Since January 2013, all hospitals and day procedure services in Australia (1312 organisations) have been assessed at least once. Of the 746 organisations that have completed two assessment cycles, 66 per cent met all core actions at initial assessment for the first accreditation cycle, compared to 73 per cent for the second accreditation cycle, demonstrating an improvement in accreditation results over time. In the 2017-18 financial year, 308 public hospitals were assessed against the NSQHSS (ACSQHC 2018).

Work is underway by the ACSQHC to develop data specifications for national hospital accreditation reporting under the Australian Health Performance Framework. It is anticipated that more detailed public reporting of these data will commence in late 2020, pending a decision by the COAG Health Council.

Adverse events in public hospitals is an indicator of governments' objective to provide public hospital services that are high quality and safe. It is defined by three measures.

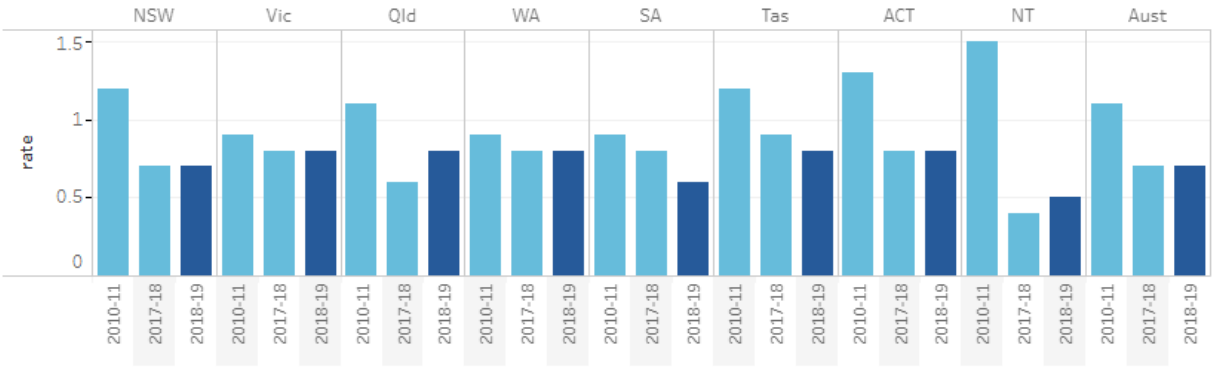
Measure 1: Selected healthcare-associated infections — the number of Staphylococcus aureus (including Methicillin-resistant Staphylococcus aureus [MRSA]) bacteraemia (SAB) patient episodes associated with public hospitals (admitted and non-admitted patients), expressed as a rate per 10 000 patient days for public hospitals.
Measure 2: Adverse events treated in hospitals — the number of separations in public hospitals that had an adverse event (including infections, falls resulting in injuries and problems with medication and medical devices) that occurred during hospitalisation, expressed as a rate per 100 public hospital separations.
Measure 3: Falls resulting in patient harm in hospitals — 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.

Guidance: Low or decreasing rates/events are desirable.

- (measure 1) Data are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.
- (measures 2 and 3) Data are comparable (subject to caveats) across jurisdictions and over time.
- (all measures) Data are complete (subject to caveats) for the current reporting period.

Select year(s) (applies to figure 12.6a):
(Multiple values)

Figure 12.6a Measure 1: **Selected healthcare-associated infections, Per 10 000 patient days** by jurisdiction, by year



Source: table 12A.35

Nationally in 2018-19, selected healthcare-associated infections was 0.7 per 10 000 patient days.

Select year(s) (applies to table 12.5):

(Multiple values)

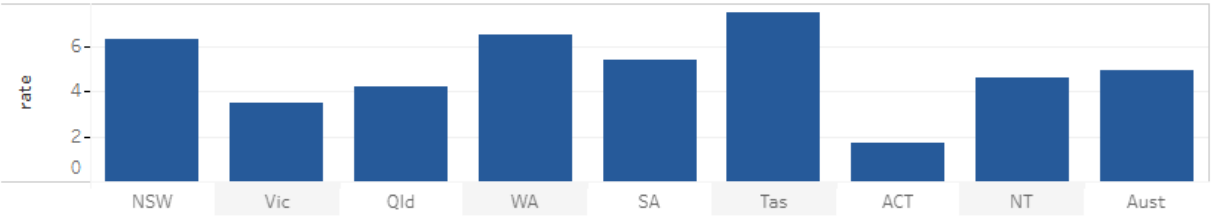
Table 12.5 Measure 2: **Adverse events treated in hospitals, Per 100 separations, Public hospitals (including psychiatric hospitals)** by jurisdiction, by year

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
2017-18	7.1	5.6	6.3	7.3	7.4	8.3	6.6	3.7	6.5
2016-17	7.0	6.1	6.5	7.3	7.6	8.3	7.0	3.6	6.6
2013-14	6.4	7.0	6.4	7.0	7.3	8.4	7.3	3.7	6.7

Source: table 12A.36

Nationally in 2017-18, 6.5 per cent of separations in public hospitals had an adverse event reported during hospitalisation, similar to previous years in this Report. Results by category (diagnosis, external cause and place of occurrence (of the injury or poisoning)) are in table 12A.36.

Figure 12.6b Measure 3: **Falls resulting in patient harm in hospitals, Per 1000 separations, All public hospitals, 2017-18** by jurisdiction



Source: table 12A.37

Nationally in 2017-18, the rate of falls resulting in patient harm was 4.9 per 1000 hospital separations; results varied across states and territories. Data are reported by Indigenous status and remoteness in table 12A.37.

Sentinel events is an indicator of governments' objective to deliver public hospital services that are high quality and safe.

Measure: 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.

Guidance: A low or decreasing number of sentinel events is desirable.

- Data are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year(s):
(Multiple values)

Table 12.6 **Numbers of Sentinel events and separations**
by jurisdiction, by year

		Selected sentinel events	Separations
NSW	2017-18	20	1,860,985
	2016-17	18	1,931,552
	2013-14	53	1,771,521
Vic	2017-18	24	1,846,342
	2016-17	23	1,772,448
	2013-14	20	1,509,766
Qld	2017-18	11	1,486,922
	2016-17	6	1,394,557
	2013-14	12	1,087,073
WA	2017-18	6	679,851
	2016-17	6	652,610
	2013-14	10	595,884
SA	2017-18	11	440,060
	2016-17	5	437,537
	2013-14	6	415,778
Tas	2017-18	3	128,746
	2016-17	1	124,412
	2013-14	1	114,033
ACT	2017-18	3	116,053
	2016-17	4	115,421
	2013-14	–	96,968
NT	2017-18	2	167,816
	2016-17	2	158,811
	2013-14	2	123,847
Aust	2017-18	80	6,726,775
	2016-17	65	6,587,348
	2013-14	104	5,714,870

Source: tables 12A.5 and 12A.38-45
– Nil or rounded to zero.

In 2017-18, there was a total of 80 sentinel events. 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. Data disaggregated by the type of sentinel event are reported in tables 12A.38–46.

Patient satisfaction provides a proxy measure of governments' objective to deliver services that are responsive to individuals throughout their lifespan and communities. It is defined by six measures.

Measures 1-3: Proportion of people who went to an emergency department in the last 12 months for their own health 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.

Measures 4-6: 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.

Guidance: 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 are comparable (subject to caveats) across jurisdictions and over time.

■ Data are complete (subject to caveats) for the current reporting period.

Select:

- (•) ED doctors or specialists
- ( ) ED nurses

Select measure (applies to figures 12.7a and 12.7b):

- (•) always or often listened carefully to them
- ( ) always or often showed respect to them
- ( ) always or often spent enough time with them

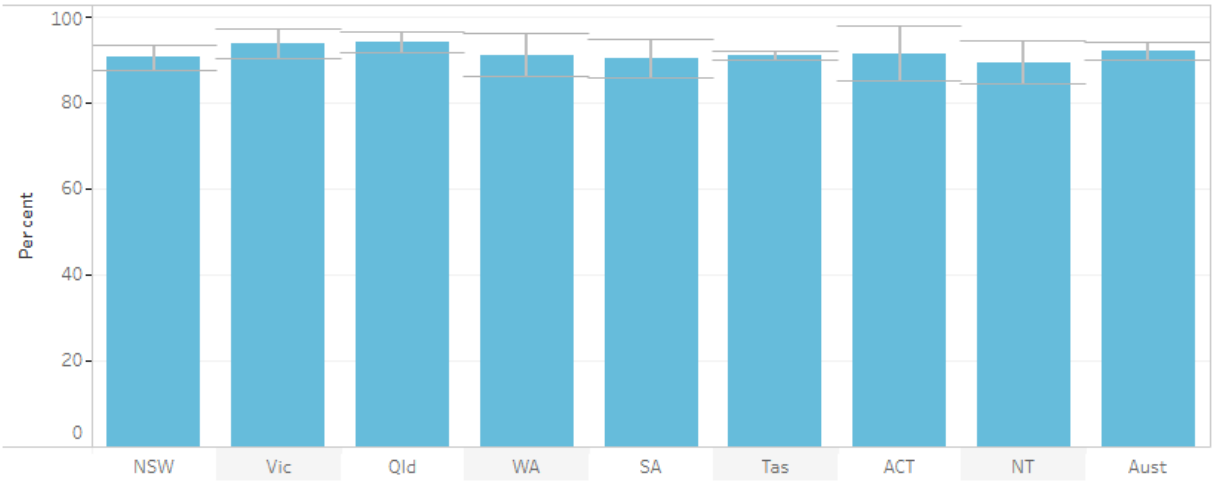
Figure 12.7a Measures 1-3: **Patient satisfaction with ED doctors or specialists, ED doctors or specialists, always or often listened carefully to them, 2018-19**
by jurisdiction

Source: table 12A.47

Select:
- (•) hospital doctors or specialists
- ( ) hospital nurses

Figure 12.7b Measures 4-6: **Patient satisfaction with hospital doctors or specialists, always or often listened carefully to them, 2018-19**

by jurisdiction



Source: table 12A.49

In 2018-19, nationally for all measures, the rate of respondents reporting that doctors and nurses listened carefully, showed respect and spent enough time with them was above 80 per cent, with results generally higher for nurses compared to doctors/specialists and hospitals compared to Emergency departments.

Continuity of care is an indicator of governments' 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.

***Measure*:** 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.

***Guidance*:** High or increasing rates of discharge plans provided to patients with complex care needs within 5 days is desirable.

Data are not yet available for reporting against this measure.

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.

Measure: 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.

Guidance: 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 are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.
- Data are complete (subject to caveats) for the current reporting period.

Select year (applies to table 12.7):

2017-18

Table 12.7 **Unplanned hospital readmissions, All public hospitals, rate Per 1000 separations, 2017-18**
by jurisdiction, by selected surgical procedure

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Appendicectomy	20.4	16.6	21.7	23.8	25.2	22.4	34.4	41.1	20.7
Cataract surgery	3.2	2.4	5.4	2.4	3.1	3.1	0.9	5.9	3.1
Hip replacement	18.4	21.0	29.8	22.5	16.9	18.9	3.9	35.7	20.9
Hysterectomy	27.8	22.0	32.6	36.7	43.2	31.1	49.2	98.4	29.2
Knee replacement	21.3	26.6	32.8	22.8	29.1	54.8	6.9	–	25.9
Prostatectomy	34.6	24.5	51.8	29.3	31.5	39.1	48.6	88.9	35.0
Tonsillectomy and Adenoidectomy	36.0	28.1	60.0	63.3	39.1	56.7	28.6	83.7	39.1

Source: table 12A.51

Of the selected surgical procedures, readmission rates are highest nationally, and for most jurisdictions, for tonsillectomy and adenoidectomy. Selected unplanned hospital readmission rates are reported by hospital peer group, Indigenous status, remoteness and socioeconomic status in table 12A.52.

Workforce sustainability is an indicator of governments' objective to provide sustainable public hospital services.

Measure: The proportions of registered nurses (including midwives) and medical practitioners in ten year age brackets, by jurisdiction and by region.

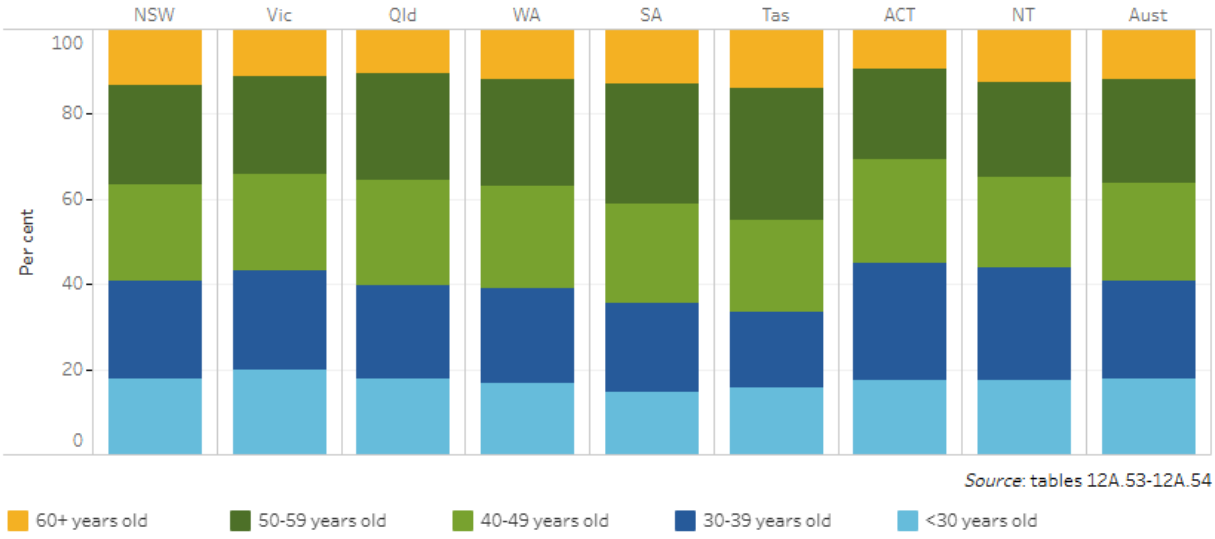
Guidance: High or increasing proportions of the workforce that are new entrants and/or low or decreasing proportions of the workforce that are close to retirement is desirable.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

Select remoteness area (applies to figures 12.8a and 12.8b):

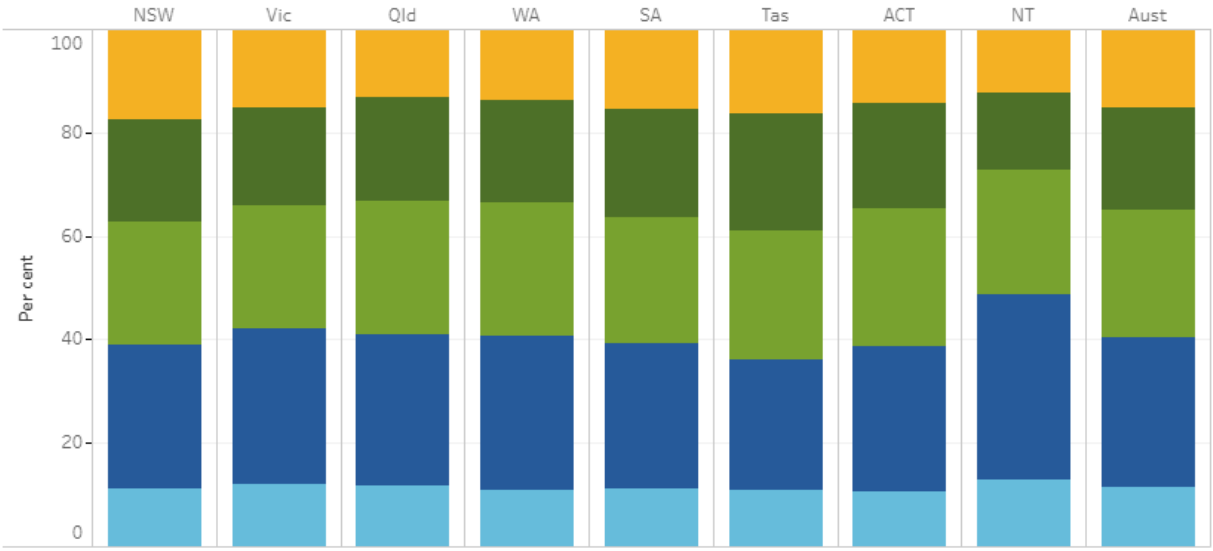
- ○ Major cities
- ○ Inner regional
- ○ Outer regional
- ○ Remote and very remote
- ◉ All areas

Figure 12.8a **Workforce sustainability, Nurses and midwives (registered and enrolled), All areas, 2018 (a)** by jurisdiction, by age group



Source: tables 12A.53-12A.54

Figure 12.8b **Workforce sustainability, Medical practitioners, All areas, 2018 (a)**
by jurisdiction, by age group



Source: tables 12A.55-12A.56

(a) There are no major cities in Tasmania, no outer regional or remote areas in the ACT, and no inner regional or major cities in the NT.

Nationally in 2018, 15.4 per cent of the FTE medical practitioner workforce and 11.9 per cent of the FTE nursing workforce were aged 60 years and over, reflecting a small increase across the most recent 6 years of reported data for nurses (table 12A.53) and medical practitioners (using a consistent method and definitions) (table 12A.55). For nurses, this may be offset by a corresponding increase over the most recent 6 years in the proportion aged under 30 years (table 12A.53). State and territory data are available in tables 12A.54 (nurses) and 12A.56 (medical practitioners).

Cost per admitted patient separation is an indicator of governments' objective to deliver services in an efficient manner. It is defined by two measures.

Measure 1: Recurrent cost per weighted separation — the average cost of providing care for an admitted patient (overnight stay or same day) adjusted for casemix.

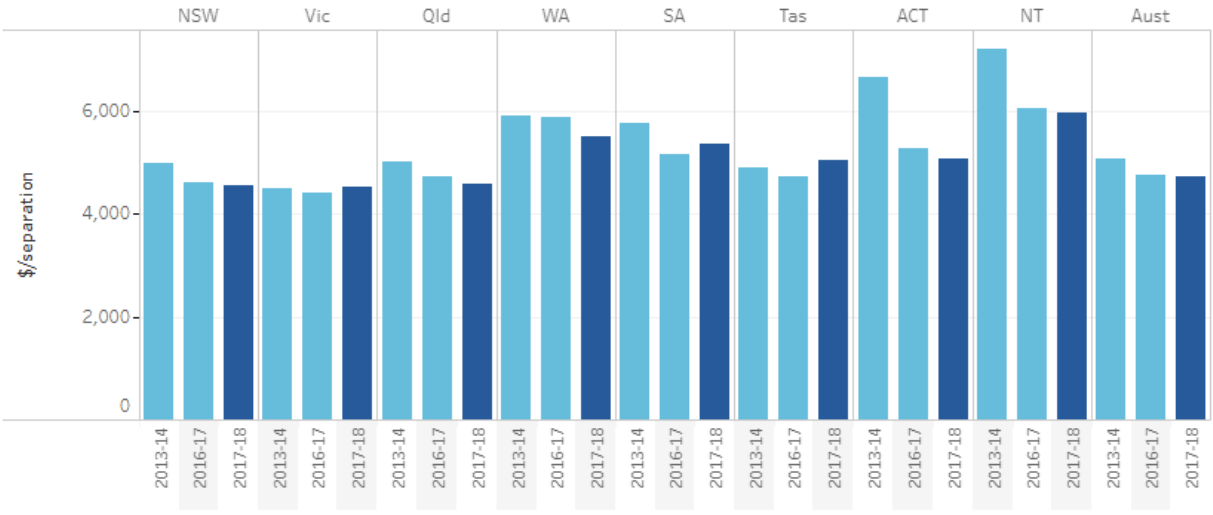
Measure 2: Capital cost per weighted separation — calculated as the user cost of capital (calculated as 8 per cent of the value of non-current physical assets including buildings and equipment but excluding land) plus depreciation, divided by the number of weighted separations.

Guidance: 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.

- (measure 1) Data are comparable (subject to caveats) across jurisdictions and over time.
- (measure 2) Data are not comparable across jurisdictions, but are comparable (subject to caveats) within jurisdictions over time.
- (both measures) Data are complete (subject to caveats) for the current reporting period.

Select year(s)
(applies to figure 12.9a):
(Multiple values)

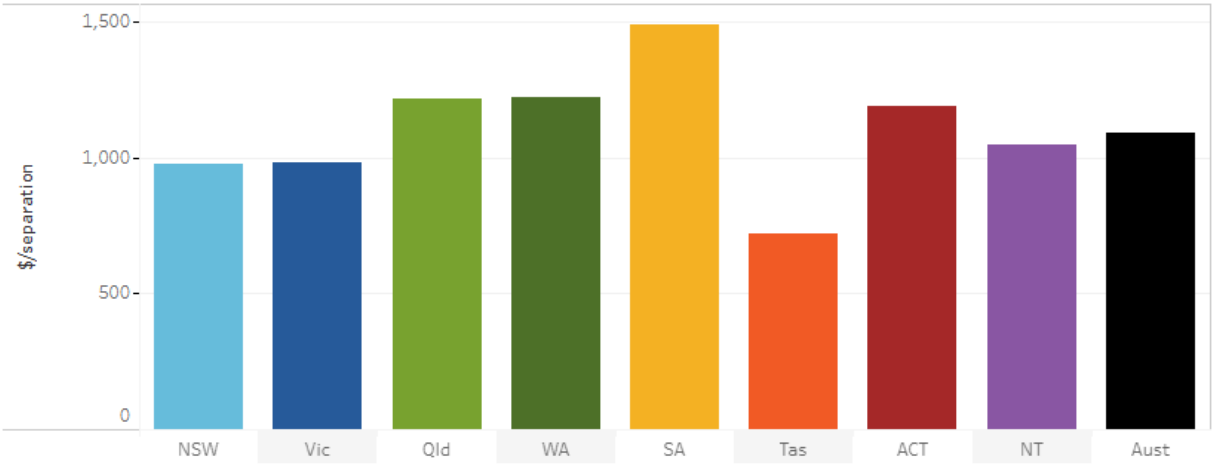
Figure 12.9a Measure 1: **Recurrent cost per weighted separation, All public hospitals, 2017-18 dollars** by jurisdiction, by year



Source: table 12A.57

Nationally in 2017-18, the recurrent cost per weighted separation was $4726. Data on the average cost per admitted patient separation are available on the subset of presentations that are acute emergency department presentations (table 12A.59).

Figure 12.9b Measure 2: **Capital cost per weighted separation, All public hospitals, 2017-18** by jurisdiction



Source: table 12A.58

Costs associated with non-current physical assets are important components of the total costs of many services delivered by government agencies. Nationally in 2017-18, the total capital cost (excluding land) per weighted separation was $1089.

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 for public hospitals is reported in table 12A.60.

Recurrent cost per non-admitted patient is an indicator of governments' objective to deliver services in an efficient manner. It is defined by two measures.

Measure 1: Average cost per non-admitted acute emergency department presentation.

Measure 2: Average cost per non-admitted service event.

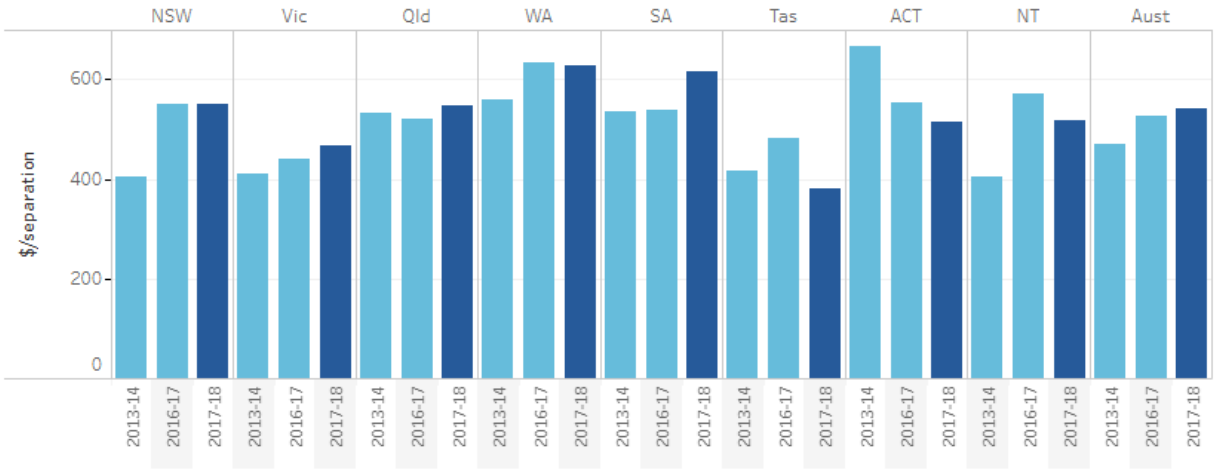
A service event is an interaction between one or more health-care provider(s) with a non-admitted patient, whilst an emergency department presentation is the arrival of a patient at an emergency department and is the earliest occasion of being registered clinically or triaged.

Guidance: A low or decreasing recurrent cost per non-admitted patient can reflect more efficient service delivery in public hospitals.

- Data are comparable (subject to caveats) across jurisdictions and over time.
- Data are complete (subject to caveats) for the current reporting period.

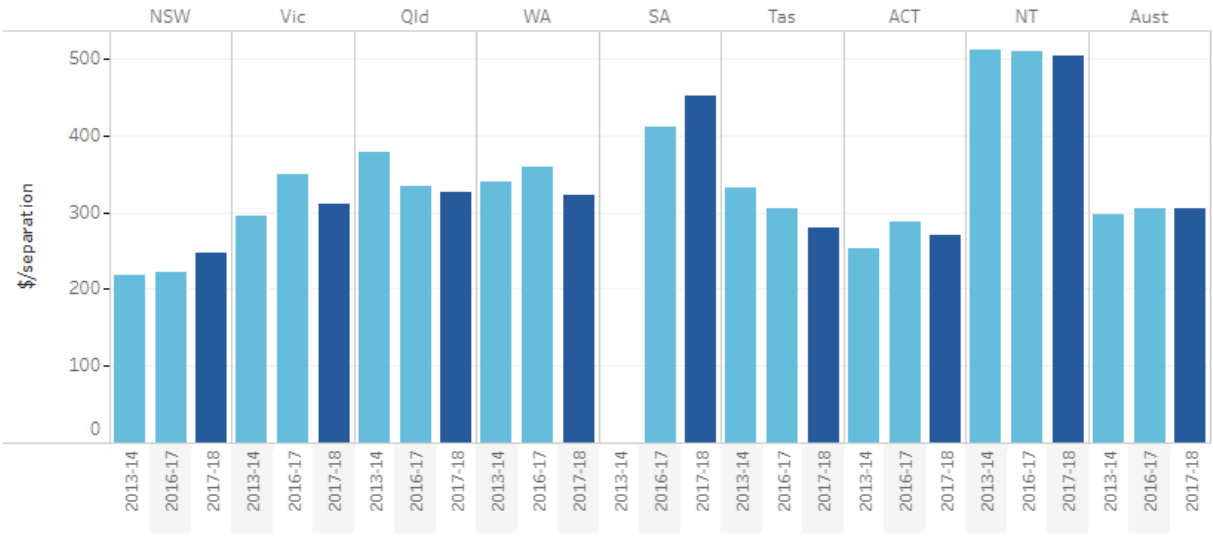
Select year(s)
(applies to both figures 12.10a and 12.10b):
(Multiple values)

Figure 12.10a Measure 1: **Recurrent cost per non-admitted patient, Average cost per presentation, Emergency department (non-admitted)**
by jurisdiction, by year



Source: table 12A.59

Figure 12.10b Measure 2: **Recurrent cost per non-admitted patient, Average cost per service event (a)** by jurisdiction, by year



Source: table 12A.61

(a) Data are not available for SA in 2013-14.

Nationally in 2017-18, the average cost per non-admitted emergency department presentation was $541 (ranging across jurisdictions from $380 to $628, and an increase from 2016-17) and per non-admitted service event was $304 (ranging across jurisdictions from $248 to $504, and similar to 2016-17).

Avoidable mortality in hospitals is an indicator of governments' objective to alleviate or manage illness and the effects of injury.

***Measure*:** Death in low-mortality diagnostic related groups expressed as a rate.

***Guidance*:** Low or decreasing rates of avoidable mortality in hospitals indicate more successful management of illness and the effects of injury.

Data are not yet available for reporting against this measure.

Refer to the interpretative material for detailed indicator interpretation, definitions and caveats. www.pc.gov.au/rogs

Data tables are referenced above by a '12A' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

Indigenous Data

Performance indicator data for Aboriginal and Torres Strait Islander people in this section are available in the data tables listed below. Contextual data and further supporting information can be found in the section.

Public hospitals data disaggregated for Aboriginal and Torres Strait Islander people

Table number	Table title
Table 12A.15	Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory
Table 12A.20	Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days)
Table 12A.37	Separations for falls resulting in patient harm in hospitals, per 1000 separations
Table 12A.52	Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles

Download supporting material

12 Public hospitals interpretative material (PDF - 606 Kb)

12 Public hospitals interpretative material (Word - 90 Kb)

12 Public hospitals data tables (XLSX - 924 Kb)

12 Public hospitals dataset (CSV - 1899 Kb)

See the interpretative material and corresponding table number in the data tables for detailed definitions, caveats, footnotes and data source(s).