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 2011 Report, the Compendium also notes where the original table, figure or text in the 2011 Report can be found. For example, where the Compendium refers to '2011 Report, p. 10.15' this is page 15 of chapter 10 of the 2011 Report, and '2011 Report, table 10A.2' is attachment table 2 of attachment 10A of the 2011 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.

The Public hospitals chapter (chapter 10) in the *Report on Government Services 2011* (2011 Report), reports on the performance of public hospitals in each Australian state and territory. Data are reported for Indigenous people for a subset of the performance indicators reported in that chapter — those data are compiled and presented here.

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
- 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.

The public hospitals chapter in the 2011 Report focuses on services provided to admitted patients and emergency services provided to non-admitted patients in public hospitals. 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 are reported for subacute and non-acute care services.

In some instances, stand-alone psychiatric hospitals are included in the 2011 Report, 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 2011 Report, chapter 12).

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

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, subacute 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.

subacute care: interdisciplinary clinical care in which the need for care depends primarily on the patient's functional status and quality of life rather than the underlying medical diagnosis or the patient's prospects of recovery from illness. Subacute care includes rehabilitation, palliative care and some mental health care, as well as geriatric evaluation and management and psychogeriatric care. Common to all is the patient no longer meets criteria for classification as 'acute', but still requires therapeutic, clinically-intense and goal-directed care.

non-acute care: includes maintenance care and newborn care.

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.

(Continued on next page)

Box 10.1 **(Continued)**

non-admitted occasion of service: an 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.

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 versions 5.1 and 5.2 are 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 2011 Report contains the following data items for Indigenous people:

- separation rates, 2008-09
- separations with a procedure recorded, July 2008–June 2009 (per cent)
- emergency department waiting times, 2008-09
- waiting times for elective surgery, 2008-09
- safety — unplanned/unexpected readmissions within 28 days of selected surgical admissions, 2008-09
- perinatal, neonatal and fetal deaths, 2004–2008.

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 hospitals in Queensland, WA, SA, and public hospitals in the NT. Following new assessments of the quality of Indigenous identification in 2007, the National e-Health and 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. More recently, the National Health Information Standards and Statistics Committee (a standing committee of NEHIPC) approved reporting of data for Tasmania and the ACT by Indigenous status at the state and territory level for COAG reporting purposes. However, pending further examination of the quality of Indigenous identification for these jurisdictions, these data will not be included in national totals. This decision was taken too late to include most data for Tasmania and the ACT in this chapter for the 2011 Report. 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 2008-09, separations for Indigenous people accounted for around 3.6 per cent of total separations and 5.6 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 2.4 per cent of the population in these jurisdictions (2011 Report, tables AA.2 and AA.7). Most separations involving Indigenous patients (92.3 per cent) in these jurisdictions occurred in public hospitals (table 10.1).

Table 10.1 **Separations, by Indigenous status of patient and hospital sector, 2008-09**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]
Public hospital separations ('000)									
Indigenous	56.8	12.7	68.7	41.0	18.5	2.5	2.0	66.2	263.8
Non-Indigenous	1 434.8	1 357.1	797.7	426.5	339.6	90.0	86.2	29.2	4 384.8
Not reported	14.4	9.9	16.9	–	16.5	2.4	1.6	–	57.7
Total	**1 506.0**	**1 379.6**	**883.3**	**467.4**	**374.5**	**94.9**	**89.9**	**95.4**	**4 706.3**
Private hospital separations ('000)									
Indigenous	1.5	0.7	4.4	14.4	1.0	np	np	np	22.1
Non-Indigenous	886.0	800.2	733.2	347.7	240.3	np	np	np	3 007.3
Not reported	19.8	10.1	76.3	–	14.2	np	np	np	120.5
Total	**907.2**	**811.0**	**813.9**	**362.2**	**255.5**	**np**	**np**	**np**	**3 149.8**
Indigenous separations as proportion of total separations (%)									
Public hospitals	3.8	0.9	7.8	8.8	4.9	2.6	2.2	69.4	5.6
Private hospitals	0.2	0.1	0.5	4.0	0.4	np	np	np	0.7
All hospitals	**2.4**	**0.6**	**4.3**	**6.7**	**3.1**	**np**	**np**	**np**	**3.6**
Separations in public hospitals as a proportion of separations in all hospitals (%)									
Indigenous	97.5	94.7	93.9	73.9	94.8	np	np	np	92.3
Non-Indigenous	61.8	62.9	52.1	55.1	58.6	np	np	np	59.3

a Excludes separations for which the care type was reported as 'newborn with no qualified days' and records for hospital boarders and posthumous organ procurement. **b** 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. **c** 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 (2010), *Australian Hospital Statistics 2008-09,* Health Services Series No. 34, Cat. no. HSE 84; table 10A.1; 2011 Report, table 10.1, p. 10.14.

In 2008-09, on an age standardised basis, 763.3 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 221.3 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**[a, b]

	NSW[c]	*Vic*[c]	*Qld*[c]	*WA*[c, d]	*SA*[c]	*Tas*	*ACT*	*NT*[c]	*Total*[e]
2004-05									
Indigenous people	np	np	733.6	821.5	822.2	np	np	1 441.0	907.0
Total population	193.3	238.3	188.1	195.2	225.3	np	np	456.2	208.1
2005-06									
Indigenous people	495.6	np	745.4	845.2	875.0	np	np	1 548.0	792.1
Total population	203.2	243.4	186.2	196.4	228.4	np	np	479.1	213.6
2006-07									
Indigenous people	528.0	624.3	756.7	876.5	929.3	np	np	1 584.8	787.5
Total population	206.0	246.7	190.2	218.4	232.6	np	np	480.1	218.8
2007-08									
Indigenous people	550.5	629.8	785.7	869.4	908.9	np	np	1 670.7	807.7
Total population	202.8	247.8	195.7	215.1	216.4	np	np	486.4	217.6
2008-09									
Indigenous people	511.5	535.8	732.5	817.3	950.5	np	np	1 656.0	763.3
Total population	205.6	249.5	204.4	215.8	217.7	np	np	495.5	221.3

a The rates are directly age standardised to the Australian population at 30 June 2001. **b** Identification of Indigenous patients is not considered complete and completeness varies across jurisdictions and time. **c** 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. **d** 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. **e** 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.

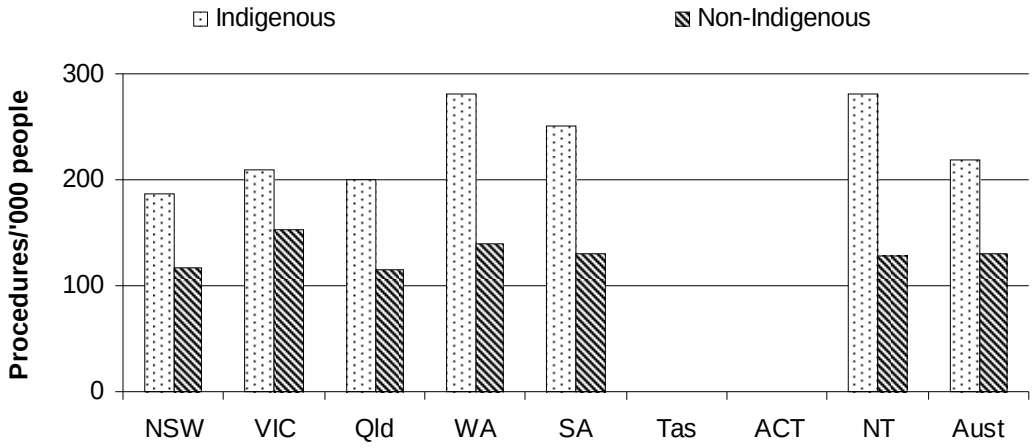
Source: AIHW (unpublished), National Hospital Morbidity Database; table 10A.2; 2011 Report, table 10.2, p. 10.15.

Separations with a procedure recorded for Indigenous patients

Hospitalisations with a procedure reported both by jurisdiction and by remoteness are presented in figures 10.1 and 10.2, 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 2008–June 2009, excluding hospitalisations for care involving dialysis, Indigenous people had higher rates of hospitalisations with a procedure reported for all states and territories and for each remoteness category (figures 10.1 and 10.2).

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.

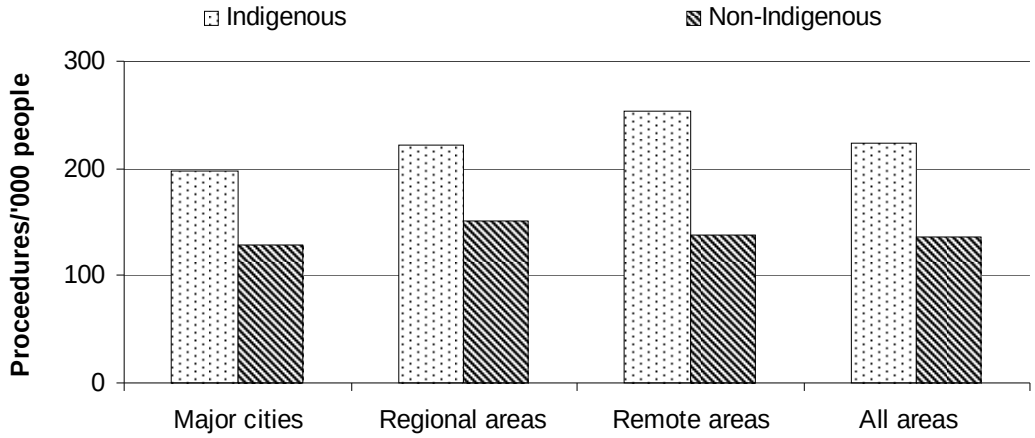
Figure 10.1 **Hospitalisations with a procedure reported, public hospitals, July 2008–June 2009[a, b, c]**



a 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. **b** 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. **c** 'All diagnoses' excludes care involving dialysis.

Source: AIHW (unpublished), National Hospital Morbidity Database, table 10A.4; 2011 Report, figure 10.9, p. 10.16.

Figure 10.2 **Hospitalisations with a procedure reported, public hospitals, July 2008–June 2009[a, b]**

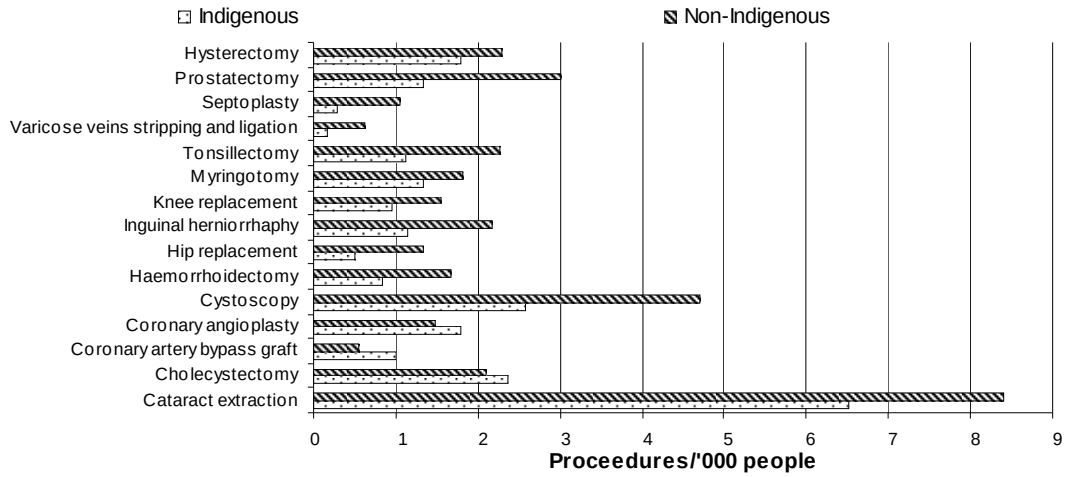


a Includes all patients treated in public hospitals and public patients treated in private hospitals in NSW, Victoria, Queensland, WA, SA and NT. Private hospital data for NT were not available therefore results for NT include public hospital data only. **b** 'All diagnoses' excludes care involving dialysis.

Source: AIHW (unpublished), National Hospital Morbidity Database, table 10A.5; 2011 Report, figure 10.10, p. 10.17.

Data for NSW, Victoria, Queensland, WA, SA and NT public hospitals for selected procedures are presented in figure 10.3. In the period July 2008–June 2009, Indigenous people had lower rates of hospital procedures for a number of selected procedures (figure 10.3).

Figure 10.3 **Selected hospital procedures, public hospitals, July 2008–June 2009[a]**



a Includes patients treated in public hospitals and public patients treated in private hospitals in NSW, Victoria, Queensland, WA, SA and NT.

Source: AIHW (unpublished), National Hospital Morbidity Database, table 10A.3; 2011 Report, figure 10.11, p. 10.17.

While Indigenous people have higher rates of separations and hospitalisations with a procedure recorded per 1000 of the population than non-Indigenous people, Indigenous people are actually less likely to undergo procedures while in hospital than non-Indigenous people. 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, patient preferences and concerns, and distance from appropriate facilities (AHMAC 2006). Other factors are also likely to affect the data, including those relating to variations in casemix, comorbidities and stage at presentation.

Framework of performance indicators for public hospitals

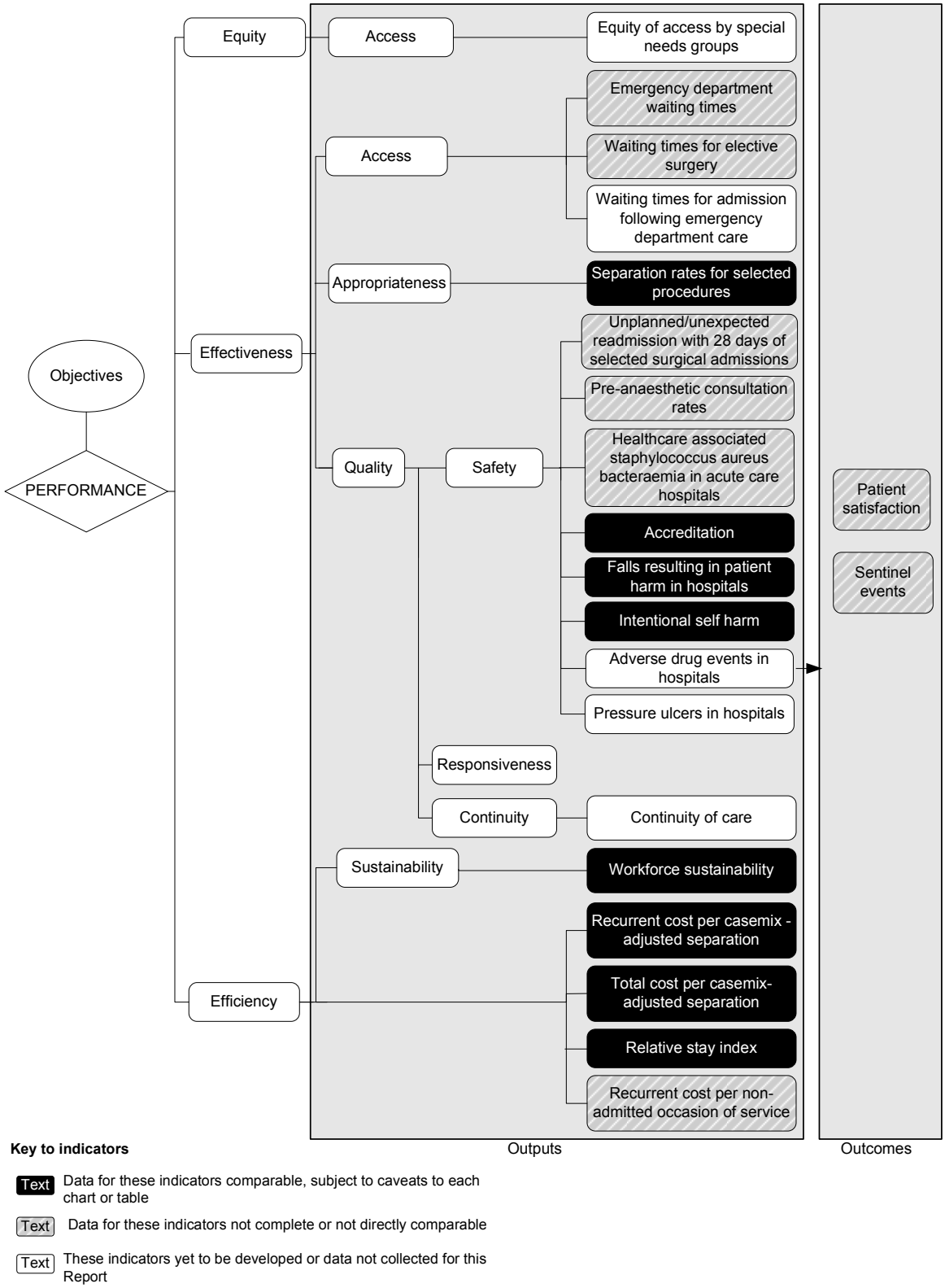
The Public hospitals performance indicator framework outlined in figure 10.4 is based on shared government objectives for public hospitals (2011 Report, box 10.2). Data for Indigenous people are reported for a subset of the performance indicators, and are presented here. It is important to interpret these data in the context of the broader performance indicator framework. The framework shows which data are comparable. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Indicator boxes presented throughout the chapter provide information about the reported indicators. As these are sourced directly from the 2011 Report, they might include references to data not reported for Indigenous people and therefore not included in this Compendium.

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 (NAs) to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 for more detail on reforms to federal financial relations). The NHA covers the area of health, and health indicators in the NIRA establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. The agreements include performance indicators, for which the Steering Committee collates annual performance information for analysis by the COAG Reform Council (CRC). Revisions have been made to the performance indicators reported in this chapter to align with the performance indicators in the NAs.

Figure 10.4 **Performance indicators for public hospitals**



Source: 2011 Report, figure 10.13, p. 10.25.

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).

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.

Emergency department waiting times

'Emergency department waiting times' is an indicator of governments' objective to provide accessible services (box 10.3).

Box 10.3 **Emergency department waiting times**

'Emergency department waiting times' measures 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 throughout Australia and New Zealand.

The nationally agreed method of calculation for waiting times is to subtract the time at which the patient presents at the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) from the time of commencement of service by a treating medical officer or nurse. Patients who do not wait for care after being triaged or clerically registered are excluded from the data.

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
- triage category 4: semi-urgent — patients seen within 60 minutes
- triage category 5: non-urgent — patients seen within 120 minutes (HDSC 2008).

(Continued next page)

Box 10.3 **(continued)**

It is desirable that a high proportion of patients are seen within the benchmarks set for each triage category. Non-urgent patients who wait longer are likely to suffer discomfort and inconvenience, and more urgent patients can experience poor health outcomes as a result of extended waits.

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage (see 2011 Report, table 10.6) and clinical practices — in particular, the allocation of cases to urgency categories.

Nationally, there was little difference between Indigenous and non-Indigenous people in the percentages of patients treated within national benchmarks across the triage categories for peer group A and B hospitals, although there were variations across states and territories for some triage categories (table 10A.6).

Waiting times for elective surgery

'Waiting times for elective surgery' is an indicator of governments' objective to provide accessible services (box 10.4).

Box 10.4 **Waiting times for elective surgery**

Two measures are reported for 'Waiting times for elective surgery':

- 'Overall 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. 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. The proportion of patients who waited more than one year is also shown.
- 'Elective surgery waiting times by clinical urgency category' reports the proportion of patients who were admitted from waiting lists after an extended wait. The three generally accepted clinical urgency categories for elective surgery are:
  - category 1 — admission is desirable within 30 days
  - category 2 — admission is desirable within 90 days
  - category 3 — admission at some time in the future is acceptable.

(Continued next page)

Box 10.4 **(continued)**

There is no specified or agreed desirable wait for category 3 patients, but the term 'extended wait' is used for patients waiting longer than 12 months for elective surgery, as well as for category 1 and 2 patients waiting more than the agreed desirable waiting times of 30 days and 90 days respectively.

For 'Overall elective surgery waiting times' fewer days waited at the 50th and 90th percentile and a smaller proportion of people waiting more than 365 days are desirable. For 'Elective surgery waiting times by clinical urgency category' a smaller 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 taken into account. 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 (2011 Report, table 10.8).

Data reported for this indicator are not directly comparable.

Data quality information for this indicator is under development.

The elective surgery waiting times data are provided for waiting lists managed by public acute hospitals. The data collection covers most public hospitals that undertake elective surgery.

Attachment table 10A.7 includes data on 'elective surgery waiting times' by Indigenous status for 2008-09. Nationally, Indigenous people had longer waiting times for elective surgery than non-Indigenous people at the 50^{th} and 90^{th} percentiles for many of the procedures reported for peer group A and B hospitals (table 10A.7).

Safety — unplanned/unexpected readmissions within 28 days of selected surgical admissions

'Unplanned/unexpected readmissions within 28 days of selected surgical admissions' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.5). This indicator has been included in the report for the first time this year and replaces the previously reported 'unplanned readmission rates indicator'.

Box 10.5 Unplanned/unexpected readmissions within 28 days of selected surgical admissions

'Unplanned/unexpected readmissions within 28 days of selected surgical admissions' show the rate at which patients unexpectedly return to hospital within 28 days for further treatment of the same condition.

The indicator is calculated as the number of separations that were unplanned or unexpected readmissions to the same hospital following a separation in which a selected surgical procedure was performed and occurred within 28 days of the previous date of separation divided by number of public hospital separations in which one of the selected surgical procedures was performed expressed per 1000 separations.

Selected surgical procedures are knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendectomy.

'Unexpected/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.

Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, if post discharge planning was inadequate, or for other reasons outside the control of the hospital (for example poor post-discharge care). High rates for this indicator suggest the quality of care provided by hospitals, or post-discharge care or planning, should be examined, because there may be scope for improvement.

There are some difficulties in identifying re-admissions that were unplanned. The unplanned and/or unexpected readmissions are limited to those having a principal diagnosis of a post-operative adverse event. This does not include all possible unplanned/unexpected readmissions, so the indicator is likely to be an under-estimate.

This indicator identifies only those patients re-admitted to the same hospital, so there is some under-reporting (for example, where patients go to another hospital). Unplanned re-admission rates are not adjusted for casemix or patient risk factors, which can vary across hospitals and across jurisdictions.

Data reported for this indicator are not complete or directly comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011

Unplanned/unexpected readmissions within 28 days of selected surgical admissions in public hospitals in 2008-09 are reported by Indigenous status and remoteness in table 10A.8. The measure reported for this indicator is significantly different from that reported previously and data are not comparable with previous reports.

Safety — falls resulting in patient harm in hospitals

'Falls resulting in patient harm in hospitals' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.6).

Box 10.6 Falls resulting in patient harm in hospitals

Falls occurring in health care settings and resulting in patient harm treated in hospital is defined as the number of separations with an external cause code for fall and a place of occurrence of health service area divided by the total number of hospital separations and is expressed as a rate per 1000 separations.

A high number of falls resulting in patient harm in hospitals can indicate hospital system and process deficiencies that compromise the quality and safety of public hospitals. Falls resulting in patient harm in hospitals can result in serious consequences for individual patients and place a significant burden on the health system.

Data reported for this indicator are comparable.

Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011

The indicator defines a fall in hospital as a fall for which the place of occurrence is coded as health service area. The health service area as a place of occurrence is broader in scope than hospitals as it includes other health care settings such as day surgery centres or hospices. Data could therefore be an overestimate as they include falls in health care settings other than hospitals. Separations for falls resulting in patient harm in public health care settings are reported by Indigenous status and remoteness in table 10A.9.

Safety — intentional self harm in hospitals

'Intentional self harm in hospitals' is an indicator of governments' objective to provide public hospital services that are safe and of high quality (box 10.7).

Box 10.7 **Intentional self harm in hospitals**

Intentional self harm in hospitals is defined as the number of hospital separations with an external cause code for intentional self harm and a place of occurrence of health service divided by the total number of hospital separations and is expressed as a rate per 1000 separations.

Self harm in hospitals can result in serious consequences for individual patients. A high rate of self harm can indicate hospital system and process deficiencies that compromise the quality and safety of public hospitals.

Data reported for this indicator are complete and directly comparable.

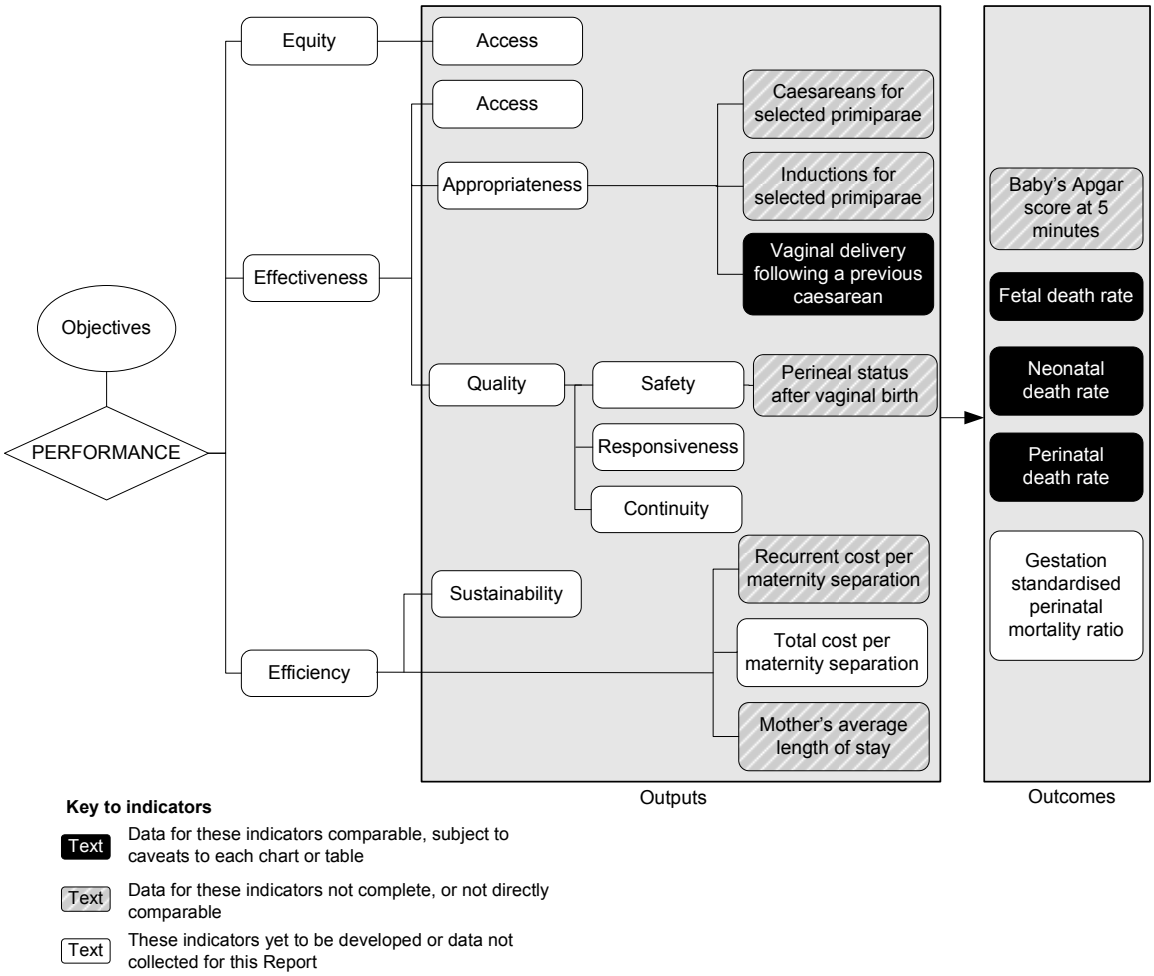
Data quality information for this indicator is at www.pc.gov.au/gsp/reports/rogs/2011

The indicator defines intentional self harm in hospital as being one for which the place of occurrence is coded as health service area. The health service area as a place of occurrence is broader in scope than hospitals as it includes other health care settings such as day surgery centres or hospices. Data could therefore be an overestimate as they include intentional self harm in health care settings other than hospitals. Separations for intentional self harm in health care settings in 2008-09 are reported by Indigenous status and remoteness in table 10A.10.

Framework of performance indicators for maternity services

The Maternity services performance indicator framework outlined in figure 10.5 is based on the same shared government objectives as for public hospitals (2011 Report, box 10.2). Data for Indigenous people are reported for a subset of the performance indicators, and are presented here. It is important to interpret these data in the context of the broader performance indicator framework. The framework shows which data are comparable. 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: 2011 Report, figure 10.28, p. 10.79.

Fetal death rate

'Fetal death rate' is an indicator of governments' objective to deliver maternity services that are safe and of high quality (box 10.8).

Box 10.8 **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.

Data quality information for this indicator is under development.

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 10.9).

Box 10.9 **Neonatal death rate**

Neonatal death is the death of a live born infant within 28 days of birth (see 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.

Data quality information for this indicator is under development.

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 10.10).

Box 10.10 **Perinatal death rate**

A perinatal death is a fetal or neonatal death (boxes 10.8 and 10.9).

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.

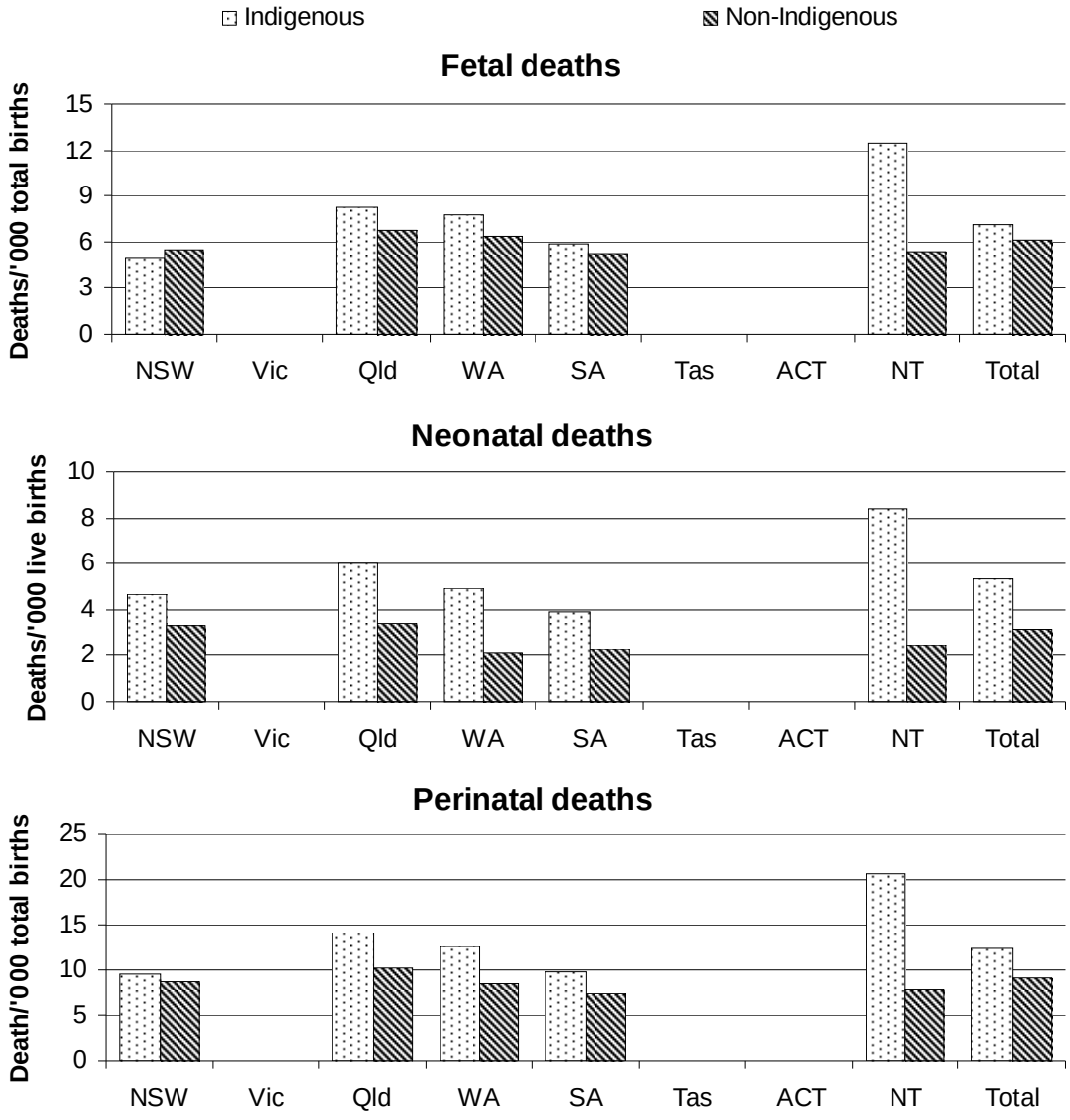
Data quality information for this indicator is under development.

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

Fetal, neonatal and perinatal deaths for Indigenous people

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 higher than those for non-Indigenous people (figure 10.6).

Figure 10.6 **Fetal, neonatal and perinatal deaths, by Indigenous status of mother 2004–2008**[a]



a 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.11; 2011 Report, figure 10.38, p. 10.95.

Future directions

Priorities for future reporting on public hospitals and maternity services include the following:

- 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, two aspects of quality — responsiveness and continuity — and the efficiency subdimension of sustainability.
- Improving the quality of Indigenous data, particularly completeness and Indigenous identification. Indigenous hospitalisation data for the ACT and Tasmania will be included in future reports. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing, with the inclusion of data for Tasmania and the ACT in national totals a priority.

Definitions of key terms and indicators

Acute care	Clinical services provided to admitted or non-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. Most episodes involve a relatively short hospital stay.
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, subacute or non-acute care services.
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 versions 5.1 and 5.2 are 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.
Elective surgery waiting times	The time elapsed for a patient on the elective surgery waiting list, from the date on which he or she was added to the waiting list for a procedure to admission or a designated census date.
Emergency department waiting times to service delivery	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.
Fetal death	Delivery of a child who did not at any time after delivery breathe or show any other evidence of life, such as a heartbeat. Excludes infants that weigh less than 400 grams or that are of a gestational age of less than 20 weeks.
Fetal death rate	The number of fetal deaths divided by the total number of births (that is, by live births registered and fetal deaths combined).
General practice	The organisational structure with one or more GPs and other staff such as practice nurses. A general practice provides and supervises healthcare for a ‘population' of patients and can include services for specific populations, such as women’s health or Indigenous health.
ICD-10-AM	The Australian modification of the International Standard Classification of Diseases and Related Health Problems. This is the current classification of diagnoses and procedures in Australia.

Live birth	Birth of a child who, after delivery, breathes or shows any other evidence of life, such as a heartbeat. Includes all registered live births regardless of birthweight.
Neonatal death	Death of a live born infant within 28 days of birth. Defined in Australia as the death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Neonatal death rate	Neonatal deaths divided by the number of live births registered.
Non-acute care	Includes maintenance care and newborn 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.
Perinatal death	Fetal death or neonatal death of an infant that weighs at least 400 grams or that is of a gestational age of at least 20 weeks.
Perinatal death rate	Perinatal deaths divided by the total number of births (that is, live births registered and fetal deaths combined).
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).
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).
Separation rate	Hospital separations per 1000 people or 100 000 people.
Subacute care	Interdisciplinary therapeutic clinically-intense and goal-directed care in which the need for care depends primarily on the patient's functional status and quality of life rather than the underlying medical diagnosis or the patient's prospects of recovery from illness. Subacute care includes rehabilitation, palliative care and some mental health care, as well as geriatric evaluation and management and psychogeriatric care. Common to all is the patient no longer meets criteria for classification as 'acute', but still requires therapeutic, clinically-intense and goal-directed 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).
Unplanned hospital re-admission	An unexpected hospital admission for treatment of: the same condition for which the patient was previously hospitalised; a condition related to one for which the patient was previously hospitalised; or a complication of the condition for which the patient was previously hospitalised.
Unplanned hospital re-admission rate	The number of unplanned re-admissions to the same hospital within 28 days of separation, during the time period under study, divided by the total number of separations (excluding deaths) for the same time period, including day stay patients.
Urgency category for elective surgery	Category 1 patients — admission is desirable within 30 days for a condition that has the potential to deteriorate quickly to the point that it can become an emergency. Category 2 patients — admission is desirable within 90 days 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.

List of 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 preface by an 'A' suffix (for example, table 10A.1 is table 1 in the Public hospitals attachment). Attachment tables are on the Review website (www.pc.gov.au/gsp).

References

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