Australian hospital statistics 2006–07

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Foreword

I am pleased to present the fourteenth *Australian hospital statistics* publication, which provides a broad range of statistics and information about what is happening within Australia's public and private hospitals. The information presented is based on data provided by state and territory health authorities. The publication is produced with the cooperation and advice of state and territory health authorities, the Australian Government, clinicians, and representatives of the private hospital sector and private health insurers. The Institute's independence and expertise underpins our role in publishing this information for the use of policy makers, service providers and the public.

The comparison of characteristics and use of hospital services over time and across population groups is of considerable interest to readers. Where appropriate, we make comparisons between jurisdictions, areas of residence, areas of socioeconomic advantage and disadvantage, and Indigenous and other Australians. Due to data quality issues, previous publications have only presented detailed statistics on Indigenous Australians admitted in Queensland, Western Australia, South Australia and the Northern Territory. Efforts by states and territories to improve Indigenous identification have allowed inclusion of these statistics for New South Wales and Victoria in this publication for the first time.

The rate of hospitalisation for Aboriginal and Torres Strait Islander peoples is more than double that for other persons. Similarly, the rate of hospitalisation for people who live in very remote areas of Australia is almost 50% higher than that for people living in major cities.

Growth in activity and expenditure within Australia's hospitals is continuing, with the strongest growth occurring within private hospitals. Same-day separations continue to increase. The length of stay for overnight cases remains fairly constant and is comparable with other OECD countries.

The report also shows that the National Health Priority Areas were represented by high numbers of separations for some diagnoses in both the public and private sectors.

Accompanying this report is a suite of additional statistical information on our website. This includes interactive online data cubes from hospital databases. The report itself can also be accessed from the website.

Timely reporting of this information involves a chain of responsibilities, from hospital clinicians and administrative staff through state and territory authorities to the AIHW's database and analysis teams. We continue to strive for timely reporting and to improve the quality and usefulness of the report. We welcome comments from readers.

Penny Allbon

Director

May 2008

Acknowledgments

This report would not have been possible without the valued cooperation and efforts of the data providers, the health authorities of the states and territories, and individual public and private hospitals (see Appendix 2). The Australian Institute of Health and Welfare (AIHW) thanks them for their timely supply of the data, validation of the AIHW's databases and assistance in the preparation of this report.

The AIHW's Australian Hospital Statistics Advisory Committee has also been of great assistance to this project. Members of the Committee are:

- Jenny Hargreaves (AIHW) (Chair)
- John Agland (New South Wales Health Department)
- Paul Basso (South Australian Department of Health)
- Patrick Bolton (Australian Healthcare Association)
- Eui-Soo Choi (New South Wales Health Department)
- Paul Collins (Private Health Insurance Administration Council)
- Sue Cornes (Queensland Health)
- Louise Edmonds (Australian Capital Territory Department of Health)
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- Kerryn Wilde (Australian Government Department of Health and Ageing)
- Kim Williams (Australian Government Department of Veterans' Affairs)

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Contents

Abbreviations

ABS	Australian Bureau of Statistics
ACHI	Australian Classification of Health Interventions
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ALOS	Average length of stay
AR-DRG	Australian Refined Diagnosis Related Group
ave	Average
Cat.	Catastrophic
CC	Complication and/or comorbidity
DHAC	Department of Health and Aged Care
DoHA	Department of Health and Ageing
DRG	Diagnosis Related Group
exp.	Expense
FTE	Full-time equivalent
HASAC	Health and Allied Services Advisory Council
HDSC	Health Data Standards Committee
HIV	Human immunodeficiency virus
ICD-9-CM	International classification of diseases, 9th Revision, Clinical modification
ICD-10-AM	International statistical classification of diseases and related health problems, 10th revision, Australian modification
IFRAC	Admitted patient fraction
MDC	Major Diagnostic Category
n.a.	Not available
NAPEDC	Non-admitted patient emergency department care
NCCH	National Centre for Classification in Health
NNAPEDCD	National Non-admitted Patient Emergency Department Care Database
n.e.c.	Not elsewhere classified
NHCDC	National Hospital Cost Data Collection
NHDC	National Health Data Committee
NHMBWG	National Health Ministers' Benchmarking Working Group
NHMD	National Hospital Morbidity Database
NHPA	National Health Priority Area
NHPC	National Health Performance Committee
NMDS	National minimum data set
NOCD	National Outpatient Care Database
n.p.	Not published
NPHED	National Public Hospital Establishments Database
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Co-operation and Development
PICQ	Performance Indicators for Coding Quality
PPH	Potentially preventable hospitalisation
Qld	Queensland
RRMA	Rural, Remote and Metropolitan Area
RSI	Relative stay index
SA	South Australia
SCRGSP	Steering Committee for the Review of Government Service Provision
SEIFA	Socio-Economic Indexes for Areas
SLA	Statistical Local Area
SRG	Service related group
SRR	Standardised separation rate ratio
Tas	Tasmania
Vic	Victoria
VMO	Visiting medical officer
WA	Western Australia
. .	Not applicable

Summary

Australian hospital statistics 2006–07 is the fourteenth annual report on the characteristics and activity of Australia's hospitals. Included in the report are public acute hospitals, public psychiatric hospitals, private free-standing day hospital facilities and other private hospitals.

This report describes information on a variety of aspects of Australia's hospital services, including admitted patient care, elective surgery waiting times, non-admitted emergency department care, outpatient care, and public hospital expenditure and resources.

Admitted patient care

During 2006–07, there were 7.6 million separations from Australian hospitals accounting for over 24.9 million patient days, compared to 7.3 million separations and 24.3 million patient days in 2005–06. The majority of separations (61%) and patient days (67%) were from public acute hospitals. Most separations were for same-day care (56%). The average length of stay for all hospitals decreased by 19.1% between 1997–98 and 2006–07, from 4.1 days to 3.3 days. In 2006–07 for public acute hospitals, the average length of stay was 3.6 days; in private hospitals it was 2.5 days.

In 2006–07, 37.2% of separations had a principal diagnosis that derived from one of five groups of conditions: *Diseases of the digestive system*; *Neoplasms*; *Diseases of the circulatory system*; *Pregnancy, childbirth and the puerperium*; and *Injury and poisoning*. The National Health Priority Areas were represented by some high-volume diagnoses. These included separations with a principal diagnosis of fracture (173,000), asthma (37,000), chronic obstructive pulmonary disease (55,000), arthritis (89,000), angina pectoris (75,000) and diabetes mellitus (78,000).

Females accounted for 53% of hospital separations with a separation rate of 383.5 per 1,000 compared to 345.5 per 1,000 for males. Indigenous Australians had high rates of hospitalisation with a separation rate of 868.3 per 1,000 population compared to 352.6 per 1,000 for other persons (noting that the Indigenous status data need improvement).

Waiting times for elective surgery

In 2006–07, there were almost 557,000 admissions for elective surgery in public hospitals reported to the National Elective Surgery Waiting Times Data Collection. The median waiting time for elective surgery in public hospitals was 32 days. *Cardio-thoracic surgery* had the shortest median waiting time (12 days); *Ophthalmology* had the longest median waiting time (71 days). Approximately 3.1% of people admitted for elective surgery from the elective surgery waiting lists had waited more than 365 days.

Emergency department care

In 2006–07, there were about 6.7 million accident and emergency department occasions of service provided in Australia's public hospitals. Of those presentations for which triage category and waiting times data are available (approximately 5.3 million presentations), 70% were seen within the time specified as appropriate for their triage category. In *Principal*

referral and Specialist women and children's hospitals, the proportion seen on time was 66%; in *Large hospitals* the proportion was 73%.

Outpatient activity

Excluding services in emergency departments, there were approximately 39.9 million individual and group non-admitted patient occasions of service in public hospitals during 2006–07. About 16.0 million of these occasions of service were in outpatient clinics. Of those individual outpatient episodes for which clinic-level information was available (approximately 11.5 million episodes), 2.2 million were occasions of service in *Allied health* clinics, and 2.2 million were in *Medical* clinics. Records were also provided for about 99,000 group occasions of service. Approximately 41,000 of these group sessions occurred in *Allied health* clinics.

Hospital resources and expenditure

In 2006–07, Australia had 739 public acute hospitals, 19 public psychiatric hospitals, 265 private free-standing day hospital facilities and 278 other private hospitals. In 2006–07, there were almost 83,000 available hospital beds in Australia, with almost 56,000 available beds in public acute and psychiatric hospitals and almost 27,000 in private hospitals. The number of available beds in public acute hospitals increased by an average of 1.8% annually, and the number of available beds/chairs in private hospital facilities increased by an average of 0.4% annually, between 2002–03 and 2006–07.

Between 1997–98 and 2006–07, the number of full-time equivalent staff in public acute and public psychiatric hospitals increased by an average of 3.3% per year (from 175,024 to 234,717). Over the same period, the number of salaried medical officers increased by an average of 5.3% per year (from 15,387 full-time equivalents to 24,526).

Recurrent expenditure on public acute and public psychiatric hospitals was $26,290 million in 2006–07, 5.6% greater than expenditure in 2005–06 after adjusting for inflation. *Salary payments* accounted for 62% of total recurrent expenditure in 2006–07, and *Medical and surgical supplies* for 9%. In public acute hospitals, the average cost per separation was $3,922 excluding depreciation and $4,067 including depreciation.

Hospitals at a glance

Key points

Between 2005–06 and 2006–07:

- the number of separations increased
- the proportion of private hospital separations increased
- the proportion of separations that were same-day increased
- the average length of stay was stable
- the cost per casemix-adjusted separation increased.

Admitted patient separations and patient days

Separations and patient days provide useful ways to measure how many admitted patients are treated in hospitals. See *Chapter 2*.

Changes between 2005–06 and 2006–07

- There were 7,602,917 separations and 24,924,565 patient days in 2006–07, compared with 7,311,983 separations and 24,330,653 patient days in 2005–06.
- Separations increased by 3.3% for public acute hospitals and by 5.1% for private hospitals after adjusting for a change in reporting arrangements.
- With the same adjustments, the number of patient days increased by 2.1% in public acute hospitals and by 3.6% in private hospitals.
- With similar adjustments, the number of same-day separations increased by 3.9% in public acute hospitals and by 6.1% in private hospitals and overnight separations increased by 2.7% and 3.3% respectively.
- Separations increased by 2.7% for public patients and by 5.5% for private patients, and separations for which private health insurance was reported as the funding source increased by 7.2%.

Changes between 1997–98 and 2006–07

- Separations from all hospitals increased by 36.7% (not adjusted for coverage and reporting changes). Separations increased by 23.9% in public acute hospitals and by 64.1% in private hospitals (including free-standing day hospital facilities).
- Separations per 1,000 population increased by 6.8% for public acute hospitals and by 42.1% for private hospitals (Figure 1).

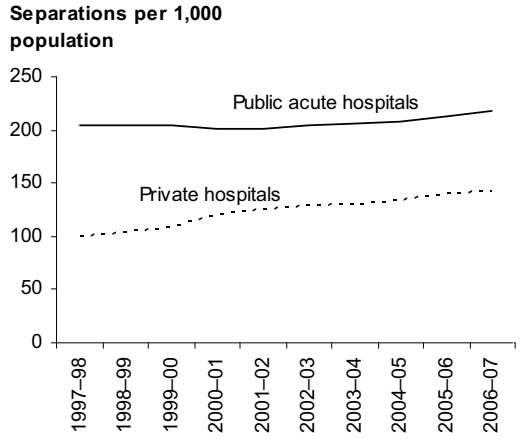


Figure 1: Separations per 1,000 population, public acute and private hospitals, Australia, 1997–98 to 2006–07

- The number of patient days in public acute hospitals increased by 10.2%. For private hospitals patient days increased by 24.9%.

- Patient days per 1,000 population decreased by 7.6% for public acute hospitals and increased by 2.4% for private hospitals (Figure 2).
- For stand-alone public psychiatric hospitals, separations per 1,000 population fell by 39.3% and there was a 58.5% fall in patient days per 1,000 population. This accompanied a fall in the number of public psychiatric hospitals.
- In 1997–98, 67.4% of separations and 67.5% of patient days were in public acute hospitals. By 2006–07, the public acute hospital share of separations had fallen to 61.1%, while the proportion of patient days was stable (67.3%).

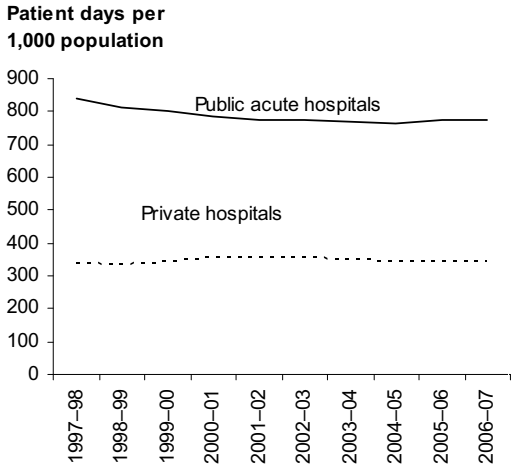


Figure 2: Patient days per 1,000 population, public acute and private hospitals, Australia, 1997–98 to 2006–07

Length of stay

The proportion of separations that are same-day is increasing, and the average length of stay in hospitals is decreasing. See *Chapter 2*.

- The proportion of same-day separations increased between 1997–98 (46.3%) and 2006–07 (55.8%).
- The number of same-day separations increased by 4.9% between 2005–06 and 2006–07 compared with a 2.8% increase in overnight separations. Same-day separations adjusted for changes in reporting increased by 4.0% in public hospitals and by 6.1% in private hospitals.
- The average length of stay, including same-day separations, in hospitals was 3.3 days in 2005–06 and 2006–07.
- The average length of stay decreased by 19.1% between 1997–98 and 2006–07, from 4.1 days to 3.3 days. The average length of private hospital stays decreased by 23.9% to 2.5 days, and public acute hospital stays decreased 10.7% to 3.6 days (Figure 3).

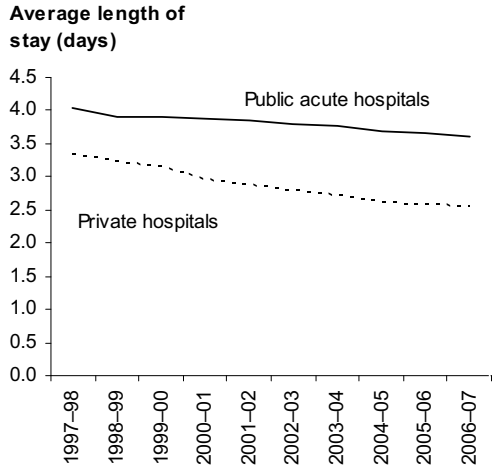


Figure 3: Average length of stay, public acute and private hospitals, Australia, 1997–98 to 2006–07

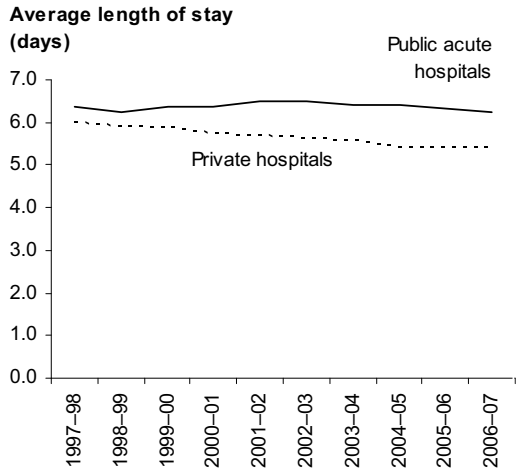
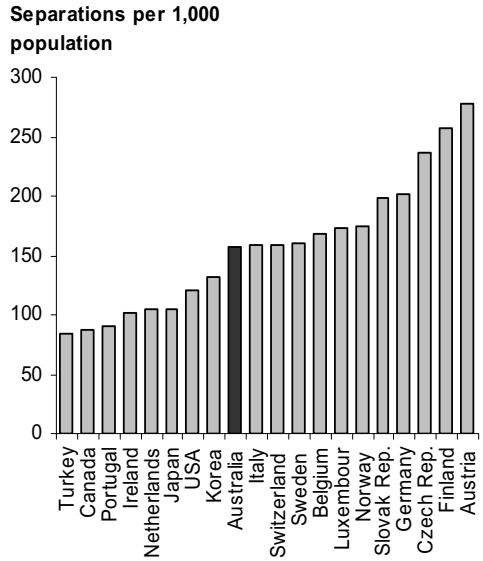


Figure 4: Average length of stay for overnight separations, public acute and private hospitals, Australia, 1997–98 to 2006–07

- For patients staying at least one night, average lengths of stay have remained

relatively constant over this period. They were 6.2 days in public acute hospitals and 5.4 days in private hospitals in 2006–07 (Figure 4).

International comparisons



Abbreviation: Rep.—Republic.

Notes

1. Data are for 2005–06 except for Australia, Belgium, Canada, Germany, Italy, Turkey and the USA which are for 2004–05.
2. Data for OECD countries vary in collection periods, from financial year, fiscal year and calendar year.

Figure 5: Overnight separations per 1,000 population, Australia, 2004–05 and selected OECD countries

- The number of overnight separations per 1,000 population in Australia for 2004–05 was in the middle of the range reported by other OECD countries for recent years (Figure 5, OECD 2007).
- Comparability of international separation rates is likely to be affected by differences in definitions of hospitals, collection periods and in admission practices.

Age group and sex

Females accounted for more separations than did males. See *Chapter 8*.

- In 2006–07, there were 4,020,928 separations for females compared with 3,581,515 separations for males, 52.9% and 47.1% of separations respectively.
- Overall, in 2006–07 there were 383.5 separations per 1,000 population for females, compared with 345.5 separations per 1,000 population for males (Figure 6).

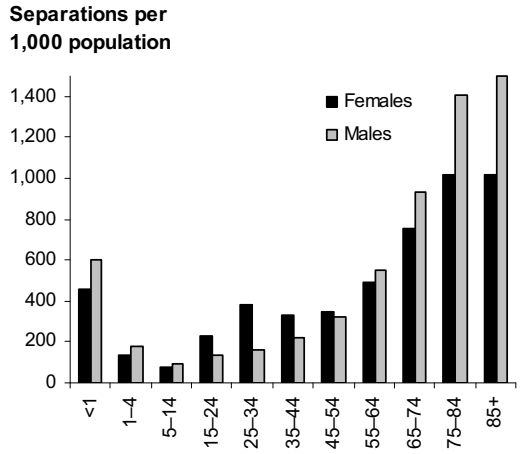


Figure 6: Separations per 1,000 population, by age group and sex, Australia, 2006–07

- The differences in the separation rates for males and females varied between age groups. The rates were higher for females than for males in all age groups between 15 and 54 years (which include child-bearing ages for women). Males had higher separation rates than females in all age groups less than 15 years old and 55 years and over.
- Separations for both males and females increased between 2002–03 and 2006–07. These increases were very marked for both males and females aged 55 and over. Most notably, separations increased by 43.7% for males aged 85 years and over and by 25.3% for females aged 55–64 years (Figure 7).
- Separations of persons aged 1–4 years decreased over this period for both males and females.

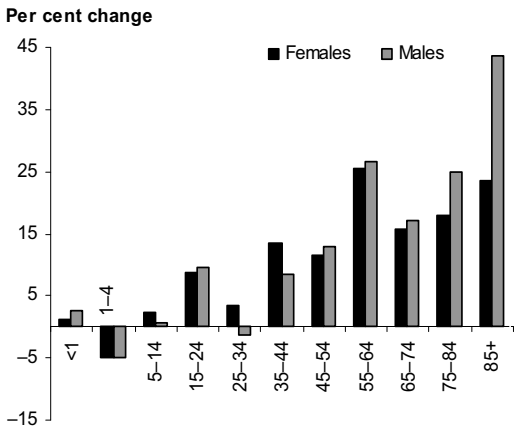


Figure 7: Change in the number of separations (per cent), by age group and sex, Australia, 2002–03 to 2006–07

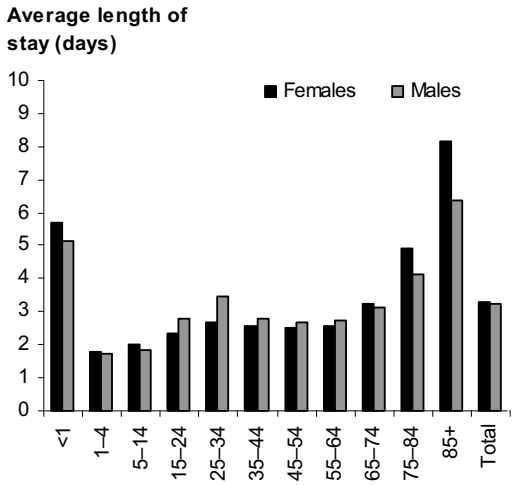


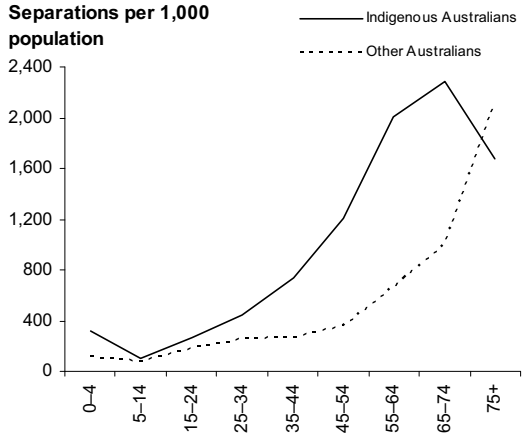
Figure 8: Average length of stay, by age group and sex, Australia, 2006–07

- Overall, the average length of stay did not vary greatly between males and females, being around 3.3 days for both. Females aged less than 15 years, and 65 years and over, had longer average lengths of stay than males in those age groups (Figure 8).

Persons identifying as Indigenous

Indigenous Australians, that is, those identifying as being of Aboriginal and/or Torres Strait Islander origin, had higher separation rates in 2006–07 than other persons. See *Chapter 8*.

- In 2006–07, the crude separation rate for Indigenous Australians (530.7 per 1,000 population) was about one and a half times the rate for Other Australians (364.2 per 1,000 population). The rates for Indigenous Australians were higher for all age groups, other than 75 years and over (Figure 9).



Notes

1. Other Australians includes both non-Indigenous and not stated/inadequately described separations.
2. This figure includes data for New South Wales, Victoria, Queensland, Western Australia, South Australia and public hospitals in the Northern Territory.

Figure 9: Separations per 1,000 population, by Indigenous status and age group, Australia, 2006–07

Remoteness Areas

Remoteness Area categories divide Australia into areas depending on distances from population centres. See *Chapter 8*.

- The number of separations per 1,000 population varied by Remoteness Area. Overall, separation rates were highest in Very Remote and lowest in Inner Regional areas (Figure 10).
- Separation rates for public hospitals were highest for patients living in Very Remote areas and lowest for patients living in Major Cities (454.1 and 204.0 separations per 1,000 population respectively).

- Separation rates for private hospitals were highest for patients living in Major Cities and lowest for patients living in Very Remote areas (152.3 and 50.4 separations per 1,000 population respectively).
- Overall, remote areas had higher public hospital separation rates than Major Cities and regional areas. In contrast, Major Cities had higher private hospital separation rates than regional and remote areas.

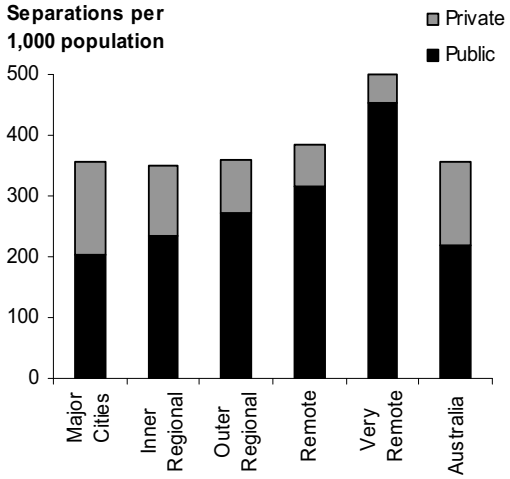


Figure 10: Separations per 1,000 population, by Remoteness Area of usual residence and hospital sector, Australia, 2006–07

Overall type of care

Separations were allocated to Australian Refined Diagnosis Related Groups (AR-DRGs) which can be used to describe whether the overall care was medical, surgical or other. Other care includes endoscopies. See *Chapter 12*.

- In public hospitals, separations with *Medical* AR-DRGs increased by 17.0% between 2002–03 and 2006–07. Separations with *Surgical* AR-DRGs increased by 8.7% and *Other* AR-DRGs increased by 6.3% in the same period (Figure 11).
- In private hospitals, separations with *Medical* AR-DRGs increased by 16.9%, those with *Surgical* AR-DRGs increased by 12.9% and those with *Other* AR-DRGs increased by 13.2% (Figure 12).

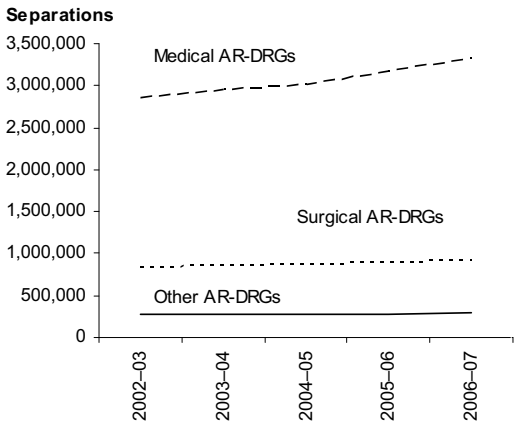


Figure 11: Separations for *Medical*, *Surgical* and *Other* AR-DRGs version 5.1, public hospitals, Australia, 2002–03 to 2006–07

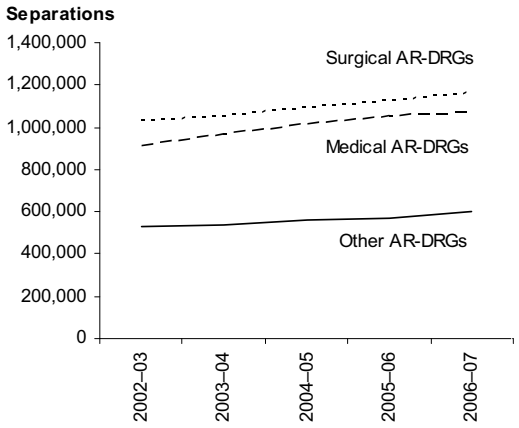


Figure 12: Separations for *Medical*, *Surgical* and *Other* AR-DRGs version 5.1, private hospitals, Australia, 2002–03 to 2006–07

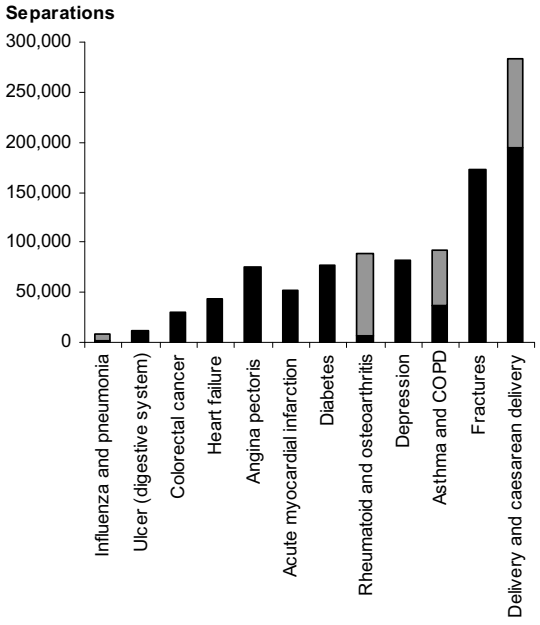
Conditions treated

The conditions (diseases or injuries and poisonings) treated in hospitals are classified using *the International statistical classification of disease and related health problems, 10th revision, Australian modification* (ICD-10-AM). Using this classification, each separation is allocated a principal diagnosis which is the diagnosis established after study to be chiefly responsible for occasioning the patient's episode of care. See *Chapter 9*.

- Overall, 37.2% of separations in 2006–07 had a principal diagnosis that

derived from one of five ICD-10-AM chapters: *Diseases of the digestive system*; *Neoplasms*; *Diseases of the circulatory system*; *Pregnancy, childbirth and the puerperium*; and *Injury and poisoning*.

- The National Health Priority Areas (NHPAs) initiatives focus on chronic diseases that have a significant health burden. They are asthma, cancer control, cardiovascular health, diabetes, injury prevention and control, mental health, and arthritis and musculoskeletal conditions.



Note: Bars with two categories of principal diagnosis are indicated using two shadings.

Figure 13: Separations, by selected principal diagnosis, Australia, 2006–07

- In 2006–07, the NHPAs were represented by some high-volume diagnoses, with principal diagnoses of:
  - fractures (173,410 separations)
  - asthma (36,588 separations)
  - chronic obstructive pulmonary disease (COPD) (54,878 separations)
  - arthritis (89,212 separations)
  - angina pectoris (75,408 separations) and
  - diabetes mellitus (77,827 separations) (Figure 13).

Selected potentially preventable hospitalisations

The selected potentially preventable hospitalisations presented in this report are thought to be avoidable if timely and adequate non-hospital care is provided. Both acute and chronic conditions are represented. Rates for potentially preventable hospitalisations are potential indicators of the effectiveness of non-hospital care. See *Chapter 4*.

- Selected potentially preventable hospitalisations represented 9.2% of all separations in 2006–07.
- Overall, the number of separations per 1,000 population for the selected potentially preventable hospitalisations increased by an average of 2.6% per year between 2002–03 and 2006–07.
- Some diseases can be prevented by vaccination. The number of separations per 1,000 population for these diseases decreased by an average of 7.2% per year between 2002–03 and 2006–07.
- For chronic conditions, excluding diabetes, potentially preventable hospitalisations per 1,000 population rose with increasing remoteness ranging from 8.1 in Major Cities to 15.6 in Very Remote regions (Figure 14).
- This pattern was also evident for acute conditions, where potentially preventable hospitalisations per 1,000 population rose with increasing remoteness from 12.3 in Major Cities to 27.1 in regions classed as Very Remote.
- For diabetes complications, potentially preventable hospitalisations per 1,000 population were markedly higher in Remote and Very Remote areas than in other areas.

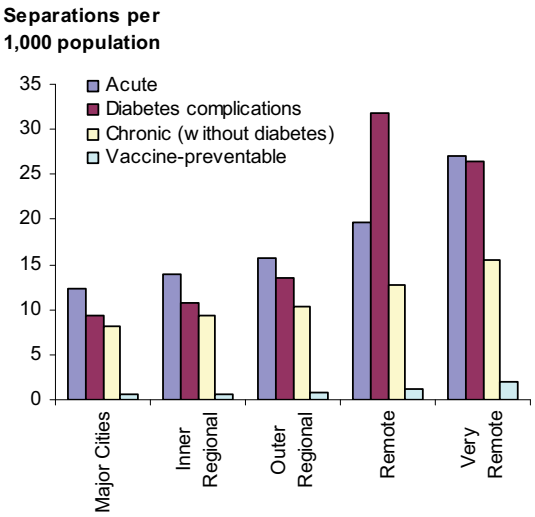


Figure 14: Selected potentially preventable hospitalisations per 1,000 population, by Remoteness Area of usual residence, Australia, 2006–07

Procedures undertaken

A procedure can be surgical or non-surgical, and can treat or diagnose a condition or be of a patient support nature such as anaesthesia. See *Chapter 10*.

- One or more procedures were reported for 82.0% of the separations in Australian hospitals in 2006–07.
- Overall, 56.2% of separations that reported a procedure occurred in the public sector. Overall, 75.1% of separations from the public sector recorded a procedure, compared with 92.8% in the private sector.
- Separations in 2006–07 for selected high-volume procedures and selected procedures that can be electively performed are shown in Figure 15.
- In 2006–07, high-volume procedures included *Haemodialysis* (943,393 separations), *Gastrointestinal endoscopy* (617,277 separations), *Chemotherapy administration* (262,500 separations), *Lens insertion* (178,866 separations) and *Arthroscopic procedures* (131,810 separations).

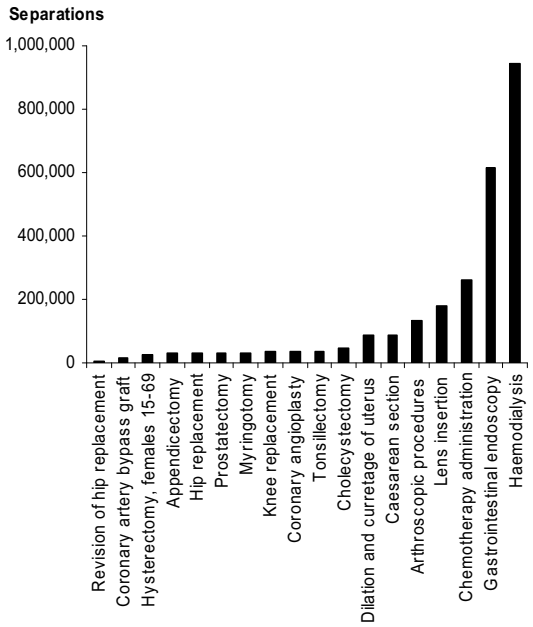


Figure 15: Separations, by selected procedure, Australia, 2006–07

- The number of separations for *Caesarean section* increased by 28.2% between 2002–03 and 2006–07. They increased by 22.3% in the private sector and by 32.0% in the public sector (Figure 16).

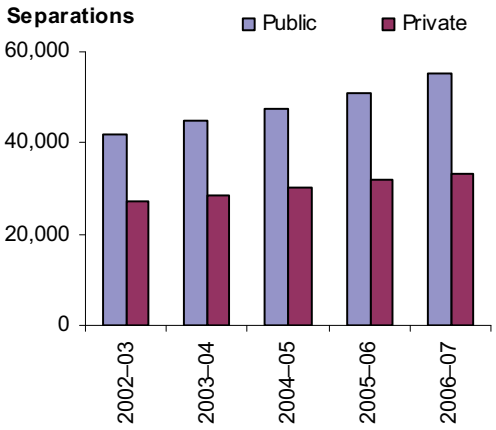


Figure 16: Separations for Caesarean section, by hospital sector, Australia, 2002–03 to 2006–07

- In 2006–07, 62.3% of the separations with a *Caesarean section* were in the public sector and 37.7% were in the private sector (55,327 and 33,439 respectively), compared with 60.5%

and 39.5% in 2002–03 (41,914 and 27,348 respectively).

Waiting times for elective surgery in public hospitals

The median waiting time for elective surgery in public hospitals in 2006–07 was 32 days. See *Chapter 6*.

- Ophthalmology, orthopaedic surgery, and ear, nose and throat surgery were the surgical specialties with the longest median waiting times (71, 50, and 46 days respectively) in 2006–07 (Figure 17).
- All other surgical specialties had a median waiting time of less than 30 days. Cardio-thoracic surgery had the shortest median waiting time (12 days).

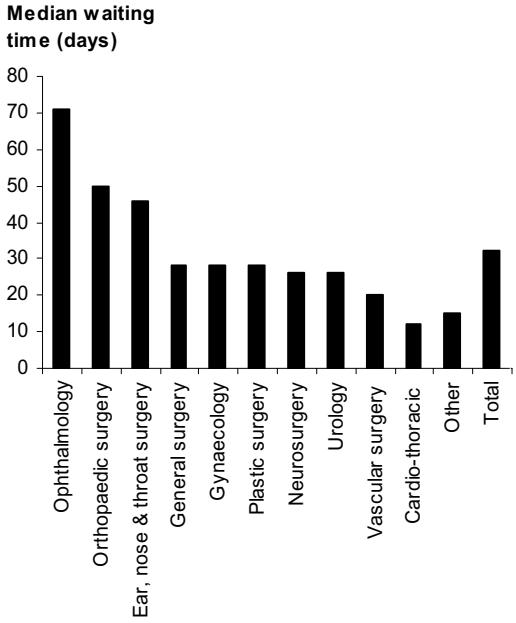


Figure 17: Public hospital median waiting time, by specialty of surgeon, Australia, 2006–07

Emergency department care in public hospitals

About 6.7 million accident and emergency presentations were provided in public hospitals in 2006–07. See *Chapter 5*.

- Data on triage category, waiting times, patient age group and sex were available for about 78% of accident and emergency presentations, mainly those delivered in emergency departments in *Principal referral and Specialist women's and children's hospitals* and *Large hospitals*.
- A higher proportion of patients were seen on time (as defined in Chapter 5) in *Large hospitals* than in *Principal referral and Specialist women's and children's hospitals*. In *Large hospitals*, 73% of emergency department presentations were seen on time, with 99% of patients who were assigned a triage category of *Resuscitation* seen on time.
- In *Principal referral and Specialist women's and children's hospitals*, 66% of emergency department presentations were seen on time, with 99% of patients who were assigned a triage category of *Resuscitation* seen on time.
- In *Large hospitals*, 70% of *Urgent* patients were seen on time compared with 63% in *Principal referral and Specialist women's and children's hospitals* (Figure 18).

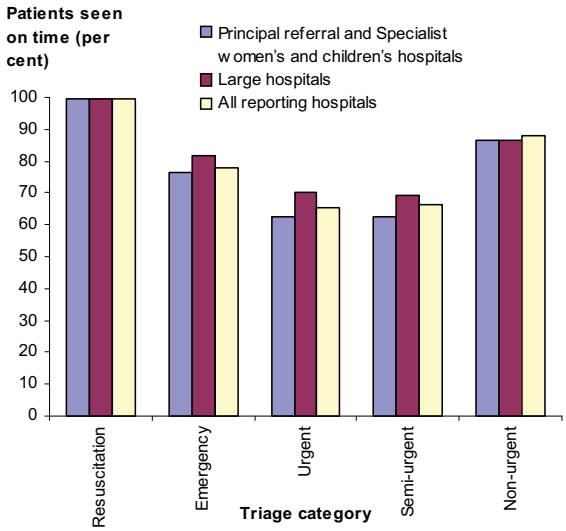


Figure 18: Public hospital emergency department presentations seen on time, by triage category and public hospital peer group, Australia, 2006–07

- Persons aged 15–24 years accounted for the largest number of emergency

department presentations (833,672, 15.8%) (Figure 19).

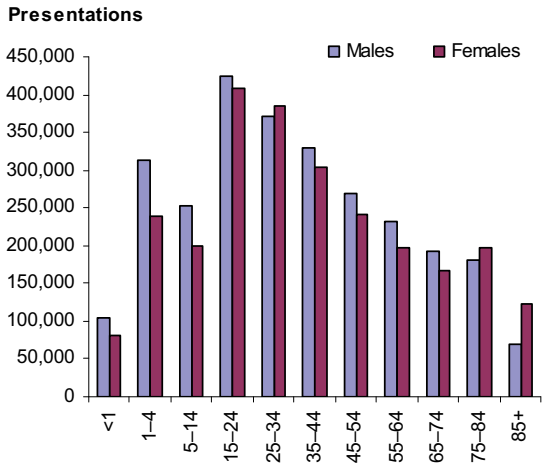


Figure 19: Emergency department presentations, by age group and sex, Australia, 2006–07

Non-admitted patient care in public hospitals

Excluding accident and emergency services, there were about 39.9 million non-admitted patient occasions of service provided by public hospitals in 2006–07. See *Chapter 2*.

- Of these, more than 15.8 million of these occasions of service were delivered in specialist outpatient clinics with the chief contributors being in *Allied health* and *Dental*. See *Chapter 5*.
- *Pharmacy*, *Pathology* and *Radiology & organ imaging* made up a further 14.9 million individual non-admitted patient occasions of service.
- There were 345,409 group session occasions of service with *Mental Health*, *Alcohol & Drug* and *Community health* together making up 32% of the group sessions.
- There were 157,953 occasions of service, including both individual and group sessions, delivered by public psychiatric hospitals.

Australian hospitals

Overall, the number of hospitals in Australia has increased over time. See *Chapter 2*.

- There were 1,301 hospitals in Australia in 2006–07.
- There were 739 public acute hospitals and 19 public psychiatric hospitals.
- There were 265 private free-standing day hospital facilities and 278 other private hospitals.
- There was an increase in the number of public acute hospitals, from 729 in 2002–03 to 739 in 2006–07.
- The number of private hospitals fell from 549 facilities in 2002–03 to 543 facilities in 2006–07.

Available beds

The number of available beds is a better indicator of the availability of hospital services than is the number of hospitals because hospital sizes vary considerably. However, comparability of hospital bed numbers can be affected by the casemix of hospitals with differing proportions of beds being available for specialised and more general purposes. See *Chapter 2*.

- In 2006–07, there were 82,662 available beds in Australia.
- There were 53,563 available beds in public acute hospitals and 2,342 in public psychiatric hospitals.
- There were an estimated 1,992 available beds in private free-standing day hospital facilities and 24,766 in other private hospitals.
- There was a 3.2% increase in available beds from 80,103 in 1997–98 to 82,662 in 2006–07, an average increase of 0.4% annually.
- The number of available beds in public acute hospitals increased by an average of 0.2% annually, from 52,801 in 1997–98 to 53,563 in 2006–07 (Figure 20).

- The number of available beds/chairs in private free-standing day hospital facilities rose by an average of 4.4% annually between 1997–98 and 2006–07 (from 1,348 to 1,992).

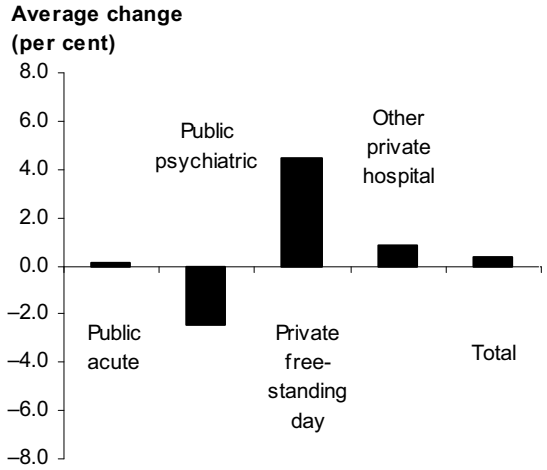


Figure 20: Average annual change in the number of available beds, by type of hospital, Australia, 1997–98 to 2006–07

Staff in Australian public hospitals

Staff numbers (See *Chapter 3*) in public acute and public psychiatric hospitals have grown over time (Figure 21).

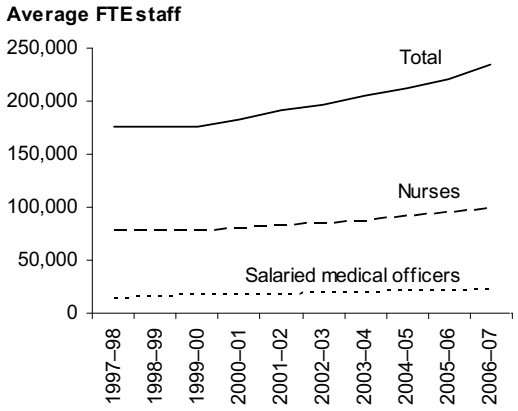


Figure 21: Average full-time equivalent staff, public hospitals, Australia, 1997–98 to 2006–07

- The number of full-time equivalent staff increased by an average of 3.3% annually between 1997–98 (175,024) and 2006–07 (234,717). The number of salaried medical officers increased by an average of 5.3% annually over this period (from 15,387 to 24,526), and the number of nurses increased by an annual average of 3.2% (from 78,239 to 103,960).

Recurrent expenditure on public hospitals

Recurrent expenditure is expenditure on goods and services that are consumed during the year, for example, salaries. See *Chapter 3*.

- Recurrent expenditure on public acute and public psychiatric hospitals (excluding depreciation) was $26,290 million in 2006–07. After adjusting for inflation, this represented an increase of 5.6% compared with 2005–06.
- The largest share of this expenditure was for salary payments, which accounted for 62% ($16,410 million) of recurrent expenditure (Figure 22).
- The major non-salary recurrent expenses in the public sector were for medical and surgical supplies, administrative expenses and drug supplies.

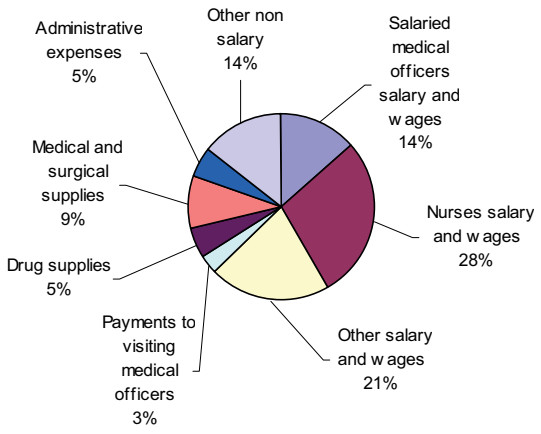


Figure 22: Recurrent expenditure, public hospitals, Australia, 2006–07

Recurrent expenditure (cost) for providing care in public hospitals

The average recurrent expenditure per casemix-adjusted separation is regarded as a measure of efficiency. See *Chapter 4*.

- The average recurrent cost of providing care per casemix-adjusted separation in public hospitals increased from $3,184 in 2002–03 to $3,922 in 2006–07 (not adjusted for inflation).
- This represents a total increase of 23.2% in this period, an average increase of 5.3% annually (Figure 23).
- In 2006–07 the average cost comprised $2,027 for non-medical labour expenditure, $803 for medical labour expenditure and $1,093 for other recurrent expenditure. Other recurrent expenditure costs include domestic services; repairs and maintenance; administration; and medical, drug and food supplies.

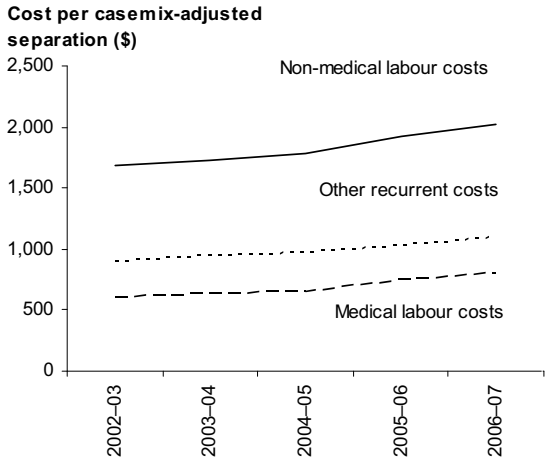


Figure 23: Cost per casemix-adjusted separation, Australia, 2002–03 to 2006–07

More information on how to interpret the data is provided in the relevant chapter quoted in each subsection. More information about the terms used is in the Glossary. Hospitals included in this report are public acute care and psychiatric hospitals, private free-standing day hospital facilities and other private hospitals (including psychiatric hospitals).