10 Public hospitals

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The Public hospitals chapter (chapter 10) in the *Report on Government Services 2013* (2013 Report) reports on the performance of public hospitals in each Australian state and territory. Data are reported for Indigenous Australians 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. This chapter reports on the performance of State and Territory public hospitals, focusing on acute care services. It also reports separately on a significant component of the services provided by public hospitals — maternity services.

The public hospitals chapter in the 2013 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 relative to other hospitals data. Data in the chapter include subacute and non‑acute care services.

In some instances, data for stand-alone psychiatric hospitals are included in this chapter. However, under the National Mental Health 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 management’ chapter (chapter 12).

**Size and scope of sector**

There are several ways to measure the size and scope of Australia’s public hospital sector. This chapter reports on: the number and size of hospitals; the number and location of public hospital beds; the number and type of public hospital separations; the proportion of separations by age group of the patient; the number of separations and incidence of treatment, by procedure and Indigenous status of the patient; the number of hospital staff; and types of public hospital activity.

#### Admitted patient care for Indigenous patients

The completeness of Indigenous identification in hospital admitted patient data varies across states and territories. Efforts to improve Indigenous identification are ongoing. In 2010-11, on an age standardised basis, 848.0 public hospital separations (including same day separations) for Indigenous Australians were reported per 1000 Indigenous people in NSW, Victoria, Queensland, WA, SA and the NT combined. This rate was markedly higher than the corresponding rate of 227.9 per 1000 for these jurisdictions’ combined total population (figure 10.1).

Figure 10.1 Estimates of public hospital separations, by Indigenous status of patient, 2010-11a, b, c

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| Figure 10.1 Estimates of public hospital separations, by Indigenous status of patient, 2010-11  More details can be found within the text surrounding this image. |

a The rates are directly age standardised to the Australian population at 30 June 2001. b Identification of Indigenous Australians is incomplete and completeness varies across jurisdictions. c Data are reported for NSW, Victoria, Queensland, WA, SA and the NT. These six jurisdictions are considered to have an acceptable quality of Indigenous identification. The total comprises these jurisdictions only.

*Source*: AIHW (unpublished), National Hospital Morbidity Database; table 10A.11; 2013 Report, figure 10.9, p. 10.11.

Hospital episodes of care involving dialysis accounted for 44 per cent of all hospitalisations for Indigenous Australians (compared with 12 per cent for non‑Indigenous Australians) in the period July 2008 to June 2010. The hospitalisation rate for Indigenous Australians for dialysis was 11 times as high as the rate for non‑Indigenous Australians. After adjusting for age differences, the hospitalisation rate (excluding dialysis) for Indigenous Australians in the two years to June 2010 was 435 per 1000 of the population compared with 305 per 1000 of the population for non‑Indigenous Australians (1.4 times as high) (AHMAC 2012).

In 2010-11, separations for Indigenous Australians accounted for around 3.8 per cent of total separations and 5.9 per cent of separations in public hospitals in NSW, Victoria, Queensland, WA, SA and the NT combined (table 10A.10). Indigenous Australians made up only around 3.0 per cent of the population in these jurisdictions (table AA.2 and 2013 Report, table AA.15). Most separations involving Indigenous Australians (91.9 per cent) in these jurisdictions occurred in public hospitals (table 10A.10).

### Framework of performance indicators for public hospitals

Public hospitals performance is reported against objectives that are common to public hospitals in all jurisdictions (box 10.1). The Health sector overview explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework.

The Council of Australian Governments (COAG) has agreed six National Agreements to enhance accountability to the public for the outcomes achieved or outputs delivered by a range of government services (see chapter 1 of the   
2013 Report for more detail on reforms to federal financial relations).

The National Healthcare Agreement (NHA) covers the area of health and aged care, and health indicators in the National Indigenous Reform Agreement (NIRA) establish specific outcomes for reducing the level of disadvantage experienced by Indigenous Australians. Both agreements include sets of performance indicators, for which the Steering Committee collates performance information for analysis by the COAG Reform Council (CRC). Performance indicators reported in this chapter are aligned with the health performance indicators in the NHA. The NHA was reviewed in 2011 and 2012 resulting in changes that have been reflected in this Report, as relevant.

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| Box 10.1 Objectives for public hospitals |
| The common government objectives for public hospitals are to provide acute and specialist services that are:   * safe and of high quality * appropriate and responsive to individual needs * affordable, timely and accessible * equitably and efficiently delivered. |
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The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of public hospital services (figure 10.2). The performance indicator framework shows which data are comparable in the 2013 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability from a Report-wide perspective   
(see 2013 Report, section 1.6). Data for Indigenous Australians 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.

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).

Figure 10.2 Public hospitals performance indicator framework

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| Figure 10.2 Public hospitals performance indicator framework  More details can be found within the text surrounding this image. |

*Source*: 2013 Report, figure 10.11, p. 10.16.

### Equity of access by special needs groups

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

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| Box 10.2 Equity of access by special needs groups |
| ‘Equity of access by special needs groups’ measures the performance of agencies providing services for three identified special needs groups: Indigenous Australians; 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. Data for the emergency department waiting times and waiting times for admitted patient services indicators are reported by Indigenous status and remoteness. |
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#### Emergency department waiting times

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

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| Box 10.3 Emergency department waiting times |
| ‘Emergency department waiting times' is defined as the proportion of patients seen within the benchmarks set by the Australasian Triage Scale. The Australasian Triage Scale is a scale for rating clinical urgency, designed for use in hospital-based emergency services in Australia and New Zealand.  These waiting times are measured using the nationally agreed method of calculation 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. |
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| Box 10.3 (Continued) |
| 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).   A high or increasing proportion of patients seen within the benchmarks set for each triage category is desirable.  Data reported for this indicator are not directly comparable.  Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013. |
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The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage (2013 Report, table 10.2) and clinical practices — in particular, the allocation of cases to urgency categories.

Emergency department waiting times by Indigenous status and remoteness, for peer group A and B hospitals are reported in the attachment (table 10A.19 and   
2013 Report, table 10A.20). Nationally, there was little difference between Indigenous and non-Indigenous Australians in the percentages of patients treated within national benchmarks across the triage categories, although there were variations across states and territories for some triage categories (table 10A.19).

#### Waiting times for admitted patient services

‘Waiting times for admitted patient services’ is an indicator of governments’ objective to provide accessible services (box 10.4). Elective surgery 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.

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| Box 10.4 Waiting times for admitted patient services |
| ‘Waiting times for admitted patient services’ is defined by three measures:   * ‘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 12 months is also shown. * For overall elective surgery waiting times, a low or decreasing number of days waited at the 50th and 90th percentiles, and a low or decreasing proportion of people waiting more than 365 days are desirable. * Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2013. * ‘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 for a condition that has the potential to deteriorate quickly to the point that it may become an emergency * category 2 — admission is desirable within 90 days for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency * category 3 — admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency. The desirable timeframe for this category is admission within 365 days.   The term ‘extended wait’ is used for category 3 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 elective surgery waiting times by clinical urgency category, a low or decreasing proportion of patients who have experienced extended waits at admission is desirable. However, variation in the way patients are classified to urgency categories should be 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 (table 10.3). * Information about data quality for this measure is at www.pc.gov.au/gsp/reports/rogs/2013. |
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| Box 10.4 (Continued) |
| * Waiting times for admission following emergency department care is currently expected to measure the percentage of patients who present to a public hospital emergency department and are admitted to the same hospital, whose time in the emergency department was less than 8 hours. This indicator is being developed as part of the NHA reporting process. Waiting times for admission following emergency department care has been identified as a key area for development in future Reports.   Data reported for this indicator are not directly comparable. |
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##### Waiting times for elective surgery

Attachment 10A includes data on elective surgery waiting times by hospital peer group, specialty of surgeon and indicator procedure. It also includes waiting times by remoteness and by Indigenous status (2013 Report, tables 10A.21–10A.25). Those living in regional areas had longer waiting times than those in major cities at the 50th and 90th percentiles at the national level (2013 Report, table 10A.24). Nationally, Indigenous Australians had longer waiting times for elective surgery than non‑Indigenous Australians at the 50th percentile and 90th percentile (table 10A.23).

### Effectiveness — quality

#### Safety — unplanned hospital readmission rates

‘Unplanned hospital readmission rates’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 10.5). Patients might be re-admitted unexpectedly if the initial care or treatment was ineffective or unsatisfactory, if post discharge planning was inadequate, or for reasons outside the control of the hospital (for example poor post-discharge care).

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| Box 10.5 Unplanned hospital readmission rates |
| ‘Unplanned hospital readmission rates’ is defined as the rate at which patients unexpectedly return to hospital within 28 days for further treatment of the same condition. It 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 which occurred within 28 days of the previous date of separation, expressed per 1000 separations in which one of the selected surgical procedures was performed. Selected surgical procedures are knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendectomy. Unplanned readmissions are those having a principal diagnosis of a post-operative adverse event for which a specified ICD-10-AM diagnosis code has been assigned.  Low or decreasing rates for this indicator are desirable. Conversely, 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.  Data reported for this indicator are not complete or directly comparable.  Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013. |
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Unplanned hospital readmission rates in public hospitals in 2010-11 are reported in 2013 Report, table 10.5. Unplanned hospital readmission rates are reported by Indigenous status and remoteness in table 10A.44.

### Framework of performance indicators for maternity services

The performance indicator framework provides information on equity, efficiency and effectiveness, and distinguishes the outputs and outcomes of maternity services (figure 10.3). The performance indicator framework shows which data are comparable in the 2013 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary. Chapter 1 of the 2013 Report discusses data comparability from a Report-wide perspective (see 2013 Report, section 1.6). The Health sector overview explains the performance indicator framework for health services as a whole, including the subdimensions of quality and sustainability that have been added to the standard Review framework.

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).

Figure 10.3 Maternity services performance indicator framework

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| Figure 10.3 Maternity services performance indicator framework  More details can be found within the text surrounding this image. |

*Source*: 2013 Report, figure 10.24, p. 10.61.

### Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see 2013 Report, chapter 1, section 1.5).

*Perinatal death rate*

‘Perinatal death rate’ is an indicator of governments’ objective to deliver maternity services that are safe and of high quality (box 10.6).

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| Box 10.6 **Perinatal death rate** |
| ‘Perinatal death rate’ is defined by the following three measures:   * 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. 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). The rate of fetal deaths is expressed per 1000 total births, by State or Territory of usual residence of the mother * 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). 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. * A perinatal death is a fetal or neonatal death. 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). It is expressed per 1000 total births, by State or Territory of usual residence of the mother.   Low or decreasing death rates are desirable and can indicate high quality maternity services. The neonatal death rate tends to be higher among premature babies, so a lower neonatal death rate can also indicate a lower percentage of pre-term births.  Differences in the fetal death rate between jurisdictions are likely to be due to factors outside the control of admitted patient maternity services (such as the health of mothers and the progress of pregnancy before hospital admission). 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. In jurisdictions where the number of fetal deaths is low, small annual fluctuations in the number affect the annual rate of fetal deaths.  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.  Data reported for this indicator are comparable.  Information about data quality for this indicator is at www.pc.gov.au/gsp/reports/rogs/2013. |
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##### Fetal death rate

Fetal 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). For three of the five jurisdictions for which data are available, the fetal death rates for Indigenous Australians are higher than those for non‑Indigenous Australians (figure 10.4).

Figure 10.4 Fetal death rate by Indigenous status of mother 2006–2010a

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| Figure 10.4 Fetal death rate by Indigenous status of mother 2006–2010  More details can be found within the text surrounding this image. |

a Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. 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.111; 2013 Report,   
figure 10.33, p. 10.74.

*Neonatal death rate*

Neonatal 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 the jurisdictions for which data are available, the neonatal death rates for Indigenous Australians are higher than those for non-Indigenous Australians (figure 10.5).

Figure 10.5 Neonatal death rate by Indigenous status of mother   
2006–2010a

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| Figure 10.5 Neonatal death rate by Indigenous status of mother 2006-2010  More details can be found within the text surrounding this image. |

a Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. 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.111; 2013 Report,   
figure 10.34, p. 10.75.

*Perinatal death rate*

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 the jurisdictions for which data are available, perinatal death rates for Indigenous Australians are higher than those for non‑Indigenous Australians in all but one jurisdiction (figure 10.6).

Figure 10.6 Perinatal death rate by Indigenous status of mother   
2006–2010a

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| Figure 10.6 Perinatal death rate by Indigenous status of mother 2006-2010  More details can be found within the text surrounding this image. |

a Data are reported individually by jurisdiction of residence for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. 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.111; 2013 Report,   
figure 10.36, p. 10.77.

### Future directions

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

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

* Improving the quality of data on Indigenous Australians. Work on improving Indigenous identification in hospital admitted patient data across states and territories is ongoing.

### Definitions of key terms and indicators

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| **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. |
| **Elective surgery waiting times** | Elective surgery waiting times are calculated by comparing the date on which patients are added to a waiting list with the date on which they are admitted. Days on which the patient was not ready for care are excluded. |
| **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 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. |
| **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). |

### 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 chapter by a ‘10A’ prefix (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).

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| **Table 10A.10** | Separations by hospital sector and Indigenous status of patient |
| **Table 10A.11** | Separations per 1000 people, by Indigenous status of patient (number) |
| **Table 10A.19** | Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory |
| **Table 10A.23** | Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) |
| **Table 10A.44** | Unplanned hospital readmission rates, by State and Territory, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2010-11 |
| **Table 10A.111** | Perinatal, neonatal and fetal deaths |

### References

ABS (Australian Bureau of Statistics) 2004, *Deaths, Australia 2003*, Cat. no. 3302.0, Canberra.

AHMAC (Australian Health Ministers’ Advisory Council) 2012, *The Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report*, AHMAC, Canberra.

HDSC (Health Data Standards Committee) 2008, *National health data dictionary. Version 14.* Cat. no. HWI 101. AIHW, Canberra.