# 11 Public hospitals

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| **Attachment tables** |
| Attachment tables are identified in references throughout this Indigenous Compendium by an ‘A’ prefix (for example, in this chapter, table 11A.1). As the data are directly sourced from the 2015 Report, the Compendium also notes where the original table, figure or text in the 2015 Report can be found. For example, where the Compendium refers to ‘2015 Report, p. 11.1’ this is page 1 of chapter 11 of the 2015 Report, and ‘2015 Report, table 11A.1’ is attachment table 1 of attachment 11A of the 2015 Report. A list of attachment tables referred to in the Compendium is provided at the end of this chapter, and the full attachment tables are available from the Review website at www.pc.gov.au/research/recurring/report-on-government-services. |
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The Public hospitals chapter (chapter 11) in the *Report on Government Services 2015* (2015 Report) reports on the performance of public hospitals in Australia. Data are reported for Aboriginal and Torres Strait Islander 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.

### Aboriginal and Torres Strait Islander data in the public hospitals chapter

The public hospitals chapter in the 2015 Report contains the following data on Aboriginal and Torres Strait Islander Australians:

* estimates of public hospital separations, by Indigenous status of patient
* fetal death rate by Indigenous status of mother
* neonatal death rate by Indigenous status of mother
* perinatal death rate by Indigenous status of mother.

The public hospitals attachment contains additional data relating to Aboriginal and Torres Strait Islander Australians including:

* separations by hospital sector
* separations per 1000 people
* patients treated within national benchmarks for emergency department waiting time
* waiting times for elective surgery in public hospitals
* separation statistics for selected hospital procedures per 1000 people, all hospitals
* unplanned hospital readmission rates
* falls resulting in patient harm in hospitals
* perinatal, neonatal and fetal deaths.

### 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 number of separations by age group of the patient; the number of separations and incidence of treatment, by the Indigenous status of the patient; the number of hospital staff; and types of public hospital activity.

#### Admitted patient care for Aboriginal and Torres Strait Islander Australians

The completeness of identification of Aboriginal and Torres Strait Islander people in hospital admitted patient data varies across states and territories. Efforts to improve identification are ongoing. In 2012-13, on an age standardised basis, 938.6 public hospital separations (including same day separations) for Aboriginal and Torres Strait Islander Australians were reported per 1000 Aboriginal and Torres Strait Islander Australians. This rate was markedly higher than the corresponding rate of 237.0 per 1000 for all Australians (figure 11.1).

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| Figure 11.1 Public hospital separations, 2012-13**a, b** |
| |  | | --- | | Figure 11.9 Public hospital separations, 2012-13  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 Aboriginal and Torres Strait Islander Australians is incomplete and completeness varies across jurisdictions. |
| *Source*: AIHW (unpublished), National Hospital Morbidity Database; table 11A.11; 2015 Report,  figure 11.9, p. 11.11. |
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Hospital episodes of care involving dialysis accounted for a large portion of same day separations, particularly for Aboriginal and Torres Strait Islander Australians. The hospitalisation rate for Aboriginal and Torres Strait Islander Australians for dialysis was   
12 times as high as the rate for other Australians. When dialysis is excluded, the same day hospitalisation rate for Aboriginal and Torres Strait Islander Australians in 2012-13   
(152.8 per 1000 of the population) was less than that for other Australians (168.7 per 1000 of the population) (AIHW 2014).

In 2012-13, separations for Aboriginal and Torres Strait Islander Australians accounted for around 4.1 per cent of total separations and 6.4 per cent of separations in public hospitals (table 11A.10). Aboriginal and Torres Strait Islander Australians made up only around   
3 per cent of the population nationally, although this rate varied significantly from   
0.9 per cent in Victoria to 29.8 per cent in the NT (table 2A.14, and 2015 Report,   
table 2A.1). Most separations involving Aboriginal and Torres Strait Islander Australians (91.7 per cent) in these jurisdictions occurred in public hospitals (table 11A.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 11.1). 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) 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 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 Aboriginal and Torres Strait Islander Australians. Both agreements include sets of performance indicators. Performance indicators reported in this chapter are aligned with health performance indicators in the most recent version of the NHA, where relevant.

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| Box 11.1 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 11.2). The performance indicator framework shows which data are comparable in the 2015 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability and data completeness from a Report-wide perspective (section 1.6). Data for Aboriginal and Torres Strait Islander Australians are reported for a subset of the performance indicators and are presented here.

The Report’s statistical context chapter 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 Aboriginal and Torres Strait Islander and ethnic status) (chapter 2).

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| Figure 11.2 Public hospitals performance indicator framework |
| |  | | --- | | Figure 11.11 Public hospitals performance indicator framework   More details can be found within the text surrounding this image. | |
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*Source*: 2015 Report, figure 11.11, p. 11.15.

### 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 11.2).

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| Box 11.2 Equity of access by special needs groups |
| ‘Equity of access by special needs groups’ measures the performance of agencies providing services for identified special needs groups including: Aboriginal and Torres Strait Islander 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 culturally and linguistically diverse backgrounds. Chapter 1 outlines special needs groups in more detail.  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 11.3).

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| Box 11.3 Emergency department waiting times |
| ‘Emergency department waiting times’ is defined by the following two measures:   * Emergency department waiting times by triage category * Proportion of emergency department presentations with length of stay of 4 hours or less.   Emergency department waiting times by triage category  Emergency department waiting times by triage category is calculated by subtracting 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.  ‘Emergency department waiting times by triage category' 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.  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. |
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| Box 11.3 (continued) |
| A high or increasing proportion of patients seen within the benchmarks set for each triage category is desirable.  Data reported for this indicator are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this measure is at www.pc.gov.au/research/recurring/report-on-government-services.  Proportion of emergency department presentations with length of stay of 4 hours or less  ‘Proportion of Emergency department presentations with length of stay of 4 hours or less’ is defined as the percentage of presentations to public hospital emergency departments where the time from presentation to physical departure is less than or equal to four hours. It is a measure of the duration of the emergency department service rather than a waiting time for emergency department care.  A high or increasing proportion of patients with a length of stay of four hours or less is desirable.  Data reported for this indicator are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this measure is at www.pc.gov.au/research/recurring/report-on-government-services. |
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##### Emergency department waiting times by triage category

The comparability of emergency department waiting times data across jurisdictions can be influenced by differences in data coverage (2015 Report, table 11.2) and clinical practices — in particular, the allocation of cases to urgency categories.

Emergency department waiting times by Indigenous status, remoteness and socioeconomic status for peer group A and B hospitals are reported in the attachment (tables 11A.20 and 2015 Report, tables 11A.21–22). Nationally, there was little difference between Aboriginal and Torres Strait Islander and other 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 11A.20).

#### Waiting times for admitted patient services

‘Waiting times for admitted patient services’ is an indicator of governments’ objective to provide accessible services (box 11.4). 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 11.4 Waiting times for admitted patient services |
| ‘Waiting times for admitted patient services’ is defined by the following three measures:   * Overall elective surgery waiting times * Elective surgery waiting times by clinical urgency category * Presentations to emergency departments with a length of stay of 4 hours or less ending in admission.   Overall elective surgery waiting times  ‘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.  Data reported for this measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this measure is at [www.pc.gov.au/research/recurring/report-on-government-serv](http://www.pc.gov.au/research/recurring/report-on-government-serv)ices.  Elective surgery waiting times by clinical urgency category  ‘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: |
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| Box 11.4 (continued) |
| * 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  (2015 Report, table 11.3).  Data reported for this measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this measure is at www.pc.gov.au/research/recurring/report-on-government-services.  Presentations to emergency departments with a length of stay of 4 hours or less ending in admission  ‘Presentations to emergency departments with a length of stay of 4 hours or less ending in admission’ is defined as the percentage of presentations to public hospital emergency departments where the time from presentation to admission to hospital is less than or equal to four hours.  A high or increasing proportion of presentations to emergency departments with a length of stay of 4 hours or less ending in admission is desirable.  Data reported for this measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this measure is at www.pc.gov.au/research/recurring/report-on-government-services. |
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Attachment 11A includes data on elective surgery waiting times by hospital peer group, specialty of surgeon and indicator procedure. It also includes waiting times by Indigenous status, remoteness and socioeconomic status (table 11A.26, 2105 Report, tables 11A.24–25 and tables 11A.27–29). Nationally, Aboriginal and Torres Strait Islander Australians had longer waiting times for elective surgery than other Australians at the 50th percentile and 90th percentile (table 11A.26).

#### Separation rates for selected procedures

‘Separation rates for selected procedures’ is an indicator of the appropriateness of hospital services (box 11.5).

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| Box 11.5 Separation rates for selected procedures |
| ‘Separation rates for selected procedures’ is defined as separations per 1000 people for certain procedures in public hospitals. The procedures are selected for their frequency, for sometimes being elective and discretionary, and because alternative treatments are sometimes available.  Higher/lower or increasing/decreasing rates are not necessarily associated with inappropriate care. However, large jurisdictional variations in rates for particular procedures can require investigation to determine whether service levels are appropriate.  Care needs to be taken when interpreting differences in the separation rates for the selected procedures. Variations in rates can be attributable to variations in the prevalence of the conditions being treated, or to differences in clinical practice across states and territories. Higher rates can be acceptable for certain conditions and not for others. Higher rates of angioplasties, for example, can represent appropriate levels of care, whereas higher rates of hysterectomies or tonsillectomies can represent an over-reliance on procedures. Some of the selected procedures, such as angioplasty and coronary artery bypass graft, are alternative treatment options for people diagnosed with similar conditions.  Data reported for this indicator are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
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Data for private hospitals are reported in table 11A.48. Table 11A.48 also reports selected separations for all hospitals by Indigenous status, remoteness and socioeconomic status. Table 11A.49 reports additional information for the selected separations for all hospitals such as numbers of separations and the standardised separation rate ratio.

#### 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 11.6). 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 11.6 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:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
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Unplanned hospital readmission rates are reported by hospital peer group, Indigenous status, remoteness and socioeconomic status in table 11A.51.

#### Safety — adverse events in public hospitals

‘Adverse events in public hospitals’ is an indicator of governments’ objective to provide public hospital services that are safe and of high quality (box 11.7). Adverse events in public hospitals can result in serious consequences for individual patients, place a significant burden on the health system and are influenced by the safety of hospital practices and procedures. Sentinel events, which are a subset of adverse events that result in death or very serious harm to the patient, are reported separately in this chapter as an outcome indicator.

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| Box 11.7 Adverse events in public hospitals |
| ‘Adverse events in public hospitals’ is defined by the following three measures:   * healthcare-associated infections * adverse events treated in hospitals * falls resulting in patient harm in hospitals.   *Healthcare-associated infections*  ‘Healthcare-associated infections’ is the number of Staphylococcus aureus (including Methicillin-resistant Staphylococcus aureus [MRSA]) bacteraemia (SAB) patient episodes associated with public hospitals, expressed as a rate per 10 000 patient days for public hospitals reporting for the SAB indicator.  A patient episode of SAB is defined as a positive blood culture for SAB. Only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.  SAB is considered to be healthcare-associated if the first positive blood culture is collected more than 48 hours after hospital admission or less than 48 hours after discharge, or if the first positive blood culture is collected 48 hours or less after admission and one or more of the following key clinical criteria was met for the patient episode of SAB:   * SAB is a complication of the presence of an indwelling medical device * SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site * an invasive instrumentation or incision related to the SAB was performed within 48 hours * SAB is associated with neutropenia (<1x109/L) contributed to by cytotoxic therapy.   Cases where a known previous blood culture has been obtained within the last 14 days are excluded. Patient days for unqualified newborns are included. Patient days for hospital boarders and posthumous organ procurement are excluded.  A low or decreasing healthcare-associated infections rate is desirable.  Data reported for this measure are:   * comparable (subject to caveats) within jurisdictions over time but are not comparable across jurisdictions * complete (subject to caveats) for the current reporting period. All required 2013-14 data are available for all jurisdictions.   Data quality information for this measure is at www.pc.gov.au/research/recurring/report-on-government-services. |
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| Box 11.7 (continued) |
| *Adverse events treated in hospitals*  ‘Adverse events treated in hospitals’ are incidents in which harm resulted to a person during hospitalisation. They are measured by separations that had an adverse event, including infections, falls resulting in injuries and problems with medication and medical devices that occurred during a hospitalisation. Hospitalisation is identified by diagnoses, places of occurrence and external causes of injury and poisoning that can indicate that an adverse event was treated and/or occurred during the hospitalisation.  Low or decreasing adverse events treated in hospitals is desirable.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.   Data quality information for this measure is at www.pc.gov.au/research/recurring/report-on-government-services.  *Falls resulting in patient harm in hospitals*  ‘Falls resulting in patient harm in hospitals’ is defined as the number of separations with an external cause code for fall and a place of occurrence of health service area, expressed as a rate per 1000 hospital separations.  It is not possible to determine if the place of occurrence was a public setting, only that it was a health service area.  A low or decreasing rate of falls resulting in patient harm in hospitals is desirable.  Data reported for this measure are:   * comparable (subject to caveats) across jurisdictions and over time * complete (subject to caveats) for the current reporting period. All required 2012-13 data are available for all jurisdictions.   Data quality information for this measure is at www.pc.gov.au/research/recurring/report-on-government-services. |
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Data are reported by Indigenous status and remoteness in table 11A.55.

### 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 11.3). The performance indicator framework shows which data are comparable in the 2015 Report. For data that are not considered directly comparable, text includes relevant caveats and supporting commentary. Chapter 1 discusses data comparability and data completeness from a Report-wide perspective (2015 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 context chapter 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 Aboriginal and Torres Strait Islander and ethnic status) (chapter 2).

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| Figure 11.3 Maternity services performance indicator framework |
| |  | | --- | | Figure 11.26 Maternity services performance indicator framework   More details can be found within the text surrounding this image. | |
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*Source*: 2015 Report, figure 11.26, p. 11.67.

### Outcomes

Outcomes are the impact of services on the status of an individual or group (while outputs are the services delivered) (see 2015 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 11.8).

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| Box 11.8 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 11.8 in the 2015 Report 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 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 across 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 (subject to caveats) across jurisdictions and over time * incomplete for the current reporting period. All required data for Aboriginal and Torres Strait Islander people were not available for Victoria, Tasmania and the ACT.   Data quality information for this indicator is at www.pc.gov.au/research/recurring/report-on-government-services. |
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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. These five states and territories are considered to have adequate levels of identification of Aboriginal and Torres Strait Islander people in mortality data (ABS 2004). There was significant variation in the fetal death rates for Aboriginal and Torres Strait Islander Australians for the five jurisdictions for which data are available (figure 11.4).

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| Figure 11.4 Fetal death rate by Indigenous status of mother 2008–2012**a** |
| |  | | --- | | Figure 11.35 Fetal death rate by Indigenous status of mother 2008–2012  More details can be found within the text surrounding this image. | |
| a Data are reported individually by jurisdiction of residence of mother for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. Data are not available for other jurisdictions. The total relates to those jurisdictions for which data are published. |
| *Source*: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 11A.121; 2015 Report,  figure 11.35, p. 11.83. |
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##### Neonatal death rate

Neonatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have adequate levels of identification of Aboriginal and Torres Strait Islander people in mortality data (ABS 2004). In four of the jurisdictions for which data are available, the neonatal death rates for Aboriginal and Torres Strait Islander Australians are higher than those for other Australians (figure 11.5).

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| Figure 11.5 Neonatal death rate by Indigenous status of mother  2008–2012**a** |
| |  | | --- | | Figure 11.37 Neonatal death rate by Indigenous status of mother  2008–2012  More details can be found within the text surrounding this image. | |
| a Data are reported individually by jurisdiction of residence of mother for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. Data are not available for other jurisdictions. The total relates to those jurisdictions for which data are published. |
| *Source*: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 11A.121; 2015 Report,  figure 11.37, p. 11.84. |
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##### Perinatal death rate

Perinatal deaths data by the Indigenous status of the mother are available for NSW, Queensland, WA, SA and the NT only. These five states and territories are considered to have adequate levels of identification of Aboriginal and Torres Strait Islander people in mortality data (ABS 2004). In three of the jurisdictions for which data are available, perinatal death rates for Aboriginal and Torres Strait Islander Australians are higher than those for other Australians (figure 11.6).

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| Figure 11.6 Perinatal death rate by Indigenous status of mother  2008–2012**a** |
| |  | | --- | | Figure 11.39 Perinatal death rate by Indigenous status of mother  2008–2012  More details can be found within the text surrounding this image. | |
| a Data are reported individually by jurisdiction of residence of mother for NSW, Queensland, WA, SA and the NT only. These jurisdictions have evidence of sufficient levels of identification and sufficient numbers of deaths. Data are not available for other jurisdictions. The total relates to those jurisdictions for which data are published. |
| *Source*: ABS (unpublished) *Perinatal deaths, Australia*, Cat. no. 3304.0; table 11A.121; 2015 Report,  figure 11.39, p. 11.86. |
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### Future directions in performance reporting

Priorities for future reporting on public hospitals and maternity services include improving the quality of data on Aboriginal and Torres Strait Islander Australians. Work on improving the identification of Aboriginal and Torres Strait Islander people in hospital admitted patient data across states and territories is ongoing.

### Definitions of key terms

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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. |
| **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 Aboriginal and Torres Strait Islander people’s health. |
| **Length of stay** | The period from admission to separation less any days spent away from the hospital (leave days). |
| **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 (where the newborn does not require acute 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). |

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| **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 an ‘A’ prefix (for example, table 11A.1 is table 1). Attachment tables are provided on the Review website (www.pc.gov.au/research/recurring/report-on-government-services).

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| **Table 11A.10** | Separations by hospital sector and Indigenous status of patient |
| **Table 11A.11** | Separations per 1000 people, by Indigenous status of patient (number) |
| **Table 11A.20** | Patients treated within national benchmarks for emergency department waiting time, by Indigenous status, by State and Territory |
| **Table 11A.26** | Waiting times for elective surgery in public hospitals, by Indigenous status and procedure, by State and Territory (days) |
| **Table 11A.48** | Separation statistics for selected hospital procedures per 1000 people, all hospitals 2012-13 |
| **Table 11A.51** | Unplanned hospital readmission rates, by Indigenous status, hospital peer group, remoteness and SEIFA IRSD quintiles, 2012-13 |
| **Table 11A.55** | Separations for falls resulting in patient harm in hospitals, per 1000 separations, 2012-13 |
| **Table 11A.121** | Perinatal, neonatal and fetal deaths |

### References

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

AIHW (Australian Institute of Health and Welfare) 2000, 2001, 2006, 2009, 2010, 2011, 2012, 2013, 2014, *Australian Hospital Statistics*, Cat. nos HSE 11, 14, 41, 71, 84, 107, 117, 134 and 145 AIHW, Canberra.