Australian Government
Australian Institute of Health and Welfare

Australia's hospitals 2010–11

at a glance

Australia's hospitals
2010–11

at a glance

Health services series no. 44
April 2012

Australian Institute of Health and Welfare
Canberra

The Australian Institute of Health and Welfare is a major national agency which provides reliable, regular and relevant information and statistics on Australia's health and welfare. The Institute's mission is *authoritative information and statistics to promote better health and wellbeing*.

This publication is part of the Australian Institute of Health and Welfare's Health services series. A complete list of the Institute's publications is available from the Institute's website <www.aihw.gov.au>.

ISSN 1036-613X

ISBN 978-1-74249-293-3

Suggested citation

Australian Institute of Health and Welfare 2012. Australia's hospitals 2010–11, at a glance. Health services series no. 44. Cat. no. HSE 118. Canberra: AIHW.

Any enquiries about or comments on this publication should be directed to:

Communications, Media and Marketing Unit
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601
Tel: (02) 6244 1032
Email: info@aihw.gov.au

Published by the Australian Institute of Health and Welfare

Please note that there is the potential for minor revisions of data in this report. Please check the online version at <www.aihw.gov.au> for any amendments.

Contents

Introduction

Hospitals are an important part of Australia's health landscape, providing services to many Australians each year.

A summary measure of the significance of Australia's hospitals is the amount that is spent on them—an estimated $46.3 billion in 2009–10, about 3.7% of Australia's gross domestic product, or about $2,181 per person (AIHW 2011). Hospital spending has been increasing faster than inflation—adjusted for inflation, it increased by 5.0% each year, on average, between 2004–05 and 2009–10.

Access to our hospital services, the quality of the services, as well as funding and management arrangements for them are under constant public scrutiny. This summary report presents an overview of statistics on our hospitals that can serve as a background to public discussion and debate.

While most data for this report are for 2010–11, some data for private hospitals were only available for 2009–10.

More detailed statistics and information on how to interpret the data can be found in the companion report, *Australian hospital statistics 2010–11*. Further detail is also available in spreadsheets and interactive data cubes at <www.aihw.gov.au>.

How many hospitals are there?

In Australia, hospital services are provided by both public and private hospitals.

The state and territory governments mainly own and manage public hospitals. Public acute hospitals mainly provide 'acute care' for short periods, although some provide longer term care, such as for rehabilitation. Public psychiatric hospitals specialise in the care of people with mental health problems, sometimes for long periods of time.

Private hospitals are mainly owned and managed by private organisations; either for-profit companies, or not-for-profit non-government organisations. They include day hospitals that provide services on a day-only basis, and hospitals that provide overnight care.

Between 2006–07 and 2010–11, the numbers of public acute hospitals and private hospitals were relatively stable.

In 2010–11, there were 1,340 hospitals in Australia:

- 735 public acute hospitals
- 17 public psychiatric hospitals
- 303 private free-standing day hospitals
- 285 other private hospitals.

The numbers for these hospitals in each state and territory are shown in Table 1.

Table 1: Public and private hospitals, states and territories, 2010–11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Public acute hospitals	218	150	166	93	78	22	3	5	735
Public psychiatric hospitals	8	1	4	1	2	1	..	..	17
Total public hospitals	*226*	*151*	*170*	*94*	*80*	*23*	*3*	*5*	*752*
Private hospitals									
Private free-standing day hospitals	91	85	53	34	28	2	9	1	303
Other private hospitals	86	81	53	24	31	6	3	1	285
Total private hospitals	*177*	*166*	*106*	*58*	*59*	*8*	*12*	*2*	*588*
All hospitals	**403**	**317**	**276**	**152**	**139**	**31**	**15**	**7**	**1,340**

How many beds are there?

As hospital sizes vary considerably, the number of beds is a better indicator of the availability of hospital services than is the number of hospitals. However, the range and types of patients that different hospitals treat (or their 'casemix') can affect the comparability of hospital bed numbers. Hospitals with different casemixes will have differing proportions of beds available for specialised and more general purposes.

Beds counted are those available for use—with appropriate staffing. The counts are not of actual physical beds, as not all may be in use. Chairs used for some same-day treatments such as chemotherapy are also included.

In 2010–11, there were:

- 55,789 beds in public acute hospitals
- 1,983 beds in public psychiatric hospitals
- 2,822 beds in private free-standing day hospitals (based on 2009–10 data, ABS 2011)
- 24,926 beds in other private hospitals (based on 2009–10 data, ABS 2011).

The number of hospital beds increased by 2.5% between 2006–07 (82,582 beds) and 2009–10 (84,648 beds), an annual average increase of less than 1%.

There was a relatively large decrease for public psychiatric hospitals over this period, reflecting the continuation of the long-term trend to deinstitutionalise services for people with mental illness, and the trend to integrate specialist psychiatric services with public acute care hospital services.

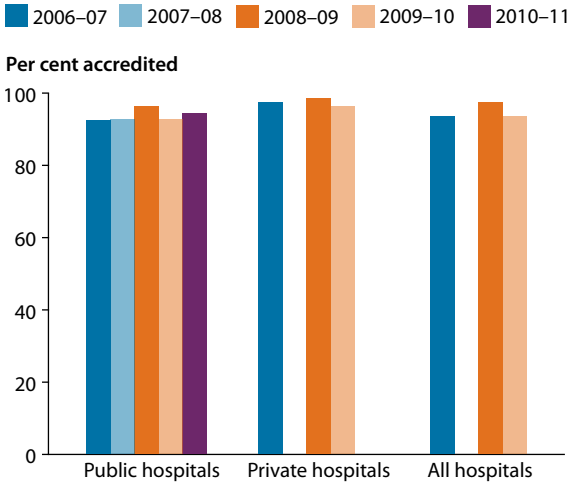
Hospital performance: **accreditation**

Hospital accreditation is regarded as a performance indicator relevant to the effectiveness of hospital services. Hospitals can be accredited through organisations such as the Australian Council on Healthcare Standards, Business Excellence Australia, and the Quality Improvement Council, or through certification with the International Organization for Standardization's 9000 quality family.

A total of 681 public hospitals with 56,545 beds (98% of public hospital beds) were known to be accredited at 30 June 2011 (Figure 1). These hospitals provided 99% of public hospital separations (completed episodes of admitted patient care) and 98% of patient days (days spent in hospital as an admitted patient).

The latest private hospital data, available from the ABS, are for 2009–10. A total of 543 private hospitals and 27,045 private hospital beds (93% of hospitals, covering 97% of beds) were accredited that year.

The proportions of accredited hospitals and beds in accredited hospitals have not changed much over recent years, reflecting continuing requirements of funding organisations for hospitals to be accredited. Between 2006–07 and 2010–11, 90% or more of hospital beds were in accredited hospitals.



Note: Accreditation statistics were not available for private hospitals for 2007–08 and 2010–11.

Figure 1: Proportion of hospital beds that were in accredited public and private hospitals, 2006–07 to 2010–11

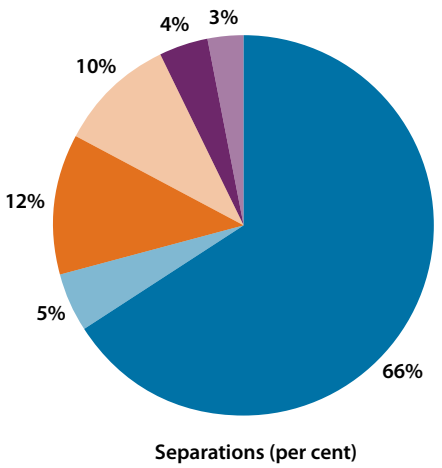
How diverse are public hospitals?

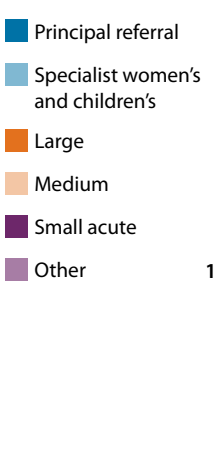
The 752 public hospitals are very diverse in size and the types of services provided for admitted and non-admitted patients (Table 2). The diversity of admitted patient services provided by each type can be gauged by the average number of diagnosis related groups reported (AR-DRGs). In 2010–11, there were:

- 78 *Principal referral* hospitals, located mainly in major cities, with at least one in each state and territory. They provided a wide range of services, including emergency department, outpatient and admitted patient services (including 5 or more separations for 431 AR-DRGs on average). These hospitals accounted for a total of 3.6 million separations or 66% of the total for public hospitals (Figure 2). There was a total of 11.5 million days spent by patients in these hospitals or 63% of the total for public hospitals (Figure 3).
- 11 *Specialist women's and children's* hospitals, located in Sydney, Melbourne, Brisbane, Perth and Adelaide. They recorded an average of 21,429 separations, specialising in maternity and other specialist services for women, and/or specialist paediatric services.
- 41 *Large* hospitals, 24 in major cities and 17 in regional and remote areas. They provided emergency department, outpatient and admitted patient services, generally with a range of activities less than that of the Principal referral hospitals (5 or more separations for 249 AR-DRGs), with an average of 16,094 separations per hospital.
- 88 *Medium* hospitals, 22 in major cities and 66 in regional areas. They delivered an average of 6,154 separations per hospital (with a narrower range of services than the Large hospitals). Most provided emergency services (rather than formal emergency departments) and some had outpatient clinics.
- 155 *Small acute* hospitals, 115 in regional areas and 40 in remote areas. They delivered mainly acute care for admitted patients, with an average of 1,294 separations per hospital, with a relatively narrow range of services. They generally did not have emergency departments although most provided emergency services.
- 17 *Psychiatric* hospitals, specialising in the treatment and care of people with mental health problems. They were located in Sydney, Melbourne, Brisbane, Perth, Adelaide and Hobart with 3 in regional Queensland centres.
- 8 specialist *Rehabilitation* hospitals, located in Sydney, Perth, Adelaide and Wollongong and two regional areas.
- 8 specialist *Mothercraft* hospitals, located in Sydney, Melbourne, Brisbane and Canberra.
- 82 *Small non-acute* hospitals, mainly in regional and remote areas. The services they provided tended to be mainly non-acute, so the average length of stay was longer than for hospitals that provided mainly acute care.
- 77 *Multipurpose services*, mainly in regional and remote areas. These hospitals were generally combined with services for residential aged care, and mainly provided non-acute admitted patient care.
- 187 other hospitals, mainly small hospitals or particular specialist hospitals, such as hospices.

Table 2: The diversity of public hospitals, 2010–11

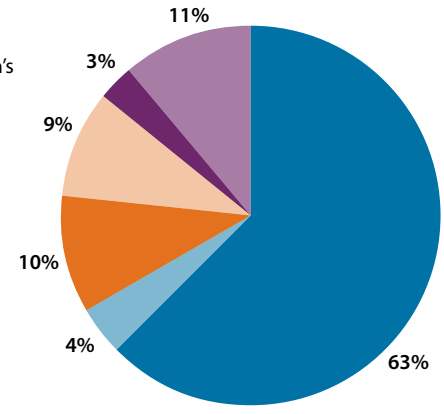
Hospital type	Number of hospitals								Beds (average)	Separations (average)	Average length of stay (days)	Non-acute care (patient days %)	AR-DRGs (5+) per hospital
	Location				Services provided								
	Major cities	Regional	Remote	Total	Emergency departments	Other emergency services	Outpatient clinics	Elective surgery					
Principal referral	52	25	1	78	78	78	77	76	415	44,444	3.3	8.9	431
Specialist women's and children's	11	0	0	11	9	9	11	11	207	21,429	3.1	0.5	224
Large	24	16	1	41	39	39	40	33	140	16,094	2.9	14.0	249
Medium	22	66	0	88	30	73	8	50	66	6,154	3.1	25.4	134
Small acute	0	115	40	155	21	149	3	18	21	1,294	2.9	8.9	49
Psychiatric	12	5	0	17	0	0	0	0	117	608	59.5	50.1	7
Rehabilitation	6	2	0	8	0	1	1	1	63	1,095	19.5	89.4	15
Mothercraft	8	0	0	8	0	0	0	0	27	1,755	3.7	0.0	11
Small non-acute	14	55	13	82	4	64	1	5	32	872	10.0	71.5	33
Multi-purpose services	0	45	32	77	0	69	0	0	12	350	4.2	34.0	14
Other	32	87	68	187	6	120	0	0	11	273	9.6	79.8	5
Total	181	418	155	752	187	602	141	194	77	7,031	3.5	17.1	94





Separations (per cent)

Figure 2: Separations for admitted patients, by public hospital type, 2010–11



Patient days (per cent)

Figure 3: Patient days for admitted patients, by public hospital type, 2010–11

The majority of beds were in larger hospitals and in more densely populated areas. In 2010–11, the largest public hospital had over 1,000 beds, but over 70% of hospitals had fewer than 50 beds.

The proportion of hospital beds in different size hospitals varied greatly by state and territory. The Northern Territory did not have any public hospitals with either more than 500 beds, or 10 beds or fewer. For South Australia, almost 30% of public hospital beds were in hospitals with fewer than 50 beds (Figure 4).

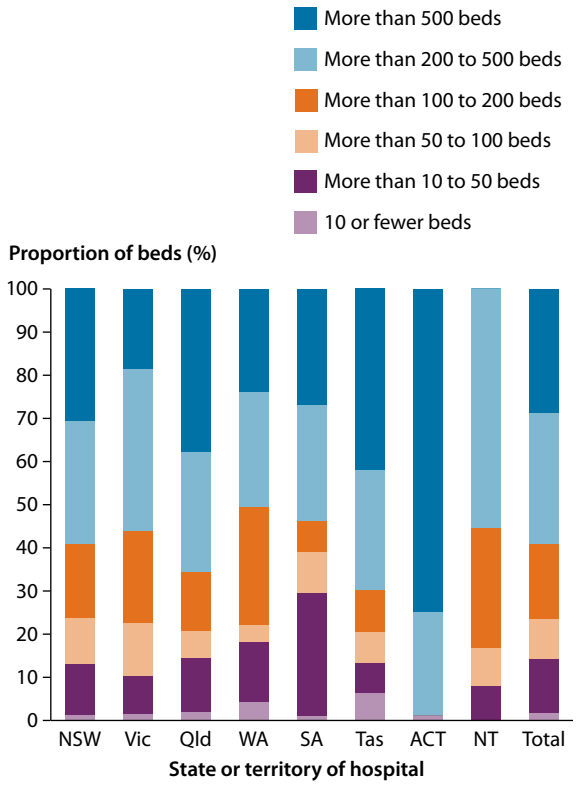


Figure 4: Proportion of beds by hospital size, states and territories, public hospitals, 2010–11

How many people are employed in Australia's hospitals?

Australia's public hospitals employed about 263,000 full-time equivalent staff in 2010–11, and private hospitals employed over 59,000 in 2009–10 (ABS 2011).

Hospital employees include medical officers (such as surgeons, anaesthetists and other specialists), nurses, diagnostic and allied health professionals (such as physiotherapists and occupational therapists), administrative and clerical staff, and domestic and other personal care staff.

These statistics do not include visiting medical officers in public hospitals (who are paid on contract, rather than as staff) and most medical officers who provide services in private hospitals (where the patients and Medicare mainly cover payment, rather than the hospitals).

Public hospitals

The largest staffing category in public hospitals is nurses, who made up 45% of the full-time equivalent staff numbers in 2010–11. Medical officers comprised 12% of staff and diagnostic and allied health professionals together comprised 14%.

The number of salaried medical officers increased by an annual average of 7.4% between 2006–07 and 2010–11, to 32,500. The number of nurses increased by an annual average of 3.5%, to 119,000 in 2010–11 (Figure 5).

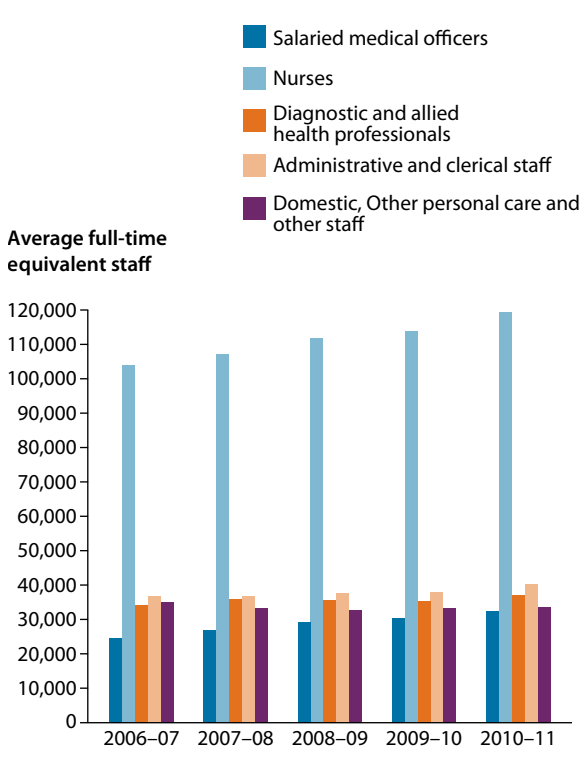


Figure 5: Average full-time equivalent staff, public hospitals, 2006–07 to 2010–11

Private hospitals

The staffing mix in private hospitals is somewhat different from that in public hospitals, because most medical services are not provided by hospital employees and the range of services provided is different. The largest staffing category in private hospitals is nurses, who made up 57% of full-time equivalent staff numbers in 2009–10. Medical officers and diagnostic and allied health professionals together comprised 8% of full-time equivalent staff (ABS 2011).

How much do hospitals spend?

Hospital expenditure includes recurrent expenditure and capital expenditure. Recurrent expenditure is money that is spent on goods and services that are consumed during the year, for example, salaries. Capital expenditure includes money spent on buildings and large pieces of equipment.

Public hospitals

In 2010–11, recurrent expenditure by public hospitals was $36,985 million (excluding depreciation). After adjusting for inflation, this represented an increase of 8.2% compared with 2009–10.

Over 62% of this expenditure was for salary payments ($22,959 million) (Figure 6).

About 70% of recurrent expenditure was on admitted patient services—rather than emergency department, outpatient and other services for non-admitted patients, and other hospital activities.

Between 2006–07 and 2010–11, recurrent expenditure by public hospitals increased by an average of 5.9% per year (after adjusting for inflation) (Figure 7).

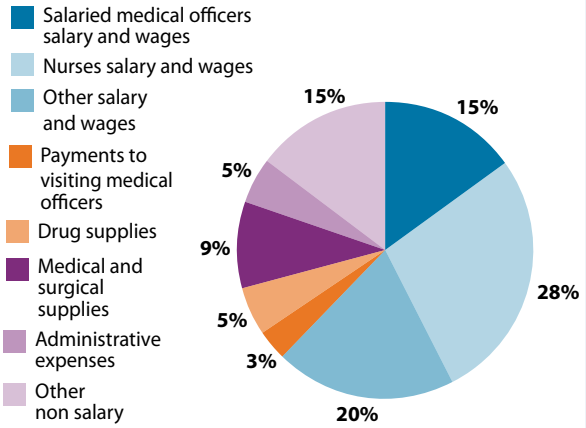


Figure 6: Recurrent expenditure, public hospitals, 2010–11

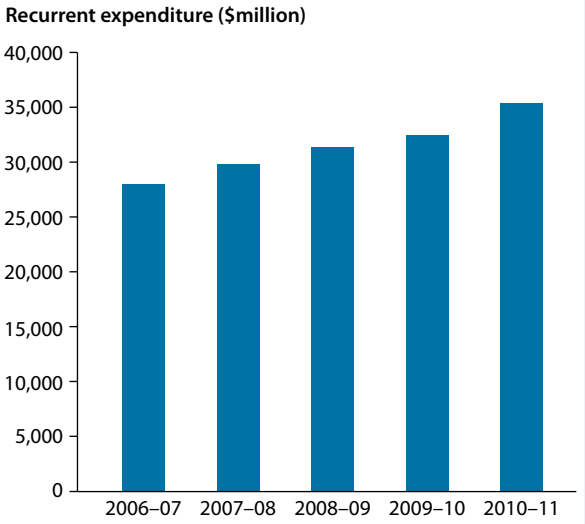


Figure 7: Recurrent expenditure, adjusted for inflation, public hospitals, 2006–07 to 2010–11

Private hospitals

In 2009–10, recurrent expenditure by private hospitals was $8,946 million (including depreciation).

About 51% of this expenditure was for salary payments ($4,552 million).

Between 2005–06 and 2009–10, recurrent expenditure by private hospitals increased by an average of 8.3% per year (after adjusting for inflation) (ABS 2011).

How are our hospital services funded?

Public and private hospitals are funded from a range of different sources, reflecting the types of patients they treat and the services they provide. Governments mainly fund emergency department and outpatient services, whereas admitted patient services are commonly funded by private (non-government) sources, as well as government sources.

The sources of funds reported here are the original sources rather than immediate sources. Hence, the Australian Government is regarded as the source of funds for the contributions that it made for public hospitals via intergovernmental agreements, even though the funds were provided to the state and territory governments that actually spent the money on public hospitals. The Australian Government is also regarded as the source of funds for the contributions it made to private hospitals via the private health insurance premium rebates, even though the funds were provided through health insurance funds or their members.

In general terms, the state and territory governments and the Australian Government provide most of the funds for public hospitals (Figure 8) (AIHW 2011). The proportion of funding that was from the Australian Government increased between 2007–08 and 2009–10 (Figure 10). Private hospitals are mainly funded by private health insurance and out-of-pocket payments by patients (Figure 9).

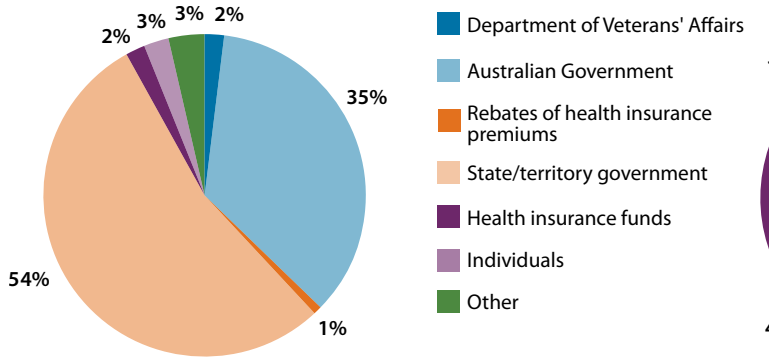


Figure 8: Funding sources for public hospitals, 2009–10

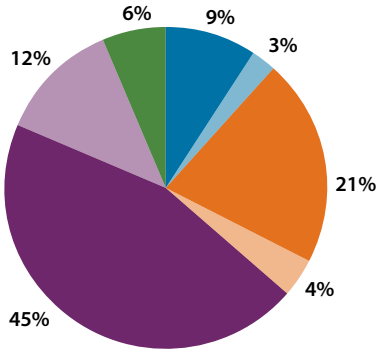


Figure 9: Funding sources for private hospitals, 2009–10

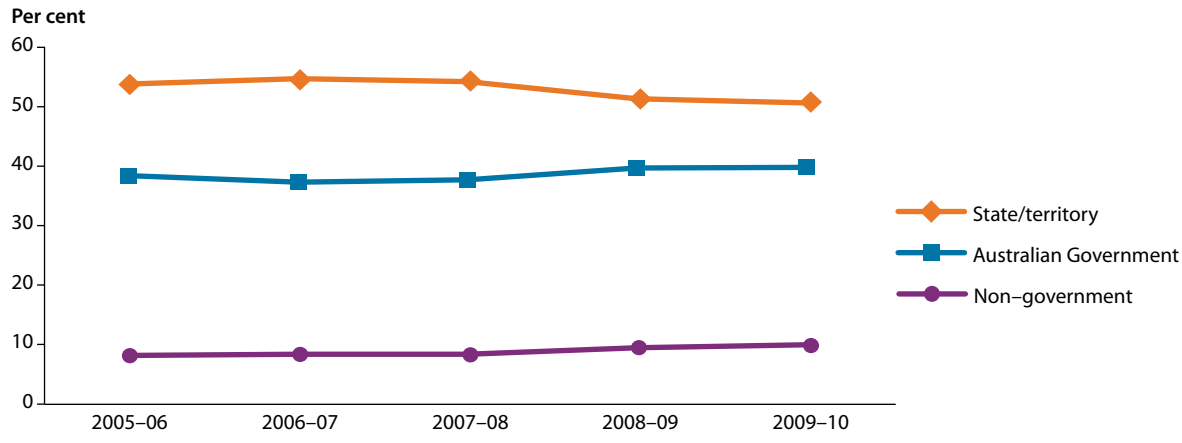


Figure 10: Funding sources for public hospitals, 2005–06 to 2009–10

What services do Australia's hospitals provide?

Australia's hospitals provide a range of services for both non-admitted and admitted patients. Services for non-admitted patients include emergency department services and outpatient clinics. For admitted patients, they include emergency and planned (elective) care, maternity services, and medical and surgical services. These admitted patient services are either provided on a same-day basis or involving a stay in hospital overnight or longer.

Variation in data on hospital services

Although there are national standards for data on hospital services, there are some variations in how hospital services are defined and counted, between public and private hospitals, among the states and territories, and over time.

For example, there is variation in admission practices for some services, such as chemotherapy and endoscopy. As a result, people receiving the same type of service may be counted as same-day admitted patients in some hospitals, and as non-admitted patients in other hospitals.

In addition, some services are provided by hospitals in some jurisdictions, and by non-hospital health services in other jurisdictions. The national data on hospital care does not include care provided by non-hospital providers, such as community health centres.

More detailed information on these variations is included in *Australian hospital statistics 2010–11* (AIHW 2012).

Emergency department services

Emergency departments provide care for patients who may have an urgent need for medical, surgical or other care. Emergency departments may also provide services for patients returning for further care, or for patients waiting to be admitted to a ward. About one in four presentations to emergency departments ends with the patient being admitted to hospital.

Public hospitals provide most emergency department services. Private hospitals provided about 527,000 emergency department services in 2009–10 (ABS 2011), about 6% of the total for that year.

Public hospitals

There were about 7.7 million emergency visits to public hospitals in 2010–11. Between 2006–07 and 2010–11, they increased by an average of 3.2% per year (Figure 11).

These visits include both those to formal emergency departments in larger hospitals and those to smaller hospitals (commonly in more remote areas) with other arrangements for providing emergency services.

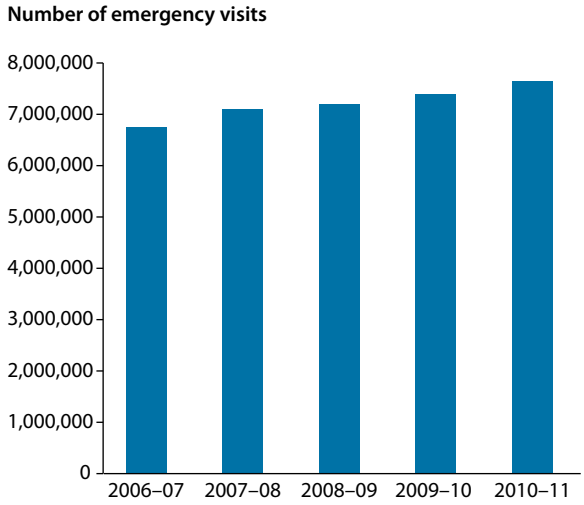


Figure 11: Public hospital emergency visits, 2006–07 to 2010–11

Hospital performance: emergency department waiting times

Each patient who presents to an emergency department is assessed according to how urgently they should receive care, using a triage category system. The most urgent cases are assigned to the *Resuscitation* triage category (should be treated immediately), and the least urgent are assigned as *Non-urgent* (should be seen within 2 hours).

Data on triage category and waiting times were available for 6.2 million emergency department presentations in major public hospitals (about 81% of all emergency visits to public hospitals). A total of 5.4 million of those (88%) were in Principal referral and specialist women's and children's hospitals and Large hospitals.

In 2010–11:

- 70% of patients were seen within the recommended time for their triage category, ranging from 65% for *Urgent* patients, to 100% for *Resuscitation* patients (Figure 12)
- 50% of patients received care in 23 minutes or less and 90% received care in 114 minutes or less.

The proportion of patients seen within the recommended time for their triage category remained relatively stable between 2006–07 and 2010–11, despite increasing numbers of emergency department presentations. *Resuscitation* patients were seen on time for either 99% or 100% of presentations each year, and *Emergency* patients were seen on time (within 10 minutes) for between 76% and 79% of presentations.

There was some variation in the proportion seen on time between jurisdictions, ranging from 58% overall for the Australian Capital Territory and the Northern Territory to 76% overall in New South Wales (Table 3). More information on the proportion seen on time by triage category for each state and territory can be found in figures 12a–12h, accompanying this report online.

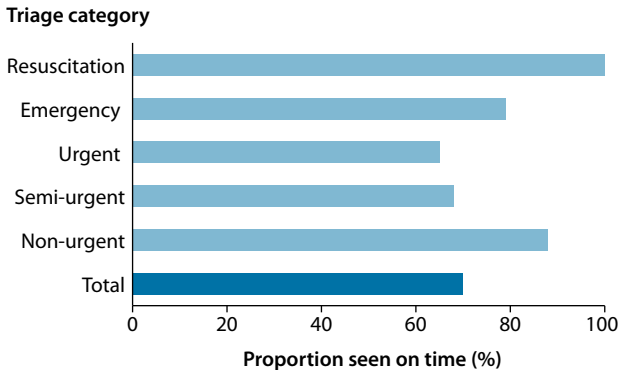


Figure 12: Proportion of presentations seen on time, public hospital emergency departments, 2010–11

Table 3: Proportion (%) of presentations seen on time by triage category, public hospital emergency departments, states and territories, 2010–11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					('000)				
Total emergency visits	2,054	1,483	1,195	649	384	144	112	141	6,163
Triage category					**Per cent**				
Resuscitation	100	100	100	99	100	100	100	100	100
Emergency	83	81	78	71	78	72	82	65	79
Urgent	71	70	60	50	66	55	54	53	65
Semi-urgent	73	65	67	65	70	63	49	54	68
Non-urgent	88	86	90	92	88	83	76	90	88
Total	**76**	**71**	**67**	**63**	**71**	**62**	**58**	**58**	**70**

Outpatient care

Outpatient care is provided in outpatient clinics, particularly by public hospitals, but also by private hospitals. Both types of hospitals also provide other non-admitted patient services (other than emergency department services) and various outreach services, such as district nursing.

Public hospitals

Outpatient clinic care includes consultations with specialists to determine the most appropriate treatment for a patient's condition. This can result, for example, in the patient being placed on a waiting list for surgery.

Other care provided to non-admitted patients includes the dispensing of medication, and provision of diagnostic procedures, including pathology, X-rays and ultrasounds—often provided in association with admitted patient care or outpatient clinic services. District and community nursing services are also delivered from hospitals for non-admitted patients.

In 2010–11, public hospitals provided almost 43 million services for non-admitted patients:

- specialist outpatient clinics delivered 16.7 million services, with the chief contributors being medical/surgical/obstetric and allied health. Most (13.0 million or 78%) were in Principal referral and specialist women's and children's hospitals and Large hospitals.
- mental health and alcohol and drug services delivered 3.4 million service episodes.
- pharmacy, pathology, radiology and organ imaging made up a further 17.2 million services
- district nursing, outreach and community health services accounted for 5.3 million service episodes
- 318,000 service episodes were for group sessions (provided to more than one patient at a time), with mental health, alcohol and drug and community health accounting for about a third of these sessions.

Between 2006–07 and 2010–11, outpatient care delivered in specialist outpatient clinics increased by an average of 1.3% per year; pharmacy, pathology and radiology and organ imaging services increased by 3.6% per year; mental health and alcohol and drug services increased by 1.8% per year; and district nursing, outreach and community health services decreased by about 1.1% per year (Figure 13).

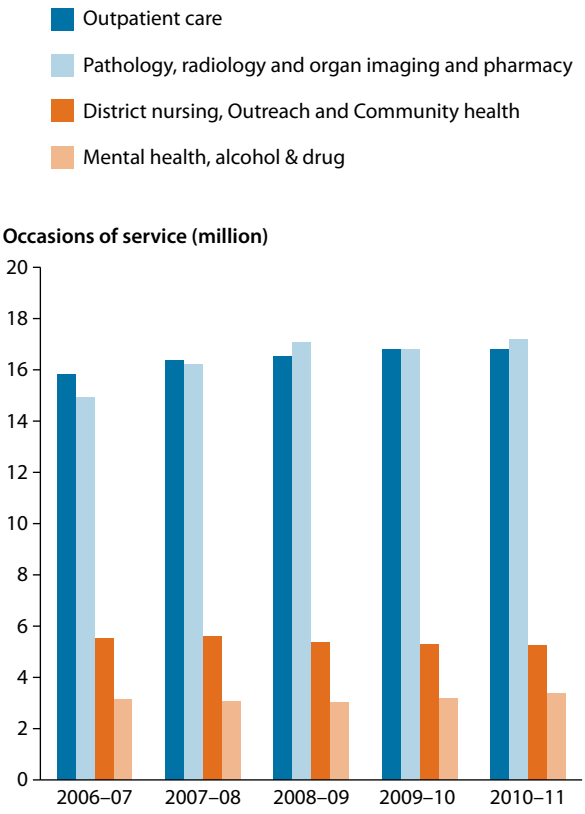


Figure 13: Non-admitted patient services, public hospitals, 2006–07 to 2010–11

Private hospitals

In 2009–10, private hospitals provided about 1.5 million non-admitted patient services (3.5% of the total for public and private hospitals), with about 1.3 million of these for outpatient services including dialysis, radiology and organ imaging, endoscopy, psychiatric, alcohol and drug, other medical/surgical/diagnostic, dental, pharmacy and allied health services. They also provided about 223,000 other services for non-admitted patients: community health, district nursing and non-medical and social services (4.1% of the total for public and private hospitals) (ABS 2011).

Admitted patient care: overview

Admission to hospital is a formal process, and follows a medical officer making a decision that a patient needs to be admitted for appropriate management or treatment of their condition, or for appropriate care or assessment of their needs.

Separations (episodes of admitted patient care) and patient days (a count of the days spent in hospital as an admitted patient) are useful measures of admitted patient services.

In 2010–11:

- about 8.9 million separations took place in Australian hospitals (Table 4)
- public hospitals accounted for 60% of separations (5.3 million), with half of these being same-day separations
- the proportion of the total that was in public hospitals ranged from 53% in Queensland to 63% in Victoria
- private hospitals accounted for 40% of separations (3.6 million), with about two-thirds of these being same-day separations (Figure 14)
- most patient days occurred in public hospitals, ranging from 61% in Queensland to 73% in New South Wales (Table 5).

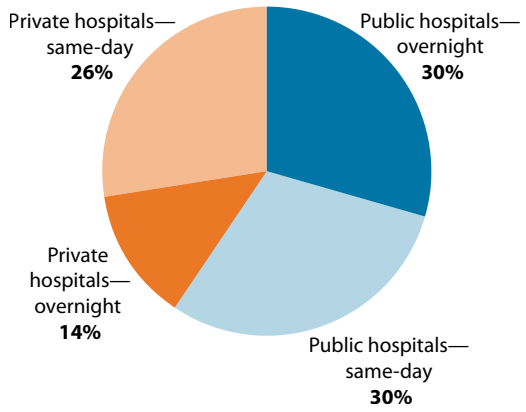


Figure 14: Same-day and overnight separations, public and private hospitals, 2010–11

Table 4: Separations ('000s), public and private hospitals, states and territories, 2010–11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Public acute	1,577	1,496	964	547	388	99	94	104	5,269
Public psychiatric	6	<1	<1	1	2	<1	. .	. .	10
Total public hospitals	*1,583*	*1,496*	*964*	*548*	*390*	*99*	*94*	*104*	*5,279*
Private hospitals									
Private free-standing day hospitals	217	198	210	114	61	n.p.	n.p.	n.p.	809
Other private hospitals	794	678	649	304	222	n.p.	n.p.	n.p.	2,764
Total private hospitals	*1,012*	*875*	*859*	*417*	*283*	*n.p.*	*n.p.*	*n.p.*	*3,573*
All hospitals	**2,595**	**2,372**	**1,824**	**966**	**673**	**n.p.**	**n.p.**	**n.p.**	**8,853**

n.p. *not published*
. . *not applicable*

Table 5: Patient days ('000s), public and private hospitals, states and territories, 2010–11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Public acute	5,918	4,680	3,105	1,719	1,502	372	312	288	17,894
Public psychiatric	274	43	102	60	113	1	. .	. .	593
Total public hospitals	*6,192*	*4,723*	*3,206*	*1,779*	*1,615*	*373*	*312*	*288*	*18,487*
Private hospitals									
Private free-standing day hospitals	218	198	210	114	61	n.p.	n.p.	n.p.	809
Other private hospitals	2,113	1,969	1,883	772	565	n.p.	n.p.	n.p.	7,598
Total private hospitals	*2,330*	*2,167*	*2,093*	*886*	*626*	*n.p.*	*n.p.*	*n.p.*	*8,408*
All hospitals	**8,523**	**6,889**	**5,300**	**2,665**	**2,240**	**n.p.**	**n.p.**	**n.p.**	**26,895**

n.p. *not published*
. . *not applicable*

How has this activity changed over time?

Between 2006–07 and 2010–11, separations increased by 16.7% overall (13.3% in public acute hospitals and 21.5% in private hospitals). This was an average increase of 3.9% per year (Figure 15).

The number of patient days in public acute hospitals increased by 6.3%. For private hospitals, patient days increased by 12.3%.

The numbers of patient days per 1,000 population were relatively stable for private hospitals between 2006–07 and 2010–11 and decreased slightly for public hospitals.

Between 2009–10 and 2010–11, separations increased overall by 3.8% (4.2% in public hospitals and 3.2% in private hospitals). Patient days increased by 2.0% overall, by 2.1% in public hospitals and 1.8% in private hospitals. After adjusting for some coverage changes, separations increased by 4.1% in public hospitals and 3.9% in private hospitals.

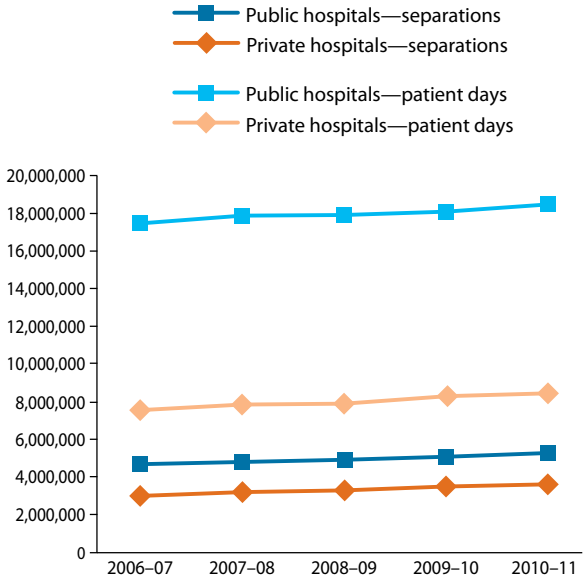


Figure 15: Separations and patient days, public acute and private hospitals, 2006–07 to 2010–11

Who used these services?

In 2010–11, there were over 4.6 million separations for women and girls compared with 4.2 million separations for men and boys (52.4% and 47.6% of separations respectively) (Figure 16). People aged 65 and over accounted for 38% of separations and 48% of patient days.

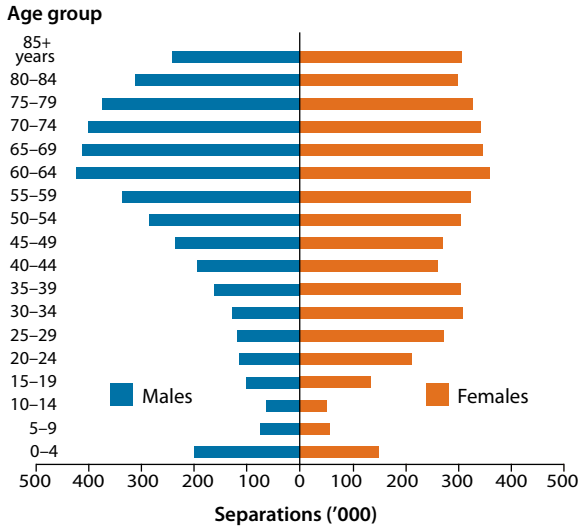


Figure 16: Separations, by age group and sex, all hospitals, 2010–11

Separations increased for both males and females between 2006–07 and 2010–11. These increases were very marked for both men and women aged 55 and over (Figure 17).

For persons aged 85 and over, there was an overall increase of 41% in separations between 2006–07 and 2010–11, an average increase of 9% each year.

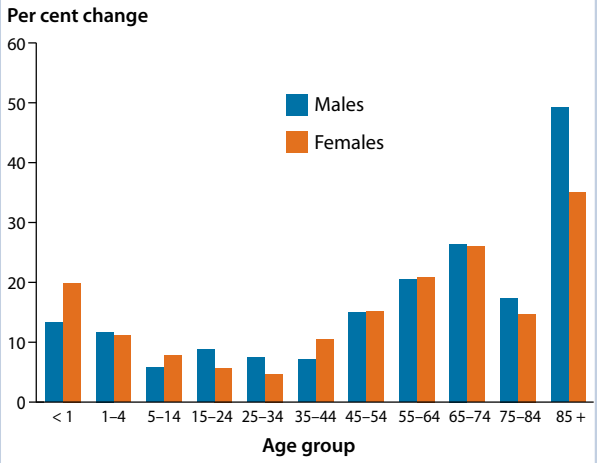


Figure 17: Change in the number of separations, by age group and sex, all hospitals, 2006–07 to 2010–11

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are hospitalised more often than other Australians (after accounting for age). Information on the number of hospitalisations for Indigenous people is limited by the accuracy with which Indigenous patients are identified in hospital records and the rates may be underestimates. The numbers here are not adjusted for under-identification.

In 2010–11:

- Indigenous Australians had a separation rate about two and a half times the separation rate for other Australians (911 per 1,000 population compared with 366 per 1,000 population).
- Indigenous Australians had more separations per 1,000 population than other Australians across all age groups (Figure 18).

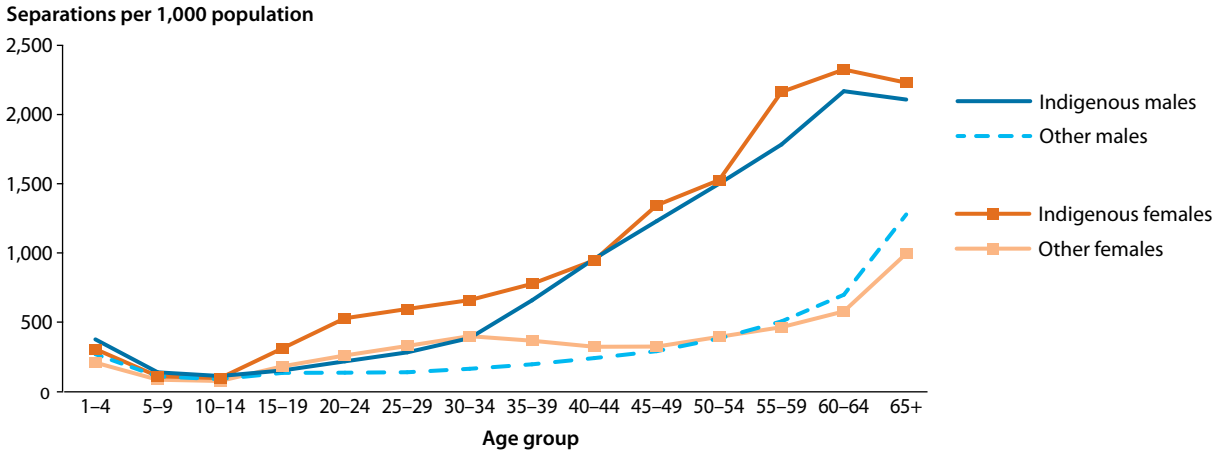


Figure 18: Separations per 1,000 population, by Indigenous status and age group, all hospitals, 2010–11

However, if hospitalisations for dialysis for kidney disease are not counted, Indigenous Australians were hospitalised only about 30% more often than other Australians (425 per 1,000 population compared with 311 per 1,000). This illustrates the impact of kidney disease on the health of Indigenous Australians, and the subsequent hospital usage for dialysis.

Remoteness

Locations in Australia can be divided into remoteness area categories, depending on distances from population centres.

The number of separations per 1,000 population varied by remoteness area. Overall, separation rates were highest for persons living in *Very remote* areas (Figure 19).

For public hospitals, the number of separations per 1,000 population was highest for patients living in *Very remote* areas and lowest for patients living in *Major cities* (512 and 210 separations per 1,000 population, respectively).

For private hospitals, the separation rate was highest for patients living in *Major cities* and lowest for patients living in *Very remote* areas (170 and 62 separations per 1,000 population respectively).

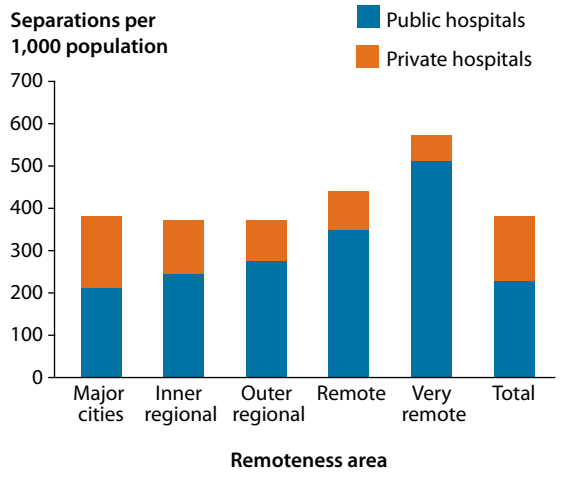


Figure 19: Separations per 1,000 population, by remoteness area of usual residence, public and private hospitals, 2010–11

Socioeconomic status

Data describing where patients live can be used to derive an approximation of their socioeconomic status (SES), which in turn can be categorised into five equal population groups of socioeconomic disadvantage/advantage. If use of admitted patient services is equal for all SES groups, we would expect an equal number of separations for each group.

The number of separations per 1,000 population varied by SES group. Overall, separation rates were highest in the lowest SES group, but there was little variation across the other 4 SES groups (Figure 20).

For public hospitals, the separation rate was highest for patients living in areas classified as being the lowest SES group and lowest for patients living in areas classified as being the highest SES group (293 and 147 separations per 1,000 population, respectively).

For private hospitals, the separation rate was highest for patients living in areas classified as being the highest SES group and lowest for patients living in areas classified as being the lowest SES group (221 and 99 separations per 1,000 population, respectively).

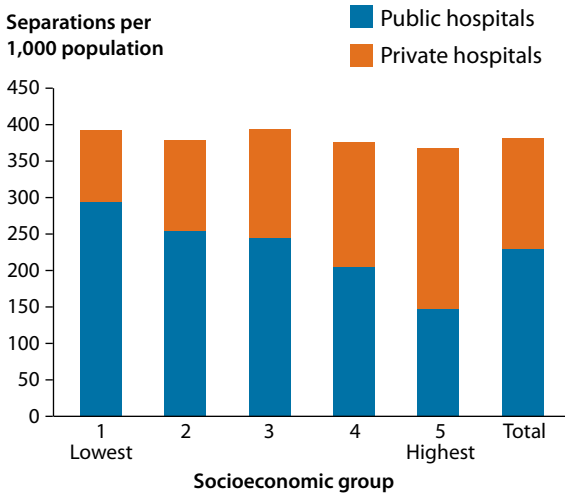


Figure 20: Separations per 1,000 population, by socioeconomic status of area of usual residence, public and private hospitals, 2010-11

Why did people receive this care?

The reason that a patient receives admitted patient care can be described in terms of a principal diagnosis. For injury and poisoning, it can also be described in terms of the cause, for example, an injury caused by a traffic accident or fall. For other types of care, it can be described in terms of a treatment for an ongoing condition (for example, dialysis for kidney failure).

In 2010–11, many separations had a principal diagnosis reported that was a disease of the digestive system (10.0%), a cancer (6.6%), an injury or poisoning (6.5%), a disease of the circulatory system (5.8%), a condition

associated with pregnancy and childbirth (5.4%) or a disease of the musculoskeletal system (5.4%).

Some high-volume diagnoses experienced relatively large changes in volume between 2006–07 and 2010–11 in either public or private hospitals, or both (Figure 21). For example, separations for care involving dialysis increased by 23% in public hospitals (to 974,000, an average annual increase of 5.3%) and by 44% in private hospitals (to 210,000, an average annual increase of 9.6%). Separations for cataracts increased by 43% in public hospitals (to 56,000) and by 48% in private hospitals (to 114,000).

In 2010–11, injury and poisoning was the principal diagnosis for over 580,000 separations in Australian hospitals. Commonly reported external causes of injury and poisoning included falls (191,000), complications of medical and surgical care (121,000), transport accidents (58,000), intentional self-harm (28,000) and accidental poisoning (10,000) (Figure 22).

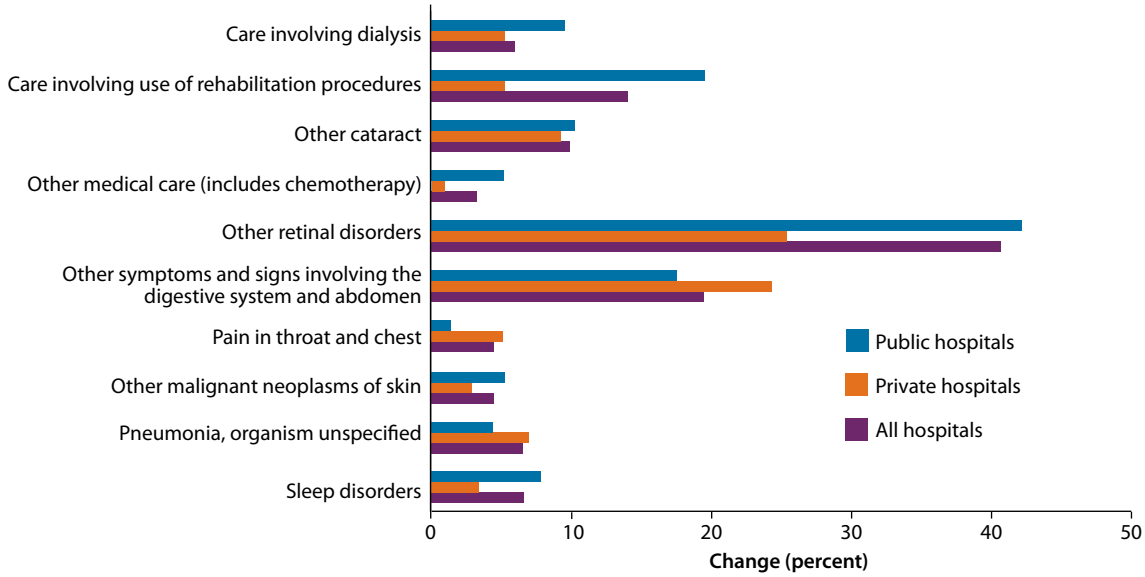


Figure 21: Change in number of separations for selected principal diagnoses, public and private hospitals, 2006–07 to 2010–11

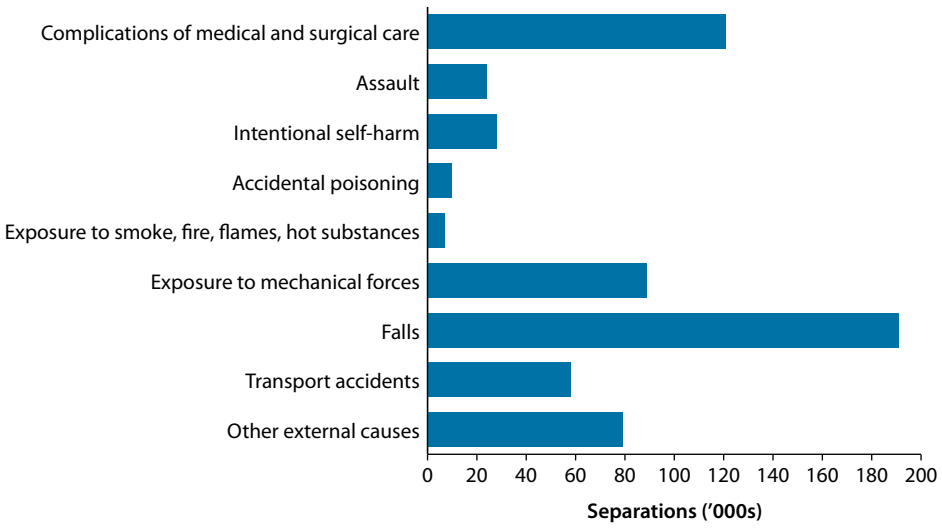


Figure 22: Injury and poisoning separations, by cause, all hospitals, 2010–11

Potentially preventable hospitalisations

The selected potentially preventable hospitalisations (PPHs) presented here are thought to have been avoidable if timely and adequate non-hospital care had been provided, either to prevent the condition occurring, or to prevent the hospitalisation for the condition. They are identified based on the diagnoses reported for admitted patients and divided into three categories—vaccine-preventable, acute and chronic conditions.

The 646,000 PPHs represented 7.3% of all hospital separations in 2010–11.

Overall, the number of PPHs per 1,000 population decreased by an average of 3.9% per year between 2006–07 and 2010–11, and decreased by 7.8% between 2009–10 and 2010–11. However, changes in how diabetes-related conditions were reported over this period were probably responsible for the majority of these decreases. The number of diagnoses reported for diabetes and impaired glucose regulation (E09–E14) decreased from almost 903,000 in 2007–08 to about 330,000 in 2010–11. Acute preventable conditions increased by an average of 7.0% per year between 2006–07 and 2010–11, and vaccine preventable conditions were relatively stable. Chronic conditions other than diabetes decreased by 0.4%.

For chronic conditions, excluding diabetes, PPHs rose with increasing remoteness in 2010–11. There were 8.9 PPHs per 1,000 population for chronic conditions in *Major cities*, and 20.0 per 1,000 in *Very remote* areas (Figure 23).

For acute conditions, the pattern was the same, ranging from 13.2 per 1,000 in *Major cities* to 29.2 per 1,000 in *Very remote* areas.

The number of PPHs per 1,000 population varied with socioeconomic status (based on where patients live). For all three categories—vaccine-preventable, acute and chronic—the rates were highest for those classified as being in the lowest SES group and lowest for those classified as being in the highest SES group (1.0 and 0.6 per 1,000, 16.0 and 11.9 per 1,000, and 17.2 and 8.4 per 1,000, respectively).

How urgent was the care?

Admissions can be categorised as *Emergency* (required within 24 hours), or *Elective* (required at some stage beyond 24 hours). *Emergency/elective* status is not assigned for some admissions (for example, obstetric care and planned care, such as dialysis).

For public hospitals, 2 out of 5 separations were *Emergency admissions*. For private hospitals, about 1 in 20 separations were *Emergency admissions*.

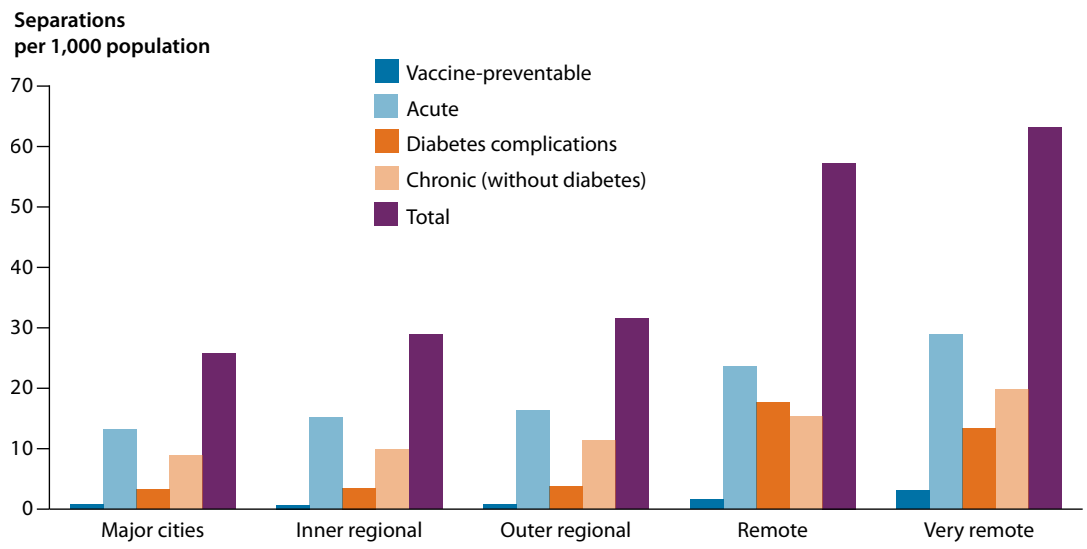


Figure 23: Potentially preventable hospitalisations by remoteness area of usual residence, all hospitals, 2010–11

What care was provided?

The care that is provided can be described in terms of the:

- broad category of service—childbirth, specialist mental health, medical (not involving a procedure), surgical (involving an operating room procedure), or other (involving a non-operating room procedure, such as endoscopy)
- intent of care—acute, sub-acute (such as rehabilitation or palliative), or non-acute (such as maintenance care)
- type of surgical or other procedure undertaken.

Broad category of service

In public hospitals, most separations were for medical care—70% in 2010–11, and 4% were for childbirth (Figure 24). About 21% of overnight separations were for surgical care, as were 14% of same-day separations.

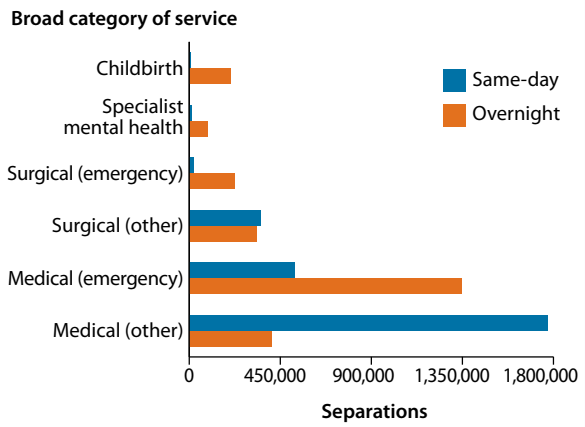


Figure 24: Same-day and overnight separations, by broad category of service, public hospitals, 2010–11

More information on broad categories of service for public hospitals for each state and territory is presented in Figures 24a–24h, accompanying this report online.

Private hospitals provided a higher proportion of separations for surgical care compared with public hospitals—37% in 2010–11. Specialist mental health care was provided for 4% of private hospital separations (Figure 25).

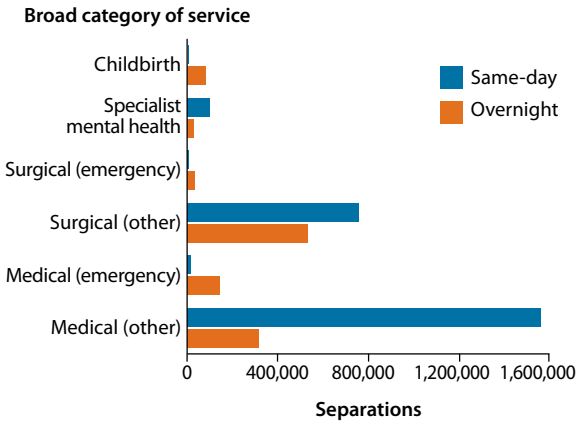


Figure 25: Same-day and overnight separations, by broad category of service, private hospitals, 2010–11

Intent of care

Most hospital separations are for acute care, that is, care with the intent to cure the condition, alleviate symptoms or manage childbirth. Acute care was reported in 2010–11 for 96% of separations and 78% of patient days for public hospitals and for 93% of separations and 83% of patient days for private hospitals.

Rehabilitation, or improved functioning, was the next most commonly reported intent of care. For 2010–11, it was reported for 1.6% of separations and 7.9% of patient days for public hospitals and for 5.6% of separations and 11.2% of patient days for private hospitals. More information about sub-acute and non-acute care is on page 33.

Procedures

Procedures can be surgical or non-surgical, can be used to treat or diagnose a condition, or be of a patient support nature, such as anaesthesia.

In 2010–11, one or more procedures were reported for 82% of separations in Australian hospitals. Over 94% of separations from private hospitals recorded a procedure, compared with 73% from public hospitals.

Overall, 54% of separations that reported a procedure occurred in the public sector.

In 2010–11, many separations had a procedure reported that was on the urinary system (16.3%), the digestive system (13.4%), the musculoskeletal system (6.6%) or the cardiovascular system (3.2%). Also commonly reported were separations with non-invasive, cognitive and other interventions, including allied health and general anaesthesia (61.1%).

Hospital performance: rates of service—hospital procedures

The rates for these hospital procedures are presented as an indicator of appropriateness and may also be indicators of accessibility of care.

Figure 26 presents separations per 1,000 population for selected hospital procedures. The national rate is accompanied by the range of rates for these procedures by state or territory. There was some variation among states and territories for the selected procedures. For example, the national rate for cataract extraction was 8.6 per 1,000 population, but the state/territory rate ranged from 6.7 per 1,000 to 10.3 per 1,000 population.

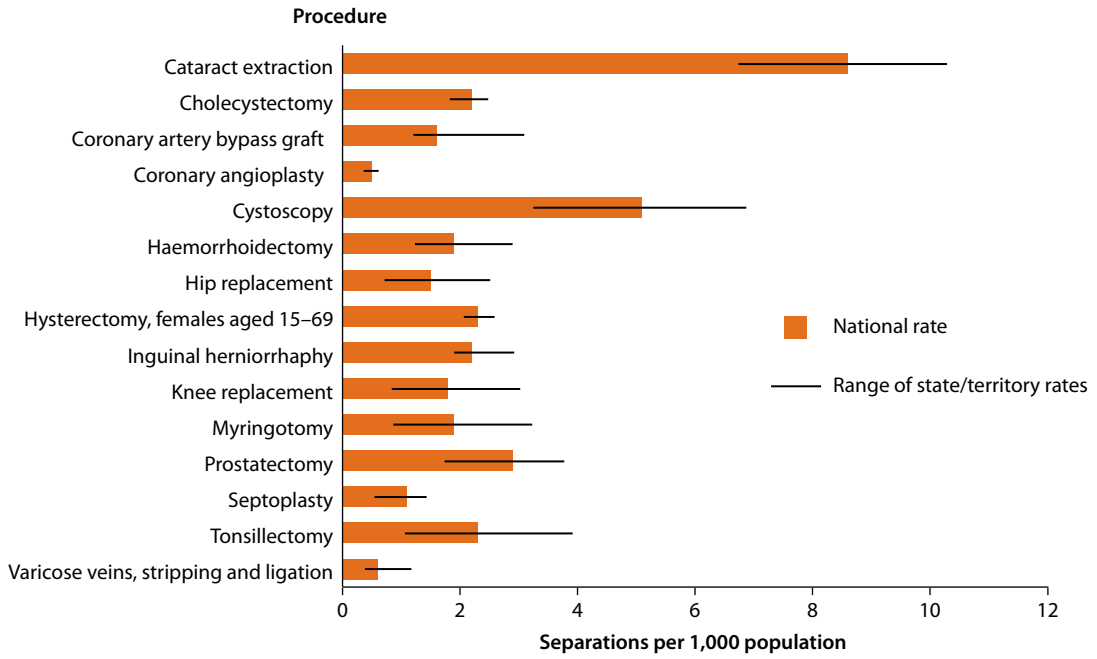


Figure 26: Separations per 1,000 population for selected hospital procedures, all hospitals, 2010–11

What was the safety and quality of the care?

Some information is available on the safety and quality of admitted patient care in hospitals, but the available information does not provide a complete picture. There is no routinely available information on some aspects of quality, such as continuity or responsiveness of hospital services.

Hospital performance: falls resulting in patient harm in hospitals

Falls resulting in patient harm in hospital are regarded as adverse events, some of which may be preventable. They can be used as one indicator of safety for hospitals.

In 2010–11, there were about 22,000 separations for which a fall was recorded as occurring in a health service area (Figure 27), an overall rate of about 2.5 per 1,000 separations. The rate was higher in public hospitals than in private hospitals (3.3 and 1.3 per 1,000, respectively). This may reflect differences between public and private hospitals, in what they do and who they treat.

These rates may underestimate falls occurring in hospitals, as the place of occurrence was not reported for about 24% of separations with a fall recorded. However, it is also possible that these rates may overestimate falls, as it is not possible to distinguish between falls in hospitals, and falls in other health service areas (such as general practitioner clinics).

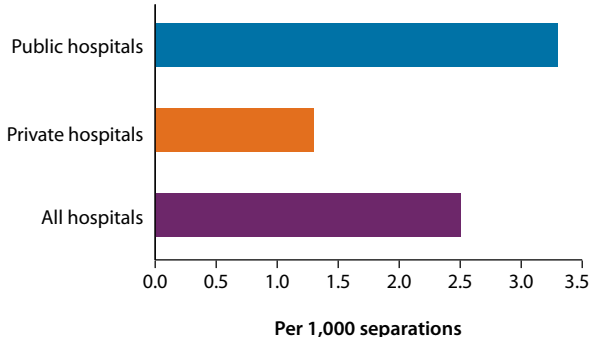


Figure 27: Falls resulting in patient harm in hospitals, per 1,000 separations, public and private hospitals, 2010–11

Hospital performance: intentional self-harm in hospitals

Intentional self-harm in hospital is regarded as an adverse event which may be preventable. Rates of intentional self-harm in hospital can be used as an indicator of safety for hospitals.

In 2010–11, there were about 1,500 separations for which intentional self-harm was recorded as occurring in a health service area, an overall rate of about 2 per 10,000 separations. This rate may underestimate intentional self-harm occurring in hospitals, as the place of occurrence was not reported for about 35% of separations with intentional self-harm recorded. However, it is also possible that this may be an overestimate, as it is not always possible to identify that intentional self-harm in took place in a hospital, as distinct from another health service area.

Hospital performance: ***Staphylococcus aureus*** bacteraemia in public hospitals

Staphylococcus aureus bacteraemia (SAB), also known as golden staph bloodstream infection, associated with hospital care is an important measure of the safety of hospital care. The aim is to have as few cases of SAB as possible. One of the most effective ways to minimise the risk of SAB and other healthcare-associated infections is good hand hygiene.

In 2010–11, there were 1,873 cases of SAB reported for Australian public hospitals overall. More than two-thirds (73%) were methicillin sensitive, and would have been treatable with commonly used antibiotics.

The cases occurred during approximately 17 million days of patient care under SAB surveillance during 2010–11.

All states and territories had rates of SAB below the national benchmark of 2.0 cases per 10,000 patient days, ranging from 0.9 cases per 10,000 patient days in Victoria, South Australia and the Australian Capital Territory to 1.4 in the Northern Territory (Figure 28).

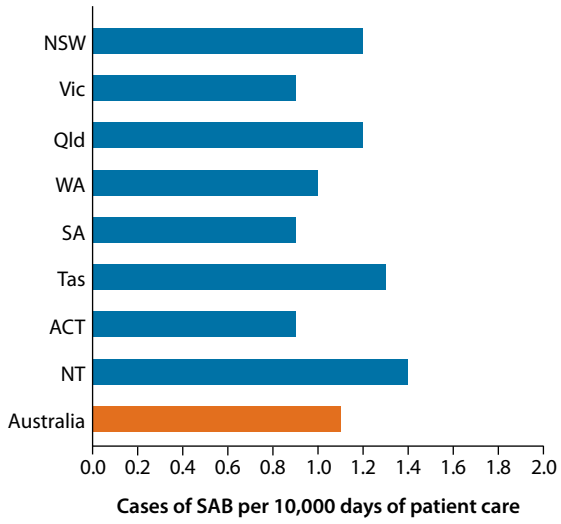


Figure 28: Cases of *Staphylococcus aureus* bacteraemia per 10,000 days of patient care in public hospitals, states and territories, 2010–11

How long did patients stay?

Information on the average length of stay summarises how long admitted patients stay in hospital.

Including both same-day care (which is counted as one day's stay, even if it is only for a few hours) and overnight care (care that is for at least one night), the average length of stay was 3.0 days in 2010–11, 2.4 days in private hospitals and 3.4 days in public acute hospitals. These averages have decreased over time (Figure 29), largely reflecting the fact that the proportion of separations that are day-only have increased.

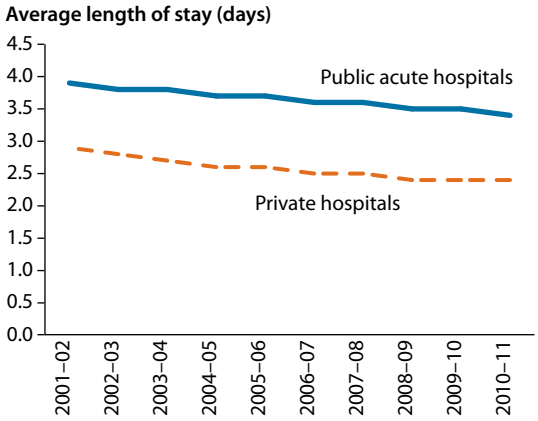


Figure 29: Average length of stay, public acute and private hospitals, 2001–02 to 2010–11

For overnight care, the average length of stay varied according to the intent of the care. For example, the average length of stay for Acute care was 3.0 days in public hospitals and 2.2 days in private hospitals (Figure 30). For Rehabilitation care, the average length of stay was 17.4 days in public hospitals and 4.8 days in private hospitals.

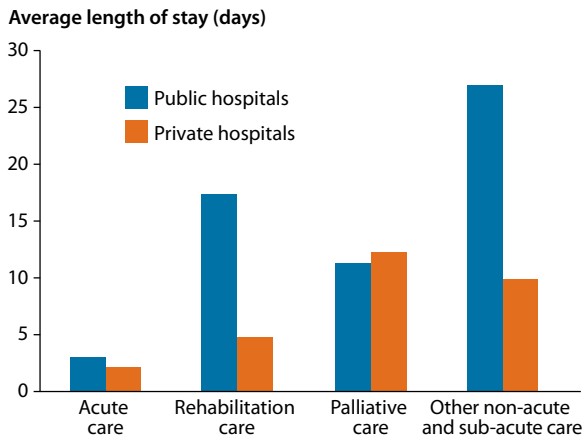


Figure 30: Average length of stay (days) by care type, public and private hospitals, 2010–11

Hospital performance: relative stay index

Relative stay indexes (RSIs) summarise the length of stay for admitted patients, with adjustments for casemix (the types of patients treated and the types of treatments provided). They are regarded as indicators of the efficiency of hospitals.

An RSI greater than 1.0 indicates that an average patient's length of stay is higher than expected, given the casemix for the separations being considered. An RSI of less than 1.0 indicates that the length of stay was less than expected.

In 2010–11, there were relatively shorter lengths of stay for medical separations (including specialist mental health) in public hospitals (0.96, compared with 1.20 in private hospitals), and for surgical separations in private hospitals (0.98, compared with 1.04 in public hospitals) (Figure 31). Overall, the relative length of stay was lower in public hospitals than in private hospitals. Childbirth is included in 'other' in this figure.

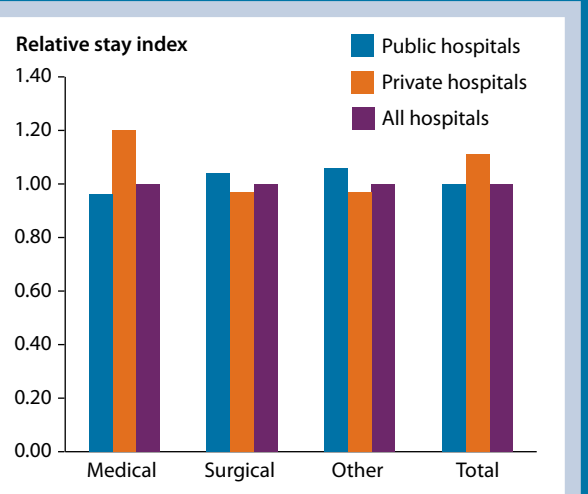
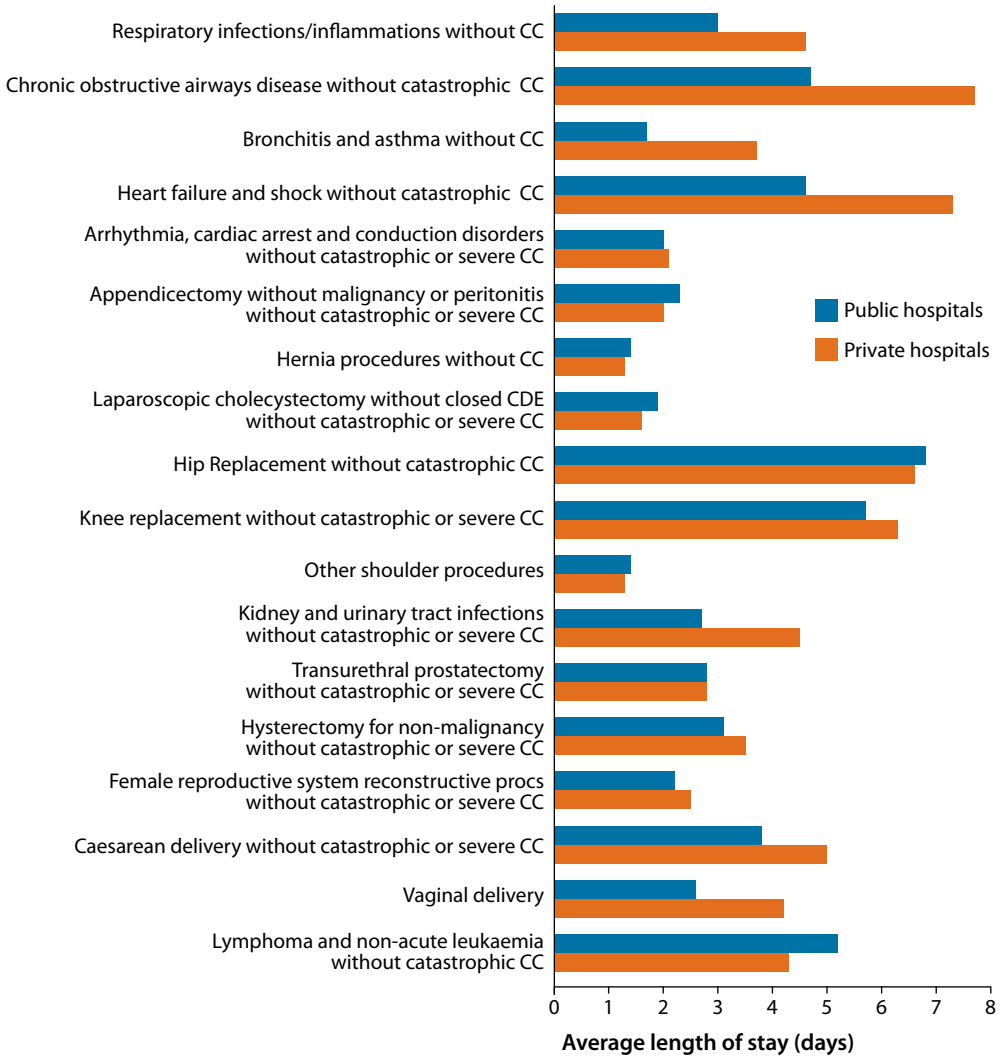


Figure 31: Relative stay index (directly standardised), for medical, surgical and other care, public and private hospitals, 2010–11

Hospital performance: average length of stay for selected types of separations

The average length of stay for selected types of separations (defined using Australian Refined Diagnosis Related Groups, AR-DRGs) is regarded as an indicator of the efficiency of hospitals.

Figure 32 presents the average lengths of stay for the selected AR-DRGs in public and private hospitals. There were notable differences (more than 1 day) in the average length of stay between public and private hospitals for seven of these AR-DRGs. The average length of stay for *Chronic obstructive airways disease without catastrophic complications or comorbidities* was 4.7 days for public hospitals and 7.7 days for private hospitals.



Abbreviations: CC—complications and/or comorbidities; CDE—common duct exploration.

Figure 32: Average length of stay (days) for selected types of separations, public and private hospitals, 2010–11

How much did it cost?

We have information on average costs for public hospitals, but not for private hospitals. The cost of care (expenditure by the hospital) varies according to the length of stay, procedures undertaken and the care needs of the patient.

Hospital performance: **cost per casemix-adjusted separation**

The average cost per separation is a measure of efficiency of admitted patient services. Patients with more complex conditions are likely to cost more than patients with less complex conditions. In order to compare the average cost per admitted patient across hospitals, it is necessary to adjust for the average complexity of patients treated in each hospital. This is called 'casemix adjustment'.

The average cost per casemix-adjusted separation in public hospitals increased from $3,922 in 2006–07 to $4,918 in 2010–11 (not adjusted for inflation).

This represents a total increase of 25.4% in this period (Figure 33), an average increase of 5.7% annually.

In 2010–11 the average cost comprised:

- $2,448 for non-medical labour expenditure
- $1,066 for medical labour expenditure
- $1,404 for other recurrent expenditure.

Other recurrent expenditure costs include domestic services; repairs and maintenance; administration; and medical, drug and food supplies. It does not include capital and other fixed costs.

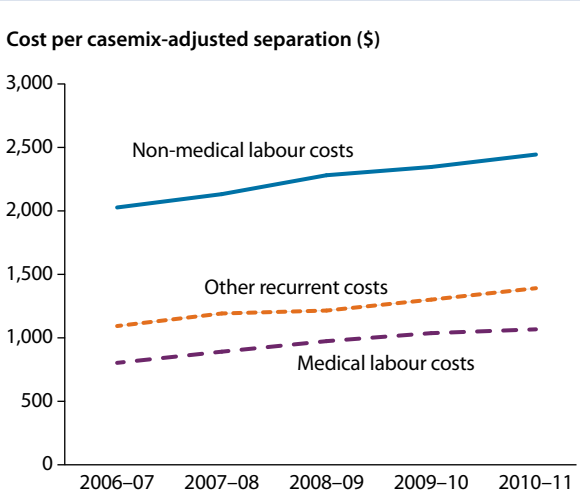


Figure 33: Cost per casemix-adjusted separation, public hospitals, 2006–07 to 2010–11

Who paid for the care?

Over half of all separations in 2010–11 were public patients (52%), who were not charged for their stay. Private health insurance accounted for a further 38%, and self-funded patients and Department of Veterans' Affairs patients accounted for about 4% each (Figure 34).

Between 2006–07 and 2010–11, there was an overall increase in separations of 3.9% per year. Separations funded by motor vehicle third party personal claims increased by 7.3% per year and those funded by private health insurance increased by 5.6% per year (Figure 35).

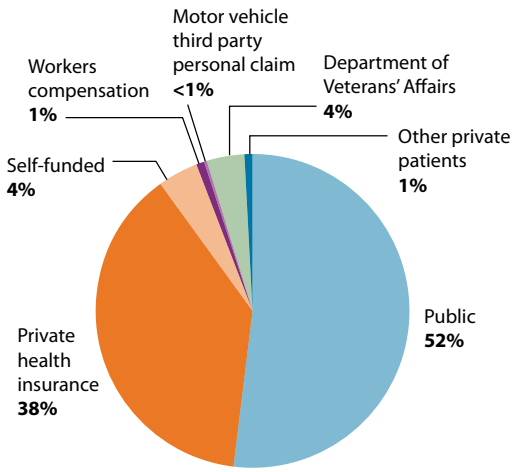


Figure 34: Proportion of separations by principal source of funds, all hospitals, 2010–11

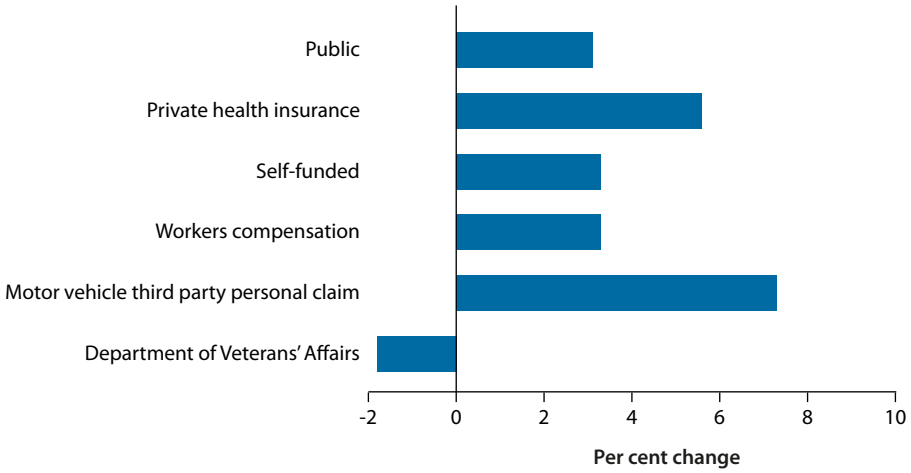


Figure 35: Average annual change in the number of separations by selected principal source of funds, all hospitals, 2006–07 to 2010–11

Admitted patient care: same-day acute care

Same-day admitted patient care occurs when the patient is admitted and separated on the same day. This section reports on same-day acute care (referred to as same-day care), where the care was not for rehabilitation or other non-acute care (which together made up 3.5% of same-day care).

In 2010–11, 4.9 million, or 58% of separations, were same-day acute care separations. This included 2.6 million or 50% of separations from public hospitals and 2.3 million or 64% of separations from private hospitals.

Between 2006–07 and 2010–11, the proportion of same-day separations increased from 54.7% to 55.8%. On average, the number of same-day separations increased by 3.6% per year for public hospitals, and 5.5% per year for private hospitals.

Who used these services?

Aboriginal and Torres Strait Islander people were hospitalised on a same-day basis at about three times the rate of other Australians. Almost one in four same-day separations were for care involving dialysis (over 1.2 million). After excluding dialysis, the rate of same-day separations for Indigenous Australians was lower than the rate for other Australians (132 and 161 per 1,000 population, respectively, Figure 36).

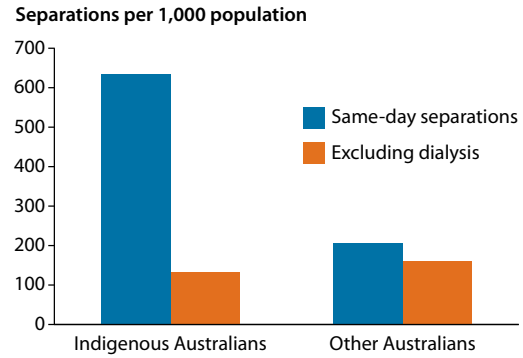


Figure 36: Same-day acute separations per 1,000 population, by Indigenous status, all hospitals, 2010–11

Persons usually resident in *Very remote* areas had 301 same-day separations per 1,000 population, compared with 213 per 1,000 nationwide.

Same-day separation rates were similar for different socioeconomic status groups, ranging from 202 per 1,000 population for the second lowest SES group to 222 per 1,000 for the middle SES group.

How urgent was the care?

About 72% of same-day separations were for elective care, 11% were for emergency care and about 17% were other care (not assigned) (Figure 37).

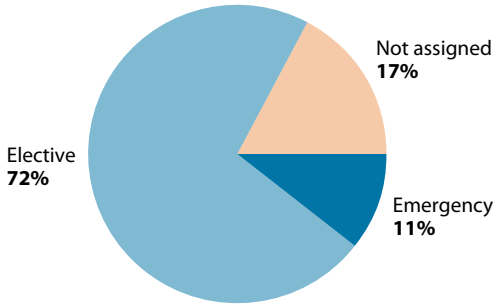


Figure 37: Same-day acute separations by urgency of admission, all hospitals, 2010–11

Why did people receive this care?

The most common principal diagnoses for same-day acute separations were:

- care involving dialysis (over 1.2 million separations for kidney failure)
- other medical care (359,000 separations, mainly chemotherapy for cancer)
- cataract (162,000 separations).

What care was provided?

In public hospitals, over three-quarters of same-day separations were for medical care (including specialist mental health). In private hospitals, about 36% of same-day separations were for medical care and about 33% were for surgical care.

Around 7.4 million procedures were reported for same-day separations. In public hospitals, about 80% of same-day separations involved a procedure and in private hospitals about 97% of same-day separations involved a procedure (2.2 million).

The most common procedure was haemodialysis, followed by pharmacotherapy (includes chemotherapy).

Who paid for the care?

In public hospitals, almost 87% of same-day separations were public patients.

In private hospitals, private health insurance funded about 79% of same-day separations.

Admitted patient care: overnight acute care

Overnight admitted patient care occurs when the patient is admitted and separated on different days (stays at least one night). This section reports on overnight acute care (referred to as overnight care), where the care was not for rehabilitation or other non-acute care (which made up 5.3% of overnight separations).

In 2010–11, 40% of separations (3.5 million) were for overnight acute care. This included 47% of separations (2.5 million) from public hospitals and 30% of separations (1.1 million) from private hospitals.

Between 2006–07 and 2010–11, the number of overnight acute separations increased, on average, by 2.6% per year for public hospitals, and by 2.2% per year for private hospitals.

Who used these services?

Indigenous Australians were hospitalised overnight at about twice the rate for other Australians.

Persons usually resident in *Very remote* areas had 264 overnight acute separations per 1,000 population, compared with 152 per 1,000 nationwide.

Separation rates varied by socioeconomic status, from 130 per 1,000 population for the highest SES group to 169 per 1,000 for the lowest SES group.

How urgent was the care?

About 52% of overnight acute separations were for emergency care, 37% were for elective care and about 11% were other planned care (not assigned) (Figure 38).

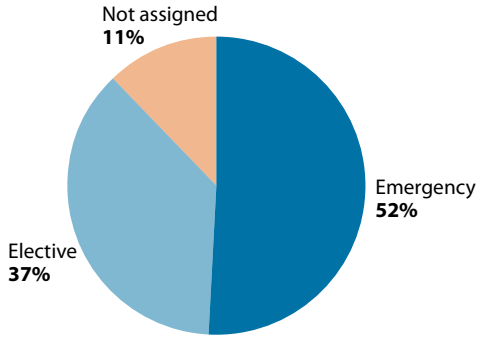


Figure 38: Overnight acute separations by urgency of admission, all hospitals, 2010–11

Why did people receive this care?

The most common principal diagnoses for overnight acute separations were:

- childbirth (about 286,000 separations)
- pain in the throat and chest (almost 75,000 separations)
- sleep disorders (63,000 separations)
- pneumonia (61,000 separations).

What care was provided?

In public hospitals, about 62% of overnight acute separations were for medical care (including specialist mental health).

In private hospitals, about 53% of overnight acute separations were for surgical care.

How long did patients stay?

The average length of stay for overnight acute separations was 5.2 days for public hospitals and 4.7 days for private hospitals. This was similar to 2009–10 (5.3 and 4.7 days, respectively).

The average length of stay for medical care was greater in private hospitals, and was notably higher in public hospitals than in private hospitals for both surgical and other care (Figure 39).

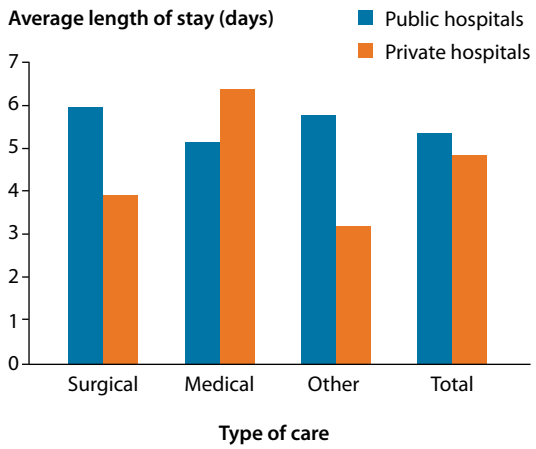


Figure 39: Average length of stay for overnight acute separations, public and private hospitals, 2010–11

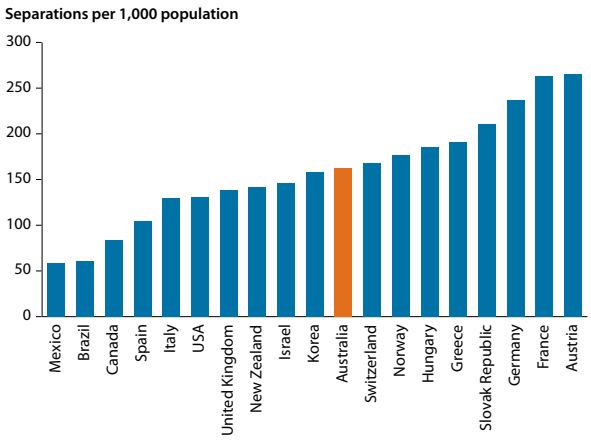
Who paid for the care?

In public hospitals, almost 83% of overnight acute separations were public patients.

In private hospitals, private health insurance funded about 83% of overnight acute separations.

International comparisons

The number of overnight separations per 1,000 population in Australia for 2010–11 was in the middle of the range that other OECD countries reported for recent years (Figure 40) (OECD 2010).



Notes

1. Data for OECD countries vary in collection periods, from financial year, fiscal year and calendar year.
2. Separations include all care types.

Figure 40: Overnight separations per 1,000 population, Australia, 2010–11 and selected OECD countries (2009)

Although OECD collate this information on as comparable a basis as possible, the comparability of international separation rates is likely to be affected by differences in definitions of hospitals, collection periods and in admission practices.

Admitted patient care: surgery

A surgical separation involves a surgical (or operating room) procedure.

In 2010–11, 2.4 million or 27% of separations included a surgical procedure. This included 19% of separations (1.0 million) from public hospitals and 38% of separations (1.4 million) from private hospitals.

The number of surgical separations increased between 2006–07 and 2010–11 by an average of 2.4% for public hospitals and 4.1% for private hospitals each year.

How urgent was the care?

About 12% of surgical separations were emergency admissions, and 83% were elective admissions. About 4% of surgical separations were childbirth-related and 1% were other planned care. The proportion of surgical separations that were emergency admissions was higher in public hospitals than in private hospitals (24% and 3% respectively).

Who used these services?

Indigenous Australians had about twice the rate of emergency admissions involving surgery compared with other Australians (24 and 12 per 1,000 population, respectively). The rate of elective admissions involving surgery was about 70% higher for other Australians compared with Indigenous Australians (85 and 49 per 1,000 population, respectively).

For emergency admissions involving surgery, persons usually resident in *Very remote* areas had the highest rate (22 per 1,000 compared with 12 per 1,000 nationwide). Persons usually resident in *Very remote* areas had 60 elective admissions for surgery per 1,000 population, compared with 84 per 1,000 nationwide (Figure 41).

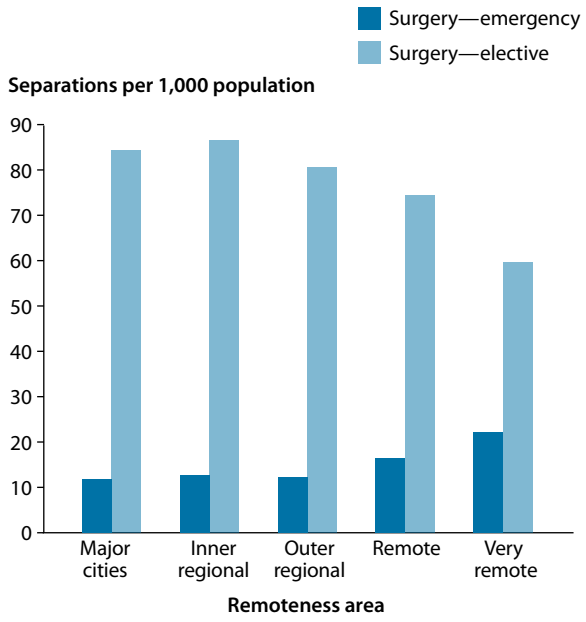


Figure 41: Surgical separations per 1,000 population, by urgency of admission and remoteness area of usual residence, all hospitals, 2010–11

Separation rates for elective admissions involving surgery varied by socioeconomic status, from 77 per 1,000 population for the lowest SES group to 90 per 1,000 for the highest SES group.

The rate for public hospital elective admissions involving surgery was lowest for those classified as being in the highest SES group (17 per 1,000) and highest for those in the lowest SES group (38 per 1,000). In contrast, the number of private hospital elective admissions involving surgery per 1,000 population was highest for those classified in the highest SES group (73 per 1,000) and decreased with socioeconomic status to 39 per 1,000 population for the lowest SES group (Figure 42).

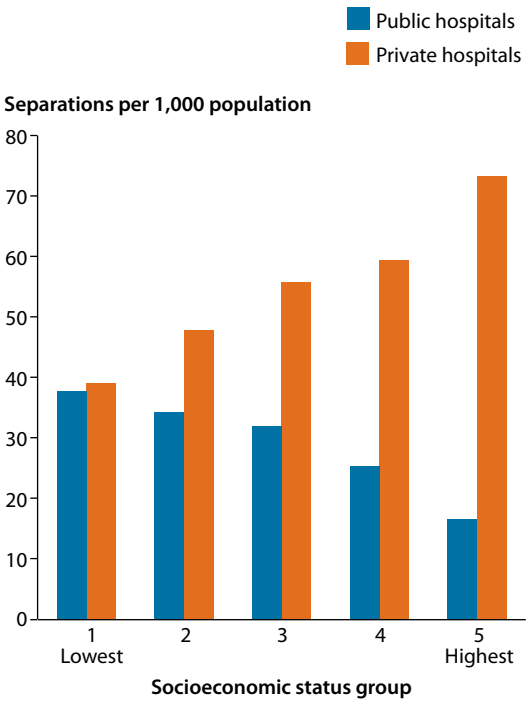


Figure 42: Elective admissions involving surgery, by socioeconomic status group, public and private hospitals, 2010–11

Why did people receive this care?

The most common principal diagnoses for emergency admissions involving surgery included:

- acute appendicitis (about 25,000 separations)
- fracture of femur (hip fracture, 19,000 separations)
- heart attack (13,000 separations).

The most common principal diagnoses for elective admissions involving surgery included:

- cataract (about 166,000 separations)
- malignant neoplasm of skin (about 91,000 separations)
- internal derangement of knee (62,000 separations).

What care was provided?

The most common surgical procedures performed for emergency admissions involving surgery included:

- appendicectomy (about 27,000 separations)
- coronary angioplasty (with stenting) (14,000 separations)
- excision procedure on musculoskeletal sites (13,000 separations).

The most common surgical procedures performed for elective admissions involving surgery included:

- lens extraction/insertion (about 188,000 separations)
- excision of skin lesion (89,000 separations)
- curettage and evacuation of uterus (83,000 separations).

How long did patients stay?

The average lengths of stay for surgery were similar for public and private hospitals. The average length of stay for emergency admissions involving surgery was 7.7 days for public hospitals and 7.5 days for private hospitals. For elective admissions involving surgery, the average length of stay was 2.4 days for public hospitals and 2.0 days for private hospitals.

Hospital performance: waiting times for elective surgery

The median waiting time for elective surgery is a measure of access to elective surgery. Data were available for a subset of elective surgery in public hospitals, defined as those removed from waiting lists for a range of surgical procedures. The median waiting time is the number of days within which 50% of patients were removed from elective surgery waiting lists.

In public hospitals, 50% of patients waited 36 days or less for elective surgery in 2010–11, an increase from 32 days in 2006–07. A total of 2.9% waited more than a year—the least since 2006–07.

- Median waiting time varied across states and territories. The lowest was 29 days in Queensland and Western Australia, and the highest was 76 days in the Australian Capital Territory (Figure 43).

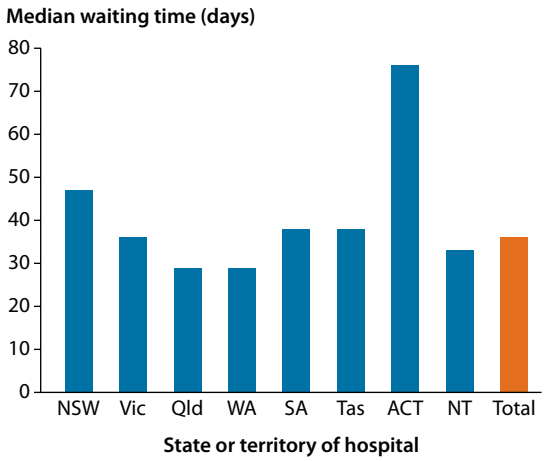


Figure 43: Median waiting times for elective surgery, public hospitals, states and territories, 2010–11

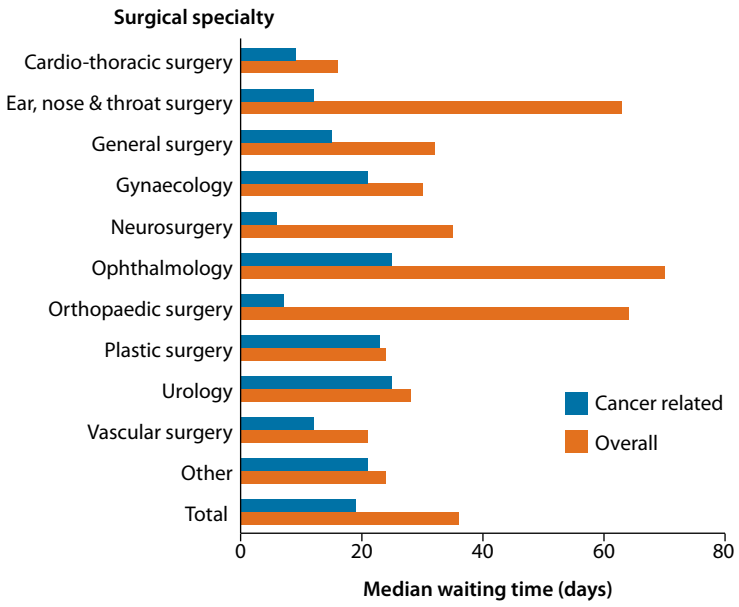


Figure 44: Median waiting times, overall and cancer-related, by specialty of surgeon, 2010–11

- Ophthalmology, orthopaedic surgery and ear, nose and throat surgery were the surgical specialties with the longest median waiting times (70, 64, and 64 days respectively) in 2010–11 (Figure 44).
- Cardiothoracic surgery had the shortest median waiting time (16 days).
- Overall, the median waiting times for patients with cancer-related principal diagnoses (19 days) were 17 days shorter than the median waiting times for patients overall (36 days) (Figure 44). For orthopaedic surgery, 50% of patients with cancer waited 7 days or less, compared with 64 days (median) overall.

- Coronary artery bypass graft was the procedure with the shortest median waiting time (17 days) and total knee replacement had the longest median waiting time (173 days) (Figure 45).

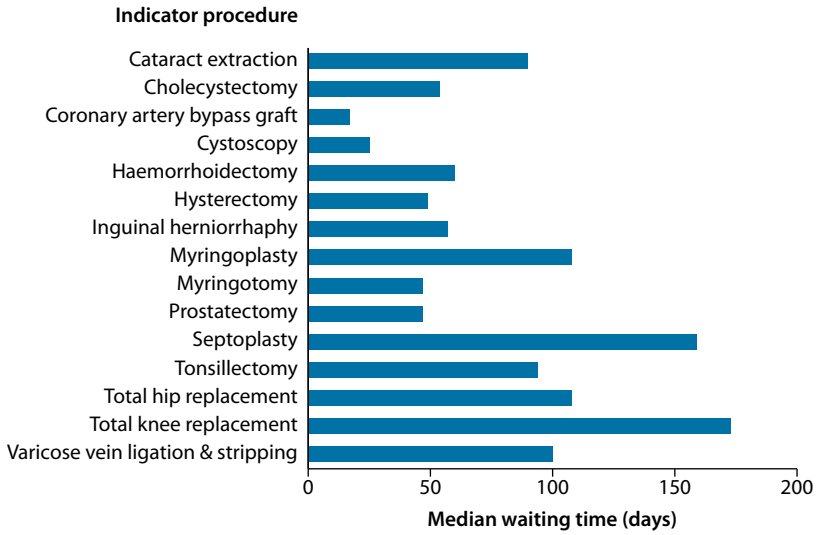


Figure 45: Median waiting times for elective surgery, by procedure, 2010–11

More information on waiting times for public hospital elective surgery by surgical specialty and by procedure for each state and territory is presented in Figures 44a–44h and Figures 45a–45h , accompanying this report online.

Admitted patient care: sub-acute and non-acute care

Overall, there were about 380,000 separations for sub- and non-acute admitted patient care in 2010–11. These accounted for about 4.2% of separations and 15.6% of patient days in public and private hospitals. This care includes Rehabilitation, Palliative, Psychogeriatric, Geriatric evaluation and management and Maintenance care (Figures 46 and 47). Rehabilitation care was the most commonly provided sub- or non-acute care type.

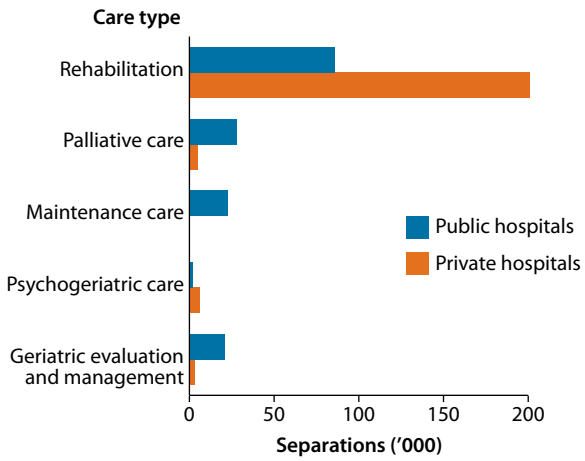


Figure 46: Separations for sub- and non-acute care, public and private hospitals, 2010–11

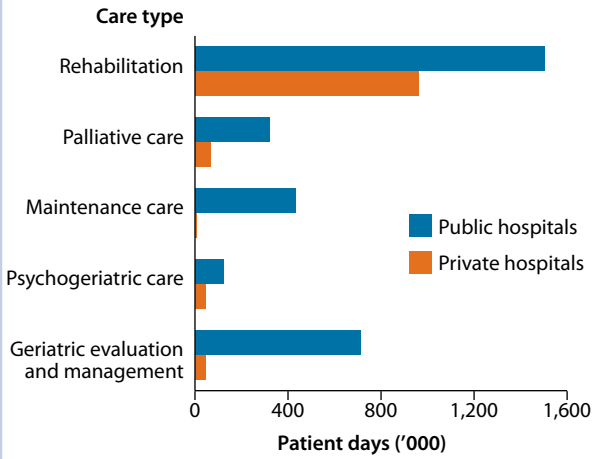


Figure 47: Patient days for sub- and non-acute care, public and private hospitals, 2010–11

The volume of these services increased over the period 2006–07 to 2010–11, particularly for Rehabilitation in private hospitals (20% per year) and Geriatric evaluation and management care in public hospitals (16% per year) (Figure 48).

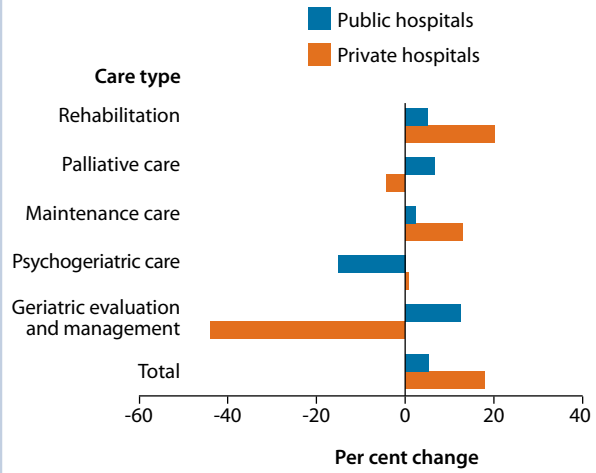


Figure 48: Change in the number of separations for sub- and non-acute care, public and private hospitals, 2006–07 to 2010–11

Who used these services?

About 56% of sub- and non-acute separations were for females, and less than 30% of sub- and non-acute separations were for people aged under 65 (Figure 49).

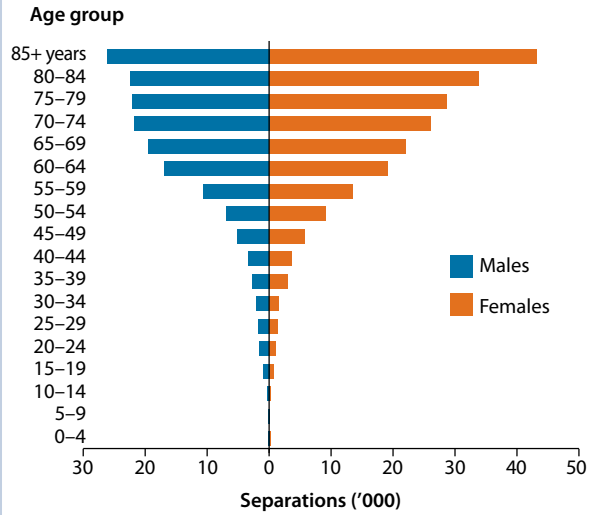


Figure 49: Separations for sub- and non-acute care, by age-group and sex, all hospitals, 2010–11

Less than 1.0% of sub- and non-acute separations were for Indigenous Australians, compared with 3.8% of admitted patient separations overall.

Persons usually resident in *Major cities* had 19 separations per 1,000 population for sub- and non-acute care, compared with 16 per 1,000 nationwide.

Separation rates varied by socioeconomic status, from 12 per 1,000 population for those classified as being in the lowest SES group to 23 per 1,000 for those classified as being in the highest SES group.

How did people access these services?

Almost half of separations for sub- and non-acute care began as either transfers from another hospital or occurred within the same hospital when the patient's type of care had changed (for example, from Acute care to Rehabilitation) (Figure 50). This contrasts with only 5% of separations overall that were transferred from another hospital or were a care type change.

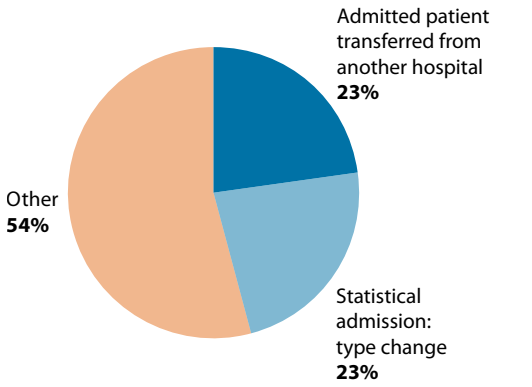


Figure 50: Separations for non-acute care, by mode of access, all hospitals, 2010–11

How urgent was the care?

Less than 4% of separations for sub- and non-acute care were reported as emergency admissions, compared with 27% of separations overall.

About 66% were reported as elective admissions and 30% were other planned care.

Why did people receive this care?

The most common principal diagnosis was for Care involving use of rehabilitation procedures (287,000 separations).

Looking at second diagnoses for separations involving Rehabilitation care, the most common were:

- arthrosis of the knee (about 48,000 separations)
- arthrosis of the hip (20,000 separations)
- fracture of femur (hip fracture, 16,000 separations).

For Palliative care, 8 out of the 10 most common principal diagnoses were cancer-related.

What care did they receive?

Around 880,000 procedures or other interventions were reported for sub- and non-acute separations. About 83% of sub- and non-acute separations in public hospitals and 95% in private hospitals involved a procedure.

The most commonly reported procedures were allied health interventions, including:

- physiotherapy (over 290,000 separations)
- occupational therapy (164,000 separations)
- social work (89,000 separations).

How long did they stay?

The average length of stay for sub- and non-acute separations was 5.2 days in private hospitals and 19.2 days in public hospitals.

- For Rehabilitation care, the average length of stay was 4.8 days in private hospitals and 17.4 days in public hospitals.
- Separations for Maintenance care had the longest average length of stay (32.2 days), followed by Geriatric evaluation and management (19.1 days) and Psychogeriatric care (18.7 days) .

Who paid for the care?

In public hospitals, about 76% of sub- and non-acute separations were public patients, 15% were funded by private health insurance and 6% were funded by the Department of Veterans' Affairs.

In private hospitals, private health insurance funded about 79% of sub- and non-acute separations, and 12% were funded by the Department of Veterans' Affairs.

How was care completed?

Just over three-quarters of separations for sub- and non-acute care ended in discharge of the patient to their usual place of residence, compared with over 92% of all admitted patient separations.

Over 6% of separations for sub- and non-acute care ended in discharge or transfer of the patient to another hospital or other health care accommodation.

A further 5% ended in discharge of the patient to a residential aged care service (that was not their usual place of residence), compared with about 1% overall.

- For Rehabilitation care 90% of patients were discharged to their usual place of residence, compared with 29% of patients for Palliative care (Figures 51 and 52)
- Over half (58%) of Palliative care separations ended in the death of the patient (Figure 52).

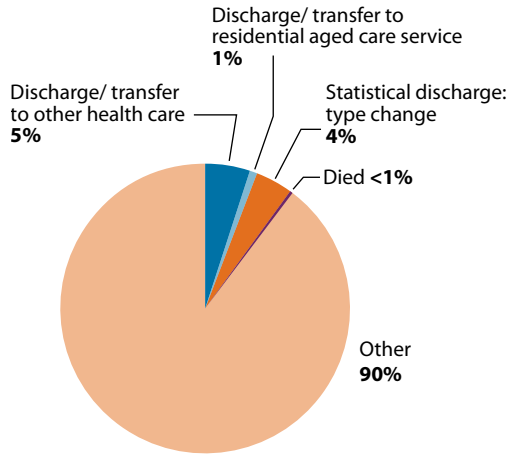


Figure 51: Separations for Rehabilitation care, by mode of separation, all hospitals, 2010–11

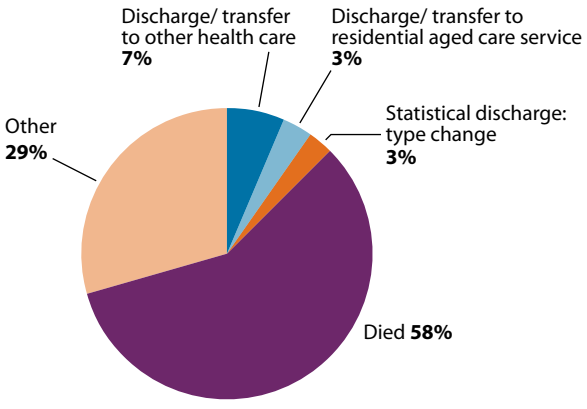


Figure 52: Separations for Palliative care, by mode of separation, all hospitals, 2010–11

Related information

More detailed statistics, and more information on how to interpret the data here can be found in:

- *Australian hospital statistics 2010–11*
- *Australian hospital statistics 2010–11: emergency department care and elective surgery waiting times* and
- *Australian hospital statistics 2010–11: Staphylococcus aureus bacteraemia in Australian hospitals*.

Further detail is also available in spreadsheets and in interactive data cubes at <www.aihw.gov.au>.

References

ABS (Australian Bureau of Statistics) 2011. Private hospitals Australia 2009–10. ABS cat. no. 4390.0. Canberra: ABS.

AIHW (Australian Institute of Health and Welfare) 2011. Health expenditure Australia 2009–10. Health and welfare expenditure series no. 46. Cat. no. HWE 55. Canberra: AIHW.

AIHW 2012. Australian hospital statistics 2010–11. Health services series no. 43. Cat. no. HSE 117. Canberra: AIHW.

OECD (Organisation for Economic Co-operation and Development) 2010. OECD health data 2010: statistics and indicators for 30 countries. Paris: OECD. Viewed 6 March 2012. <www.oecd.org/health/healthdata>.

Australia's hospitals 2010–11 at a glance provides information on Australia's 1,340 public and private hospitals.

In 2010–11, there were 8.9 million hospitalisations, including 2.2 million admissions involving surgery.

Public hospitals provided 7.7 million non-admitted patient emergency services, with 70% of patients seen within recommended times for their triage category.

This publication is a companion to *Australian hospital statistics 2010–11*.