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Australian Institute of Health and Welfare

Australia's hospitals 2011–12

at a glance

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at a glance

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Contents

Introduction

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

A summary measure of their significance is the amount that is spent on them—an estimated $49.7 billion in 2010–11, about 3.7% of Australia's gross domestic product, or about $2,227 per person (AIHW 2012). Hospital spending has been increasing faster than inflation—adjusted for inflation, it increased by 5.4% each year, on average, between 2006–07 and 2010–11.

Access to our hospital services, the quality of the services, and their funding and management arrangements 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 in this report are for 2011–12, some data for private hospitals and for hospital funding were only available for 2010–11.

More detailed statistics and information on how to interpret the data is in the companion report, *Australian hospital statistics 2011–12* (AIHW 2013a). 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.

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 2007–08 and 2011–12, the number of public acute hospitals and private hospitals was relatively stable.

In 2011–12, there were 1,345 hospitals in Australia comprising:

- 736 public acute hospitals
- 17 public psychiatric hospitals
- 307 private free-standing day hospitals
- 285 other private hospitals.

The numbers of hospitals in each state and territory are in Table 1.

Table 1: Public and private hospitals, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Public acute hospitals	218	150	166	94	78	22	3	5	736
Public psychiatric hospitals	7	1	4	2	2	1	. .	. .	17
Total public hospitals	*225*	*151*	*170*	*96*	*80*	*23*	*3*	*5*	*753*
Private hospitals									
Private free-standing day hospitals	94	85	52	35	26	n.p.	n.p.	n.p.	307
Other private hospitals	93	81	52	21	29	n.p.	n.p.	n.p.	285
Total private hospitals	*187*	*166*	*104*	*56*	*55*	*n.p.*	*n.p.*	*n.p.*	*592*
All hospitals	**412**	**317**	**274**	**152**	**135**	**n.p.**	**n.p.**	**n.p.**	**1,345**

n.p. not published
. . not applicable

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 included.

In 2011–12, there were:

- 56,582 beds in public acute hospitals
- 1,838 beds in public psychiatric hospitals
- 2,957 beds in private free-standing day hospitals (based on 2010–11 data, ABS 2012)
- 25,394 beds in other private hospitals (based on 2010–11 data, ABS 2012).

The number of hospital beds increased by 3.9% between 2007–08 (82,582 beds) and 2010–11 (85,820 beds), an annual average increase of about 1%.

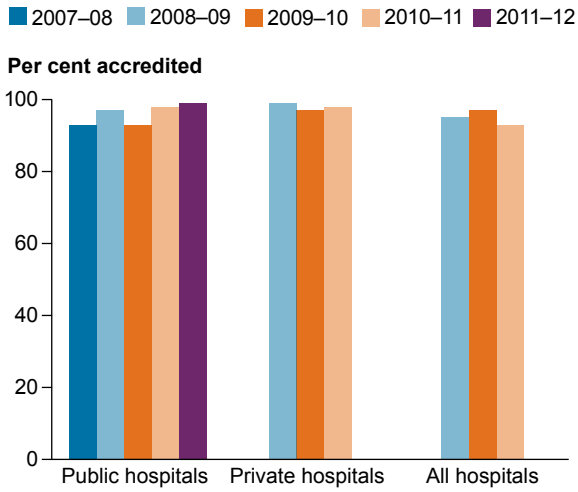
There was a relatively large decrease for public psychiatric hospitals over this period (21%), reflecting the continuing long-term trend to deinstitutionalise services for people with mental illness, and the trend to integrate specialist psychiatric services with public acute care hospital services.

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 707 public hospitals with 57,713 beds (99% of public hospital beds) were known to be accredited at 30 June 2012 (Figure 1). These hospitals provided almost 100% of public hospital separations (completed episodes of admitted patient care) and 99% of patient days (days spent in hospital as an admitted patient).

The latest private hospital data, available from the Australian Bureau of Statistics, are for 2010–11. A total of 567 private hospitals with 27,825 beds (96% of hospitals, covering 98% of beds) were accredited that year.



Note: Accreditation statistics were not available for private hospitals for 2007–08 and 2011–12.

Figure 1: Proportion of hospital beds that were in accredited public and private hospitals, 2007–08 to 2011–12

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 2007–08 and 2011–12, 90% or more of hospital beds were in accredited hospitals.

How diverse are public hospitals?

The 753 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 reported Australian Refined Diagnosis Related Groups (AR-DRGs).

In 2011–12, there were:

- 80 *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 436 AR-DRGs on average). These hospitals accounted for a total of 3.8 million separations, or 70% of the total for public hospitals (Figure 2). There was a total of 12.7 million days spent by patients in these hospitals, or 67% 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 21,956 separations, specialising in maternity and other specialist services for women, and/or specialist paediatric services.
- 40 *Large* hospitals, 23 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 252 AR-DRGs), with an average of 16,871 separations per hospital.
- 83 *Medium* hospitals, 20 in major cities and 63 in regional areas. They delivered an average of 6,534 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, 114 in regional areas and 41 in remote areas. They delivered mainly acute care for admitted patients, with an average of 1,307 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.
- 75 *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.
- 78 *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.
- 198 other hospitals, mainly small hospitals or particular specialist hospitals, such as hospices.

Table 2: The diversity of public hospitals, 2011–12

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	53	26	1	**80**	80	80	79	78	417	45,673	3.3	9.4	436
Specialist women's and children's	11	0	0	**11**	9	9	11	9	210	21,956	3.0	0.5	229
Large	23	16	1	**40**	37	37	39	34	138	16,871	2.8	14.4	252
Medium	20	63	0	**83**	41	69	5	59	69	6,534	3.0	27.6	138
Small acute	0	114	41	**155**	23	149	2	42	22	1,307	2.8	9.6	50
Psychiatric	11	6	0	**17**	0	0	0	0	108	600	69.1	48.8	8
Rehabilitation	6	2	0	**8**	0	0	1	1	74	1,170	18.5	89.1	15
Mothercraft	8	0	0	**8**	0	0	0	0	28	1,839	3.6	0.0	10
Small non-acute	14	50	11	**75**	5	57	1	16	33	929	9.7	74.2	33
Multipurpose services	0	45	33	**78**	0	70	0	4	12	349	3.9	31.4	13
Other	34	95	69	**198**	8	128	0	0	11	298	9.0	78.9	5
Total	**180**	**417**	**156**	**753**	**203**	**599**	**138**	**243**	**78**	**7,311**	**3.4**	**17.6**	**95**

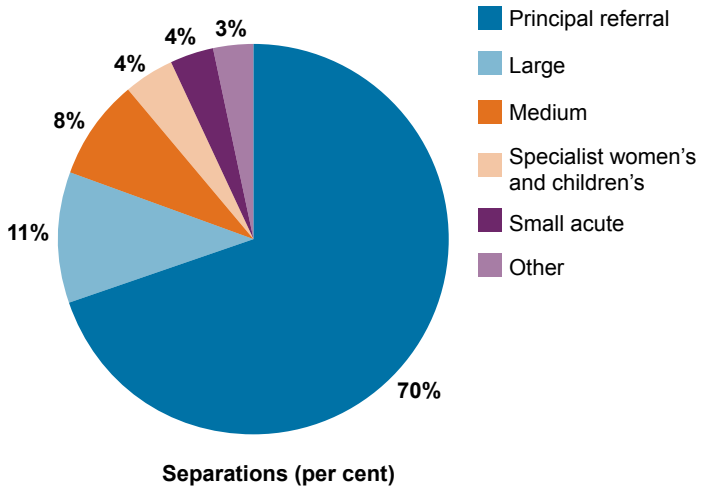


Figure 2: Separations for admitted patients, by public hospital type, 2011–12

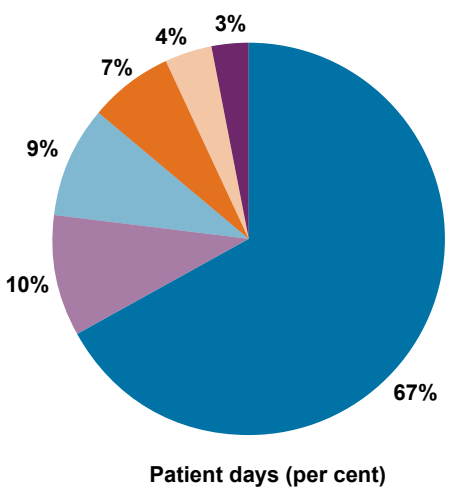


Figure 3: Patient days for admitted patients, by public hospital type, 2011–12

The majority of beds were in larger hospitals and in more densely populated areas. In 2011–12, the largest public hospital had more than 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. In Victoria, a higher proportion of hospital beds were in hospitals with more than 200 to 500 beds (38%) than in hospitals with more than 500 beds (19%) (Figure 4).

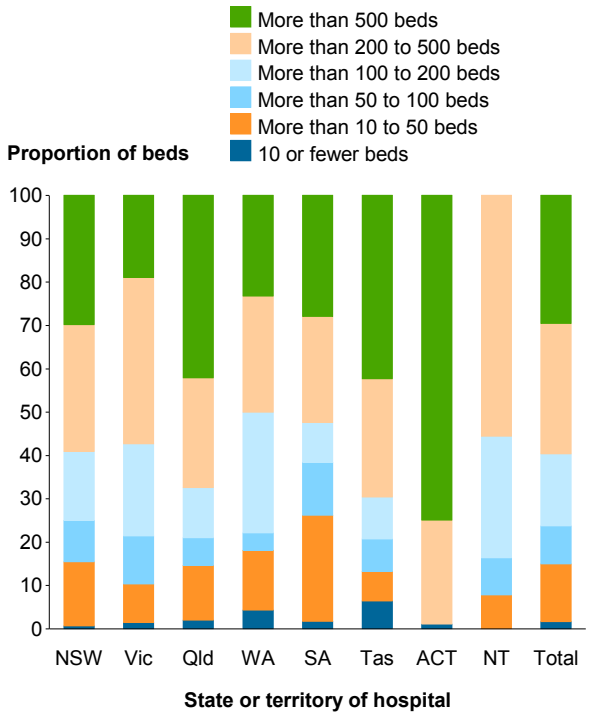


Figure 4: Proportion of beds by hospital size, states and territories, public hospitals, 2011–12

How many people are employed in Australia's hospitals?

Australia's public hospitals employed about 271,000 full-time equivalent staff in 2011–12, and private hospitals employed more than 58,000 in 2010–11 (ABS 2012).

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 comprised 46% of the full-time equivalent staff numbers in 2011–12. Salaried medical officers comprised 13% of staff and diagnostic and allied health professionals together comprised 14%.

The number of salaried medical officers increased by an annual average of 6.2% between 2007–08 and 2011–12, to 34,300. The number of nurses increased by an annual average of 3.6%, to 123,000 in 2011–12 (Figure 5).

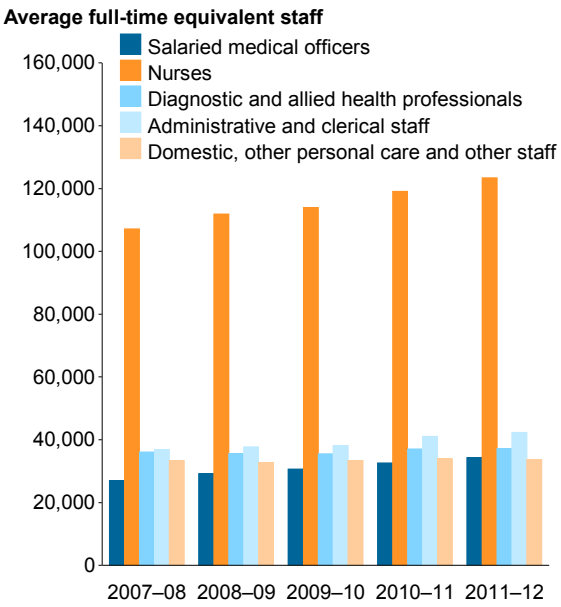


Figure 5: Average full-time equivalent staff, public hospitals, 2007–08 to 2011–12

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 comprised 57% of full-time equivalent staff numbers in 2010–11. Medical officers and diagnostic and allied health professionals together comprised 7% of full-time equivalent staff (ABS 2012).

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 2011–12, recurrent expenditure by public hospitals was $40,384 million (excluding depreciation). After adjusting for inflation, this represented an increase of 5.9% compared with 2010–11.

More than 62% of this expenditure was for salary payments ($25,146 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 2007–08 and 2011–12, recurrent expenditure by public hospitals increased by an average of 11.4% per year (after adjusting for inflation) (Figure 7).

Private hospitals

In 2010–11, recurrent expenditure by private hospitals was $9,610 million (including depreciation).

About 50% of this expenditure was for salary payments ($4,787 million).

Between 2006–07 and 2010–11, recurrent expenditure by private hospitals increased by an average of 8.4% per year (after adjusting for inflation) (ABS 2012).

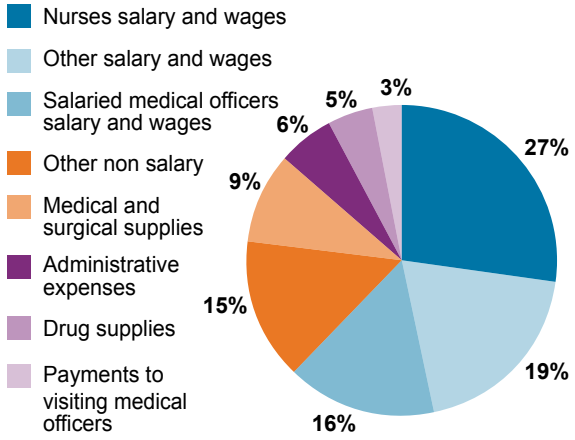


Figure 6: Recurrent expenditure, public hospitals, 2011–12

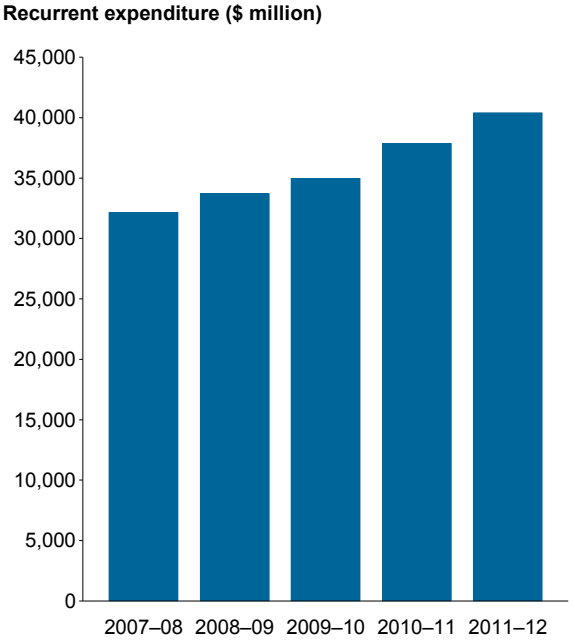


Figure 7: Recurrent expenditure, adjusted for inflation, public hospitals, 2007–08 to 2011–12

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 original sources of funds are reported here 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 2012). Private hospitals are mainly funded by private health insurance and out-of-pocket payments by patients (Figure 9).

The proportion of public hospital funding that was from the Australian Government increased between 2006–07 and 2008–09, then decreased (Figure 10).

Figure 8: Funding sources for public hospitals, 2010–11

Figure 9: Funding sources for private hospitals, 2010–11

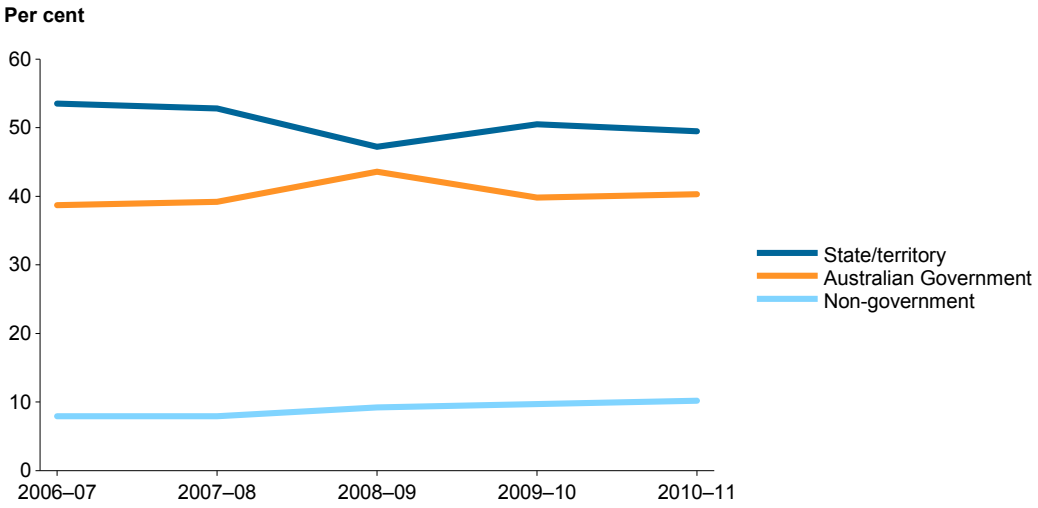


Figure 10: Funding sources for public hospitals, 2006–07 to 2010–11

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 in *Australian hospital statistics 2011–12* (AIHW 2013a).

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 1 in 4 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 2010–11 (ABS 2012), about 6% of the total for that year.

Public hospitals

There were about 7.8 million emergency visits to public hospitals in 2011–12. Between 2007–08 and 2011–12, they increased by an average of 2.4% 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.

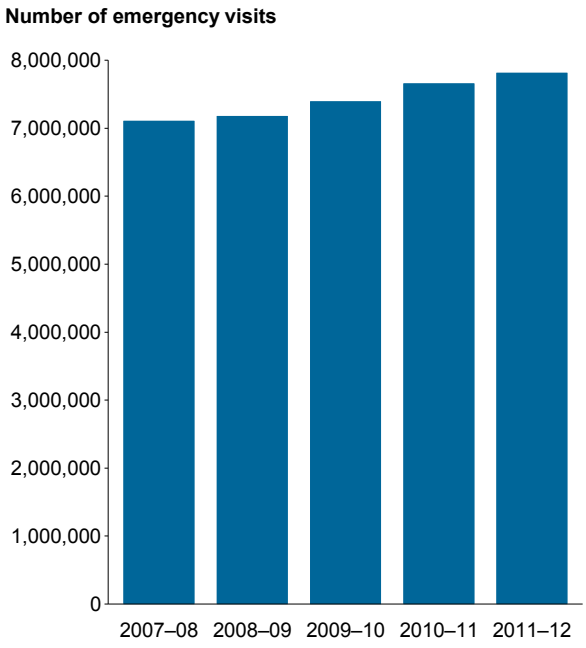


Figure 11: Public hospital emergency visits, 2007–08 to 2011–12

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 6.5 million presentations to public hospital emergency departments (about 84% of all emergency visits to public hospitals). A total of 5.6 million of those (88%) were in *Principal referral and specialist women's and children's hospitals* and *Large hospitals*.

In 2011–12:

- 72% of patients were seen within the recommended time for their triage category, ranging from 66% for *Urgent* patients, to 100% for *Resuscitation* patients (Figure 12)
- 50% of patients received care in 21 minutes or less and 90% received care in 108 minutes or less.

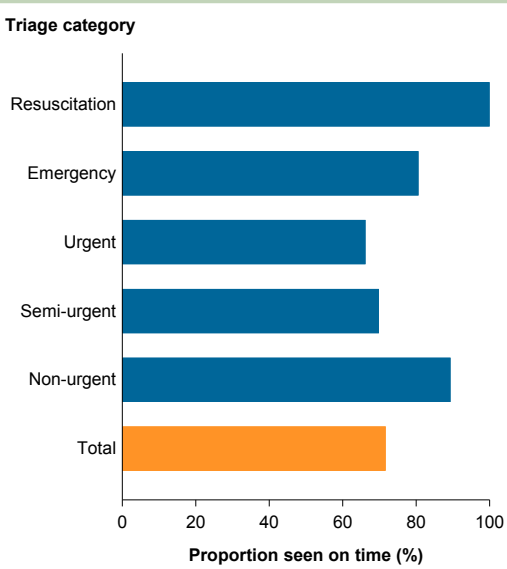


Figure 12: Proportion of emergency presentations seen on time, public hospital emergency departments, 2011–12

The proportion of patients seen within the recommended time for their triage category improved between 2007–08 and 2011–12, 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 77% and 80% of presentations.

There was some variation in the proportion seen on time between jurisdictions, ranging from 54% overall for the Northern Territory to 76% overall in New South Wales and South Australia (Table 3). More information on the proportion seen on time by triage category for each state and territory is in figures 12a–12h, accompanying this report online.

Table 3: Proportion (per cent) of presentations seen on time by triage category, public hospital emergency departments, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
					('000)				
Total presentations	2,235	1,509	1,239	732	427	142	118	145	6,547
Triage category					**Per cent**				
Resuscitation	100	100	100	99	100	100	100	100	100
Emergency	82	83	82	76	79	77	76	64	80
Urgent	71	72	63	52	70	64	50	49	66
Semi-urgent	74	67	69	67	77	71	47	49	70
Non-urgent	89	87	90	94	92	88	81	89	89
Total	**76**	**72**	**69**	**65**	**76**	**71**	**55**	**54**	**72**

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 2011–12, public hospitals provided over 45.3 million services for non-admitted patients. Of these:

- Specialist outpatient clinics delivered 16.9 million services, with the chief contributors being medical/surgical/obstetric and allied health
- Mental health and alcohol and drug services delivered 2.8 million service episodes
- Pharmacy, pathology, radiology and organ imaging comprised a further 19.3 million services
- District nursing, outreach and community health services accounted for 6.3 million service episodes
- 304,000 service episodes were for group sessions (provided to more than one patient at a time), with community health and other outreach accounting for about a third of these sessions.

Between 2007–08 and 2011–12, outpatient care delivered in specialist outpatient clinics increased by an average of less than 1% per year; pharmacy, pathology and radiology and organ imaging services increased by 5% per year; mental health and alcohol and drug services decreased by 2% per year; and district nursing, outreach and community health services increased by about 3% per year (Figure 13).

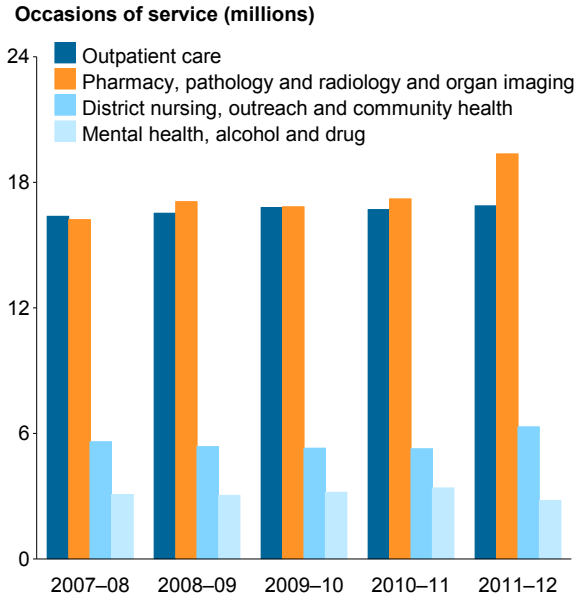


Figure 13: Non-admitted patient services, public hospitals, 2007–08 to 2011–12

Private hospitals

In 2010–11, private hospitals provided about 1.6 million non-admitted patient services (3.5% of the total for public and private hospitals), with about 1.5 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 180,000 other services for non-admitted patients, comprising community health, district nursing and non-medical and social services (ABS 2012).

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 2011–12:

- about 9.3 million separations took place in Australian hospitals (Table 4)
- public hospitals accounted for 60% of separations (5.5 million), and half of these were 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 (3.7 million), and about two-thirds of these were 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).

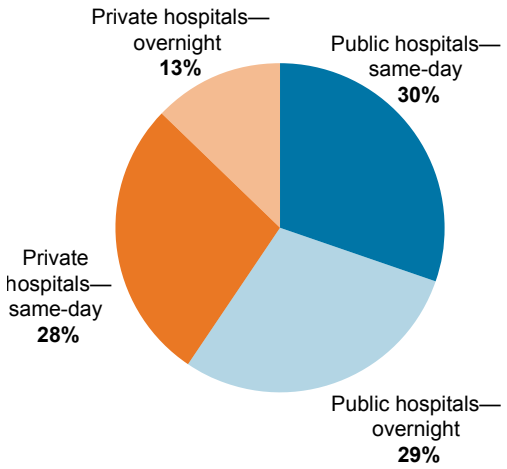


Figure 14: Same-day and overnight separations, public and private hospitals, 2011–12

Table 4: Separations ('000s), public and private hospitals, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Public acute	1,655	1,543	1,001	587	405	99	97	113	5,502
Public psychiatric	5	<1	<1	1	2	<1	. .	. .	10
Total public hospitals	*1,661*	*1,544*	*1,001*	*588*	*407*	*100*	*97*	*113*	*5,511*
Private hospitals									
Private free-standing day hospitals	226	209	212	120	65	n.p.	n.p.	n.p.	844
Other private hospitals	845	708	689	316	225	n.p.	n.p.	n.p.	2,901
Total private hospitals	*1,070*	*918*	*901*	*436*	*290*	*n.p.*	*n.p.*	*n.p.*	*3,745*
All hospitals	**2,731**	**2,462**	**1,902**	**1,024**	**697**	**n.p.**	**n.p.**	**n.p.**	**9,256**

n.p. not published
. . not applicable

Table 5: Patient days ('000s), public and private hospitals, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Public acute	6,130	4,742	3,116	1,795	1,560	348	327	294	18,313
Public psychiatric	305	40	147	61	119	5	. .	. .	678
Total public hospitals	*6,435*	*4,782*	*3,263*	*1,857*	*1,679*	*354*	*327*	*294*	*18,991*
Private hospitals									
Private free-standing day hospitals	226	209	212	120	65	n.p.	n.p.	n.p.	844
Other private hospitals	2,227	2,052	1,965	785	569	n.p.	n.p.	n.p.	7,901
Total private hospitals	*2,453*	*2,262*	*2,177*	*906*	*634*	*n.p.*	*n.p.*	*n.p.*	*8,745*
All hospitals	**8,888**	**7,044**	**5,440**	**2,762**	**2,313**	**n.p.**	**n.p.**	**n.p.**	**27,736**

n.p. not published
. . not applicable

How has this activity changed over time?

Between 2007–08 and 2011–12, separations increased by 17.6% overall. This was an average increase of 4.1% per year (3.8% in public acute hospitals and 4.6% in private hospitals) (Figure 15).

Over the same period, the number of patient days increased at a slower rate than separations, reflecting an increase in same-day admissions. Patient days increased by 1.5% per year for public hospitals and by 2.9% per year for private hospitals.

Between 2010–11 and 2011–12, separations increased overall by 4.6% (4.4% in public hospitals and 4.8% in private hospitals). Patient days increased by 2.4% in public hospitals and 4.0% in private hospitals.

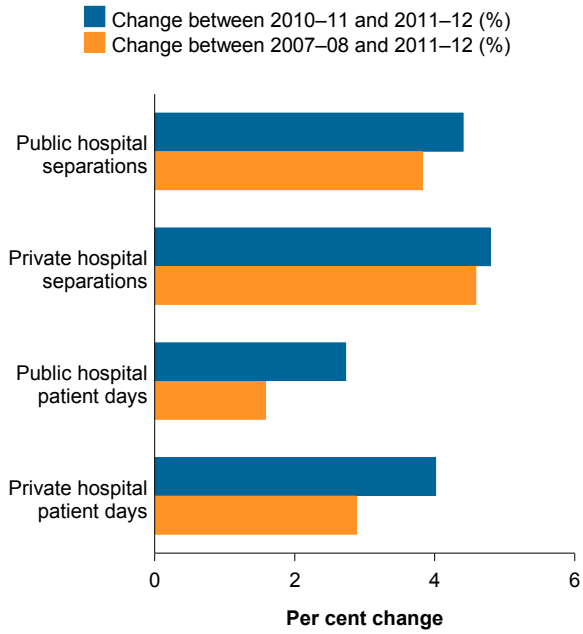


Figure 15: Change in separations and patient days (per cent), public acute and private hospitals, 2007–08 to 2011–12

Who used these services?

In 2011–12, there were almost 4.9 million separations for women and girls compared with 4.4 million for men and boys (52% and 48% of separations, respectively) (Figure 16). People aged 65 and over accounted for 39% of separations and 48% of patient days.

Separations increased for both males and females between 2007–08 and 2011–12. 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 40% in separations between 2007–08 and 2011–12, an average increase of 9% each year.

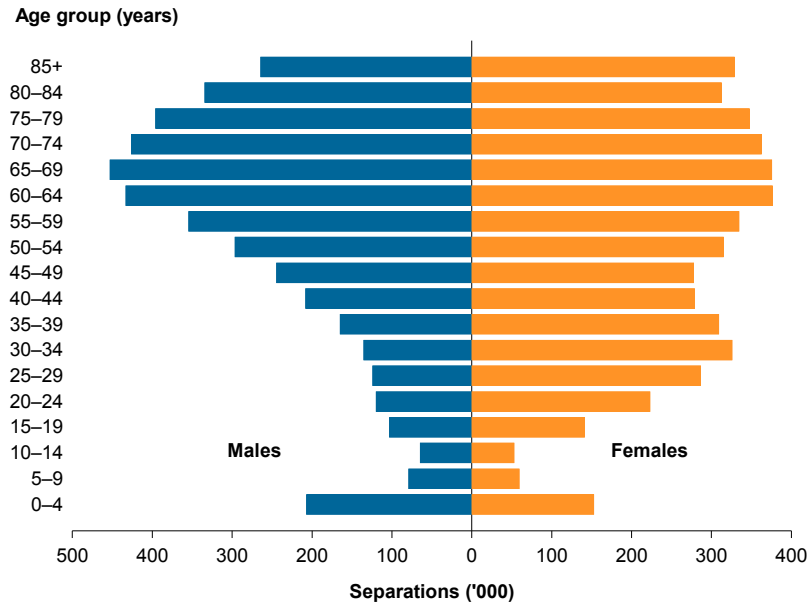


Figure 16: Separations, by age group and sex, all hospitals, 2011–12

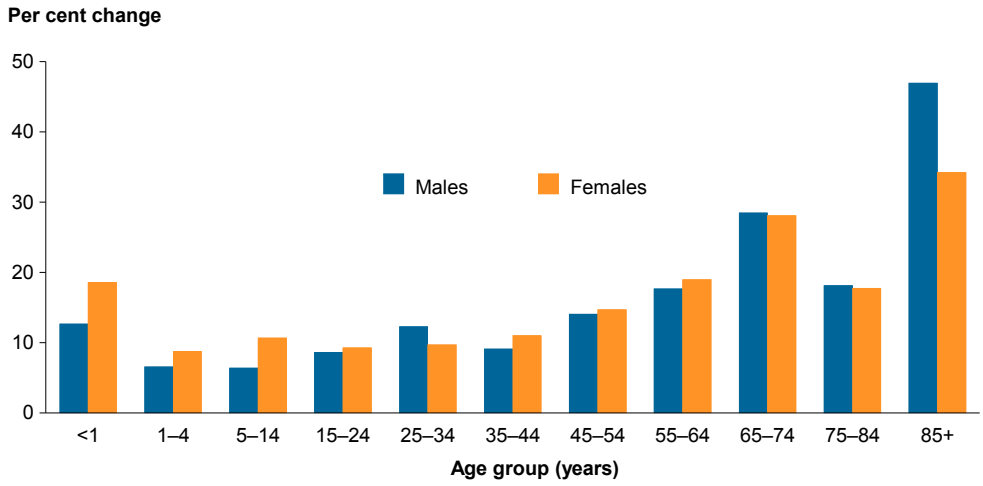


Figure 17: Change in the number of separations, by age group and sex, all hospitals, 2007–08 to 2011–12

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 2011–12:

- Indigenous Australians had a separation rate more than two and a half times the separation rate for other Australians (973 per 1,000 population compared with 385 per 1,000 population)
- Indigenous Australians had more separations per 1,000 population than other Australians across all age groups (Figure 18).

However, if hospitalisations for dialysis for kidney disease are not counted, Indigenous Australians were hospitalised only about 33% more often than other Australians (451 per 1,000 population compared with 340 per 1,000). This illustrates the impact kidney disease has on the health of Indigenous Australians, and the subsequent hospital usage for dialysis.

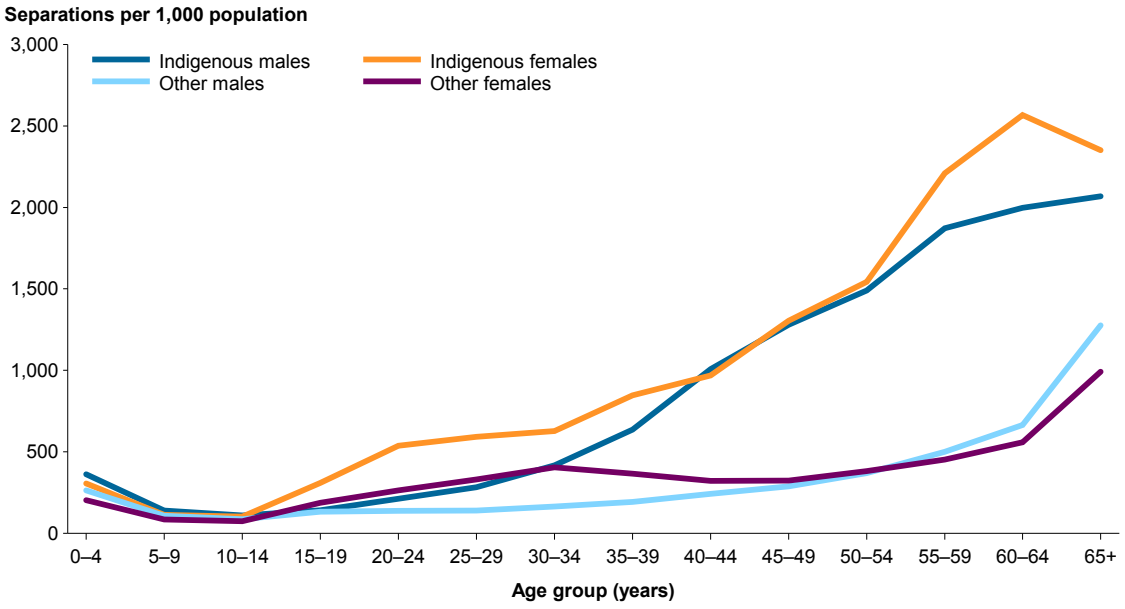


Figure 18: Separations per 1,000 population, by Indigenous status and age group, all hospitals, 2011–12

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* (524 and 216 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 (175 and 70 separations per 1,000 population, respectively).

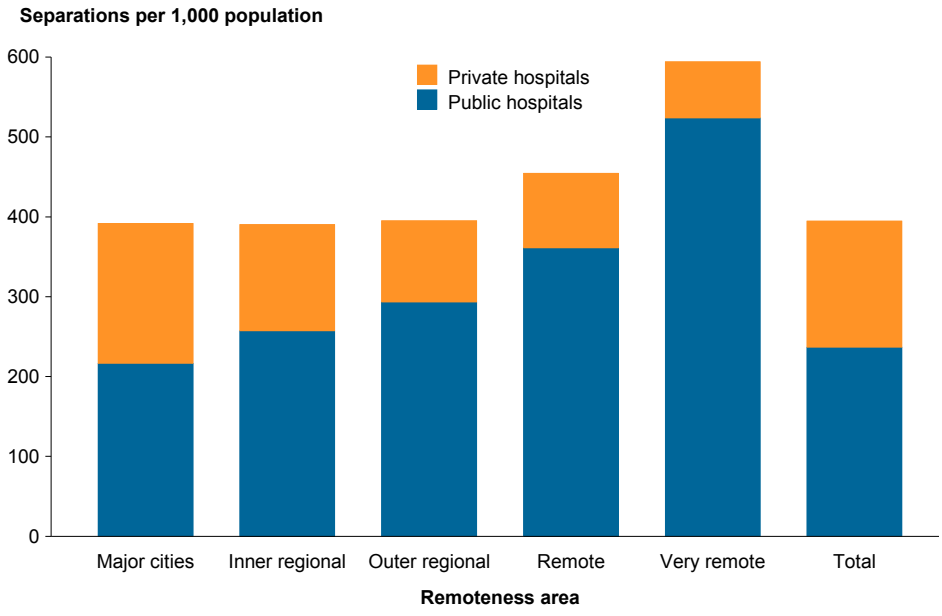


Figure 19: Separations per 1,000 population, by remoteness area of usual residence, public and private hospitals, 2011–12

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.

Overall, there was little variation across the SES groups in the number of separations per 1,000 population (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 (305 and 152 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 (227 and 103 separations per 1,000 population, respectively).

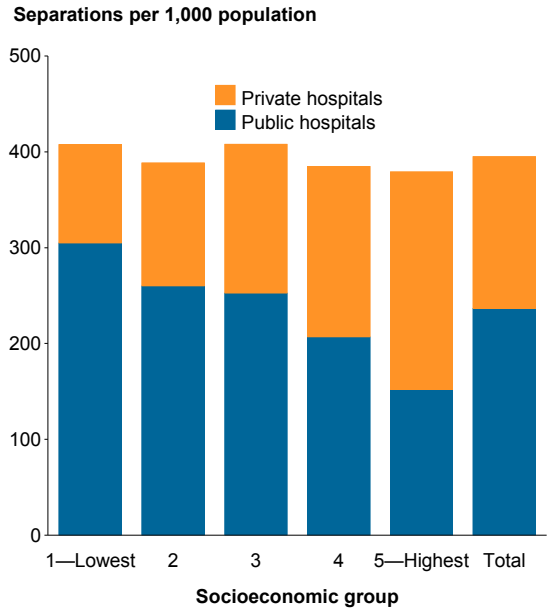


Figure 20: Separations per 1,000 population, by socioeconomic status of area of usual residence, public and private hospitals, 2011–12

Why did people receive this care?

The reason that a patient receives admitted patient care can be described in terms of a principal diagnosis. Sometimes it is described in terms of a treatment for an ongoing condition (for example, dialysis for kidney failure).

In 2011–12, for public and private hospitals combined, about 27% of separations had a principal diagnosis in the *International statistical classification of diseases and related health problems, 10th revision, Australian modification* (ICD-10-AM) chapter *Factors influencing health status and contact with health services*, which includes dialysis, chemotherapy and rehabilitation.

The 10 principal diagnosis chapters presented in Figure 21 accounted for a further 52% of public hospital separations and 61% of private hospital separations.

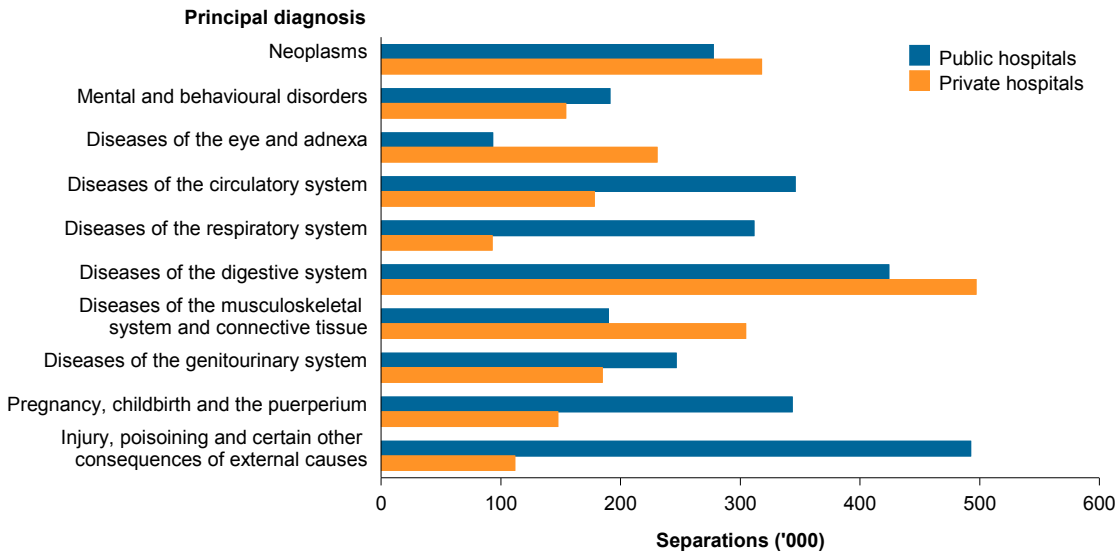


Figure 21: Separations for selected principal diagnoses in ICD-10-AM chapters, public and private hospitals, 2011–12

Many separations had a principal diagnosis reported that was a disease of the digestive system (10%), a cancer (6%), an injury or poisoning (7%), or a disease of the circulatory system (6%).

Public hospital separations accounted for more than 77% of separations with a principal diagnosis in *Diseases of the respiratory system* (for example, asthma, pneumonia, chronic obstructive pulmonary disease) and almost 70% of pregnancy or childbirth separations (Figure 21).

Private hospitals accounted for more than 71% of separations with a principal diagnosis in *Diseases of the eye and adnexa* (for example, cataract extraction).

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 672,000 PPHs represented 7.3% of all hospital separations in 2011–12.

Overall, the number of PPHs per 1,000 population decreased by an average of 3.8% per year between 2007–08 and 2011–12. However, changes in how diabetes-related conditions were reported over this period were probably responsible for the majority of these decreases. Acute preventable conditions increased by an average of 7.5% per year between 2007–08 and 2011–12, and vaccine-preventable conditions were relatively stable. Chronic conditions (other than diabetes) decreased by 0.2%.

For chronic conditions, excluding diabetes, PPHs rose with increasing remoteness. In 2011–12, there were 9.0 PPHs per 1,000 population for chronic conditions in *Major cities*, and 21.7 per 1,000 in *Very remote* areas (Figure 22).

For acute conditions, the pattern was the same, ranging from 13.9 per 1,000 in *Major cities* to 31.1 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 (1.1 and 0.6 per 1,000, 16.8 and 12.7 per 1,000, and 17.5 and 8.4 per 1,000, respectively).

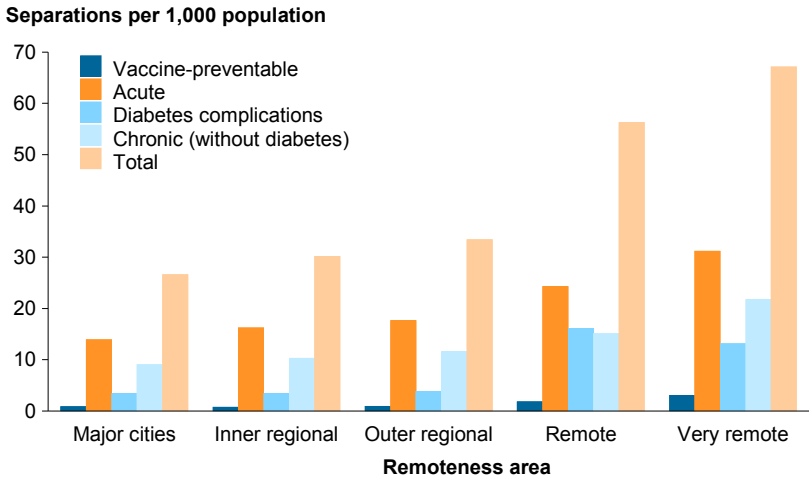


Figure 22: Potentially preventable hospitalisations by remoteness area of usual residence, all hospitals, 2011–12

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*.

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 (maintenance care)
- type of surgical or other procedure undertaken.

Broad category of service

In public hospitals, most separations were for medical care—77% in 2011–12, and 4% were for childbirth (Figure 23). About 21% of overnight separations were for surgical care, as were 14% of same-day separations.

Private hospitals provided a higher proportion of separations for surgical care than public hospitals—37% in 2011–12. Specialist mental health care was provided for 4% of private hospital separations.

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 2011–12 for 95% of separations and 80% of patient days for public hospitals and for 93% of separations and 85% of patient days for private hospitals.

Rehabilitation, or improved functioning, was the next most commonly reported intent of care. For 2011–12, it was reported for 1.7% of separations and 8.6% of patient days for public hospitals, and for 6.1% of separations and 12.0% of patient days for private hospitals. More information about subacute and non-acute care is on page 30.

Procedures

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

In 2011–12, one or more procedures were reported for 82% of separations in Australian hospitals. Almost 95% of separations from private hospitals recorded a procedure, compared with 74% from public hospitals. Overall, 54% of separations that reported a procedure occurred in the public sector.

In 2011–12, many separations had a procedure reported that was for the urinary system (16%), the digestive system (13%), the musculoskeletal system (7%) or was gynaecological (4%). Also commonly reported were separations with non-invasive, cognitive and other interventions, including allied health and general anaesthesia (61%).

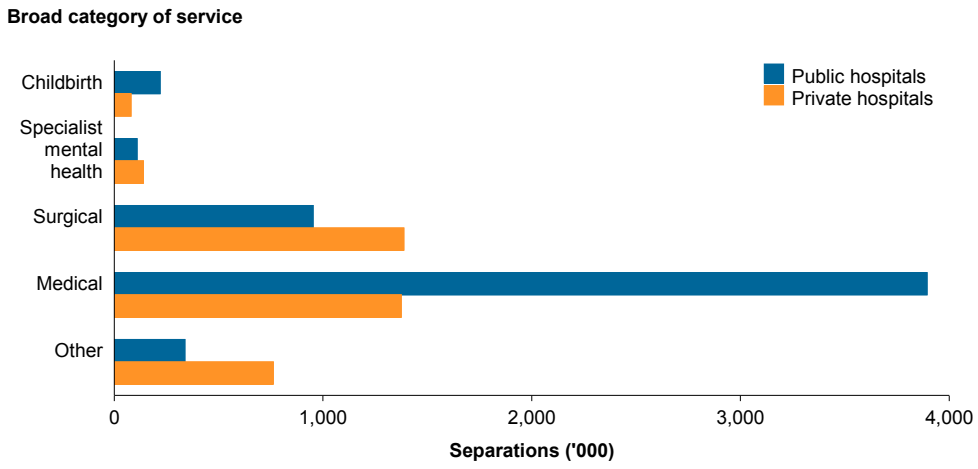


Figure 23: Separations by broad category of service, public and private hospitals, 2011–12

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 24 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 8.8 per 1,000 population, but the state/territory rates ranged from 6.4 per 1,000 to 10.5 per 1,000 population.

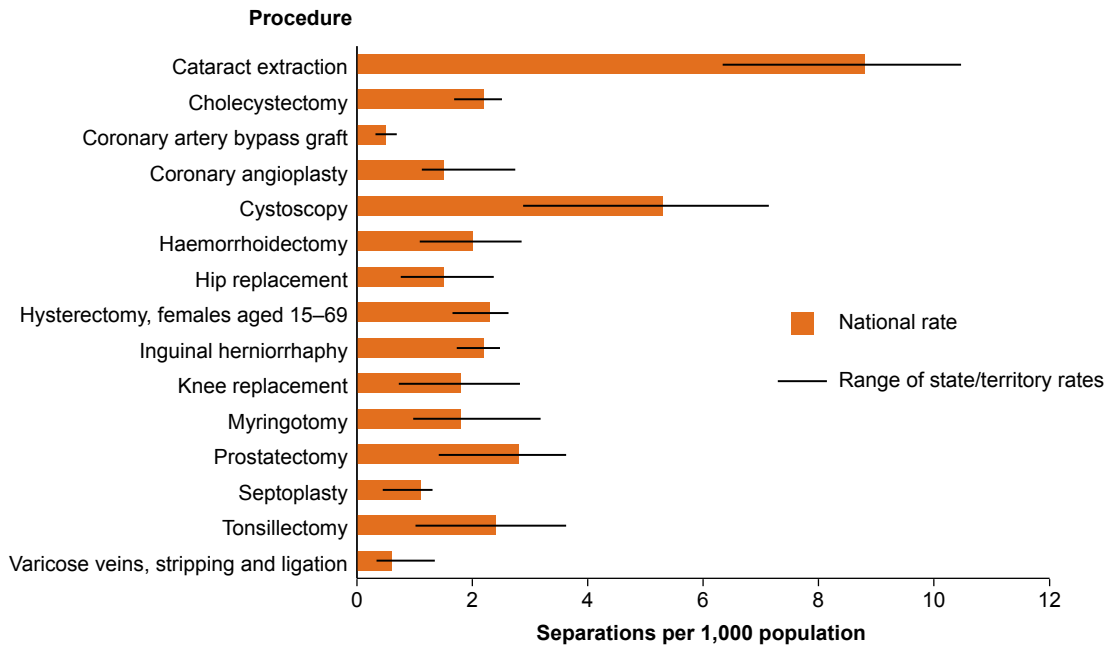


Figure 24: Separations per 1,000 population for selected hospital procedures, all hospitals, 2011–12

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: adverse events treated in hospital

Adverse events are defined as incidents in which harm resulted to a person receiving health care. They include infections, falls resulting in injuries, and problems with medication and medical devices. Some of these adverse events may be preventable.

Hospital separations data include information on 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. However, other diagnosis codes may also suggest that an adverse event has occurred, and some adverse events are not identifiable using these codes.

In 2011–12, 5.3% of separations reported an ICD-10-AM code indicating an adverse event. The proportion of separations with an adverse event was 6.1% for public hospitals and 3.9% for private hospitals (Table 6). The data for public hospitals are not comparable with the data for private hospitals because their casemixes differ and recording practices may be different.

For public hospital separations, 1.8% of same-day separations reported an adverse event compared with 10.7% of overnight separations. For private hospitals, 1.4% of same-day separations reported an adverse event compared with 9.4% of overnight separations.

Separations for sub- and non-acute care had higher rates of adverse events than acute care separations (9.3 and 5.0 separations with an adverse event per 100, respectively), and emergency admissions had higher rates of adverse events than non-emergency admissions (9.1 and 3.8 separations with an adverse event per 100, respectively).

Table 6: Separations with an adverse event per 100 separations, public and private hospitals, 2011–12

	Public hospitals	Private hospitals	Total
Separations with an adverse event	338,579	147,731	486,310
Separations with an adverse event per 100 separations			
Same-day separations	1.8	1.4	1.6
Overnight separations	10.7	9.4	10.3
Acute care separations	5.9	3.7	5.0
Sub- and non-acute care separations	11.2	7.4	9.3
Emergency admission	8.9	11.9	9.1
Non-emergency admission	4.2	3.5	3.8
Total	**6.1**	**3.9**	**5.3**

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

Staphylococcus aureus bacteraemia (SAB), also known as golden staph bloodstream infection, 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 2011–12, there were 1,734 cases of SAB reported for Australian public hospitals overall. More than three-quarters (76%) were methicillin sensitive, and would have been treatable with commonly used antibiotics.

The cases occurred during about 18.5 million days of patient care under SAB surveillance during 2011–12.

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, Queensland and South Australia to 1.3 in the Northern Territory (Figure 25).

For more information, see *Australian hospital statistics 2011–12: Staphylococcus aureus bacteraemia in Australian hospitals* (AIHW 2013b).

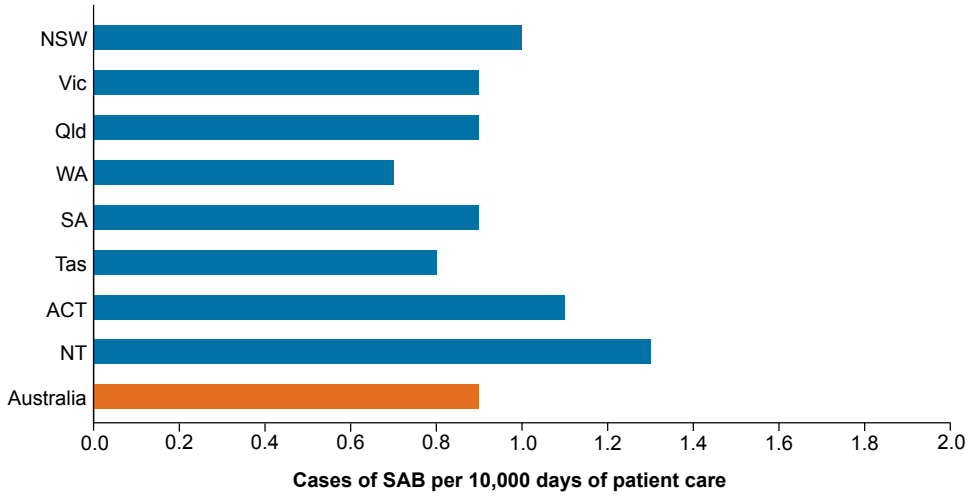


Figure 25: Cases of *Staphylococcus aureus* bacteraemia per 10,000 days of patient care in public hospitals, states and territories, 2011–12

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 1 day's stay, even if it is only for a few hours) and overnight care (care that is for at least 1 night), the average length of stay was 3.0 days in 2011–12, 2.3 days in private hospitals and 3.4 days in public acute hospitals. These averages have decreased over time (Figure 26), largely reflecting the fact that the proportion of separations that are day-only have increased.

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 2.9 days in public hospitals and 2.1 days in private hospitals (Figure 27). For Rehabilitation care, the average length of stay was 17.0 days in public hospitals and 4.6 days in private hospitals.

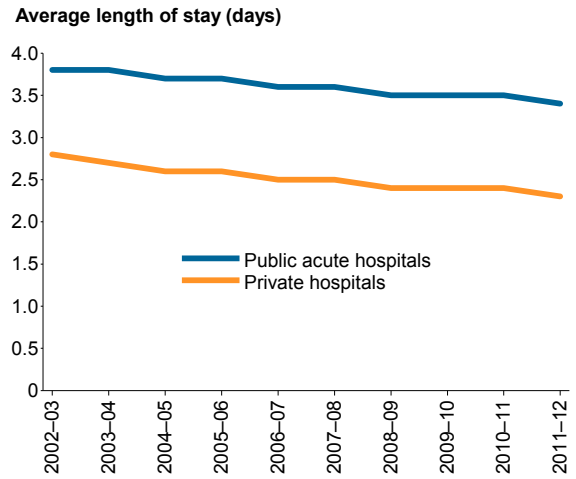


Figure 26: Average length of stay, public acute and private hospitals, 2002–03 to 2011–12

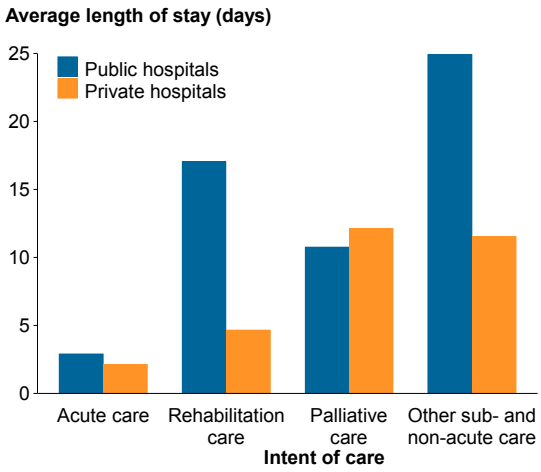


Figure 27: Average length of stay (days) by care type, public and private hospitals, 2011–12

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 2011–12, there were relatively shorter lengths of stay for medical separations (including specialist mental health) in public hospitals (0.96, compared with 1.24 in private hospitals), and for surgical separations in private hospitals (0.98, compared with 1.04 in public hospitals) (Figure 28). Overall, the relative length of stay was lower in public hospitals than in private hospitals. Childbirth is included in 'other' in this figure.

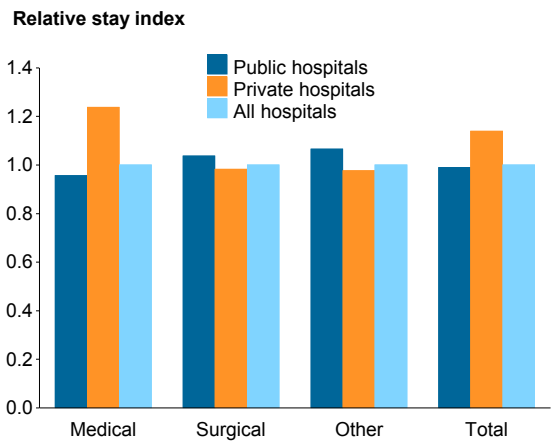
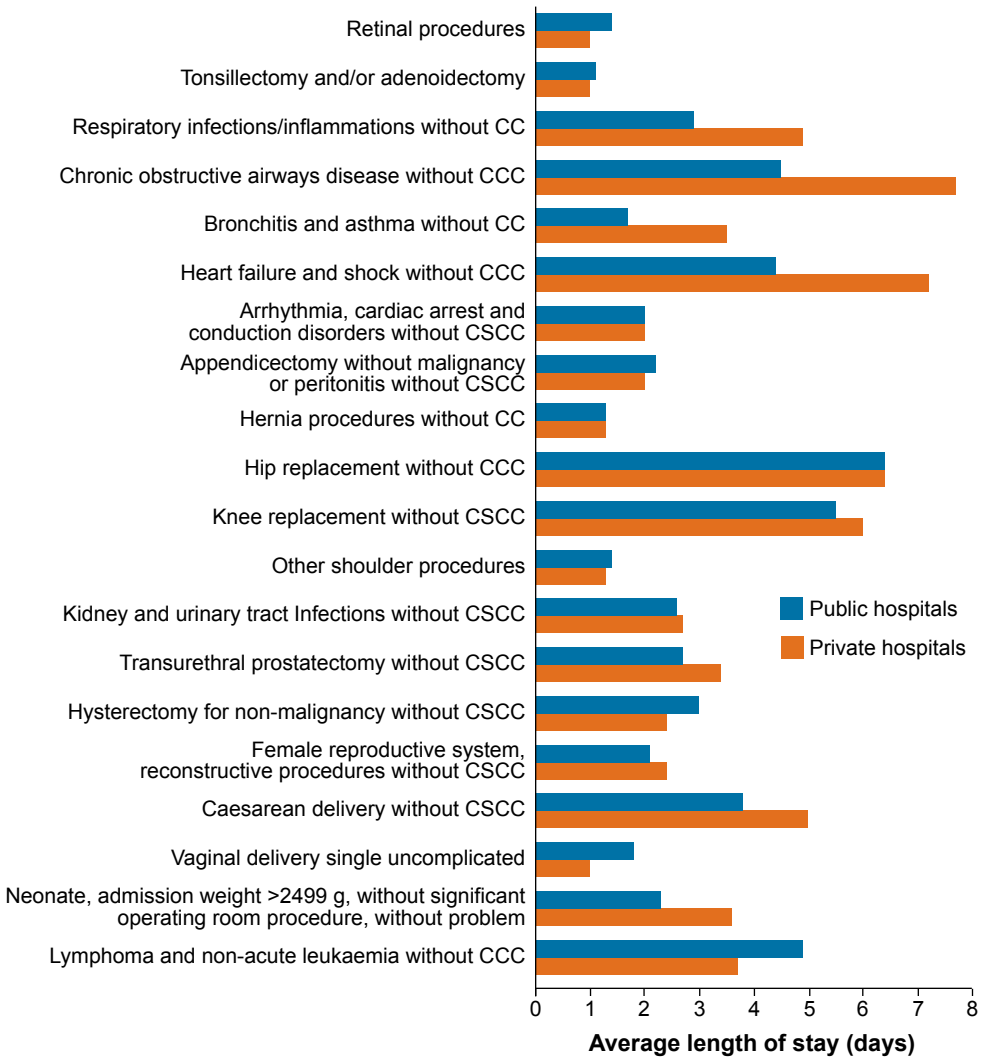


Figure 28: Relative stay index (directly standardised), for medical, surgical and other care, public and private hospitals, 2011–12

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

The average length of stay for selected types of separations (defined using AR-DRGs) is regarded as an indicator of the efficiency of 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 4.5 days for public hospitals and 7.7 days for private hospitals (Figure 29).



CC—complications and comorbidities, CCC—catastrophic complications and comorbidities, CSCC—catastrophic and/or severe complications and comorbidities.

Figure 29: Average length of stay (days) for selected types of separations, public and private hospitals, 2011–12

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. 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 $4,215 in 2007–08 to $5,204 in 2011–12 (not adjusted for inflation).

There was a total increase of 20.3% in this period (Figure 30), an average increase of 4.7% annually.

In 2011–12 the average cost comprised:

- $2,564 for non-medical labour expenditure
- $1,163 for medical labour expenditure
- $1,477 for other recurrent expenditure.

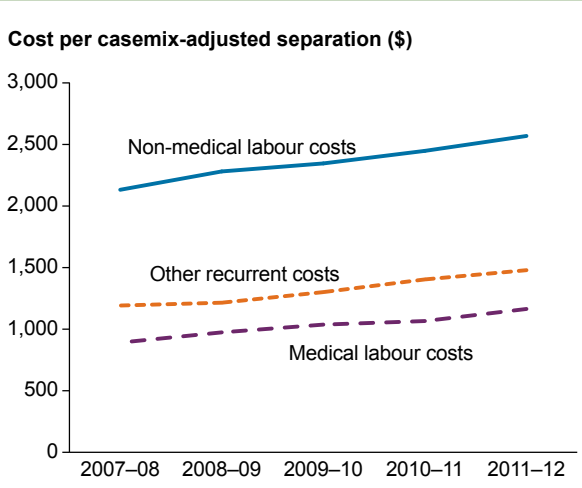


Figure 30: Cost per casemix-adjusted separation, public hospitals, 2007–08 to 2011–12

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.

Who paid for the care?

More than half of all separations in 2011–12 were public patients (52%), who were not charged for their stay. Private health insurance accounted for a further 39%, and self-funded patients accounted for about 4% (Figure 31).

Between 2007–08 and 2011–12, there was an overall increase in separations of 4.1% per year. Separations funded by motor vehicle third-party personal claims increased by 7.6% per year and those funded by private health insurance increased by 5.5% per year (Figure 32). Separations funded by the Department of Veterans' Affairs decreased by an average of 1.4% per year.

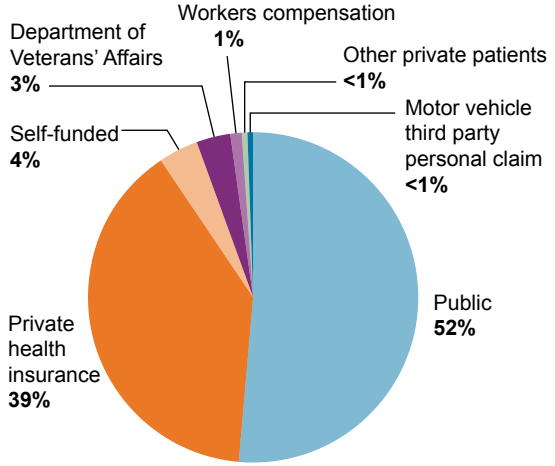


Figure 31: Proportion of separations by principal source of funds, all hospitals, 2011–12

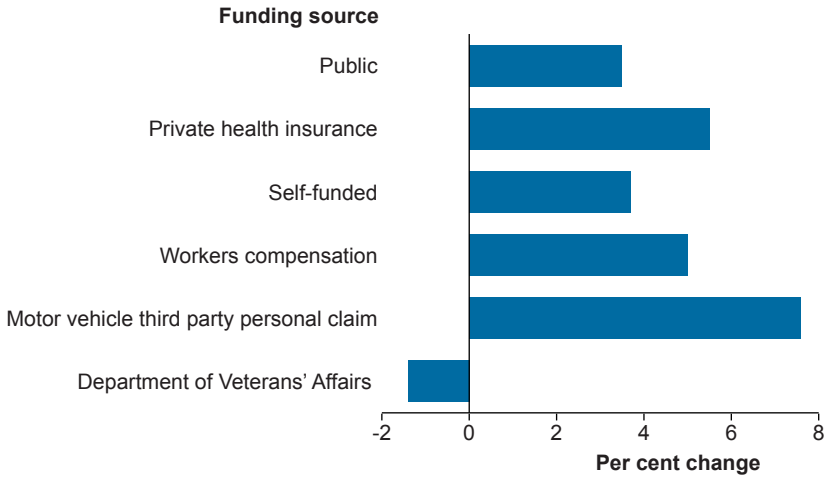


Figure 32: Average annual change in the number of separations by selected principal source of funds, all hospitals, 2007–08 to 2011–12

Admitted patient care: same-day acute care

Same-day admitted patient care occurs when the patient is admitted and separated on the same date. 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 comprised 3.8% of same-day care).

In 2011–12, 5.2 million, or 56% of separations, were same-day acute care separations. This included 2.8 million public hospital separations and 2.4 million private hospital separations.

Between 2007–08 and 2011–12, the proportion of same-day separations increased from 56.2% to 58.1%. On average, the number of same-day separations increased by 4.3% per year for public hospitals, and 4.9% per year for private hospitals.

Who used these services?

Aboriginal and Torres Strait Islander people were hospitalised on a same-day basis at about 3 times the rate of other Australians. Almost 1 in 4 same-day separations were for care involving dialysis (more than 1.2 million). After excluding dialysis, the rate of same-day separations for Indigenous Australians was lower than the rate for other Australians (139 and 169 per 1,000 population, respectively) (Figure 33).

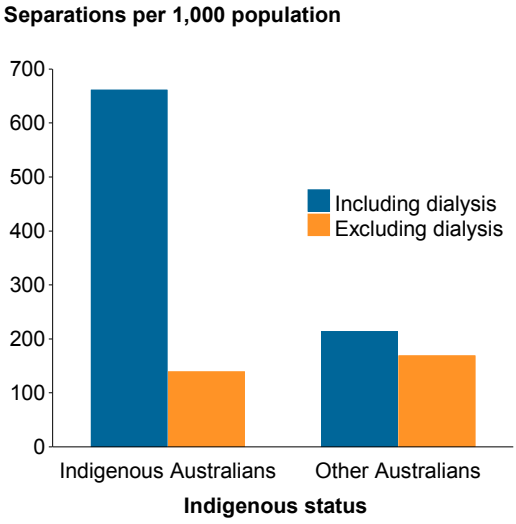


Figure 33: Same-day acute separations per 1,000 population, by Indigenous status, all hospitals, 2011–12

Persons usually resident in *Very remote* areas had 322 same-day separations per 1,000 population, compared with 221 per 1,000 nationwide.

Same-day separation rates were similar for different socioeconomic status groups, ranging from 210 per 1,000 population for the second lowest SES group to 232 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 for other care (not assigned).

Why did people receive this care?

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

- care involving dialysis (more than 1.2 million separations for kidney failure)
- other medical care (376,000 separations, mainly chemotherapy for cancer)
- cataract (173,000 separations).

What care was provided?

In public hospitals, more than three-quarters of same-day separations were for medical care (including specialist mental health). In private hospitals, about 37% of same-day separations were for medical care and about 34% were for surgical care.

About 7.7 million procedures were reported for same-day separations. In public hospitals, about 79% of same-day separations involved a procedure and in private hospitals about 97% of same-day separations involved a procedure.

The most common procedure (apart from anaesthesia) was haemodialysis, followed by pharmacotherapy (which 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 80% 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 1 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 comprised 5.7% of overnight separations).

In 2011–12, 40% of separations (3.7 million) were for overnight acute care. This included 2.6 million public hospital separations and 1.1 million private hospital separations.

Between 2007–08 and 2011–12, the number of overnight acute separations increased, on average, by 3.0% per year for public hospitals, and by 2.1% 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 261 overnight acute separations per 1,000 population, compared with 157 per 1,000 nationwide.

Separation rates varied by socioeconomic status, from 133 per 1,000 population for the highest SES group to 175 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).

Why did people receive this care?

The most common principal diagnoses for overnight acute separations were:

- childbirth (about 274,000 separations)
- pain in the throat and chest (almost 75,000 separations)
- sleep disorders (67,000 separations)
- pneumonia (60,000 separations).

What care was provided?

In public hospitals, about 66% of overnight acute separations were for medical care (including specialist mental health).

In private hospitals, about 54% of overnight acute separations were for surgical care.

How long did patients stay?

The average length of stay for overnight acute separations was 5.0 days for public hospitals and 4.6 days for private hospitals.

The average lengths of stay for medical care and childbirth were greater in private hospitals than in public hospitals. For surgical and other care, average lengths of stay were notably higher in public hospitals (Figure 34).

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 84% of overnight acute separations.

International comparisons

The number of overnight separations per 1,000 population in Australia for 2011–12 was in the middle of the range reported for other Organisation for Economic Co-operation and Development (OECD) countries in recent years (Figure 35) (OECD 2012).

The comparability of international separation rates is likely to be affected by differences in definitions of hospitals, collection periods and in admission practices.

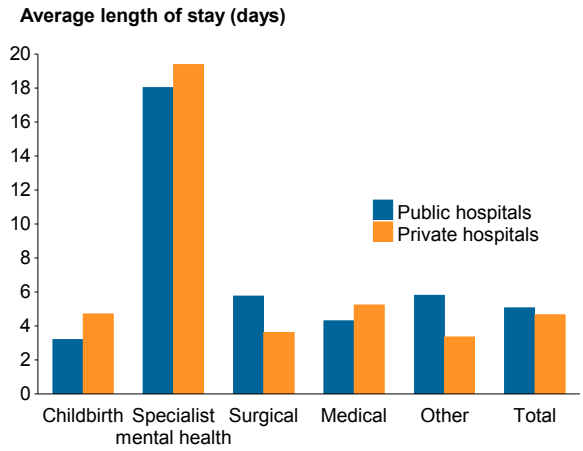
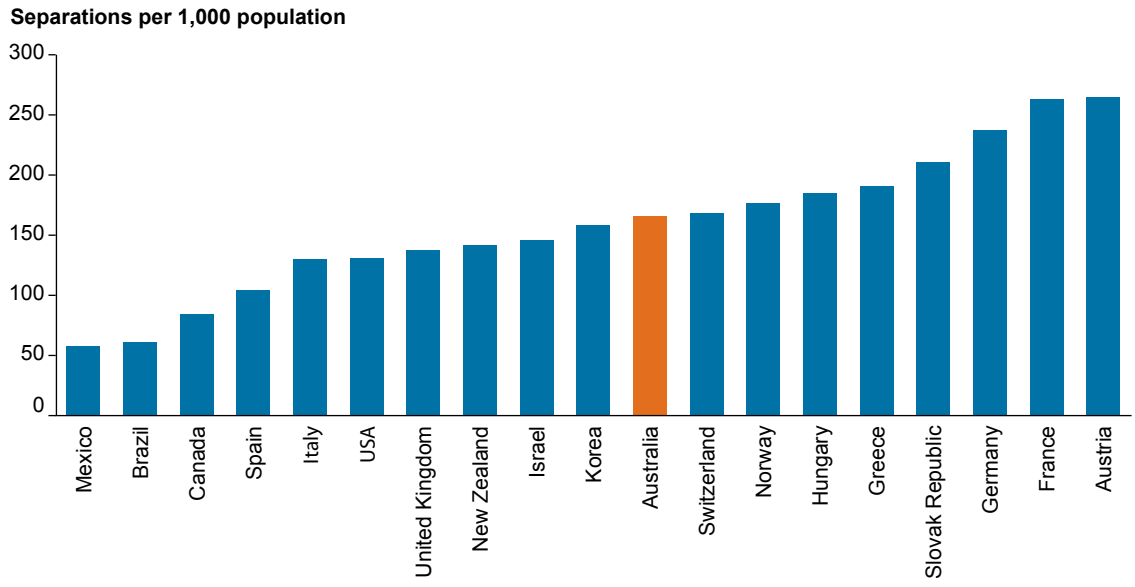


Figure 34: Average length of stay for overnight acute separations, public and private hospitals, 2011–12



Notes

1. Data for OECD countries vary in collection periods, by financial year and calendar year. Data are for 2009 or 2010 except for Australia (2011–12).
2. Separations include all care types.

Figure 35: Overnight separations per 1,000 population, Australia, 2011–12 and selected OECD countries (2009 or 2010)

Admitted patient care: surgery

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

In 2011–12, 2.4 million, or 26%, of separations included a surgical procedure. This included 1.0 million public hospital separations and 1.4 million private hospital separations.

The number of surgical separations increased between 2007–08 and 2011–12 by an average of 2.6% for public hospitals and 3.7% 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 (25% and 3% respectively).

Who used these services?

Indigenous Australians had about twice the rate of emergency admissions involving surgery compared with other Australians (25 and 13 per 1,000 population, respectively). The rate of elective admissions involving surgery was about 60% higher for other Australians as for Indigenous Australians (87 and 54 per 1,000 population, respectively).

For emergency admissions involving surgery, persons usually resident in *Very remote* areas had the highest rate (21 per 1,000 compared with 13 per 1,000 nationwide). Persons usually resident in *Very remote* areas had 59 elective admissions involving surgery per 1,000 population, compared with 87 per 1,000 nationwide (Figure 36).

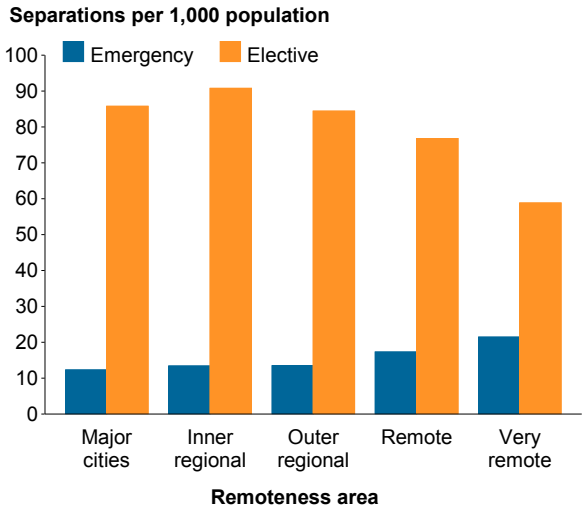


Figure 36: Surgical separations per 1,000 population, by urgency of admission and remoteness area of usual residence, all hospitals, 2011–12

Separation rates for elective admissions involving surgery varied by socioeconomic status, from 79 per 1,000 population for the lowest SES group to 91 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 (16 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 (75 per 1,000) and decreased with socioeconomic status to 40 per 1,000 population for the lowest SES group (Figure 37).

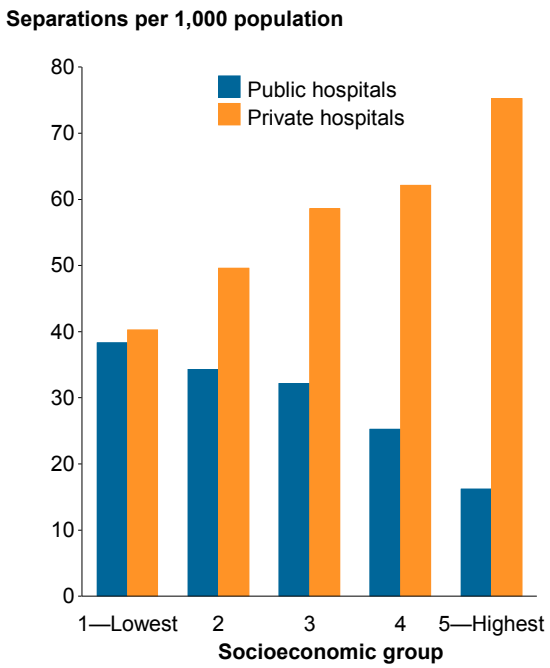


Figure 37: Elective admissions involving surgery, by socioeconomic status of area of usual residence, public and private hospitals, 2011–12

Why did people receive this care?

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

- acute appendicitis (about 27,000 separations)
- fracture of femur (hip fracture, 19,000 separations)
- heart attack (14,000 separations).

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

- cataract (about 176,000 separations)
- malignant neoplasm of skin (about 95,000 separations)
- procreative management (68,000 separations).

What care was provided?

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

- appendicectomy (about 30,000 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 198,000 separations)
- excision of skin lesion (90,000 separations)
- curettage and evacuation of uterus (84,000 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 7.3 days for both public and private hospitals.

For elective admissions involving surgery, the average length of stay was 2.4 days for public hospitals and 1.9 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 patients 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 2011–12, an increase from 34 days in 2007–08. A total of 2.7% waited more than a year—the lowest percentage since 2007–08.

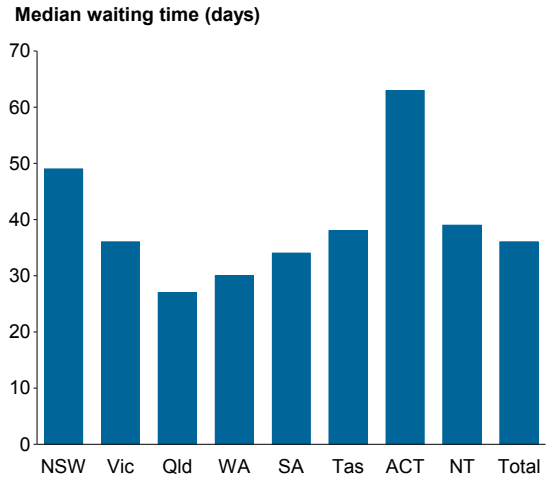


Figure 38: Median waiting times for elective surgery, public hospitals, states and territories, 2011–12

- Median waiting time varied across states and territories. The lowest was 27 days in Queensland, and the highest was 63 days in the Australian Capital Territory (Figure 38).
- Ophthalmology, ear, nose and throat surgery and orthopaedic surgery were the surgical specialties with the longest median waiting times (74, 66, and 63 days respectively) in 2011–12 (Figure 39).
- 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 39). For orthopaedic surgery, 50% of patients with cancer waited 7 days or less, compared with 64 days overall.

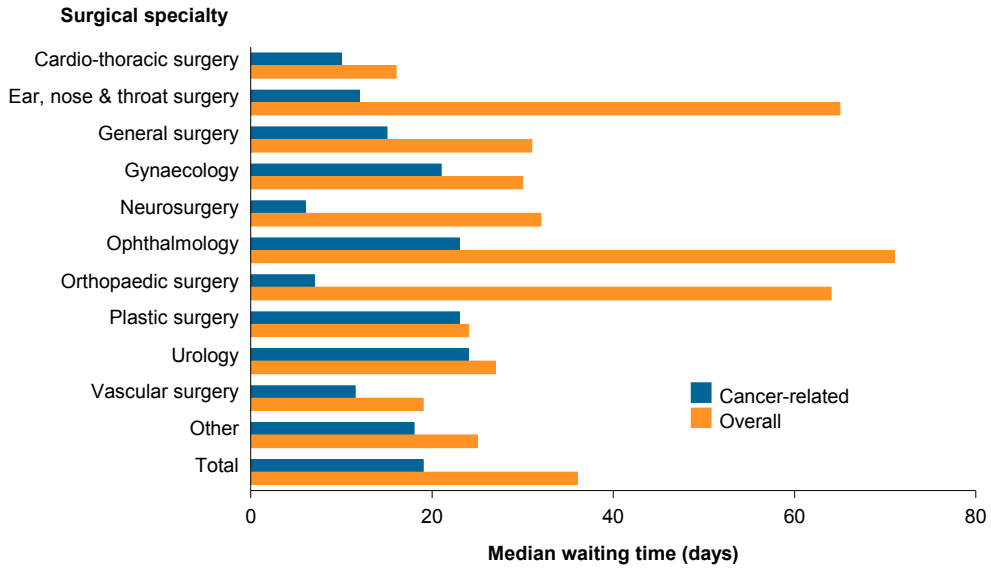


Figure 39: Median waiting times, overall and cancer-related, by specialty of surgeon, 2011–12

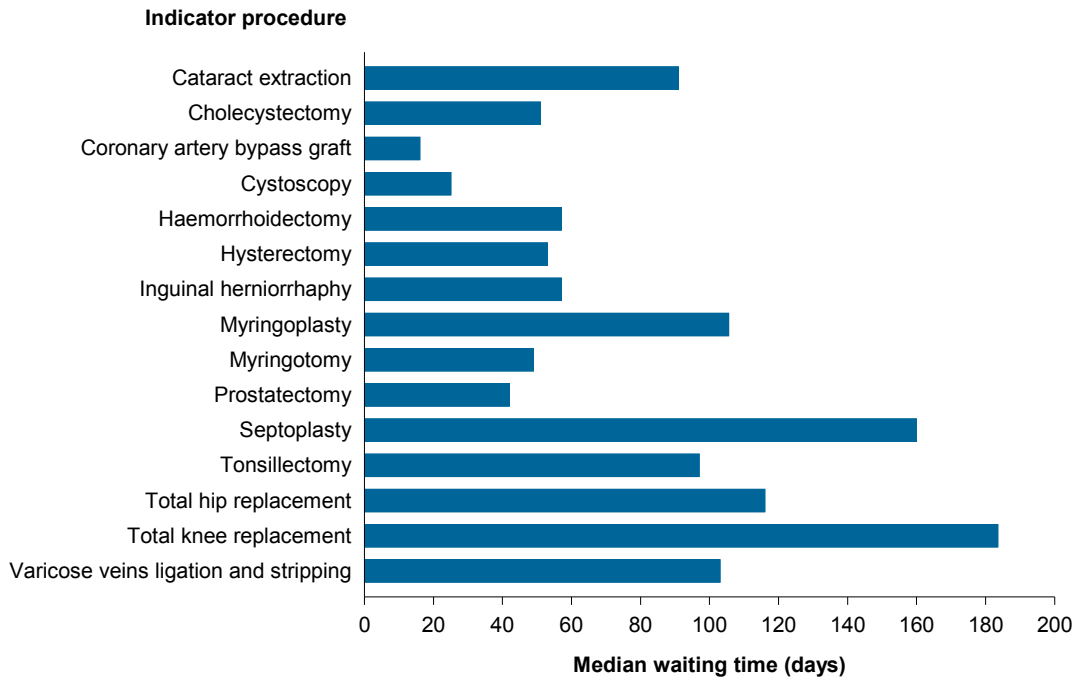


Figure 40: Median waiting times for elective surgery, by procedure, 2011–12

- Coronary artery bypass graft was the procedure with the shortest median waiting time (16 days) and total knee replacement had the longest median waiting time (184 days) (Figure 40).

More information on waiting times for public hospital elective surgery by surgical specialty and by procedure for each state and territory is in figures 39a–39h and figures 40a–40h, accompanying this report online.

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

Overall, there were about 424,000 separations for sub- and non-acute admitted patient care in 2011–12. This care comprises Rehabilitation, Palliative, Psychogeriatric, Geriatric evaluation and management and Maintenance care, which together accounted for about 4.6% of separations and 16.5% of patient days in public and private hospitals.

Rehabilitation care was the most commonly provided sub- or non-acute care type and was associated with long stays. It accounted for 1.7% of all separations and 8.6% of patient days for public hospitals and 6.1% of separations and 12.0% of patient days for private hospitals.

The volume of these services increased from 2007–08 to 2011–12, particularly for Rehabilitation in private hospitals (18% per year) and Geriatric evaluation and management care in public hospitals (20% per year) (Figure 41).

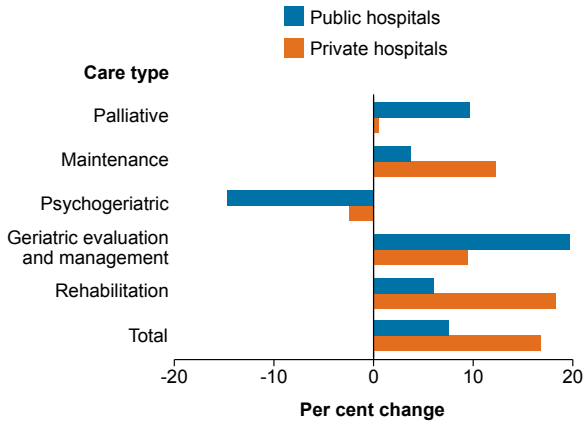


Figure 41: Change (per cent) in the number of separations for sub- and non-acute care, public and private hospitals, 2007–08 to 2011–12

Who used these services?

About 56% of sub- and non-acute separations were for females, and less than 30% were for people aged under 65 (Figure 42).

Less than 1.0% of sub- and non-acute separations were for Indigenous Australians, compared with 4.6% of admitted patient separations overall.

Persons usually resident in *Major cities* had 20 sub- and non-acute separations per 1,000 population, compared with 17 per 1,000 nationwide.

Sub- and non-acute separation rates varied by socioeconomic status, from 13 per 1,000 population for those classified as being in the lowest SES group to 26 per 1,000 for those classified as being in the highest SES group.

How did people access these services?

About 46% of sub- and non-acute separations 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). This contrasts with only 5% of separations overall that were transferred from another hospital or were a care type change.

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.

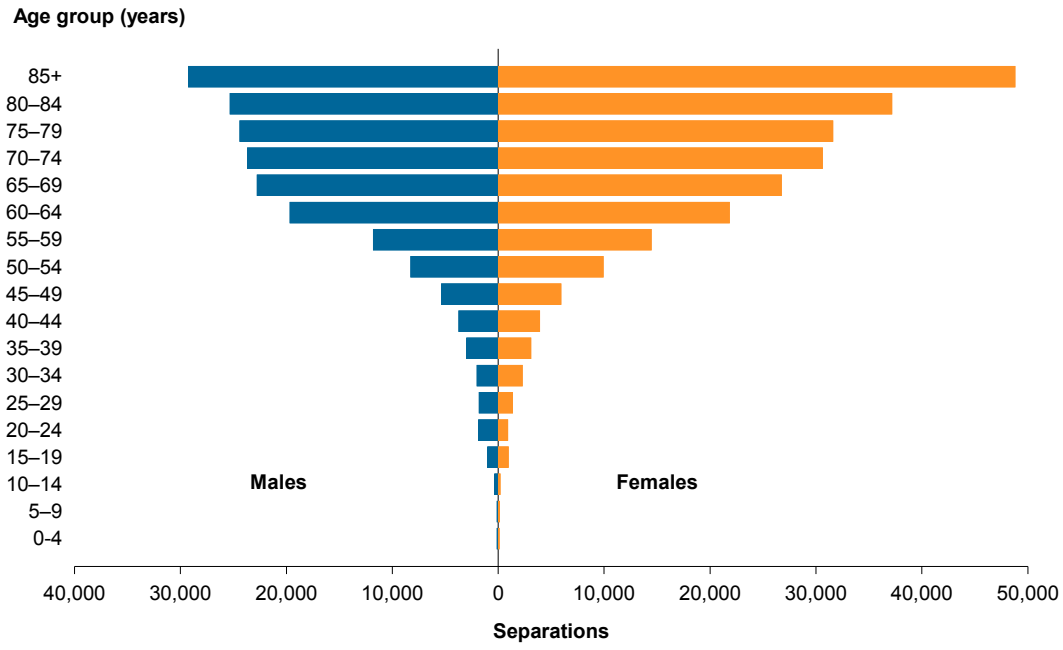


Figure 42: Separations for sub- and non-acute care, by age group and sex, all hospitals, 2011–12

Why did people receive this care?

The most common principal diagnosis was for Care involving use of rehabilitation procedures (325,000 separations).

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

- arthrosis of the knee (about 57,000 separations)
- arthrosis of the hip (25,000 separations)
- fracture of femur (hip fracture, 17,000 separations).

For Palliative care, 64% of principal diagnoses were cancer-related.

What care did they receive?

About 1.0 million procedures or other interventions were reported for sub- and non-acute separations. About 82% 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 (330,000 separations)
- occupational therapy (189,000 separations)
- social work (100,000 separations).

How long did they stay?

The average length of stay for sub- and non-acute separations was 5.1 days in private hospitals and 18.4 days in public hospitals.

- For Rehabilitation care, the average length of stay was 4.6 days in private hospitals and 17.0 days in public hospitals.
- Separations for Maintenance care had the longest average length of stay (32.0 days), followed by Geriatric evaluation and management and Psychogeriatric care (18.0 and 15.8 days, respectively).

Who paid for the care?

In public hospitals, about 76% of sub- and non-acute separations were public patients, 16% were funded by private health insurance and 6% were funded by the Department of Veterans' Affairs.

In private hospitals, private health insurance funded about 80% of sub- and non-acute separations, and 11% were funded by the Department of Veterans' Affairs.

How was care completed?

Just over 76% 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.

About 8% ended in discharge or transfer of the patient to another hospital or other health care accommodation and a further 4% 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 87% of patients were discharged to their usual place of residence, compared with 29% of patients for Palliative care (figures 43 and 44)
- More than half (59%) of Palliative care separations ended in the death of the patient.

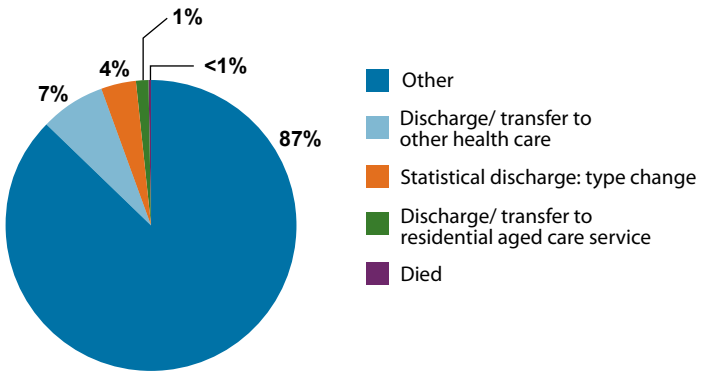


Figure 43: Separations for Rehabilitation care, by mode of separation, all hospitals, 2011–12

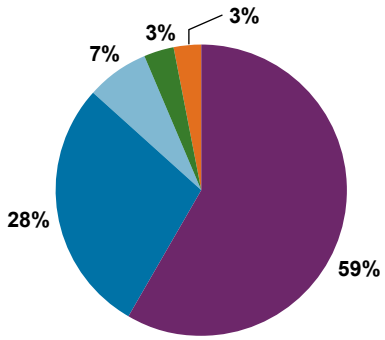


Figure 44: Separations for Palliative care, by mode of separation, all hospitals, 2011–12

Related information

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

AIHW 2013. Australian hospital statistics 2011–12

Health services series no. 50.
Cat. no. HSE 134. Canberra: AIHW.

AIHW 2013. Australian hospital statistics 2011–12:
Staphylococcus aureus bacteraemia in Australian hospitals

Health services series no. 47.
Cat. no. HSE 129. Canberra: AIHW.

AIHW 2013. Australian hospital statistics: national emergency access and elective surgery targets 2012

Health services series no. 48.
Cat. no. HSE 131. Canberra: AIHW.

AIHW 2012. Australian hospital statistics 2011–12:
emergency department care

Health services series no. 45.
Cat. no. HSE 126. Canberra: AIHW.

AIHW 2012. Australian hospital statistics 2011–12:
elective surgery waiting times

Health services series no. 46. Cat. no. HSE 127. Canberra: AIHW.

Data quality statements relevant to the data sources used in this report are available online at <meteor.aihw.gov.au> .

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

References

ABS (Australian Bureau of Statistics) 2012. Private hospitals Australia 2010–11. ABS cat. no. 4390.0. Canberra: ABS.

AIHW (Australian Institute of Health and Welfare) 2012. Health expenditure Australia 2010–11. Health and welfare expenditure series no. 47. Cat. no. HWE 56. Canberra: AIHW.

AIHW 2013a. Australian hospital statistics 2011–12. Health services series no. 50. Cat. no. HSE 134. Canberra: AIHW.

AIHW 2013b. Australian hospital statistics 2011–12: *Staphylococcus aureus* bacteraemia in Australian hospitals. Health services series no. 47. Cat. no. HSE 129. Canberra: AIHW.

OECD (Organisation for Economic Co-operation and Development) 2012. OECD health data 2012: statistics and indicators for 30 countries. Paris: OECD. Viewed 6 March 2013, <www.oecd.org/health/healthdata>.

Australia's hospitals 2011–12 at a glance provides information on Australia's 1,345 public and private hospitals. In 2011–12, there were 9.3 million hospitalisations, including 2.4 million admissions involving surgery. Public hospitals provided 7.8 million non-admitted patient emergency services, with 72% of patients seen within recommended times for their triage category. This publication is a companion to *Australian hospital statistics 2011–12*.