Australian Government
Australian Institute of Health and Welfare

Hospital resources 2017–18: Australian hospital statistics

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About

In 2017–18:

- There were 693 public hospitals and 657 private hospitals in Australia.
- The Australian Government provided 41% of public hospital funding and 24% of private hospital funding.
- Recurrent expenditure on public hospitals was $71 billion, with about 62% of this spent on salaries, wages and superannuation.

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Findings from this report:

- There was $71 billion in recurrent expenditure on public hospitals in 2017–18
- There were 693 public hospitals and 657 private hospitals in Australia in 2017–18
- 41% of public hospital funding and 24% of private hospital funding was provided by the Australian Government
- About 42% of public hospital staff were Nurses (157,000) and 12% were Salaried medical officers (46,000)

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At a glance

Expenditure

$71 billion

total recurrent expenditure on public hospital services in 2017-18

▲ **3.3%** between 2016-17 and 2017-18

55%

of which was spent on

Admitted patient care

Hospitals and beds

1,350

hospitals

across Australia in 2017-18

693 public hospitals

657 private hospitals

2.5

public hospital beds

per 1,000 population

1.4

private hospital beds

per 1,000 population

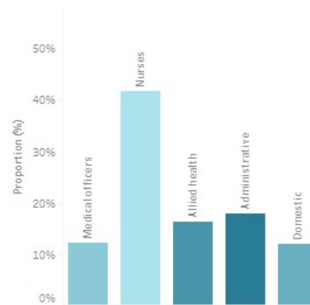
Hospital staff and salaries

378,205

full-time equivalent staff

in public hospitals in 2017-18

▲2.5% between 2016-17 and 2017-18



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Summary

Spending on public hospital services

In 2017–18, total recurrent expenditure on public hospital services was $71 billion (including depreciation).

About 55% of this amount was spent on admitted patient care, 20% on outpatient care, 10% on emergency care services, 2% on teaching, training and research, 2% on aged care and 10% on other activities.

After adjusting for inflation, national recurrent expenditure on public hospital services increased by 3.3% between 2016–17 and 2017–18.

Funding of public hospitals

The most recent funding data available from 2016–17 shows that, 92% of public hospitals services were funded by the state/territory government and the Australian government. In contrast; 69% of private hospital funding came from non-government sources.

Between 2012–13 and 2016–17, funding for public hospitals rose by 1.8% on average each year (after adjusting for inflation), from $50 billion to $54 billion. Funding for private hospitals rose by 2.9% on average each year, from $14 billion to $16 billion.

Staff in public hospitals

Nationally, 378,000 full-time equivalent staff were employed in providing public hospital services in 2017–18. About 42% of staff were Nurses (157,000) and 12% were Salaried medical officers (46,000).

Hospitals and average available beds

In 2017–18, there were 693 public hospitals in Australia, with 62,000 available beds. About one-third of public hospital beds were in principal referral hospitals (located mostly in metropolitan areas).

Between 2013–14 and 2017–18, the number of public hospital beds per 1,000 population remained relatively stable, fluctuating between 2.51 and 2.56 beds per 1,000.

There were 657 private hospitals (2016–17 data) with 34,300 licensed beds (including day hospital facilities).

Between 2012–13 and 2016–17, the number of licensed beds in private hospitals rose by 3.6% on average each year. The number of licensed beds per 1,000 population also increased during this period from 1.3 in 2012–13 to 1.4 in 2016–17.

Specialised service units

Public hospitals provided a range of specialised units that deliver specific types of services for admitted and non-admitted patients.

In 2017–18, the most common specialised service provided was Domiciliary care (home-based care, provided by 354 hospitals), followed by Nursing home care (285 hospitals). There were 82 Intensive care units (level III and above) and 32 Neonatal intensive care units (level III and above).

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Introduction

Hospital resources 2017–18: *Australian hospital statistics* presents information about public and private hospitals in Australia. It continues the Australian Institute of Health and Welfare's (AIHW) series of Australian hospital statistics reports, which describe the characteristics, and activity of Australia's hospitals.

This report presents an overview of public hospitals in 2017–18, covering funding of hospitals, recurrent expenditure, the number of full-time equivalent staff employed and the types of specialised services provided. It also describes public hospitals in terms of number and types of hospitals and availability of beds. Comparative information for the previous 4 reporting periods is included.

The report also presents selected information for private hospitals for 2016–17 and comparative information for the previous 4 reporting periods, sourced from the Australian Bureau of Statistics' (ABS) Private hospitals Australiareport.

What data are reported?

Different data sources are used in this report for public hospitals, private hospitals and hospital funding:

- For public hospitals, this report is based on data from the AIHW's National Public Hospital Establishments Database (NPHED), which includes information for individual public hospitals, local hospital networks and for state/territory health authorities. More information about the NPHED is in Appendix A
- For private hospitals, the information in this report is based on the Australian Bureau of Statistics' (ABS) Private Health Establishments Collection 2016–17 (PHEC)
- For hospital funding, the information in this report is sourced from the AIHW's Health Expenditure Database 2016–17.

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Funding and recurrent expenditure

Information on funding and expenditure over time are expressed in both current and constant prices. Current prices reflect the amounts reported for each reference period. Constant prices adjusts current prices for the effects of inflation; that is, it aims to remove the effects of inflation. Hence, prices in different years can be compared on a dollar-for-dollar basis.

The constant prices presented in this chapter were derived from the current prices using the ABS's *Government Final Consumption Expenditure, State and Local—Hospitals and Nursing Homes* deflator for both public and private hospitals, expressed in terms of prices in final reference year (that is, using 2016–17 as the base year for funding, and using 2017–18 as the base year for recurrent expenditure).
Data visualisation indicating funding sources for public and private hospitals, constant prices ($ billion) 2012-13 to 2016-17

Visualisation not available for printing

Funding

Public and private hospitals are funded from a range of different sources, reflecting the types of patients they treat and the services they provide (see Appendix A for more information).

Emergency department and outpatient services are mainly funded by governments, whereas admitted patient services are commonly funded by both private (non-government) and government sources.

Public hospitals

In 2016–17, the state and territory governments and the Australian Government provided most of the funds for public hospitals:

- state and territory governments provided 51% ($27.3 billion)
- the Australian Government provided 41% ($21.7 billion).

Between 2012–13 and 2016–17 (after adjusting for inflation):

- total funding rose by an average of 1.8% each year, from $50 to $54 billion
- funding from the Australian Government increased by an average of 3.8% each year, from $18.7 to $21.7 billion
- funding from non-government sources decreased by an average of 0.2% each year
- funding from state and territory governments increased by 0.5% each year.

Private hospitals

In 2016–17:

- about 69% ($10.8 billion) of private hospital funding was non-government, including:
  - private health insurance funds ($7.8 billion)
  - individuals (or out-of-pocket expenses $1.8 billion)
  - other ($1.2 billion).
- Australian Government and State/territory governments provided about 31% ($4.8 billion) of private hospital funding including:
  - private health rebates ($2.9 billion)
  - Department of Veterans' Affairs ($817 million).

Between 2012–13 and 2016–17:

- total funding rose by an average of 2.9% each year, from $13.9 to $15.6 billion
- funding from non-government sources increased by an average of 4.2% each year, from $9.2 to $10.8 billion
- funding from the state and territory governments increased by 16.6% each year
- funding from the Australian Government decreased by an average of 2.3% each year.

Commonwealth funding arrangements

Public hospitals differ in how they are funded by the Australian Government:

- activity-based funded (ABF) hospitals receive funding based on the amount and type of activity
- block-funded hospitals are not considered suitable for activity-based funding due to the inability to meet the technical requirements of ABF reporting, a lack of economy of scale, or remoteness.

In consultation with jurisdictions, the Independent Hospital Pricing Authority (IHPA) develops block-funding criteria and identifies whether hospital services and functions are eligible for block-funding only, activity-based funding only or a mixture of activity-based and block funding.

In 2017–18, 285 public hospitals were designated as activity-based funded hospitals and 403 public hospitals as block-funded. The funding designation was not assigned for 5 hospitals.

It should be noted that the funding designation information reported for the NPHED does not include a category for hospitals that are funded partly by activity-based funding and partly by block funding. See Appendix A for more information.

Where to go for more information

More information on:

- comparability of revenue, recurrent expenditure and staffing information by administrative level is available in Table 1.1
- funding sources for public and private hospitals is available in tables 2.1 and 2.2
- Commonwealth funding arrangements is available in Table 2.3.

Available for download in the Data section of this report.

More information on funding of public hospitals is available in:

- Health expenditure Australia 2016–17
- National Health Reform public hospital funding, National report June 2018

Recurrent expenditure

This section presents information on public and private hospital expenditure, including information on expenditure over time, in both current and constant prices.

Recurrent expenditure is the money spent by hospitals, local hospital networks and state/territory health authorities on the goods and services they use, such as salary payments, drugs, medical and surgical supplies.

Two expenditure totals for public hospitals are reported here. One that includes depreciation and another excluding depreciation.

Recurrent expenditure can be categorised into salary and non-salary expenditure:

Salary expenditure includes salaries and wages, payments to staff on paid leave, workers' compensation, leave, and salaries paid to contract staff where the contract was for the supply of labour and where full-time equivalent staffing data were available.

Non-salary expenditure includes payments to *Visiting medical officers*, superannuation payments, drug supplies, medical and surgical supplies (which includes consumable supplies only and not equipment purchases), food supplies, domestic services, repairs and maintenance, patient transport, administrative expenses, interest payments, depreciation and other recurrent expenditure.

Public hospitals expenditure

In 2017–18:

- total recurrent expenditure on public hospital services was $71 billion (including depreciation).
- $42.7 billion recurrent expenditure was reported at the public hospital level
- $21.4 billion recurrent expenditure was reported at the LHN level
- $3.1 billion recurrent expenditure was reported at the state/territory health authority level
- salary payments accounted for 60% of the total $67 billion (excluding depreciation) spent on public hospital services.

The total recurrent expenditure information presented from 2014–15 to 2017–18 is not comparable with the total recurrent expenditure information presented for 2013–14. The data for 2014–15 to 2017–18 includes expenditure at the LHN level and at the state/territory health authority level (for 2014–15, excludes Queensland for both LHN level and at the state/territory health authority level). Therefore, percentage changes (increase or decrease) between 2013–14 and 2017–18 are not shown. See Appendix A for more information on limitations of the data related to recurrent expenditure.

Expenditure on different types of care in public hospitals

In 2017–18:

- *Admitted patient care* accounted for 55% of recurrent expenditure on public hospital services, ranging from 43% for Western Australia to 78% for the Northern Territory.
- *Non-admitted patient care* (including services both in and out of scope for the NHRA) accounted for about 20% of recurrent expenditure, ranging from 10% for Victoria to 30% for Queensland.
- *Direct teaching, training and research* accounted for about 2% of recurrent expenditure, ranging from 0% in the Victoria and the Northern Territory to 4% in New South Wales.

Private hospitals expenditure

For private hospitals, the recurrent expenditure data reported for 2016–17 are considered comparable with the data reported for 2012–13 to 2015–16. Recurrent expenditure for private hospitals in 2016–17 was $13.8 billion. In constant price terms (adjusted for inflation), recurrent expenditure by private hospitals increased by an average of 4.5% each year between 2012–13 and 2016–17 (ABS 2018).

Where to go for more information

More information on:

- recurrent expenditure over time, by state and territory and by peer group
- private hospital recurrent expenditure
- NHRA product streams.

Is available in tables 2.4 through 2.8 and S2.1, available to download in the Data section of this report.

Information on data limitations and methods is available in Appendix A and Appendix B.

References

IHPA (Independent Hospitals Pricing Authority) 2016. National efficient cost determination 2016–17, March 2016. Sydney: IHPA.

Health expenditure Australia 2016–17. Health and welfare expenditure series no. 64x. Cat. no. HWE 74. Canberra: AIHW.

Private hospitals Australia 2016–17. ABS cat. no. 4390.0. Canberra: ABS.

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Hospital staff

This information includes detail on the numbers of full-time-equivalet (FTE) staff:

- for public hospital services and their average salaries, by state and territory, over time and for 2017–18
- for private hospitals for 2016–17 (most recent available data).

Public hospitals

Between 2016–17 and 2017–18:

- there was a 1.1% increase in the number of FTE staff overall
- salaried medical officers increased by 2.3%
- the number of nurses increased by 2.1%.

In 2017–18:

- 157,000 *Nurses* accounted for 42% of staff
- 46,000 FTE *Salaried medical officers* accounted for 12% of staff.

Private hospitals

The staffing mix in private hospitals is different from that in public hospitals. This is because most medical services are provided by visiting medical specialists (who are not hospital employees), and the range of services provided is different.

Between 2012–13 and 2016–17, the number of FTE staff in private hospitals rose by 3.5% on average each year.

In 2016–17:

- 93% of private hospital staff (64,500 FTEs) worked in private hospitals not specialising in same-day care
- 1,400 FTEs for *Salaried medical professionals* were reported by private hospitals, accounting for 2% of FTE staff in both private free-standing day hospital facilities and private hospitals not specialising in same-day care
- 38,300 FTE *Nurses* were reported by private hospitals, accounting for 52% of FTE staff in private free-standing day hospital facilities and 56% of FTE staff in other private hospitals.

Average salaries in public hospitals

The average salary is calculated as total expenditure reported as salary for each category of staff, divided by the number of FTE staff in that category.

Between 2013–14 and 2017–18:

- the average salary for staff employed in providing public hospital services increased by 2.9% on average each year
- public hospital average salaries for *Nurses* and *Salaried medical officers* increased by 2.7% and 3.0% on average each year, respectively.

Changes in average salary for staff providing public hospital services between 2013–14 and 2017–18 are affected by changes in the provision of staffing information and information about recurrent expenditure on salary and wages among jurisdictions. Therefore, these data should be interpreted with caution. See Appendix A for more information.

Where to go for more information

More information on:

- staffing by public hospital peer groups is available in Tables 3.1, 3.2, S3.1
- salaries is available in Tables 3.3 and 3.4.

Is available to download in the Data section of this report.

More information on the health workforce is available in the Workforce topic area of the AIHW website.

More information on private hospitals is available in the ABS's report Private hospitals Australia 2016–17.

Information on data limitations and methods is available in Appendix A and Appendix B.

References

ABS 2018. Private hospitals Australia 2016–17. ABS cat. no. 4390.0. Canberra: ABS. Available to view on the ABS website.

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Hospitals and average available beds

This section presents an overview of public and private hospitals in 2017–18 and changes over time, covering the overall numbers of hospitals, local hospital networks and the number of hospital beds. It also includes an international comparison—against the OECD average for the number of hospital beds per 1,000 population, by state and territory.

Caution should be used in comparing the data for public hospitals and private hospitals as there are differences in the data definitions used between the NPHED and the PHEC.

Hospitals

The numbers of public and private hospitals in Australia can vary over time, reflecting the opening or closing of hospitals, the reclassification of hospitals as non-hospital facilities (or vice-versa) and the amalgamation of existing hospitals.

In addition, the number of hospitals reported can be affected by jurisdictional variations in administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospital buildings or campuses. See Appendix A and Appendix B for more information.

Public hospitals

There were 693 public hospitals in 2017–18 compared with 747 in 2013–14. Much of this decrease was due to the reclassification of 46 establishments in Queensland between 2013–14 and 2014–15.

About 25% of public hospitals (179) were located in *Major cities*. The greatest number of public hospitals was reported for *Outer regional areas* (210, or 30%).

However, most of the larger public hospitals are located in the more populated areas, and this is evidenced by the number of hospital beds that were located in each remoteness area.

Private hospitals

Between 2012–13 and 2016–17, the number of private hospitals reporting to the PHEC rose from 601 to 657. Numbers of private hospitals increased for all jurisdictions.

Counts of private hospitals can also vary, depending on the source of the information. See Appendix A for more information.

Average available beds

Public hospitals

Between 2013–14 and 2017–18, public hospital bed numbers rose by an average of 1.3% per year, from 58,600 to almost 62,000 beds—about one third the rate of average annual increase in public hospitalisations over the same period. Public hospital beds per 1,000 population were relatively stable, ranging between 2.5 to 2.6 beds per 1,000 population over the same period.

In 2017–18:

- there were 61,647 available beds in public hospitals, with 2,161 (3.5%) of these in public psychiatric hospitals
- almost 86% of beds in *Public hospitals (other than psychiatric)* were available for overnight stay patients
- the proportion of beds available for same-day patients in *Public hospitals (other than psychiatric)* ranged from 9% in New South Wales to 20% in Queensland
- available beds per 1,000 population in *Public hospitals (other than psychiatric)* ranged from 2.2 per 1,000 in Western Australia, to 2.6 per 1,000 in New South Wales, South Australia and the Australian Capital Territory.

Nationally, about 68% of public hospital beds were located in *Major cities* (42,000 beds) and 18% were located in *Inner regional* areas (11,300 beds).

The number of public hospital beds per 1,000 population ranged from 2.4 beds per 1,000 population in *Major cities* to 4.0 beds per 1,000 population in *Remote* areas.

In 2017–18, Australia had 3.9 beds per 1,000 population in public and private hospitals compared with an average of 4.7 beds per 1,000 population for countries analysed by the Organisation for Economic Co-operation and Development (OECD) and ranked in the middle of the 35 OECD and other selected countries.

The ratio of available beds to the population does not necessarily indicate the accessibility of hospital services. A hospital can provide services for patients who usually reside in other areas of the state or territory, or in other jurisdictions. The patterns of bed availability across regions may also reflect the availability of other health-care services and patterns of disease and injury.

Private hospitals

Between 2012–13 and 2016–17:

- private hospital bed numbers rose by an average of 3.6% per year (from 29,800 to 34,300)
- the number of beds per 1,000 population increased from 1.31 to 1.42 per 1,000, or by an average of 2.0% per year
- the number of licensed beds in *Other private hospitals* (those that do not specialise in same-day care) increased by an average of 3.6% per year, and the number of licensed beds per 1,000 population in *Other private hospitals* rose from around 1.18 to 1.28 beds per 1,000
- the number of licensed beds/chairs in *Private free-standing day hospital facilities* increased by 3.0% each year.

In 2016–17, about 34,300 licensed beds were reported for private hospitals (data for 2017–18 are not available), with 3,310 (9.6%) of these in *Private free-standing day hospital facilities*.

Local hospital networks

Local hospital networks are defined as those entities recognised as such by the relevant state or territory health authority. They directly manage single or small groups of public hospital services and their budgets, and are directly responsible for hospital performance (METeOR identifier 584333).

The LHNs vary greatly in location, size and in the types of hospitals that they include. LHNs may include both public and private hospitals. The information presented below relates to public hospitals only.

In 2017–18, there were 135 LHNs, including 85 in Victoria, and 1 each in Tasmania and the Australian Capital Territory.

Many LHNs in Victoria consist of a single public hospital. Other networks might consist of a *Principal referral* or *Public acute group A* hospital and a range of smaller and/or more specialised hospitals.

Where to go for more information

For more information on the number of public and private hospitals and beds

- over time, see Table 4.1 to 4.4 and Table 4.8 to 4.11
- by state and territory, see Table 4.5 to 4.6 and Table 4.6, 4.11. 4.12
- by remoteness area, see Table 4.7 and Table 4.13

available for download in the Data section of this report.

For more information on

- Local hospital networks see Table 4.15
- OECD comparisons for average available beds per 1,000 population see Table 4.14 and Figure 4.1

available for download in the Data section of this report.

Information on data limitations and methods is available in Appendix A and Appendix B.

References

OECD (Organisation for Economic Co-operation and Development) 2018. OECD.stat. Paris: OECD. Viewed April 2019. Available to access on the OECD.stat website.

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Diversity of public hospitals

Australia's 693 public hospitals are very diverse. This diversity can be described in various ways, including by:

- public hospital peer groups—which classify public hospitals into groups of similar hospitals
- hospital size—based on the number of average available beds
- the availability of specialised service units
- specialised admitted patient clinical units (Service Related Groups)—representing clinical divisions of hospital activity.

Peer groups

All states and territories had at least one *Principal referral* hospital and at least one *Public acute group A* hospital. *Women's and children's* hospitals were located in New South Wales, Victoria, Queensland, Western Australia and South Australia. *Psychiatric* hospitals were located in New South Wales, Victoria, Queensland, Western Australia, South Australia and Tasmania.

All *Principal referral* hospitals had 24-hour emergency departments, outpatient clinics and provided elective surgery. On average, *Principal referral* hospitals had 653 beds.

Most *Public acute group A* hospitals had 24-hour emergency departments (60 out of 63), most provided elective surgery (59 out of 63) and all had outpatient clinics. On average, *Public acute group A* hospitals had 279 beds.

Specialised service units

In 2017–18, the most common specialised service units offered by public hospitals were *Domiciliary care* (provided by 354 public hospitals), followed by those for *Nursing home care* (provided by 285 public hospitals) and *Obstetric/maternity services*. There were 82 *Intensive care units (level III and above)*, and 32 *Neonatal intensive care units (level III and above)*.

Service related groups

The Service Related Groups (SRG) classification categorises admitted patient episodes into groups representing specialised clinical units (or divisions) of hospital activity. The SRG classification can be used to help plan services, to analyse and compare hospital activity, to examine patterns of service needs and access, and to project potential trends in services.

The number of public hospitals reporting more than 360 patient days in an SRG can be used as an indicative measure of the number of specialised clinical units, as it indicates that at least 1 bed was occupied for most of the year for the SRG.

The availability of specialised clinical units varies by both the remoteness area (of the hospital) and the peer group of the hospital.

More than 60% of Drug and alcohol specialised clinical units were located in Major cities and 54% of Renal dialysis specialised clinical units were in Regional areas (comprising Inner regional and Outer regional areas combined) areas.

Where to go for more information

More information on hospital characteristics, including:

- specialist services units by peer groups see Table 5.1 and Table 5.2
- hospital size see Table 5.3
- specialised service units see Table 5.4, 5.5 and 5.6
- service related groups see Table C2, C.S1, and Table C.S3 to C.S6
- detailed information for each public hospital included in the NPHED see Table AS.1

are available to download in the Data section of this report.

Information on hospital peer groups is available in the AIHW report Australian hospital peer groups.

Selected information for individual public hospitals is available on the AIHW's MyHospitals website. The information includes:

- number of available beds (as a range)
- services provided at the hospital.

More information on services provided for admitted and non-admitted patients is available in:

- Admitted patient care 2017–18: Australian hospital statistics
- Emergency department care 2017–18: Australian hospital statistics
- Non-admitted patient care 2017–18: Australian hospital statistics

Information on data limitations and methods is available in Appendixes A and B.

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Appendixes

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Appendixes

This appendix includes a data quality summary and additional information relevant to interpreting the National Public Hospital Establishments Database (NPHED) and other data presented in this report, including variations in reporting and in the categorisation of hospitals as public or private

Information relevant to interpretation of the ABS's Private hospitals Australia report is available on the ABS website

National Public Hospital Establishments Database data quality statement summary

Data source information and key data quality issues

For 2017–18, the NPHED is based on data reported by state and territory health authorities for the Local Hospital Networks/Public hospital establishments National minimum data set (LHN/PHE NMDS).

The AIHW has undertaken the collection and reporting of the data in this report under the auspices of the Australian Health Ministers' Advisory Council, through the National Health Information Agreement.

The LHN/PHE NMDS is defined in the AIHW's Metadata Online Registry (METeOR) (METeOR identifier 642698).

The scope of the LHN/PHE NMDS includes 3 levels of hierarchical reporting:

- public hospital establishments, including public acute and psychiatric hospitals, and alcohol and drug treatment centres. It also includes public hospitals that provide subacute and non-acute care (for example, rehabilitation and palliative care hospitals).
- Local Hospital Networks (LHN)
- at the jurisdictional level, all public hospital services that are managed by a state or territory health authority and are included in the General list of In-scope Public Hospital Services, which has been developed under the National Health Reform Agreement (2011) and excluding data which are already reported in the PHE or LHN levels (above).

The LHN/PHE NMDS allows the collection of recurrent expenditure, revenue, admitted contracted care and staffing information whether delivered and/or managed by hospitals or other administrative units (LHNs and state/territory health authorities).

Similar information at the public hospital establishments-level has been reported in the *Australian hospital statistics* reports since the first report on the 1993–94 and 1994–95 collection periods. Information at the LHN-level and at the jurisdiction-level has been reported since 2014–15.

The LHN/PHE NMDS also includes data elements to allow the reporting of recurrent expenditure on contracted care and the number of beds available for contracted care—this information is not presented, as not all states and territories reported it, and the information did not appear to be comparable among them.

Where possible, information is reported at the lowest level of reporting possible (for example, by hospital establishment), and is not duplicated at higher levels of reporting. For example, expenditure data reported at the state/territory health authority level does not include any data reported at the LHN level or at hospital level.

At the establishment-level, the NPHED holds data for each public hospital in Australia, including public acute hospitals, psychiatric hospitals, drug and alcohol hospitals and dental hospitals in all states and territories. Hence, public hospitals not administered by the state and territory health authorities (hospitals operated by correctional authorities for example, and hospitals in offshore territories) are not included. The collection does not include data for private hospitals.

Local hospital networks are defined as those entities recognised as such by the relevant state or territory health authority.

Summary of key data quality issues

States and territories are primarily responsible for the quality of the data they report. However, the AIHW undertakes extensive validations on receipt of data, checking for valid values, logical consistency and historical consistency. Where possible, data in individual data sets are checked with data from other data sets. Potential errors are queried with the state/territory health authorities, and corrections and resubmissions may be made in response to these queries. Except as noted, the AIHW does not adjust data to account for possible data errors or missing or incorrect values.

Where possible, variations in reporting have been noted in the text. Comparisons between states and territories and between reporting years should be made with reference to the accompanying notes in the chapters and in the appendixes. The AIHW takes active steps to improve the consistency of these data over time.

- In 2017–18, the NPHED included all public hospitals. It also included LHN-level and/or state/territory health authority-level reporting for all states and territories.

- The number of hospitals reported can be affected by administrative and/or reporting arrangements and is not necessarily a measure of the number of physical hospital buildings or campuses. Changes in the numbers of hospitals over time can also reflect the opening of new hospitals, the closure of hospitals, the reclassification of hospitals as non-hospital facilities (or vice-versa) and the amalgamation of existing hospitals. For example:
  - Between 2013–14 and 2014–15, 46 very small reporting hospitals in Queensland and 3 establishments in South Australia that were previously classified as hospitals were reclassified as non-hospital facilities, accounting for most of the decrease in the national number of public hospitals. In addition, the Mater Children's Hospital and Royal Children's Hospital (both in Queensland) closed. A hospice in New South Wales and an aged care/rehabilitation facility in Victoria ceased reporting as separate campuses to the NPHED.
  - For 2014–15, the Lady Cilento Children's Hospital (Queensland), the Fiona Stanley Hospital (Western Australia) and the Ursula Frayne Centre (Victoria) opened. Rankin Park Hospital (New South Wales) commenced reporting as a separate campus, whereas its data were previously amalgamated with another hospital.
  - For 2015–16, Byron Central Hospital (New South Wales) opened, and Byron Bay Hospital closed—both hospitals were reported. Nolan House, Albury (New South Wales) commenced reporting as a separate campus, whereas its data were previously amalgamated with Albury Hospital. The St John of God Midland Public Hospital (Western Australia) opened and Swan District Hospital closed—both hospitals were reported.
  - For 2016–17, the Sunshine Coast University Hospital (Queensland) commenced reporting. Reporting ceased for Byron Bay Hospital, St Vincent's Lismore, Cudal War Memorial Hospital, Rankin Park Hospital (New South Wales), Next Step Drug and Alcohol Services, and the Royal Perth Hospital Shenton Park Campus (Western Australia).
  - For 2017–18, the Perth Children's Hospital opened and the Princess Margaret Hospital closed.
- In 2017–18, there was variation among states and territories in the administrative levels at which revenue, recurrent expenditure and staffing information were reported, including:
  - New South Wales reported this information for all 3 administrative levels.
  - Victoria reported information at the LHN and state health authority levels, and none at the public hospital level. Before 2014–15, Victoria reported this information at the network level for hospitals within networks that consisted of more than one hospital, and at the hospital level for LHNs that consisted of individual hospitals. LHN-level reporting in Victoria is therefore likely to be equivalent to the combination of hospital level and LHN-level reporting for other jurisdictions.
  - Queensland reported this information for all 3 administrative levels.
  - Western Australia reported this information for all 3 administrative levels.
  - South Australia reported this information at the hospital level only. Data attributable to the LHN level and state health authority level were included in the data provided at the hospital level.
  - Tasmania reported this information at the hospital level and at the LHN level.
  - the Australian Capital Territory reported this information at the hospital and LHN levels. Data reported at the LHN level include information for The Canberra Hospital. Data attributable to the territory health authority level were included in the data provided at the hospital and LHN levels.
  - the Northern Territory reported this information at the hospital level and data attributable to the LHN level and territory health authority level were included in the data reported at the hospital level.
- *Revenue* data are not presented in this report because the data provided by states and territories for the category *National Health Funding Pool* differed from the 2017–18 funding reported by the National Health Funding Body (NHFB). These differences may be because:
  - the NHFB figures represent payments into the pool, not payments to service providers
  - there are differences in the timing of the reported data.
- *Available beds for admitted contracted care* and *Recurrent expenditure on contracted care* are not reported in this publication. For 2014–15 to 2017–18, not all jurisdictions were able to report these data, and the comparability of the data was not adequate for reporting.
- Information on hospital accreditation reported for the NPHED does not appear to be consistent with data reported by the Australian Commission on Safety on Quality in Health Care, and is not comparable across jurisdictions.
- Differences in accounting, counting and classification practices across jurisdictions and over time may affect the comparability of these data. There was apparent variation between states and territories in the reporting of revenue, recurrent expenditure, depreciation, available beds and staffing categories. In particular, for 2013–14, data were not available at the LHN- and State/territory health authority-level, and were also not available for:
  - recurrent expenditure on different types of care, such as admitted patient care, non-admitted patient care, emergency care services and teaching, training and research
  - the type of salaried medical officers—whether a *Specialised salaried medical officer* or *Other salaried medical officer*
  - the non-salary recurrent expenditure categories for *Administrative expenses-insurance*, *Administrative expenses-other*, *Depreciation-building*, *Depreciation-other*, *Lease costs* and *Other on-costs*.
  - sources of funding (revenue), including appropriation from government sources

- the range and types of patients treated by a hospital (casemix) can affect the comparability of bed numbers with, for example, different proportions of beds being available for special and more general purposes. In addition:
  - the average number of available beds presented in this report may differ from the counts published elsewhere. For example, counts based on a specified date, such as 30 June, may differ from the average available beds for the reporting period.
  - at the time of publication, the Northern Territory were unable to provide average available bed numbers for the Top End Health Service. Therefore, average available beds are underestimated for the Northern Territory, and overall.
  - Between 2013–14 and 2014–15, 46 very small reporting hospitals in Queensland were reclassified as non-hospital health services. The 46 hospitals combined reported 20 average available beds (in total) in 2013–14.
  - In 2014–15, Tasmania reclassified a number of mental health, aged care and same-day beds in hospitals, resulting in an apparent increase of 103 beds between 2013–14 and 2014–15. After adjusting for this change, Tasmania estimates that average available beds increased by about 0.8% between 2013–14 and 2014–15.
- The collection of data by staffing category is not consistent among states and territories.
- The outsourcing of services with a large labour-related component (such as food services and domestic services) can have a substantial impact on estimates of costs, and this can vary among jurisdictions.

Hospital funding and expenditure information

In this report, data presented on the funding of hospitals are sourced from the AIHW's Health Expenditure Database (HED).

Financial data reported from the HED are not directly comparable with data reported for public hospital services from the NPHED. Hospital expenditure reported for the purpose of the HED collection may cover activity that is not covered by the NPHED. The HED data include trust fund expenditure, whereas the NPHED does not.

The 2017–18 data from the HED will be available in the second half of 2019.

Hospital funding is reported here as the money provided for the overall public and private hospital systems within each jurisdiction and nationally.

The original (or indirect) sources of funds are reported here rather than the immediate (or direct) sources. As such, the Australian Government is regarded as the source of funds for the contributions that it made for public hospitals via intergovernmental agreements, and for the contributions it made to private hospitals via the private health insurance premium rebates. For the purpose of this report, the sources of funding are disaggregated as:

- Australian Government (including funding via intergovernmental agreements, Department of Veterans' Affairs and private health insurance premium rebates)
- state and territory governments
- non-government sources (including private health insurance, injury compensation insurers, self-funded patients and other sources of private revenue).

The information in this section was sourced from the AIHW's Health Expenditure Database (HED), which draws data from a wide variety of government and non-government sources. Hospital funding estimates can differ from hospital recurrent expenditure reported to the NPHED —for example, depending on the administrative structures and reporting practices in the jurisdiction.

Financial data reported for public hospital services from the HED are not directly comparable with the expenditure data reported from the NPHED for the same period. The HED financial data included trust fund expenditure and central office costs, whereas the NPHED did not. The HED data for public hospital services reflect only that part of public hospitals' expenses that were used in providing hospital services. That is, they exclude expenses incurred in providing community and public health services, dental care, patient transport services and health research undertaken by public hospitals.

Private hospital information

The most recent data available for private hospitals and private free-standing day hospital facilities is for 2016–17, based on the Australian Bureau of Statistics (ABS) in the Private Health Establishments Collection (PHEC).

Establishment information on private hospitals and private free-standing day hospital facilities were previously collected by the Australian Bureau of Statistics (ABS) in the Private Health Establishments Collection (PHEC). These data were reported in the ABS's Private Hospitals Australia reports (ABS 2018, and earlier).

Counts of private hospitals can also vary, depending on the source of the information. Therefore, there may be discrepancies between counts of private hospitals from the ABS's PHEC and the numbers of private hospitals contributing to the AIHW's National Hospital Morbidity Database (NHMD). The states and territories reported the latter information, which may not correspond with the way in which private hospitals report to the ABS's PHEC.

The PHEC data were discontinued after the 2016–17 reference period and therefore data for 2017–18 are not available.

For private hospitals, average annual changes are presented between 2012–13 and 2016–17, and between 2015–16 and 2016–17.

Annual change rates are not adjusted for any changes in data coverage, changes in metadata and/or re-categorisation of the hospital as public or private, except where noted in the text.

Contracted care

There is some variation between jurisdictions as to whether hospitals that predominantly report public hospital services, but are privately owned and/or operated, are reported as public or private hospitals. A list of such hospitals with information on how each is reported is in Table A2 available to download in the Data section of this report. The categorisations listed are those used for this report; reports produced by other agencies may categorise these hospitals differently.

For example, Peel and Joondalup hospitals are private hospitals that predominantly treat public patients under contract to the Western Australian Department of Health. The public health services provided by these two hospitals are reported separately from the private hospital activity.

The Hawkesbury District Health Service was categorised as a private hospital until 2002–03 and has been categorised as a public hospital in AIHW reports since 2003–04. From 2017–18, public hospital activity for the Hawkesbury District Health Service will be reported separately from the private hospital activity.

A list of all public and private hospitals contributing to this report is in table A.S1 available to download in the Data section of this report.

Data reported for the public hospital administrative levels

The collection of public hospital data at LHN level or at state/territory health authority level, in conjunction with the data reported at the individual hospital level, allows data to be reported by states and territories at the level relevant to service management and/or provision.

In sections of this report that present public hospital information on recurrent expenditure and full-time equivalent (FTE) staff, detailed information is presented for the total of all administrative levels. Summary data are presented for the three administrative levels:

- *Public hospitals*—presents information reported for individual public hospitals.
- *Local hospital network*—presents information reported at the LHN level.
- *state/territory health authority*—presents information reported at the state/territory health authority level.

For 2017–18, there was variation among states and territories in the administrative levels at which revenue, recurrent expenditure and staffing information were reported. Table 1.1 available to download in the Data section of this report, summarises the comparability of the data reported by administrative level for each state and territory. For example, the data are comparable at:

- the hospital level for New South Wales, Queensland and Western Australia
- the LHN level for New South Wales and Western Australia
- the combined hospital and LHN levels for New South Wales, Victoria, Queensland and Western Australia
- at the state/territory health authority level for New South Wales, Victoria, Queensland and Western Australia
- the total of all 3 levels for all jurisdictions.

For public hospitals, average annual changes are presented between 2013–14 and 2017–18, and between 2016–17 and 2017–18, unless otherwise stated.

Annual change rates are not adjusted for any changes in data coverage, changes in metadata and/or re-categorisation of the hospital as public or private, except where noted in the text.

The 'major public hospital' in each LHN was identified as the hospital with the greatest amount of admitted patient activity among the included hospitals.

Limitations of the data on staffing

Staffing information for public hospitals for 2013–14 was largely staff employed by individual hospitals, and did not include all staff employed by state or territory governments for the provision of public hospital services.

Between 2014–15 and 2017–18, staffing information reported to the NPHED includes FTE staff reported for public hospitals, for LHNs and for state/territory health authorities. For more information, see Table 1.1 available to download from the Data section of this report.

In addition, for 2017–18:

- For Western Australia and the Northern Territory, *Salaried medical officers* were not disaggregated into *Specialist medical officers* and *Other salaried medical officers* as these sub-categories were not comparable with the data for other jurisdictions.
- Western Australia reported estimated staffing information and associated salaries for 3 private hospitals delivering public hospital services.
- For South Australia, all public hospital salaries for administrative, clerical, domestic and other personal care staff were estimated.
- The collection of data by staffing category for public hospitals was not consistent among states and territories. In particular, there was variation in the reporting of *Diagnostic and allied health professionals, Administrative and clerical staff* and *Domestic and other personal care staff*.

Staffing numbers can include staff on contract (for example, nurses and medical officers), but exclude staff contracted to provide products (for example, contractors employed to refurbish an area).

Different reporting practices and the use of outsourcing services with a large labour-related component (such as food services, domestic services and information technology) can have a substantial impact on staffing figures and may also explain some of the variation in average salaries reported between jurisdictions. The degree of outsourcing of higher paid versus lower paid staffing functions affects the comparison of averages. For example, outsourcing the provision of domestic services but retaining domestic service managers to oversee

the activities of the contractors tends to result in higher average salaries for the domestic service staff. Information was not available on numbers of visiting medical officers who were contracted by public hospitals to provide services to public patients and paid on a sessional or fee-for-service basis in public hospitals.

Limitations of the data on expenditure on public hospital services

For 2013–14, recurrent expenditure information on public hospitals reported to the NPHED was largely expenditure by hospitals and did not necessarily include all expenditure on hospital services by each state or territory government. For example, recurrent expenditure on the purchase of public hospital services at the state/territory or at the LHN level from privately owned and/or operated hospitals may not have been included.

Between 2014–15 and 2017–18, recurrent expenditure reported to the NPHED includes expenditure on public hospital services by public hospitals, by LHNs and by state/territory health authorities and includes expenditure on the provision of contracted care by private hospitals. For more information, see the 'Data reported for the public hospital administrative levels' section above, and Table 1.1 available to download from the Data section of this report. In addition:

- between 2014–15 and 2017–18, for the purpose of reporting recurrent expenditure on public hospital services by public hospital peer group in this report, the AIHW assigned the recurrent expenditure reported by Victoria at LHN level to the 'major hospital' in the LHN—identified as the hospital with the greatest amount of admitted patient activity in the LHN.
- between 2013–14 and 2014–15, Queensland reclassified 46 very small reporting hospitals as non-hospital services that accounted for about $89 million of recurrent expenditure in 2013–14. In addition, expenditure on pathology services for Queensland was not reported as these were purchased from a state-wide pathology service rather than being provided by hospital employees.
- between 2014–15 and 2016–17, Tasmania reported estimated recurrent expenditure for all public hospitals.

Variation in expenditure on visiting medical officers may reflect differences in outsourcing arrangements. Variations in the outsourcing arrangements may also be reflected in variations in other recurrent expenditure categories reported in Table 2.7, available for download in the Data section of this report.

Estimated data indicators

For 2017–18, estimated data indicators were included for each category in *Salary and wage expenditure*, *Non-salary expenditure* and Revenue. The estimated data indicators specify whether the information reported reflected actual data, or estimated data.

At the public hospital level, Queensland provided estimated salary expenditure for 3 hospitals. All jurisdictions provided estimates for *Revenue*.

More information on estimated data is available in Table A1 available to download in the Data section of this report.

Hospital beds

Differences in administrative practices and in the measures of beds used between public and private hospitals should be considered when interpreting the information presented in this section.

For public hospitals, counts of available beds are averaged over the reporting period and include:

- *Average available beds for same-day patients*—beds, chairs or trolleys exclusively or predominantly available to provide accommodation for same-day patients
- *Average available beds for overnight-stay patients*—beds exclusively or predominantly available to provide overnight accommodation for patients (other than neonatal cots and beds occupied by hospital-in-the-home patients).

For private hospitals, the numbers of beds reported are licensed beds—the maximum number of beds specified in the hospital's registration process. For private free-standing day hospital facilities, they include chairs, trolleys, recliners and cots.

Private hospital beds are not directly comparable to public hospital beds.

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Appendixes

Definitions

If not otherwise indicated, data elements were defined according to the definitions in the Local Hospital Networks/Public hospital establishments NMDS 2017–18 are also available online in the AIHW metadata online registry, METeOR. These are summarised in the Glossary.

Geographical classification

Information on the location of public hospitals is reported to the NPHED. The remoteness area of each public hospital was determined based on its street address.

Data on geographical location of the hospital location are defined using the ABS's Australian Statistical Geography Standard (ASGS) Remoteness Structure 2016 which categorises geographical areas in Australia into remoteness areas. The classification is as follows:

- *Major cities*—for example: Sydney, Melbourne, Brisbane, Adelaide and Perth
- *Inner regional*—for example: Hobart, Launceston, Wagga Wagga and Bendigo
- *Outer regional*—for example: Darwin, Moree, Cairns, Charters Towers and Albany
- *Remote*—for example: Port Lincoln, Esperance, Queenstown and Alice Springs
- *Very remote*—for example: Mount Isa, Coober Pedy, Port Hedland and Tennant Creek.

Australian Refined Diagnosis Related Groups

In this report, Australian Refined Diagnosis Related Groups (AR-DRG) sourced from the National Hospital Morbidity Database (NHMD) are used to measure the complexity of cases in hospitals (for example, counts of AR-DRGs for which a hospital reported at least 5 separations) and to derive the clinical specialties that are provided by hospitals (for example, using Service Related Groups).

For more information on the AR-DRG classification, see Admitted patient care 2017–18: Australian hospital statistics.

Presentation of data

Throughout the publication, percentages may not add up to 100.0 because of rounding. Percentages and rates printed as 0.0 or 0 generally indicate a zero. The symbol '<0.1' has been used to denote less than 0.05 but greater than 0.

Suppression of data

The AIHW operates under a strict privacy regime which has its basis in Section 29 of the Australian Institute of Health and Welfare Act 1987 (AIHW Act). Section 29 requires that confidentiality of data relating to persons (living and deceased) and organisations be maintained. The *Privacy Act 1988* governs confidentiality of information about living individuals.

The AIHW is committed to reporting that maximises the value of information released for users while being statistically reliable and meeting legislative requirements described above.

Data (cells) in tables may be suppressed in order to maintain the privacy or confidentiality of a person or organisation, or because a proportion or other measure related to a small number of events and may therefore not be reliable.

Analysis methods

Counting activity

Counts of separations and patient days were sourced from admitted patient care data reported for the NHMD for 2017–18.

Records for 2017–18 are for hospital separations in the period from 1 July 2017 to 30 June 2018. Data on patients who were admitted on any date before 1 July 2017 are included, provided that they also separated between 1 July 2017 and 30 June 2018. A record is included for each separation, not for each patient, so patients who separated more than once in the year have more than one record in the NHMD.

Records for *Newborn* episodes without qualified days and records for *Hospital boarders* and *Posthumous organ procurement* were excluded from counts of separations. However, for analyses based on SRGs, *Newborn* episodes without qualified days were also included.

A patient day (or day of patient care) means an admitted patient occupied a hospital bed (or chair in the case of some same-day patients) for all or part of a day. The length of stay for an overnight patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting days the patient was on leave. A same-day patient is allocated a length of stay of 1 day.

Patient day statistics can be used to provide information on hospital activity that, unlike separation statistics, account for differences in length of stay. As the database contains records for patients separating from hospital during the reporting period (1 July 2017 to 30 June 2018), this means that not all patient days reported will have occurred in that year.

It is expected, however, that patient days for patients who separated in 2017–18, but who were admitted before 1 July 2017, will be counterbalanced overall by the patient days for patients in hospital on 30 June 2018 who will separate in future reporting periods.

Estimated resident populations

All populations are based on the estimated resident population as at 30 June preceding the reporting period (that is, for the reporting period 2017–18, the estimated resident population as at 30 June 2017 was used), drawn from the 2016 Census data.

Hospital peer groups

This report uses the AIHW current peer group classification, developed by the AIHW in consultation with the Australian Hospital Statistics Advisory Committee and the Private Hospital Statistics Advisory Committee in 2013 and 2014. Peer group classifications are outlined in the 2015 report Australian hospital peer groups.

The peer group to which each public hospital is assigned is included in Table AS.1 available to download in the Data section of this report.

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Appendixes

The Service Related Group (SRG) classification can be used to help plan services, analyse and compare hospital activity, examine patterns of service needs and access, and project potential trends in services.

The SRG classification categorises admitted patient episodes into groups representing specialised clinical units or divisions of hospital activity, based on aggregations of AR-DRGs.

This report uses SRG version 5.0, developed by the New South Wales Ministry of Health, which assigns SRGs based on AR-DRG version 7.0.

SRGs were allocated using the data in the NHMD. While the method largely involves aggregations of AR-DRG information, the assignment of some separations to SRGs is based on other information, such as procedures, diagnoses and care types. Separations with non-acute care are allocated to separate SRG categories according to the type of care, because the main service type of these separations cannot be ascertained from their diagnoses or procedures.

For public hospitals, separations may have been assigned to the *Perinatology* SRG depending on whether or not the hospital had a specialist neonatal intensive care unit, as reported to the NPHED. For private hospitals, the *Perinatology* SRG was not assigned as the available data do not indicate whether the hospital had a specialist neonatal intensive care unit. Therefore, all private hospital *Newborns* with qualified days were assigned to the SRG *Qualified neonate*. An 'unallocated' SRG was assigned for separations with an *Error DRG*.

Activity in 2017–18

This appendix provides supplementary information on the level of activity for each SRG for public and private hospitals (measured using the number of separations and patient days).

Table 5.7, available to download from the Data section of this report, presents the 20 most common specialised clinical units for public hospitals—by remoteness area of hospital and by peer group, respectively. The number of specialised clinical units was based on the number of hospitals for which there were at least 360 patient days reported for the SRG.

Table C2, available to download from the Data section of this report, contains the number of separations and patient days in each SRG for public and private hospitals.

Renal dialysis (SRG 23) had the largest number of separations in public hospitals (1.21 million). This was followed by *General medicine* (SRG 27) (561,000). In the private sector, *Diagnostic gastrointestinal* (SRG 16) recorded the highest number of separations (463,000), followed by *Rehabilitation* (SRG 84) (372,000).

Rehabilitation (SRG 84) recorded the highest number of patient days (1.97 million) in public hospitals, followed by *Psychiatry/mental health—acute* (SRG 82) (1.89 million).

For private hospitals, *Rehabilitation* (SRG 84) recorded the highest number of patient days (1.42 million), followed by *Orthopaedics* (SRG 49) (928,000).

Where to go for more information

Detailed SRG information for public and private hospitals, by state and territory see Tables CS.1 to CS.6.

Tables CS.1 and C.S2 contain the number of public hospitals that, in 2017–18, reported more than 50 separations or more than 360 patient days for each SRG by state and territory and public hospital peer groups, respectively. These tables have been included as indicative measures of the number of specialised clinical units.

These tables are available to download in the Data section of this report.

References

NCCC (National Casemix and Classification Centre) 2012. Australian Refined Diagnosis Related Groups, version 7.0. Wollongong: University of Wollongong.

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Glossary

Some definitions in the Glossary contain an identification number from the Metadata Online Registry (METeOR). METeOR is Australia's central repository for health, community services and housing assistance metadata, or 'data about data'. It provides definitions for data for health and community services-related topics and specifications for related national minimum data sets.

acquired immune deficiency syndrome (AIDS) unit: A facility dedicated to the treatment of AIDS patients. METeOR identifier: 619614.

activity-based funding: A method of funding health services based on the amount and type of activity. METeOR identifier: 651815.

acute care hospital: See establishment type.

acute renal dialysis unit: A facility dedicated to dialysis of renal failure patients requiring acute care. METeOR identifier: 619627.

acute spinal cord injury unit: A facility dedicated to the initial treatment and subsequent ongoing management and rehabilitation of patients with acute spinal cord injury, largely conforming to Australian Health Minister's Advisory Council guidelines for service provision. METeOR identifier: 619640.

administrative and clerical staff: Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this category. METeOR identifier: 620091.

administrative expenditure: The expenditure incurred by establishments (but not central administrations) of a management expenses/administrative support nature, such as any rates and taxes, printing, telephone, stationery and insurance (including workers compensation). METeOR identifier: 542106.

administrative expenses—insurance: Expenditure incurred by establishments for the purposes of insurance (excluding workers' compensation premiums and medical indemnity). METeOR identifier: 542106.

admitted acute care expenditure: Expenditure incurred by an establishment for admitted patients receiving acute care, including expenditure associated with the care of unqualified newborns (reported under the mother's episode of care), but excluding mental health care. METeOR identifier: 706373.

admitted mental health care expenditure: Expenditure incurred by an establishment for admitted patients receiving mental health care defined as care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder. METeOR identifier: 706373.

admitted patient: A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). METeOR identifier: 268957.

admitted subacute care expenditure: Expenditure incurred by an establishment for admitted patients receiving subacute care, but excluding mental health care. METeOR identifier: 643188.

alcohol and drug treatment centre: A facility/service dedicated to the treatment of alcohol and drug dependence. METeOR identifier 619655.

Australian Refined Diagnosis Related Groups (AR-DRGs): An Australian system of diagnosis-related groups (DRGs). DRGs provide a clinically meaningful way of relating the number and type of patients treated in a hospital (that is, its casemix) to the resources required by the hospital. Each AR-DRG represents a class of patients with similar clinical conditions requiring similar hospital services.

average available beds for overnight-stay patients: The number of beds available to provide overnight accommodation for patients—other than neonatal cots (non-special-care) and beds occupied by hospital-in-the-home patients—averaged over the counting period. METeOR identifier: 616014.

average available beds for same-day patients: The number of beds, chairs or trolleys available to provide accommodation for same-day patients, averaged over the counting period. METeOR identifier: 616017.

average length of stay: The average number of patient days for admitted patient episodes.

beds: Public hospital bed numbers and private hospital bed numbers presented in this report are based on different definitions. Public hospital bed numbers are for average available beds—the average number of beds immediately available for use (with staffing). Private hospital bed numbers represent the number of licensed or registered beds. See Chapter 2 for more information.

block-funding: A method of funding health services for which activity-based funding is not applicable due to low volumes, the absence of 'economies of scale' or the inability to satisfy the technical requirements of activity-based funding (IHPA 2014).

burns unit (level III): A facility dedicated to the initial treatment and subsequent rehabilitation of severely injured burns patient (usually more than 10% of the patient's body surface affected). METeOR identifier: 619702.

cardiac surgery unit: A facility dedicated to operative and peri-operative care of patients with cardiac disease. METeOR identifier: 619713.

care type: Defines the overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (care other than admitted care). METeOR identifier: 584408.

casemix: The range and types of patients (the mix of cases) treated by a hospital or other health service. Casemix classifications (such as AR-DRGs) provide a way of describing and comparing hospitals and other services for management purposes.

clinical genetics unit: A facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of, or anxious about genetic disorders. METeOR identifier: 619723.

Commonwealth funded aged care expenditure: Expenditure incurred by an establishment for Australian Government-funded aged care patients (such as residential aged care and Multi-Purpose Services). METeOR identifier: 706373.

comprehensive epilepsy centre: A facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy. METeOR identifier: 619743.

constant prices: Constant price expenditure adjusts current prices for the effects of inflation; that is, it aims to remove the effects of inflation. Hence, expenditures in different years can be compared on a dollar–for–dollar basis, using this measure of changes in the volume of health goods and services.

contracted care expenditure: Expenditure on the provision of contracted care by private hospitals incurred by an establishment. METeOR identifier: 684914.

coronary care unit: A facility dedicated to acute care services for patients with cardiac diseases. METeOR identifier: 619758.

current prices: Expenditures reported for a particular year, unadjusted for inflation.

deflator: A deflator is a value (or a set of values) that adjusts current prices for the effects of inflation, resulting in constant prices, in terms of some base period.

depreciation: Depreciation represents the expensing of a long-term asset over its useful life.

depreciation—building: Building depreciation includes depreciation charges for buildings and fixed fit-out such as items fitted to the building (for example, lights and partitions). See non-salary expenditure. METeOR identifier: 542106.

diabetes unit: A facility dedicated to the treatment of patients with diabetes. METeOR identifier: 619769.

diagnostic and allied health professionals: Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff). METeOR identifier: 620091. See full time equivalent staff.

direct teaching, training and research expenditure: Expenditure incurred by an establishment for direct teaching, training and research. METeOR identifier: 706373.

domestic and other staff: Staff engaged in the provision of food and cleaning services including those primarily engaged in administrative duties such as food services manager. Dieticians are excluded. This category also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening staff). METeOR identifier: 620091.

domestic services expenditure: The cost of all domestic services, including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses, but not including salaries and wages, food costs or equipment replacement and repair costs. METeOR identifier: 542106.

domiciliary care service unit: A facility dedicated to the provision of nursing or other professional paramedical care or treatment and non-qualified domestic assistance to patients in their own homes or in residential institutions not part of the establishment. METeOR identifier: 619790.

drug supplies expenditure: The cost of all drugs, including the cost of containers. METeOR identifier: 542106.

elective surgery: Elective care where the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians. METeOR identifier: 568780.

emergency care services expenditure: Expenditure incurred by an establishment on non-admitted patients receiving care through emergency care services. Excludes admitted patients receiving care through the emergency department. METeOR identifier: 706373.

enrolled nurses: Enrolled nurses are registered with the national registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. Mothercraft nurses). METeOR identifier: 620091.

establishment type: Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment. METeOR identifier: 684439.

estimated data indicator: An indicator of whether data relating to an establishment have been estimated. METeOR identifier: 548891.

food supplies expenditure: Expenditure incurred by establishments on all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery. METeOR identifier: 542106.

full-time equivalent staff: Full-time equivalent staff units are the on-the-job hours paid for (including overtime), and hours of paid leave of any type for a staff member (or contract employee where applicable), divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). METeOR identifiers: 620091 and 616025.

geriatric assessment unit: A facility dedicated to the Commonwealth-approved assessment of the level of dependency of (usually) aged individuals either for purposes of initial admission to a long-stay institution or for purposes of reassessment of dependency levels of existing long-stay institution residents. METeOR identifier: 619809.

hospice: See establishment type.

hospice care unit: A facility dedicated to the provision of palliative care to terminally ill patients. METeOR identifier: 619860.

hospital: A health-care facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients. METeOR identifier: 268971.

hospital expenditure: Recurrent expenditure on public hospital services presented in this report reflects recurrent expenditure on public hospital services incurred by individual hospitals, by local hospital networks (LHNs) and by state and territory health authorities

in-vitro fertilisation unit: A facility dedicated to the investigation of infertility and provision of in-vitro fertilisation services. METeOR identifier: 619877.

Independent Hospital Pricing Authority (IHPA) funding designation: The designation given to an establishment by the Independent Hospital Pricing Authority relating to a type of funding the establishment receives. METeOR identifier: 684457.

infectious diseases unit: A facility dedicated to the treatment of infectious diseases. METeOR identifier: 619888.

intensive care unit (level III): A facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services. METeOR identifier: 619894.

interest payments: Payments made by or on behalf of the establishment in respect of borrowings (such as interest on bank overdraft) provided the establishment is permitted to borrow. This does not include the cost of equity capital (dividends on shares) in respect of profit-making private establishments. METeOR identifier: 542106.

lease costs: A lease is an agreement whereby the lessor conveys to the lessee in return for a payment or series of payments the right to use an asset for an agreed period of time. METeOR identifier: 542106.

length of stay: The length of stay of an overnight patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting days the patient was on leave. A same-day patient is allocated a length of stay of 1 day. METeOR identifier: 269982.

licensed bed: A bed in a private hospital, licensed by the relevant state or territory health authority.

local hospital networks: Local hospital networks directly manage single or small groups of public hospital services and their budgets, and are directly responsible for hospital performance. METeOR identifier: 491016.

maintenance renal dialysis centre: A facility dedicated to maintenance dialysis of renal failure patients. It may be a separate facility (possibly located on hospital grounds) or known as a satellite centre or a hospital-based facility but is not a facility solely providing training services. METeOR identifier: 619920.

major plastic/reconstructive surgery unit: A facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery. METeOR identifier: 619941.

medical and surgical supplies expenditure: The cost of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs. METeOR identifier: 270358.

National Health Reform Agreement (NHRA) 2011 product streams: The different types of care describe total recurrent expenditure broken down by the NHRA product stream (METeOR identifiers: 706373and 679213).

neonatal intensive care unit (level III): A facility dedicated to the care of neonates requiring care and sophisticated technological support. METeOR identifier 619947.

neurosurgical unit: A facility dedicated to the surgical treatment of neurological conditions. METeOR identifier: 619953.

non-admitted care (in-scope for NHRA) expenditure: Expenditure incurred by an establishment on non-admitted patients receiving services deemed to be in-scope of the National Health Reform Agreement. METeOR identifier: 706373.

non-admitted care (out of scope for NHRA) expenditure: Expenditure incurred by an establishment on non-admitted patients receiving services deemed not to be in-scope of the National Health Reform Agreement. METeOR identifier: 706373.

non-admitted patient: A patient who does not undergo a hospital's formal admission process. METeOR identifier: 268973.

non-admitted patient clinics: The organisational units or organisational arrangements through which a hospital provides a service to a non-admitted patient. METeOR identifier: 400598.

non-salary expenditure: Includes payments to visiting medical officers, superannuation, drug supplies, medical and surgical supplies (which include consumable supplies only and not equipment purchases), food supplies, domestic services, repairs and maintenance, patient transport, administrative expenses, interest, depreciation, lease costs, other on-costs and other recurrent expenditure. METeOR identifiers: 616030.

non-salary expenditure not elsewhere recorded: The expenditure incurred by establishments on all other recurrent expenditure costs not elsewhere recorded. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers). Includes expenditure by the establishment on contracted care arrangements. METeOR identifier: 542106.

nursing home care unit: A facility dedicated to the provision of nursing home care. METeOR identifier: 619959.

obstetric/maternity service unit: A facility dedicated to the care of obstetric/maternity patients. METeOR identifier: 619977.

oncology unit: A facility dedicated to multidisciplinary investigation, management, rehabilitation and support services and treatment services (including surgery, chemotherapy and radiation) for cancer patients. METeOR identifier: 619990.

other administrative expenses: Expenditure incurred by establishments of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery but excluding insurance, workers' compensation premiums and medical indemnity. METeOR identifier: 542106.

other admitted care expenditure: Expenditure incurred by an establishment for other admitted patients, including expenditure associated with maintenance care, but excluding mental health care. METeOR identifier: 706373.

other aged care expenditure: Expenditure incurred by establishments for other aged care patients, excluding Australian Government-funded aged care patients (such as residential aged care and Multi-Purpose Services). METeOR identifier: 706373.

other care (out of scope for NHRA) expenditure: Expenditure incurred by an establishment on services not reported elsewhere. METeOR identifier: 706373.

other on-costs: The expenditure incurred by establishments on employee-related expenses, excluding salaries, wages and superannuation employer contributions, paid on behalf of establishment either by the establishment, or another organisation such as a state health authority. METeOR identifier: 542106.

other personal care staff: Includes attendants, assistants or home assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents; they are not formally qualified or undergoing training in nursing or allied health professions. METeOR identifier: 620091.

other salaried medical officers: Non-specialist medical officers employed by the establishment on a full-time or part-time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee-for-service basis. This category includes non-specialist salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent). METeOR identifier: 620091.

outpatient: See non-admitted patient. METeOR identifier: 268973.

patient transport cost: The direct cost of transporting patients, excluding salaries and wages of transport staff where payment is made by an establishment. METeOR identifier: 542106.

payments to visiting medical officers: Payments made by an institutional health care establishment to visiting medical officers for medical services provided to hospital (public) patients on an honorary, sessional or fee-for-service basis. METeOR identifier: 542106.

peer group: Groupings of hospitals into broadly similar groups in terms of characteristics.

performance indicator: A statistic or other unit of information that directly or indirectly, reflects either the extent to which an expected outcome is achieved or the quality of processes leading to that outcome.

private hospital: A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Acute care and psychiatric hospitals are included, as are private free-standing day hospital facilities.

psychiatric hospital: See establishment type.

psychiatric unit/ward: A unit/ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders. METeOR identifier: 620003.

public hospital: A hospital controlled by a state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients. See also establishment type.

Public hospital peer groups: Public hospital peer groups categorise hospitals into broadly similar groups in terms of characteristics. For more information, see Appendix C.

recurrent expenditure: Expenditure incurred by organisations on a recurring basis, for the provision of health goods and services. This includes, for example, salaries and wages expenditure and non-salary expenditure such as payments to visiting medical officers. This excludes capital expenditure. METeOR identifier: 542106.

registered nurses: Includes persons with at least a 3-year training certificate and nurses holding post graduate qualifications. Registered nurses must be registered with the national registration board. This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, midwife (including pupil midwife), psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse and nurse educator. This category also includes nurses engaged in administrative duties no matter what the extent of their engagement, for example, directors of nursing and assistant directors of nursing. METeOR identifier: 620091.

rehabilitation unit: A facility designed by the state/territory health authority and dedicated to providing post-acute rehabilitation. METeOR identifier: 620010.

remoteness area: A classification of the remoteness of a location using the Australian Statistical Geography Standard Remoteness Structure (2016), based on the Accessibility/Remoteness Index of Australia which measures the remoteness of a point based on the physical road distance to the nearest urban centre.

repairs and maintenance expenditure: The costs incurred in maintaining, repairing, replacing and providing additional equipment; maintaining and renovating buildings, and minor additional works. METeOR identifier: 542106.

salary and wages expenditure: Expenditure on salaries and wages to employees of an establishment. METeOR identifier: 616005.

separations: The total number of episodes of care for admitted patients, which can be total hospital stays (from admission to discharge, transfer or death) or portions of hospital stays beginning or ending in a change of type of care (for example, from acute to rehabilitation) that cease during a reference period. METeOR identifier: 270407.

Service Related Group (SRG): A classification based on AR-DRG aggregations for categorising admitted patient episodes into groups representing clinical divisions of hospital activity.

sleep centre: A facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders. METeOR identifier: 620026.

specialised service unit: A facility or unit dedicated to the treatment or care of patients with particular conditions or characteristics, such as an intensive care unit. METeOR identifier: 269612.

specialist paediatric service unit: A specialised facility dedicated to the care of children aged 14 or under. METeOR identifier: 620033.

specialist salaried medical officers: Specialist medical officers employed by the hospital on a full-time or part-time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee-for-service basis. This category includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent). METeOR identifier: 270494 and 620091.

student nurses: Persons employed by the establishment currently studying in years 1 to 3 of a 3-year certificate course. This includes any person commencing or undertaking a three-year course of training leading to registration as a nurse by the national registration board. This includes full-time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post-basic training courses. METeOR identifier: 620091.

superannuation employer contributions: Contributions paid on behalf of establishment employees by the establishment to a superannuation fund providing retirement and related benefits to establishment employees. METeOR identifier: 542106.

trainee/pupil nurses: Includes any person commencing or undertaking a 1-year course of training leading to registration as an enrolled nurse on the national registration board (includes all trainee nurses). METeOR identifier: 620091.

transplantation unit—bone marrow: A facility for bone marrow transplantation. METeOR identifier: 619693.

transplantation unit—heart, lung: A facility for heart and heart-lung transplantation. METeOR identifier: 619822.

transplantation unit—liver: A dedicated facility for liver transplantation. METeOR identifier: 619914.

transplantation unit—pancreas: A facility for pancreas transplantation. METeOR identifier: 619997.

transplantation unit—renal: A facility for renal transplantation. METeOR identifier: 620019.

visiting medical officer: A medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid or fee-for-service basis. METeOR identifier: 620091.

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Notes

Amendments

2 Dec 2020 - Table 5.3 was updated to include Queensland average available beds by hospital size.

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- Tomi Adejoro (South Australian Department for Health and Wellbeing)
- Peita Bonato (Australian Capital Territory Health Directorate)
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