Australian Government
Australian Institute of
Health and Welfare

Endometriosis

Web report | Last updated: **21 May 2025** | Topic: Chronic disease

About

This web report is part of Australian Centre for Monitoring Population Health

Endometriosis is an inflammatory condition that can be painful, affect fertility and lead to reduced participation in school, work and social activities. Around 1 in 7 women born in 1973–78 were diagnosed with endometriosis by age 44–49.

This report brings together the latest data to highlight the impact of endometriosis in Australia. It includes information on prevalence, hospitalisations, emergency department presentations, burden of disease and health system expenditure.

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Findings from this report:

- The rate of endometriosis hospitalisations has doubled among females aged 20–24 in the past decade
- Around two-thirds (65%) of endometriosis-related hospitalisations took place in a private hospital
- 19 out of every 1,000 hospitalisations among females aged 15–44 were related to endometriosis
- Endometriosis is the 3rd leading cause of non-fatal disease burden due to female reproductive and maternal conditions

Summary

Endometriosis is a chronic condition that can be painful, affect fertility and lead to reduced participation in school, work and sporting activities.

Prevalence of endometriosis

A historically under-recognised condition, diagnosis of endometriosis is often delayed, with an average of between 6 and 8 years between onset of symptoms and diagnosis. However in recent years, prevalence estimates suggest that women are being diagnosed with endometriosis at earlier ages. This increase may reflect increased awareness of endometriosis among the general public and health professionals, leading to increased diagnosis and/or reporting of diagnosis among women born more recently.

Around 1 in 7 (14%) women born in 1973–78 were estimated to have been diagnosed with endometriosis by age 44–49.

By age 31, 9.2% of women born in 1989–95 had been diagnosed with endometriosis compared with 6.9% of women born in 1973–78.

See How common is endometriosis? for more information.

Burden of disease due to endometriosis

The health loss from living with illness and injury caused by endometriosis is measured as the non-fatal burden, or years lived with disability (YLD) due to endometriosis.

The rate of YLD for endometriosis has increased from 0.5 per 1,000 females in 2003 to 0.7 in 2024, after adjusting for differences in age structure over time.

Endometriosis remains the third leading cause of non-fatal disease burden among females due to reproductive and maternal conditions, after genital prolapse and polycystic ovarian syndrome.

See Burden of disease for more information.

Health system spending on endometriosis

Health system spending comprises estimated costs from hospital services, primary health care and referred medical services which can be attributed to treating endometriosis.

An estimated $293 million was spent on endometriosis in the Australian health system in 2022–23.

Since 2013–14, total spending on endometriosis has more than doubled from $142 million to $293 million in 2022–23.

See Health system expenditure for more information.

Hospitalisations due to endometriosis

Almost all (95%) endometriosis-related hospitalisations involved a procedure. Surgical procedures used in the treatment of endometriosis include the removal of lesions via laparoscopy (key-hole surgery) or laparotomy (abdominal surgery), and in severe cases, removal of the uterus (hysterectomy) or parts of the bowel.

In 2022–23 there were 44,200 endometriosis-related hospitalisations.

This represents 335 hospitalisations per 100,000 females, up from 250 in 2012–13.

Hospitalisation rates doubled among females aged 20–24, from 325 hospitalisations per 100,000 females in 2012–13 to 650 per 100,000 in 2022–23.

In 2022–23, age-standardised rates of endometriosis-related hospitalisations were highest among:

Non-Indigenous Australians – 1.2 times the rate for First Nations women.

Females living in the least disadvantaged socioeconomic areas – 1.3 times the rate in the most disadvantaged areas.

Females living in Major cities of Australia – 1.5 times the rate for those living Remote and very remote areas.

In 2022–23, most endometriosis-related hospitalisations:

Lasted 2 days or less, with 44% being same-day hospitalisations.

Were partly or fully funded by private health insurance (57%).

Took place in a private hospital (65%).

See Hospitalisations for more information.

Emergency department presentations due to endometriosis

Emergency departments (EDs) provide urgent care for symptoms of endometriosis, such as severe pain and bleeding. People presenting to the ED with symptoms of endometriosis before they have received a diagnosis are likely to be recorded as having other symptom-based diagnoses, such as abdominal and pelvic pain or heavy bleeding.

In 2023–24 there were 4,800 endometriosis-related ED presentations.

Where endometriosis was the main reason for attending the ED, the rate of presentations increased slightly from 29 per 100,000 females in 2018–19 to 32 per 100,000 in 2023–24.

Three-quarters (76%) of ED presentations were triaged as needing to be seen within 30 minutes or less.

See Emergency department presentations for more information.

What is endometriosis?

On this page:

What is endometriosis?

Endometriosis is a disease where tissue similar to the lining of the uterus grows in other parts of the body (Endometriosis Australia 2023). Endometriosis most often affects the reproductive organs but can also be found in other areas, such as around the bowel and bladder. These tissues are collectively known as endometriosis. Endometriosis can cause inflammation and scarring, which can lead to painful 'adhesions' joining together pelvic organs which are normally separate.

Endometriosis is a progressive chronic condition. Recent research views endometriosis as an inflammatory, multi-system illness (Saunders et al. 2021; Taylor et al. 2021; Zondervan et al. 2020). There is some evidence to suggest associations exist between endometriosis and other chronic conditions, such as selected cancers and cardiovascular disease (Shafrir et al. 2018).

What causes endometriosis?

The cause of endometriosis is unclear. A family history of endometriosis appears to increase the risk of developing the condition (Jean Hailes for Women's Health 2023a). Other theories that have been suggested throughout the years are metaplasia (the conversion of normal pelvic tissue into endometriosis) and retrograde (backwards) menstruation (Healthdirect 2021). Other contributing factors may include early age at first period, short menstrual cycles, heavy or long periods, older age of first pregnancy, immune system problems, low body weight, and alcohol consumption.

What are the symptoms of endometriosis?

Symptoms of endometriosis vary between individuals. Some people experience no symptoms, while others experience severe pain, heavy menstrual bleeding, bleeding between periods, abdominal bloating, fatigue, anxiety and depression, among other symptoms (Jean Hailes for Women's Health 2023a). Pain is a common symptom and can include abdominal, lower back or pelvic pain, painful menstruation, pain during or after intercourse, pain during ovulation, and pain during urination or defaecation. In some cases endometriosis can affect fertility due to the impact on reproductive organs (Jean Hailes for Women's Health 2023b).

The severity of symptoms does not necessarily reflect the extent of the condition. For example, a person with minimal endometriosis may experience more pain than a person with severe endometriosis (Jean Hailes for Women's Health 2023a).

Symptoms of endometriosis can occur from menarche (start of menstruation) through to menopause (WHO 2021). After menopause, symptoms may ease for many but not for all (Jean Hailes for Women's Health 2023a).

Diagnosing endometriosis

There are several systems for classifying endometriosis based on the extent and location of the endometriosis, though none have been universally accepted (RANZCOG 2021). It is recommended that treatment is based on symptoms and an individual's needs, preferences, and priorities for care.

The 'gold standard' for definitive diagnosis of endometriosis is a laparoscopic procedure including biopsy and destruction of endometriotic lesions (RANZCOG 2021). However, other methods may be used to reasonably suspect endometriosis and begin treatment without surgery, known as a 'clinical diagnosis' (Agarwal et al. 2019; Taylor et al. 2018).

Diagnosis of endometriosis is often delayed, with an average of between 6 and 8 years between onset of symptoms and diagnosis (Armour et al. 2020, O'Hara et al. 2022). Nonspecific symptoms, lack of specific biomarkers, lack of awareness of the condition, and stigma and symptom normalisation have been identified as key contributors to the diagnostic delay (Zondervan et al. 2020). In the study which found an average delay of 8 years, this time was comprised of 3 years from symptom onset to seeking medical care, and 5 years from the first medical appointment to a surgical diagnosis of endometriosis (Armour et al. 2020). However, the diagnostic delay appears to be decreasing over time, both for the time to seek medical care and time to receive a diagnosis.

The National Action Plan for Endometriosis

The National Action Plan for Endometriosis was launched in 2018 with the goal of 'a tangible improvement in the quality of life for individuals living with endometriosis, including a reduction in the impact and burden of disease at individual and population levels'. The plan has 3 priority areas:

- awareness and education – this involves developing and delivering community awareness campaigns, promoting early education on women's health in schools, improving access to information for people living with endometriosis, and improving awareness and understanding of endometriosis among health professionals
- clinical management and care – this involves developing clinical guidelines and clinical care standards; promoting early access to intervention, care and treatment options; improving affordability, accessibility and consistency of management; ensuring endometriosis is recognised as a chronic condition by all health practitioners; and narrowing the gap in quality of life between people with endometriosis and their peers
- research – this involves building a collaborative environment for endometriosis research, mining existing data and improving data linkage between sources, and conducting further research to understand causes and impacts and progress towards a cure (Department of Health 2018a).

Progress made against the plan is outlined in the Endometriosis Progress Report 2024 Update (Department of Health and Aged Care 2024).

Reducing the prevalence and impact of endometriosis and associated chronic pelvic pain is also listed as a key priority for chronic conditions and preventive health in the National Women's Health Strategy 2020–2030 (Department of Health 2018b).

Endometriosis data by sex and gender

Endometriosis can affect women and girls, transgender, non-binary, and gender-diverse people assigned female at birth (Department of Health 2018). In this report, terminology used to refer to those experiencing endometriosis is based on that used in the underlying data collection.

Australian Longitudinal Study on Women's Health (ALSWH 2020a; ALSWH 2020b)

- 1973–78 cohort: invitations were sent in 1996 based on information from the Medicare database in 1996, where an individual's sex was recorded as female, and their date of birth was between 1973 and 1978.
- 1989–95 cohort: participants were recruited online in 2012 and 2013, mainly from social media. Participants from this cohort were asked their sex in the 2013 survey. It is not known whether participants interpreted this to mean sex at birth or gender identity.
- The gender identity of participants in the study is not known, as this information is not routinely collected. Participants in this study may identify as female or have a different gender identity.

National Hospital Morbidity Data/National Non-admitted Patient Emergency Department Database

- Hospitalisation and emergency department presentation data are based on hospital admissions records. Patients' sex was recorded as 'male', 'female' or 'other'.
- Depending on the practices of the hospital, this may be based on what the patient selected, or how hospital staff completed the record. It may also be based on an existing hospital record for the patient, which may no longer reflect how they identify.
- It is important to note that it is not known if the people completing these records interpreted sex to mean sex at birth or gender identity.
- A small number of hospitalisations/ED presentations (<10) were reported with a sex of 'male' or 'other'. To preserve confidentiality, data presented in this report have been restricted to hospitalisations/ED presentations with a sex of 'female' only. The estimated resident population for Australian females is used for the denominator when calculating rates.

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How common is endometriosis?

Page highlights:

- Around 1 in 7 (14%) women born in 1973–78 were estimated to have been diagnosed with endometriosis by age 44–49.
- By age 31, a higher proportion of women in the younger cohort had been diagnosed with endometriosis (9.2% of those born in 1989–95 compared with 6.9% born in 1973–78).

According to the Australian Longitudinal Study on Women's Health, 14% of women born in 1973–1978 were estimated to have been diagnosed with endometriosis by age 44–49. This comprised an estimated 7.6% with surgically confirmed endometriosis and 6.6% with clinically suspected endometriosis.

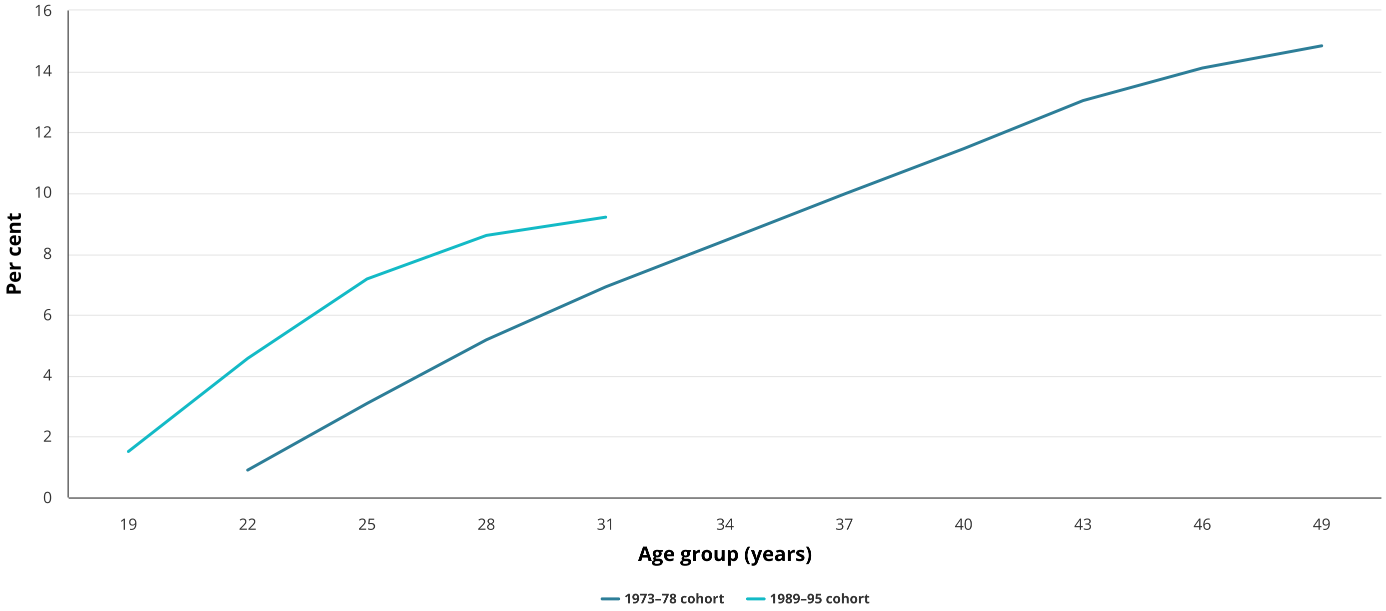
Among a younger cohort of women born in 1989–95, 8.8% were estimated to have been diagnosed with endometriosis by age 26–31. This comprised an estimated 3.8% with surgically confirmed endometriosis and 5.0% with clinically suspected endometriosis.

As expected, the cumulative incidence of endometriosis increased with age as women have more time to receive a diagnosis (Figure 1). Of women in the 1989–95 cohort who had turned 31, 9.2% were estimated to have been diagnosed with endometriosis compared with 6.9% of women born in 1973–78 at this age.

Differences between the two cohorts are also evident in the age-specific incidence rates. To date, the peak age-specific incidence occurred at 22 for the 1989–95 cohort, compared with 25 for the 1973–78 cohort.

These differences may reflect increased awareness of endometriosis among the general public and health professionals, leading to increased diagnosis among women born more recently.

Figure 1: Cumulative incidence of endometriosis, by cohort and age



Note: Age refers to age at last birthday.
Source: Australian Longitudinal Study on Women's Health (ALSWH). Information on endometriosis was collected from ALSWH survey 2 onwards.

Estimating the prevalence of endometriosis with the Australian Longitudinal Study on Women's Health

The Australian Longitudinal Study on Women's Health (ALSWH) is a national study focusing on women's health. The ALSWH provides information about endometriosis among women in 2 specific cohorts – those born in 1973–78 and those born in 1989–95. Researchers from the University of Queensland used data from surveys of women in the study, linked with administrative health data, to estimate the prevalence and cumulative incidence of endometriosis in these cohorts. The estimates were based on:

- participant-reported diagnosis of, or treatment for, endometriosis
- records of claims for an endometriosis specific Medicare item
- records of dispensed endometriosis-specific medications subsidised under the Pharmaceutical Benefits Scheme (PBS)
- hospitalisations where a diagnosis of endometriosis was recorded.

The estimates were further categorised into surgically confirmed and clinically suspected endometriosis. **Surgically confirmed** endometriosis was defined as participants who had a diagnosis of endometriosis recorded in the Medicare Benefits Schedule (MBS) or hospitals data. **Clinically suspected** endometriosis was defined as participants who self-reported a diagnosis of endometriosis in the ALSWH only, or who had only been prescribed a restricted medication for endometriosis based on PBS data.

For further information on the data sources and methods used in this research, see the Technical notes.

Other Australian prevalence

There is a lack of comparable Australian prevalence estimates in recent decades. In an earlier Australian study, a questionnaire of around 3,000 female twins aged 18 and over conducted in 1993–1994 found that 7% of respondents had ever had endometriosis (Treloar et al. 1999). The twins were considered representative of the general population, with regard to age, education and marital status.

International prevalence estimates

In international research, the prevalence of endometriosis is estimated to be about 10% among women of reproductive age (WHO 2021; Zondervan et al. 2020). This estimate is based on a United States study conducted from 1976 to 1984 which identified histologic diagnosis of endometriosis among 858 women undergoing vaginal hysterectomy for preoperative diagnoses excluding endometriosis, pelvic pain and adhesions (Wheeler 1989). A more recent United States study involving an online survey of women aged 18–49 estimated the prevalence of diagnosed endometriosis as 6.1% (Fuldeore & Soliman 2017).

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Impact of endometriosis

Page highlights:

Burden of disease

- There were 8,356 years lived with disability (YLD) due to endometriosis in 2024.
- The YLD rate for endometriosis has increased from 0.5 per 1,000 females in 2003 to 0.7 in 2024, after adjusting for differences in age structure over time.
- Endometriosis is the third leading cause of non-fatal disease burden among females due to reproductive and maternal conditions, after genital prolapse and polycystic ovarian syndrome.

Health system expenditure

- In 2022–23, less than 1% of Australian health system expenditure ($293 million) was attributable to endometriosis.
- Since 2013–14, total spending on endometriosis has more than doubled from $142 million to $293 million in 2022–23.

Endometriosis can have a substantial impact on individuals. Symptoms can be debilitating and may affect quality of life, fertility, and lead to reduced participation in school, work and social activities.

Measures of impact covered in this section include burden of disease and health expenditure.

Burden of disease

Burden of disease measures the gap between the ideal of living to old age in good health, and the current situation where healthy life is shortened or lost by illness, injury, disability and death. It combines health loss from living with illness and injury (non-fatal burden, or years lived with disability, or YLD) and dying prematurely (fatal burden, or years of life lost, or YLL) to estimate total health loss (total burden, or disability-adjusted life years, or DALY). For endometriosis, there is no burden due to dying prematurely, so only non-fatal burden (YLD) is reported. One YLD is one year of 'healthy life' lost due to illness.

What is the burden of disease due to endometriosis?

The Australian Burden of Disease Study 2024 found that there were 8,356 YLD from endometriosis in Australia, a rate of 0.6 per 1,000 females (crude rate) (AIHW 2024a). The disease burden due to endometriosis:

- represents 0.5% of the non-fatal burden among females in Australia
- represents 13% of the non-fatal burden among females due to reproductive and maternal conditions, the third highest burden in this condition group
- is highest among females aged 30–34 with 1,688 YLD, equivalent to 1.7 YLD per 1,000 females (Figure 2)
- results in endometriosis being the 15th leading cause of non-fatal burden among females aged 30–34.

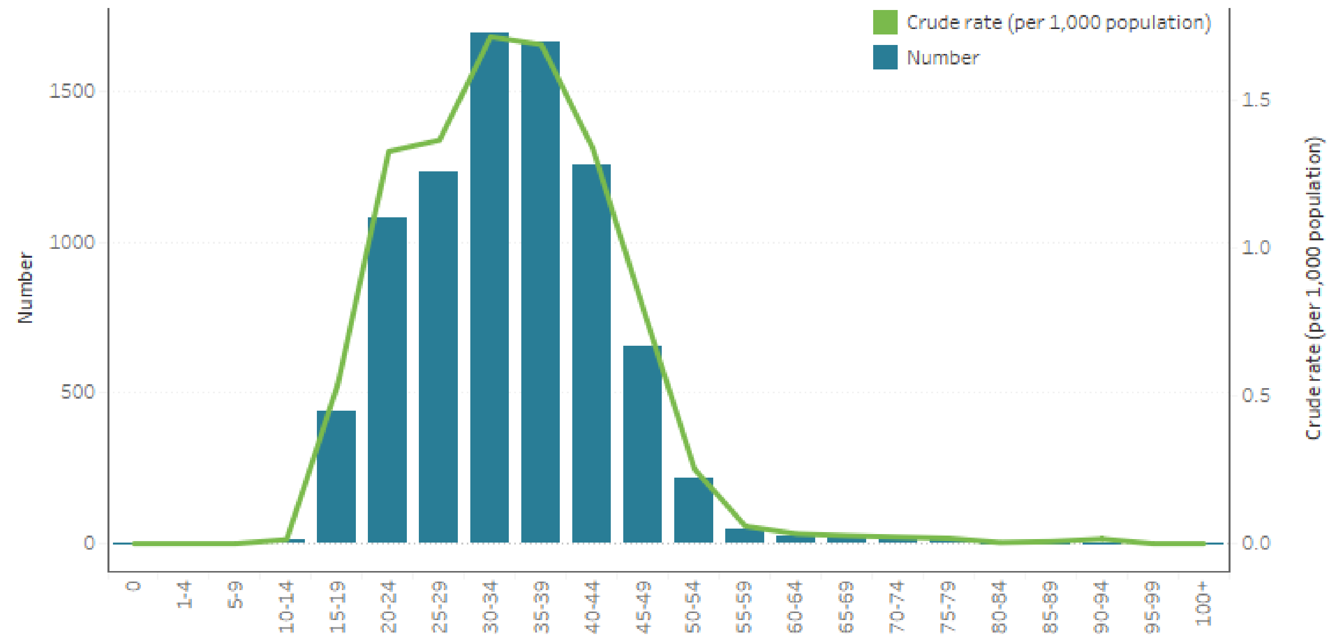
The age-standardised YLD rate for endometriosis has increased from 0.5 per 1,000 females in 2003 to 0.7 in 2024. This change may be driven by changes in disease prevalence, community awareness or diagnosis.

Figure 2: Non-fatal burden of disease due to endometriosis, 2003–2024

Select year:
2024

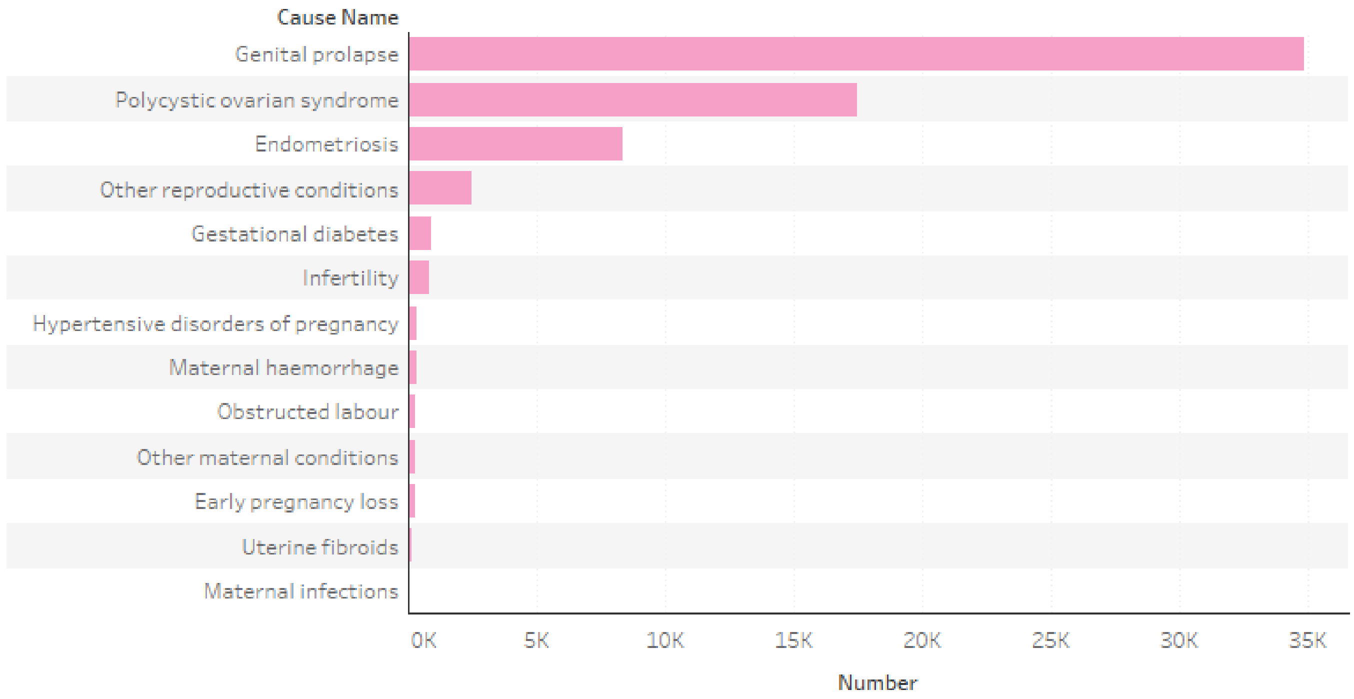
In **2024**, there were **8,356 YLD** in Females from Endometriosis, equivalent to **0.7** per 1,000 population (age-standardised rate) and **0.5%** of the non-fatal burden in Australia.

YLD in Females by age, 2024



Note: Diseases displaying a rate of 0.00 per 1,000 population refer to a rate <0.005 per 1,000 population.

YLD in Females, reproductive and maternal conditions disease group, 2024



Notes:
1. Rates were age-standardised to the 2001 Australian Standard Population and are expressed as per 1,000 population.
2. Refer to the technical notes for more information on data sources and methods used in the Study.
Source: AIHW Australian Burden of Disease Database.
https://www.aihw.gov.au

Health system expenditure

The AIHW Disease expenditure database showed that in 2022–23, an estimated $293 million was spent on endometriosis in the Australian health system (AIHW 2024b). This represents less than 1% of spending attributable to specific disease groups.

This expenditure consisted of:

- $255 million for hospitals (including public hospital admitted patient, outpatient and emergency department services and private hospital services)
- $25 million for referred medical services (including pathology, medical imaging and specialist services)
- $14 million for primary health care (including General Practitioner services and Pharmaceutical Benefits Scheme expenditure).

Around 84% of total expenditure on endometriosis was attributed to females of reproductive age (aged 15–44 years). Females aged 35–39 years had the highest expenditure amongst all age groups, accounting for around 20% of total endometriosis expenditure.

Over the period 2013–14 to 2022–23:

- total spending on endometriosis more than doubled from $142 million to $293 million in nominal terms (an increase of $152 million)
- after adjusting for the effects of inflation, real expenditure on endometriosis grew $118 million.

These estimates include payments from all sources of funds, such as the Australian and State and Territory Governments, Private Health Insurance, and out of pocket payments by patients, where spending can be attributed to the treatment of endometriosis. It is likely to underestimate spending where data are lacking on endometriosis-related services, such as primary care services and medicines.

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Treatment & management of endometriosis

Page highlights:

Hospitalisations

- There were 44,200 endometriosis-related hospitalisations in 2022–23, a 54% increase since 2012–13 (28,700 hospitalisations). This represents 335 hospitalisations per 100,000 females (up from 250 in 2012–13).
- The rate of endometriosis hospitalisations doubled among females aged 20–24 in the past decade, from 325 hospitalisations per 100,000 females in 2012–13 to 650 per 100,000 in 2022–23.
- There were 1,300 endometriosis-related hospitalisations for First Nations people, representing 2.9% of endometriosis-related hospitalisations.
- The age standardised-rate for endometriosis-related hospitalisation in *Major cities* was 1.5 times the rate in *Remote and very remote* areas.
- Around two-thirds (65%) of endometriosis-related hospitalisations took place in a private hospital.

Emergency department presentations

- There were more than 4,800 endometriosis-related emergency department (ED) presentations in 2023–24. This represents around 35 presentations per 100,000 females.
- Around three-quarters (76%) of endometriosis-related ED presentations were triaged as needing to be seen within 30 minutes or less.

There is no known cure for endometriosis. Treatments are available to manage the symptoms associated with endometriosis and improve quality of life, including:

- pain relievers
- hormonal treatments, including hormonal contraceptives, which suppress ovulation and periods
- surgery for the removal of lesions via laparoscopy (key-hole surgery) or laparotomy (abdominal surgery).

In severe cases, surgery may be performed to remove the uterus (hysterectomy) or remove parts of the bowel affected by endometriosis (The Royal Women's Hospital 2023). In most cases, hysterectomy is performed to treat other causes of uterus pain (for example, adenomyosis), and to prevent possible future regrowth of endometriosis around these organs. Where endometriosis has contributed to reduced fertility, surgery to remove lesions may be used to improve fertility.

Individuals may also seek treatment from allied health or complementary therapies, such as physiotherapy, acupuncture, traditional Chinese medicine, exercise, and diet modifications (RANZCOG 2021).

General practitioners are often the first point of contact for those with suspected endometriosis and are therefore instrumental in identifying symptoms, prescribing medication or providing referrals to specialists for further testing and/or treatment. The management of endometriosis in primary care presents a substantial data gap. See Data gaps and opportunities for further information.

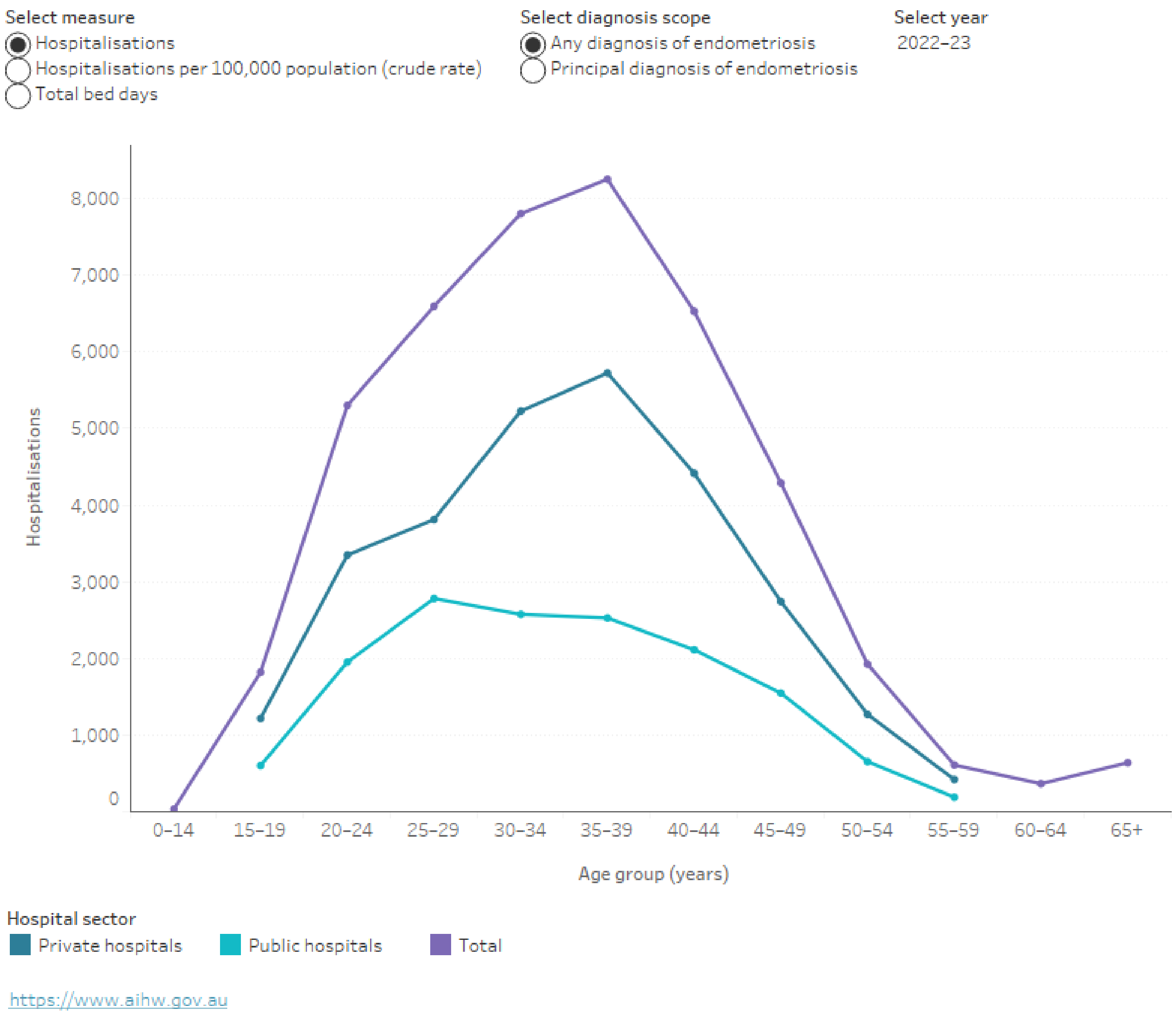
Hospitalisations

According to the AIHW National Hospital Morbidity Database (NHMD), there were 44,200 endometriosis-related hospitalisations in 2022–23. This represents 335 hospitalisations per 100,000 females. Around half (51%) of endometriosis-related hospitalisations in 2022–23 had endometriosis as the principal diagnosis (the main reason for hospitalisation).

Age

Most endometriosis-related hospitalisations (82% in 2022–23) are among females aged 15–44 (Figure 3), which are generally regarded as a woman's reproductive years. This represents 19 out of every 1,000 hospitalisations among females in this age group.

Figure 3: Age profile of endometriosis-related hospitalisations, 2012–13 to 2022–23



Select measure
● Hospitalisations
○ Hospitalisations per 100,000 population (crude rate)
○ Total bed days

Select diagnosis scope
● Any diagnosis of endometriosis
○ Principal diagnosis of endometriosis

Select year
2022–23

Notes:

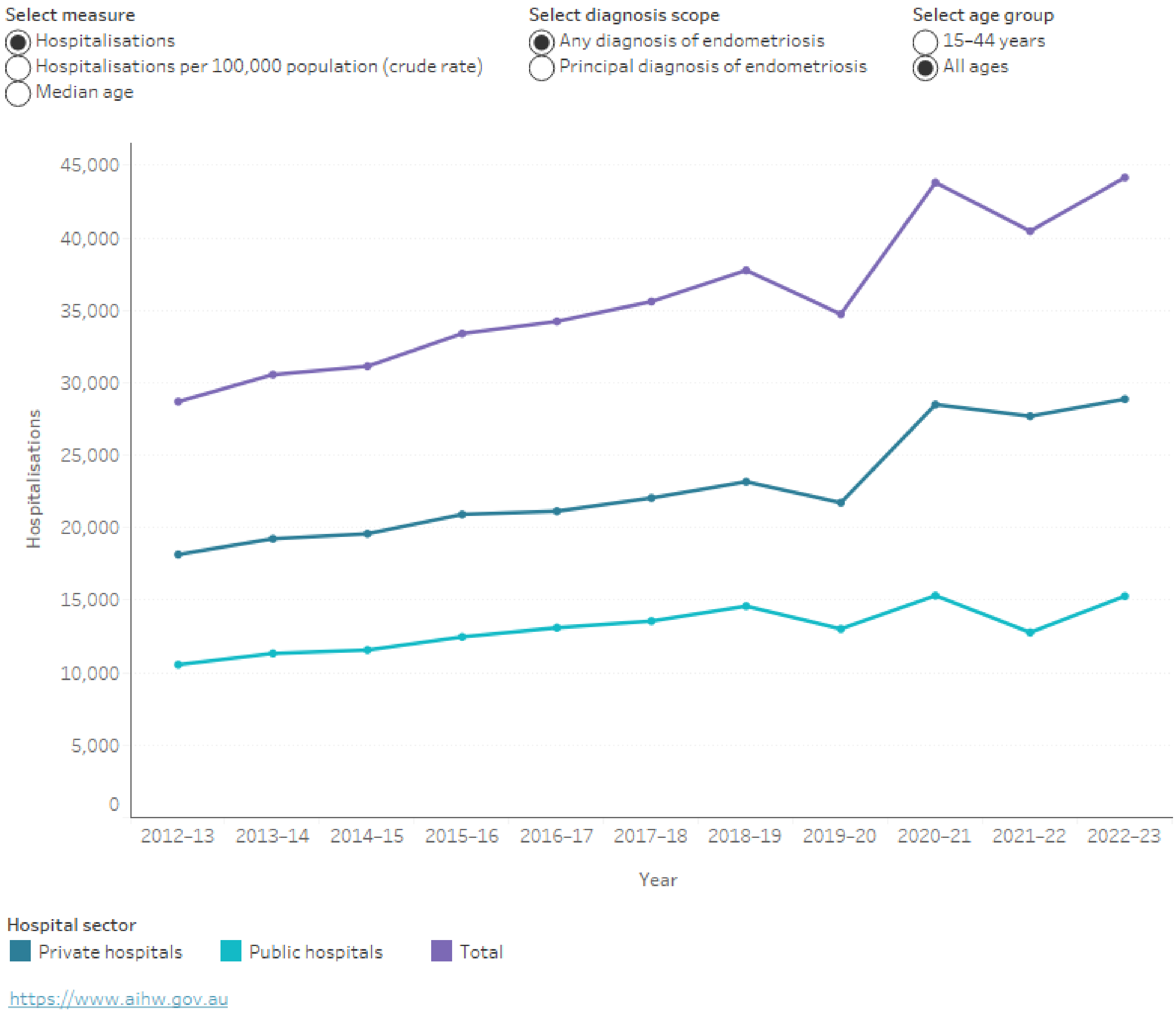
1. Rates were calculated using the December estimated resident population for females.
2. To preserve confidentiality, data by hospital sector (public/private) have been suppressed for age groups 0–14, 60–64 and 65+.

Source: AIHW National Hospital Morbidity Database (NHMD).

Trends over time

Rates of endometriosis-related hospitalisation increased among females aged 15–44 over the past decade. The greatest increase was among those aged 20–24, where the rate of endometriosis hospitalisations doubled, from 325 hospitalisations per 100,000 females in 2012–13 to 650 per 100,000 in 2022–23 (Figure 4). This was particularly driven by the increase in the rate of hospitalisations in private hospitals among this age group, which more than doubled from 170 to 410 hospitalisations per 100,000 females.

Figure 4: Endometriosis-related hospitalisations, 2012–13 to 2022–23



Select measure
● Hospitalisations
○ Hospitalisations per 100,000 population (crude rate)
○ Median age

Select diagnosis scope
● Any diagnosis of endometriosis
○ Principal diagnosis of endometriosis

Select age group
○ 15–44 years
● All ages

Note: Rates were calculated using the December estimated resident population for females.

Source: AIHW National Hospital Morbidity Database (NHMD).

Variation between population groups

In 2022–23, endometriosis-related hospitalisations varied between population groups (Figure 5). These differences could reflect potential variations in access to health services, including different barriers to access, or differences in health-seeking behaviour between population groups, rather than a difference in disease prevalence.

First Nations people

There were 1,300 endometriosis-related hospitalisations for Aboriginal and Torres Strait Islander (First Nations) women in 2022–23, representing 255 hospitalisations per 100,000 females. In 2022–23, about 2.9% of endometriosis-related hospitalisations were First Nations women, lower than the proportion of all female hospitalisations who were First Nations women (6.0%).

The age-standardised rate for endometriosis-related hospitalisations among non-Indigenous Australians was 1.2 times the rate for First Nations women.

Socioeconomic area

The age-standardised rate for endometriosis-related hospitalisation in the highest 20% of socioeconomic areas (the areas of least disadvantage) was 1.3 times the rate in the lowest 20% (the areas of most disadvantage).

Remoteness area

The age standardised-rate for endometriosis-related hospitalisation in *Major cities* was 1.5 times the rate in *Remote and very remote* areas. This contrasts with the pattern seen for all female hospitalisations, for which the age-standardised rate in *Remote and very remote* areas is twice the rate in *Major cities*.

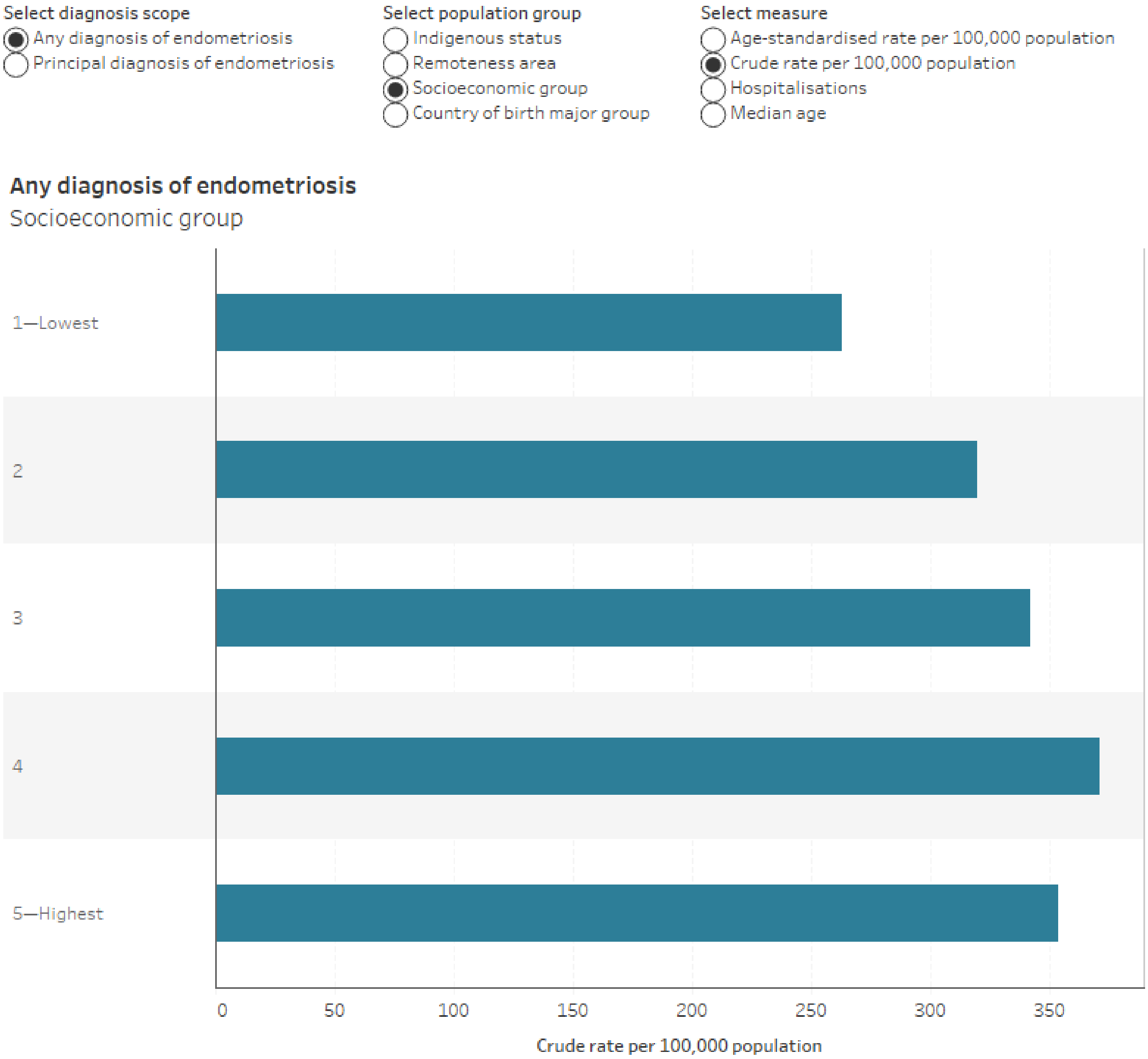
Country of birth

In 2022–23, 25% of endometriosis-related hospitalisations were among females born outside of Australia. This is similar to the proportion for all female hospitalisations (27%), and likely reflects the pattern seen in the general population, with 31% of females born outside of Australia according to the Census of Population and Housing (ABS 2024).

The rate of endometriosis-related hospitalisation varied by the region of birth. Rates were highest among patients born in the Americas, and lowest among patients born in Southern and Eastern Europe.

Median age also varied with country of birth. The median age of Australian-born endometriosis patients was lower than all other regions.

Figure 5: Endometriosis-related hospitalisations, by population group, 2022–23



Select diagnosis scope
● Any diagnosis of endometriosis
○ Principal diagnosis of endometriosis

Select population group
○ Indigenous status
○ Remoteness area
● Socioeconomic group
○ Country of birth major group

Select measure
○ Age-standardised rate per 100,000 population
● Crude rate per 100,000 population
○ Hospitalisations
○ Median age

Source: AIHW National Hospital Morbidity Database (NHMD).
https://www.aihw.gov.au

Funding source

Most endometriosis-related hospitalisations were partly or fully funded by private health insurance (57%). A further 31% were for public patients, while 8.1% were for self-funded patients. Almost two-thirds (65%) of endometriosis-related hospitalisations took place in a private hospital.

Compared with all female hospitalisations in 2022–23, endometriosis-related hospitalisations were more likely to be partly or fully funded by private health insurance, self-funded, and/or occur in a private hospital (Table 1).

Table 1a: Endometriosis hospitalisations by funding source, 2022–23

Funding source	Endometriosis hospitalisations, ages 15–44 (%)	Endometriosis hospitalisations, all ages (%)	All female hospitalisations, ages 15–44 (%)	All female hospitalisations, all ages (%)

Private health insurance (partly or fully funded)	56.2	56.7	32.5	41.0
Medicare[(a)]	30.4	30.6	55.4	49.1
Self-funded	9.0	8.1	7.2	4.2
Other	4.5	4.6	4.9	5.7
Total	**100.0**	**100.0**	**100.0**	**100.0**

(a) Also includes a small number of overseas visitors covered by Reciprocal Health Care Agreements and those ineligible for Medicare who’s services were free of charge at the discretion of the hospital.

Source: AIHW National Hospital Morbidity Database (NHMD).

Table 1b: Endometriosis hospitalisations by hospital sector, 2022–23

Hospital sector	**Endometriosis hospitalisations, ages 15–44 (%)**	**Endometriosis hospitalisations, all ages (%)**	**All female hospitalisations, ages 15–44 (%)**	**All female hospitalisations, all ages (%)**
Public hospital	34.6	34.6	62.4	57.4
Private hospital	65.4	65.4	37.6	42.6
Total	**100.0**	**100.0**	**100.0**	**100.0**

Source: AIHW National Hospital Morbidity Database (NHMD).

Length of stay

Most endometriosis-related hospitalisations lasted 2 days or less, with 44% being same-day hospitalisations. The average length of stay was slightly shorter for hospitalisations with endometriosis as a principal diagnosis, compared with that for all endometriosis-related hospitalisations.

The average length of stay for endometriosis-related hospitalisations was shorter than that for all female hospitalisations:

- 1.5 days compared with 2.7 days for all female hospitalisations
- 2.0 days compared with 5.5 days for all female hospitalisations excluding same-day hospitalisations.

Procedures

In 2022–23, 95% of endometriosis-related hospitalisations involved at least 1 procedure (Table 2). *Laparoscopic excision of lesion of pelvic cavity* was the most common procedure, occurring in 45% of endometriosis-related hospitalisations.

Table 2: Most common procedures undertaken during endometriosis-related hospitalisations, 2022–23

Rank	**Procedure code**	**Procedure name**	**Description**	**Per cent of hospitalisations**
1	35637-10	Laparoscopic excision of lesion of pelvic cavity	Removal of lesions by cutting	44.5
2	35630-00	Diagnostic hysteroscopy	Examination of the inside of the uterus	40.9
3	35640-00	Dilation and curettage of uterus [D&C]	In which the lining of the uterus is scraped away	37.9
4	30393-00	Laparoscopic division of abdominal adhesions	In which adhesions are cut and divided	24.4
5	35703-00	Test for tubal patency	Assessment of whether fallopian tubes are blocked, used in investigating infertility	17.5
6	35637-02	Laparoscopic diathermy of lesion of pelvic cavity	Removal of lesions by burning	16.1
7	35503-00	Insertion of intrauterine device [IUD]	Insertion of a contraceptive device, which is also used in the treatment of endometriosis	15.4
8	36812-00	Cystoscopy	Examination of the inside of the bladder	15.2
9	35638-10	Laparoscopic salpingectomy, bilateral	Removal of both fallopian tubes	13.1

10	35653-07	Laparoscopic total abdominal hysterectomy	Removal of the uterus	13.0

Notes:

1. Procedures were counted only once if the same procedure was conducted more than once in a hospitalisation.
2. Procedures for cerebral anaesthesia (ACHI block code 1910) were not included in this analysis – these are companion procedures for many other procedures.
3. ‘Diagnostic hysteroscopy’ is the name of a procedure in the ACHI and does not imply that this procedure is being used to diagnose endometriosis.

Source: AIHW National Hospital Morbidity Database (NHMD).

Emergency department presentations

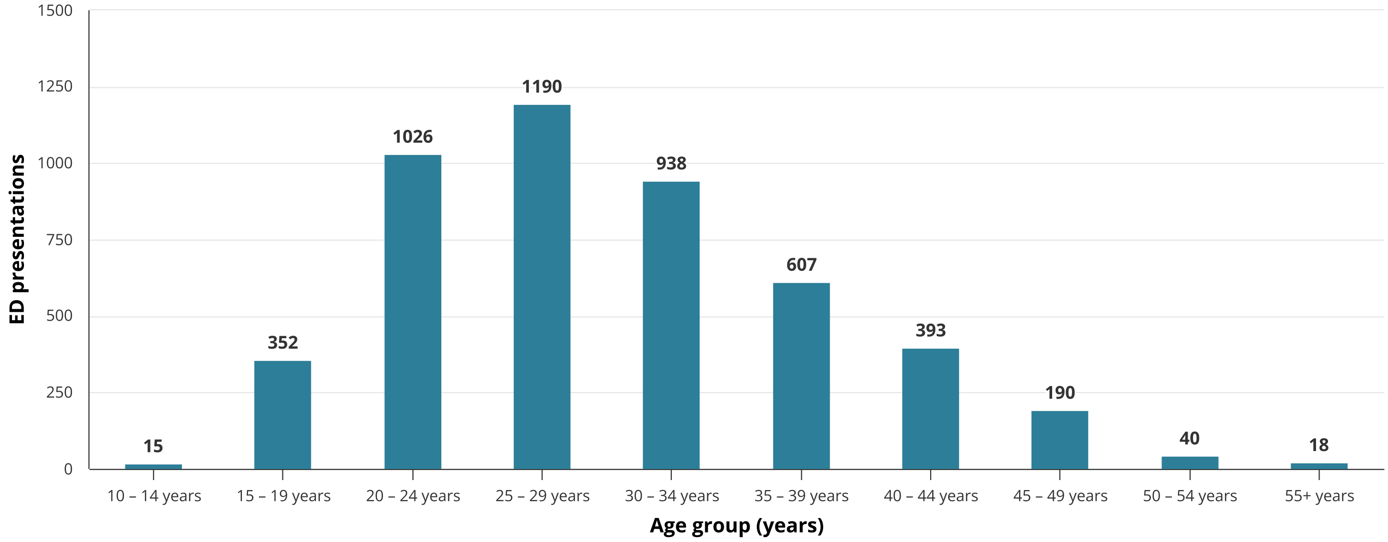
According to the AIHW National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), there were 4,800 endometriosis-related emergency department (ED) presentations in 2023–24. This represents around 35 presentations per 100,000 females. Almost all (90%) presentations had endometriosis listed as the principal diagnosis.

Most endometriosis-related ED presentations were among females aged 15–44 (Figure 6). The rate of endometriosis-related ED presentations was highest in the 25–29 age group.

Around 71% of endometriosis-related ED presentations in 2023–24 ended with the patient leaving the hospital without being admitted or referred to another hospital. For 26% of the endometriosis-related presentations the patient was admitted to the same hospital for further care.

Figure 6: Number and rate of endometriosis-related emergency department presentations, by age group, 2023–24

Measure:
Number
Rate



Notes:

1. Includes presentations with a principal and/ or additional diagnosis of endometriosis.
2. Rates were calculated using the December estimated resident population for females.

Source: National Non-admitted Patient Emergency Department Care Database (NNAPEDCD).

Triage category

Triage category is used to indicate the level of urgency of a patient’s need for care. Of all endometriosis-related ED presentations in 2023–24:

- 11% were categorised as ‘requiring immediate or emergency care’ (within 10 minutes)
- 65% as ‘urgent’ (within 30 minutes)
- 23% as ‘semi-urgent’ (within 60 minutes) and
- 1.4% as ‘non-urgent’ (within 120 minutes).

Trends over time

Where endometriosis was the main reason for attending the ED (the principal diagnosis), the rate of ED presentations is trending upwards after fluctuating in the years surrounding the COVID-19 pandemic. Overall, between 2018–19 and 2023–24, ED presentations have slightly increased from 29 per 100,000 females to 32 per 100,000 (Figure 7). This is similar to the pattern seen among all female ED presentations during this period, which also fluctuated during the COVID-19 pandemic.

An individual may present to the ED with symptoms of endometriosis before they have received a diagnosis. In these cases, diagnoses related to pain, abnormal bleeding or menstrual issues are likely to be recorded. Figure 7 displays ED presentations for several diagnoses which may be related to endometriosis.

Figure 7: Emergency Department presentations for endometriosis and other selected diagnoses (principal diagnosis), 2018–19 to 2023–24

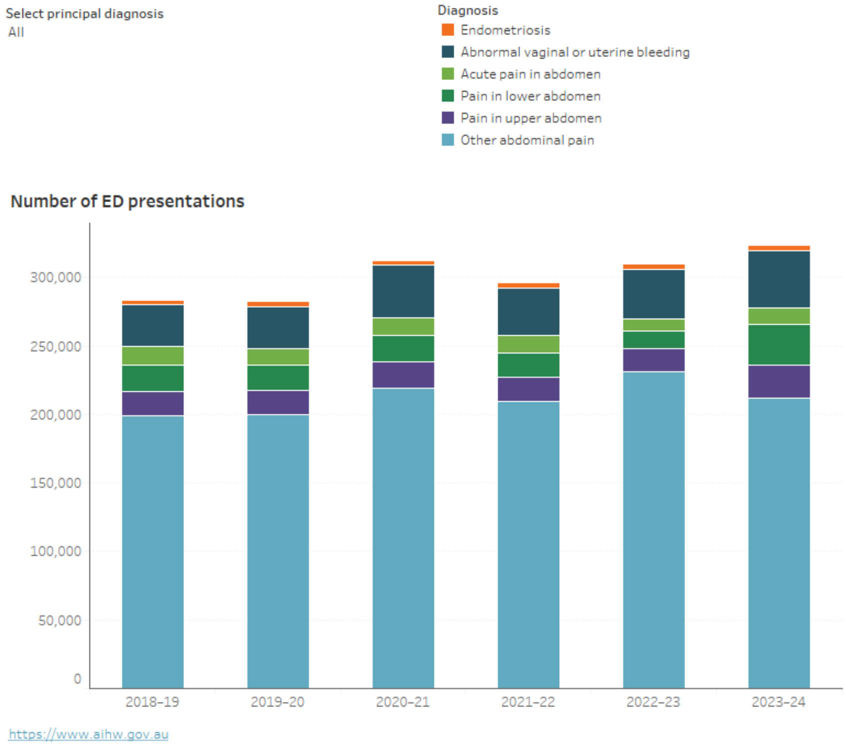


Chart shows the number of presentations for possible related diagnoses, including abnormal vaginal/uterine bleeding, acute pain in abdomen, pain in upper and lower abdomen and other pain in abdomen.

Note: Rates were calculated using the December estimated resident population for females.

Source: National Non-admitted Patient Emergency Department Care (NNAPEDC) Database.

References

ABS (Australian Bureau of Statistics) (2024), *Australia's Population by Country of Birth*, ABS Website, accessed 13 March 2025.

RANZCOG (Royal Australian and New Zealand College of Obstetricians and Gynaecologists) (2021) *Endometriosis clinical practice guideline*, RANZCOG, accessed 25 October 2022.

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Data gaps and opportunities

Comprehensive, accurate and timely data are necessary for effective population health monitoring of endometriosis. The National Action Plan for endometriosis calls for improved data capture, use and linkage to improve understanding of the current state, impact, and burden of endometriosis in Australia (Department of Health 2018).

Gaps and limitations

The analysis in this report predominantly describes hospital and emergency department care for endometriosis, which likely reflects management of more severe symptoms. Information on the use of primary care, specialist care or pharmaceutical treatment would provide a more complete picture of endometriosis in Australia, but is limited by the absence of suitable data sources. Current gaps on the health of people living with endometriosis include:

- national, comparable and reportable data on primary and allied health care activity and outcomes
- outcomes of endometriosis-related hospitalisations and emergency department presentations
- emergency department presentations due to endometriosis symptoms prior to receiving a diagnosis
- diagnosis and treatment pathways for people with endometriosis, including multiple hospitalisations or emergency department presentations and waiting times
- information on some population groups, including First Nations people, people with disability, culturally and linguistically diverse populations, refugees and LGBTIQA+ populations
- the impacts of endometriosis on a person's life, including school and work attendance and performance, daily activities, relationships, and mental health.

Data linkage opportunities

Where data are available, analysis can be limited by the inability to identify endometriosis as the purpose of treatment. Linked data presents an opportunity for improved understanding of the experiences and treatment patterns for people with endometriosis. Examples of linked data sources which could be explored for endometriosis include:

- The National Health Data Hub: The NHDH, formerly the National Integrated Health Services Information (NIHSI) analytical asset, is a major national linked health data asset which brings together information on health services, aged care services, disability services, immunisations and demography. Analysis could describe patient pathways and health service use in the years preceding and succeeding a diagnosis of endometriosis. This analysis could also explore the use of Medicare Benefits Schedule services and the medicines provided under the Pharmaceutical Benefits Scheme for the treatment of endometriosis.
- Person Level Integrated Data Asset: PLIDA, formerly the Multi-Agency Data Integration Project (MADIP), is a secure data asset combining information on health, education, government payments, income and taxation, employment, and population demographics (including the Census) over time. Analysis could explore the impact of endometriosis beyond a person's health, such as reduced participation in school, work and sporting activities.

Data development opportunities

The Australian Government provided funding in the 2024–25 Federal Budget for the AIHW to develop a national sexual and reproductive health monitoring framework, data strategy and regular reporting. Menstrual disorders, including endometriosis, are one of the priority areas for the first phase of this work. See Sexual & reproductive health for more information.

Investment in endometriosis research

The National Health and Medical Research Council has expended $18.9 million towards research relevant to endometriosis between 2000 and 2022.

From its inception in 2015 to 31 May 2023, the Medical Research Future Fund has invested $19.11 million in 11 grants with a focus on endometriosis research. Examples include:

- $3.93 million to the University of Melbourne for improving diagnosis and treatment of endometriosis
- $1.94 million to the University of New South Wales for The Australian Endometriosis Clinicians Collaborative (AECC)
- $1.47 million to Deakin University for CoDeEndo: Co-Designing, Evaluating, and Implementing Supportive Care for Endometriosis.

References

Department of Health and Aged Care (2018a) *National Action Plan for Endometriosis,* Department of Health and Aged Care, Australian Government, accessed 15 July 2022.

Technical notes

On this page:

The Australian Longitudinal Study on Women's Health

The Australian Longitudinal Study on Women's Health (ALSWH) is an ongoing large population-based prospective cohort study focusing on women's health. Detailed information on the study methods have been published elsewhere (Brown et al. 1999; Dobson et al. 2015; Loxton et al. 2015; Rowlands et al. 2021).

The analysis presented in this report is based on data from 2 ALSWH cohorts – 14,247 women born in 1973–78 and 17,015 women born in 1989–95.

Survey data

Data for endometriosis in the 1973–78 cohort were available from 8 surveys between 2000 and 2022. Data for endometriosis in the 1989–95 cohort were available from 5 surveys between 2013 and 2019. The specific ALSWH survey questions used to measure endometriosis are included in Table TN1. For both cohorts, the woman's survey response date was used as the date of her first record of endometriosis.

Administrative health data

Three additional sources of administrative health data were used to identify records of endometriosis. The codes used to identify endometriosis, and the time periods that data were available for each data source, are presented in Table TN2. Deterministic linkage of Medicare Benefits Schedule (MBS) records and Pharmaceutical Benefits Scheme (PBS) records for all ALSWH participants was conducted using their unique Medicare number. Hospital data, managed by individual states and territories, were extracted by the health data linkage units in these jurisdictions and linked to ALSWH data using probabilistic matching based on name, date of birth, address and address history.

For the 1973–78 cohort, hospital data were available for all 8 Australian states and territories, but the time periods for which data were available varied (see Table TN3). Hospital data for the 1989–95 cohort were not available for New South Wales or the Australian Capital Territory. Hospital data for all other jurisdictions covered most of the ALSWH survey period for this cohort (2012–2018).

For the 1973–78 cohort, 13,501 women (95%) consented to the linkage of survey data with their administrative health records. For the 1989–95 cohort, 16,972 (almost 100%) consented to the linkage of survey data with their administrative health records.

Statistical analysis

The overall prevalence of endometriosis for each cohort was calculated by combining survey data and administrative health data. Women who completed the baseline survey and who were successfully linked with MBS, PBS or admitted patient hospital data were used to calculate prevalence.

The cumulative incidence estimates by age were derived using the Kaplan-Meier method; instead of the traditional method of using time to failure, age at endometriosis diagnosis was used. The confidence intervals were derived using the variance estimate given by Greenwood's formula (Greenwood 1926).

For women born 1973–78, by age 44–49, a total of 1,914 cases of endometriosis were identified, corresponding to a prevalence of 14.2% (95% CI: 13.6–14.8%). Of these cases, 1,030 (7.6%, 95% CI: 7.2–8.1%) were confirmed by surgery, while 884 (6.6%, 95% CI: 6.1–7.0%) were categorised as clinically suspected.

For women born in 1989-95, by age 26–31,1,502 cases of endometriosis were diagnosed, corresponding to a prevalence of 8.8% (95% CI: 8.4–9.3%). Among these cases, 654 (3.8%, 95% CI: 3.5–4.1%) were confirmed by surgery, while 848 (5.0%, 95% CI: 4.7–5.3%) were categorised as clinically suspected.

Table TN1: ALSWH survey questions assessing endometriosis

Cohort	Initial survey question	Subsequent surveys
1973–78 cohort	Have you ever been told by a doctor that you have: endometriosis?[(a)] Response options: 'In the last 4 years' or 'More than 4 years ago'[(b)]	In the last 3 years, have you ever been diagnosed or treated for: endometriosis?
1989–95 cohort	Have you ever been diagnosed or treated for: endometriosis?	Have you ever been diagnosed or treated for: endometriosis?[(c)]

a. Endometriosis first assessed at survey 2 for this cohort.
b. Women's responses to both questions were combined to form 1 estimate.
c. Question not assessed at survey 4 for this cohort.

Table TN2: Administrative health data sources used to identify endometriosis

Data source	Code(s)	Data available
MBS	35641	2000–August 2021
PBS	Goserelin (code: 01454M) Medroxyprogesterone 10 mg X 100 tablets (code: 02722G) Nafarelin (code: 02962X)	July 2002–August 2021
Admitted patient hospital data	International Statistical Classification of Diseases and Related Health Problems, 9th revision, clinical modification (ICD-9-CM) diagnostic codes 617.0–617.9 International Statistical Classification of Diseases and Related Health Problems, 10th revision, Australian modification (ICD-10-AM) diagnostic codes N80.0–N80.9	January 1970–March 2021[(a)]

a. Refer to Table TN3 for specific dates.

Table TN3: Years of availability for hospital data, by state/territory and cohort

State/territory	Earliest record	Latest record	Data available for 1973–78 cohort	Data available for 1989–95 cohort
NSW	May 2001	March 2021	Yes	Yes
Vic	July 1993	December 2020	Yes	Yes
Qld	July 2007	June 2020	Yes	Yes
WA	January 1970	December 2017	Yes	Yes
SA(a)	January 2001	June 2020	Yes	Yes
Tas(a)	January 2007	December 2019	Yes	Yes
ACT(a)	July 2004	June 2020	Yes	Yes
NT(a)	July 2000	June 2019	Yes	Yes

a. Public hospital data only.

What is an endometriosis-related hospitalisation?

Hospitalisation data presented in this report are based on admitted patient episodes of care from the National Hospital Morbidity Database (NHMD), including multiple events experienced by the same individual in a given time frame.

A **separation** is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). In this report, separations are referred to as **hospitalisations**.

Hospitalisations with endometriosis as the principal diagnosis are hospitalisations for which endometriosis was determined to be chiefly responsible for occasioning the episode of admitted patient care.

Hospitalisations with endometriosis as an additional diagnosis only are hospitalisations for which another condition was chiefly responsible for the episode of care, but endometriosis was determined to affect patient management.

Some hospitalisations have endometriosis listed as both a principal and additional diagnosis. These hospitalisations are counted with the principal diagnosis group and excluded from the additional diagnosis group to avoid double counting.

Endometriosis-related hospitalisations are hospitalisations with a principal and/or additional diagnosis of endometriosis.

A **procedure** is a clinical intervention that is surgical in nature, carries a procedural risk, carries an anaesthetic risk, requires specialised training and/or requires special facilities or equipment only available in an acute care setting.

The health classification used for morbidity reporting in Australia is the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) which is used alongside the Australian Classification of Health Interventions (ACHI) which classifies procedures and interventions.

National Hospital Morbidity Database

The National Hospital Morbidity Database (NHMD) is compiled from data supplied by the state and territory health authorities. It is a collection of electronic confidentialised summary records for hospitalisations (also known as separations or episodes of care) in public and private hospitals in Australia.

The NHMD is based on the Admitted Patient Care National Minimum Data Set (APC NMDS). It records information on admitted patient care in hospitals in Australia, and includes demographic, administrative and length-of-stay data, as well as data on the diagnoses of patients, the procedures they underwent in hospital and external causes of injury and poisoning.

The hospital separations data do not include episodes of non-admitted patient care given in outpatient clinics or emergency departments. Patients in these settings may be admitted later, with the care provided to them as admitted patients being included in the NHMD.

For more information on the NHMD, see *National Hospitals Data Collection*.

The following care types were excluded when undertaking the analysis: 7.3 (newborn – unqualified days only), 9 (organ procurement – posthumous) and 10 (hospital boarder).

A small number of hospitalisations (<10) were reported with a sex of 'male' or 'other'. To preserve confidentiality, data presented in this report have been restricted to hospitalisations with a sex of 'female' only.

Principal and additional diagnosis codes

Diagnoses were coded using the ICD-10-AM, with the edition applicable to the relevant data year as follows:

- Eleventh edition: 2023–24, 2022–23, 2021–22, 2020–21 and 2019–20
- Tenth edition: 2018–19 and 2017–18
- Ninth edition: 2015–16 and 2016–17
- Eighth edition: 2013–14 and 2014–15
- Seventh edition: 2011–12 and 2012–13.

Endometriosis-related hospitalisations were selected from the NHMD as follows:

- for all endometriosis-related hospitalisations, with a principal and/or additional diagnosis of endometriosis (ICD-10-AM codes N80.0–N80.9)
- for hospitalisations with a principal diagnosis of endometriosis, with a principal diagnosis of endometriosis (ICD-10-AM codes N80.0–N80.9)

The diagnosis code for endometriosis of the uterus (N80.0) is also used for the condition adenomyosis (a condition in which the cells that normally line the uterus are found in the muscular wall of the uterus). Although people who have adenomyosis often have endometriosis, endometriosis and adenomyosis are different conditions.

It is not possible to distinguish which of the records with the diagnosis 'endometriosis of the uterus' relate to adenomyosis and which relate to endometrial lesions on the surface of the uterus (that is, endometriosis). Records with the diagnosis 'endometriosis of the uterus' have been included in this report, which may result in an overestimate of endometriosis hospitalisations.

What is an endometriosis-related emergency department presentation?

Emergency department data presented in this report are based on non-admitted patient episodes of care from the National Non-admitted Patient Emergency Department Care Database (NNAPEDCD), including multiple events experienced by the same individual in a given time frame.

An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical conditions and/or injury.

Endometriosis-related emergency department presentations are emergency department presentations with a principal and/or additional diagnosis of endometriosis.

Triage is the process by which a patient is briefly assessed to determine the urgency of their problem and priority for emergency care.

The health classification used for emergency department presentation diagnosis reporting in Australia is the Emergency Department ICD-10-AM Principal Diagnosis Short List.

National Non-admitted Patient Emergency Department Care Database

The National Non-admitted Patient Emergency Department Care Database (NNAPEDCD) is compiled from data supplied by the state and territory health authorities. It is a collection of electronic confidentialised summary records for presentations to public hospital emergency departments in Australia.

The NNAPEDCD is based on the Non-admitted Patient Emergency Department Care (NAPEDC). The NNAPEDCD provides information on the care provided (including waiting times for care) for non-admitted patients registered for care in public hospital emergency departments that have:

- purposely designed and equipped area with designated assessment, treatment, and resuscitation areas
- the ability to provide resuscitation, stabilisation, and initial management of all emergencies
- availability of medical staff in the hospital 24 hours a day
- designated emergency department nursing staff 24 hours per day 7 days per week, and a designated emergency department nursing unit manager.

Emergency departments (including 'accident and emergency' or 'urgent care centres') that do not meet the criteria above are not in scope for the NMDS, but data may have been provided for some of these by some states and territories.

A small number of emergency department presentations (<10) were reported with a sex of 'male' or 'other'. To preserve confidentiality, data presented in this report have been restricted to emergency department presentations with a sex of 'female' only.

Diagnoses were coded using Emergency Department ICD-10-AM Principal Diagnosis Short List, with the edition applicable to the relevant data year as follows:

- Eleventh edition: 2021–22, 2020–21 and 2019–20
- Tenth edition: 2018–19.

Prior to 2018–19, diagnoses were recorded using different classification systems between jurisdictions. In this report 2018–19 is the earliest year of data presented.

ED presentation for endometriosis, and other reported diagnoses, were identified as outlined in Table TN4.

Table TN4: Emergency Department analysis diagnosis codes

Reporting group	Diagnosis code	Diagnosis
Endometriosis	N80	Endometriosis

Abnormal vaginal or uterine bleeding	N93.9	Bleeding, vaginal or uterine, abnormal (except postmenopausal bleeding)
Acute pain in abdomen	R10.0	Pain in abdomen, acute
Pain in upper abdomen	R10.1	Pain in abdomen, upper
Pain in lower abdomen	R10.3	Pain in abdomen, lower (includes groin)
Other abdominal pain	R10.2	Pelvic and perineal pain
	R10.4	Other and unspecified abdominal pain

For more information on the NHMD, see *National Hospitals Data Collection*.

Australian Burden of Disease Study

The Australian Burden of Disease Study undertaken by the AIHW provides information on the burden of disease for the Australian population. Burden of disease analysis measures the impact of fatal burden (or years of life lost, YLL) and non-fatal burden (years lived with disability, YLD), with the sum of non-fatal and fatal burden equating the total burden (disability-adjusted life year, DALY).

The 2024 study builds on the AIHW's previous burden of disease studies and disease monitoring work. It provides Australian-specific estimates for over 200 diseases and injuries, grouped into 17 disease groups, for 2003, 2011, 2015, 2018 and 2024.

For more information, see *Australian Burden of Disease Study 2024*.

Australian Disease Expenditure Database

The AIHW Disease Expenditure Database provides a broad picture of the use of health system resources classified by disease groups and conditions.

It contains estimates of expenditure by the Australian Burden of Disease Study diseases and injuries, age group, and sex for admitted patient, emergency department and outpatient hospital services, out-of-hospital medical services, and prescription pharmaceuticals. Pharmaceutical benefit scheme expenditure includes over and under co-payment prescriptions.

It does not allocate all expenditure on health goods and services by disease – for example, neither administration expenditure nor capital expenditure can be meaningfully attributed to any particular condition due to their nature.

For more information, see *Health system spending on disease and injury in Australia 2022–23*.

Methods

Crude rates

The denominator for rate calculations was the estimated resident population (ERP) values for females as of 31 December for the given year (for example, crude rates for 2022–23 used the December 2022 population), unless otherwise noted.

Age-standardised rates

Age-standardisation is a method of removing the influence of age when comparing populations with different age structures – either different populations at one time or the same population at different times.

Direct age-standardisation was used in this report. The Australian ERP as at 30 June 2001 has been used as the standard population.

First Nations hospitalisations

Rates were calculated using the female Aboriginal and Torres Strait Islander population estimates and projections (series B) based on the 2021 Census (ABS 2024), and non-Indigenous population estimates derived by subtracting the Indigenous population estimates from the female Australian ERP (ABS 2025). Financial year populations were calculated as the average of the 30 June population estimates for the two relevant calendar years.

Age-standardised rates are for ages 15 and over due to small numbers of endometriosis-related hospitalisations in younger age groups. Age-standardised rates were calculated using 5-year age groups from 15 to 50+. Rates were standardised to the 2001 Australian standard population.

Hospitalisations by socioeconomic area

Socioeconomic areas are classified according to area-based quintiles using the ABS Index of Relative Socio-economic Disadvantage (IRSD). Further information is available on the ABS website.

The population denominator for rates of hospitalisation by socioeconomic area is the mid-point average of the 30 June ERP values for females for the two relevant calendar years.

Hospitalisations by remoteness area

Comparisons of regions in this report use the ABS Australian Statistical Geography Standard (ASGS) 2021 Remoteness Structure. In some instances, data for remoteness areas have been combined because of small sample sizes. Further information is available on the ABS website.

The population denominator for rates of hospitalisation by remoteness area is the mid-point average of the 30 June ERP values for females for the two relevant calendar years.

Hospitalisations by country of birth

Country of birth is reported based on the Standard Australian Classification of Countries (SACC), using the Major group classification presented as region of birth. Further information is available on the ABS website.

The population denominator for rates of hospitalisation by country of birth is the mid-point average of the 30 June ERP values for females for the two relevant calendar years.

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Notes

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- Centre for Health Record Linkage (CHeReL), NSW Ministry of Health and ACT Health, for the NSW Admitted Patients Data Collection, and the ACT Admitted Patient Care Data Collections.
- Queensland Health, including the Statistical Services Branch, for the Qld Hospital Admitted Patient Data Collection.
- Department of Health Western Australia, including the Data Linkage Branch, and the WA Hospital Morbidity Data Collection.
- SA NT Datalink, and SA Department for Health and Wellbeing and Northern Territory Department of Health, for the SA Public Hospital Separations and NT Public Hospital Inpatient Activity Data Collections.
- Tasmanian Data Linkage Unit, and the Department of Health, Tasmania, for the Public Hospital Admitted Patient Episodes Data Collection.
- Victorian Department of Health as the source of the Victorian Admitted Episodes Dataset, and the Centre for Victorian Data Linkage (Victorian Department of Health) for the provision of data linkage.

Gita D Mishra is an NHMRC Leadership Fellow.

Data

Report editions

This release

Endometriosis | 21 May 2025

Previous releases

- Endometriosis in Australia 2023 |
  Web report | 14 Dec 2023
- Endometriosis in Australia: prevalence and hospitalisations |
  Publication | 29 Aug 2019

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