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Number 22

# **Australian hospital statistics 2002–03**

Australian Institute of Health and Welfare  
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# Foreword

*Australian Hospital Statistics 2002–03* completes a decade of the Australian Institute of Health and Welfare's annual reporting of comprehensive statistics on Australia's hospitals. Detailed information is presented on hospital care and hospitals in 2002–03, as are summaries of changes over time, and comparisons between public and private hospitals.

As previously, the report is based largely on data in the Institute's National Hospital Morbidity Database, the National Public Hospital Establishments Database and the National Elective Surgery Waiting Times Data Collection. These are compiled each year with the assistance of the state and territory health authorities, which have also provided data on waiting times for emergency department care and on numbers of private hospitals and beds. This report would not be possible without the unseen but important and much appreciated collection of data by the state and territory health authorities, and by individual public and private hospitals.

Statistics illustrating changes over time are often the most useful and interesting in any field, and hospitals are not an exception to this rule. The report therefore has a focus on time series information, included in the summary *Hospitals at a glance* section and in 4 other chapters. This collection of time series statistics provides a useful resource for understanding the changing and different roles of public and private hospitals over recent years.

The performance of hospitals is also often of wide interest, and the chapter on performance indicators has once again been revised to include expanded and refined performance indicator information. The Institute is continuing to work towards making hospital performance indicators available in pre-published form for use in other reports that present similar information.

An electronic version of this report can be found on the Institute's website. It is accompanied by an expanding suite of statistical information that is not included in the hard copy form of this publication, including interactive cubes of data on admitted patients from the National Hospital Morbidity Database.

The Institute will continue to work with the data providers and the Australian Hospital Statistics Advisory Committee to maintain timeliness, and to improve the quality and usefulness of this report. Comments from readers are always welcome.

Richard Madden  
Director  
June 2004



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The AIHW's Australian Hospital Statistics Advisory Committee has also been of great assistance to this project. Members of the Committee are:

- Ken Tallis (AIHW) (Chair)
- John Agland (New South Wales Health Department)
- Paul Basso (South Australian Department of Human Services)
- Ian Bull (ACT Department of Health and Community Care)
- Ron Casey (Australian Bureau of Statistics)
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- Stephen Duckett (invited expert)
- Andrew George-Gamlyn (Australian Health Care Association)
- Amanda Lanagan (NT Department of Health and Community Services)
- Merryn Lancaster (Victorian Department of Human Services)
- Lynette Lee (Clinical Casemix Committee of Australia)
- Brendan Ludvigsen (New South Wales Health Department)
- Paul Mackey (Australian Private Hospitals Association Limited)
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- Catherine Perry (National Centre for Classification in Health)
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- Karen Wheeler (Tasmanian Department of Health and Human Services)

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# Abbreviations

ABS	Australian Bureau of Statistics	NHPA	National Health Priority Areas
ACHS	Australian Council on Healthcare Standards	NHPC	National Health Performance Committee
ACT	Australian Capital Territory	n.p.	Not published
AIHW	Australian Institute of Health and Welfare	NSSRG	Non-specialist service related group
ALOS	Average length of stay	NSW	New South Wales
AMI	Acute myocardial infarction	NT	Northern Territory
AR-DRG	Australian Refined Diagnosis Related Group	O.R.	Operating room
Ave	Average	OECD	Organisation for Economic Co-operation and Development
behav.	Behavioural	Op.	Operation
CABG	Coronary artery bypass graft	PICQ	Performance Indicators for Coding Quality
Cat.	Catastrophic	PPH	Potentially preventable hospitalisation
CC	Complication and/or comorbidity	Proc(s)	Procedure(s)
CDE	Common duct exploration	Qld	Queensland
COPD	Chronic Obstructive Pulmonary Disease	RRMA	Rural, Remote and Metropolitan Area
dis.	Diseases	RSI	Relative stay index
DoHA	Department of Health and Ageing	SA	South Australia
DHAC	Department of Health and Aged Care	SCRGSP	Steering Committee for the Review of Government Service Provision
DRG	Diagnosis Related Group	Seps	Separations
ECMO	Extracorporeal membrane oxygenation	Sev	Severe
ECT	Electroconvulsive therapy	SLA	Statistical Local Area
Exp.	Exposure to	SRG	Service related group
FTE	Full-time equivalent	SRR	Standardised separation rate ratio
HASAC	Health and Allied Services Advisory Council	SSRG	Specialist service related group
HIV	Human immunodeficiency virus	Tas	Tasmania
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification	URI	Upper respiratory tract infection
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification	Vic	Victoria
ID	(Knowledgebase) identification number	VMO	Visiting medical officer
IFRAC	Admitted patient fraction	W	With
ISO	International Standards Organisation	W/O	Without
mal.	Malignant	WA	Western Australia
MDC	Major Diagnostic Category	..	Not applicable
Mis	Misadventure		
n.a.	Not available		
NCCH	National Centre for Classification in Health		
n.e.c.	Not elsewhere classified		
NHCDC	National Hospital Cost Data Collection		
NHDC	National Health Data Committee		
NHMBWG	National Health Ministers' Benchmarking Working Group		

# Hospitals at a glance

*Australian Hospital Statistics 2002–03* is the tenth of the Australian Institute of Health and Welfare's annual summary reports describing the characteristics and activity of Australian hospitals. The aim of this section is to provide an overview of Australian hospitals. It illustrates changes in hospital activity over time and some differences between hospitals in the public and private sectors.

More information to interpret the data is in the relevant chapter quoted in each subsection. More information about the terms used is in the glossary. Australian hospitals included in this report include public acute care and psychiatric hospitals, private free-standing day hospital facilities and other private hospitals (including psychiatric hospitals).

## Separations and patient days

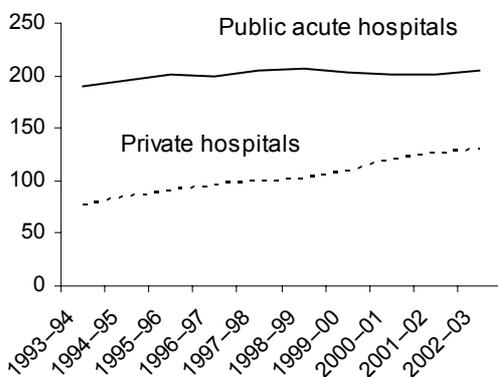
Separations and patient days provide useful ways to measure how many admitted patients are treated in hospitals. See Chapter 2.

- Overall, separations and patient days in Australian hospitals have increased over time.
- Between 1993–94 and 2002–03, hospital separations increased by 44.4%. There was a 23.6% increase for public acute hospitals and a 95.1% increase for private hospitals (including free-standing day hospital facilities).
- Between 1993–94 and 2002–03 the number of patient days for public acute hospitals decreased by 2.5%, while for private hospitals they increased markedly, by 39.2%.
- Between 2001–02 and 2002–03 activity increased in all hospitals with separations and patient days increasing by 4.0% and 1.5% respectively.
- In 2002–03 there were 6,653,772 separations and these were associated with 23,550,400 patient days. This is compared with 6,398,171 separations and 23,201,050 patient days in 2001–02.
- Between 2001–02 and 2002–03, separations increased by 3.2% for public acute hospitals, and by 5.3% for private hospitals. For states in which there was no change in coverage of private hospitals (New South Wales, Queensland and Western Australia), or for which estimates of under-enumeration of private hospital separations were available (Victoria and South Australia, see Appendix 4 and Chapter 2), the increases were 3.2% and 3.0%, respectively.
- Separations for public patients increased by 3.1% between 2001–02 and 2002–03, and by 5.4% for private patients. For New South Wales, Queensland, Western Australia combined with Victoria and South Australia (adjusted for coverage change), the increases were about 3.1% for both.
- Private patients for whom private health insurance was reported as the funding source increased by 5.4% overall between 2001–02 and 2002–03, and by about 2.7% in New South Wales, Queensland, Western Australia combined with Victoria and South Australia (adjusted for coverage change).
- Over the same period, the number of patient days for public acute hospitals increased by 1.9%, while for private hospitals they increased by 2.3%. For New South Wales, Queensland, Western Australia combined with Victoria and South Australia (adjusted

for coverage change), there was a 1.9% increase for public acute hospitals and a 0.1% increase for private hospitals, approximately.

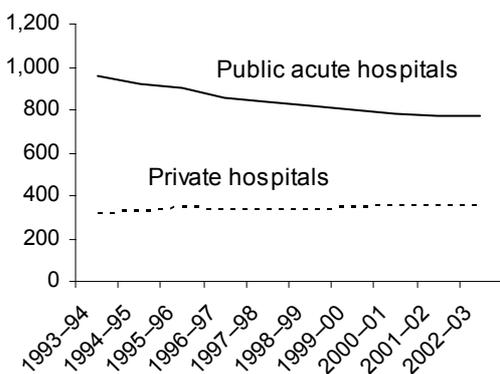
- Separations per 1,000 population increased by 7.6% for public acute hospitals and increased by 66.9% for private hospitals between 1993-94 and 2002-03 (Figure 1).
- Patient days per 1,000 population decreased by 19.2% for public acute hospitals and increased by 14.5% for private hospitals (Figure 2).

**Separations per 1,000 population**



**Figure 1: Separations per 1,000 population, Australia, 1993-94 to 2002-03**

**Patient days per 1,000 population**



**Figure 2: Patient days per 1,000 population, public acute and private hospitals, Australia, 1993-94 to 2002-03**

- For public psychiatric hospitals separations per 1,000 population fell by 23.9% between 1996-97 and 2002-03 and there was a 37.1% fall in patient days per 1,000 population.

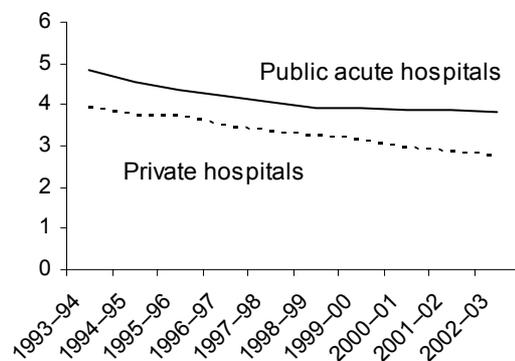
- In 1993-94, 71.5% of separations and 75.7% of patient days in acute care hospitals were in public acute hospitals. In 2002-03, these percentages were 62.0% and 69.2%, respectively, showing a shift from the use of public acute to private hospitals during this period.

### Length of stay

The proportion of separations that are same day is increasing and the average length of stay in hospitals is declining. See *Chapter 2*.

- The proportion of same day separations increased by 12.2%, from 47.9% in 1998-99 to 53.8% in 2002-03.
- The number of same day separations increased by 30.2% (2,747,000 to 3,577,000 separations), 16.4% in public hospitals and 53.4% in private hospitals.
- The average length of stay in hospitals decreased to 3.5 days in 2002-03, from 3.6 days in 2001-02.
- This follows the overall pattern of decline shown in previous years (a decline of 23.9% between 1993-94 and 2002-03, from 4.6 days to 3.5 days) (Figure 3).
- Private hospital stays averaged 2.8 days compared with 3.8 days in public acute hospitals in 2002-03.

**Average length of stay (days)**



**Figure 3: Average length of stay, Australia, 1993-94 to 2002-03**

- For patients staying at least one night, average lengths of stay were 6.5 days in public acute hospitals and 5.6 days in private hospitals (Figure 4).

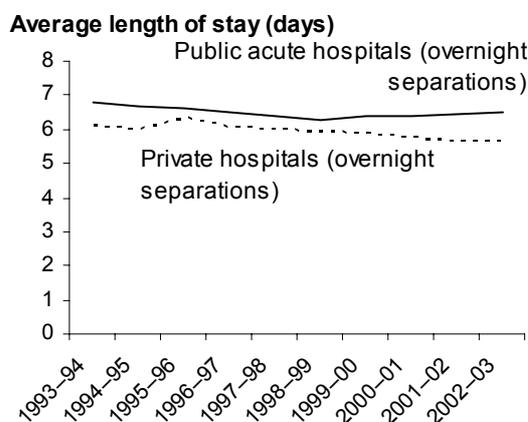


Figure 4: Average length of stay for overnight separations, Australia, 1993-94 to 2002-03

### Females and males

Females accounted for more separations than males. See *Chapter 7*.

- In 2002-03, there were 3,556,294 separations for females compared to 3,097,234 separations for males, 53.4% and 46.5% of separations respectively.
- Overall in 2002-03, there were 357.5 separations per 1,000 population for females, compared to 315.7 separations per 1,000 population for males.
- The differences in the separation rates for males and females varied within age groups. There were more separations per 1,000 population for females than for males in the 15 to 54 year age groups (which include child-bearing ages for women). Male children and males over the age of 55 had higher separation rates than females in those age groups (Figure 5).
- The average length of stay did not vary greatly between males and females, 3.6 days and 3.5 days, respectively. Female children and females over the age of 75 had longer lengths of stay than males in those age groups although males had

more separations per 1,000 population (Figure 6).

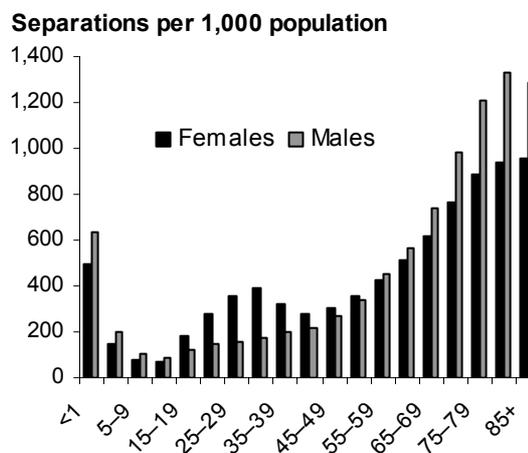


Figure 5: Separations per 1,000 population by age group and sex, 2002-03

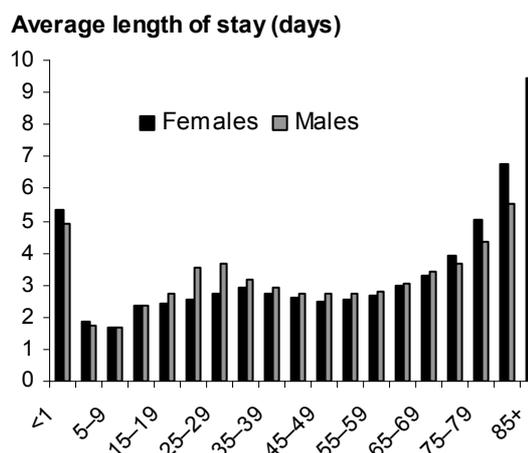


Figure 6: Average length of stay by age group and sex, 2002-03

### Persons identifying as Indigenous

Persons who identify as Indigenous are of Aboriginal or Torres Strait Islander descent. See *Chapter 7*.

- Indigenous persons had higher separation rates than non-Indigenous persons.
- The separation rate for Indigenous persons was higher than the rate for non-Indigenous persons for all age groups, particularly for age groups 35-44 years and older.

- Excluding separations with a principal diagnosis of 'care involving dialysis', the separation rate for Indigenous persons was still higher than the rate for non-Indigenous persons, but the difference for persons aged over 35 years was not as marked (Figure 7).

#### Separations per 1,000 population

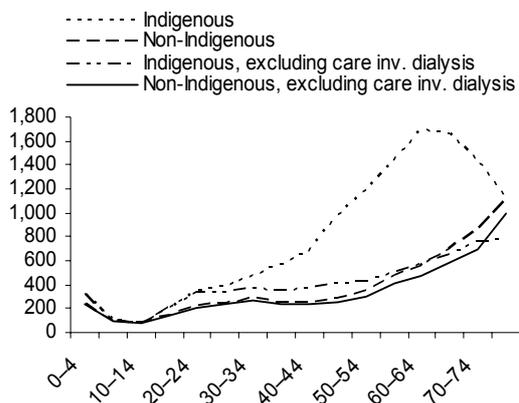


Figure 7: Separations per 1,000 population by Indigenous status and age group, 2002-03

#### Patient area of residence

Remoteness Area categories divide Australia into areas depending on their distance from population centres. See Chapter 7.

- The pattern of separations per 1,000 population by Remoteness Area of usual residence was different for public and private hospitals (Figure 8).
- For public hospitals, separation rates were highest for patients living in very remote areas (429.4 separations per 1,000 population). The separation rate was lowest for patients living in major cities (192.1 separations per 1,000 population).
- For private hospitals, separations per 1,000 population ranged from 44.8 in very remote areas to 139.9 in major cities.
- Overall, remote areas have higher separation rates for public and private hospitals than major cities.

#### Separations per 1,000 population

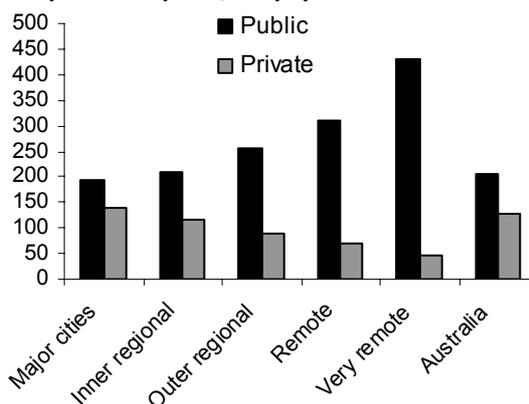


Figure 8: Separations per 1,000 population by Remoteness Area of usual residence and hospital sector, 2002-03

#### Overall type of care

All separations are allocated to a Australian Refined Diagnosis Related Group (AR-DRG) which can be used to describe whether the overall care was medical, surgical or other. Other care includes endoscopies. See Chapter 11.

- In public hospitals, separations with medical AR-DRGs increased by 11.5% between 1998-99 and 2002-03. Separations with surgical AR-DRGs decreased by 6.9% and other AR-DRGs decreased by 5.6% in the same period (Figure 9).

#### Separations

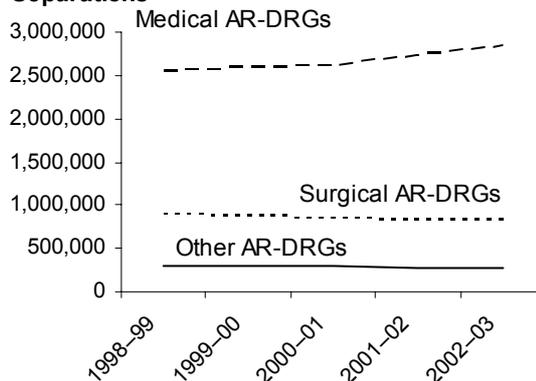
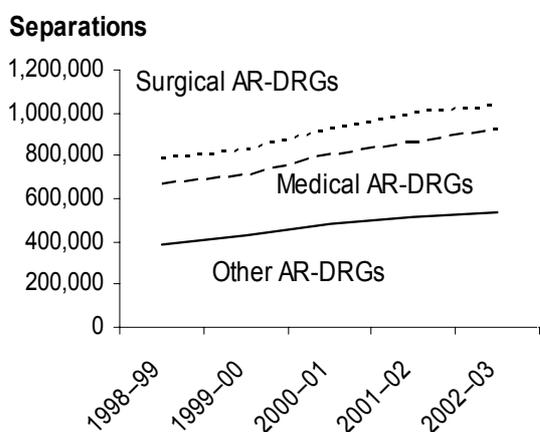


Figure 9: Separations for medical, surgical and other AR-DRGs version 5.0, public hospitals, Australia, 1998-99 to 2002-03

- Between 1998-99 and 2002-03 separations for medical AR-DRGs

increased by 38.4% in private hospitals. There was an increase of 32.1% in the number of separations with surgical AR-DRGs and a 38.2% increase in separations with other AR-DRGs (Figure 10).



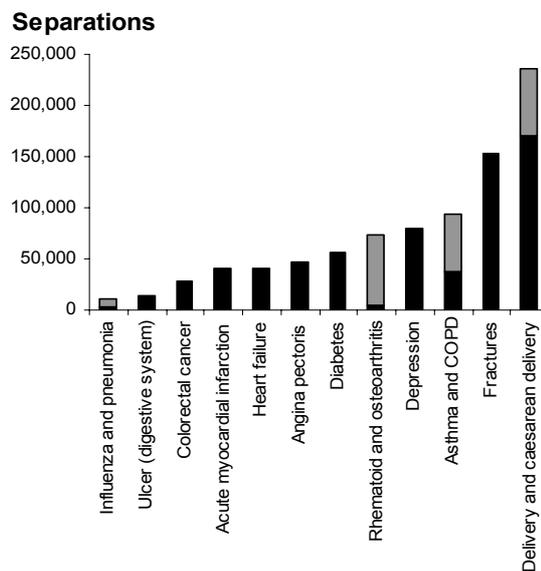
**Figure 10: Separations for medical, surgical and other AR-DRGs version 5.0, private hospitals, Australia, 1998-99 to 2002-03**

### Conditions treated

A range of conditions (diseases or injuries and poisonings) are treated in hospitals. These conditions are classified using the International Classification of Diseases, 10th Revision, Australian Modification (ICD-10-AM). ICD-10-AM is divided into chapters which describe the body site or sort of condition. Using this classification each separation is allocated a principal diagnosis, which is the diagnosis established after study to be chiefly responsible for occasioning the patient’s episode of care. See *Chapter 8*.

- Overall, over half of all separations in 2002-03 had a principal diagnosis from six ICD-10-AM chapters: Diseases of the digestive system; Neoplasms; Diseases of the circulatory system; Pregnancy, childbirth and the puerperium; Injury and poisoning and Contact with health services (which includes care involving dialysis, chemotherapy and rehabilitation procedures).

- The National Health Priority Areas (NHPAs) initiatives focus on chronic diseases that have a significant health burden. They are: asthma, cancer control, cardiovascular health, diabetes, injury prevention and control, mental health and arthritis and musculoskeletal conditions.
- In 2002-03 the NHPAs were represented by some high-volume diagnoses. There were 152,438 separations with a principal diagnosis of fracture (Injury); 37,053 separations with a principal diagnosis of asthma (Asthma) and 56,836 with chronic obstructive pulmonary disease (COPD); 73,009 separations with a principal diagnosis of arthritis (Arthritis); 46,469 separations with a principal diagnosis of angina pectoris (Cardiovascular disease) and 55,926 separations with a principal diagnosis of diabetes (Diabetes) (Figure 11).



Note: Columns with two categories of principal diagnoses are indicated using two shadings.

**Figure 11: Separations ('000) by selected principal diagnosis, 2002-03**

### Selected potentially preventable hospitalisations

The selected potentially preventable hospitalisations presented in this report

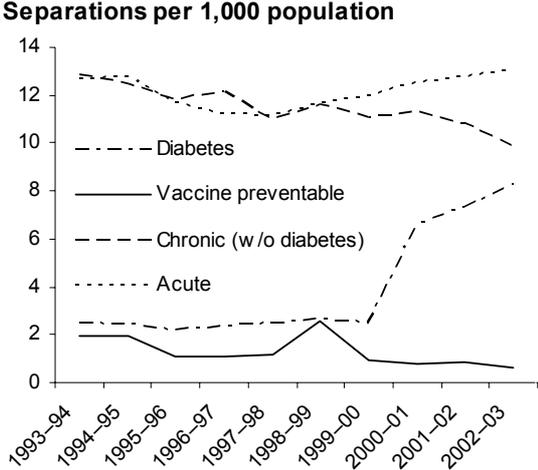
are those where hospitalisation is thought to be avoidable if timely and adequate non-hospital care is provided. Both acute and chronic conditions are represented. Rates for potentially preventable hospitalisations are potential indicators of the effectiveness of non-hospital care. See *Chapter 4*.

- The separation rate per 1,000 population for the selected potentially preventable hospitalisations has changed over time. Overall, the rate per 1,000 population increased an average of 4.9% per year between 1997-98 and 2002-03.
- Some diseases can be prevented by vaccination. The number of separations per 1,000 population for these diseases decreased an average of 11.6% per year between 1993-94 and 2002-03. Fluctuations reflected varying numbers of separations for influenza each year (Figure 12).
- Potentially preventable hospitalisations decreased by an average of 2.9% for chronic conditions, excluding diabetes. The increase for diabetes between 1999-00 and 2000-01 reflects changes between the first and second editions of ICD-10-AM, which affected the way diabetes was coded.
- Potentially preventable hospitalisations fluctuated around 12 separations per 1,000 population for acute conditions between 1993-94 and 2002-03.

**Procedures undertaken**

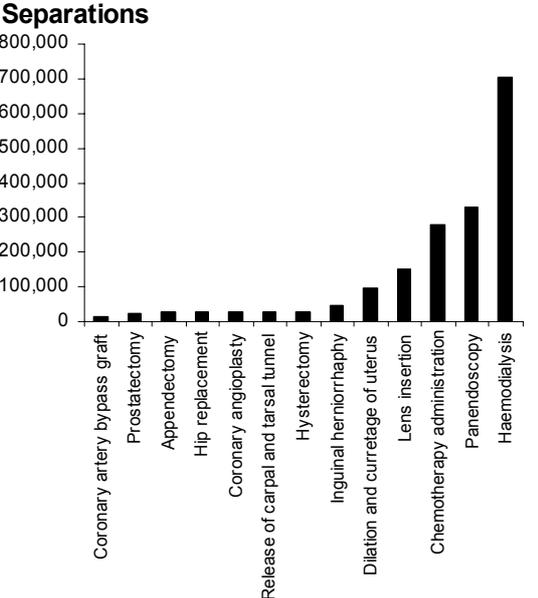
A procedure can be surgical or non-surgical and can treat or diagnose a condition or be of a patient-support nature such as anaesthesia. See *Chapter 9*.

- One or more procedures was reported for 80% of separations for Australian hospitals in 2002-03.



**Figure 12: Selected potentially preventable hospitalisations, 1993-94 to 2002-03**

- Overall, 56.4% per cent of separations that reported a procedure occurred in the public sector, while 43.6% of separations with a procedure occurred in the private sector. This reflects that 73.3% of separations from the public sector recorded a procedure compared to 90.5% in the private sector.



**Figure 13: Separations for selected procedures, 2002-03**

- In 2002-03 there were 27,229 separations reported with hip replacement, 150,654 separations with lens insertion and 15,922 separations

with coronary artery bypass graft (Figure 13).

- Some procedures are being increasingly undertaken in the private sector, for example coronary artery bypass grafts (CABG).
- Between 1993–94 and 2002–03 the number of separations for CABG decreased by 1.5%. Separations increased by 29.0% in the private sector during this time, while they decreased by 16.3% in the public sector (Figure 14).
- In 2002–03, 57.4% of the separations with CABG were from the public sector while 42.6% were from the private sector (9,142 and 6,780 respectively), compared to 67.5% and 32.5% in 1993–94 (10,917 and 5,254 separations).

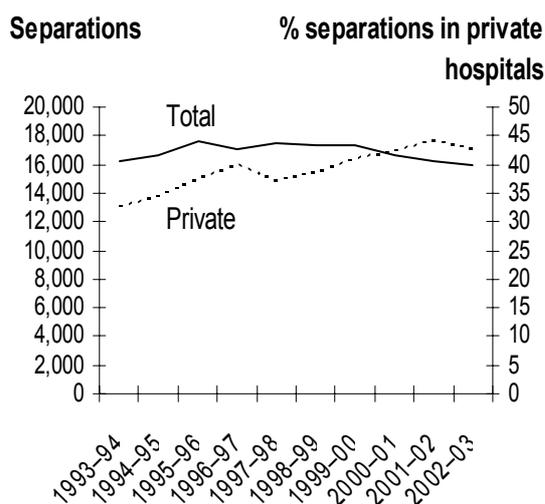


Figure 14: Separations for coronary artery bypass graft and the proportion of separations in private hospitals, 1993–94 to 2002–03

### Waiting times for elective surgery

- The median waiting time for elective surgery in public hospitals in 2002–03 was 28 days. See *Chapter 5*.
- Ophthalmology, orthopaedic and ear, nose and throat surgery were the surgical specialties with the longest median waiting times (61, 45 and 40

days respectively) in 2002–03 (Figure 15).

- All other surgical specialties had a median waiting time of less than 30 days. Cardio-thoracic surgery had the shortest median waiting time (12 days).

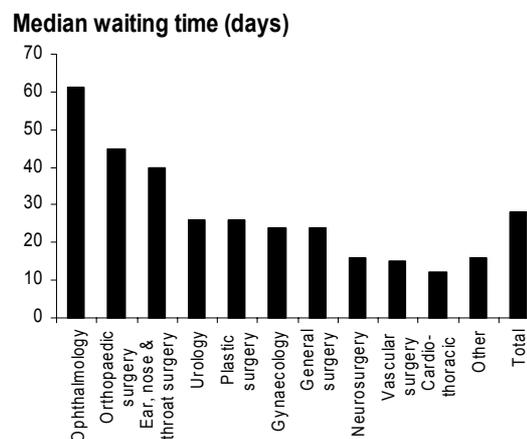
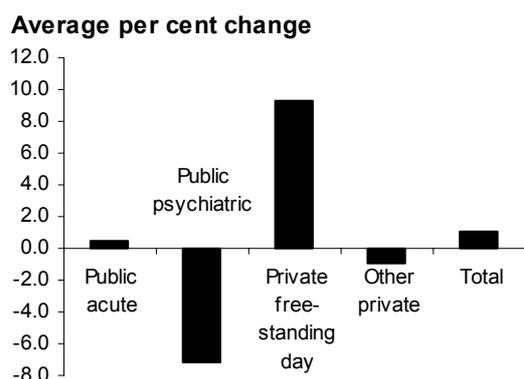


Figure 15: Median waiting time by specialty of surgeon, 2002–03

### Australian hospitals

Overall, the number of hospitals in Australia has increased over time. See *Chapter 2*.

- There were 1,297 hospitals in Australia in 2002–03.
- In the public sector in 2002–03 there were 729 public acute hospitals and 19 public psychiatric hospitals.
- In the private sector in 2002–03 there were 248 private free-standing day hospital facilities and 301 other private hospitals.
- There was a marked increase in the number of private free-standing day hospital facilities, from 111 in 1993–94 to 248 in 2002–03 (an average of 9.3% increase per year, although this increase was from a small base) (Figure 16).
- The number of public psychiatric hospitals declined by 48.6% over this period (an average of 7.1% decline per year since 1993–94).



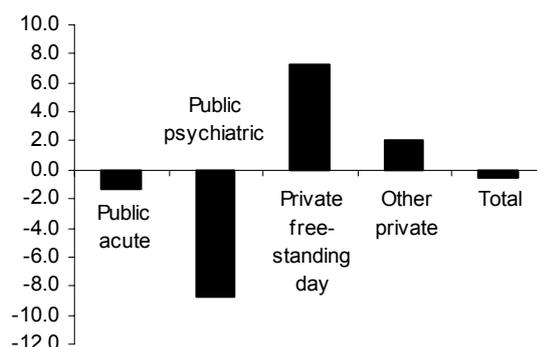
**Figure 16: Average annual change in the number of hospitals, Australia, 1993-94 to 2002-03**

### Available beds

The number of available beds is a better indicator of the availability of hospital services than the number of hospitals because hospital sizes vary considerably. However, comparability of hospital bed numbers can be affected by the casemix of hospitals with differing proportions of beds being available for specialised and more general purposes. See *Chapter 2*.

- There were 79,312 available beds in Australia in 2002-03.
- In the public sector in 2002-03 there were 49,841 available beds in public acute hospitals and 2,358 in public psychiatric hospitals.
- In the private sector there were an estimated 1725 available beds in private free-standing day hospital facilities in 2002-03 and 25,387 in other private hospitals.
- There was a 5.3% reduction in available beds between 1993-94 and 2002-03, an average decline of 0.6% per year.
- Although the number of public acute hospitals increased, the number of available beds decreased by 1.3% per year on average (Figure 17).

### Average per cent change



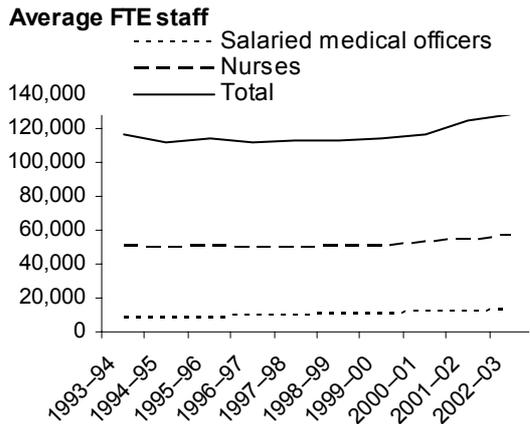
**Figure 17: Average annual change in the number of available beds, Australia, 1993-94 to 2002-03**

- The number of available beds/chairs in private free-standing day hospital facilities increased an average of 7.3% per year between 1993-94 and 2002-03 from 917 to 1,725.
- Although the number of other private hospitals fell, the number of available beds increased by 2.0% per year on average between 1993-04 and 2002-03.
- The number of available beds in public psychiatric hospitals decreased by 56.0%, between 1993-94 and 2002-03 and on average 8.7% per year during this time.

### Hospital staff

Staff numbers in public acute and psychiatric hospitals have remained fairly constant over time. Data for New South Wales for 2002-03 were not available and thus New South Wales has been excluded from Figure 18 for all years. See *Chapter 3*.

- Overall, the number of full-time equivalent staff increased an average of 1.0% per year between 1993-94 and 2002-03 (Figure 18). The number of salaried medical officers increased an average of 4.5% per year over this period and the number of nurses increased an average of 1.0%.



Note: Excluding New South Wales.

**Figure 18: Average full-time equivalent staff, public acute and psychiatric hospitals, 1993-94 to 2002-03**

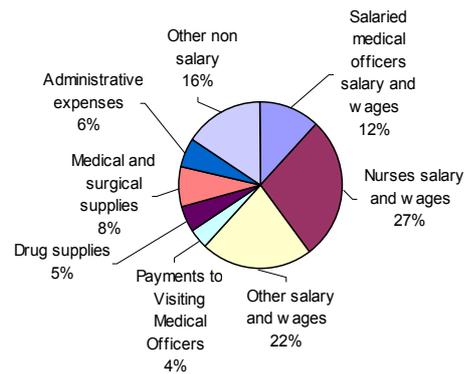
### Recurrent expenditure on public hospitals

Recurrent expenditure is expenditure on goods and services which are consumed during the year, for example, salaries. Data for New South Wales for 2002-03 are preliminary. See *Chapter 3*.

- Recurrent expenditure on public acute and psychiatric hospitals was \$18,323 million in 2002-03.
- The largest share of expenditure was for salary payments, which accounted for 61.8% (\$11,318 million) of expenditure by public hospitals (Figure 19).
- The major non-salary expenses in the public sector were for medical and surgical supplies, administrative expenses and drug supplies.

### Recurrent expenditure (cost) for providing care in public hospitals

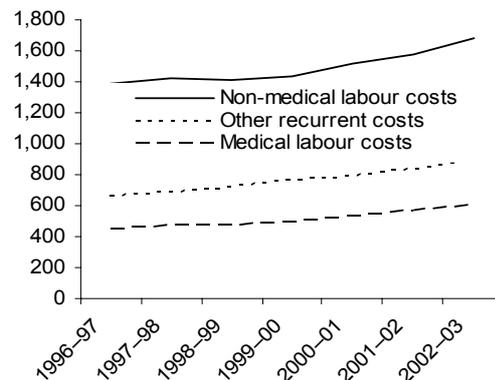
The amount of recurrent expenditure for each casemix-adjusted separation is regarded as a measure of efficiency. See *Chapter 4*.



**Figure 19: Recurrent expenditure, public acute and psychiatric hospitals, 2002-03**

- The average recurrent cost of providing care per casemix-adjusted separation in public hospitals increased from \$2,496 in 1996-97 to \$3,184 in 2002-03 (not adjusted for inflation).
- This represents a total increase of 27.5% in this period, an average of 4.1% increase per year (Figure 20).
- In 2002-03 the cost comprised \$1,683 for non-medical labour expenditure, \$601 for medical labour expenditure and \$899 for other recurrent expenditure. Other recurrent expenditure costs include domestic services; repairs and maintenance; administration and medical, drug and food supplies.

### Cost per casemix adjusted separation (\$)



**Figure 20: Cost per casemix adjusted separation, 1996-97 to 2002-03, by recurrent expenditure type**