



Australian Government
Australian Institute of
Health and Welfare

AIHW

**Australia's
hospitals
at a glance**
2018-19



Australia's
hospitals
at a glance

2018-19



The Australian Institute of Health and Welfare is a major national agency whose purpose is to create authoritative and accessible information and statistics that inform decisions and improve the health and welfare of all Australians.

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A day in the life of Australian hospitals

In 2018–19, **on average each day**:

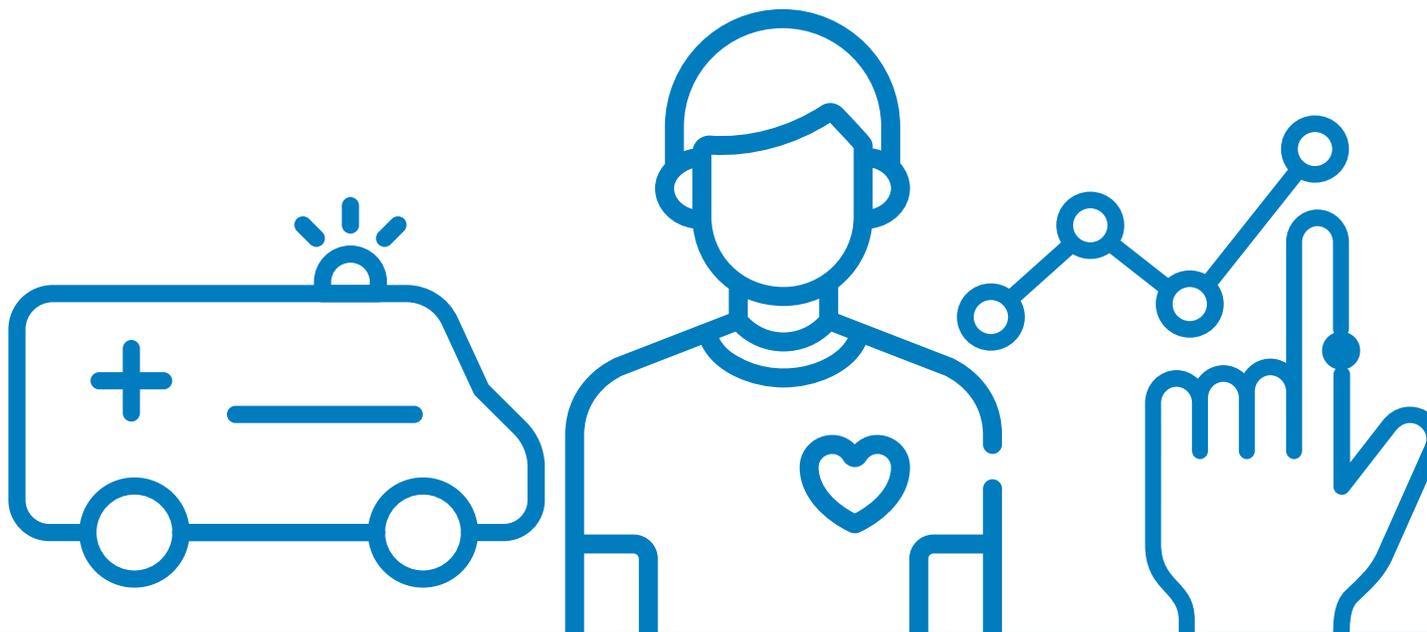
- **\$203 million** is spent on public and private hospital services
- there were **31,400 hospitalisations** in public and private hospitals
- **163,000 nurses** and **48,200 doctors** were employed in public hospitals
- **22,900** people presented for care at Australia's **294** public hospital emergency departments
- **107,000** services were provided to non-admitted patients
- there were **2,077** admissions to public hospitals from elective surgery waiting lists
- A hospital acquired complication occurred in **458** hospitalisations
- **4 cases** of *Staphylococcus aureus* blood stream infection occurred in public hospitals.

Introduction

Hospitals are an important part of Australia's health care system. In Australia, public hospitals are largely owned and managed by state and territory governments, and private hospitals are owned and managed by private for-profit and not-for-profit organisations. All hospitals can receive funding from governments, individuals and insurers.

Australia has more than 1,300 public and private hospitals that, in 2018–19, collectively provided almost 30.9 million days of patient care. This is an increase since 2014–15 when 28.7 million days of patient care were provided.

In addition, in 2018–19 emergency departments in public hospitals responded to 8.4 million presentations, and public hospital outpatient clinics delivered 39.0 million patient services, ranging from pathology to dental treatment. These have also increased since 2014–15, when 7.4 million emergency department presentations occurred and 34.9 million non-admitted patient services were provided.



About Australia's hospitals at a glance 2018–19

Australia's hospitals at a glance 2018–19 presents key statistics about Australia's hospitals and is a companion report to the data presented in the MyHospitals section of the AIHW website.

It contains information on:

- **admitted patient care** (including data on who is admitted to hospital, the reason for the admission, and what procedures and care occurred during their stay, as well as hospital resources including the number of hospitals and beds, the composition of the workforce, and spending)
- **emergency department care** (including who visits the emergency department, how long they wait and the reason for the visit)
- **elective surgery in public hospitals**
- **non-admitted patient care** (including information on the services people receive at hospital outpatient clinics)



Data in this report are sourced from the following collections held by the AIHW:

- National hospital morbidity database
- National non-admitted patient emergency department care database
- National elective surgery waiting times data collection
- Non-admitted patient care databases
- National public hospital establishments database

While most of the information is for 2018–19, the most recent data available for hospital expenditure are from 2017–18 and some data for private hospitals are from 2016–17. Information on private hospital resources was sourced from the Australian Bureau of Statistics' publication *Private hospitals, Australia, 2016–17* (ABS 2018).

Further detail about your local hospital, hospitals within your region, state or territory and nationally are available online at www.aihw.gov.au/myhospitals. The website includes more information about the data, comprehensive data tables and interactive visualisations. MyHospitals is part of the broader Australian Health Performance Framework body of work available on the AIHW website at <https://www.aihw.gov.au/reports-data/australias-health-performance/australias-health-performance-framework>.

1

Spending on hospitals

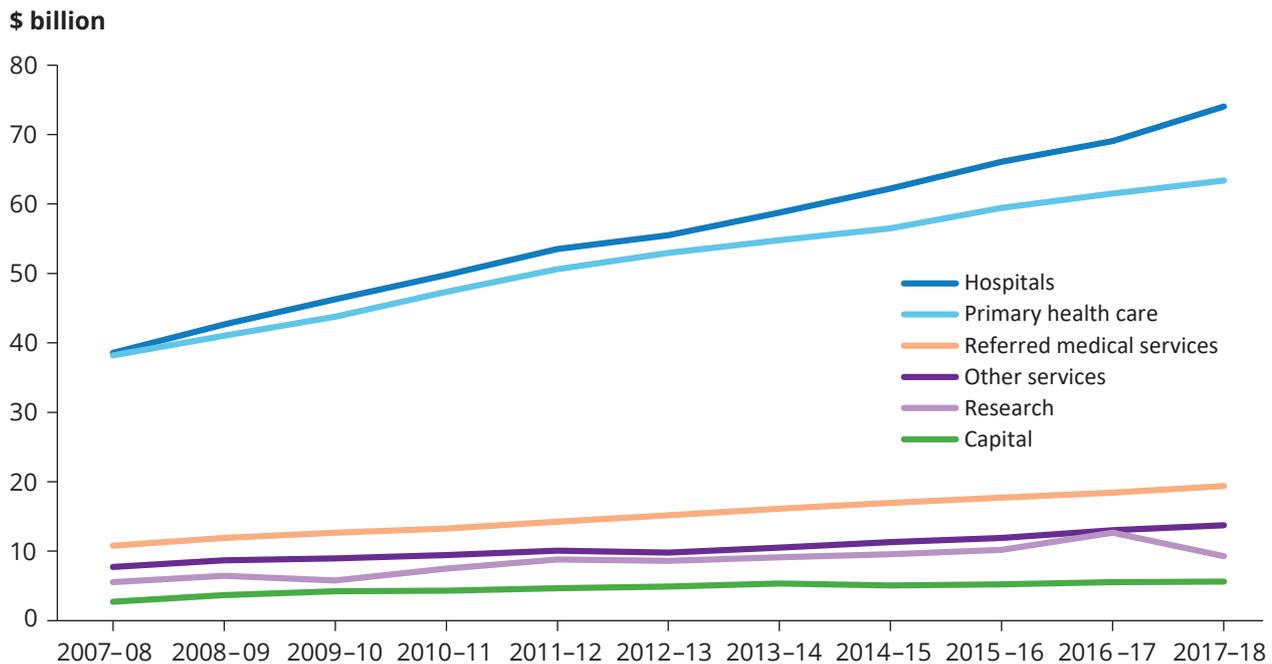


1 How much is spent on hospital care?

Public and private hospitals are funded from a range of sources, including the Australian Government, state and territory governments, private health insurance funds and out-of-pocket payments by individuals. Hospitals can vary greatly in terms of the types of services they provide and the patients they treat, depending on their main source of funding along with other factors.

In 2017-18, hospitals accounted for the highest proportion of spending across all areas of health expenditure (40%)—\$74 billion.

Total health expenditure by area of expenditure, current prices, 2007-08 to 2017-18

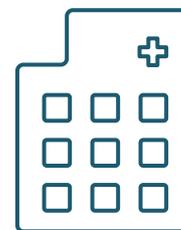


Public hospitals

In 2017–18, \$57.7 billion was spent on public hospitals in Australia by the Australian Government, state and territory governments, and non-government sources. State and territory governments, which have primary responsibility for administering public hospitals, contributed the most funding:

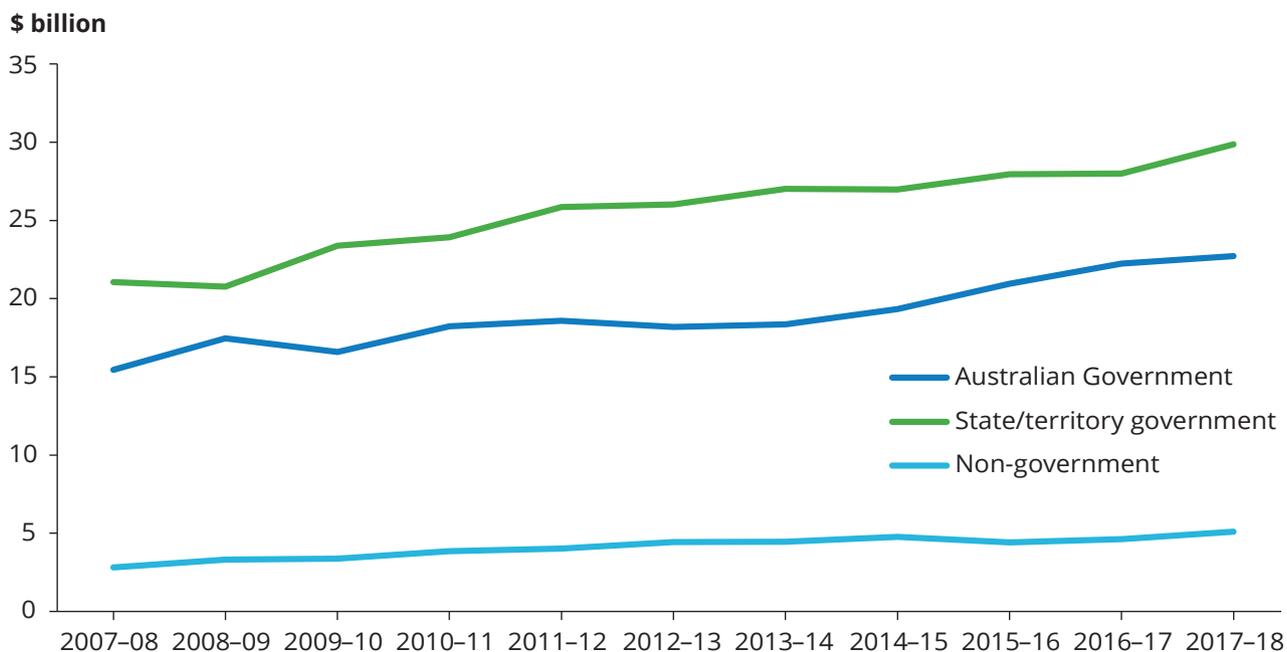
- State and territory governments—\$29.9 billion (52%)
- Australian Government—\$22.7 billion (39%) (not including payments made by the Australian Government as Medicare benefits associated with private patients)
- Non-government entities—\$5.1 billion (8.9%) (including individuals and private health insurers)

Between 2007–08 and 2017–18, Australian Government expenditure on public hospitals increased 3.9% per year on average and state and territory expenditure increased 3.6% per year on average.



Public hospitals

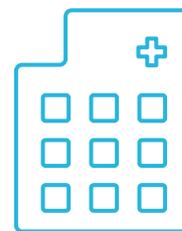
Expenditure on public hospitals, by source of funds, constant prices, 2007–08 to 2017–18



Private hospitals

In 2017–18, 71% (\$11.6 billion) of the estimated \$16.3 billion spent on private hospitals was funded by the non-government sector:

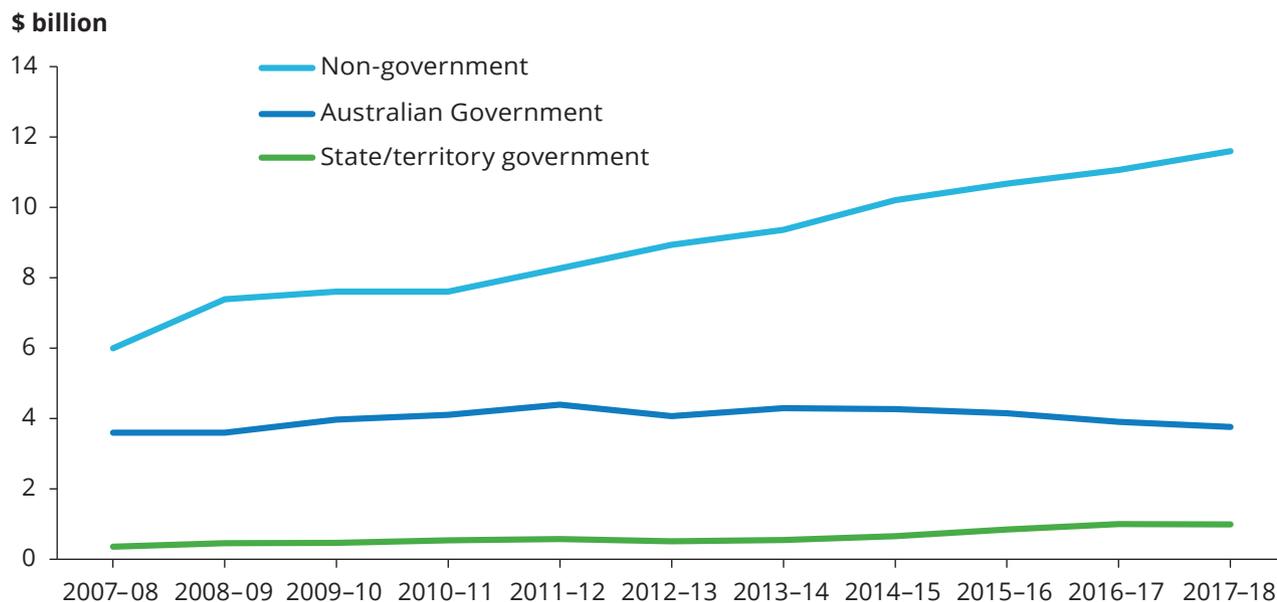
- Private health insurance providers—\$8.2 billion (50%)
- Australian Government—\$3.8 billion (23%)
- Individuals—\$2.2 billion (13%)
- Other non-government—\$1.2 billion (7.6%)
- State and territory governments—\$1.0 billion (6.0%)



Private hospitals

Between 2007–08 and 2017–18, total funding increased by an average of 5.1% each year. The proportion of funding provided by the Australian Government increased 0.5% and funding from state and territory governments and other sources increased, on average, 10.8% and 6.8% respectively. This may have been, at least in part, a result of the introduction of means testing of the private health insurance premium rebate in 2012, which shifted funding from the Australian Government to private health insurance providers (AIHW 2019).

Expenditure on private hospitals, by source of funds, constant prices, 2007–08 to 2017–18



2

Hospital workforce



2 Who works in our hospitals?

The hospital workforce in Australia is large and diverse, covering many occupations including:

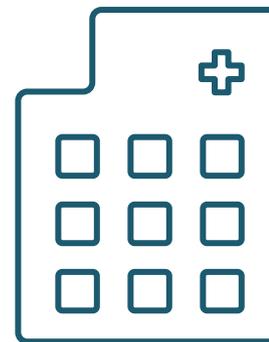
- salaried medical officers
- nurses
- diagnostic and allied health professionals (such as physiotherapists and occupational therapists)
- administrative and clerical staff
- domestic and other personal care staff.

Public hospitals

The workforce discussed here includes people employed to manage and deliver public hospital services at the local hospital network-level and the state/territory health authority-level as well as in public hospitals.

These staff numbers do not include visiting medical officers in public hospitals who are generally not employed directly by the hospital.

Workforce numbers are expressed as the number of full time equivalent (FTE) staff.



Public hospitals

In 2018–19, 391,000 FTE staff were employed to provide services in public hospitals.

Type of staff	Average number of full-time equivalent staff	Average salaries (per year):
Nurses	163,271 (42%)	\$105,685
Administrative and clerical staff	70,045 (18%)	\$86,034
Diagnostic and allied health professionals	62,032 (16%)	\$101,391
Salaried medical officers	48,210 (12%)	\$223,009
Domestic and other personal care staff	46,955 (12%)	\$66,033

Numbers of FTE staff have increased 4.3% per year on average since 2014–15. The average annual salary is about \$111,000 per year (across all staff).

3

Hospital activity



3 What care do our hospitals provide?

Australia's hospitals are providing care to increasing numbers of patients—more people are seeking care at emergency departments and more patients are being admitted for surgery.

How is hospital activity measured?

For this report hospital activity is measured by the number of:

- hospitalisations in public and private hospitals
- presentations to public hospital emergency departments
- non-admitted patient services provided in public hospitals
- admissions from public hospital elective surgery waiting lists.

What type of care do patients receive?

The broad types of admitted patient care are medical care, care involving an intervention or procedure such as surgery, and other acute care, along with childbirth, mental health care and sub-acute and non-acute care. The majority of hospitalisations are for acute medical care. In addition, many hospitalisations, particularly same-day hospitalisations, are for procedures, investigations, evaluation or other health management.

How many hospitalisations were there?

Admission to hospital is an administrative process. It follows a medical officer's decision that a patient needs to be admitted for appropriate management or treatment of their condition, and/or for appropriate care or assessment of their needs. Patients may be admitted and discharged on the same day, or may stay in hospital for one or more nights.

In 2018–19, there were 11.5 million hospitalisations in Australia's public and private hospitals. About 6.8 million (60%) of these were in public hospitals, and about 4.6 million (40%) in private hospitals.

Between 2014–15 and 2018–19, the number of hospitalisations has increased by an average of 3.3% per year—3.7% for public hospitals and 2.6% for private hospitals. This is higher than the population growth rate over this period, which was 1.6% per year (ABS 2019a).

Characteristics of admitted patient care, public, private and all hospitals, 2018–19

	Public hospitals	Private hospitals	All hospitals
Hospitalisations	6.8 million (an average increase of 3.7% per year since 2014–15)	4.6 million (an average increase of 2.6% per year since 2014–15)	11.5 million (an average of 3.3% per year since 2014–15)
Medical	4.7 million	1.4 million	6.1 million
General intervention (Surgical)	1.1 million	1.6 million	2.6 million
Specific intervention (Other)	480,000	932,000	1.4 million
Childbirth	232,000	67,000	299,000
Mental health care	146,000	214,000	360,000
Sub-acute and non-acute care	204,000	399,000	603,000
Overnight versus same-day	46% overnight stays; 54% same-day	28% overnight stays; 72% same-day	39% overnight stays; 61% same-day
Number of days of patient care	20.7 million (average increase of 1.8% per year since 2014–15)	10.1 million (average increase of 1.9% per year since 2014–15)	31.0 million (average increase of 1.9% per year since 2014–15)
Average length of stay (for overnight stays)	5.4 days	5.3 days	5.4 days

In 2018–19, 6 in 10 (61% or 7.0 million) hospitalisations were for patients who were admitted and discharged on the same day. Between 2014–15 and 2018–19, overall, same-day hospitalisations per 1,000 population increased 1.9% on average per year and overnight separations did not increase.



61% same-day

Public hospitals

- Same-day hospitalisations* increased **2.7%** on average per year.
- Overnight hospitalisations* increased **0.5%** on average per year.

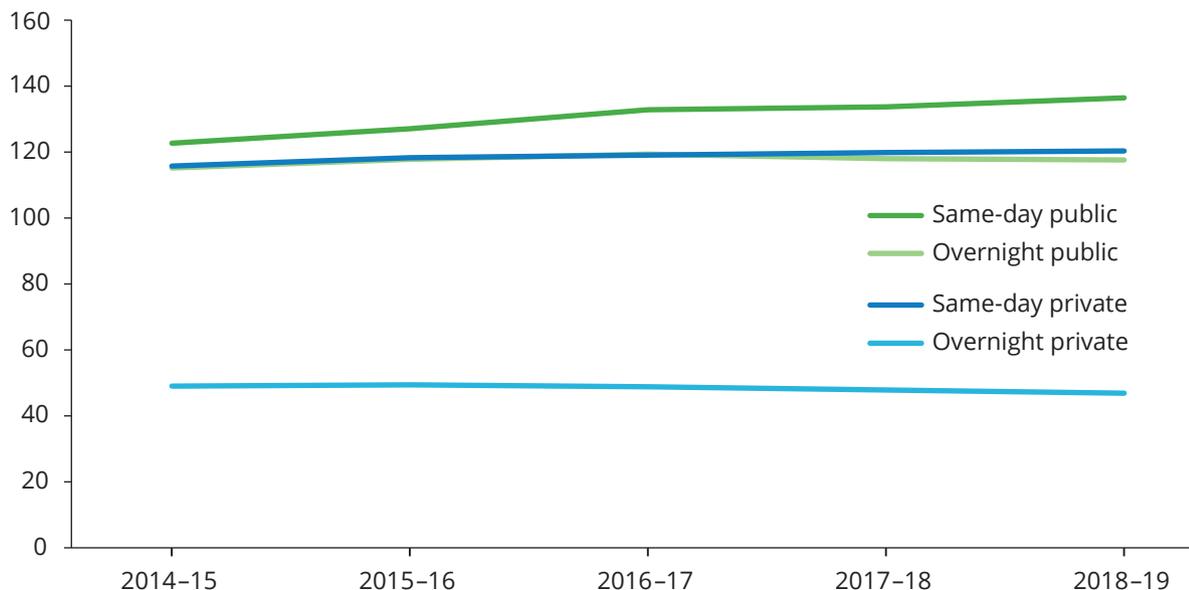
Private hospitals

- Same-day hospitalisations* increased **1.0%** on average per year.
- Overnight hospitalisations* decreased **1.1%** on average per year.

* per 1,000 population

Same-day and overnight hospitalisations per 1,000 population, 2014–15 to 2018–19

Hospitalisations per 1,000 population



How long do people stay in hospital?

Because the length of a hospitalisation can vary from same-day to many days or weeks, another useful measure of activity is the average length of time a patient spends in hospital.

The average length of stay in hospitals is often regarded as an indicator of efficiency and quality of care. It is influenced by patient characteristics, the illnesses treated, and the procedures performed in public and private hospitals, as well as differing administrative and clinical practices.

Longer stays can be indicative of poor-quality care, inefficient hospital processes and delays in providing treatment. Errors and poor care co-ordination may leave people stuck in hospital waiting for ongoing care to be arranged. Patients who stay longer in hospitals are at greater risk of hospital acquired complications such as infection. Shorter stays reduce the cost of care and increase the availability of hospital care. However, some people may be discharged too early, when staying in hospital longer could have improved their outcomes or reduced chances of readmission (OECD 2019).

On average, people are spending less time in hospital—between 2014–15 and 2018–19, the average length of stay for all hospitalisations fell from 2.8 days to 2.7 days. The average length of stay was longer in public hospitals than private hospitals.

Average length of stay (days) for selected AR-DRGs (minor complexity), public and private hospitals, 2014–15 and 2018–19

AR-DRG	Public hospitals		Private hospitals	
	2014–15	2018–19	2014–15	2018–19
Tonsillectomy and/or adenoidectomy	1.1	1.1	1.0	1.0
Appendicectomy	2.0	2.1	1.9	1.8
Caesarean delivery	3.5	2.9	4.9	4.6
Vaginal delivery	2.2	1.7	3.9	3.8
Heart failure and shock	4.2	3.3	7.0	6.0
Knee replacement	4.9	4.2	5.3	4.7
Bronchitis and asthma	1.5	1.4	3.1	3.3

Why do people go to hospital?

People experience different health issues at different times of their lives, so the reasons for hospitalisation vary by age and by sex. For example, in 2018–19:



Babies and children under 5 were hospitalised most often for respiratory illnesses such as asthma, whereas patients aged 5–14 were most often hospitalised for diagnoses related to injury and poisoning.



Males aged 15–24 were also most often hospitalised for diagnoses related to injury and poisoning, however, females in this age group were most often hospitalised for diagnoses related to pregnancy and childbirth.



Females aged 25–44 were also predominantly hospitalised for pregnancy and childbirth, whereas males of that age were hospitalised for other factors influencing health status (this includes examinations, investigations, observation, evaluation and other health management).



Adults aged 45–64 were most often hospitalised for other factors influencing health status and digestive system diseases. For people aged 65 and over, hospitalisation for other factors influencing health status, cancer and musculoskeletal conditions are the most common reasons for hospitalisation.

Top 3 reasons males go to hospital, by age group, 2018–19

Males		Under 5	5–14	15–24	25–44	45–64	65+
	1st	Respiratory system diseases	Injury & poisoning	Injury & poisoning	Other factors influencing health status	Other factors influencing health status	Other factors influencing health status
	2nd	Perinatal period conditions	Digestive system diseases	Digestive system diseases	Digestive system diseases	Digestive system diseases	Cancer
	3rd	Symptoms, signs & abnormal findings	Respiratory system diseases	Mental & behavioural disorders	Injury & poisoning	Symptoms, signs & abnormal findings	Diseases of the circulatory system

Top 3 reasons females go to hospital, by age group, 2018–19

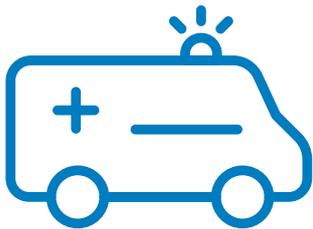
Females		Under 5	5–14	15–24	25–44	45–64	65+
	1st	Respiratory system diseases	Digestive system diseases	Pregnancy, childbirth and the puerperium	Pregnancy, childbirth and the puerperium	Other factors influencing health status	Other factors influencing health status
	2nd	Perinatal period conditions	Injury & poisoning	Digestive system diseases	Other factors influencing health status	Digestive system diseases	Musculoskeletal system diseases
	3rd	Symptoms, signs & abnormal findings	Respiratory system diseases	Mental & behavioural disorders	Digestive system diseases	Symptoms, signs & abnormal findings	Symptoms, signs & abnormal findings

How much care do our emergency departments provide?

Emergency departments are an essential component of the health care system. In Australia, there are 294 public hospitals that have purpose-built emergency departments; which are staffed 24 hours a day and provide care to patients who require urgent medical, surgical or other attention.

Emergency department activity is measured by the number of presentations.

In 2018–19, there were 8.4 million presentations to emergency departments—or 22,900 each day. This has increased from an average of 20,200 presentations each day in 2014–15—an increase of 3.2% a year.



In 2018–19,
more than **79%** of presentations
occurred between 8am and 10pm.



The busiest days for emergency
department visits were Sundays
and Mondays.

How urgent was the care?

When a patient presents to the emergency department, they are assigned a triage category by a registered nurse or medical practitioner. The triage category allocated reflects the urgency of the patient's need for medical and nursing care.

Emergency department presentations by triage category, 2018–19

	Triage category					Total
	Resuscitation (should be seen immediately)	Emergency (within 10 minutes)	Urgent (within 30 minutes)	Semi-urgent (within 60 minutes)	Non-urgent (within 2 hours)	
Presentations	64,515	1,136,383	3,176,986	3,275,094	695,831	8,352,192
Proportion (%) of all presentations	0.8	14	38	39	8.3	100

In 2018–19, over one quarter (26%) of patients arrived at the emergency department by ambulance or air rescue service, with the remaining 74% arriving by other forms of transport, including by private car.

What are the most common reasons people present to emergency departments?

A patient's diagnosis is established at the end of the patient's emergency department stay and is the main reason for their visit to the emergency department.

In 2018–19, one-quarter (25%) of presentations were for injury or poisoning. A similar proportion of presentations (23%) were for symptoms, signs and abnormal findings (abnormal results of clinical or other investigative procedures). These are ill-defined conditions for which no other diagnosis has been determined, such as abnormalities of heart beat, abnormalities of breathing, chest pain, nausea and vomiting, headache, and convulsions that are not attributable to other diagnoses.

The most common diagnoses recorded for emergency department presentations vary by the age and sex of the patient.

Top 3 reasons males present to emergency departments, by age group, 2018–19

Males	Under 5	5–14	15–24	25–44	45–64	65+	
	1st	Respiratory system diseases	Injury & poisoning	Injury & poisoning	Injury & poisoning	Symptoms, signs & abnormal findings	Symptoms, signs & abnormal findings
	2nd	Injury & poisoning	Symptoms, signs & abnormal findings	Symptoms, signs & abnormal findings	Symptoms, signs & abnormal findings	Injury & poisoning	Injury & poisoning
	3rd	Symptoms, signs & abnormal findings	Respiratory system diseases	Mental & behavioural disorders	Mental & behavioural disorders	Diseases of the genitourinary system	Diseases of the circulatory system

Top 3 reasons females present to emergency departments, by age group, 2018–19

Females	Under 5	5–14	15–24	25–44	45–64	65+	
	1st	Injury & poisoning	Injury & poisoning	Symptoms, signs & abnormal findings	Symptoms, signs & abnormal findings	Symptoms, signs & abnormal findings	Symptoms, signs & abnormal findings
	2nd	Respiratory system diseases	Symptoms, signs & abnormal findings	Injury & poisoning	Injury & poisoning	Injury & poisoning	Injury & poisoning
	3rd	Symptoms, signs & abnormal findings	Respiratory system diseases	Diseases of the genitourinary system	Pregnancy, childbirth and the puerperium	Musculoskeletal system diseases	Diseases of the circulatory system

How many services did non-admitted clinics provide?

Every year, many Australians receive hospital services as non-admitted patients (outpatients). Non-admitted patient clinics are categorised into 4 main classes:

- Procedural clinics—which provide minor surgical and non-surgical procedures (that do not require the patient to be admitted) by a surgeon or other medical specialist
- Medical consultation clinics—which provide services by a medical or nurse practitioner. There may also be input from allied health personnel and/or clinical nurse specialists
- Diagnostic service clinics—which provide diagnostic services such as imaging, screening, clinical measurement and pathology
- Allied health and/or clinical nurse specialist intervention clinics—which provide services by an allied health professional or clinical nurse specialist.

In 2018–19, 39.0 million patient service events were provided by non-admitted patient clinics.

17.9 million (46%) services in Allied health and/or clinical nurse specialist intervention clinics

11.4 million (29%) services in Medical consultation clinics

6.4 million (16%) Diagnostic services

3.3 million (8.4%) services in Procedural clinics

4

Hospital safety and quality



4 How safe are our hospitals?

The safety and quality of the care provided in Australia's hospitals is important to patients and their families, and is a key focus for governments, service providers and health professionals.

Clinicians work hard to ensure that their patients receive care that is safe and of high-quality. Measuring safety and quality enables the identification of areas where services are doing well and areas where improvement is required. This information can be used to develop and improve practice and policy within health care services.

How is safety and quality of care measured?

Various measures are used to monitor the safety and quality of hospital services, including the rates of:

- *Staphylococcus aureus* bloodstream (SAB) infections
- hospital-acquired complications
- unplanned readmissions

Patient experience surveys can also provide an indication of the quality of care provided from the patient's perspective.

This information provides only part of the picture of safety and quality of care in Australia's hospitals and broader health system. Further information is needed about the quality of care, continuity of care and the responsiveness of hospital services.

Staphylococcus aureus bloodstream infections

Staphylococcus aureus (also *S. aureus*, or 'Golden staph') is a type of bacteria that can cause *Staphylococcus aureus* bacteraemia (SAB), an infection of the bloodstream.

SAB can be acquired after a patient receives medical care or treatment in a hospital. Contracting a *Staph. aureus* bloodstream infection while in hospital can be life threatening and hospitals aim to have as few cases as possible.

In 2018–19, the nationally-agreed benchmark aimed for no more than 2.0 cases of healthcare-associated SAB infections per 10,000 days of patient care for public hospitals in each state and territory.

In 2018–19:

- **1,573 SAB infections** occurred during 21.0 million days of patient care which are under surveillance. Patient days under SAB infection surveillance covered 99% of days of patient care in public hospitals
- This represents a SAB rate of **0.75 cases** per 10,000 days of patient care

All states and territories had public hospital SAB rates below the national benchmark of 2.0 cases per 10,000 days of patient care. Between 2014–2015 and 2018–2019, SAB rates have remained at under 0.8 cases per 10,000 patient days.

Hospital-acquired complications

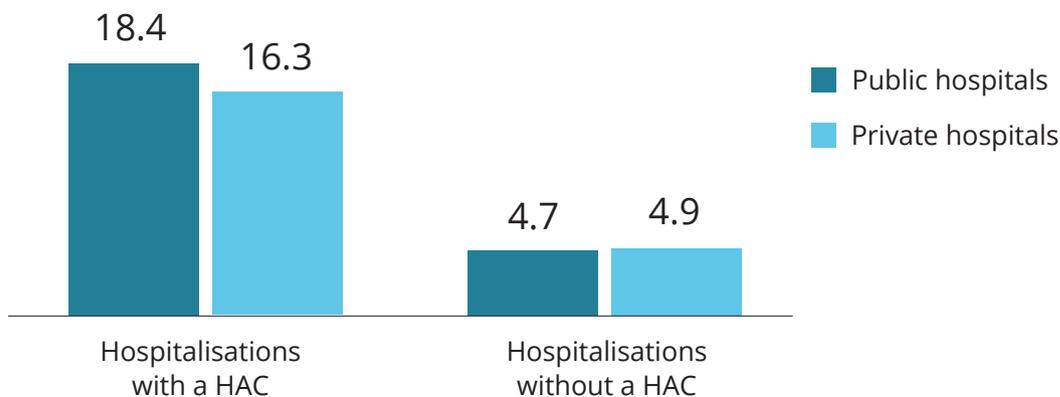
A hospital-acquired complication is a complication that arises during a patient's hospitalisation which may have been preventable, and which can have a severe impact on both the patient and the care required.

Hospital-acquired complications include pressure injuries, healthcare-associated infections, malnutrition, neonatal birth trauma, cardiac complications, and delirium. They may affect a patient's recovery, overall outcome and can result in a longer length of stay in hospital. A patient may have one or more hospital-acquired complication during a hospitalisation.

In 2018–19:

- there were 2.2 hospitalisations per 100 hospitalisations with at least one hospital-acquired complication in public hospitals
- there were 1.1 hospitalisations per 100 hospitalisations with at least one hospital-acquired complication in private hospitals
- the highest rates were related to healthcare associated infections (affecting 89,800 hospitalisations) and cardiac complications (affecting 32,000 hospitalisations).

Average length of stay (days) for hospitalisations with and without a hospital-acquired complication (HAC) 2018–19

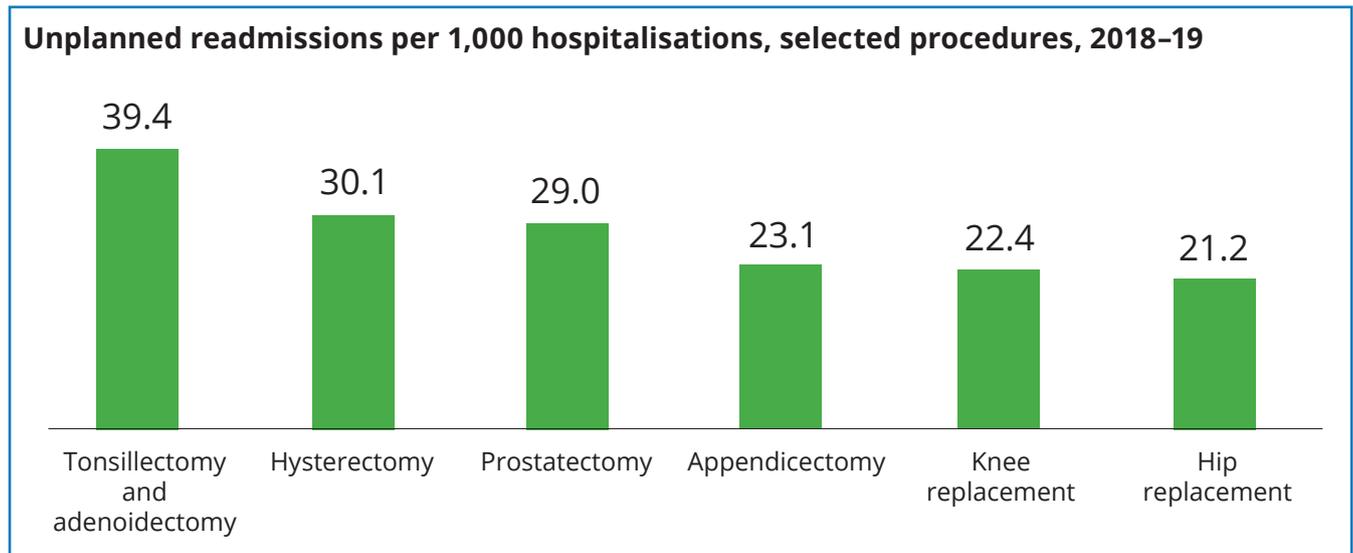


Unplanned readmissions

An unplanned or unexpected readmission occurs when a patient has been discharged from hospital following surgery, is admitted again to the same hospital within a certain time interval, and the reason for the readmission is for a complication following surgery. In this report, the interval is within 28 days of selected types of surgery.

Reducing avoidable hospital readmissions improves patient safety and health outcomes, and leads to greater efficiency in the health system.

In 2018–19, rates of unplanned readmissions in public hospitals were highest for *Tonsillectomy and adenoidectomy*, *Hysterectomy* and *Prostatectomy*.



What do patients say about their hospital experience?

The Australian Bureau of Statistics conducts an annual survey of people aged 15 and over who have had interactions in the previous 12 months with a range of healthcare providers/services, including emergency department visits and hospital admissions (ABS 2018).

Emergency department

- 83% of patients responded that **doctors** 'always' or 'often' spent enough time with them in the emergency department.
- 87% of patients responded that **nurses** 'always' or 'often' spent enough time with them in the emergency department.
- 88% of patients responded that **doctors** 'always' or 'often' showed respect to them in the emergency department.
- 91% of patients responded that **nurses** 'always' or 'often' showed respect to them in the emergency department.

Admitted patients

- 91% of patients responded that **doctors** 'always' or 'often' listened carefully to them in hospital.
- 93% of patients responded that **nurses** 'always' or 'often' listened carefully to them in hospital.

5

Access to hospitals



5 How accessible are hospital services?

Providing access to appropriate and timely hospital care is an integral component of health care. In essence, it is about being able to get the health care you need, when you need it.

A person's ability to access appropriate and quality health care is influenced by their own health needs as well as factors such as where they live, their socioeconomic circumstances, and their cultural background (WHO 2006).

How is access to health care measured?

This report explores hospital accessibility by looking at the:

- number of services available, including hospitals and emergency departments
- location of services and hospitals
- waiting times to access elective surgery and emergency department care
- geographic location, socioeconomic disadvantage and Indigenous status of the people who use hospital services.

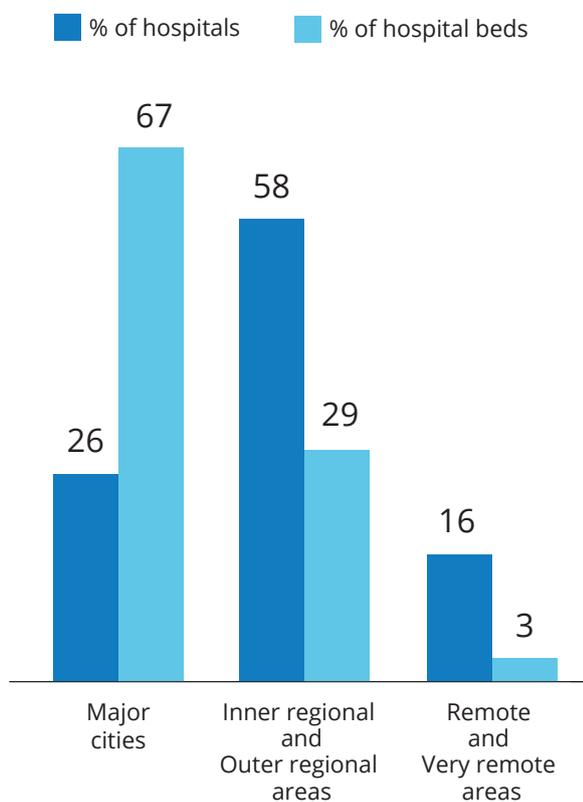
Where are hospitals and beds located?

The number and type of hospitals, and the beds available, are measures of access to health care services. Public hospitals in *Major cities* are more likely to be larger and to offer a broader range of services, whereas hospitals in more remote areas tend to be smaller and offer a smaller range of services. This can affect the timeliness and availability of services for people living in more remote areas.

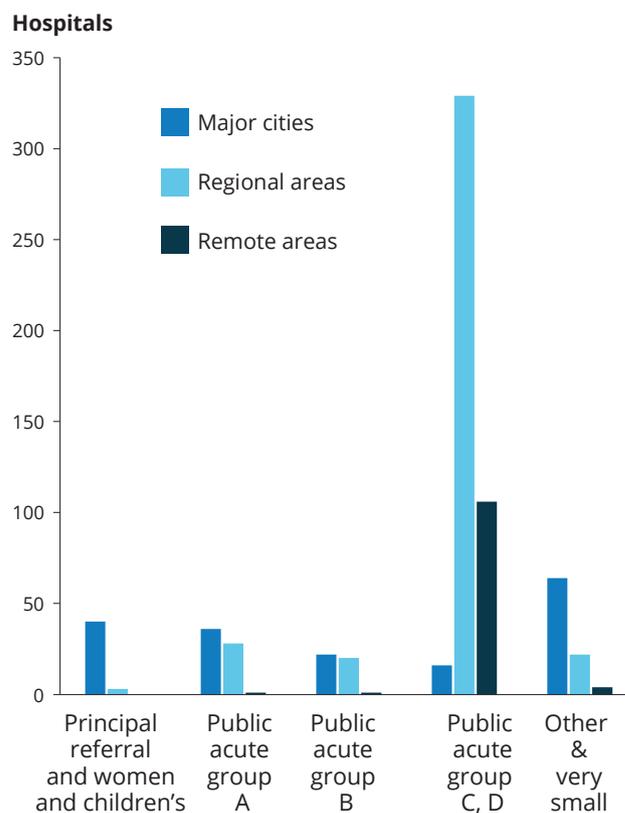
In 2018–19, there were 692 public hospitals whose location, size, and services varied by remoteness area. Of these public hospitals, 179 are in *Major cities*, 402 were in *Inner regional* and *Outer regional* areas, and 111 were in *Remote* and *Very remote areas*. There were 63,100 available public hospital beds, ranging from 2.5 per 1,000 population in *Major cities* to 3.9 per 1,000 population in *Remote* and *Very remote areas*. Just over two-thirds of the hospital beds in Australia were in *Major cities*.

Most of the larger public hospitals were located in the more populated areas, and this is evidenced by the number of hospital beds that were located in each remoteness area. Although 26% of hospitals are in *Major cities*, 67% of hospital beds are located in *Major cities*, 58% of hospitals and 29% of hospital beds are in *Inner regional areas*, and 16% of hospitals and 3% of hospital beds in *Remote areas*.

Proportion of total public hospitals and beds by remoteness area, 2018-19



Number of hospitals, by remoteness area and type of hospital, 2018-19



Access to admitted patient care

Admitted patients are those who undergo an admissions process to receive treatment and/or care in a public or private hospital.

In 2018–19, hospitalisation rates varied across levels of socioeconomic disadvantage for public and private hospitals.

For public hospitals, the highest rates of hospitalisation were for patients living in the most disadvantaged areas (314 hospitalisations per 1,000 population) with rates decreasing as the level of disadvantage decreases. For private hospitals, the highest rates were for patients living in the least disadvantaged areas (239 hospitalisations per 1,000 population) with hospitalisation rates decreasing as the level of disadvantage increases.

Patterns of hospitalisations also varied by remoteness area; the highest rates of hospitalisation in private hospitals was for patients whose area of residence was in *Major cities*, whereas the highest rates of hospitalisations in public hospitals were for patients whose area of residence was in *Very remote* areas. Hospitalisations in public hospitals increase with increasing remoteness of the patient's area of residence, while hospitalisations in private hospitals decrease with increasing remoteness of the patient's area of residence.

In 2018–19,

4.9% of hospitalisations (559,000) were reported for people of Aboriginal and Torres Strait Islander origin, who represent 3.3% of the Australian population (ABS 2019b).

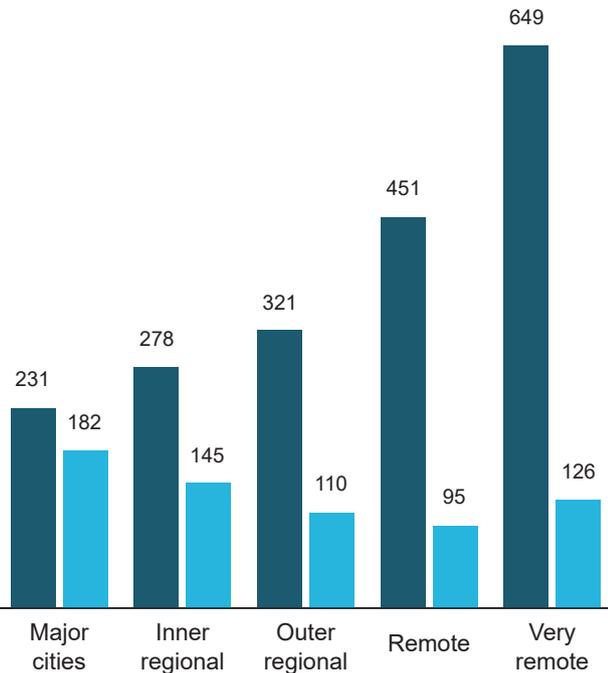


Remoteness area

(of usual residence)

Hospitalisations per 1,000 population by remoteness area of usual residence, public and private hospitals, 2018-19

Public hospitals Private hospitals

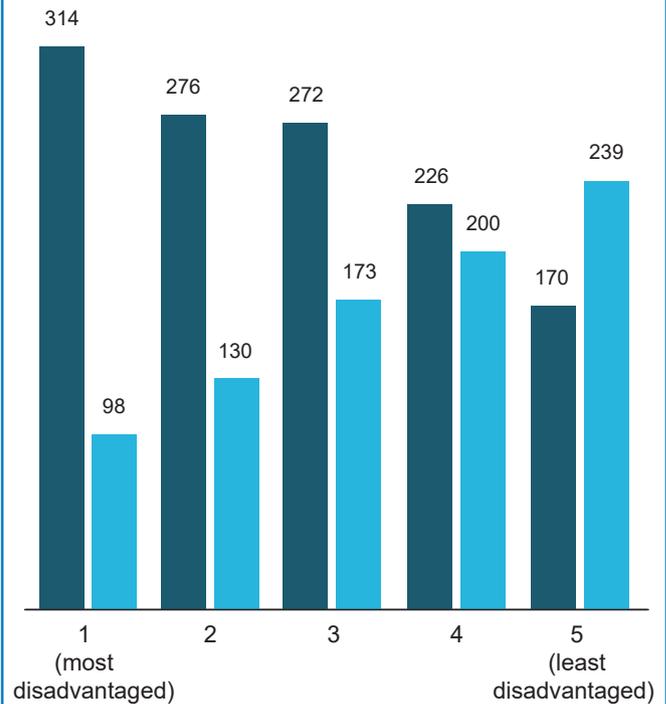


Socioeconomic status

(of area of usual residence)

Hospitalisations per 1,000 population by socioeconomic disadvantage, public and private hospitals, 2018-19

Public hospitals Private hospitals



Access to emergency department care

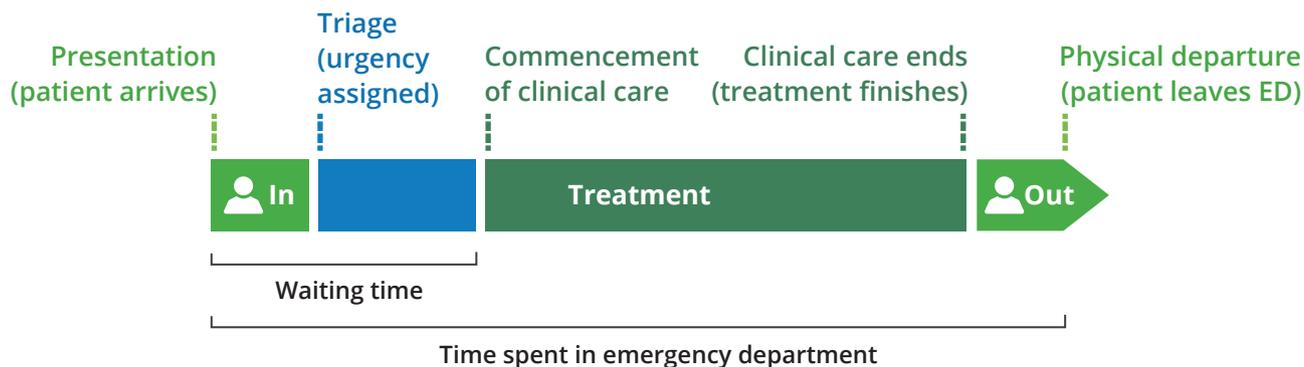
Waiting time

How long people spend waiting in the emergency department before they receive care (waiting time) can be used as a measure of the accessibility of emergency department care.

Waiting time statistics are presented here as:

- 50th percentile (median) waiting time
- proportion seen on time.

Emergency department waiting time measures represent the time elapsed from presentation to commencement of clinical care.



Note: The length of the segments is illustrative only.

A patient is said to be 'seen on time' if they receive care within the time considered appropriate for their triage category.

Triage categories:

- 1. Resuscitation:** immediate, within seconds
- 2. Emergency:** within 10 minutes
- 3. Urgent:** within 30 minutes
- 4. Semi-urgent:** within 60 minutes
- 5. Non-urgent:** within 120 minutes

50th percentile (median) waiting time

In 2018–19, 50% of patients were seen within 19 minutes. This has stayed relatively consistent since 2014–15, when 50% of patients were seen within 18 minutes.

50th percentile (median) waiting time (minutes) for emergency presentations, by remoteness of area of usual residence and triage category, 2018–19

Triage category	Remoteness area of usual residence					Total
	Major cities	Inner regional	Outer regional	Remote	Very remote	
Resuscitation	0	0	0	0	0	0
Emergency	7	6	6	5	6	6
Urgent	23	19	17	14	15	21
Semi-urgent	32	27	23	20	22	29
Non-urgent	28	22	16	18	20	24
Total	21	18	16	15	16	19

In 2018–19, median waiting times were longest for people living in *Major cities* (**21 minutes**) and shortest for those living in *Remote areas* (**15 minutes**).

Proportion seen on time

In 2018–19, 71% of presentations to emergency departments were ‘seen on time’—ranging from 100% of patients requiring immediate care (Resuscitation) to 63% of patients who needed care within 30 minutes (Urgent).

Proportion seen on time (%) for emergency presentations, by remoteness of area of usual residence and triage category, 2018–19

Triage category	Remoteness area of usual residence					Total
	Major cities	Inner regional	Outer regional	Remote	Very remote	
Resuscitation	100	100	100	100	100	100
Emergency	73	78	77	81	76	75
Urgent	60	68	72	76	73	63
Semi-urgent	70	75	78	80	80	73
Non-urgent	90	92	94	95	95	91
Total	68	74	77	81	80	71

The proportion of patients seen on time can vary by hospital peer group. *Principal referral* and *women’s and children’s hospitals* had the lowest overall proportion of presentations ‘seen on time’ (66%), and *Public acute group C*, *Public acute group D*, *Very small* and *Other hospitals* had the highest proportions (all 85%). For an explanation of hospital peer group see the Terminology section.

Between 2014–15 and 2018–19, the proportion of patients who were seen on time **declined** from 74% to **71%**.

Time spent in the emergency department

Another measure of access to services is the total time a patient spends in the emergency department. In 2018–19, 50% of emergency department presentations were completed within 2 hours 58 minutes, and 90% were completed within 7 hours and 29 minutes.

For patients who were not subsequently admitted to hospital, 90% completed their care within 5 hours 30 minutes, but for patients subsequently admitted to hospital, 90% completed their care within 11 hours 43 minutes.

The time which 90% of patients spent in the emergency department also varied by triage category—ranging from 3 hours and 49 minutes for patients who needed care within 120 minutes (*Non-urgent*) to 10 hours and 49 minutes for patients requiring immediate care (*Resuscitation*).

Emergency department presentations, 90th percentile length of stay (hours: minutes) by triage category, 2018–19

	Triage category					
	Resuscitation	Emergency	Urgent	Semi-urgent	Non-urgent	Total
Time spent	10:49	10:13	8:43	5:55	3:49	7:29

Access to surgery in Australia's hospitals

People can be admitted to hospital for emergency surgery, or for less urgent procedures they can be booked in as part of an elective admission to hospital. Access to surgical services can be affected by issues such as the person's geographical location, the availability of other healthcare services, and how many people are on public hospital elective surgery waiting lists.

Emergency admissions involving surgery

In 2018–19:

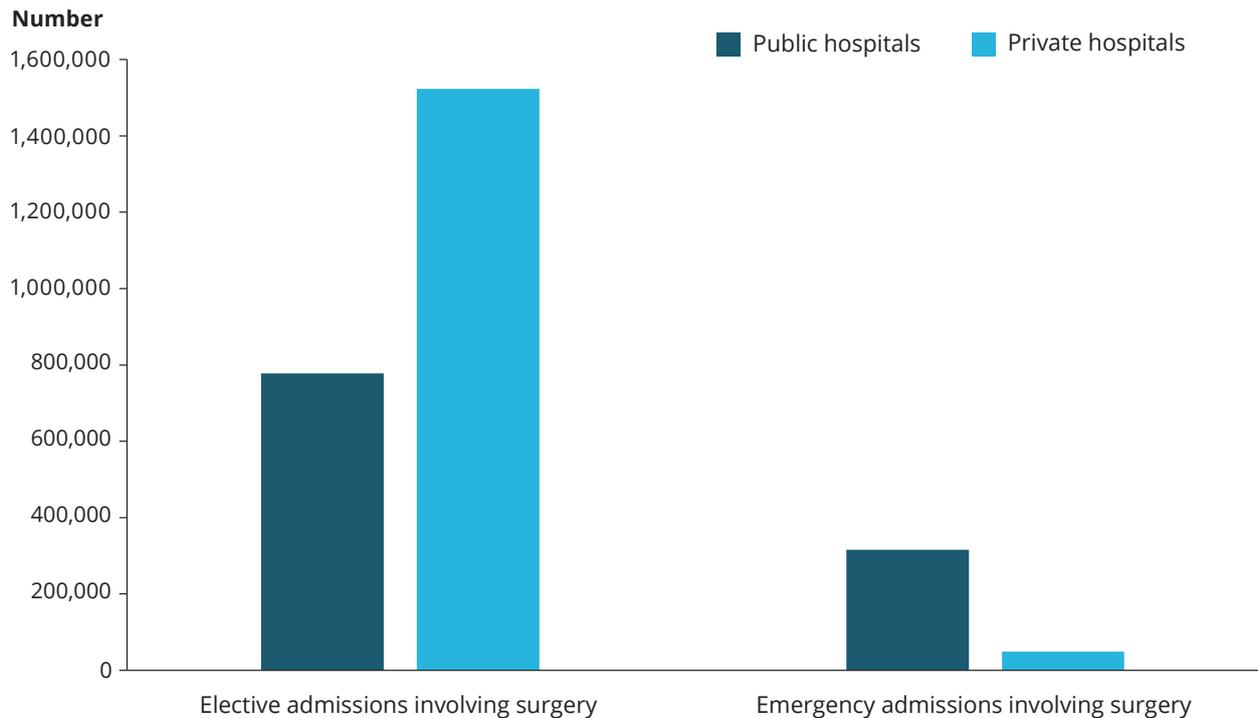
- 365,000 emergency admissions involved surgery—87% (316,000) were in public hospitals and 13% (49,100) were in private hospitals
- people living in *Very remote* areas were almost twice as likely to have an emergency admission involving surgery as people living in *Major cities* (25.6 versus 12.9 hospitalisations per 1,000 population)
- the three most common reasons for emergency admissions involving surgery were appendicitis, fractured femur and heart attack.

Elective admissions involving surgery

In 2018–19:

- 2.3 million elective admissions involved surgery—66% (1.5 million) were in private hospitals and 34% (778,000) were in public hospitals
- people living in *Major cities* were nearly one and a half times as likely to have an elective admission involving surgery as people living in *Very remote* areas (84.4 compared with 59.8 hospitalisations per 1,000 population)
- the three most common reasons for elective admissions involving surgery were cataracts, skin cancer and retinal disorders.

Emergency and elective admissions involving surgery, public and private hospitals, 2018-19



Admissions from public hospital elective surgery waiting lists

In 2018-19:

- 758,000 patients were admitted for elective surgery from public hospital waiting lists
- *Removal of cataracts* was the most common procedure (9.5%), followed by *Cystoscopy* (8.3%)
- the most common surgical specialty was *General surgery* (21%), followed by *Urological surgery* (14%) and *Orthopaedic surgery* (14%)

- 64% of admissions from waiting lists for elective surgery were for patients living in *Major cities*, 23% for patients in *Inner regional* areas, and 10% for patients in *Outer regional* areas
- people living in *Remote* areas had the highest rate of admissions (39.6 hospitalisations per 1,000 population) followed by *Very remote* (35.8 per 1,000) and *Inner regional* areas (33.5 per 1,000)
- People living in *Major cities* had the lowest rate of admission from waiting lists for elective surgery (25.2 hospitalisations per 1,000 population).

Waiting times for admission from elective surgery waiting lists

In 2018–19:

- 50% of patients admitted to hospital from public hospital elective surgery waiting lists waited for 41 days or less, and 90% waited for 279 days or less
- 2.1% of people admitted for surgery waited more than 365 days
- of the most common procedures that patients were waiting for, *Breast lump—excision and/or biopsy* had the shortest median waiting time with 50% of patients being admitted within 16 days, followed by *Coronary artery bypass grafting* at 18 days
- common procedures with the longest median waiting times were *Septoplasty*—a procedure to correct a deviated septum, allowing for better airflow through the nose (266 days)—and *Total knee replacement* (214 days)
- 50% of Aboriginal and Torres Strait Islander people were admitted to hospital within 53 days, whereas 50% of Other Australians were admitted within 41 days
- the time within which 50% of patients were admitted for their awaited procedure ranged from 36 days in *Remote* areas to 45 days in *Outer regional* areas
- the time within which 50% of patients were admitted ranged from 34 days for patients living in the least disadvantaged areas to 45 days for people living in the most disadvantaged socioeconomic areas.

Terminology

Acute care includes surgery, diagnostic or therapeutic procedures for the treatment of illness or injury. Management of childbirth is also considered acute care.

Administrative and clerical staff are staff engaged in administrative and clerical duties.

Admitted patient care is care provided to a patient who has been formally admitted to a hospital. It can be provided as same-day or overnight care.

Australian Refined Diagnosis Related Groups (AR-DRGs) is an Australian admitted patient classification system which provides a clinically meaningful way of relating the number and type of patients treated in a hospital (known as hospital case-mix) to the resources required by the hospital. Each AR-DRG represents a class of patients with similar clinical conditions requiring similar hospital services.

Diagnostic and allied health professionals: Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature. This category includes all allied health professionals and laboratory technicians.

Domestic and other staff: Staff engaged in the provision of food and cleaning services including those primarily engaged in administrative duties such as food services manager.

Emergency department waiting time is calculated as the time between arrival at the emergency department and start of clinical care.

Emergency departments provide care for patients who may have an urgent need for medical, surgical or other care.

Full-time equivalent staff: Full-time equivalent staff units are the on-the-job hours paid for, divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job.

Non-admitted patient services are provided by public hospital outpatient clinics without the patient being admitted to hospital.

Other personal care staff: Includes attendants, assistants or home assistants, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents.

Other salaried medical officers: Non-specialist medical officers employed by the establishment on a full-time or part-time salaried basis.

Outpatient clinics provide a range of health services, including consultations with specialist medical practitioners, diagnostic services or other procedures, and allied health or specialist nursing care.

Overnight hospitalisations are hospital stays in which the patient spends at least one night in hospital.

Peer groups define groups of similar hospitals based on shared characteristics such as size and type of services provided. The groupings used in this report for public hospitals are:

- *Principal referral* and *Women's and children's* hospitals. Acute hospitals that provide a very broad range of services, have a range of highly specialised service units, and have very large patient volumes.
- *Public acute group A*. Hospitals that provide a wide range of services typically including a 24-hour emergency department, intensive care unit, coronary care unit and oncology unit, but do not provide the breadth of services provided by *Principal referral* hospitals.
- *Public acute group B*. Hospitals that have a 24-hour emergency department and typically provide elective surgery and have specialised units such as obstetric, paediatric and psychiatric units.
- *Public acute group C*, *Public acute group D* and *Very small* hospitals. Hospitals that provide a more limited range of services, but may have an obstetric unit, provide surgical services and/or some form of emergency facility.
- *Other hospitals*. This grouping may include *Psychiatric* hospitals, which specialise in providing mental health services; *Subacute and non-acute* hospitals, which can provide rehabilitation, palliative care, geriatric evaluation and management, psychogeriatric and/or maintenance care; *Early parenting centres* and *Drug and alcohol* hospitals.

Procedural clinics provide diagnosis and treatment including medical imaging, endoscopy, dialysis and surgical procedures.

Remoteness areas divide Australia into 5 classes of remoteness based on a measure of road access to localities containing services such as health, education and retail. The 5 areas are *Major cities*, *Inner regional*, *Outer regional*, *Remote* and *Very remote*.

Same-day hospitalisations are hospital stays in which the patient is discharged on the same day as they were admitted.

Socioeconomic status is a classification using the average socioeconomic status (SES) of the patient's area of usual residence. This is presented in quintiles; the lowest SES group represents areas containing the most disadvantaged 20% of the population and the highest group representing the 20% of the population with the least disadvantage.

Specialist salaried medical officers: Specialist medical officers employed by the hospital on a full-time or part-time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee-for-service basis. This includes salaried medical officers engaged in administrative duties.

Subacute and non-acute care are care types other than 'acute care'. They include rehabilitation care, palliative care, certain types of geriatric care, and maintenance care.

Triage category is used in emergency departments to indicate the urgency of the patients' need for medical and nursing care. Patients are triaged into 1 of 5 categories that is allocated by a registered nurse or medical practitioner. Each category has a recommended time for the commencement of clinical care. The categories are:

1. Resuscitation: immediate, within seconds
2. Emergency: within 10 minutes
3. Urgent: within 30 minutes
4. Semi-urgent: within 60 minutes
5. Non-urgent: within 120 minutes

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Australia's hospitals at a glance 2018-19 presents key statistics about Australia's hospitals and is a companion report to the data presented in the MyHospitals section of the AIHW website at www.aihw.gov.au/myhospitals.

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