

Australia's hospitals 2009–10

at a glance

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Introduction

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

A summary measure of the significance of Australia's hospitals is the amount that is spent on them—an estimated \$41.8 billion in 2008–09, about 3.3% of Australia's domestic product, or about \$1,922 per person (AIHW 2010). And hospital spending has been increasing faster than inflation—adjusted for inflation, it increased by 5.1% each year, on average, between 2004–05 and 2008–09.

Access to our hospital services, the quality of the services, as well as funding and management arrangements for them, are under constant public scrutiny. This summary report presents an overview of statistics on our hospitals that can serve as a background to public discussion and debate.

While most data for this report are for 2009–10, some data for private hospitals were only available for 2008–09.

More detailed statistics, and more information on how to interpret the data can be found in the companion report, *Australian hospital statistics 2009–10*. Further detail is also available in spreadsheets and interactive data cubes at <www.aihw.gov.au>.

How many hospitals are there?

In Australia, both public and private hospitals provide hospital services.

The state and territory governments mainly own and manage public hospitals. Public acute hospitals mainly provide 'acute care' for short periods, although some provide longer term care, such as for rehabilitation. Public psychiatric hospitals specialise in the care of people with mental health problems, sometimes for long periods of time.

Private hospitals are mainly owned and managed by private organisations, either for-profit companies or not-for-profit non-government organisations. They include day hospitals that provide services on a day-only basis, and hospitals that provide overnight care.

Between 2005–06 and 2009–10, the numbers of public acute hospitals and private hospitals were relatively stable.

In 2009–10, there were 1,326 hospitals in Australia:

- 736 public acute hospitals
- 17 public psychiatric hospitals
- 293 private day-only hospitals
- 280 other private hospitals.

The numbers for these hospitals in each state and territory are shown in Table 1.

Table 1: Public and private hospitals, states and territories, 2009–10

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospital									
Public acute hospitals	218	149	166	94	78	23	3	5	736
Public psychiatric hospitals	8	1	4	1	2	1	0	0	17
Total	226	150	170	95	80	24	3	5	753
Private hospitals									
Private free-standing day hospital facilities	89	82	53	32	25	2	9	1	293
Other private hospitals	84	79	53	23	31	6	3	1	280
Total	173	161	106	55	56	8	12	2	573
Total	399	311	276	150	136	32	15	7	1,326

How many beds are there?

As hospital sizes vary considerably, the number of beds is a better indicator of the availability of hospital services than is the number of hospitals. However, the range and types of patients that different hospitals treat (or their 'casemix') can affect the comparability of hospital bed numbers. Hospitals with different casemixes will have differing proportions of beds available for specialised and more general purposes.

Beds counted are those available for use—with appropriate staffing. The counts are not of physical beds, not all of which may be in use. Chairs used for some same-day treatments, such as chemotherapy, are also included.

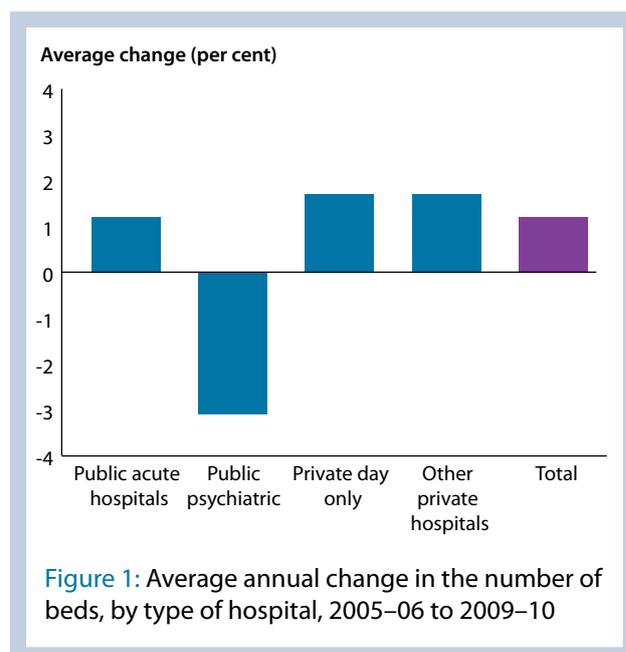
In 2009–10, there were:

- 54,812 beds in public acute hospitals
- 2,088 beds in public psychiatric hospitals
- 2,260 beds in private day-only hospitals
- 25,778 beds in other private hospitals.

The number of hospital beds increased by 3.3% between 2005–06 (80,828 beds) and 2009–10 (84,938 beds), an annual average increase of 1.2%.

There was a relatively large increase in beds in private hospitals, compared with public acute hospitals (Figure 1).

The relatively large decrease for public psychiatric hospitals reflected the continuation of the long-term trend to deinstitutionalise services for people with mental illness, and the trend to integrate specialist psychiatric services with public acute care hospital services.



Hospital performance: accreditation

Hospital accreditation is regarded as a performance indicator relevant to the effectiveness of hospital services. Hospitals can be accredited through organisations such as the Australian Council of Healthcare Standards, Business Excellence Australia, and the Quality Improvement Council, or through certification with the International Organization for Standardization's 9000 quality family.

A total of 637 public hospitals with 52,651 beds (93% of public hospital beds) were known to be accredited at 30 June 2010 (Figure 2). These hospitals provided 95% of public hospital separations (completed episodes of admitted patient care) and 93% of patient days (days spent in hospital as an admitted patient).

For 2009-10, a total of 543 private hospitals and 27,045 private hospital beds were accredited (93% of hospitals, covering 97% of beds).

The proportions of accredited hospitals and beds in accredited hospitals have not changed much over recent years, reflecting continuing requirements of funding organisations for hospitals to be accredited. Between 2005-06 and 2009-10, 90% or more of hospital beds were in accredited hospitals.

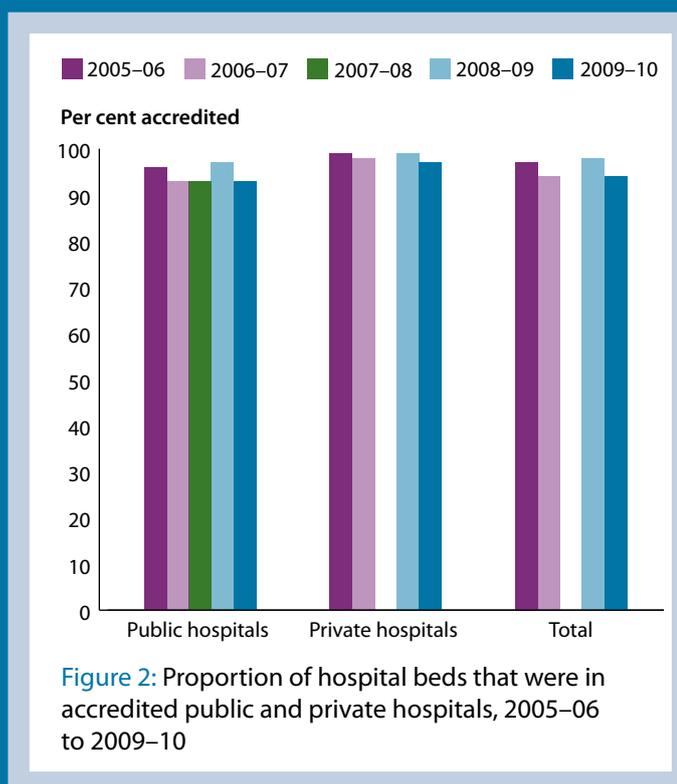


Figure 2: Proportion of hospital beds that were in accredited public and private hospitals, 2005-06 to 2009-10

How diverse are public hospitals?

The 753 public hospitals are very diverse in size and the types of services provided for admitted and non-admitted patients (Table 2). The diversity of admitted patient services provided by each type can be gauged by the average number of diagnosis related groups reported (AR-DRGs). In 2009-10, there were:

- 75 *Principal referral* hospitals, located mainly in major cities, with at least one in each state and territory. They provided a wide range of services, including

emergency department, outpatient and admitted patient services (including 5 or more separations for 454 AR-DRGs on average). These hospitals accounted for a total of 3.3 million separations or 65% of the total for public hospitals (Figure 3). There was a total of 10.9 million days spent by patients in these hospitals or 61% of the total for public hospitals (Figure 4).

- 11 *Specialist women's and children's* hospitals, located in Sydney, Melbourne, Brisbane, Perth and Adelaide. They recorded an average of 20,635 separations, specialising in maternity and other specialist services for women, and/or specialist paediatric services.

- 43 *Large* hospitals, 26 in major cities and 17 in regional and remote areas. They provided emergency department, outpatient and admitted patient services, generally with a range of activities less than for the Principal referral hospitals (5 or more separations for 265 AR-DRGs), with an average of 15,190 separations per hospital.
- 92 *Medium* hospitals, 23 in major cities and 69 in regional areas. They delivered an average of 5,899 separations per hospital (with a narrower range of services than the Large hospitals). Most had accident and emergency services (rather than formal emergency departments) and some had outpatient clinics.
- 154 *Small acute* hospitals, 116 in regional areas and 38 in remote areas. They delivered mainly acute care for admitted patients, with an average of 1,218 separations per hospital in the year, with a relatively narrow range of services. They generally did not have emergency departments although most provided accident and emergency services.
- 17 *Psychiatric* hospitals, specialising in the treatment and care of people with mental health problems. They were located in Sydney, Melbourne, Brisbane, Perth, Adelaide and Hobart with 3 in regional Queensland centres.
- 8 specialist *Rehabilitation* hospitals, located in Sydney, Perth and Adelaide.
- 8 specialist *Mothercraft* hospitals, located in Sydney, Melbourne, Brisbane and Canberra.
- 83 *Small non-acute* hospitals, mainly in regional and remote areas. The services they provided tended to be mainly non-acute, so the average length of stay was longer than in the hospitals that provided mainly acute care.
- 78 *Multipurpose services*, mainly in regional and remote areas. These hospitals were generally combined with services for residential aged care, and mainly provide non-acute admitted patient care.
- 184 other hospitals, mainly small hospitals or particular specialist hospitals, such as hospices.

Table 2: The diversity of public hospitals, 2009–10

Hospital type	Number of hospitals								Average beds	Separations (average)	Average length of stay (days)	Non-acute care (patient days%)	AR-DRGs (5+) per hospital
	Location				Service provided								
	Major cities	Regional	Remote	Total	Emergency departments	Accident and emergency services	Outpatient clinics	Elective surgery					
Principal referral	50	24	1	75	75	75	74	74	413	43,591	3.3	8.4	454
Specialist women's and children's	11	0	0	11	9	9	11	11	199	20,635	3.1	0.4	231
Large	26	16	1	43	41	41	38	36	142	15,190	3.0	13.9	265
Medium	23	69	0	92	30	76	8	46	64	5,899	3.1	23.2	143
Small acute	0	116	38	154	20	146	2	20	22	1,218	3.1	9.1	51
Psychiatric	13	4	0	17	0	0	0	0	123	658	58.8	52.4	10
Rehabilitation	6	2	0	8	0	0	1	1	69	975	21.8	90.8	13
Mothercraft	8	0	0	8	0	0	0	0	26	1,681	3.7	0.0	9
Small non-acute	16	54	13	83	3	61	1	3	32	805	11.0	71.8	30
Multi-purpose services	0	45	33	78	0	70	0	0	12	346	3.9	29.1	13
Other	28	86	70	184	6	122	0	1	11	284	9.7	79.3	7
Total	181	416	156	753	184	600	135	192	76	6,716	3.6	17.1	98

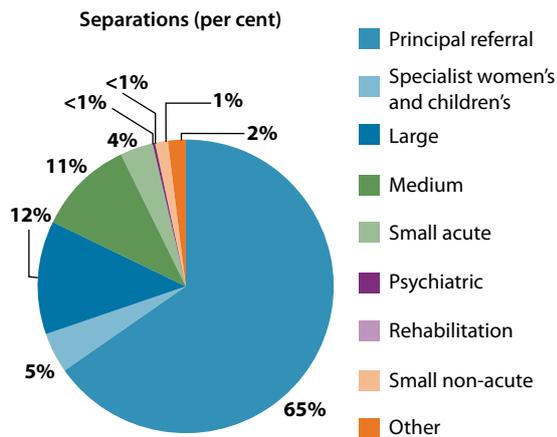


Figure 3: Separations for admitted patients, by public hospital type, 2009–10

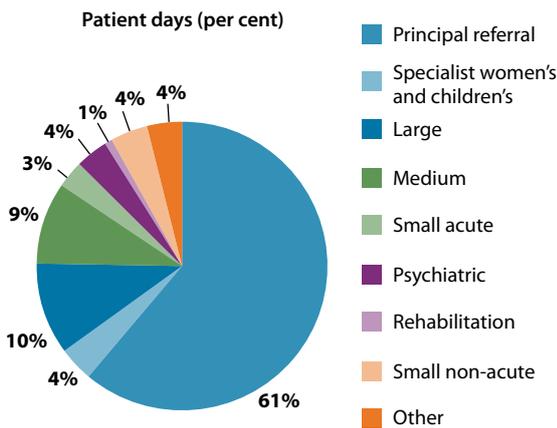


Figure 4: Patient days for admitted patients, by public hospital type, 2009–10

The majority of beds were in larger hospitals and in more densely populated areas. In 2009–10, the largest public hospital had over 1,000 beds, but over 70% of hospitals had fewer than 50 beds.

The proportion of hospital beds in different size hospitals varied greatly by state. The Northern Territory did not have any public hospitals with either more than 500 beds or 10 beds or fewer. For Victoria, almost 40% of public hospital beds were in hospitals with 200 to 500 beds (Figure 5).

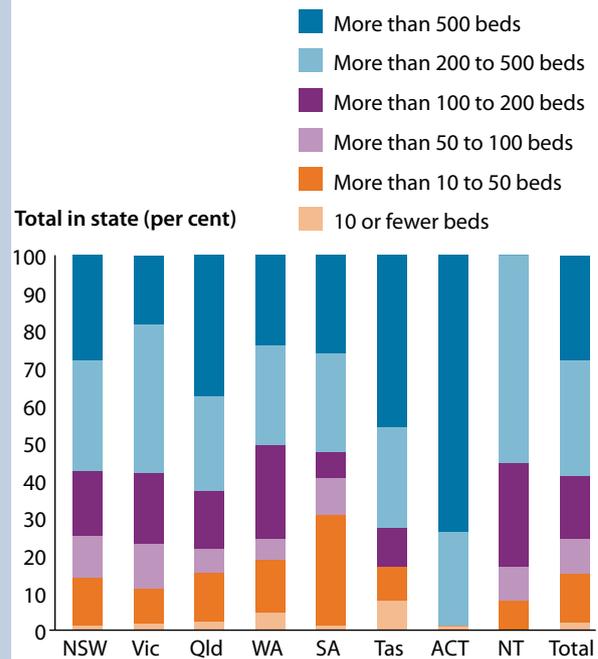


Figure 5: Proportion of beds by hospital size, states and territories, 2009–10

How many people are employed in Australia's hospitals?

Australia's public hospitals employed about 251,000 full-time equivalent staff in 2009–10, and private hospitals employed over 52,000 in 2008–09 (ABS 210).

These statistics do not include visiting medical officers in public hospitals (who are paid on contract, rather than as staff) and most medical officers who provide services in private hospitals (where the patients and Medicare mainly cover payment, rather than the hospitals).

Hospital employees include medical officers (such as surgeons, anaesthetists and other specialists), nurses, diagnostic and allied health professionals (such as physiotherapists and occupational therapists), administrative and clerical staff, and domestic and other personal care staff.

Public hospitals

The largest staffing category in public hospitals is nurses, who made up 45% of the full-time equivalent staff numbers in 2009–10. Medical officers comprised 12% of staff and diagnostic and allied health professionals together comprised 14%.

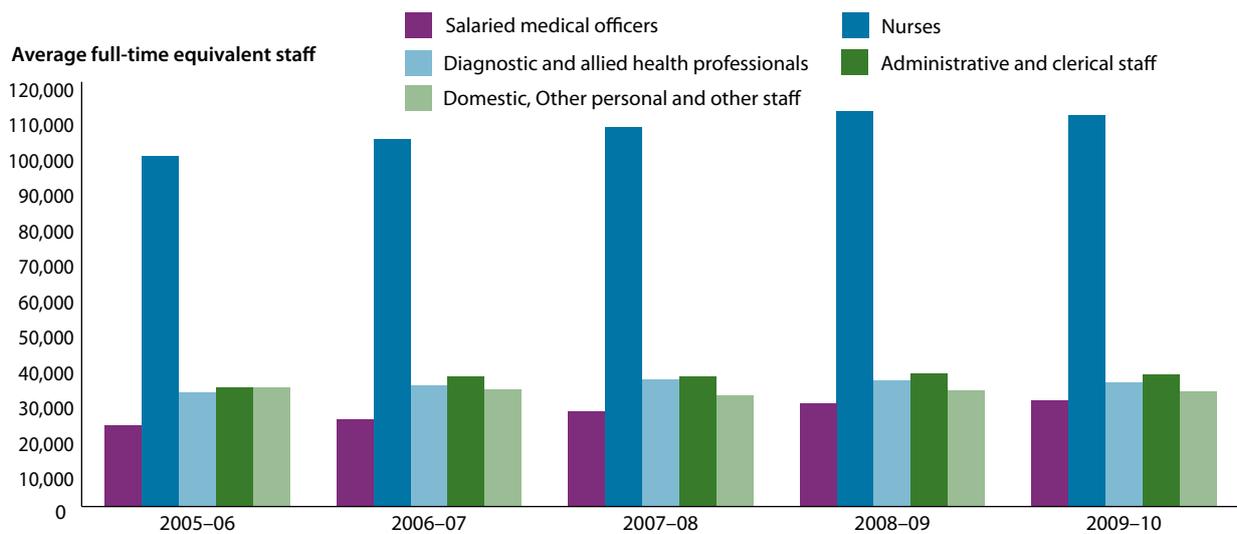


Figure 6: Average full-time equivalent staff, public hospitals, 2005-06 to 2009-10

The number of salaried medical officers increased by an average of 7.5% annually between 2005-06 and 2009-10, to 31,000. The number of nurses increased by an annual average of 3.6%, to 114,000 in 2009-10 (Figure 6).

Private hospitals

The staffing mix in private hospitals is somewhat different from that in public hospitals, because most medical services are not provided by hospital employees and the range of services provided is different. The largest staffing category in private hospitals is nurses, who made up 60% of the full-time equivalent staff numbers in 2008-09. Medical officers and diagnostic and allied health professionals comprised 7% of full-time equivalent staff.

How much do hospitals spend?

Hospital expenditure includes recurrent expenditure and capital expenditure. Recurrent expenditure is money that is spent on goods and services that are consumed during the year, for example, salaries. Capital expenditure includes money spent on buildings and large pieces of equipment.

Public hospitals

In 2009-10, recurrent expenditure by public hospitals was \$33,706 million (excluding depreciation). After adjusting for inflation, this represented an increase of 3.7% compared with 2008-09.

Over 62% of this expenditure was for salary payments (\$21,099 million) (Figure 7).

About 70% of recurrent expenditure was on admitted patient services—rather than emergency department, outpatient and other services for non-admitted patients, and other hospital activities.

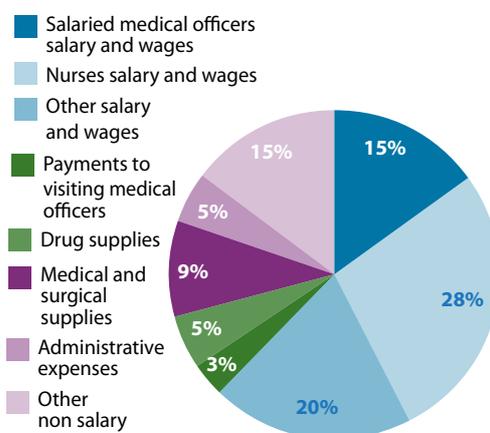


Figure 7: Recurrent expenditure, public hospitals, 2009-10

Between 2005–06 and 2009–10, recurrent expenditure by public hospitals increased by an average of 5.2% per year (after adjusting for inflation) (Figure 8).

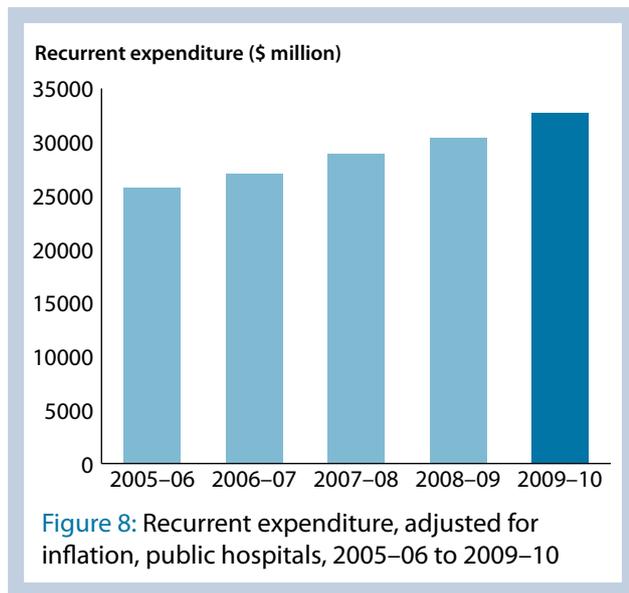


Figure 8: Recurrent expenditure, adjusted for inflation, public hospitals, 2005–06 to 2009–10

Private hospitals

In 2008–09, recurrent expenditure by private hospitals was \$8,137 million (including depreciation) (ABS 2010).

About 51% of this expenditure was for salary payments (\$4,124 million).

Between 2005–06 and 2009–10, recurrent expenditure by private hospitals increased by an average of 2.4% per year (after adjusting for inflation).

How are our hospital services funded?

Public and private hospitals are funded from a range of different sources, reflecting the types of patients they treat and the services they provide. Governments mainly fund emergency department and outpatient services, whereas admitted patient services are commonly funded by private (non-government) sources, as well as government sources.

The sources of funds reported here are the original sources rather than immediate sources. Hence, the Australian Government is regarded as the source of funds for the contributions that it made for public hospitals via the Australian Health Care Agreements, even though the funds were provided to state and territory governments for their spending on public hospitals. The Australian Government is also regarded as the source of funds for

the contributions it made to private hospitals via the private health insurance premium rebates, even though the funds were provided through health insurance funds or their members.

In general terms, the state and territory governments and the Australian Government provide most of the funds for public hospitals (Figure 9) (AIHW 2010). The proportion of funding that was from the Australian Government declined between 2004–05 and 2006–07, then increased in 2007–08 (Figure 11). Private health insurance and out-of-pocket payments by patients mainly fund private hospitals (Figure 10).

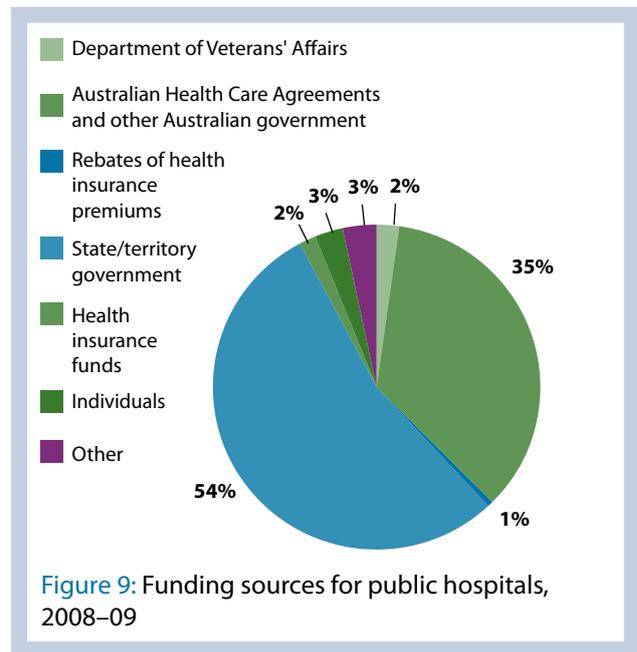


Figure 9: Funding sources for public hospitals, 2008–09

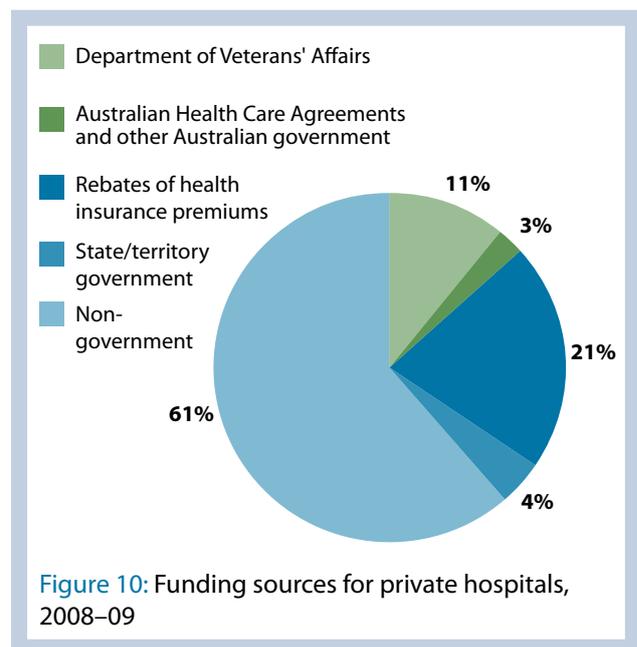


Figure 10: Funding sources for private hospitals, 2008–09

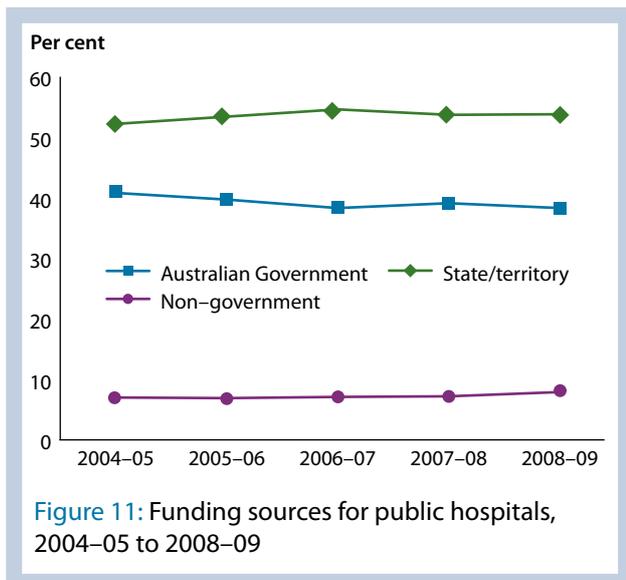


Figure 11: Funding sources for public hospitals, 2004-05 to 2008-09

What services do Australia's hospitals provide?

Australia's hospitals provide a range of services for both non-admitted and admitted patients. Services for non-admitted patients include emergency department services and outpatient clinics. For admitted patients, they include emergency and planned (elective) care, maternity services, medical and surgical services, either provided on a same-day basis, or involving a stay in hospital overnight or longer.

Variation in data on hospital services

Although there are national standards for data on hospital services, there are some variations in how hospital services are defined and counted, between public and private hospitals, among the states and territories, and over time.

For example, there is variation in admission practices for some services, such as chemotherapy and endoscopy. As a result, people receiving the same type of service may be counted as same-day admitted patients in some hospitals, and as non-admitted patients in other hospitals.

In addition, hospitals provide some services in some jurisdictions, and non-hospital health services provide them in other jurisdictions. The national data on hospital care does not include care provided by non-hospital providers, such as community health centres.

Emergency department services

Emergency departments provide care for patients who may have an urgent need for medical, surgical or other care. Emergency departments may also provide services for patients returning for further care, or for patients waiting to be admitted to a ward. About one in four presentations to emergency departments ends with the patient being admitted to hospital.

Public hospitals provide most emergency department services. Private hospitals provided about 501,000 emergency department services in 2008-09 (ABS 2010), about 6% of the total for that year.

Public hospitals

There were about 7.4 million accident and emergency visits to public hospitals in 2009-10. Between 2005-06 and 2009-10, they increased by an average of 4.0% per year (Figure 12).

These visits include both those to formal emergency departments in larger hospitals and those to smaller hospitals (commonly in more remote areas) with other arrangements for providing accident and emergency services.

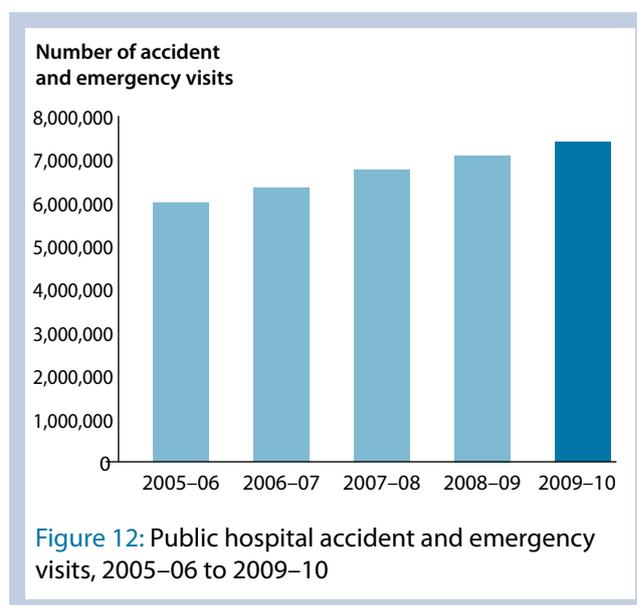


Figure 12: Public hospital accident and emergency visits, 2005-06 to 2009-10

Hospital performance: emergency department waiting times

Each patient who presents to an emergency department is assessed according to how urgently they should receive care, using a triage category system. The most urgent cases are assigned to the *Resuscitation* triage category (should be treated immediately), and the least urgent are assigned as *Non-urgent* (should be seen within 2 hours).

Data on triage category and waiting times were available for 5.9 million emergency department presentations in major public hospitals (about 81% of all accident and emergency visits to public hospitals). A total of 5.1 million of those (87%) were in Principal referral and Specialist women's and children's hospitals and Large hospitals.

In 2009–10:

- 70% of patients were seen within the recommended time for their triage category, ranging from 65% for *Urgent* patients, to 100% for *Resuscitation* patients (Figure 13)
- 50% of patients received care in 23 minutes or less and 90% received care in 115 minutes or less.

The proportion of patients seen within the recommended time for their triage category remained relatively stable between 2005–06 and 2009–10, despite increasing numbers of emergency department presentations. *Resuscitation* patients were seen on time for either 99% or 100% of presentations each year, and *Emergency* patients were seen on time for between 76% and 78% of presentations.

There was some variation in the proportion seen on time between jurisdiction, ranging from 56% overall in the Northern Territory to 75% overall in New South Wales (Table 3). More information on the proportion seen on time by triage category for each state and territory can be found in figures 13a–13h, accompanying this report online.

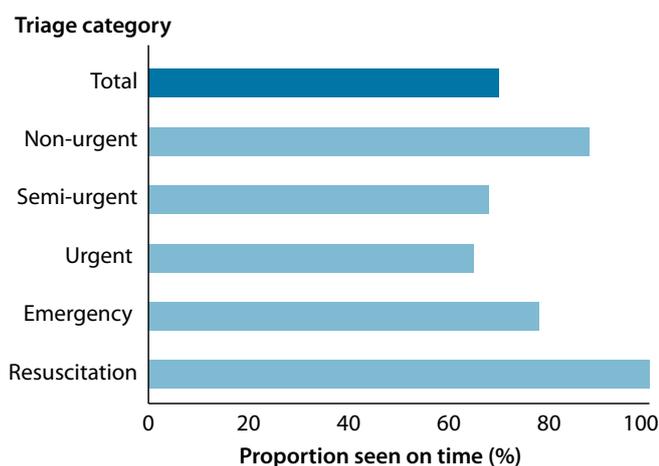


Figure 13: Proportion of public hospital emergency department presentations seen on time, 2009–10

Table 3: Proportion (%) of emergency department presentations seen on time by triage category, major public hospitals, states and territories, 2009–10

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
	('000)								
Total emergency visits	1,989	1,393	1,106	593	369	140	106	127	5,822
Triage category	Per cent								
Resuscitation	100	100	99	99	100	99	100	100	100
Emergency	82	80	77	71	78	71	83	63	78
Urgent	70	71	60	55	63	52	60	49	65
Semi-urgent	73	67	66	64	63	63	56	51	68
Non-urgent	89	85	89	92	85	88	77	91	88
Total	75	72	66	64	67	63	63	56	70

Outpatient care

Outpatient care is provided in outpatient clinics, particularly by public hospitals, but also by private hospitals. Both types of hospitals also provide other non-admitted patient services (other than emergency department services) and various outreach services, such as district nursing.

Public hospitals

Outpatient clinic care includes consultations with specialists to determine the most appropriate treatment for a patient's condition. This can result, for example, in the patient being placed on a waiting list for surgery.

Other care provided to non-admitted patients includes the dispensing of medication, and diagnostic procedures, including pathology, X-rays and ultrasounds—often provided in association with admitted patient care or outpatient clinic services. District and community nursing services are also delivered from hospitals for non-admitted patients.

In 2009–10, public hospitals provided over 42 million service episodes for non-admitted patients:

- specialist outpatient clinics delivered 16.8 million services, with the chief contributors being medical/surgical/obstetric and allied health. Most (12.8 million or 76%) were in Principal referral and Specialist women's and children's hospitals and Large hospitals.
- mental health and alcohol and drug services delivered 3.2 million service episodes.
- pharmacy, pathology, radiology and organ imaging made up a further 16.8 million services
- district nursing, outreach and community health services accounted for 5.3 million service episodes
- 328,000 service episodes were for group sessions (provided to more than one patient at a time), with mental health, alcohol and drug and community health accounting for 40% of the sessions.

Between 2005–06 and 2009–10, outpatient care delivered in specialist outpatient clinics increased by an average of 3.0% per year; pharmacy, pathology and radiology and organ imaging services increased by 3.8% per year; mental health and alcohol and drug services increased by 0.8% per year; and district nursing, outreach and community health services decreased by about 2.9% per year (Figure 14).

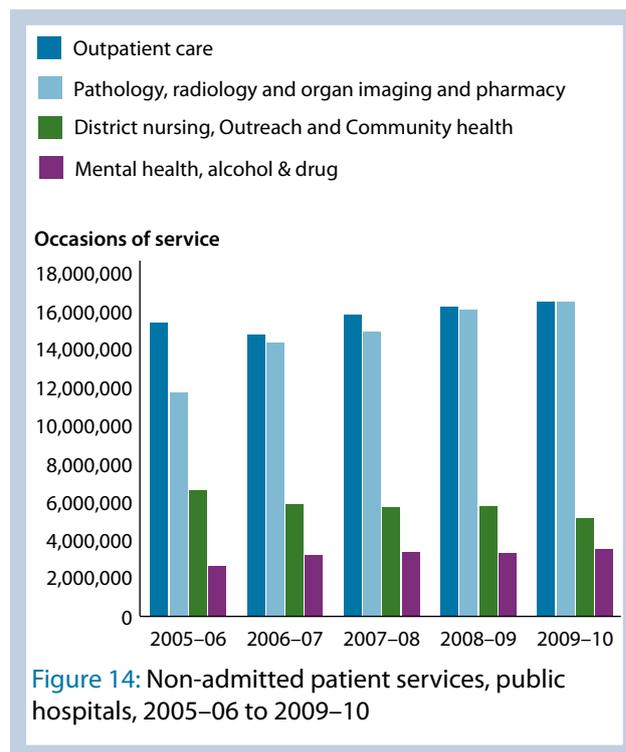


Figure 14: Non-admitted patient services, public hospitals, 2005–06 to 2009–10

Private hospitals

In 2008–09, private hospitals provided about 1.5 million non-admitted patient services (6.7% of the total for public and private hospitals), with about 1.1 million of these for outpatient services including dialysis, radiology and organ imaging, endoscopy, psychiatric, alcohol and drug, other medical/surgical/diagnostic, dental, pharmacy and allied health services (ABS 2010). They also provided about 206,000 other services for non-admitted patients (0.5% of the total for public and private hospitals): community health, district nursing and non-medical and social services.

Admitted patient care: overview

Admission to hospital is a formal process, and follows a medical officer making a decision that a patient needs to be admitted for appropriate management or treatment of their condition, or for appropriate care or assessment of their needs.

Separations (episodes of admitted patient care) and patient days (a count of the days spent in hospital as an admitted patient) are useful measures of admitted patient services.

In 2009–10:

- about 8.5 million separations took place in Australian hospitals
- public hospitals (5.1 million separations) accounted for 60% of separations, with half of these being same-day separations
- the proportion of the total that was in public hospitals ranged from 52% in Queensland to 62% in New South Wales and Victoria
- private hospitals (3.5 million) accounted for 40% of separations, with two-thirds of these being same-day separations (Figure 15)
- and most patient days occurred in public hospitals, ranging from 60% in Queensland to 73% in New South Wales (Table 5).

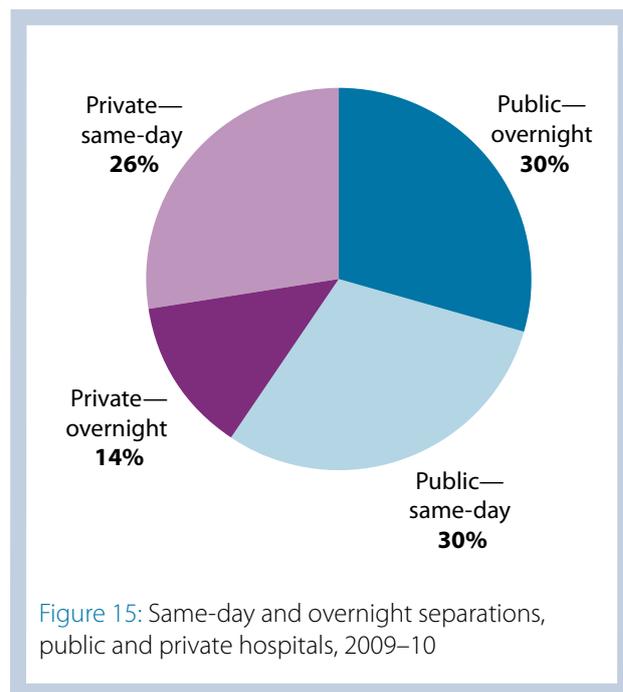


Table 4: Separations ('000s), public and private hospitals, states and territories, 2009–10

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Public acute	1,541	1,424	923	504	381	101	88	100	5,062
Public psychiatric	6	1	<1	2	2	1	11
Total public hospitals	1,547	1,425	923	506	383	102	88	100	5,073
Private hospitals									
Private free-standing day hospital facilities	213	188	213	104	57	n.p.	n.p.	n.p.	783
Other private hospitals	748	697	632	278	213	n.p.	n.p.	n.p.	2,678
Total private hospitals	961	886	845	381	270	n.p.	n.p.	n.p.	3,462
All hospitals	2,508	2,310	1,768	887	653	n.p.	n.p.	n.p.	8,535

n.p. not published
 .. not applicable

Table 5: Patient days ('000s), public and private hospitals, states and territories, 2009–10

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public hospitals									
Public acute	5,816	4,547	3,030	1,647	1,495	372	296	273	17,476
Public psychiatric	281	59	98	76	97	52	663
Total public hospitals	6,097	4,607	3,128	1,722	1,591	424	296	273	18,139
Private hospitals									
Private free-standing day hospital facilities	213	188	213	104	57	n.p.	n.p.	n.p.	783
Other private hospitals	2,012	2,047	1,850	726	560	n.p.	n.p.	n.p.	7,479
Total private hospitals	2,225	2,235	2,063	829	617	n.p.	n.p.	n.p.	8,262
All hospitals	8,323	6,842	5,191	2,552	2,209	n.p.	n.p.	n.p.	26,401

n.p. not published
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How has this activity changed over time?

Between 2005–06 and 2009–10 separations increased by 16.7% (13.6% in public acute hospitals and 21.6% in private hospitals) (Figure 16).

The number of patient days in public acute hospitals increased by 6.7%. For private hospitals, patient days increased by 12.6%.

The numbers of patient days per 1,000 population were relatively stable for both public and private hospitals between 2005–06 and 2009–10.

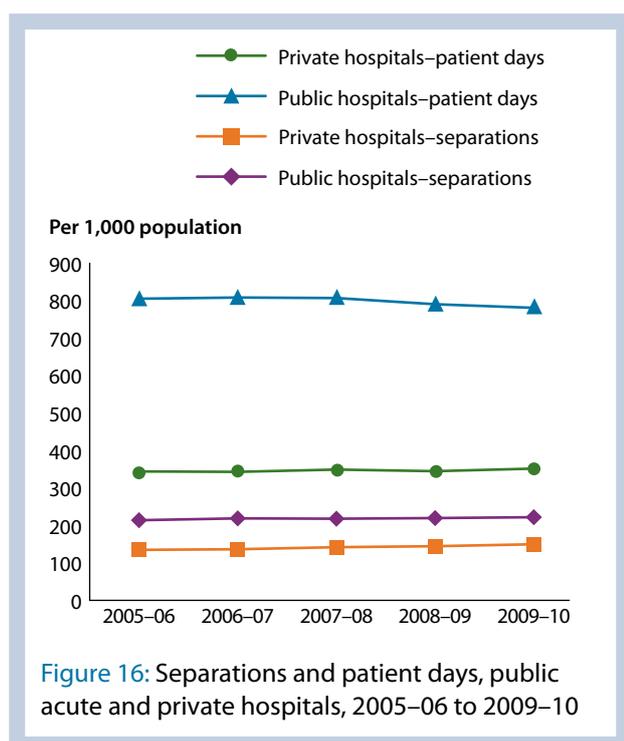


Figure 16: Separations and patient days, public acute and private hospitals, 2005–06 to 2009–10

Who used these services?

In 2009–10, there were over 4.5 million separations for women and girls compared with 4.1 million separations for men and boys (52.6% and 47.4% of separations respectively) (Figure 17).

Separations increased for both males and females between 2005–06 and 2009–10. These increases were very marked for both males and females aged 55 and over (Figure 18).

Most notably, separations increased by 49% for males and by 33% for females aged 85 years and over.

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are hospitalised more often than other Australians (after accounting for age). Information on the number of hospitalisations for Indigenous people is limited by the accuracy with which Indigenous patients are identified in hospital records and the rates may be underestimates. The numbers here are not adjusted for underidentification.

In 2009–10:

- Indigenous Australians had a separation rate almost two and a half times the separation rate for other Australians (898 per 1,000 population compared with 370 per 1,000 population).
- Indigenous Australians had more separations per 1,000 population than other Australians across all age groups (Figure 19).

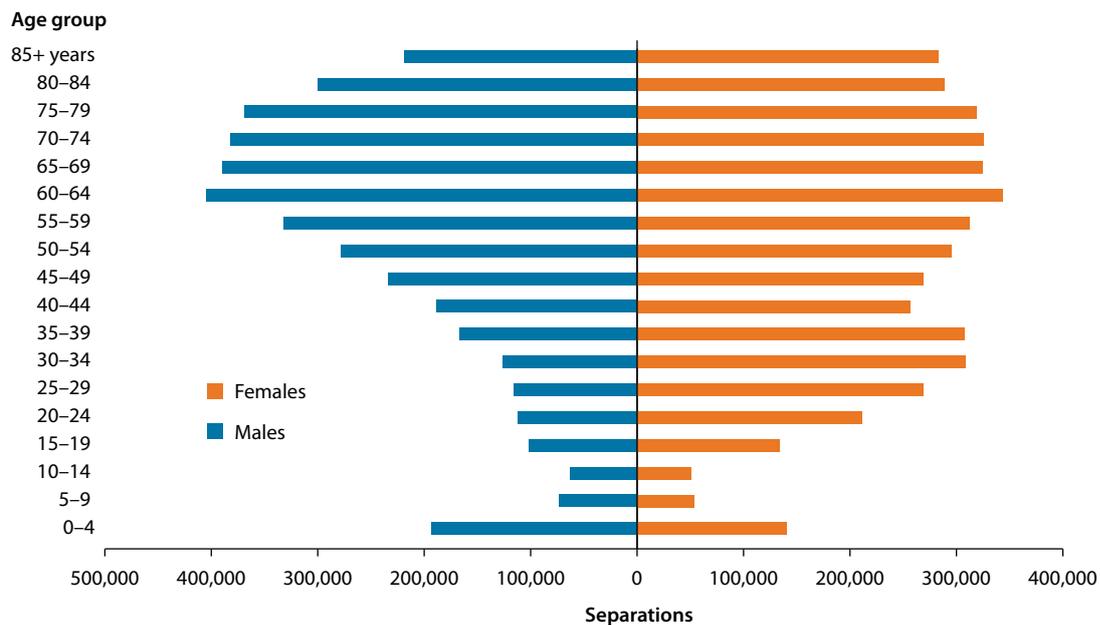


Figure 17: Separations, by age group and sex, 2009-10

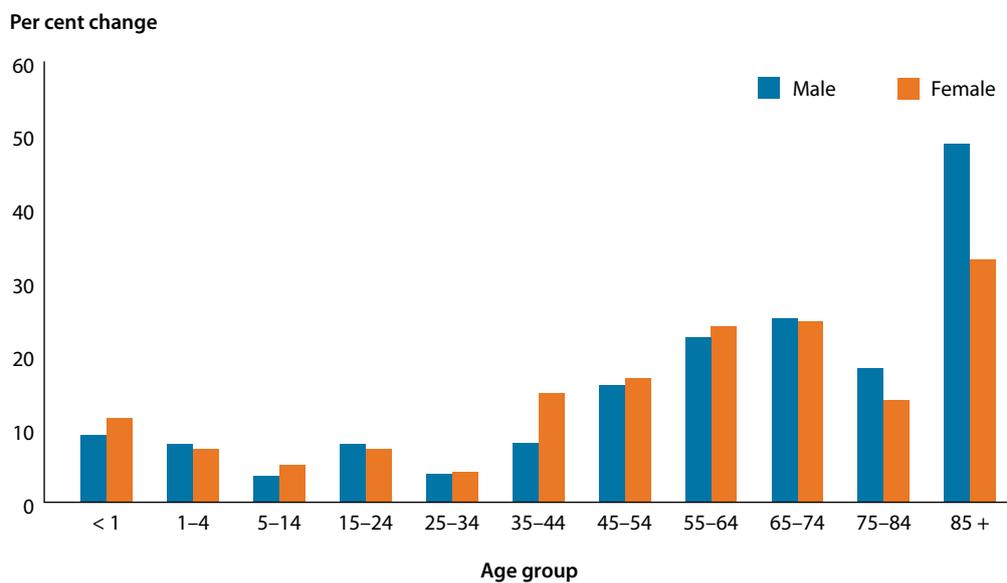


Figure 18: Change in the number of separations, by age group and sex, Australia, 2005-06 to 2009-10

However, if hospitalisations for dialysis for kidney disease are not counted, Indigenous Australians were hospitalised about 30% more often (433 per 1,000 population compared with 328 per 1,000). This illustrates the impact of kidney disease on the health of Indigenous Australians, and their subsequent hospital usage for dialysis.

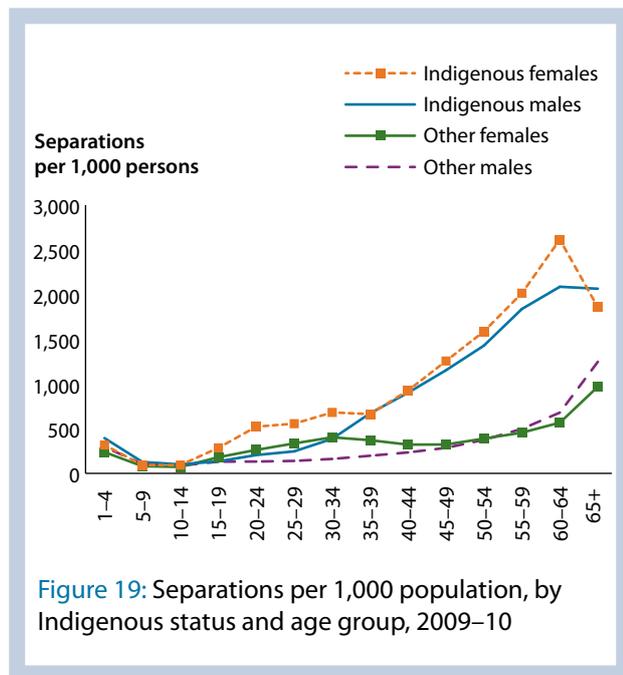


Figure 19: Separations per 1,000 population, by Indigenous status and age group, 2009–10

Remoteness

Locations in Australia can be divided into remoteness area categories, depending on distances from population centres.

The number of separations per 1,000 population varied by remoteness area. Overall, separation rates were highest for persons living in *Very remote* areas (Figure 20).

For public hospitals, the number of separations per 1,000 population was highest for patients living in *Very remote* areas and lowest for patients living in *Major cities* (482 and 206 separations per 1,000 population, respectively).

For private hospitals, the separation rate was highest for patients living in *Major cities* and lowest for patients living in *Very remote* areas (169 and 58 separations per 1,000 population respectively).

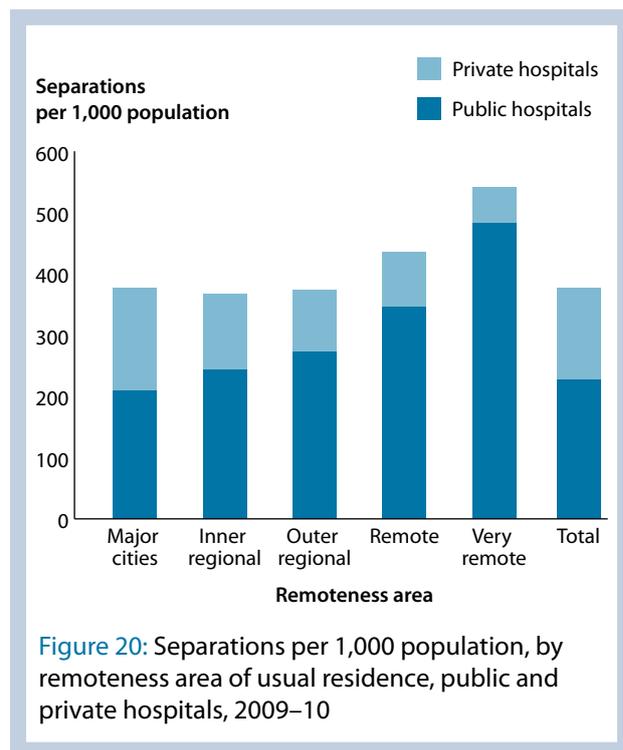


Figure 20: Separations per 1,000 population, by remoteness area of usual residence, public and private hospitals, 2009–10

Socioeconomic status

Data describing where patients live can be used to derive an approximation of their socioeconomic status (SES), which in turn can be categorised into five equal population groups of socioeconomic disadvantage/ advantage. If use of admitted patient services is equal for all SES groups, we would expect an equal number of separations for each group.

The number of separations per 1,000 persons varied by SES group. Overall, separation rates were highest in the lowest SES group (Figure 21), but there was little variation across the other 4 SES groups.

For public hospitals, the separations rate was highest for patients living in areas classified as being the lowest SES group and lowest for patients living in areas classified as being the highest SES group (291 and 146 separations per 1,000 population, respectively).

For private hospitals, the separations rate was highest for patients living in areas classified as being the highest SES group and lowest for patients living in areas classified as being the lowest SES group (221 and 102 separations per 1,000 population, respectively).

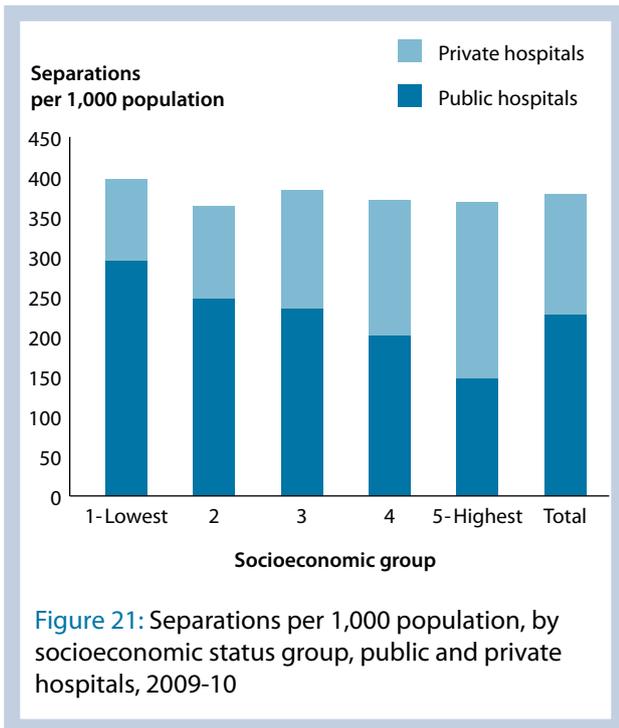


Figure 21: Separations per 1,000 population, by socioeconomic status group, public and private hospitals, 2009-10

Why did people receive this care?

The reason that a patient receives admitted patient care can be described in terms of a principal diagnosis. For injury and poisoning, it can also be described in terms of the cause of the injury, for example, a traffic accident

or fall. For other types of care, it can be described in terms of a treatment for an ongoing condition (for example, dialysis for kidney failure).

In 2009–10, many separations had a principal diagnosis reported that was a disease of the digestive system (10.2%), a cancer (6.8%), an injury or poisoning (6.8%), a disease of the circulatory system (5.7%), a condition associated with pregnancy and childbirth (5.6%), a disease of the respiratory system (4.4%), or a mental disorder (4.0%).

Some high-volume diagnoses have experienced relatively large changes in volume between 2005–06 and 2009–10 in either public or private hospitals or both (Figure 22). For example, separations for care involving dialysis increased by 26% in public hospitals (to 931,000) and 31% in private hospitals (to 200,000). Separations for angina pectoris decreased by 16% in public hospitals (to 46,000) and by 14% in private hospitals (to 19,000).

In 2009–10, injury and poisoning was the principal diagnosis for over 557,000 separations in Australian hospitals. External causes of injury and poisoning commonly reported included falls (178,000), complications of medical and surgical care (115,000), transport accidents (59,000), intentional self-harm (28,000) and accidental poisoning (10,000) (Figure 23).

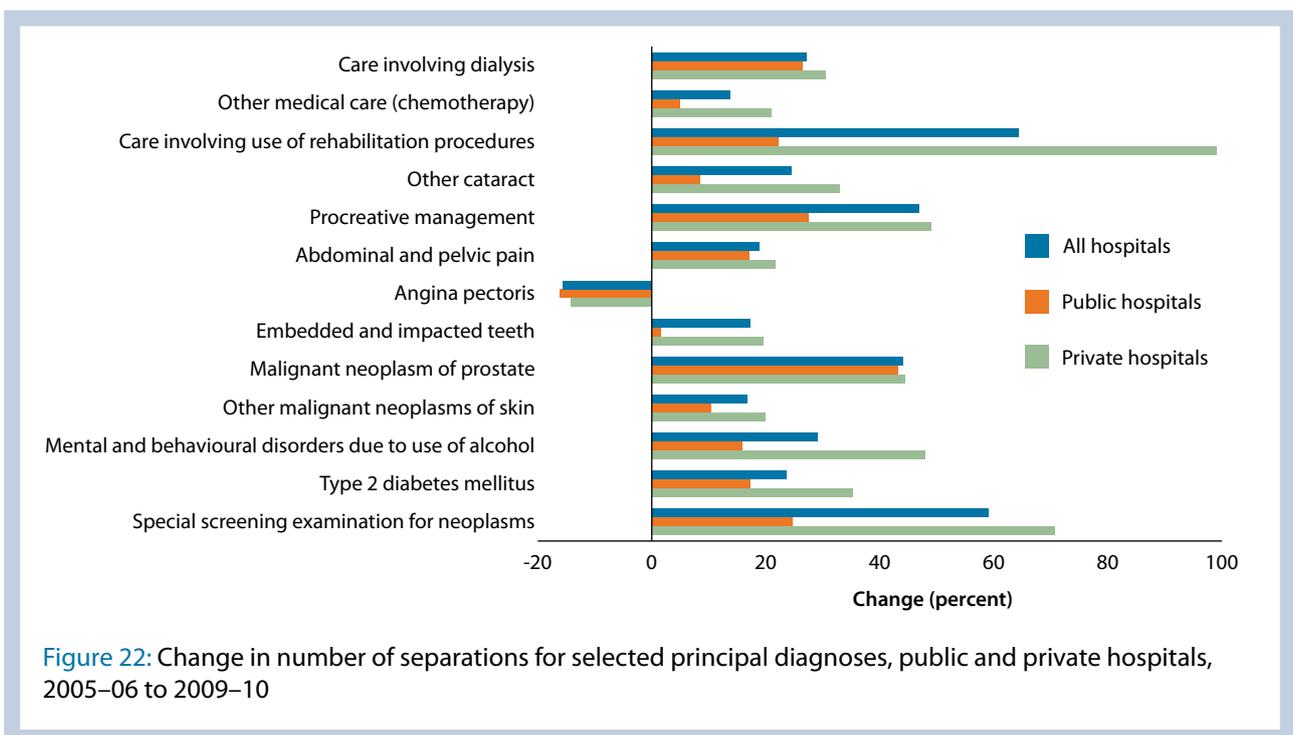


Figure 22: Change in number of separations for selected principal diagnoses, public and private hospitals, 2005–06 to 2009–10

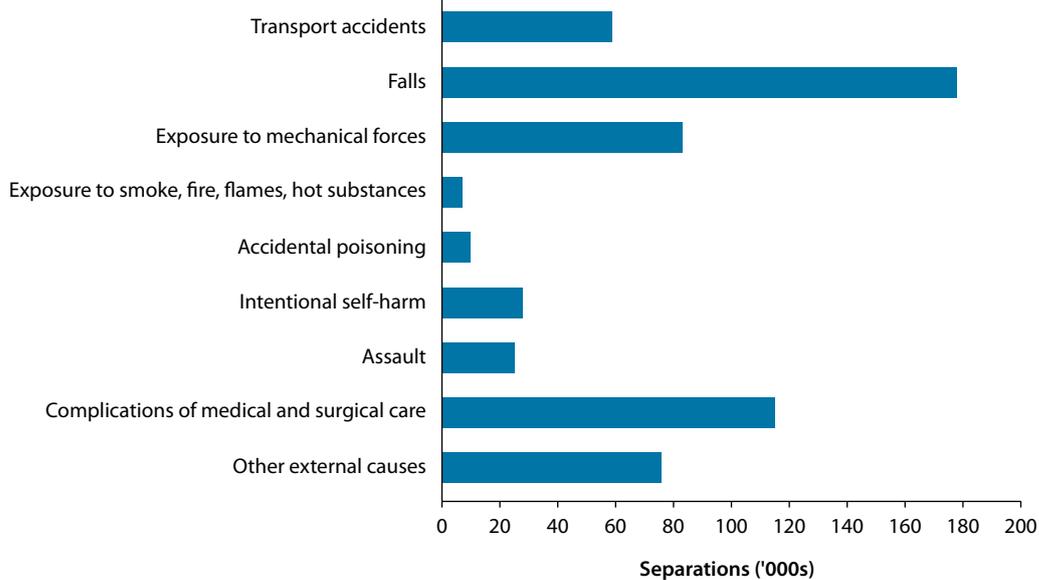


Figure 23: Injury and poisoning separations, by cause, 2009–10

Potentially preventable hospitalisations

The selected potentially preventable hospitalisations (PPHs) presented here are thought to have been avoidable if timely and adequate non-hospital care had been provided, either to prevent the condition occurring, or to prevent the hospitalisation for the condition. They are identified based on the diagnoses reported for admitted patients, and divided into three categories—vaccine preventable, acute and chronic conditions.

The 696,000 PPHs represented 8.1% of all hospital separations in 2009–10.

Overall, the number of PPHs per 1,000 population decreased by an average of 1.6% per year between 2005–06 and 2009–10, and decreased by 1.7% between 2008–09 and 2009–10. However, this latest decrease is likely to reflect a change in how diabetes-related conditions were reported.

For chronic conditions, without diabetes, PPHs rose with increasing remoteness. There were 8.8 PPHs for chronic conditions per 1,000 population in *Major cities*, and 19.0 per 1,000 in *Very remote* areas (Figure 24).

For acute conditions, the pattern was the same, ranging from 12.9 per 1,000 in *Major cities* to 29.2 per 1,000 in *Very remote* areas.

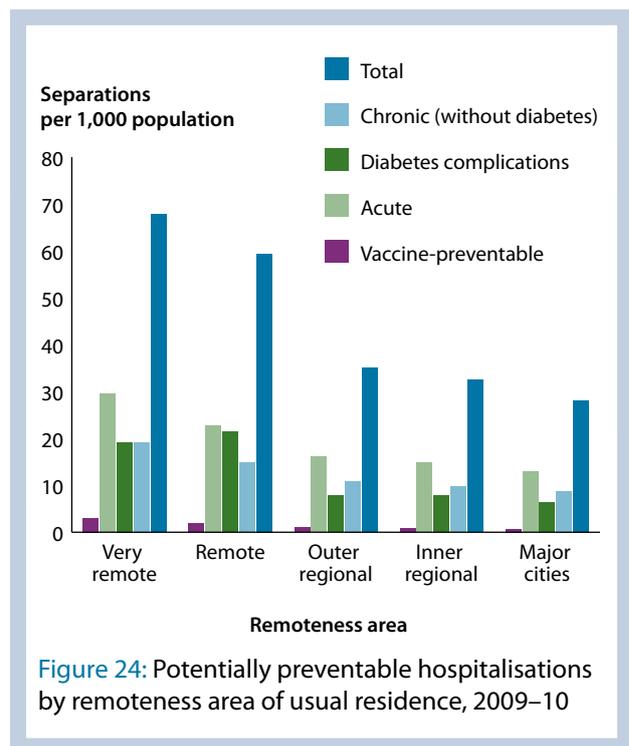


Figure 24: Potentially preventable hospitalisations by remoteness area of usual residence, 2009–10

The number of PPHs per 1,000 population varied with socioeconomic status (based on where patients live). For all three categories—vaccine-preventable, acute and chronic—the rates were highest for those classified as being in the lowest SES group and lowest for those classified as being in the highest SES group (1.1 and 0.6 per 1,000, 16.0 and 11.7 per 1,000, and 20.8 and 10.7 per 1,000, respectively).

How urgent was the care?

Admissions can be categorised as Emergency (required within 24 hours), or Elective (required at some stage beyond 24 hours). Emergency/elective status is not assigned for some admissions (for example, obstetric care and planned care, such as dialysis).

For public hospitals, 2 out of 5 separations were Emergency admissions. For private hospitals, about 1 in 20 separations were Emergency admissions.

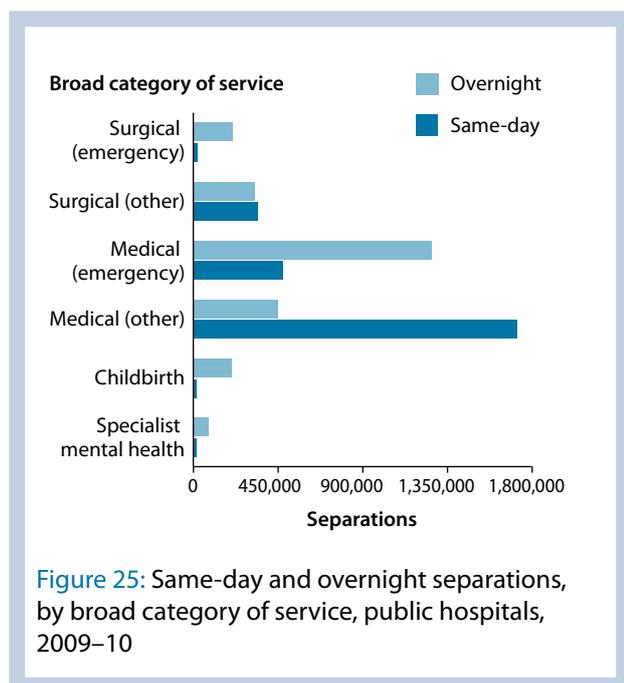
What care was provided?

The care that is provided can be described in terms of the:

- broad category of service—Childbirth, Specialist mental health, Medical (not involving a procedure), Surgical (involving an operating room procedure), or Other (involving a non-operating room procedure, such as endoscopy)
- intent of care—acute, sub-acute (such as rehabilitation or palliative), or non-acute (such as maintenance care)
- type of surgical or other procedure undertaken.

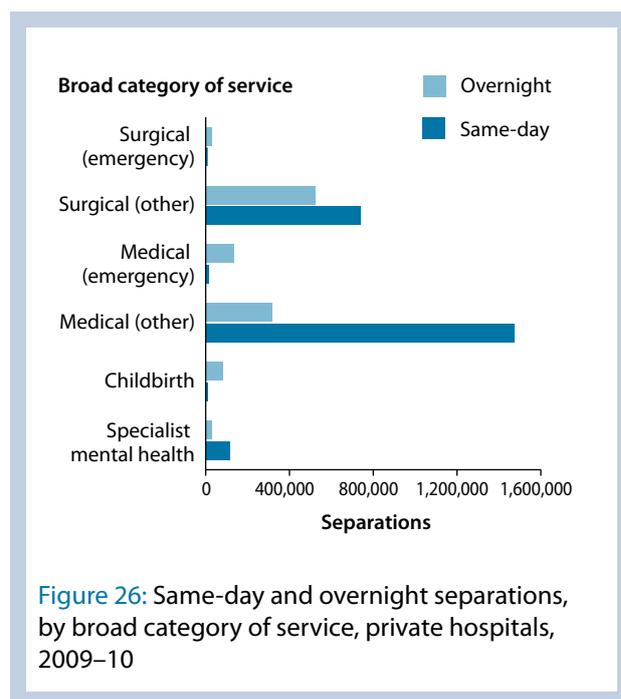
Broad category of service

In public hospitals, most separations were for Medical care—76% in 2009–10 and 4% were for Childbirth (Figure 25). About 21% of overnight separations were for surgical care, as were 14% of same-day separations.



More information on broad categories of service for public hospitals for each state and territory is presented in figures 25a–25h, accompanying this report online.

Private hospitals provided a higher proportion of separations for Surgical care compared with public hospitals—41% in 2009–10. Specialist mental healthcare was provided for 4% of private hospital separations (Figure 26).



Intent of care

Most hospital separations are for acute care, that is, care with the intent to cure the condition, alleviate symptoms or manage childbirth. Acute care was reported in 2009–10 for 95% of separations and 80% of patient days for public hospitals and for 94% of separations and 86% of patient days for private hospitals.

Rehabilitation, or improved functioning, was the next most commonly reported intent of care. It was reported for 2009–10 for 1.6% of separations and 8.3% of patient days for public hospitals and for 4.9% of separations and 10.6% of patient days for private hospitals.

More information about non-acute care is on page 33.

Procedures

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

In 2009–10, one or more procedures were reported for 83% of separations in Australian hospitals.

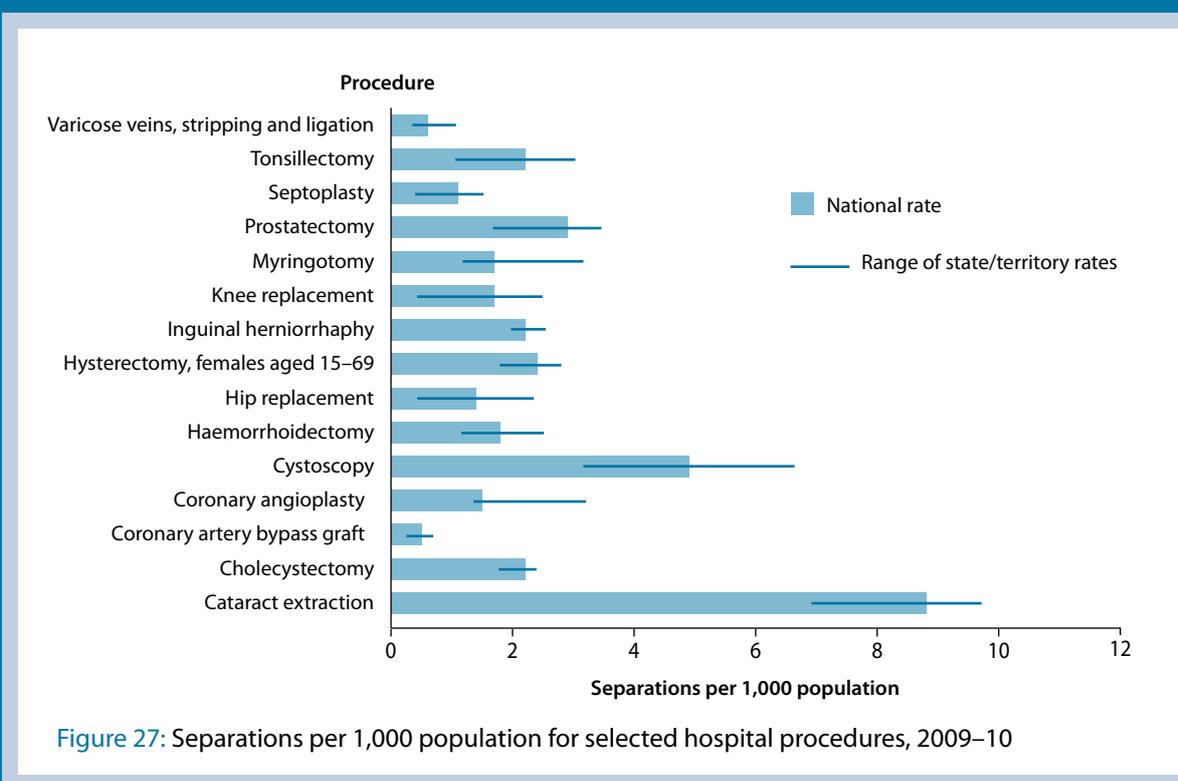
Over 94% of separations from private hospitals recorded a procedure, compared with 77% from public hospitals. Overall, 55% of separations that reported a procedure occurred in the public sector.

In 2009–10, many separations had a procedure reported that was on the urinary system (16.3%), the digestive system (13.4%), the musculoskeletal system (6.6%) or the cardiovascular system (3.8%). Also commonly reported were separations with imaging services (8.0%) and separations with non-invasive, cognitive and other interventions, including allied health and general anaesthesia (61.2%).

Hospital performance: rates of service—hospital procedures

The rates for these hospital procedures are presented as an indicator of appropriateness and may also be indicators of accessibility of care.

Figure 27 presents separations per 1,000 population for selected hospital procedures. The national rate is accompanied by the range of rates for these procedures by state or territory. There was some variation among states and territories for the selected procedures. For example, the national rate for cataract extraction was 8.8 per 1,000 population, but the state/territory rate ranged from 6.9 per 1,000 to 9.8 per 1,000 population.



What was the safety and quality of the care?

Some information is available on the safety and quality of admitted patient care in hospitals, but the available information does not provide a complete picture.

There is no routinely available information on some aspects of quality, such as continuity or responsiveness of hospital services.

Hospital performance: **re-admissions following surgery**

The proportion of separations for selected types of surgery that result in readmission to hospital within 28 days is regarded as an indicator of the safety and quality of admitted patient care in hospitals. Data for this indicator are only available for public hospitals, and only for readmissions to the hospital in which the surgery was performed. Readmissions to other hospitals are not included, so the readmission rates are likely to be underestimated.

In 2009–10, hysterectomy was followed by readmissions on about 3% of occasions, followed by tonsillectomy and/or adenoidectomy, and prostatectomy. Readmissions following cataract surgery were relatively much rarer (Figure 28).

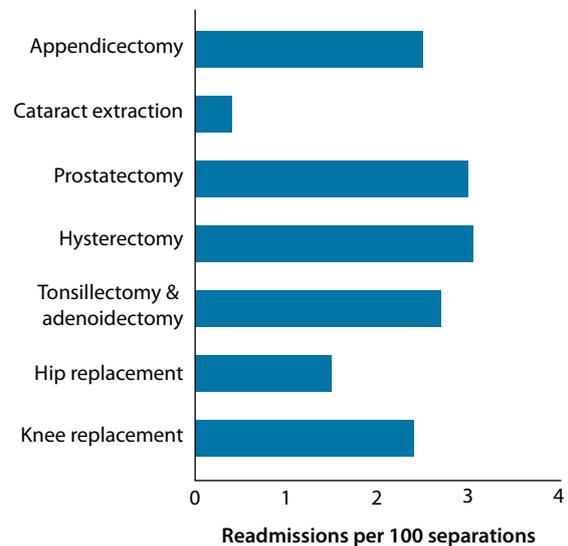


Figure 28: Readmissions within 28 days to the same public hospital following selected types of surgery, 2009–10

Hospital performance: falls resulting in patient harm in hospitals

Falls resulting in patient harm in hospital are regarded as adverse events, some of which may be preventable. They can be used as one indicator of safety for hospitals.

In 2009–10, there were about 20,000 separations for which a fall was recorded as occurring in a health service area (Figure 29), an overall rate of about 2.4 per 1,000 separations. The rate was higher in public hospitals than in private hospitals (3.1 and 1.3 per 1,000, respectively). This may reflect differences between public and private hospitals, in what they do and who they treat.

These rates may underestimate falls occurring in hospitals, as the place of occurrence was not reported for about 24% of separations with a fall recorded. However, it is also possible that these rates overestimate falls as it is not possible to distinguish between falls in hospitals and falls in other health service areas (such as general practitioner clinics).

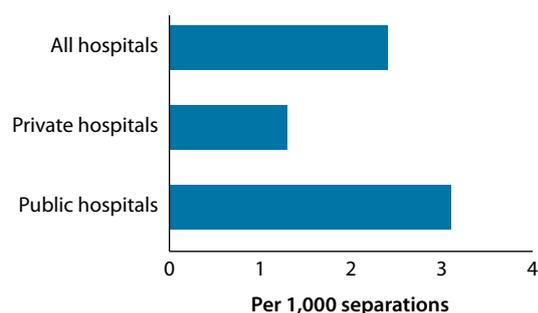


Figure 29: Falls resulting in patient harm in hospitals, per 1,000 separations, public and private hospitals, 2009–10

Hospital performance: intentional self-harm in hospitals

Intentional self-harm in hospital is regarded as an adverse event which may be preventable. Rates of intentional self-harm in hospital can be used as an indicator of safety for hospitals.

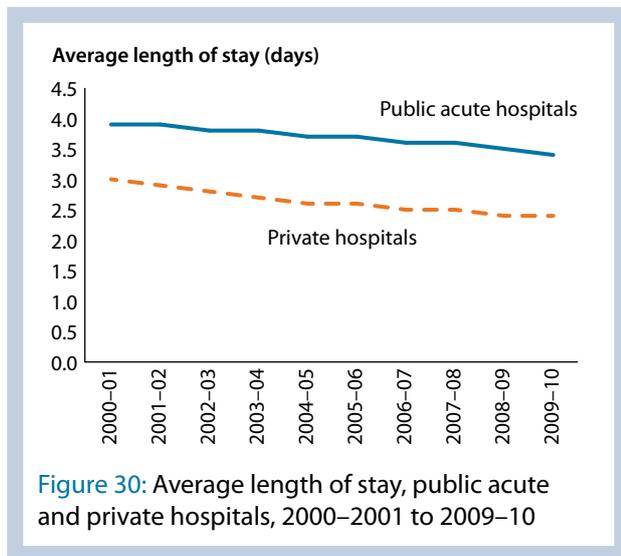
In 2009–10, there were about 1,300 separations for which intentional self-harm was recorded as occurring in a health service area, an overall rate of about 2 per 10,000 separations.

This rate may underestimate intentional self-harm occurring in hospitals, as the place of occurrence was not reported for about 35% of separations with intentional self-harm recorded. However, it is also possible that this may be an overestimate, as it is not always possible to identify that intentional self-harm took place in a hospital, as distinct from another health service area.

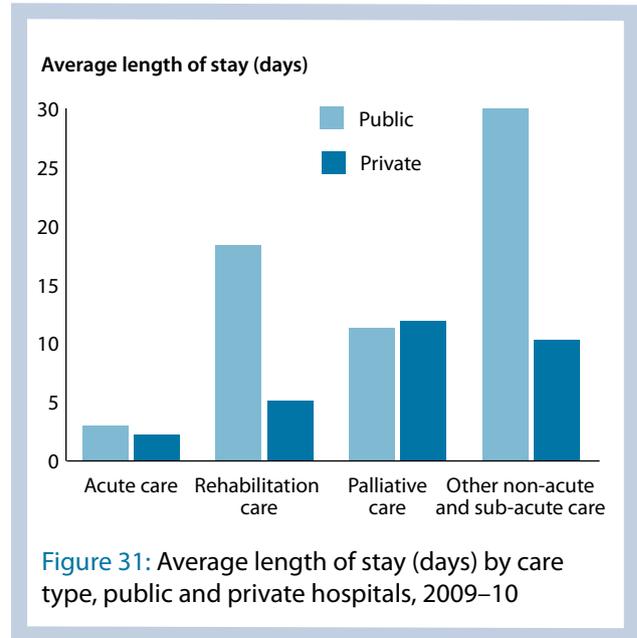
How long did patients stay?

Information on the average length of stay summarises how long admitted patients stay in hospital.

Including both same-day care (which is counted as one day's stay, even if it is only for a few hours) and overnight care (care that is for at least one night), the average length of stay was 3.1 days in 2009–10, 2.4 days in private hospitals and 3.4 days in public acute hospitals. These averages have decreased over time (Figure 30), largely reflecting the fact that the proportion of separations that are day-only have increased.



For overnight care, the average length of stay varied according to the intent of the care. For example, the average length of stay for Acute care was 3.1 days in public hospitals and 2.2 days in private hospitals (Figure 31). For Rehabilitation care, the average length of stay was 18.4 days in public hospitals and 5.2 days in private hospitals.

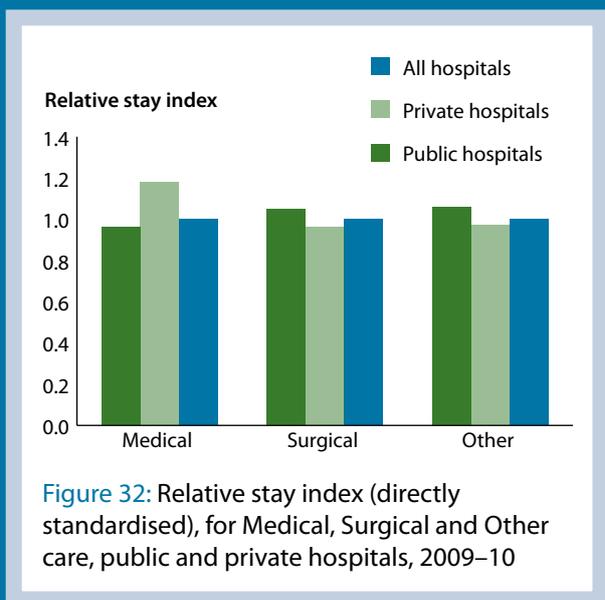


Hospital performance: relative stay index

Relative stay indexes (RSIs) summarise the length of stay for admitted patients, with adjustments for casemix (the types of patients treated and the types of treatments provided). They are regarded as indicators of the efficiency of hospitals.

An RSI greater than 1.0 indicates that an average patient's length of stay is higher than expected, given the casemix for the separations being considered. An RSI of less than 1.0 indicates that the length of stay was less than expected.

In 2009–10, there were relatively shorter lengths of stay for Medical separations (including Specialist mental health) in public hospitals (0.96, compared with 1.18 in private hospitals), and for Surgical separations in private hospitals (0.96, compared with 1.05 in public hospitals) (Figure 32). Overall, the relative length of stay was lower in public hospitals than in private hospitals. Childbirth is included in Other in this figure.



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

The average length of stay for 20 selected types of separations (defined using Australian Refined Diagnosis Related Groups, AR-DRGs) is regarded as an indicator of the efficiency of hospitals.

Figure 33 presents the average lengths of stay for these 20 selected AR-DRGs in public and private hospitals. There were notable differences (more than 1 day) in the average length of stay between public and private hospitals for seven of these AR-DRGs. The average length of stay for *Major affective disorders age 0<70 without catastrophic or severe complications or comorbidities* was 14.1 days for public hospitals and 18.6 days for private hospitals.

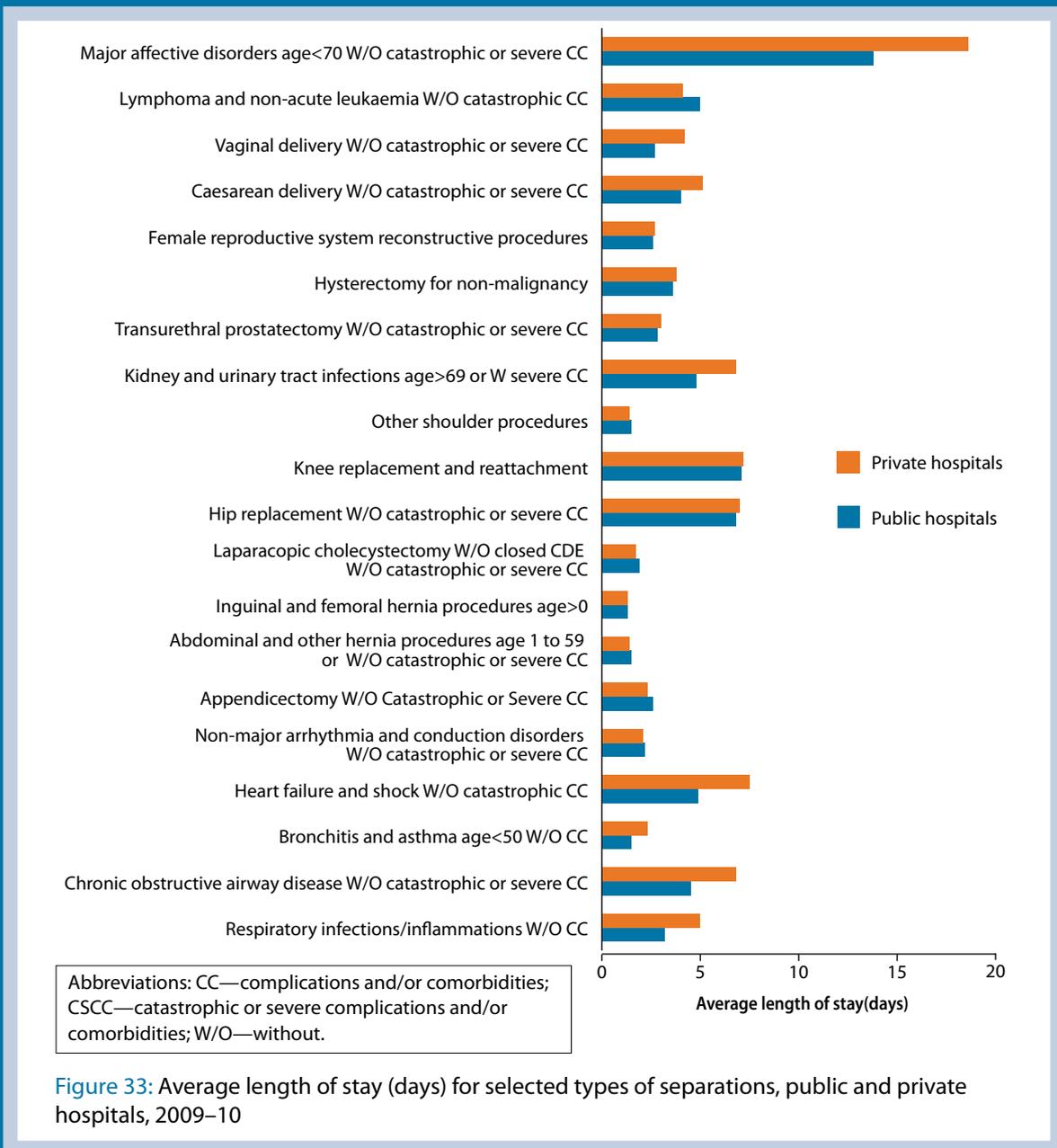


Figure 33: Average length of stay (days) for selected types of separations, public and private hospitals, 2009–10

How much did it cost?

We have information on average costs for public hospitals, but not for private hospitals. The cost of care (expenditure by the hospital) varies according to the length of stay, procedures undertaken and the care needs of the patient.

Hospital performance: cost per casemix-adjusted separation

The average cost per separation is a measure of efficiency of admitted patient services. Patients with more complex conditions are likely to cost more than patients with less complex conditions. In order to compare the average cost per admitted patient across hospitals, it is necessary to adjust for the average complexity of patients treated in each hospital. This is called 'casemix adjustment'.

The average cost per casemix-adjusted separation in public hospitals increased from \$3,698 in 2005–06 to \$4,706 in 2009–10 (not adjusted for inflation).

This represents a total increase of 27.0% in this period (Figure 35), an average increase of 6.2% annually.

In 2009–10 the average cost comprised:

- \$2,357 for non-medical labour expenditure
- \$1,041 for medical labour expenditure
- \$1,308 for other recurrent expenditure.

Other recurrent expenditure costs include domestic services; repairs and maintenance; administration; and medical, drug and food supplies. It does not include capital and other fixed costs.

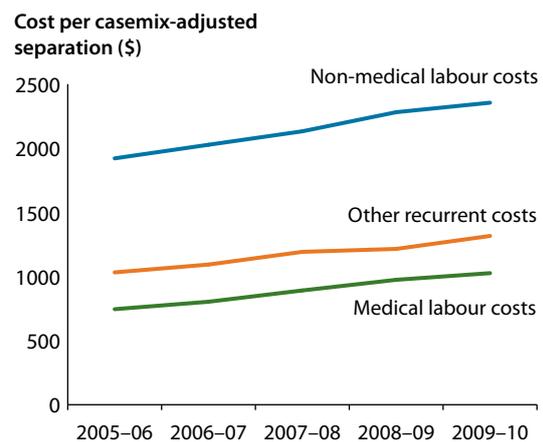


Figure 34: Cost per casemix-adjusted separation, public hospitals, 2005–06 to 2009–10

Who paid for the care?

Over half of all separations in 2009–10 were public patients (52%), who were not charged for their stay. Private health insurance accounted for a further 38%, and self-funded patients and Department of Veterans' Affairs patients accounted for about 4% each (Figure 35).

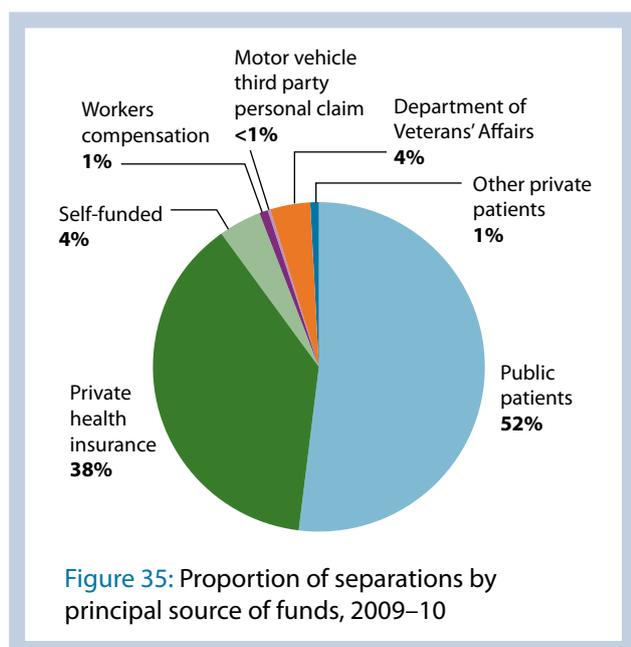


Figure 35: Proportion of separations by principal source of funds, 2009–10

Between 2005–06 and 2009–10, there was an overall increase in separations of 3.9% per year. Separations funded by private health insurance increased by more than the overall increase (6.4% per year) (Figure 36).

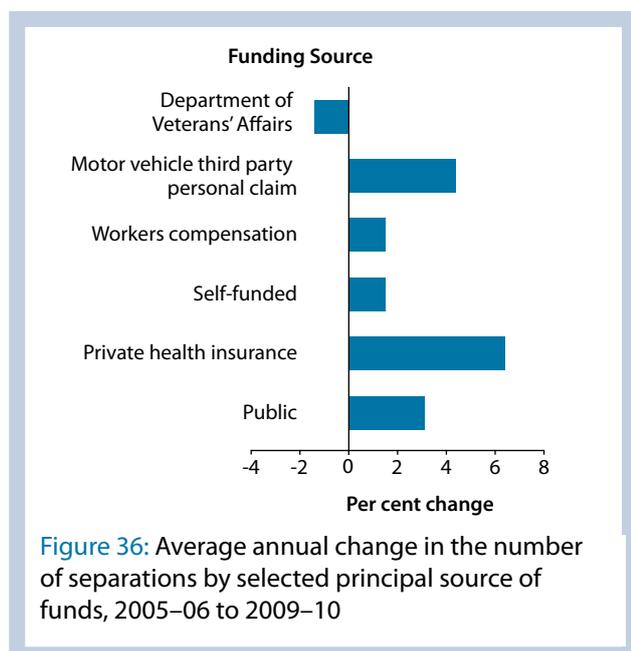


Figure 36: Average annual change in the number of separations by selected principal source of funds, 2005–06 to 2009–10

Admitted patient care: same-day acute care

Same-day admitted patient care occurs when the patient is admitted and separated on the same day. This section reports on same-day acute care (referred to as same-day care), where the care was not for rehabilitation or other non-acute care (which together made up 3.1% of same-day care).

In 2009–10, 4.8 million, or 55.6% of separations, were same-day acute care separations. This included 2.5 million or 49.9% of separations from public hospitals and 2.2 million or 64.0% of separations from private hospitals.

Between 2005–06 and 2009–10, the proportion of same-day separations increased from 54.2% to 55.6%. On average, the number of same-day separations increased by 3.8% per year for public hospitals, and 5.8% per year for private hospitals.

Who used these services?

Aboriginal and Torres Strait Islander people were hospitalised on a same-day basis at about three times the rate of other Australians. Almost one in four same-day separations were for care involving dialysis (over 1.0 million). After excluding dialysis, the rate of same-day separations for Indigenous Australians was lower than the rate for other Australians (Figure 37).

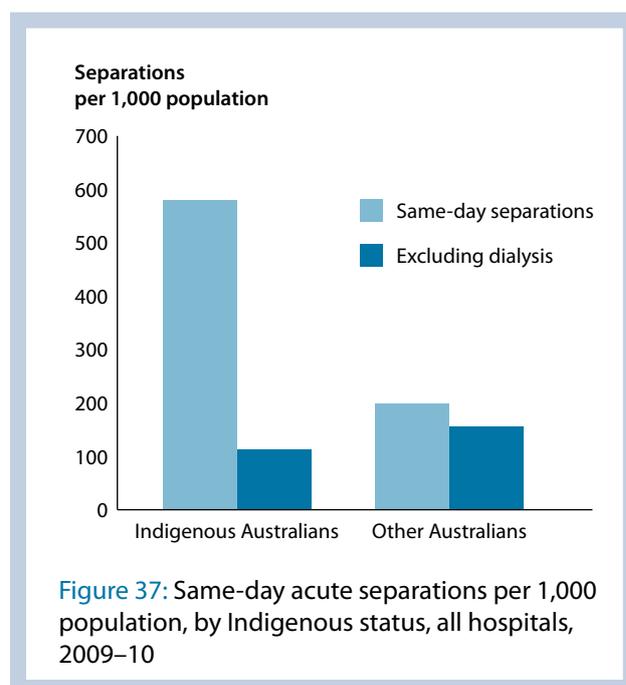


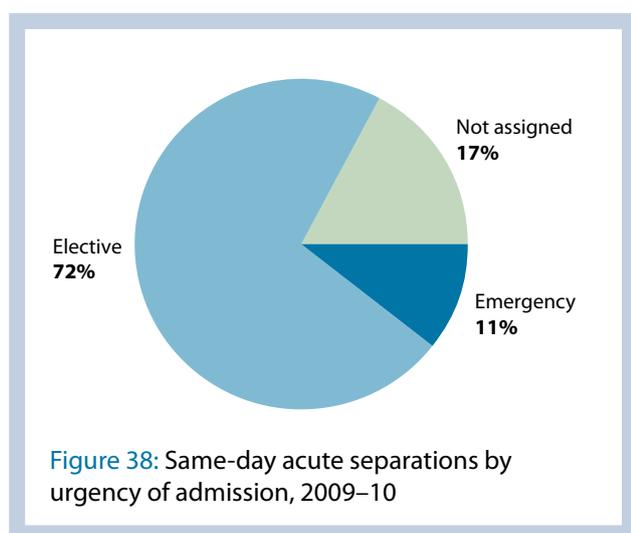
Figure 37: Same-day acute separations per 1,000 population, by Indigenous status, all hospitals, 2009–10

Persons usually resident in *Very remote* areas had 279 same-day separations per 1,000 population, compared with 210 per 1,000 nationwide.

Same-day separation rates were similar for different socioeconomic status (SES) groups, ranging from 191 per 1,000 population for the second lowest SES group to 215 per 1,000 for the middle SES group.

How urgent was the care?

Over 72% of same-day separations were for elective care, 11% were for emergency care and about 17% were other care (not assigned) (Figure 38).



Why did people receive this care?

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

- care involving dialysis (over 1.1 million separations for kidney failure)
- other medical care (343,000 separations, mainly chemotherapy for cancer)
- cataract (134,000 separations).

What care was provided?

In both public and private hospitals, the majority of same-day acute separations were for Medical care (including Specialist mental health).

Around 7.3 million procedures were reported for same-day separations. In public hospitals, about 83% of same-day separations involved a procedure and about 96% of same-day separations in private hospitals involved a procedure (2.1 million).

The most common procedure was haemodialysis, followed by pharmacotherapy (includes chemotherapy).

Who paid for the care?

In public hospitals, almost 87% of same-day separations were public patients.

In private hospitals, private health insurance funded about 78% of same-day separations.

Admitted patient care: overnight acute care

Overnight admitted patient care occurs when the patient is admitted and separated on different days (stays at least one night). This section reports on overnight acute care (referred to as overnight care), where the care was not for rehabilitation or other non-acute care (which made up 5.1% of overnight separations).

In 2009–10, 3.4 million or 40.2% of separations were overnight acute care separations. This included 2.4 million or 46.7% of separations from public hospitals and 1.1 million or 30.6% of separations from private hospitals.

Between 2005–06 and 2009–10, the number of overnight acute separations increased, on average, by 2.6% per year for public hospitals, and by 2.2% per year for private hospitals.

Who used these services?

Indigenous Australians were hospitalised overnight at about twice the rate for other Australians.

Persons usually resident in *Very remote* areas had 253 overnight acute separations per 1,000 population, compared with 151 per 1,000 nationwide.

Separation rates varied by socioeconomic status, from 130 per 1,000 population for the highest SES group to 170 per 1,000 for the lowest SES group.

How urgent was the care?

About 50% of overnight acute separations were for emergency care, 39% were for elective care and about 11% were other planned care (not assigned) (Figure 39).

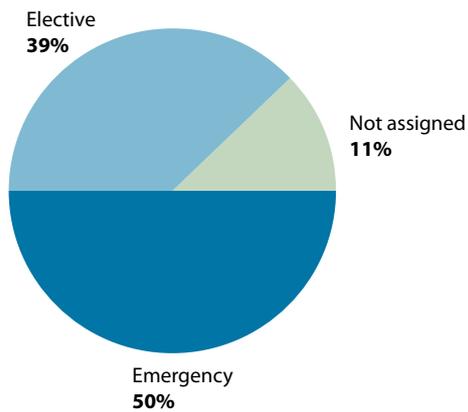


Figure 39: Overnight acute separations by urgency of admission, 2009–10

Why did people receive this care?

The most common principal diagnoses for overnight acute separations included:

- pain in the throat and chest (almost 71,000 separations)
- sleep disorders (59,000 separations)
- pneumonia (54,000 separations)
- various heart-related conditions (over 170,000 separations), such as heart failure, angina pectoris, acute myocardial infarction (heart attack) and atrial fibrillation and flutter.

What care was provided?

In public hospitals, over 72% of overnight acute separations were for Medical care (including Specialist mental health).

In private hospitals, over 55% of overnight acute separations were for Surgical care.

How long did patients stay?

The average length of stay for overnight acute separations was 5.3 days for public hospitals and 4.7 days for private hospitals. This was shorter than for 2008–09 (5.4 and 4.8 days, respectively).

The average length of stay for Medical care was greater in private hospitals, and was notably higher in public hospitals than in private hospitals for Surgical and Other care (Figure 40).

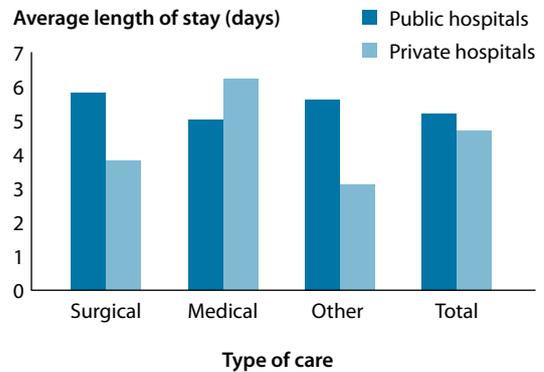


Figure 40: Average length of stay for overnight acute separations, public and private hospitals, 2009–10

Who paid for the care?

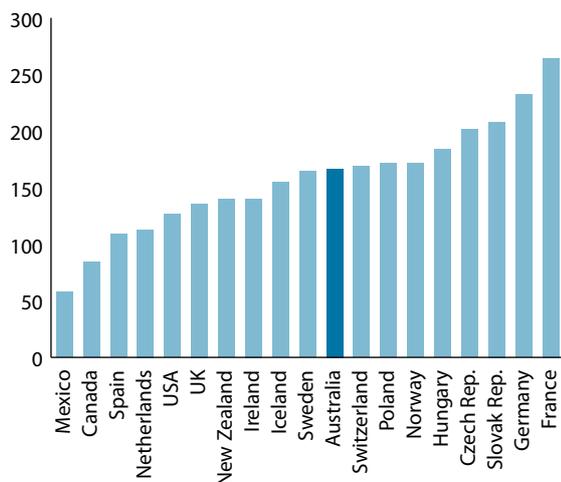
In public hospitals, almost 84% of overnight acute separations were public patients.

In private hospitals, private health insurance funded over 83% of overnight acute separations.

International comparisons

The number of overnight separations per 1,000 population in Australia for 2009–10 was in the middle of the range that other OECD countries reported for recent years (Figure 41) (OECD 2009).

Separations per 1,000 population



Rep. Republic.

Notes

1. Data for OECD countries vary in collection periods, from financial year, fiscal year and calendar year. Data are for 2008 except for Australia (2009–10), the USA and Canada (2006) and Sweden (2007).
2. Separations include all care types.

Figure 41: Overnight separations per 1,000 population, Australia, 2009–10 and selected OECD countries (2008)

Although the OECD collates this information on as comparable a basis as possible, the comparability of international separation rates is likely to be affected by differences in definitions of hospitals, collection periods and in admission practices.

Admitted patient care: elective surgery

Separations for elective surgery are defined as having a surgical procedure, and being admitted on an elective basis. Elective surgery can be provided on a same-day basis or in an overnight admission (a hospitalisation that lasts for at least one night). Public elective surgery describes elective surgery provided in public hospitals and elective surgery provided to public patients in private hospitals.

There were almost 1.9 million elective surgery separations in 2009–10, 661,000 in public hospitals and 1.2 million in private hospitals.

The number of elective surgery separations increased between 2005–06 and 2009–10 by an average of 1.5% for public hospitals and 4.9% for private hospitals each year.

Who used these services?

There was some variation in the rates of access to both public elective surgery and elective surgery for other patients by socioeconomic status (SES).

The public elective surgery separation rate was lowest for those classified as being in the highest SES group (18 per 1,000) and highest for those in the lowest SES group (40 per 1,000).

In contrast, the number of 'other' elective surgery separations per 1,000 population (in private hospitals) was highest for those classified in the highest SES group (75 per 1,000) and decreased with socioeconomic status to 41 per 1,000 population for the lowest SES group (Figure 42).

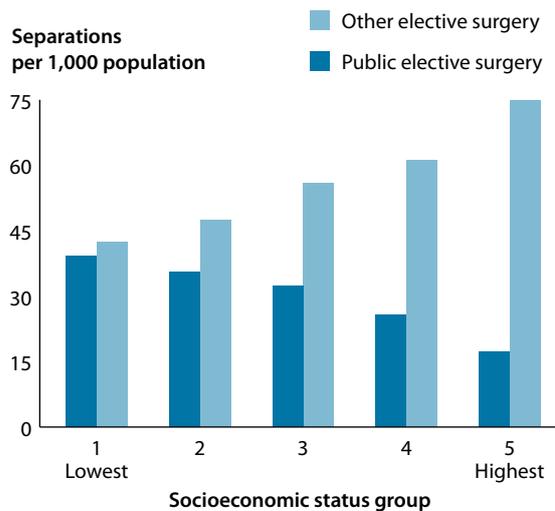


Figure 42: Separations per 1,000 population for public and other elective surgery, by socioeconomic status group, 2009–10

Hospital performance: waiting times for elective surgery

The median waiting time for elective surgery is a measure of access to elective surgery. Data were available for a subset of elective surgery in public hospitals, defined as those removed from waiting lists for a range of surgical procedures. The median waiting time is the number of days within which 50% of patients were removed from elective surgery waiting lists.

In public hospitals, 50% of patients waited 36 days or less for elective surgery in 2009–10, an increase from 32 days in 2005–06. A total of 3.6% waited more than a year—the least since 2005–06.

- Median waiting time varied across states and territories. The lowest was 27 days, and the highest was 73 days (Figure 43).
- Ophthalmology, ear, nose and throat surgery and orthopaedic surgery were the surgical specialties with the longest median waiting times (70, 63 and 62 days respectively) in 2009–10 (Figure 44).
- Cardiothoracic surgery had the shortest median waiting time (14 days).
- Coronary artery bypass graft was the procedure with the shortest median waiting time (15 days) and total knee replacement had the longest median waiting time (181 days) (Figure 45).
- Overall, the median waiting times for patients with cancer-related principal diagnoses (median 20 days) were 15 days shorter than the median waiting times for patients overall (median 35 days) (Figure 46). For ear, nose and throat surgery, patients with cancer waited 15 days, compared with 64 days overall.

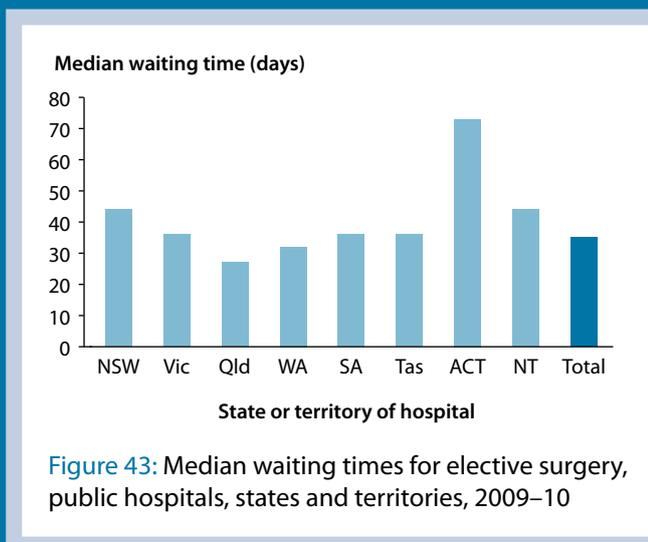


Figure 43: Median waiting times for elective surgery, public hospitals, states and territories, 2009–10

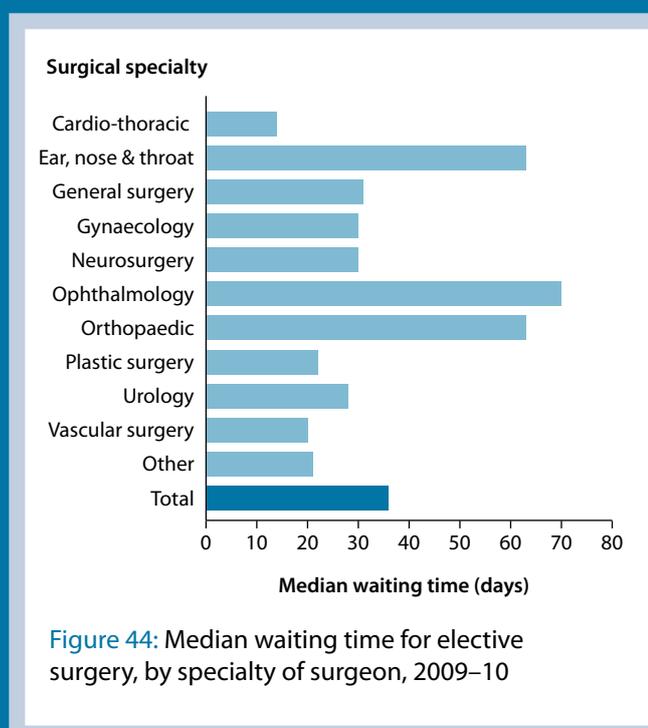


Figure 44: Median waiting time for elective surgery, by specialty of surgeon, 2009–10

More information on waiting times for public hospital elective surgery by surgical specialty and by procedure for each state and territory is presented in figures 44a-44h and figures 45a-45h, accompanying this report online.

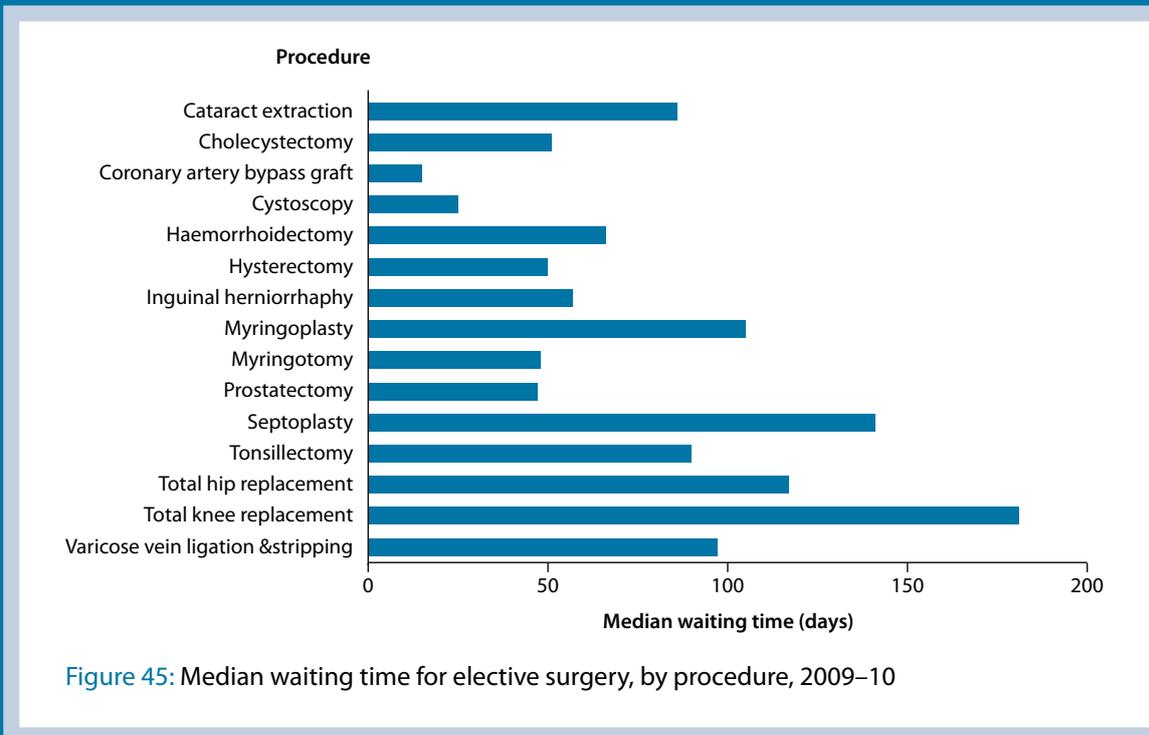


Figure 45: Median waiting time for elective surgery, by procedure, 2009–10

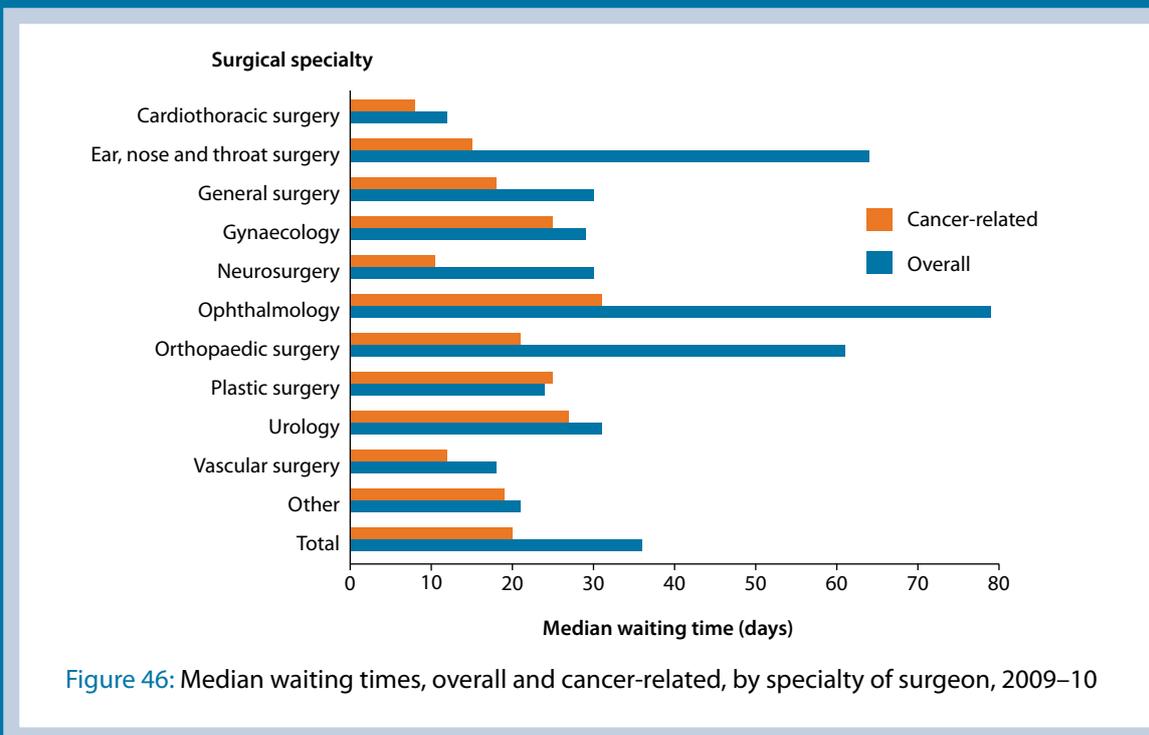
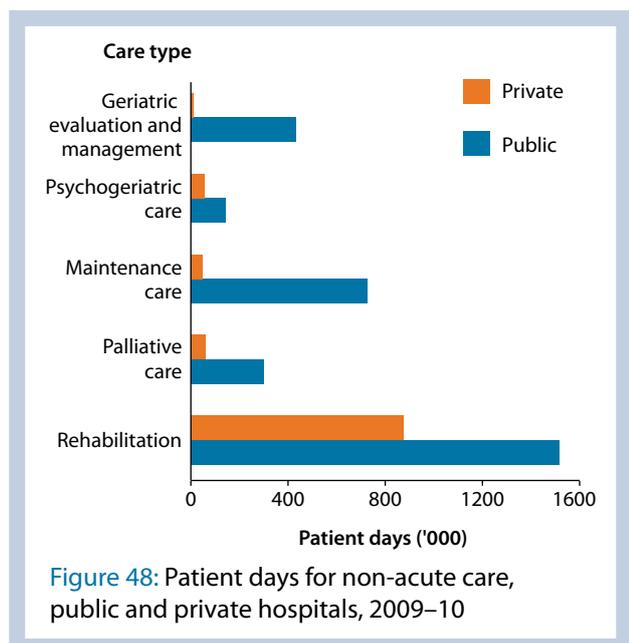
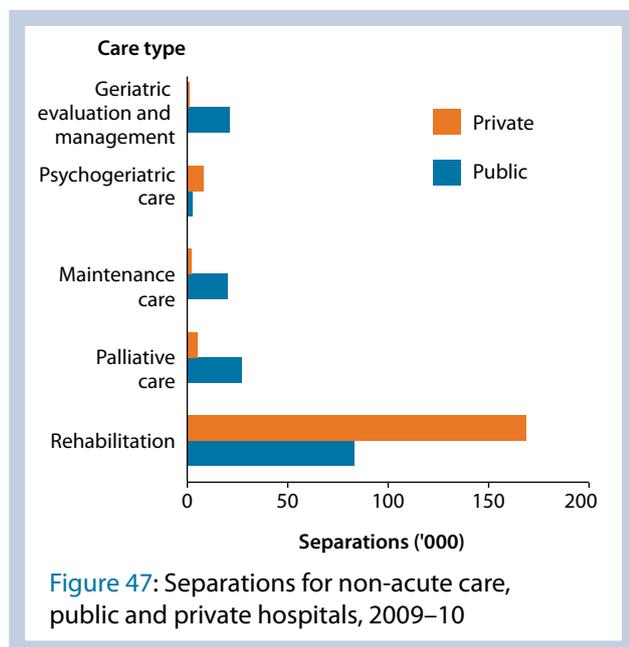


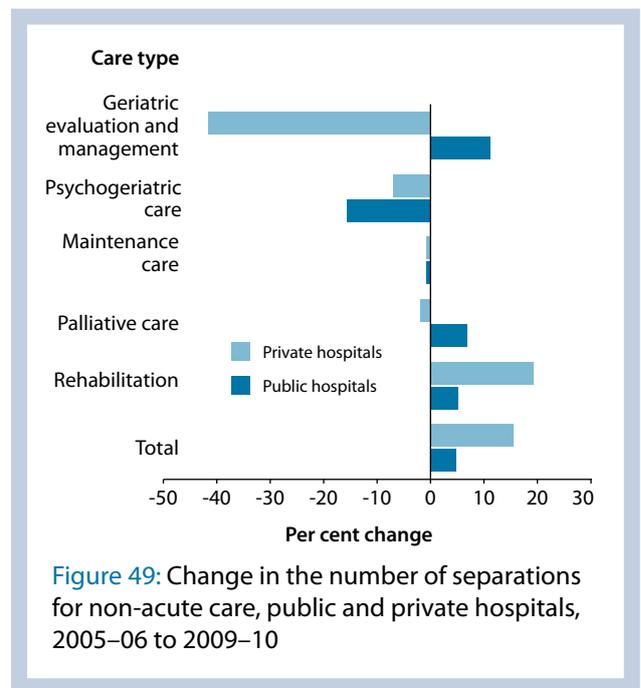
Figure 46: Median waiting times, overall and cancer-related, by specialty of surgeon, 2009–10

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

Overall, there were about 337,000 separations for sub-acute and non-acute admitted patient care in 2009–10. These accounted for about 3.9% of separations and 15.6% of patient days in public and private hospitals. This care includes Rehabilitation, Palliative, Psychogeriatric, Geriatric evaluation and management and Maintenance care (figures 47 and 48). Rehabilitation care was the most commonly provided care type. The term 'non-acute care' is used below to describe both sub-acute and non-acute care.

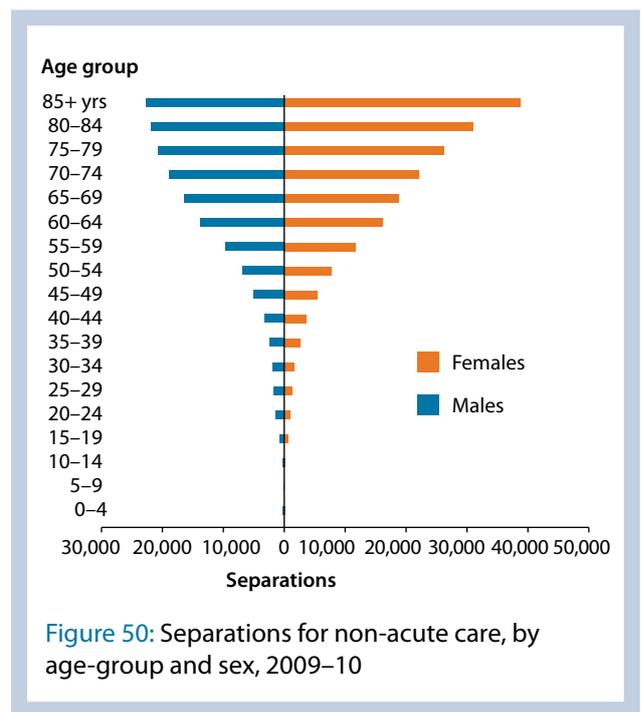


The volume of these services increased over the period 2005–06 to 2009–10, particularly for Rehabilitation in private hospitals (19% per year) and Geriatric evaluation and management care in public hospitals (11% per year) (Figure 49).



Who used the services?

About 56% of non-acute separations were for females, and less than 30% of non-acute separations were for people aged under 65 years (Figure 50).



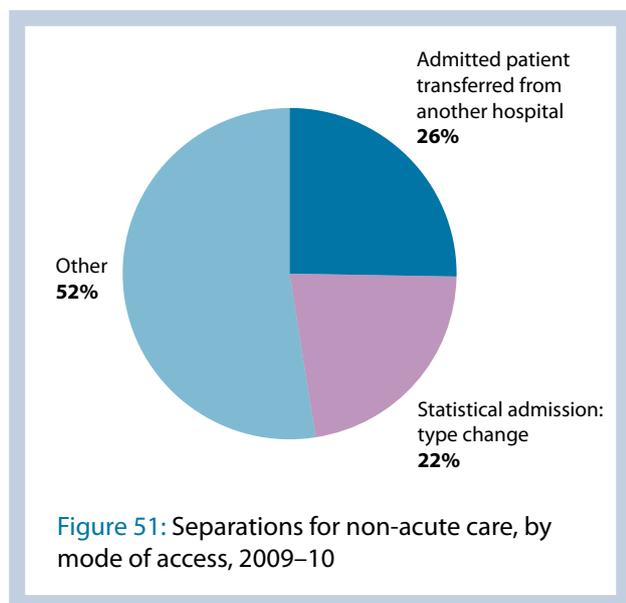
About 1.0% of non-acute separations were for Indigenous Australians, compared with 3.7% of admitted patient separations overall.

Persons usually resident in *Major cities* had 17 separations per 1,000 population for non-acute care, compared with 14 per 1,000 nationwide.

Separation rates varied by socioeconomic status, from 11 per 1,000 population for those classified as being in the lowest SES group to 21 per 1,000 for those classified as being in the highest SES group.

How did people access these services?

About half of separations for non-acute care were either transfers from another hospital or occurred within the same hospital when the patient's type of care had changed (for example, from Acute care to Rehabilitation) (Figure 51). This contrasts with only 5% of separations overall that were transferred from another hospital or were a care type change.



How urgent was the care?

Under 5% of separations for non-acute care were reported as emergency admissions, compared with 26% of separations overall.

Over 66% were reported as elective admissions and 29% were other planned care.

Why did people receive this care?

The most common principal diagnosis was for Care involving use of rehabilitation procedures (227,000 separations).

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

- arthrosis of the knee (37,000 separations)
- arthrosis of the hip (18,000 separations)
- fracture of the femur (hip fracture, 15,000 separations).

For Palliative care, 9 out of the top 10 most common principal diagnoses were cancer-related. For Other non-acute care, the most common principal diagnosis was *Problems related to medical facilities and other health care*.

What care did they receive?

Around 783,000 procedures or other interventions were reported for non-acute separations. In public hospitals, about 81% of non-acute separations involved a procedure and about 92% of private hospital non-acute separations involved a procedure.

The most common were allied health interventions, including:

- physiotherapy (over 251,000 separations)
- occupational therapy (153,000 separations)
- social work (86,000 separations)
- hydrotherapy (51,000 separations).

How long did they stay?

The average length of stay for non-acute separations was 5.6 days in private hospitals and 20.4 days in public hospitals.

- For Rehabilitation care, the average length of stay was 5.2 days in private hospitals and 18.4 days in public hospitals.
- Separations for Maintenance care had the longest average length of stay (35.8 days), followed by Geriatric evaluation and management (20.2 days) and Psychogeriatric care (19.1 days).

Who paid for the care?

In public hospitals, over 77% of non-acute separations were public patients, and 6% were funded by the Department of Veterans' Affairs.

In private hospitals, private health insurance funded about 78% of non-acute separations, and 13% were funded by the Department of Veterans' Affairs.

How was care completed?

Just over three-quarters of separations for non-acute care were discharged to their usual place of residence, compared with over 92% of all admitted patient separations.

Over 6% of separations for non-acute care were discharged or transferred to another hospital or other health care accommodation.

A further 5% were discharged to a residential aged care service (that was not their usual place of residence), compared with about 1% overall.

- For Rehabilitation care 89% of separations were discharged to their usual place of residence, compared with 31% of separations for Palliative care (figures 52 and 53)
- Over half (57%) of Palliative care separations ended in the death of the patient (Figure 52).

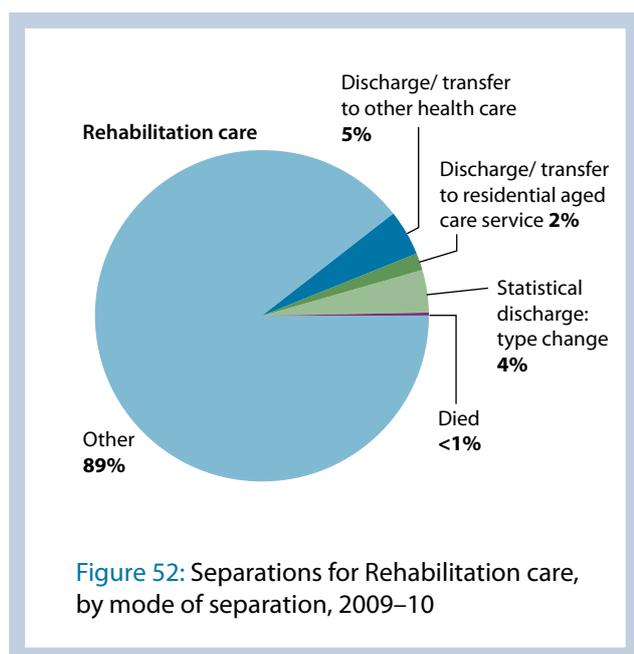


Figure 52: Separations for Rehabilitation care, by mode of separation, 2009–10

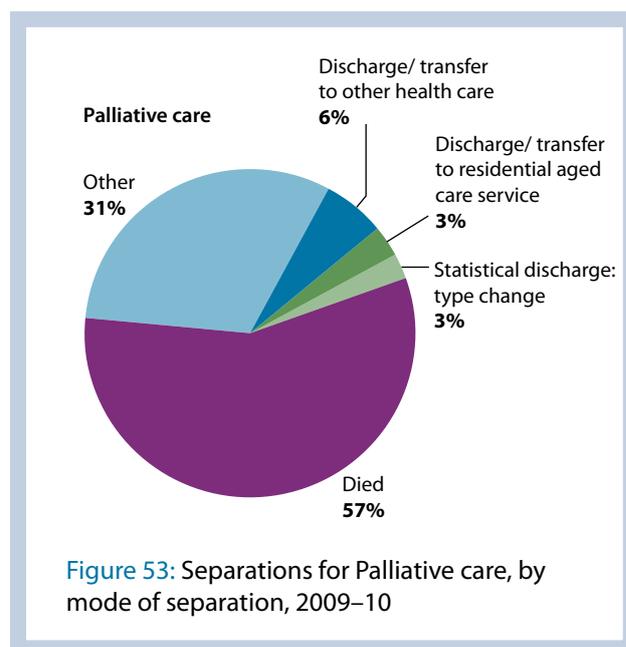


Figure 53: Separations for Palliative care, by mode of separation, 2009–10

Additional information

More detailed statistics, and more information on how to interpret the data here is in the companion report, *Australian hospital statistics 2009–10*. Further detail is also available in interactive data cubes at www.aihw.gov.au.

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