

In 1999–2000, Indigenous males and females were more likely than the non-Indigenous population to be admitted to hospital. Population procedure rates indicate that Indigenous persons were also more likely to undergo a procedure than non-Indigenous persons. As population procedure rates are based on the entire Indigenous population, they do not indicate the likelihood of undergoing a procedure once a person is admitted to hospital. Indigenous patients were less likely than non-Indigenous patients to undergo a procedure once admitted to hospital.

Almost all hospital separations and procedures for patients identified as Indigenous occurred in public hospitals. Persons identified as Indigenous were less likely than non-Indigenous patients to have a separation or procedure recorded in a private hospital.

The main reason for hospitalisation for persons identified as Indigenous was ‘care involving dialysis’, used in the treatment of kidney failure. ‘Care involving dialysis’ accounted for approximately 29% of all separations for patients identified as Indigenous. Males identified as Indigenous were six times as likely to be hospitalised for ‘care involving dialysis’ as non-Indigenous males and Indigenous females 14 times as likely to be hospitalised. ‘Pregnancy, childbirth and puerperium’; injury and poisoning; and ‘respiratory diseases’ were other common ICD-10-AM principal diagnosis chapters for hospitalisation for persons identified as Indigenous. Indigenous peoples were also more likely than non-Indigenous people to be hospitalised for all other ICD-10-AM principal diagnosis chapter groupings, with the exception of ‘neoplasms’, ‘musculoskeletal system and connective tissues diseases’ and ‘congenital anomalies’.

While hospital utilisation data provide insights into the health of the population, they are not accurate indicators of the health of the total community. Hospital morbidity collections are limited to information about the reasons for which people are hospitalised and the procedures they undergo in hospital and do not include information on those who access other health services, such as general practitioners and community health clinics, those who have not accessed health care at all and non-admitted hospital services.

Other factors, such as availability of and access to other medical services, may influence hospital utilisation; as may social factors relating to culture, socioeconomic status of patients, transport availability and the ability to speak English. Consequently the data reported do not describe levels of need or ill health in the Australian Indigenous community. A rising rate of hospitalisation, for example, could mean that health status is deteriorating, that access to hospitals has improved, that Indigenous identification has improved, or a combination of each (ABS & AIHW 2001).

Despite incomplete Indigenous identification in hospital records and the restricted perspective on health status that hospital utilisation data provide, hospital morbidity collections remain a key health indicator. Work coordinated by the Australian Bureau of Statistics (ABS), in partnership with State and Territory authorities, is targeting improvements in the completeness with which Aboriginal and Torres Strait Islander peoples are identified in administrative data collections, including hospital morbidity collections. Recent projects have also been undertaken by the Australian Health Ministers' Advisory Council (AHMAC) to improve the completeness of coverage of Indigenous identification by using less confronting methods of collection of Indigenous status. Nevertheless, further progress is needed to enhance the value of such an important data source on the health of Indigenous persons.