Admitted patient palliative care and hospital-based facilities

This section presents information on episodes of admitted patient palliative care occurring in hospitals, using data on palliative care-related hospitalisations from the National Hospital Morbidity Database (NHMD). The NHMD is a collation of data about admitted patient care in Australian hospitals, based on the Admitted Patient Care National Minimum Data Set. Further information can be found in the data sources section.

Information is presented on hospitalisations for which palliation was provided. Time series data for the period from 2012–13 to 2016–17 are presented to show the changes in hospitalisations for palliative care over this period. Wherever possible, corresponding data on all hospitalisations have been provided for comparative purposes.

This section also presents information on public acute and private hospital-based hospice care units.

The information in this section was last updated in May 2019.

Key points

- 77,369 palliative care-related hospitalisations were reported from public acute and private hospitals in Australia in 2016–17.
- 53.1% of palliative care-related hospitalisations were for people aged 75 and over.
- 25.6% increase in palliative care-related hospitalisations between 2012–13 and 2016–17, compared to a 17.6% increase in hospitalisations for all reasons over the same period.
- 51.6% of all hospitalisations in which the patient died, the patient had received palliative care in 2016–17.
- 46.7% of palliative care hospitalisations involved cancer as the principal diagnosis in 2016–17.
- 133 public acute hospitals reported that they had a hospice care unit in 2016–17, and about a third (31.6%) were located in New South Wales.
- 1 in 5 (19.8%) of the 673 public acute hospitals (excluding public psychiatric hospitals) in Australia had a hospice care unit in 2016–17.
A palliative care-related hospitalisation is defined as an episode of admitted patient care for which the principal clinical intent was palliation during all or part of that episode. Two NHMD data items—Care type and Additional diagnosis—are used to capture information on palliative care: if either (or both) has a code of ‘palliative care’, that hospitalisation is considered in scope (see Identifying palliative care hospitalisations for further information).

Admitted patient palliative care in 2016–17

In 2016–17, there were 77,369 palliative care-related hospitalisations reported from public acute and private hospitals in Australia, accounting for about 1 in 140 (0.7%) of all hospitalisations (11.0 million). A higher proportion of palliative care-related hospitalisations were for males (53.5%) than females (46.5%), and the rate was also higher for males than females (34.2 and 29.3 per 10,000 population, respectively).

People aged 75 and over accounted for over half (53.1%) of all palliative care-related hospitalisations in 2016–17; the average patient age of all palliative care hospitalisations was 73.1 with little difference between the sexes. This was considerably older than the average age of 55.0 years for hospitalisations for all reasons. Only about 1 in 10 (10.5%) of the total number of palliative care-related hospitalisations was for patients aged under 55.

The population rates of palliative care-related hospitalisations for males and females were similar up until age 55, from which point men had higher rates of palliative care, with the difference between the sexes becoming greater with increasing age. For those aged 85 years and over, males had a palliative care-related hospitalisation rate of 500.2 per 10,000 population, compared to 333.4 for females, even though the number of palliative care hospitalisations in this age group was higher for females than males, reflecting females higher average life expectancy compared to males.

Profile of palliative care-related hospitalisations in 2016–17

Where was palliative care provided?

In 2016–17, similar to previous years’ findings, a high proportion of palliative care-related hospitalisations were recorded from public hospitals (84.6% or about 65,500 hospitalisations), compared to 59.8% of all hospitalisations. For states and territories where private sector data were able to be published, the highest proportions of hospitalisations in public hospitals were in New South Wales (95.3%) and Victoria (88.2%) with the lowest in Western Australia (64.7%).

Tasmania reported the highest population rate at 42.2 palliative care-related hospitalisations per 10,000 population for public hospitals, followed by the
Australian Capital Territory (30.6) (Figure APC.1). Western Australia had the lowest population rate within public hospitals, at 17.7 palliative care-related hospitalisations per 10,000 population. In those states where private sector data were able to be published, Western Australia reported the highest rate (9.6 per 10,000 population) for palliative care-related private hospitalisations, about 7 times higher than the rate for New South Wales (1.4). For those states and territories where all hospitalisations were able to be published, South Australia had the highest rate of palliative care-related hospitalisations in all hospitals (38.5 per 10,000 population), followed by Victoria (34.6). Western Australia had the lowest overall rate for all hospitals (27.3).

**Source data:** <xls-icon> Admitted patient palliative care and hospital-based facilities Table APC.3 (538KB XLS)

**How long did patients stay?**

In 2016–17, almost all (95.0%) palliative care-related hospitalisations involved an overnight hospital stay, compared with 39.6% for all hospitalisations (AIHW 2018). Palliative care-related hospitalisations accounted for about 791,740 patient days, with an average length of stay (ALOS) of 10.2 days—almost 4 times as long as the ALOS of 2.8 days for all hospitalisations. When only those hospitalisations that involved an overnight stay are considered, the difference narrows to 10.7 days for palliative care-related hospitalisations and 5.6 days for all hospitalisations (AIHW 2018). The total ALOS per palliative care-related
hospitalisation which included same day separations was 9.9 days for males and 10.6 days for females.

The average length of stay was longer in private than public hospitals for all jurisdictions where private hospitals data can be reported, with the exception of South Australia. The greatest difference was in Queensland, with a 5.0 day longer ALOS in private compared to public hospitals (Figure APC.2) in 2016–17. The ALOS in public hospitals for overnight hospitalisations was highest in the Northern Territory (10.9 days). For private hospitals, South Australia recorded the highest overnight ALOS, at 15.9 days. Nationally, ALOS was higher in private (13.3 days) than public hospitals (10.3 days) for overnight hospitalisations.

Figure APC.2: Palliative care-related hospitalisations, average length of stay, public and private hospitals, by state and territory, 2016–17

<table>
<thead>
<tr>
<th>State or territory</th>
<th>Public</th>
<th>Private</th>
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<tr>
<td>NSW</td>
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<tr>
<td>Total</td>
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</tbody>
</table>

Notes:
1. Data for private hospitals in Tasmania, the Australian Capital Territory and the Northern Territory are not shown for confidentiality reasons. 'Total hospitalisations' includes data for all jurisdictions.
2. Total hospitalisations include same-day and overnight hospitalisations. By definition, the ALOS for same-day hospitalisations equals 1 day.

Source: AIHW. Table APC.5

Who paid for the care?

In 2016–17, public patient funding accounted for 76.5% of palliative care-related hospitalisations in public hospitals; private health insurance was the next most common funding source (19.4%). By comparison, public patient funding for all hospitalisations in public hospitals was 83.0% and private health insurance 13.8%.

In private hospitals, private health insurance was the funding source for 69.2% of palliative care-related hospitalisations, compared with 82.7% of all hospitalisations.
hospitalisations. Public patient funding was more likely for palliative care-related hospitalisations in private hospitals (17.9%) than all hospitalisations (4.5%), and less likely to be funded by private health insurance (69.2% compared with 82.7%).

The funding pattern for public hospitals differed across jurisdictions: in New South Wales, 68.7% of palliative care-related hospitalisations were public patients compared with 88.4% in the Northern Territory. Private hospitals also varied, with 45.3% of palliative care-related hospitalisations funded as public patients in Western Australia compared with 0.9% in Victoria.

How was the care completed?

The ‘mode of completing a hospitalisation’ indicates the status of a patient at the end of the hospitalisation; for example, whether the person died, or their destination after discharge from hospital.

More than half of all palliative care-related hospitalisations ended with the patient’s death (52.3%), compared with less than 1 in a hundred (0.7%) for all hospitalisations. The next most common reason for completing hospitalisation was ‘other’ (28.7% i.e. discharge to own accommodation, usual residence or welfare institution), followed by transfer to another acute hospital (7.9%). Patterns of completed palliative care-related hospitalisations were similar across both public and private hospitals. However, jurisdictional differences were evident within and across sectors. The proportion of palliative care-related hospitalisations in public hospitals ending with the patient’s death was lowest in the Northern Territory (42.9%) and highest in Queensland (56.0%). For private hospitals where state or territory data were able to be published, Western Australia reported the highest percentage of hospitalisations ending with the patient’s death (63.7%), which was higher than the national average for the sector (53.5%). Palliative care patients from private hospitals were more likely to be transferred to another hospital in New South Wales and Victoria compared with other jurisdictions reported.

Characteristics of admitted palliative care patients

This section presents information on the number and proportion of palliative care-related hospitalisations for various demographic groups.

Socioeconomic status

Socioeconomic status generally refers to the level of economic and social resources of an individual (such as income, education and employment) and it is well established that it is associated with health outcomes (AIHW 2016). The Index of Relative Socio Economic Disadvantage (IRSD) is used here to indicate socioeconomic status of the area in which the individual lives.
In 2016–17, people living in areas classified as having the lowest socioeconomic status (Quintile 1) accounted for a higher proportion of palliative care-related hospitalisations (22.3%) in public hospitals than those living in other areas. The rate of palliative care-related public hospitalisations was also highest for those living in these areas (35.6 per 10,000 population). Conversely, the rate of public palliative care-related hospitalisations was lowest for those living in the highest socioeconomic status areas (17.7 per 10,000). These patterns are similar to those for all hospitalisations.

An opposite pattern is apparent for palliative care-related hospitalisations in private hospitals, where the rate was highest for those living in the highest socioeconomic status areas (6.7 per 10,000 population). This pattern was also seen for all private hospitalisations for this socioeconomic group (2,440.6 per 10,000 population). In addition to accessing private hospitals for palliative care, higher socioeconomic status individuals may also be accessing other types of non-admitted patient palliative care e.g. from private, freestanding hospice care facilities or community based palliative care services.

**Indigenous status**

Aboriginal and Torres Strait Islander people are disadvantaged relative to other Australians across a range of health-related and socioeconomic indicators (AIHW 2015a). This may affect their use of, and access to, admitted patient palliative care.

A total of 1,557 palliative care-related hospitalisations for Indigenous Australians were reported in 2016–17, with the majority (95.4%) occurring in public hospitals. There were a similar number of hospitalisations for Indigenous males and females, whereas there were more hospitalisations for other Australian males than females. The rate of palliative care-related hospitalisations in public hospitals is about twice as high for Indigenous Australians as for other Australians (45.6 and 23.3 per 10,000 population, respectively) with the rate of all public hospitalisations 3.8 times higher for Indigenous Australians than other Australians.

**Remoteness of patient’s usual residence**

As would be expected, most palliative care-related hospitalisations in 2016–17 across both public and private hospital sectors were for patients whose usual residence was in *Major cities* (68.1%), with the proportion of palliative care-related hospitalisations decreasing as remoteness increased. However, the population rate for *Major cities* public hospital hospitalisations of 25.5 per 10,000 population, was lower than the rate for *Inner regional* (30.4 per 10,000) and *Outer regional* areas (32.3 per 10,000).

Males accounted for a greater proportion of the palliative care-related hospitalisations than females in all remoteness categories for both public and private hospitals.
Diagnosis

The principal diagnosis recorded for a hospitalisation is ‘the diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care’ (AIHW 2015b; ACCD 2015). Additional diagnoses are those ‘conditions or complaints either coexisting with the principal diagnosis or arising during the episode of admitted patient care’. One or more additional diagnoses can be assigned to the care episode (AIHW 2018; ACCD 2015).

About half of all palliative care-related hospitalisations recorded a principal diagnosis of cancer in 2016–17 (46.7%). Of these, a principal diagnosis of secondary site cancer (that is, a malignant tumour originating from a cancer elsewhere in the body) was assigned to about 1 in 4 (23.5%).

Of the almost 1.1 million cancer-related hospitalisations recorded in 2016–17, 36,133 (3.4%) were palliative care-related. Nearly one-third (30.7%) of all hospitalisations related to a principal diagnosis of pancreatic cancer were palliative care-related, followed by lung cancer (27.4%) and brain cancer (20.8%).

For diseases with a principal diagnosis other than cancer, the most frequently reported principal diagnoses were stroke and sepsis (4.2% and 3.7% of palliative care-related hospitalisations, respectively). About 1 in 8 (12.8%) hospitalisations for pneumonitis due to solids and liquids were palliative care-related.

Change over time

Between 2012–13 and 2016–17 the number of palliative care-related hospitalisations increased by 25.6%, from about 61,600 to almost 77,400. The number of all hospitalisations increased by 17.6% over the same period.

The population rate of palliative care-related hospitalisations trended upward from 26.9 to 31.7 per 10,000 population between 2012–13 and 2016–17. Increases in the rate of admitted patient palliative care were evident across all age groups over this period, with some variability in the degree of increase.

Change over time by sector

The number of admitted patient palliative care-related hospitalisations between 2012–13 and 2016–17 increased in both public and private hospitals. The number of public palliative care-related hospitalisations increased by 25.7%, with public hospitalisations for all reasons increasing by 19.1% over the same period.

Numbers of palliative care-related hospitalisations in private hospitals also increased, resulting in a net increase of 25.0% over the same period. This is slightly lower than the increase in all private hospital hospitalisations, which showed 15.3% growth between 2012–13 and 2016–17.

For public hospitals, the rate of palliative care-related hospitalisations increased from 22.7 in 2012–13 to 26.8 per 10,000 in 2016–17. The rate of palliative care hospitalisations in private hospitals also increased over the same period from 4.2
to 4.9 per 10,000 population. For all hospitals, the rate of palliative-related hospitalisations increased from 26.9 to 31.7 per 10,000 over the period.

Figure APC.3: Palliative care-related hospitalisations, rate per 10,000 population, public and private hospitals, 2012-13 to 2016-17

![Graph showing the trend of palliative care-related hospitalisations](image)

Note: Crude rates are based on the preliminary Australian estimated resident population as at 31 December of the reference year. Source: AIHW. Table APC.12

Source data: <xls-icon> Admitted patient palliative care and hospital-based facilities Table APC.12 (538KB XLS)

**Change over time by jurisdiction**

For public hospitals, the largest average annual increase in palliative care-related hospitalisations between 2012–13 and 2016–17 was for Western Australia (31.5%), 5 times the national average annual increase of 5.9%. The number of palliative care-related hospitalisations in the Northern Territory was essentially flat over the period. The population rate of palliative care-related hospitalisations increased across most states and territories between 2012–13 and 2016–17. For public hospitals, the national population rate increased from 22.7 to 26.8 per 10,000 population over the period.

Among the states and territories where data could be reported for private hospitals, the number of palliative care-related hospitalisations varied over time and across jurisdictions over the period, with a 5.7% average annual increase (25.0% total increase) between 2012–13 and 2016–17. Private hospitals in New South Wales and Western Australia reported average negative growth over the same period (-1.0 and -2.0% respectively), while all other reportable states and territories had an average annual increase in the number of palliative care-related hospitalisations ranging from 3.8% in Victoria to 16.5% in Queensland.
(Figure APC.4). For private hospitals, the national population rate of palliative care-related hospitalisations increased gradually between 2012–13 (4.2 per 10,000 population) and 2016–17 (4.9).

For those states and territories where data could be reported for all hospital sectors, there was an increase in the number of palliative care-related hospitalisations between 2012–13 and 2016–17 (5.9% average annual increase, 25.6% total increase). For these states and territories, Western Australia reported the highest average annual increase in all hospitals of 13.6. For all hospitals, the national population rate of palliative care-related hospitalisations increased.

For those states and territories where data could be reported for all hospital sectors, there was an increase in the number of palliative care-related hospitalisations between 2012–13 and 2016–17 (5.9% average annual increase, 25.6% total increase). For these states and territories, Western Australia reported the highest average annual increase in all hospitals of 13.6. For all hospitals, the national population rate of palliative care-related hospitalisations increased.

**Figure APC.4: Private hospital palliative care-related hospitalisations, by state and territory, 2012-13 to 2016-17**

![Graph showing the number of hospitalisations by state and territory from 2012-13 to 2016-17.](www.aihw.gov.au/pcsia)

*Note: Data for private hospitals for Tasmania, the Australian Capital Territory and the Northern Territory are not shown for confidentiality reasons. Source: AIHW. Table APC.13*

**Source data:** <xls-icon> Admitted patient palliative care and hospital-based facilities Table APC.13 (538KB XLS)

**Change over time in length of stay**

The number of patient days for palliative care-related hospitalisations in admitted patient settings increased by 20.2% between 2012–13 and 2016–17, to a total of 791,740 patient days. The ALOS for palliative care-related hospitalisations trended downwards over the same period (Figure APC.5).
This section presents data on a subset of palliative care-related hospitalisations—those that ended with the patient’s death. Some admitted patients who died in hospital but were not identified as being ‘palliative care patients’ may also have received some palliation during the hospitalisation that ended with their death. However, as elsewhere in this section, the focus is on those hospitalisations for which palliation was a substantial component of the care provided.

### Place of death

In 2016–17, about 160,000 people died in Australia (ABS 2018a). According to data from the NHMD, about 78,500 (49.0%) of these people died as an admitted patient in hospital.

Most states and territories operate hospital-in-the-home (HITH) programs, under which patients are provided with hospital-type care, are categorised as an admitted patient, but receive this care in their home as a substitute for hospital accommodation (AIHW 2012). Admitted patients receiving HITH may have their final hospitalisation in their home; although it is also possible for HITH patients to return to hospital during their final hospitalisation. It should be noted that

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**Source data:** [xls-icon](source-data) Admitted patient palliative care and hospital-based facilities Table APC.15 (538KB XLS)
data quality issues may confound the HITH analysis presented here (see Table APC.16 for further information).

After excluding the small number of HITH patients reported, it is estimated that about 78,300 people died in hospital in 2016–17 which is almost half (49.0%) of all deaths in Australia during that financial year. The proportion of deaths that occurred within the admitted patient setting has ranged from a low of 48.8% to a high of 50.2% over the 5-year period from 2012–13 to 2016–17.

**Palliative care patients and death**

In 2012–13, 42.1% of admitted patients had been a palliative care patient during the hospitalisation that ended with their death. This proportion has steadily increased such that by 2016–17, 51.6% of people who died as an admitted patient had been a palliative care patient during their final hospitalisation. Although it is difficult to be definitive about the reasons for this increase over time, the growth and ageing of Australia’s population, and the corresponding increase in the prevalence of chronic, progressive and generally incurable illnesses has broadened the type of patient groups requiring palliative care (AIHW 2014; Murtagh et al. 2013).

The number of palliative care patients who died during hospitalisation varied by diagnosis. About half (46.4% or 18,783 patients) of all palliative care patients who died in hospital in 2016–17 had cancer as a principal diagnosis. Of these patients, around 1 in 5 had secondary site cancer (3,587; 19.1%) and 1 in 6 had lung cancer (3,155; 16.8%). Of the non-cancer diseases, 1 in 8 (2,554; 11.8%) patients who died as palliative care patients had a principal diagnosis of a stroke, and 1 in 11 (1,972; 9.1%) sepsis.

About 4 out of 5 admitted patients (79.4%) with a principal diagnosis of cancer who died in 2016–17 were palliative care patients during their final hospital admission. Of the patients with a principal diagnosis of cancer who died during their final hospital admission, high percentages of patients with cancer of the brain (86.5%), breast (84.9%) and pancreas (84.1%) received palliative care. Among admitted patients with a non-cancer principal diagnosis who died, high rates of palliative care occurred where principal diagnoses of renal failure (56.7%), mental and behavioural disorders (55.3%) and stroke (52.2%) were recorded.

**Hospital-based facilities**

Data relating to hospice care units across public hospitals are derived from the National Public Hospital Establishments Database (NPHED). Data for private hospitals, including facilities and specialised services for acute and psychiatric hospitals, are derived from the Private Health Establishments Collection, which is sourced from an annual survey collecting information relating to private hospital activities in Australia (ABS 2018b). Further details on the NPHED database can be found in the data sources section.
Hospice units in public hospitals

A hospice care unit is a specialist unit delivering palliative care services and can include both free-standing facilities and wards within a hospital. However, hospices are identified differently in the NPHED across states and territories. Although palliative care services may be delivered in a range of settings, numbers of hospice care units are reported in this section due to their specialised role in palliative care delivery. In addition, the information derived from the NPHED does not include all hospice services in Australia; for example, private health-care providers/hospitals providing hospice care services are not in scope of the NPHED.

In 2016–17, a total of 133 public acute hospitals nationally reported having a hospice care unit. This represents 1 in 5 (19.8%) of the 673 public acute hospitals (excluding public psychiatric hospitals) in Australia. Just under one-third (31.6%) of hospitals with a hospice care unit were located in New South Wales (Figure APC.6). About one-quarter (26.4%) of public acute hospitals in Major cities had a hospice care unit, and 1 in 5 (17.3%) in Regional and Remote (19.1%) area hospitals respectively.

Figure APC.6: Public acute hospitals with hospice care units, states and territories, 2016-17

Source data: <xls-icon> Admitted patient palliative care and hospital-based facilities
Table APC.20 (538KB XLS)
Private acute and psychiatric hospitals

There were 300 private acute and psychiatric hospitals nationally in 2016–17. Of these, 24 (8.0%) had hospice units recorded. The average total number of hospice unit beds available nationally was 281, with an estimated 68,917 patient days and an average length of stay of 11.7 days (ABS 2018b).

References


AIHW 2015a. The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW.


AIHW 2016. Australia’s health 2016. Australia’s health series no. 15. Cat. no. AUS 199. Canberra: AIHW.


Data sources

National Hospital Morbidity Database (NHMD)
Data on admitted patient palliative care are sourced from the NHMD. These data pertain to admitted patients in public and private hospitals in Australia. Some of these hospitals have hospices affiliated with them.

The NHMD includes administrative data, demographic information on patients, and clinical information including diagnoses and procedures performed. This annual collection is compiled and maintained by the AIHW, using data supplied by state and territory health authorities. Information from almost all hospitals in Australia is included in the database: from public acute and public psychiatric hospitals, private acute and psychiatric hospitals, and from private free-standing day hospital facilities (AIHW 2018).

Episode-based data
The NHMD is episode based, with the term ‘hospitalisation’ used to refer to an episode of admitted patient care; individual patients may have multiple hospitalisations ending in discharge, transfer or statistical discharge with a change in care type and ultimately death. Each record in the NHMD is based on a single episode of treatment for an admitted patient, with such episodes classified in the ‘Care type’ data item as Acute care, Palliative care, Rehabilitation care, Newborn and other types of care. When a patient receives only one type of care during a hospital stay (such as only Acute care or only Palliative care), the length of stay for that hospitalisation is equal to the total length of time the patient spent in hospital during that stay. However, where patients receive different types of care during one hospital stay (for example, a person may be admitted for active cancer treatment but then later reclassified as a palliative care patient), the patient may be statistically discharged from the hospital after the first type of care and then statistically readmitted into a second phase of care. Thus, a single patient may have two or more hospitalisations during any one hospital stay. Since each record within the NHMD is based on an episode of care, the hospitalisation count is a count of episodes, not persons.

Coverage
For each of the years considered in this website, the coverage of the NHMD has been very good. For 2016–17, coverage for the NHMD was high: data from almost all public hospitals were included except for an early parenting centre in the Australian Capital Territory. The great majority of private hospitals also provided data, the exceptions being the private free-standing day hospital facilities and one overnight private hospital in the Australian Capital Territory.

Hospitals may be re-categorised as public or private between or within years (see AIHW 2018 for further information). This should be taken into account when comparing data by sector over time.
Data on state/territory of hospitalisation should be interpreted with caution because of cross-border flows of patients. This is particularly the case for the Australian Capital Territory. In 2016–17, 17% of hospitalisations in the Australian Capital Territory were for patients who lived in New South Wales.

The Indigenous status data are of sufficient quality for statistical reporting purposes for all hospitalisations. An estimated 88% of Indigenous patients were correctly identified in Australian public hospital admission records in 2011–12. Based on the results of this study, a correction factor of 1.09 was calculated, suggesting that the ‘true’ number of Indigenous persons should be about 9% higher than indicated in the hospital record (AIHW 2013).

**Standard admitted patient care data exclusions**

As per the standard practice when analysing admitted patient data in the NHMD, the data presented in this website exclude those records for which the 'Care type' data item was reported as newborn (unqualified days only), hospital boarder or organ procurement (posthumous).

**Further information**

Comprehensive hospital statistics from the NHMD are released by the AIHW on an annual basis in *Admitted patient care: Australian Hospital Statistics* and further information about the NHMD can be obtained from those publications. Metadata information for the NMDSs that are the basis for the AIHW National Hospital Databases are published in the AIHW’s online metadata registry—METeOR, and the National Health Data Dictionary:

From 1 July 2013, care types have been reported using revised definitions, with the aim to improve consistency in reporting for the subacute and non-acute care types. Therefore, changes in the care type definitions should be considered when interpreting changes over time.

A complete data quality statement for the NHMD database is available at

**National Public Hospital Establishments Database (NPHED)**

The NPHED holds establishment-level data for each public hospital in Australia, including public acute hospitals, psychiatric hospitals, drug and alcohol hospitals, and dental hospitals in all states and territories. The collection covers hospitals within the jurisdiction of the state and territory health authorities only. Hence, public hospitals not administered by the state and territory health authorities (hospitals operated by the Australian Government Department of Health, Department of Defence or correctional authorities, for example, and hospitals located in offshore territories) are not included. The collection does not include data for private hospitals.

For 2016–17, the collection was based on the NMDS for public hospital establishments. Information is included on a hospital’s resources, expenditure,
average available bed numbers, peer group, and the statistical local area and remoteness area of its location. For more information on the data collection method and other relevant data issues, refer to the 2016–17 NPHED data quality statement.

**Data on geographical location**

Data on geographical location are collected on hospitals in the NPHED and on the area of usual residence of patients in the NHMD. Data on the remoteness of the hospital location were defined using the Australian Bureau of Statistics (ABS) Australian Statistical Geography Standard (ASGS) remoteness structure 2011 (ABS 2011) and determined by the hospital street address.

The ASGS’s remoteness structure categorises geographical areas in Australia into remoteness areas:

- **Major cities**
- **Inner regional**
- **Outer regional**
- **Remote**
- **Very remote**.

Further information on the ASGS can be found on the [ABS website](https://www.abs.gov.au).

**References**


### Key Concepts

**Admitted patient palliative care and hospital-based facilities**

<table>
<thead>
<tr>
<th>Key Concept</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Additional diagnosis</strong></td>
<td>Conditions or complaints either coexisting with the principal diagnosis or arising during the episode of care. Additional diagnoses are recorded in accordance with ICD-10-AM Australian Coding Standards.</td>
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<tr>
<td><strong>Admitted patients</strong></td>
<td>Patients who undergo a hospital’s formal admission process to receive treatment and/or care.</td>
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<tr>
<td><strong>Average length of stay</strong></td>
<td>The length of stay for an overnight patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting any days the patient was ‘on leave’. Average length of stay refers to the average number of patient days for admitted patient episodes. Patients admitted and separated on the same day are allocated a length of stay of 1 day.</td>
</tr>
<tr>
<td><strong>Care type</strong></td>
<td>Care type refers to the overall nature of a clinical service provided to an admitted patient during an episode of care. Examples of care types are Acute care, Rehabilitation care, Palliative care and Geriatric evaluation and management.</td>
</tr>
<tr>
<td><strong>Funding source</strong></td>
<td>The principal source of funds for an admitted patient episode (hospitalisation).</td>
</tr>
<tr>
<td><strong>Hospice care unit</strong></td>
<td>A type of specialist unit delivering palliative care services and can include both free-standing hospices and/or palliative care wards within a hospital.</td>
</tr>
<tr>
<td><strong>Hospitalisation</strong></td>
<td>Hospitalisation (or separation) refers to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay (beginning or ending in a change of type of care; for example, from Acute care to Rehabilitation).</td>
</tr>
<tr>
<td><strong>Index of Relative Socio-Economic Disadvantage (IRSD)</strong></td>
<td>One of four Socio-Economic Indexes for Areas (SEIFA) developed by the ABS (ABS 2008). The IRSD represents the socioeconomic position of Australian communities by measuring aspects of disadvantage, such as low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations. Areas are then ranked according to their level of disadvantage.</td>
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</table>
When the IRSD is used in this report, people living in the 20% of areas with the greatest overall level of disadvantage are described as living in the ‘lowest socioeconomic areas’. The 20% of people at the other end of the scale—those living in areas with the least overall level of disadvantage—are described as living in the ‘highest socioeconomic areas’.

It is important to note that the IRSD reflects the overall or average socioeconomic position of the population of an area; it does not show how individuals living in the same area might differ from each other in their socioeconomic position. See Classifications for further information.

| **Palliative care-related hospitalisations** | Defined, for the purposes of this report, as those hospitalisations for which palliative care was a substantial component of the care provided. Such hospitalisations were identified as those for which the principal clinical intent of the care was palliation during part or all of the hospitalisation, as evidenced by a code of Palliative care for the ‘Care type’ and/or an additional diagnosis. |
| **Patient day** | The occupancy of a hospital bed (or chair in the case of some same day patients) by an admitted patient for all or part of a day. |
| **Principal diagnosis** | The diagnosis established after study to be chiefly responsible for occasioning the patient’s episode of admitted patient care. |