

# Hospitals – Admitted patient care and specialised facilities for palliative care

## On this page

- Introduction
- Who was hospitalised for palliative care?
- What were the characteristics for their hospital stay?
- Who paid for the hospital care?
- How have hospitalisations changed over time?
- How many public hospitals have specialised palliative care units?
- How much was spent by public hospitals for palliative care?

In 2020–21, there were 90,700 hospitalisations where palliative care was provided during all or part of the episode of care in Australia. This section provides information related to these hospitalisations and the characteristics of people admitted for palliative care over the period 2015–16 to 2020–21. It also presents information on [specialist palliative care inpatient units](#) and expenditure for palliative care in public hospitals. Further information on palliative care-related hospitalisations can be found in the [Data sources](#) section and the [Identifying palliative care-related hospitalisations](#) section.

The information in this section was last updated in May 2023.

### **Identifying palliative care in hospital data (dropdown box)**

People with life-limiting illness may require care in a hospital setting, such as a hospital ward (specialist palliative care ward or other areas of the hospital), an emergency department or an outpatient clinic.

[Palliative care-related hospitalisations](#) refer to those episodes of admitted patient care where palliative care was a component of the care provided during all or part of the episode. These hospitalisations can be divided into 2 groups depending on how they are identified in the hospital data:

- [palliative care hospitalisation](#): hospitalisations with a recorded care type of palliative care, and
- [other end-of-life care hospitalisation](#): hospitalisations with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care.

Note that the use of the term “other end-of-life care” in this report refers to the broader palliative care definition and is not limited to end-of-life care (generally defined as people who are likely to die within the next 12 months).

For more information see the [Technical information: Identifying palliative care-related hospitalisations](#).

## Key points

In 2020–21, among 90,700 palliative care-related hospitalisations:

- 50,000 were for palliative care and 40,700 for other end-of-life care, equating to 19.5 and 15.9 per 10,000 population, respectively
- males accounted for more than half – 53% both for palliative care hospitalisations and other end-of-life care hospitalisations
- those aged 75 and over accounted for over 1 in 2 – 56% both for palliative care hospitalisations and other end-of-life care hospitalisations
- 2 in 5 (42%) had a principal diagnosis of cancer – 1 in 2 (50%) for palliative care hospitalisations and almost 1 in 3 (31%) for other end-of-life care hospitalisations
- average length of stay was almost twice as long as for all overnight hospitalisations (hospitalisations that exclude same-day stays) – 10 days (9.2 days for palliative care and 11.1 days for other end-of-life care) compared with 5.3 days for all hospitalisations
- 1 in 2 hospitalisations (53%) ended with the patient dying in hospital (65% for palliative care hospitalisations and 40% for other end-of-life care hospitalisations).

Between 2015–16 and 2020–21, there was a 23% increase in the number of palliative care-related hospitalisations – this increase was at a steeper rate than for all hospitalisations (12% increase) over the same period.

In 2020–21, based on establishment-level data:

- 112 or 1 in 6 (17%) public acute hospitals (excluding public psychiatric hospitals) in Australia had a specialised palliative care inpatient unit
- the total palliative care expenditure in public hospitals care was \$481.4 million (19% of all sub-acute care costs or 1.1% of total cost in these public hospitals), with an average cost per palliative care episode of \$13,300 and average cost per palliative care phase of \$7,800.

## Data downloads:

[PDF VERSION OF THIS SECTION](#)

[LATEST DATA TABLES](#)

## Who was hospitalised for palliative care?

### National Hospital Morbidity Database (dropdown box)

This section presents information on in-patient admitted palliative-care related hospitalisations, sourced from the [National Hospital Morbidity Database](#) (NHMD), which includes demographic, clinical, and administrative information on patients. 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 ([Appendix A](#), AIHW 2022). The latest available data for inclusion in this report was 2020–21.

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. 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. In cases of more than one care type, length of stay refers to the length of the episode of care, not the total duration of a patient’s hospital stays.

In 2020–21, there were 11.8 million hospitalisations across Australia, including 90,700 hospitalisations where palliative care was provided during all or part of the episode of care (referred to as palliative care-related hospitalisations, see [Identifying palliative care in hospital data](#) for further details). More than half of these hospitalisations (55% or 50,000) had a care type of palliative care (referred to as palliative care hospitalisation), while 40,700 had a diagnosis of palliative care but the type of care delivered was not recorded as palliative care (referred to as other end-of-life care hospitalisation). This equates to 19.5 palliative care hospitalisations per 10,000 population and 15.9 other end-of-life care hospitalisations per 10,000 population (Table APC.1).

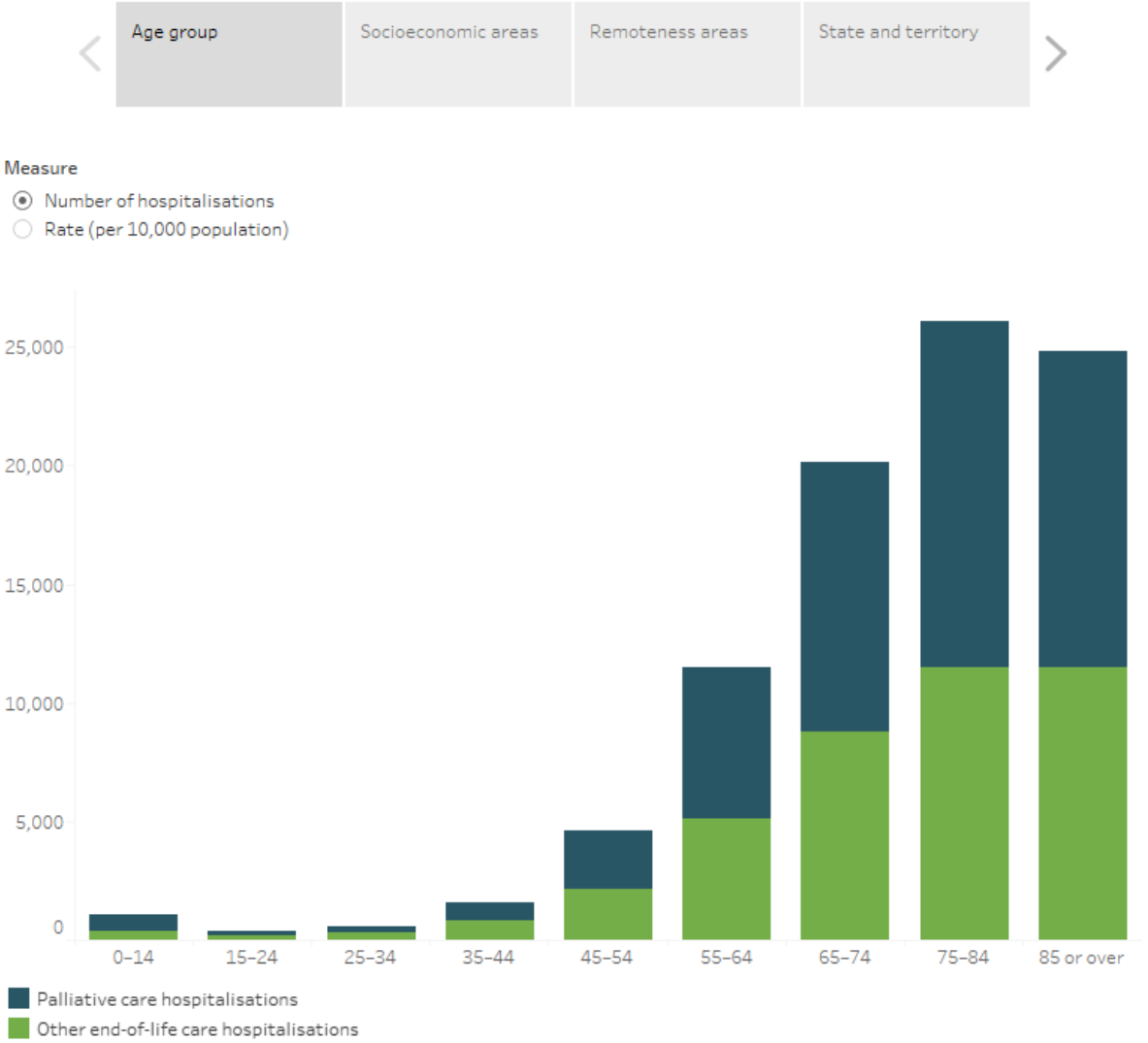
Most of the palliative care-related hospitalisations were recorded in public hospitals (85%), a higher proportion than that recorded for all hospitalisations (59%, Table APC.2).

In 2020–21, among 90,700 [palliative care-related hospitalisations](#):

- More were for males (53%) than females – a different pattern to that for hospitalisations for all reasons where females accounted for more than half (52%; see Table APC.1).

- Over half (56%) were for people aged 75 and over – the average age at admission for palliative care-related hospitalisations was 74 years, which was considerably older than that for hospitalisations for all reasons (56 years). Almost 1 in 10 (9.0%) palliative care-related hospitalisations were for those aged under 55 (Table APC.1).
- 2,400 were for Aboriginal and Torres Strait Islander people (1,400 for palliative care and 1,000 for other end-of-life care hospitalisations), with the majority occurring in public hospitals (95%) – a higher proportion than that observed for all hospitalisations (87% in public hospitals; see Table APC.5).
- Those living in the lowest [socioeconomic areas](#) had hospitalisation rates in public hospitals twice as high as those in the highest socioeconomic areas – 43 compared with 20 per 10,000 population. Conversely, in private hospitals those in the highest socioeconomic areas had palliative care-related hospitalisation rates 2.6 times as high as those in the lowest socioeconomic areas (8.5 compared with 3.2 per 10,000 population, respectively). These same patterns were also observed for hospitalisations for all reasons, although for private hospitals the differences were not as marked (Figure APC.1 and Table APC.4).
- Those living in *Inner regional* and *Outer regional areas* had the highest rate of palliative care hospitalisations in public hospitals – 22 and 24 per 10,000 population in *Inner regional* and *Outer regional areas* compared with 15 and 16 in *Major cities* and *Remote and very remote areas* (combined). For other end-of-life care hospitalisations, the rate of hospitalisations in public hospitals, increased with increasing remoteness (from 13 per 10,000 population in *Major cities* to 17 per 10,000 population in *Remote and very remote areas* combined), consistent with the pattern for all hospitalisations. However, a different pattern was observed for private hospitals where palliative care-related hospitalisations decreased with increasing remoteness, consistent with the pattern for all hospitalisations (Figure APC.1 and Table APC.3).

**Figure APC.1: Characteristics of those hospitalised for palliative care or other end-of-life care, 2020-21**



Source: AIHW. Table APC.1.  
<http://www.aihw.gov.au/pcsia>

## Variation across geographical areas

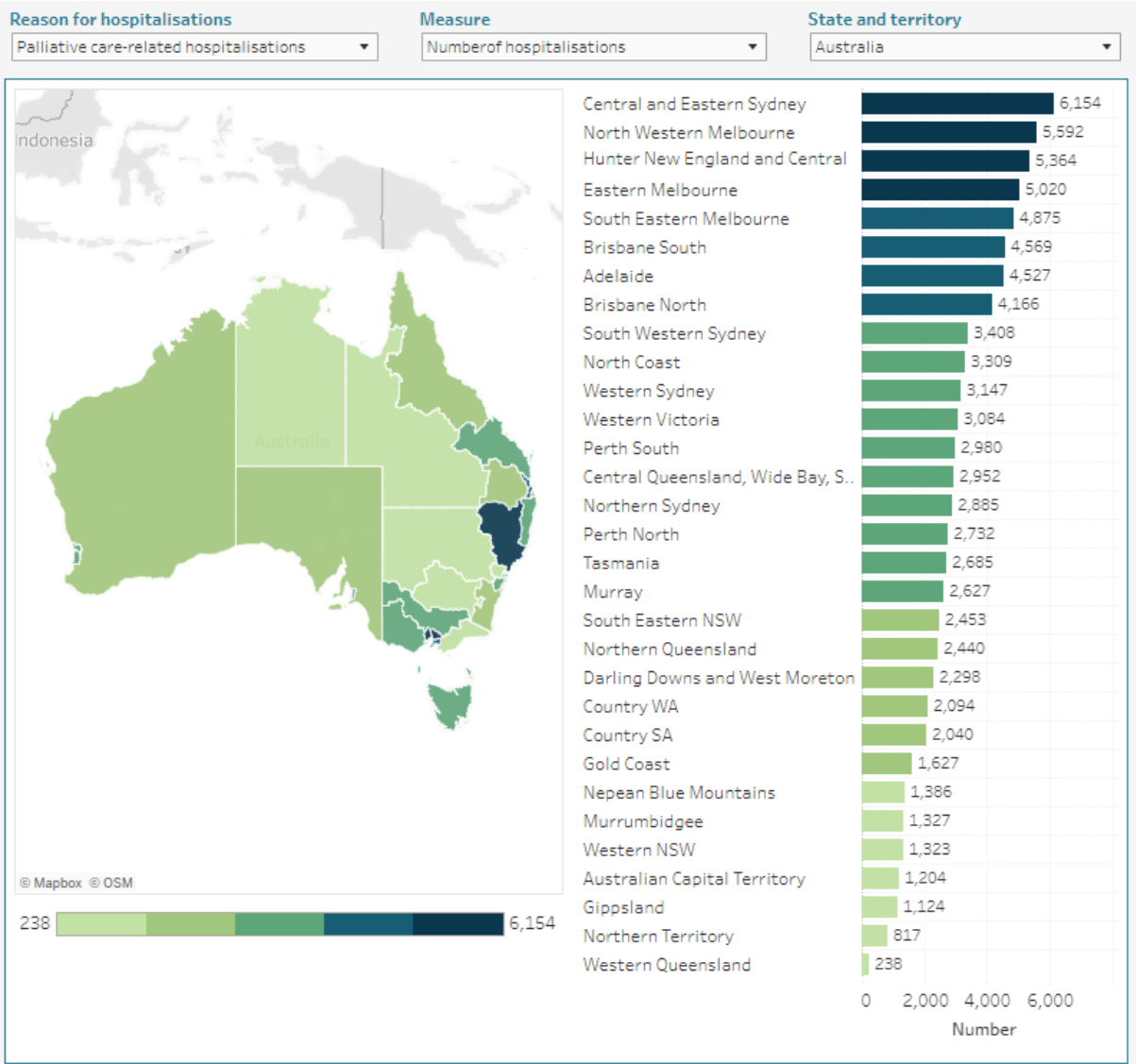
The rate of palliative care-related hospitalisations varied across the states and territories, ranging from 29 hospitalisations per 10,000 population in Western Australia to 38 hospitalisations per 10,000 population in New South Wales (with publishable data).

- In public hospitals, Tasmania recorded the highest rate (41 per 10,000 population) and Western Australia the lowest (19 per 10,000 population), while in private hospitals (with publishable data) Western Australia and Queensland recorded the highest (9.4 and 9.0 per 10,000 population) and New South Wales the lowest (3.0 per 10,000 population; Figure APC.1).

Across the [Primary Health Networks \(PHN\)](#) areas, the rate of palliative care-related hospitalisations varied as well, ranging from 24 hospitalisations per 10,000 population in Western Australia Perth North PHN area to 62 hospitalisations per 10,000 population in New South Wales North Coast PHN area (Figure APC.2).

- For palliative care hospitalisations, those living in New South Wales North Coast PHN area also had the highest rate (45 per 10,000 population), while those living in Country South Australia PHN area had the lowest rate (11 per 10,000 population).
- This pattern differed from other end-of-life care hospitalisations, where those living in Western Victoria PHN area had the highest rate (30 per 10,000 population), while those living in Queensland Gold Coast PHN area had the lowest rate (4.8 per 10,000 population).
- In contrast, for hospitalisations for all reasons, those living in Northern Territory PHN area had the highest rate (7,700 per 10,000 population), while those living in Western Sydney PHN area had the lowest rate (3,400 per 10,000 population).

**Figure APC.2: Palliative care-related hospitalisations, by Primary Health Networks (PHN) areas, 2020-21**



Source: AIHW. Table APC.6.  
<http://www.aihw.gov.au/pcsia>



## What were the characteristics for their hospital stay?

### Primary reason for hospitalisation

In 2020–21, among 90,700 [palliative care-related hospitalisations](#), cancer was the most common [principal diagnosis](#) recorded for palliative care-related hospitalisations (42%) – 1 in 2 (50%) for palliative care hospitalisations and almost 1 in 3 (31%) for other end-of-life care hospitalisations (Table APC.7a).

- Secondary site cancer (cancer of an unknown or ill-defined primary site) was the most frequently reported cancer (11% and 9.9% for palliative care and other end-of-life care hospitalisations, respectively), followed by lung cancer (8.2% and 3.8% for palliative care and other end-of-life care hospitalisations, respectively).
- Most frequently reported principal diagnosis other than cancer was cerebrovascular disease (4.6%) and septicaemia (3.7%) for palliative care hospitalisations, and other ill-defined causes (5.4%) and septicaemia (5.1%) for other end-of-life care hospitalisations (Table APC.7a).

### Average length of stay

In 2020–21, [average length of stay](#) for overnight palliative care-related hospitalisations (hospitalisations that exclude same-day stays) was almost twice as long as all overnight hospitalisations – 10 days (9.2 days for palliative care hospitalisations and 11.1 days for other end-of-life care hospitalisations) compared with 5.3 days for all hospitalisations (Figure APC.3). Among palliative care-related hospitalisations:

- Patients spent on average longer in private hospitals than public hospitals – 12.4 days in private hospitals compared with 8.7 days in public hospitals for overnight palliative care hospitalisations and 12.8 days compared with 10.7 days, respectively, for overnight other end-of-life care hospitalisations. In contrast, the average length of stay for overnight hospitalisations for all reasons was relatively similar in private and public hospitals (5.1 and 5.4 days).
- The average length of overnight hospital stays varied across states and territories in public hospitals – ranging from 7.0 days in Queensland to 11 days in the Australian Capital Territory for palliative care hospitalisations. A similar pattern was observed for other end-of-life care hospitalisations (8.6 days and 13 days respectively for these jurisdictions).
- In public hospitals, the average length of stay declined for palliative care overnight hospitalisations (from 10.1 days to 8.7 days between 2015–16 to 2020–21), while average length of stay remained relatively stable for palliative care hospitalisations in private hospitals (around 12–13 days), other end-of-life care (around 11 days in all

hospitals) and hospitalisations for all reasons (5.3–5.5 days in all hospitals) over the same period.

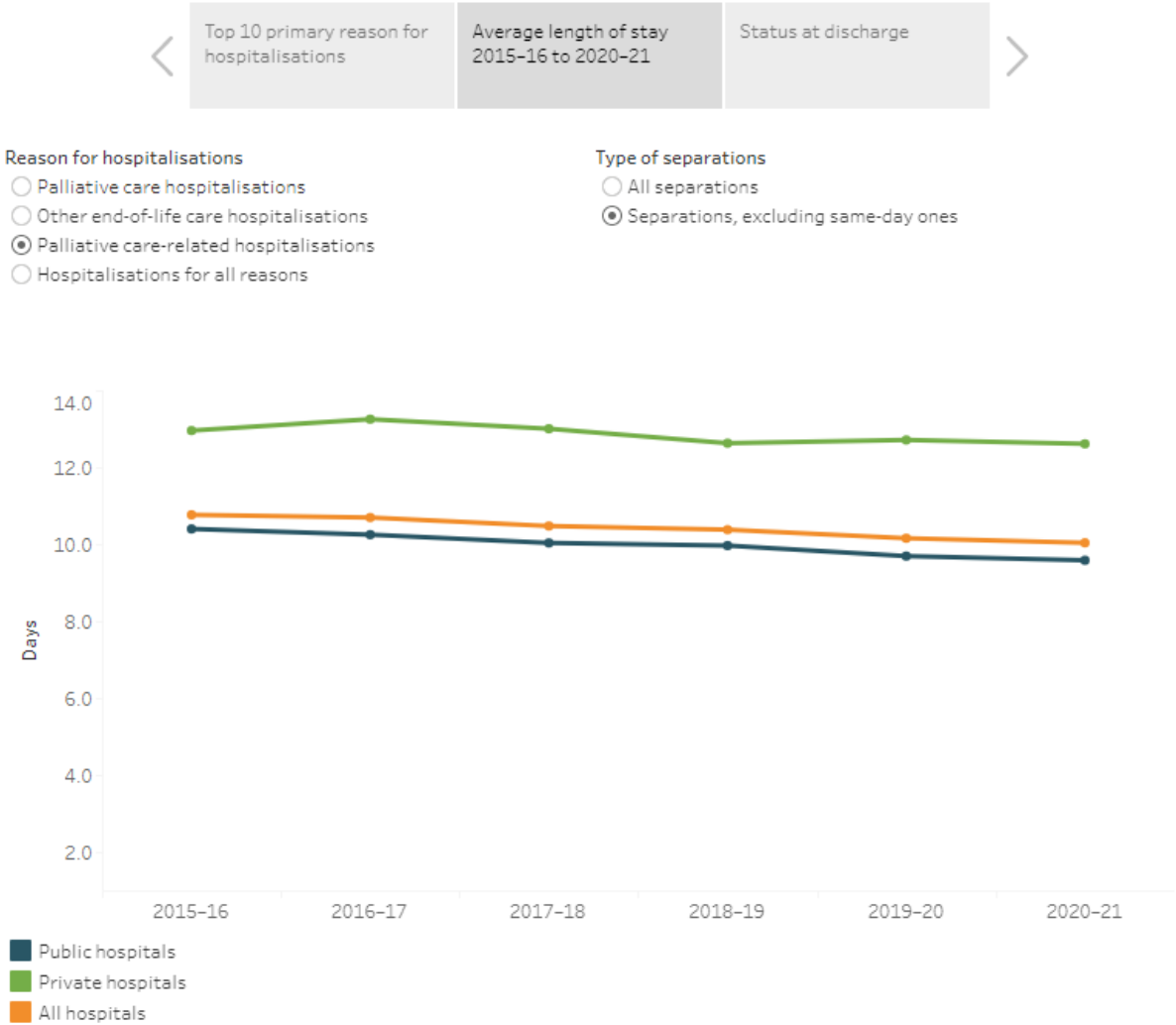
## Status at discharge

In 2020–21, 1 in 2 palliative care-related hospitalisations (53%) ended with the patient dying in hospital – 65% for palliative care hospitalisations (66% in public hospitals and 53% in private hospitals). For other end-of-life care hospitalisations, 40% ended with a patient's death (37% in public hospitals and 51% in private hospitals).

- In public hospitals, the proportion of hospitalisations for palliative care that ended in death ranged from 63% in South Australia to 77% in Tasmania, and for other end-of-life care hospitalisations ranged from 15% in the Northern Territory to 47% in Victoria and South Australia (Table APC.9).
- The next most common [status at discharge](#) was to usual residence (27%) – 23% for palliative care hospitalisations and 32% for other end-of-life care hospitalisations (Figure APC.3).

In 2020–21, 3 in 5 (63%) people who died in hospital had received palliative care or other end-of-life care during their final hospitalisation (42% had a record for palliative care and 21% for other end-of-life care). This proportion was higher in patients with a principal diagnosis of cancer compared with those whose principal diagnosis was other than cancer (85% and 53% respectively; Table APC.7b).

**Figure APC.3: Characteristics of palliative care-related hospital stay, 2020-21**



Source: AIHW, Table APC.13.  
<http://www.aihw.gov.au/pcsia>

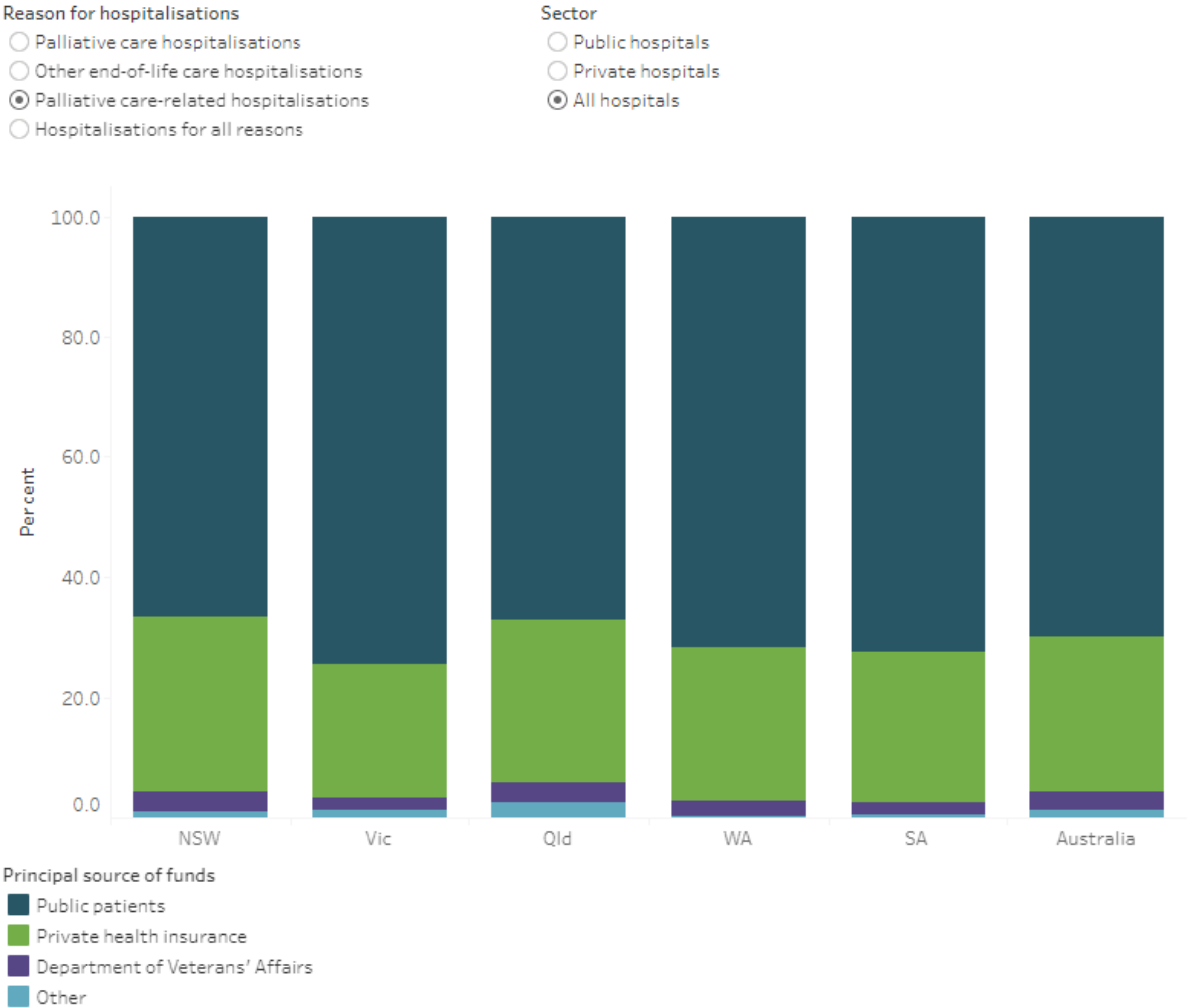
## Who paid for the care?

Public and private hospitals both receive [funding](#) from the Australian Government, state and territory governments, private health insurance funds and out-of-pocket payments by individuals. However, the relative contributions made by these sources of funds vary across the sectors, reflecting the types of patients they treat, the services they provide, and the administrative arrangements in which they operate (AIHW 2021).

In 2020–21:

- In public hospitals, public patient funding accounted for a lower proportion of palliative care-related hospitalisations than for all hospitalisations – 78% for palliative care, 81% for other end-of-life care and 86% for all hospitalisations. In contrast, private health insurance accounted for a higher proportion of funding for palliative care-related hospitalisations – 19% for palliative care and 16% for other end-of-life care, compared with 11% for all hospitalisations.
- In private hospitals, private health insurance was the funding source for 59% of palliative care hospitalisations, lower than that for other end-of-life care (85%) and all hospitalisations (80%; Figure APC.4).

**Figure APC.4: Proportion of principle funding source for palliative care-related hospitalisations, by sector, 2020–21**



*Notes:*  
 1. Data for private hospitals and all hospitals (public and private combined) in Tasmania, Australian Capital Territory and Northern Territory were not published for confidentiality reasons.  
 2. Data for some states and territories were not reported due to small number.  
 Source: AIHW, Table APC.10.  
<http://www.aihw.gov.au/pcsia>

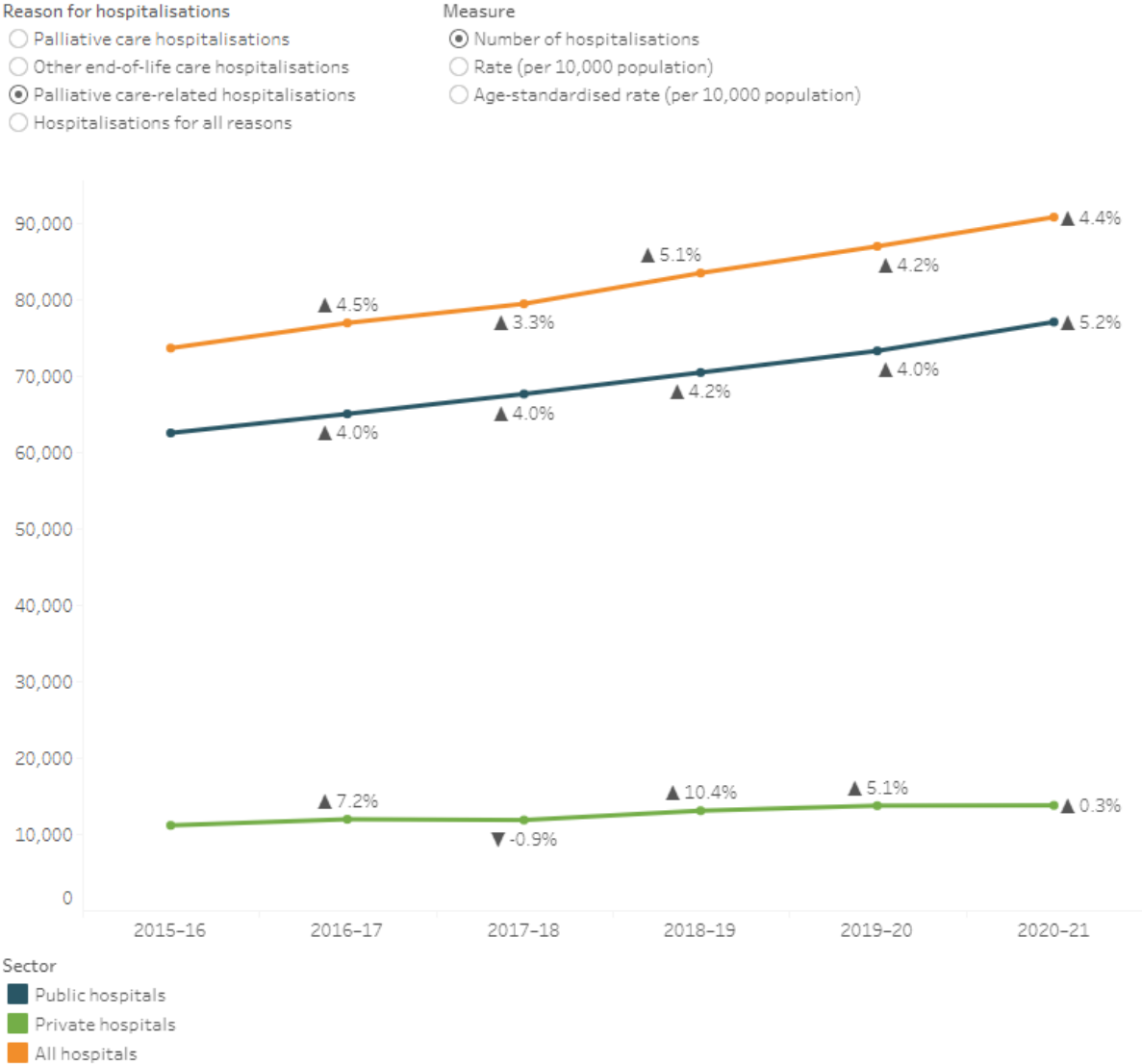
## How have hospitalisations changed over time?

Between 2015–16 and 2020–21, the number of palliative care-related hospitalisations increased more rapidly than hospitalisations for all reasons – 23% increase (from 73,600 to 90,700) compared with 12% increase (from 10.5 to 11.8 million), respectively. Among palliative care-related hospitalisations, the increase was steeper for other end-of-life care than palliative care hospitalisations over this period (29% compared with 19%, respectively). These increases in palliative care and all hospitalisations were observed in both public and private hospitals (Table APC.12).

While palliative care-related hospitalisations increased by 3–5% each year between 2015–16 and 2020–21, hospitalisations for all reasons had shown some fluctuations over the last 6 years – increased by 2–4% between 2015–16 and 2018–19, declined by 3% in 2019–20 and then increased by 6% the following year. These falls and rises in hospitalisations for all reasons in the 2 years to 2020–21 may reflect the introduction of public health measures (such as lockdowns and business/activity restrictions) in the early months of the COVID-19 pandemic to contain the spread of the virus, and the subsequent easing of restrictions in late 2020 through to mid-June 2021.

Between 2015–16 and 2020–21, the hospitalisation rate also increased – for palliative care-related hospitalisations from 31 to 35 per 10,000 population (17 to 20 per 10,000 population for palliative care hospitalisations and 13 to 16 per 10,000 population for other end-of-life care hospitalisations) and from 4,400 to 4,600 per 10,000 population for hospitalisations for all reasons. When adjusting for changes in the age structure of the population over this period, the increases in hospitalisation rates had been considerable smaller – the age-standardised palliative-care related hospitalisation rate increased from 26 to 28 per 10,000 population and from 4,100 to 4,200 per 10,000 population for hospitalisations for all reasons (Figure APC.5). This suggests that the ageing of Australia’s population is contributing to the growth in palliative care-related hospitalisations.

**Figure APC.5: Trends in palliative care-related hospitalisations, by sector, 2015–16 to 2020–21**



Source: AIHW. Table APC.12.  
<http://www.aihw.gov.au/pcsia>

## How many public hospitals have specialised palliative care units?

### National Public Hospital Establishments Database (dropdown box)

The National Public Hospital Establishments Database (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 (excludes hospitals operated by the Australian Government Department of Health and Aged Care, Department of Defence, or correctional authorities, for example, and hospitals located in offshore territories). The collection does not include data for private hospitals.

For more information on the data collection method and other relevant data issues, refer to the [Data sources](#) and [2020–21 NPHEd Data quality statement](#) (NPHEd 2021).

In 2020–21, a total of 112 public acute hospitals reported having a [specialist palliative care inpatient unit](#) nationally (see Table NPHEd.1 and [Data sources](#) for further details on this data collection). This represented 1 in 6 (17%) of the 674 public acute hospitals (excluding public psychiatric hospitals) in Australia included in the National Public Hospital Establishment Database (NPHEd).

New South Wales and Western Australia had the highest number of public acute hospitals with specialist palliative care inpatient units (33 and 31, respectively), and Western Australia had the highest proportion of public acute hospitals with specialist palliative care units (37%).

Around 1 in 4 (27%) public acute hospitals in *Major cities* had a specialist palliative care inpatient unit, around twice the rate in other areas (14% in *Inner regional and Outer regional areas* combined and 12% in *Remote and Very remote areas* combined).



## How much was spent by public hospitals for palliative care?

### National Hospital Cost Data Collection (**dropdown box**)

The National Hospital Cost Data Collection (NHCDC) is an annual collection of public hospital cost data in Australia managed by the Independent Health and Aged Care Pricing Authority (IHACPA) and is the primary data collection used to develop the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for the funding of public hospital services.

IHACPA uses classifications to categorise, cost and price hospital activity. Hospital activity relates to the management of (diagnostics and interventional) and the resources used by the patient in relation to their treatment. Classification systems are used to describe activity related to the following types of patient care: admitted acute care, subacute and non-acute care, non-admitted care, emergency care and mental health care. Palliative care is assigned to subacute care, a specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life.

State and territory health departments submit their cost data to IHACPA. To support consistency in the costing process, IHACPA works with stakeholders to develop and implement national costing standards that prescribes the set of line items and cost centres used for mapping hospital costs. IHACPA then creates **cost buckets** as cost pools within the hospital, by combining line items and cost centres, which are made up of:

- **Line items:** these represent types of costs (for example, salaries and wages or goods and services) incurred by hospitals which are reported on in the general ledgers of hospitals.
- **Cost centres:** these represent departmental cost, objects within a hospital that relate to a particular function of the hospital – for example, the hospital operating room (IHACPA 2022).

The current version of the standards is the [Australian Hospital Patient Costing Standards Version 4.1](#). For further information, see [IHACPA's Data collection page](#).

In 2020–21, among the 340 public hospitals that reported subacute care data to the Independent Health and Aged Care Pricing Authority (IHACPA), 259 hospitals had provided palliative care to patients, with a hospital cost of \$481.34 million. This

represents 19% of all subacute care cost (\$2.56 billion) and 1.1% of total cost (\$44.49 billion) in these 259 hospitals (Table NHCDC.1).

In 2020–21, of the 36,100 palliative care episodes and 61,800 [palliative care phases](#) recorded, the average cost per palliative care [episode](#) was \$13,300 and \$7,800 per palliative care phase.

Almost half of this cost per episode related to ward nursing (34%) and ward medical (15%) [cost buckets](#), 13% to ward supplies and 6% for allied health. Further, salaries and wages for nursing accounted for the biggest share (51%) of salaries for palliative care ([line items](#)), followed by salaries and wages for non-visiting medical officers (20%; Table NHCDC.1).

## References

AIHW (Australian Institute of Health and Welfare) (2021) [Health expenditure Australia 2019–20](#), Canberra: AIHW, Australian Government, accessed 17 January 2023.

AIHW (2022) [Australia's health 2022](#), Canberra: AIHW, Australian Government, accessed 28 January 2023.

IHACPA (Independent Health and Aged Care Pricing Authority) (2022) [National Hospital Cost Data Collection \(NHCCD\) Public Hospitals Report – Round 26 \(financial year 2021–22\)](#), Canberra: IHACPA, accessed 20 January 2023.

NPHEd (National Public Hospital Establishments Database) (2021) [Data Quality statement 2021](#), Hospital resources 2020–21: Australian hospital statistics, accessed 20 February 2023.

## Data sources

### National Hospital Morbidity Database

Data on admitted patient palliative care are sourced from the National Hospital Morbidity Database (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 ([Appendix A, AIHW 2022b](#)). The latest available data at the date of publication of this report was 2020–21.

### 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. In cases of more than one care type, length of stay refers to the length of the episode of care, not the total duration of the patient’s hospital stays.

### Coverage

For each of the years considered in this report, the coverage of the NHMD has been very good. For example, in 2020–21, coverage for the NHMD was high – data from all public

hospitals were included (AIHW 2022b). Most private hospitals also provided data, the exceptions being the private free-standing day hospital facilities and two overnight private hospitals in the Australian Capital Territory. Note that the data for private hospitals and all hospitals (public and private combined) in Tasmania, the Australian Capital Territory and the Northern Territory were not published for confidentiality reasons.

Hospitals may be re-categorised as public or private between or within years (see [NPHED 2021](#) for further information). This should be considered 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 2020–21, 18% of hospitalisations in the Australian Capital Territory were for patients who lived in New South Wales.

The AIHW *Indigenous identification in hospital separations data: quality report* assessed the quality of Indigenous identification in Australian public hospitalisations. The results of this study indicated that data for all jurisdictions should be used in any analyses of Indigenous hospitalisation rates and that the ‘true’ number of Indigenous persons was close to 9% higher than the number indicated in hospital records (AIHW 2013). This should be considered when interpreting the hospital data by Indigenous status. Note, no adjustment has been applied to the Indigenous counts in the hospital data in this report.

## Standard admitted patient care data exclusions

As per the standard AIHW practice when analysing admitted patient data in the NHMD, the data presented in this report 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 patients* (AIHW 2022a) and further information about the NHMD can be obtained from those publications. Metadata information for the Admitted Patient Care and Local Hospital Networks/Public Hospital Establishments National Minimum Data Set (NMDS), that are the basis for the AIHW National Hospital Databases (AIHW 2022b), 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 2020–21 database is available online.

## National Public Hospital Establishments Database

The National Public Hospital Establishments Database (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 and Aged Care, 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 2020–21, the collection was based on the Local Hospital Networks/Public Hospital Establishments national minimum data set (LHN/PHE NMDS). 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 [2020–21 NPHEd Data quality statement](#) (NPHEd 2021).

## National Hospital Cost Data Collection

The National Hospital Cost Data Collection (NHCDc) is an annual collection of public hospital cost data in Australia, managed by the Independent Health and Aged Care Pricing Authority (IHACPA), and is the primary data collection used to develop the National Efficient Price (NEP) and National Efficient Cost (NEC) Determinations for the funding of public hospitals services.

IHACPA uses classifications to categorise, cost and price hospital activity. Hospital activity relates to the management of (diagnostics and interventional) and the resources used by the patient in relation to their treatment. Classification systems are used to describe activity related to the following types of patient care: admitted acute care, subacute and non-acute care, non-admitted care, emergency care and mental health care. Palliative care belongs to subacute care, a specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life.

The health departments of Australia's states and territories submit their cost data to IHACPA. Taken together, the collection represents the primary source of information about the cost of treating patients in Australian hospitals. To support consistency in the costing process, IHACPA works with stakeholders to develop and implement national costing standards. The Standards prescribes the set of line items and cost centres used for mapping hospital costs. IHACPA then creates cost buckets as cost pools within the hospital, by combining line items and cost centres.

The current version of the standards is the [Australian Hospital Patient Costing Standards Version 4.1](#). For more information about data specifications, see [IHACPA's Data collection](#) page.

## References

AIHW (Australian Institute of Health and Welfare) (2013) *Indigenous identification in hospital separations data: quality report*, Cat. no. IHW 90, Canberra: AIHW, Australian Government, accessed 28 January 2023.

AIHW (2022a) *Admitted patients*, Canberra: AIHW, Australian Government, accessed 17 January 2023.

AIHW (2022b) *Admitted patient care NMDS 2020–21*, Canberra: AIHW, Australian Government, accessed 26 January 2023.

NPHEd (National Public Hospital Establishments Database) (2021) *Data Quality statement 2021*, Hospital resources 2020–21: Australian hospital statistics, accessed 20 February 2023.

# Key Concepts

## Admitted patient palliative care and hospital-based facilities

Key Concept	Description
<b>Additional diagnosis</b>	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment. Additional diagnoses are recorded in accordance with ICD-10-AM Australian Coding Standards.
<b>Admitted patients</b>	Patients who undergo a hospital's formal admission process to receive treatment and/or care. This treatment and/or care is provided over a period and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).
<b>Age-standardisation</b>	Method to remove the influence of age when comparing rates between population groups with different age structures. This is used as the rate of many diseases vary strongly (usually increasing) with age, and so too can service use, for example, hospitalisations – a population group with an older age structure will likely have more hospitalisations. The age structures of different populations are converted to the same 'standard' structure, and then the relevant rates, such as hospitalisations, that would have occurred within that structure are calculated and compared.
<b>Average length of stay</b>	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.
<b>Care type</b>	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.
<b>Cost bucket</b>	According to National Hospital Cost Data Collection (NHCDC), cost buckets represent different combinations of the line items and costs centres and can be considered as cost pools within the hospital.
<b>Cost centre</b>	According to National Hospital Cost Data Collection (NHCDC), cost centres represent departmental cost objects within a hospital that relate to a particular function of the hospital – for example, the hospital operating room.
<b>Episode of care</b>	The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type (see care type and hospitalisation).
<b>Funding source</b>	The principal source of funds for an admitted patient episode (hospitalisation).
<b>Hospitalisation</b>	An episode of hospital care that starts with the formal admission process and ends with the formal separation process (synonymous with admission and separation). An episode of care can be completed by the patient’s being discharged, being transferred to another hospital or care facility, or dying, or by a portion of a hospital stay starting or ending in a change of type of care (for example, from acute to rehabilitation).
<b>Index of Relative Socio-Economic Disadvantage</b>	<p>1 of 4 Socio-Economic Indexes for Areas (SEIFA) compiled by the ABS. The Index of Relative Socio-Economic Disadvantage (IRSD) has been used in this report to indicate socioeconomic position for five groups (quintiles) – from the most disadvantaged (worst off or lowest socioeconomic area) to the most advantaged (best off or highest socioeconomic area).</p> <p>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</p>

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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.

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**Line item**

According to National Hospital Cost Data Collection (NHDC), line items represent types of costs (for example, salaries and wages or goods and services) incurred by hospitals which are reported on in the general ledgers of hospitals.

**Other end-of-life care hospitalisations**

Defined, for the purposes of this report, as hospitalisations with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care.

Note that the use of the term “other end-of-life care” in this report refers to the broader palliative care definition and is not limited to end-of-life care (generally defined as people who are likely to die within the next 12 months). Further information can be found in the [Identifying palliative care-related hospitalisations](#) section.

**Palliative care hospitalisations**

Defined, for the purposes of this report, as hospitalisations with a recorded care type of palliative care. Further information can be found in the [Identifying palliative care-related hospitalisations](#) section.

**Palliative care-related hospitalisations**

Defined, for the purposes of this report, as hospitalisations refer to those episodes of admitted patient care where palliative care was a component of the care provided during all or part of the episode. These hospitalisations can be divided into 2 groups depending on how they are identified in the hospital data:

- [palliative care hospitalisation](#): hospitalisations with a recorded care type of palliative care, and

- **other end-of-life care hospitalisation:** hospitalisations with a recorded diagnosis of palliative care, but the care type is not recorded as palliative care.

Note that the use of the term “other end-of-life care” in this report refers to the broader palliative care definition and is not limited to end-of-life care (generally defined as people who are likely to die within the next 12 months).

**Palliative care phase**

The stage of a patient's illness. The palliative care phase refers to a distinct clinical period which reflects the stage of the patient's illness. Palliative care phase provides a good indication of the type of care required by a palliative care patient.

An episode of admitted patient palliative care may comprise of a single phase or multiple phases, depending on changes in the patient's condition. Phases are not sequential, and a patient may move back and forth between phases within the one episode of admitted patient palliative care.

**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.

**Primary Health Networks**

Primary Health Networks (PHNs) were established on 1 July 2015. These networks are intended to play a critical role in connecting health services across local communities so that patients, particularly those needing coordinated care, have the best access to a range of health care providers, including practitioners, community health services and hospitals. Primary health networks work directly with general practitioners, other primary care providers, secondary care providers and hospitals.

PHNs connect health services across a specific geographic area (a PHN area), with the boundaries defined by the Australian Government Department of Health and Aged Care (see [Primary Health Networks \(PHNs\) national map of PHN boundaries](#) for details).

	There are 31 PHN areas that cover the whole of Australia, which closely align with the state and territory local hospital networks.
<b>Principal diagnosis</b>	The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care (hospitalisation). Diagnoses are recorded using the relevant edition of the International statistical classification of diseases and related health problems, 10th revision, Australian modification (ICD-10-AM).
<b>Private hospital</b>	A privately (non-government) owned and operated institution catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Acute care and psychiatric hospitals are included in this category as are private free-standing day facilities.
<b>Public hospital</b>	A hospital controlled by a state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients.
<b>Specialist palliative care inpatient unit</b>	A type of specialist unit delivering palliative care services and can include both free-standing hospices and/or palliative care wards within a hospital.
<b>Status at discharge</b>	Status at discharge was calculated using the variable of 'Separation mode' in Admitted Patient Care data.  Status at separation of person (discharge/transfer/death) and place to which person is released, as represented by a code. For further information on 'Separation mode', please refer to its <a href="#">Metadata Online Register page</a> .