Department of Health

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Tasmanian Government

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Professor Michael Pervan
Chief Executive Officer
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Dear Professor Pervan

Thank you for your letter dated 20 March 2023 regarding the National Hospital Cost Data Collection 2021-22 Data Quality Statement.

Please find attached the Tasmanian Government's Department of Health Data Quality Statement for the 2021-22 NHCDC submission.

Should you require any further information, please contact Kyle Lowe, Director Monitoring Reporting and Analysis on 6166 1074.

Yours sincerely

Shane Gregory
Associate Secretary

12 May 2023

Enc: Attachment 1 - Department of Health Tasmania - Data Quality Statement 2021-22

Department of Tasmania Data Quality Statement 2021-22

1. Governance processes and results

1.1 Governance arrangement

The Local Health Network (LHN) for Tasmania, the Tasmanian Health Service (THS), currently has four major hospitals, 18 rural sites and two state-wide facilities. This has not changed from the previous submission.

Patient costing is undertaken annually by the Department of Health (DoH) Clinical Costing Unit (CCU), on behalf of the THS. Due to Tasmania's size, the CCU performs functions for both the LHN and the Department of Health, building and submitting the costing data to the Independent Health and Aged Care Pricing Authority (IHACPA).

Each year, the CCU meets with relevant business managers to review cost centre expenditure, make any adjustments that are needed to better align the financial ledger to the costing ledger, and review current allocations statistics, updating as required. Throughout the year, data quality checks are carried out, and any issues identified are addressed with relevant business managers.

An internal quality assurance check list is used throughout the year to ensure that costing is accurate and key aspects are checked. Areas of focus include:

- reconciliation from audited financial statement through to submission file
- checks for negative cost centres, line items and episodes
- comparison of ledger changes at the line item and cost centre level between years
- confirmation that overhead-to-final ratios are as expected
- casemix is compared across sites and against national averages
- review of low and high-cost patients
- checks on patient data quality
- confirmation that utilisation data between years is reasonable and as expected and
- confirmation that bucket matrix results are as expected

The CCU has also developed a suite of automated audit reports that are run regularly to ensure that feeder data is accurate and free from identifiable errors. Costing data is available to key stakeholders through internal dashboard reports, allowing users to view data from a jurisdictional level down to episodic data for the current and previous years.

For most years, an annual costing report is written and distributed to allow for comments and feedback from key stakeholders. This report covers:

- scope of reporting
- costs included in the costing ledger and how this differs to the financial statement
- admitted acute – broken down by changes to each major hospital, same day to overnight, medical vs surgical, elective surgery and bucket analysis
- emergency department – average cost, changes in length of stay, admitted vs non admitted grouped by major hospitals
- non-admitted – average cost, tier 2 class comparison by major hospitals

- sub-acute – expenditure, changes in average cost and length of stay by major hospitals and
- rural sites, work in progress and non-ABF activity.

1.2 Summary of 2021-22 results

For costing purposes, the THS currently has four major hospitals, 18 rural sites and two state-wide facilities.

Total expenditure for the 2021-22 costing ledger totalled $2.54 billion, incorporating:

- the expenditure portion of the THS audited financial statement - $2.2 billion
- THS salary and wages workers compensation recoveries - $6 million
- corporate cost centres that provide a service the THS - $112 million
- expenditure related to National Partnership Covid Response (NPCR)- $201 million and
- 2020-21 Work in Progress (WIP) carried forward into 2021-22 - $74 million

WIP expenditure is spread throughout the following streams:

- admitted acute - 42 per cent - $1 077 million
- emergency departments - eight per cent - $208 million
- non-admitted - 10 per cent - $249 million
- admitted sub-acute - three per cent - $88 million
- other admitted accounts – two per cent - $61 million
- mental health accounts - six per cent - $150 million
- other non-submitted cost accounts - 28 per cent - $713 million and
- end of year work in progress (WIP) - four per cent - $103 million

A comparison between Round 26 and Round 25 is as follows:

- The audited THS general ledger for 2021-22 was $2.2 billion, an increase of nine per cent on the previous year.
- Total expenditure in the costing ledger totalled $2.54 billion, an increase 18 per cent from 2020-21.
- Expenditure submitted as part of the National Hospital Cost Data Collection (NHCDC) totalled $1.67 billion compared to $1.48 billion the year before, resulting in a 13 per cent increase.
- Episodes submitted as part of the NHCDC increased by 22 per cent from the previous year from 1.03 million episodes to 1.26 million episodes. The main changes to streams were in the acute stream increasing by 13 per cent, and 26 per cent in outpatient appointments. The acute increase is due to a general increase across all service groups, while the large increase in outpatients is down to a large increase in diagnostic services related to Covid testing.
- Expenditure not submitted as part of the NHCDC totalled $876 million, an increase of $199 million on the previous year. This increase is due to an increase in total expenditure related to NPCR. Tasmania brings in all expenditure related to NPCR regardless of whether it occurs in the LHN or outside. This allows for easier reconciliation between expenditure submitted to the national funding body and costs excluded as part of the NHCDC.

Activity Cost Comparisons

The table below shows the comparison of the number of episodes and cost by care groups between 2021-22 and 2020-21 submitted to IHCPA as part of the NHCDC.

Table 1: Comparison of the number of episodes and cost by care groups between 2021-22 and 2020-21 submitted to IHCPA as part of the NHCDC

Care Group	Type	2020-21	2021-22	% Change
Inpatient	Episodes	136,654	154,079	13%
	Full Cost	$889,997,777	$1,056,894,849	19%
Emergency Department	Episodes	170,848	173,894	2%
	Full Cost	$169,149,306	$198,562,524	17%
Mental Health	Episodes	13,215	14,598	10%
	Full Cost	$74,099,205	$81,886,391	11%
Outpatient	Episodes	708,390	893,210	26%
	Full Cost	$271,156,224	$241,282,901	-11%
Sub-Acute	Episodes	3,824	3,980	4%
	Full Cost	$70,762,338	$81,444,449	15%

Overall, the increases in both episodes and cost for Inpatient and Mental Health are consistent between years. Emergency Department (ED) and Sub-Acute experienced a slightly higher increase in cost than the growth in presentations.

Outpatient is the only area that experienced an increase in episodes and a decrease in full cost.

Other changes include:

- Inpatients increased by 17 425 episodes in 2021-22 or 13 per cent with the expenditure increasing by a similar percentage. The variation aligns with the jump in the expenditure of $167 million. The increase in inpatient cost was caused by the increase in presentations, increase in expenditure related to acute and an improvement in outpatient reporting shifting expenditure to inpatient and other streams.
- Emergency Department (ED) had a minor increase in presentations of approximately 3 000, or two per cent, while the cost rose by 17 per cent. The cost bucket structures between the two years are consistent with the major proportion in the ED bucket, followed by Imaging and Oncosts. The increase was caused by cost centres which directly contribute to ED increasing by $24 million.
- Mental health increased in the number of episodes and costs, increasing by 10 and 11 per cent respectively. This is due to improvements in data capture for community mental health episodes and phases data.
- The total outpatient cost for the 2021-22 financial year was $241 million, which is a decrease of $30 million or 11 per cent from the previous financial year, while the number of episodes increased by 26 per cent. This change was due to improvements in outpatient duration reporting. The change reduced the average duration, shifting expenditure from outpatients to

other streams but predominantly inpatients. The number of Covid tests being reported increased also contributing to the overall growth in outpatient appointments.

- The sub-acute episodes increased by four per cent, resulting in an overall 15 per cent increase in associated expenditure. This was due to the general increase in the length of stay of maintenance and palliative care episodes.

1.3 Compliance to the Australian Hospital Patient Costing Standards (AHPCS)

The Tasmanian Department of Health has followed the current AHPCS costing standards apart from the areas noted below.

Expenditure data is reported for the whole of the LHN regardless of whether it is to be submitted to IHACPA or not. This allows for easier reconciliation from the financial statement and costing ledger to the cost file submitted. Any expenditure that does not form part of the costing standards is allocated to a non-patient product to allow it to be reported on internally.

Cost centres that are brought into the costing software are allocated to the appropriate group based on the service they provide, being either an indirect or direct and appropriate NHCDC function. Distribution of the indirect cost centres is to other indirect cost centres as well as final cost centres and is based on an appropriate distribution method in consultation with key stakeholders.

Final cost centres are distributed to patients in several ways but fall in to three broad categories:

- Utilisation data is distributed using a relative value unit of the source data item cost.
- Hospital Services are generally distributed based on time, be it time on ward, time in theatre, time in ED or anaesthetics time
- Other Services covers items like outsourced contracted procedures (distributed by DRG or contract cost) and manually loaded data, for example, interpreter services or community carers.

The following are areas requiring future improvement to fully comply with the costing standards.

1.2 Identify Relevant Expenses – Third Party

Where possible we have identified any third-party costs and included them according to the standards. There may be areas within the LHN where we have not been informed of, or been able to identify, other third-party expenses.

6.1 Review and Reconcile – Data Quality Framework

Tasmania is partially compliant with this standard. The jurisdiction has a robust quality framework in place using a Quality Assurance (QA) checklist, QA reports and regular correspondence with stakeholders, as well as annual reviews of cost centres with relevant business managers. Tasmania also produces a costing report in most years, as well as internal business intelligence reports.

Minimal independent testing is done outside of the CCU and no external auditing is done on costing data. Further work is being done to improve usage of costing data as well as considering other mechanisms of review, to support compliance with this standard.

4 Teaching and Training

Teaching and Training (TT) is only partially recorded at a cost centre level where it has been identified by the relevant stakeholders. This expenditure is then allocated to a non patient product and excluded from the NHCDC submission. There is no dedicated software available or staff to record TT. There are several projects underway to enable the capture of TT data, and the state

government is implementing a new payroll system which will capture some staff training. The costing unit has a working group with Finance, HR, and the Funding Unit to review, and where possible, capture dedicated TT activities.

5 Research

Research is only identified based on a specified general ledger criterion. Expenditure contained in research cost centres is not reviewed regularly and may not include salary and wages for staff paid from cost centres outside of these research cost centres.

29 Mental Health

While the standards have been followed for the costing of mental health, data quality is not robust and further work needs to be done to improve data quality.

2. Other relevant information

Data quality and reporting for both subacute and mental health phase and episode data is an area that will need continual enhancement and refinement. Further work needs to be done to improve data capture and accuracy, along with matching to the National Minimum Data Set (NMDS) for both Australian national Subacute and Non-Acute Patient Classification (AN-SNAP) and Australian Mental Health Care Classification) AMHCC.

In 2021-22, expenditure on contracted care increased and there are challenges aligning invoices received to patient episodes, for the purposes of costing. This can result in an invoice received in the next year not being applied to patients that have had surgery in current reporting cycle. With no direct link between expenditure and patient episodes, the contract price is used as a relative value unit to distribute the expenditure to contracted patients for that year.

Outpatient appointments is another area for review in the coming cycle.

3. NHCDC declaration

All data provided by Tasmania to the 2021-22 NHCDC has been prepared in accordance with the Three-Year Data Plan 2021–22 to 2023–24, Data Compliance Policy June 2021, and the Australian Hospital Patient Costing Standards (AHPCS) Version 4.1.

Best endeavours were undertaken to ensure complete and factual reporting and compliance. Data provided in this submission has been reviewed for adherence to the AHPCS Version 4.1 and is complete and free of known material errors.

Assurance is given that to the best of my knowledge the data provided are suitable to be used for the primary purpose of the NHCDC, which includes the development of the National Efficient Price.

Shane Gregory
Associate Secretary
Department of Health – Tasmania

12 May 2023