

National Hospital Cost Data Collection (NHCDC) Public Sector Review 2021-22

July 2024



IHACPA

NHDC Public Sector Review 2021-22 — July 2024

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1 Executive Summary

1.1 Introduction

The National Hospital Cost Data Collection (NHCDC) is the annual collection of public hospital costing data and is the primary data collection used to inform the development of the national efficient price (NEP). In 2021-22, NHCDC cost data was submitted from 667 hospitals (including health entities) across all jurisdictions.

To ensure that the quality of NHCDC data is robust and fit-for-purpose, the Independent Health and Aged Care Pricing Authority (IHACPA) commissions an annual validation process to verify that jurisdictions included appropriate costs and patient activity.

IHACPA engaged Paxon Consulting to undertake the NHCDC Public Sector Review 2021-22. The objectives of the review were to confirm that jurisdictions correctly applied version 4.1 of the Australian Hospital Patient Costing Standards (AHPCS), ensure the general ledger reconciled with the submitted cost data, and consult jurisdictions on the future of the independent financial review (IFR).

The AHPCS provides direction to costing practitioners through the development of standards for specific elements of the costing process and reporting requirements. The AHPCS Version 4.1 is comprised of:

- Part 1: Standards – provides costing principles.
- Part 2: Business Rules – provides practical guidance on how Standards are translated into action.
- Part 3: Costing Guidelines – provides step-by-step guidance on how to cost services.

1.2 Process

The NHCDC Public Sector Review 2021-22 was delivered in 3 key phases as outlined below:

- Phase 1: Desktop Review - Review the NHCDC Public Sector Submissions 2021-22, Data Quality Statements 2021-22, Self-Assessments 2021-22, and the 2020-21 Independent Financial Review (IFR) findings.
- Phase 2: Development of Targeted Questions - Targeted questions were developed for each jurisdiction based on each stage of the AHPCS, the NHCDC Submission 2021-22, and general ledger reconciliation. This included constraints or limitations related to general ledger expenses, activity data, and allocation statistic methodologies.
- Phase 3: Bilateral Meetings - Consulted all states and territories on their application of each stage of the AHPCS, NHCDC Submission 2021-22, general ledger reconciliation to the NHCDC 2021-22, and purpose and scope of future IFRs.

Questions were developed to guide the bilateral meetings in line with the 6 stages of the AHPCS, as described in Table 1.

Table 1: Jurisdictional review themes

Costing Stage	Description	Finding
Stage 1: Identify Relevant Expenses	The process of identifying financial information used as the basis for hospital costing, including the identification of all relevant product costs, such as third-party expenses, offsets, and recoveries. The objective is to provide consistent and complete recognition of all expenses incurred by an organisation in providing its products.	The scope of expenses identified within core financial records and the general ledger are robust and follow the costing standards. Variation is observed across specific areas of financial data such as contracted care (including patient transport), third-party expenses and private patient service expenditure and are typically related to the availability of appropriate data feed systems that clearly delineates these expenditures and their related products.
Stage 2: Create the Cost Ledger	Stage 2 aims to ensure a consistent approach in establishing the cost ledger as the basis for product costing. This includes matching expenses to cost objects and hierarchy with an economically feasible approach that is consistent, defensible and reflects causal relationships.	Jurisdictions reported a generally consistent approach to cost allocation. The application of specific costing methodologies was aligned with costing standards in relation to the use of allocation statistics, product fractions and relative value units. There was variation in the use of these specific methodologies observed across health services and between jurisdictions.
Stage 3: Create Final Cost Centres	Stage 3, the creation of final cost centres, specifies the approach to allocate product cost centres to final cost centres. The standards outline how expenses are allocated to overhead cost centres.	Several jurisdictions report using a single general ledger and chart of accounts allowing consistent costing and allocation at the jurisdictional level. Some variation was reported, between individual health networks and jurisdictions, in the approach used to allocate costs across intermediate and final products.
Stage 4: Identify Products	Stage 4, identification of products, addresses how the organisation will determine product types, product costs and specifies the minimum requirements and preferred source of information required to measure cost objects and products. The aim of this stage and the related costing standard is to ensure that all products provided by the organisation are grouped into product categories that sufficiently differentiate between patient products and non-patient products, and nationally consistent measures of patient products are drawn from local systems.	Allocation of third-party expenses and contracted care was typically achieved in alignment with the costing standards, with exceptions related to the availability of robust financial data (refer Stage 1 above). The information requirements and feeder systems necessary to facilitate effective hospital costing is well established. Specific instances of data limitations were identified across new areas of costing in some jurisdictions, such as non-admitted, mental health and palliative care (episode and phase level), however, these systems are seeing incremental improvement in the accuracy and specificity of data collected. The maturing of these systems is in line with changing costing and pricing requirements.
Stage 5: Assign Expenses to Products	Stage 5, assignment of expenses to products, specifies how expenses accumulated in final cost centres are to be matched to final products. Intermediate products are linked to the final products that they helped produce, and products partially completed allocated to correctly reflect the expense incurred to produce the associated products.	Most jurisdictions assign expenses to final and intermediate products in accordance with the standards, which includes correctly identifying work in progress patients and costs. Most states and territories utilise relative value units to distribute costs if there is a lack of patient level data. Other methods include the utilisation of time-based data – e.g., time spent on a ward or theatre to allocate costs to products. All states and territories confirmed that the work in progress patient data reported by IHACPA was correct.
Stage 6: Review and Reconcile	Stage 6 of the costing process outlines the recommended approach and processes that should be undertaken to review the costing process and outputs. This outlines the data quality framework to be applied to the product costing process and guidelines for addressing the treatment of negative costs. This stage aims ensure that product cost information reported for internal and external purposes is fit-for-use and aligns with the Standards and Business Rules.	Assurance, review and reconciliation processes are robust and well established within most jurisdictions. Most jurisdictions undertake this process at multiple levels, typically at the health network level as well as at the system manager level (jurisdiction health department).

1.3 Recommendations

The scope of the NHCDC Review 2021-22 was to:

- review each jurisdiction’s application of the Australian Hospital Patient Costing Standards Version 4.1
- reconcile each jurisdiction’s general ledger with the cost data submitted
- consult jurisdictions on the future of the Independent Financial Review (IFR).

Table 2 outlines 3 recommendations relating to the future of the NHCDC and IFR, developed following the jurisdictional consultations. For further information on the recommendations, refer to the [Recommendations Chapter](#).

Table 2: Recommendations

No.	Recommendations
1	The IFR as a reconciliation process to be discontinued and the jurisdictions to continue to provide IHACPA with a Data Quality Statement outlining exceptions in the application of the Australian Hospital Patient Costing Standards and the general ledger reconciliation.
2	The NHCDC Advisory Committee to develop a work plan that investigates the cost variations across the jurisdictions through selected focus areas.
3	IHACPA to develop an NHCDC Data Quality Framework to improve the cost and activity data collections in consultation with the states and territories.

1.4 Summary Findings

Australian Hospital Patient Costing Standards (AHPCS)

The NHCDC 2021-22 dataset is a robust data source used to develop the national efficient price (NEP). There were common themes across all the bilateral meetings, including:

- Governance and quality assurance processes were well established across all jurisdictions, but particularly in larger jurisdictions with well-established costing infrastructure and capabilities.
- Most jurisdictions noted challenges in costing admitted and community mental health activity, although this is improving across jurisdictions. For this reason, the application of the AHPCS and the resulting quality of the data is expected to have a high variance across jurisdictions.
- Challenges in the collection and costing of phase level palliative care data was seen to experience similar challenges as those identified for mental health, across several jurisdictions.
- Issue with the identification, collection, and matching of third-party data remains a challenge across several participating jurisdictions reflecting fundamental technical challenges associated with this area of hospital costing.

General Ledger Reconciliation

Consultation sought confirmation of each jurisdiction's NHCDC submission, comparing figures sourced from IHACPA's summary NHCDC output tables with information on adjustments made to the general ledger (GL) prior to commencement of the costing process (creation of the cost ledger). Table 3 contains a summary of GL information used in various stages of the hospital costing process.

A total of \$67.3 billion of expenses were reported in the costing ledger submissions across all jurisdictions. Following adjustments for unqualified newborns, the final NHCDC dataset constitutes \$62.8 billion for all jurisdictions. Unlinked costs, work in progress (WIP), and other excluded costs of \$598.9 million and \$224.2 million respectively result in a final linked cost for the NHCDC submission of \$61.9 billion.

No material variances were identified between jurisdictional and IHACPA records through this process. This confirms all appropriate costs included in the GL have been included in the NHCDC 2021-22 national dataset. Note the variation between the total costing ledger and the total NHCDC submission for NSW and Tasmania represents costs of block funding, teaching, training, and research costs.

Table 3: General Ledger Reconciliation, \$ million

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
General ledger (GL)	22,539.2	21,286.6	18,193.5	7,048.3	8,467.0	2,204.3	2,218.8	1,931.6
Adjustments to the GL – <i>Inclusions</i>	561.1	691.4	263.3	-183.5	87.0	345.3	40.1	-
Adjustments to the GL – <i>Exclusions</i>	192.4	6,709.3	4,428.7	-2,041.6	2,113.3	-	968.6	450.0
Total Costing Ledger	22,907.9	15,268.7	14,028.1	4,823.2	6,440.7	2,549.6*	1,290.3	1,481.6
Total NHCDC Submission Received	17,750.8	15,268.7	14,028.1	4,823.2	6,440.7	1,668.2	1,290.3	1,481.6
Unqualified Baby Adjustment	-	0.1	0.1	-	0.0	0.0	-	-
NHCDC Dataset	17,750.8	15,268.6	14,028.0	4,823.2	6,440.6	1,668.2	1,290.3	1,481.6
NHCDC Unlinked Cost	0.8	265.5	9.4	104.4	124.5	49.7	44.2	0.4
WIP (2 years) and Exclude Cost Bucket	10.4	42.5	64.0	13.1	41.2	0.5	50.5	2.0
NHCDC Linked Cost (NHCDC data set minus Unlinked cost; WIP and exclude cost bucket)	17,739.7	14,960.6	13,954.6	4,705.7	6,274.9	1,618.0	1,195.6	1,479.2

Quality Assurance Process

To ensure that the quality of the NHCDC data is robust, the review process included an assessment of key quality assurance (QA) processes within each jurisdiction based on the consultations with each state and territory as well as the Data Quality Statements and Self-Assessments. The QA processes were reviewed at the data collection, data validation, and data governance stages of the submission process for the current year (2021-22) and was compared to the prior collection year (2020-21) for any significant changes. At each of these stages, the QA processes were assessed to determine whether they were effective, consistent across the jurisdiction and supported a robust NHCDC submission to IHACPA.

At the data source stage, Western Australia do not reconcile activity data to the source data, while all other jurisdictions reconciled. Queensland does not reconcile activity data to the source data at a jurisdictional level. However, it is undertaken at a Hospital and Health Service level throughout the clinical costing process. All jurisdictions complete, at a minimum, an annual reconciliation of the GL to audited financial statements. At the data validation stage, all jurisdictions complete appropriate activities to identify data exclusions and outliers, review the cost allocation proportions, trend analysis and specific business rules tests. All jurisdictions have processes in place to review the data outputs, ensuring they are reasonable, and all jurisdictions review the cost allocations, except Western Australia. South Australia, Tasmania and the ACT do not utilise jurisdictional guidelines to support costing and rely on the AHPCS.

Table 4 shows the QA processes undertaken in New South Wales (NSW), Victoria, Queensland, and South Australia (SA).

Table 4: Summary of NSW, Victoria, Queensland, and SA quality assurance activities

QA Process	NSW	Vic	Qld	SA
Source data and systems				
Reconciliation back to GL and audited statements	GL is reconciled for each costing cycle	Yes	Annual reconciliation and checks	Annual reconciliation and checks
Reconciliation of activity data back to source systems	Numerous checks performed when activity data is extracted from source systems	Yes, by Department of Health.	N/A	Numerous checks performed when activity data is extracted from source systems.
Costing data – validation				
Trend analysis to prior periods across cost products	All draft DNR submissions are subjected to a series of cost result tests by the ABM group.	Yes, DH also summarises trends over 4 – 5 year period to highlight change.	Yes, annually	Yes
Reasonableness test of excluded data and outliers				

QA Process	NSW	Vic	Qld	SA
Analysis of outliers at the cost, LOS, or cost bucket level				
Direct and overhead percentage allocations				
Specific business rule tests	Numerous tests examining the compliance with key costing business rules	Yes, several checks are conducted on submission outputs.	Yes	Central team control feeder data and QA the data and run through the business rules for each LHN
Costing data – governance				
Regular updates with costing staff	Monthly Costing Standards User Group (CSUG) held across the state.	Monthly meeting with cost practitioners.	Monthly meetings of Clinical Costing Working Group and HHS Funding and Costing Network.	Conducted monthly – process and agenda soon to be renewed to improve value-add
Local guidelines supporting the AHPCS standards framework	NSW CAG	Yes	Yes	No
Review of cost allocations	NSW DNR submission process includes draft period for comparing cost results with peers.	DH conducts checks during site submissions to VCDC	Yes, as part of the NHCDC data transformation process	Yes, annually
Review on reasonableness of costing data output	NSW DNR submission process includes draft period for comparing cost results with peers.	Yes – any major variations highlighted, and reason is reporting in briefing to Deputy Secretary	Data is reviewed for reasonableness and completeness.	Data is reviewed for reasonableness and completeness. IHACPA QA reports provided to LHNs
Formal sign-off	NSW Health Secretary	Deputy Secretary signs submission to NHCDC. The reconciliation report is signed off by the CFO and the DQS is signed off by the executive director.	Director-General	CEO

Table 5 shows the quality assurance processes undertaken in Western Australia, Tasmania, Northern Territory (NT), and the Australian Capital Territory (ACT).

Table 5: Summary of WA, Tasmania, NT, and ACT quality assurance activities

QA Process	WA	Tas	NT	ACT
Source data and systems				
Reconciliation back to GL and audited statements	Yes, Annual reconciliation and checks	Annual reconciliation and checks	GL is reconciled for each costing cycle	Annual reconciliation and checks undertaken by ACTHD and Health Services

QA Process	WA	Tas	NT	ACT
Reconciliation of activity data back to source systems	N/A	Annual reviews on feeder and source systems	Numerous checks performed when activity data is extracted from source system	Annual reviews on feeder and source systems and Health Services reporting team.
Costing data – validation				
Trend analysis to prior periods across cost products	Yes, annually	Yes, annually	Yes	Yes, annually
Reasonableness test of excluded data and outliers				
Analysis of outliers at the cost, LOS, or cost bucket level				
Direct and overhead percentage allocations				
Specific business rule tests	Yes, annually	Yes	Yes, various business rules are tested when data is loaded	Yes – through PPM2
Costing data – governance				
Regular updates with costing staff	Yes. Business User Group and WA Clinical Costing Standards Group (CCSG) meet monthly. BUG includes technical support to discuss PPM usage, new features, upgrades, technical issues, improvements to HSS staging and extraction processes; CCSG explores continuous improvement, information sharing and learnings, and QA processes.	Ad hoc	Regularly in contact with external costing consultants.	Finance Team and Clinical Costing Personnel during the submission time.
Local guidelines supporting the AHPCS standards framework	Yes	No	Yes, annually	No
Review of cost allocations	N/A	Yes, annually	Yes	Yes – annually
Review on reasonableness of costing data output	Yes. Multiple reviews undertaken, with any issues reported back to HSPs	Data is reviewed for reasonableness and completeness.	Data is reviewed for reasonableness and completeness.	Data is reviewed for reasonableness and completeness.
Formal sign-off	Yes, Director – General	Final sign off by THS	CEO	Final sign off by the CFO and DQS by CEO

2 New South Wales

2.1 Summary

New South Wales (NSW) submitted cost data from 139 hospitals (including health services) across 16 local health districts (LHDs) and 2 speciality health networks with 14.2 million records and a cost of \$17.7 billion in 2021-22, excluding Pharmaceuticals Benefits Scheme costs. IHACPA consulted NSW to confirm the Standards were correctly applied and reviewed any exceptions. The bilateral meeting also included a discussion on the future of the independent financial review.

The review of NSW's costing, and governance processes indicated a technical and robust approach to hospital costing, applied consistently across the state. The governance and quality assurance processes were highly developed, supporting costing activities. The quality of reported data and current practices of assigning costs is robust, including the linking of intermediate products and identification of contracted care. There is a well-established method of allocating costs to patients (e.g., third-party costs) and ensuring any discrepancies are rectified.

NSW LHNs utilise the same costing system and level of service data across all sites. Additionally, standardised tools, activity data extracts, and data quality checks underpin a rigorous review process with all costs included in the general ledger allocated.

2.2 Australian Hospital Patient Costing Standards

Stage 1 – Identify Relevant Expenses

NSW reported full compliance with the standards in Stage 1 – identify relevant expenses, except for Standard 1.2 – the identification of third-party expenses. NSW partially complied with Standard 1.2 as while most third-party expenses are included in the cost ledger, there are costs that are held in trust accounts (e.g., private patients costs) and centrally (e.g., pathology) that are not included in the general and cost ledger and not included in the annual statements. Costs that are held centrally are not allocated to the respective local health district (LHD). For example, income through Medicare Benefit Scheme (MBS) claims made when treating private patients are held in trust accounts and are excluded from the audited financial statement and are not included in the NHCDC. The LHDs review the cost data submitted by hospitals to determine whether they comply with the Standards and exclude any data that does not comply.

Contracted care costs are allocated to the health entity that contracted the service. The cost for the service is invoiced to the contracting health entity under the goods and services line item, rather than the line item related to the service provided.

Stage 2 and 3 – Create the Cost Ledger and Create Final Cost Centres

NSW reported partial compliance with Standards 2.1 and 2.2 – the cost ledger framework and matching cost objects and expenses. Variation in the level of service data available across LHNs

limits the ability to achieve full compliance with requirements relating to object and expense matching.

NSW reported partial compliance with Standard 3.2 – the allocation of expenses in overhead cost centres. This was due to the limited availability of allocation statistics that are utilised in allocating overhead costs. However, NSW was fully compliant with Standard 3.1 – allocation of expenses in production cost centres.

Stage 4 and 5 – Identify Products and Assign Expenses to Products

NSW reported full compliance with the standards in Stages 4 and 5 – identify products and assign expenses to products. NSW use Power Performance Manager 2 (PPM2) to assign expenses to intermediate and final products to patients within the Electronic Medical Records (EMR). PPM2 completes internal checks to ensure the expenses are allocated correctly and costing practitioners review and rectify discrepancies found.

There are challenges with the linking rules of intermediate products for the admitted and emergency department patients as well as with private providers. These issues vary across health entities and are currently being investigated.

Stage 6 – Review and Reconcile

NSW reported partial compliance with Standards 6.1 and 6.2 – data quality framework and reconciliation to source data. While a comprehensive data quality framework is in place, a systematic review of product areas that do not have service data is yet to be undertaken. Similarly, while detailed activity and expense reconciliations are undertaken, NSW considers these could be strengthened.

Costing is standardised across all districts through a common costing software, utilising the same mapping accounts, general ledgers, and chartered accounts. Standardised tools, activity data extracts, and data quality checks contribute to ensuring consistency in reporting, continuously refined through consultations with costing practitioners. PPM2 is utilised across all sites in the jurisdiction.

NSW completes internal quality assurance processes to ensure the NHCDC contains high-quality data that can be used to develop the national efficient price. As a result, cost data from the Illawarra Shoalhaven Local Health District (LHD), Mental health for Greenwich Hospital (Northern Sydney LHD), and Palliative Care for Broken Hill Hospital (Far West LHD) was not submitted in 2021-22. It has been identified that NSW conducted several annual checks and assessments prior to a formal sign off by the NSW Health Chief Executive (CE) to ensure a robust costing submission to IHACPA.

To ensure all in-scope cost have been included in the NHCDC 2021-22, a reconciliation review was completed between NSW's general ledger and the costs submitted to IHACPA. NSW's general ledger reconciles with the cost ledger as well as the costs submitted to IHACPA.

3 Victoria

3.1 Summary

Victoria submitted cost data from 89 hospitals (including health services) across 40 local health networks (LHNs) with 8.7 million records and a cost of \$15.0 billion in 2021-22. IHACPA consulted Victoria to confirm the Standards were correctly applied, review any exceptions, and discuss the future of the independent financial review.

Findings of the review indicate that Victoria capture and allocate costs accurately. Costing guidelines are in place to ensure expenses are captured accurately, including the contracted care costs based on financial arrangements between jurisdictions and local health networks.

Victoria has standardised guidance on the allocation of third-party costs to ensure costs are appropriately allocated to patients. However, there are variations in the application of this guidance across health entities.

3.2 Australian Hospital Patient Costing Standards

Stage 1 – Identify Relevant Expenses

Victoria reported full compliance with the standards in Stage 1 – identify relevant expenses. Costing practices are guided by the Victorian Activity Based Costing (VICABC) documentation to develop the Victorian Cost Data Collection (VCDC). The VICABC identifies the relevant information needed for costing and the reporting requirements for submitting cost data to Victoria Health. Ancillary private patient radiology and pathology costs were excluded for specific establishments due to the lack of available data.

There is a sufficient guidance for the costing of contracted care services. However, there are challenges in the identification of the underlying financial arrangements between the purchaser and provider of services. This makes it difficult to accurately allocate costs to specific line items. The contracted care costs reported to IHACPA are predominately based on the financial arrangements between local health networks.

Stage 2 and 3 – Create the Cost Ledger and Create Final Cost Centres

Victoria reported full compliance with the standards in Stage 2 and 3 – create the cost ledger and final cost centres. However, there inconsistency in the application of the standards and methodologies used for cost allocation across the state. For example, there are variations in processes used to identify patients and service dates. Relative value units (RVUs) are weighted units that reflect the comparative costs of production of one product or service against another, across the full range of products or services produced within the same department. Victoria identified that each department and health service is unique and while the method used to calculate RVUs is relatively consistent, there may still be some variation.

Each health entity provides the Victorian Department of Health with a data quality statement to ensure the submission complies with the AHPCS and is appropriate for the NHDC. The impact of COVID-19 has led to the separate handling of COVID-19-related costs, with subsequent changes to reporting guidelines.

Stage 4 and 5 – Identify Products and Assign Expenses to Products

Victoria reported full compliance with the standards in Stages 4 and 5 – identify products and assign expenses to products. In instances where patient activity data is not available at the health service level, the expenses associated with delivering these services are costed at an aggregate level and allocated to patients using methods such as RVUs.

This costing process is guided by financial reporting, stakeholders, and the VICABC. For example, for the non-admitted stream, there are instances where costs are reported at an aggregate level due to a lack of patient level data. Significant improvements have been made in the reporting of non-admitted patient care costs. However, further collaboration with health services is required to advance activity-based reporting at patient level for non-admitted services.

It was noted that posthumous organ donation expenses have been allocated to the associated products but may not align with the relevant AHPCS costing standards and guideline.

Stage 6 – Review and Reconcile

Victoria reported full compliance with the standards in Stage 6 – review and reconcile. The VICABC contains a comprehensive and robust data quality framework, assurance and a 5-stage process to guide the costing practitioners identify costing information and submission requirements. Each health entity provides a data quality statement to the Victorian Department of Health, confirming their data preparation, how the VICABC guidance has been applied and that the submission complies with the AHPCS. Victoria ensures continuous improvements in guidelines and allocation methodologies through a monthly user group meetings with costing practitioners.

Victoria completes an internal quality assurance process to ensure the NHDC contains data that can be used to develop the national efficient price. It has been identified that Victoria conducted several annual checks and assessments prior to a formal sign off by the Deputy Secretary to ensure a robust costing submission to IHACPA.

To ensure all in-scope cost have been included in the NHDC 2021-22, a reconciliation review was completed between Victoria's general ledger and the costs submitted to IHACPA. Victoria's general ledger reconciles with the cost ledger as well as the costs submitted to IHACPA.

4 Queensland

4.1 Summary

Queensland submitted cost data from 349 hospitals (including health services) across 16 Hospital and Health Services (HHS) with 12.6 million records and a cost of \$14.0 billion in 2021-22. IHACPA consulted Queensland to confirm the Standards were correctly applied and reviewed any exceptions. The bilateral meeting also reviewed costs in the general ledger to ensure they reconciled with the cost data submitted and discussed the future of the independent financial review.

No issues are reported with the allocation process and strategies are in place to ensure all costs are appropriately included and excluded. Costs are rigorously allocated to patients to ensure appropriate allocations across patient journeys. Standardised general ledgers are in place to ensure ledgers flow across HHS' and all third-party costs are appropriately allocated with billings to relevant entities.

4.2 Australian Hospital Patient Costing Standards

Stage 1 – Identify Relevant Expenses

Queensland reported full compliance with the standards in Stage 1 – identify relevant expenses. Queensland Health operates a unified state-wide general ledger where each HHS maintains a subledger within the overarching main ledger. All costs related to the provision of public health services by Queensland Health are consolidated within the ledger. Virtual patients are used when patient level data is not available, rather than dividing the cost across other patients, so the cost of treatment is accurately reflected in the submission.

There is no offsetting of expenses with revenue accounts with the Pharmaceuticals Benefits Scheme (PBS) and Medicare Benefits Schedule (MBS) data incorporated into revenue accounts. For external business units, only actual expenses are recorded in the ledger for the HHS' consuming these services.

Stage 2 and 3 – Create the Cost Ledger and Create Final Cost Centres

Queensland reported full compliance with the standards in Stages 2 and 3 – create the cost ledger and final cost centres. A virtual patient is created to attribute patient-level data when the data for services are not at the patient level.

Queensland does not utilise product fractions, which are ratios applied to production cost centres that relate to the various product categories associated with patient or non-patient products. The cost allocation is based on the expenses incurred to match the patient journey as much as possible. However, RVUs are used where appropriate as per the Standards.

Stage 4 and 5 – Identify Products and Assign Expenses to Products

Queensland reported full compliance with the standards in Stages 4 and 5 – identify products and assign expenses to products. Patient transport and third-party costs are allocated to the relevant patient where possible. However, if the cost data is unavailable, costs are allocated to virtual patients using RVUs. The cost allocation and assignment of expenses is completed by HHS' and may vary depending on the health entity as required.

Queensland noted that changes to the information and feeder systems to external oral health activity has improved the costing of oral health services.

Limitations in reporting and collection systems have inhibited the ability to link certain pathology, imaging, and pharmacy records to their associated episodes. As there is not a dedicated patient level data set for patient transfer expenses, costs of these expense in the ledger are spread across all patients.

Queensland previously allocated overhead costs across HHS', but this process has changed so that overheads are held within HHS subledgers and allocated to patients by the HHS using the overhead allocation process and product specific RVUs.

Stage 6 – Review and Reconcile

Queensland reported full compliance with the standards in Stage 6 – review and reconcile. Queensland implements quality assurance checks and processes at the HHS and Department level, with a final reconciliation process undertaken with individual HHS' before submission. The review process involves a monthly costing process, with costing systems generating a range of automated reports. These are used to identify any issues and are reviewed once a year to ensure all issues are addressed and resolved.

Queensland completes validation reports to identify any costing issues and HHS' review the average cost per separation for variation and high or low cost outliers. As part of their end-of-year NHDC report, Queensland Health generate a 5-year cost weight report for each HHS. In this report, end patient level results will be reviewed, investigating high or low-cost outliers, minimum, maximum, and average cost per end-class.

Queensland completes internal quality assurance processes to ensure the NHDC contains high-quality data that can be used to develop the national efficient price. It has been identified that Queensland conducted several annual checks and assessments prior to a formal sign off by the Director General to ensure a robust costing submission to IHACPA.

To ensure all in-scope cost have been included in the NHDC 2021-22, a reconciliation review was completed between Queensland's general ledger and the costs submitted to IHACPA.

Queensland's general ledger reconciles with the cost ledger as well as the costs submitted to IHACPA.

5 South Australia

5.1 Summary

South Australia submitted cost data from 21 hospitals (including health services) across 10 local health networks (LHNs) with 4.5 million records and a cost of \$4.7 billion in 2021-22. IHACPA consulted South Australia to confirm the Standards were correctly applied and reviewed any exceptions. The bilateral meeting also reviewed costs in the general ledger to ensure they reconciled with the cost data submitted and discussed the future of the independent financial review.

The review of South Australia's costing and governance processes has indicated that costs are assigned appropriately. However, guidelines are required around the inclusion and exclusion of certain costs. These costs are robustly allocated to patients with quality assurance checks that ensure a minimum level of consistency and accuracy.

While development of local costing standards and guidelines are in progress, there is currently no standardised approach to costing practices across LHNs for the general ledger. Third-party costs are appropriately accounted for with accurate methodologies in place to ensure accuracy including patient level based on invoices received, recorded as goods and services. Some guidelines are required around allocation of third-party patient product costs. A robust validation and review process is in place to ensure costs are assigned appropriately.

5.2 Australian Hospital Patient Costing Standards

Stage 1 – Identify Relevant Expenses

South Australia reported full compliance with the standards in Stage 1 – identify relevant expenses. Data quality for health entities is updated through centralised patient costing systems and is checked and signed off on by the CFO to ensure high standards of the cost data are maintained. This includes the documentation of the costing process for offsets, recoveries, salaries, and wages.

Currently, trust accounts do not sit within the general ledger, making it difficult to identify and include these costs in the cost ledger. However, all third-party expenses are appropriately accounted for and correctly allocated.

Costing aeromedical retrieval services remains challenging due to data quality issues with flight discharge information. Efforts are being made to work with the ambulance units to address this issue.

Stage 2 and 3 – Create the Cost Ledger and Create Final Cost Centres

South Australia reported full compliance with the standards in Stages 2 and 3 – create the cost ledger and create final cost centres. There is a comprehensive methodology for cost allocation

being built across LHNs to ensure uniformity for centralised services, such as pharmacy and pathology costs.

The process of matching final/intermediate products is well-established and quality assurance checks are consistently performed to correct any discrepancies in the data. Costs are monitored quarterly, and continuous costing ensures ongoing improvements to accuracy.

RVUs are used where there is a lack of available patient level data, specifically in areas such as pathology. In the case of prostheses, health services that cannot allocate products at the patient level, will utilise RVUs from health services that can trace products back to the patient.

Stage 4 and 5 – Identify Products and Assign Expenses to Products

South Australia reported full compliance with the standards in Stages 4 and 5 – identify products and assign expenses to products. LHNs have standardised QA processes, covering aspects such as activity and cost data linking and negative costs. South Australia regularly generates QA reports to identify and address any discrepancies in the data.

Third-party patient products are costed using patient level data and various metrics such as FTE, bed days, frequency, statistics for theatres, and activity statistics for utilities and administrative costs. These are updated annually to ensure accuracy.

South Australia does not allocate private patient pathology costs at the patient level due to limitations in the availability of data.

Stage 6 – Review and Reconcile

South Australia reported full compliance with the standards in Stage 6 – review and reconcile. South Australia maintains a centralised costing function that runs a review, reconciliation, and assurance process in consultation with submitting LHNs.

A cost reconciliation process is undertaken across all LHNs to ensure that all expenses and allocation methods are correctly undertaken, and any discrepancies addressed. Any costs that need to be distributed across LHNs due to contracting arrangements are handled before the cost is entered into the costing system.

South Australia completes internal quality assurance processes to ensure the NHCDC contains high-quality data that can be used to develop the national efficient price. It has been identified that South Australia conducted several annual checks and assessments prior to a formal sign off by the CEO to ensure a robust costing submission to IHACPA.

To ensure all in-scope cost have been included in the NHCDC 2021-22, a reconciliation review was completed between South Australia's general ledger and the costs submitted to IHACPA. South Australia's general ledger reconciles with the cost ledger as well as the costs submitted to IHACPA.

6 Western Australia

6.1 Summary

Western Australia submitted cost data from 36 hospitals (including health services) across 5 health service providers (HSPs) with 4.2 million records and a cost of \$6.3 billion in 2021-22. IHACPA consulted Western Australia to confirm the Standards were correctly applied and reviewed any exceptions. The bilateral meeting also reviewed costs in the general ledger to ensure they reconciled with the cost data submitted and discussed the future of the independent financial review.

The review of Western Australia's costing and governance processes demonstrated that there are rigorous costing processes in place, specifically for the allocation of overhead expenses and third-party costs.

6.2 Australian Hospital Patient Costing Standards

Stage 1 – Identify Relevant Expenses

Western Australia reported full compliance with the standards in Stage 1 – identify relevant expenses; except for blood costs as they were not submitted in the NHCDC 2021-22. Non-hospital products are currently excluded from cost ledgers. The definition of hospital and non-hospital products and services has been evolving due to the introduction of ABF models and changing service delivery. Currently, any non-acute services offered by hospitals that are deemed non-hospital are excluded from the cost ledger.

Patient transport expenses, as per the agreements with the Royal Flying Doctors Service (RFDS) and St John Ambulance (SJA), are mostly excluded with a possibility of under allocation of costs concerning inter-hospital patient transport.

Virtual care expenses are costed within the Western Australia Country Health Service (WACHS) when pre-arranged; otherwise, these are charged to the hospital where the service is provided.

Stage 2 and 3 – Create the Cost Ledger and Create Final Cost Centres

Western Australia reported full compliance with the standards in Stages 2 and 3 – create the cost ledger and create final cost centres. There has been an increased focus on standardising costing practices wherever feasible across Health Service Providers (HSP), but variation may occur due to specific HSP requirements.

The utilisation of RVUs is informed by costing practices and are regularly updated based on discussions with business managers, with the intention of reducing assumptions.

Stage 4 and 5 – Identify Products and Assign Expenses to Products

Western Australia reported full compliance with all standards in Stages 4 and 5 – identify products and assign expenses to products; except for standard 4.2. Western Australia partially complied with standard 4.2 as mental health and palliative care costs were not submitted at the phase level due to data limitations.

Western Australia also reported that the costing guidelines relating to teaching and training, research, and blood products were not followed in the self-assessment. This is due to costs currently calculated using an established local methodology, that do not comply with the standards and are excluded from the submission.

Data linking issues continue to persist for palliative care costing due to variations in phase admission and assessment times.

Contracted care services in WA, primarily dialysis procedures, were manually adjusted to ensure the cost data linked to the activity data as there was a discrepancy of the health entity information in both datasets.

Stage 6 – Review and Reconcile

Western Australia reported full compliance with the standards in Stage 6 – review and reconcile. Quality assurance and reconciliation processes are undertaken at the individual HSP level as well as at the Department level. Within the PPM system WA utilise standardised systematic checks for validation at the HSP level. The state health department outline a minimum set of standard QA checks completed by HSPs within Power BI.

HSP's are required to complete an authorisation letter that is submitted to WA Health alongside the cost submission. Authorisation is required from the CFO/CEO before submission to the System Manager. HSPs submit an interim, draft and final dataset annually to WA Health, who then validate the HSP submissions. The submissions are reviewed against benchmarks and when the data does not align with expected results, HSPs will be asked to review and resubmit if an error is identified.

Western Australia completes internal quality assurance processes to ensure the NHCDC contains high-quality data that can be used to develop the national efficient price. It has been identified that Western Australia conducted several annual checks and assessments prior to a formal sign off by the Director General to ensure a robust costing submission to IHACPA.

To ensure all in-scope cost have been included in the NHCDC 2021-22, a reconciliation review was completed between Western Australia's general ledger and the costs submitted to IHACPA. Western Australia's general ledger reconciles with the cost ledger as well as the costs submitted to IHACPA.

7 Tasmania

7.1 Summary

Tasmania submitted cost data from 24 hospitals (including health services) across one local health network (LHN) with 1.2 million records and a cost of \$1.6 billion in 2021-22. IHACPA consulted Tasmania to confirm the Standards were correctly applied and reviewed any exceptions. The bilateral meeting also reviewed costs in the general ledger to ensure they reconciled with the cost data submitted and discussed the future of the independent financial review.

The review of Tasmania's costing and governance processes has indicated costs are appropriately included and excluded with robust allocation methodology in place to ensure costs are appropriately allocated to patients. However, improvements could be made relating to the provision of better jurisdictional guidelines for the standardisation of costing practices across LHN's (e.g., third-party costs). The validation and review processes in place were identified as reasonable. However, a jurisdictional guideline covering the validation process is required to ensure a standardised approach.

7.2 Australian Hospital Patient Costing Standards

Stage 1 – Identify Relevant Expenses

Tasmania reported full compliance with the standards in Stage 1 – identify relevant expenses; except for standard 1.2 - third party expenses, reporting partial compliance. There are instances where third-party expenses were not clearly identified by the LHNs to the Tasmanian Department of Health's costing team.

There are efforts currently being undertaken to standardise and implement a new system that can assist in better recording cost data. Collaboration with the budget and finance department is ongoing to establish this system.

Tasmania is also currently reviewing the costing of patient transport as there is some expenditure not currently included in the general ledger due to the complexities of the funding arrangements and services provided. For example, the cost associated with patient transfers between hospitals are not included, as patient-level data is not available. However, private ambulance costs are included due to the availability of this cost data. The costs associated with emergency transports are not added until the patient is admitted to the emergency department, delaying the availability of cost data.

It should be noted that workers' compensation recoveries are offset against salaries and wages.

Stage 2 and 3 – Create the Cost Ledger and Create Final Cost Centres

Tasmania reported full compliance with the standards in Stages 2 and 3 – create the cost ledger and create final cost centres.

There are 2 methods used for cost allocation – physical allocation statistics and financial allocation statistics – that are applied to wards and the emergency department. RVUs are also used instead of inpatient fractions due to the lack of available data. Tasmania does not utilise any cost allocation software such as CostPro, instead costing codes have been developed to undertake the cost allocation annually.

It should be noted that the Launceston General Hospital has started admitting patients for chemotherapy, contributing significantly to the increase in the number of acute patient episodes.

Stage 4 and 5 – Identify Products and Assign Expenses to Products

Tasmania reported full compliance with all standards in Stages 4 and 5 – identify products and assign expenses to products. However, there are limitations in the ability to identify teaching and training expenses due to data quality issues, resulting in the exclusion of these expenses. There are also data quality issues regarding the linking of subacute, mental health (phase and episode level) and palliative care cost data with activity data.

The costing of contracted care activities continues to be challenging. In the absence of patient-level data, costs are distributed based on the contracted value, but there is a possibility of costs not reconciling due to the financial year boundary.

Changes in costs have occurred, due to the allocation of costs between specialties for inpatient and outpatient services. The decrease in cost is related to the way non-admitted specialist appointments are handled. The scripting process has been adjusted to better reflect service delivery. Low volume services can lead to high-cost rates, significantly distorting pricing.

Stage 6 – Review and Reconcile

Tasmania reported partial compliance with Standard 6.1 – data quality framework, but fully compliant with Standard 6.2 – reconciliation to source data. While a robust data quality framework is in place, there is minimal independent assurance of the cost data and no formal auditing.

The Tasmanian Department of Health completes patient costing annually. Due to the size of Tasmania's health system, the Department performs the functions of a local health network, costing health services and submitting them to IHACPA.

Tasmania completes internal quality assurance processes to ensure the NHDC contains high-quality data that can be used to develop the national efficient price. The QA process includes annual review of activity data with source feeder systems, trend analysis and a consultation and governance process overlaying the costing process. It is noted Tasmania maintains no local costing guidelines. It has been identified that Tasmania conducted several annual checks and assessments prior to a formal sign off by the Associate Secretary to ensure a robust costing submission to IHACPA.

To ensure all in-scope cost have been included in the NHDC 2021-22, a reconciliation review was completed between Tasmania's general ledger and the costs submitted to IHACPA. Tasmania's general ledger reconciles with the cost ledger as well as the costs submitted to IHACPA.

8 Northern Territory

8.1 Summary

The Northern Territory submitted cost data from 6 hospitals (including health services) across 6 facilities with 0.7 million records and a cost of \$1.2 billion in 2021-22. IHACPA consulted Northern Territory to confirm the Standards were correctly applied and reviewed any exceptions. The bilateral meeting also reviewed costs in the general ledger to ensure they reconciled with the cost data submitted and discussed the future of the independent financial review.

The review of Northern Territory's costing and governance processes has indicated issues in terms of cost inclusions and exclusions, with appropriate standards required for cost identification and allocation. Costs are appropriately allocated to patients. The validation and review processes currently in place are robust.

8.2 Australian Hospital Patient Costing Standards

Stage 1 – Identify Relevant Expenses

The Northern Territory reported full compliance with the standards in Stage 1 – identify relevant expenses; except for standard 1.1 - general, reporting partial compliance. The partial compliance was due to trust accounts not forming part of the general ledger and not included in the costing process.

The costing of patient transport and emergency retrieval services are improving. The Northern Territory utilises several data sources to validate the contractual fees paid and cost per flight, particularly in collaboration with the Royal Flying Doctor's Service (RFDS). Referral pathways to tertiary or interstate facilities result in high costs and fail to align with the funding models.

Stage 2 and 3 – Create the Cost Ledger and Create Final Cost Centres

Northern Territory reported full compliance with the standards in Stages 2 and 3 – create the cost ledger and create final cost centres. However, not all costing guidelines are followed as these are not practicable to implement due to system and data limitations, noting that the principles in the Standards have been followed to allocate costs appropriately.

The Northern Territory utilises the length of stay as the relevant RVU where there is a lack of available data. This method is utilised for a patient dialysis unit and admitted patients.

Stage 4 and 5 – Identify Products and Assign Expenses to Products

Northern Territory reported full compliance with all standards in Stages 4 and 5 – identify products and assign expenses to products; except for standard 4.2 – information requirements, reporting partial compliance. The partial compliance was due to costing mental health care at the episode

level as phase level activity data was not available. Costing guidelines relating to teaching, training, research, and posthumous organ donation were not adhered to due to limitations in data availability.

There are issues related to non-admitted services that are not successfully matched with the final products, particularly in cases where activity is captured in the primary care system. The costing and linking mental health care costs with activity continues to be challenging.

Northern Territory's average cost for subacute and non-acute episodes is approximately 3times the national average due to non-acute episodes. There are limited options to discharge patients from subacute to long term maintenance care or aged care facilities, resulting in prolonged stays within the hospital system and a higher average cost.

Stage 6 – Review and Reconcile

Northern Territory reported full compliance with the standards in Stage 6 – review and reconcile. A Clinical, Finance and Data reference group and additional QA and validation processes were introduced in 2021-22 to improve the quality of the NHCDC submission.

The data quality is improving with the implementation of Power BI shared across all hospitals services. Sharing results with clinicians holds the potential for identifying data quality opportunities and addressing feedback and cost validation at the patient level. Improving data quality in a time of change poses challenges due to rising workforce expectations and financial pressures. Maintaining access to stakeholders without compromising data quality is notably challenging. This presents increasing difficulty in resource allocation and sustainability.

The Northern Territory Department of Health (NT Health) undertakes patient level costing centrally, which is supported by external consultants who provide end-to-end costing services to deliver the costing study and analysis. Patient level costing is undertaken bi-annually using the Power Performance Manager (PPM) costing platform. NT Health successfully implemented 6 monthly costing in the 2021-22 financial year and migrated to PPM software version 3 to realise the improved functionality provided by the software upgrade.

NT Health also completes internal quality assurance processes to ensure the NHCDC contains high-quality data that can be used to develop the national efficient price. QA processes include an annual review of activity data with source feeder systems, trend analysis and a consultation and governance process overlaying the costing process. It has been identified that Northern Territory conducted several annual checks and assessments prior to a formal sign off by the CEO to ensure a robust costing submission to IHACPA.

To ensure all in-scope cost have been included in the NHCDC 2021-22, a reconciliation review was completed between the Northern Territory's general ledger and the costs submitted to IHACPA. The Northern Territory's general ledger reconciles with the cost ledger as well as the costs submitted to IHACPA.

9 Australian Capital Territory

9.1 Summary

The Australian Capital Territory (ACT) submitted cost data from 3 hospitals across 3 facilities (including health services) with 1.9 million records and a cost of \$1.5 billion in 2021-22. IHACPA consulted the ACT to confirm the Standards were correctly applied and reviewed any exceptions. The bilateral meeting also included a discussion on the future of the independent financial review. IHACPA has reconciled ACT's general ledger to the NHCDC submission.

The ACT has partnered with Epic to implement a Territory-wide Digital Health Record (DHR) system at all public health services including public hospitals, Walk-in Centres, community health centres and justice health services. The implementation of this system has impacted the ACT's ability to report activity data and undertake costing of health services.

The review of the ACT's costing and governance processes has indicated that better guidelines and standards are required to identify in scope and out of scope costs. Costs are appropriately allocated to patients. Costing at the territory level is appropriately assigned to the Cost Ledger, applying the AHPCS. However, there are no standards and guidelines in place to ensure a rigorous cost allocation methodology and validation process in place to ensure costs are appropriately assigned.

9.2 Australian Hospital Patient Costing Standards

Stage 1 – Identify Relevant Expenses

The ACT reported full compliance with the standards in Stage 1 – identify relevant expenses. ACT Health is currently undertaking a comprehensive review of costs that were previously excluded from the NHCDC submission, such as corporate overhead costs, corporate costs, and information and communications technology costs. The inclusion of these additional costs in future submissions will lead to an increase in the average cost. The COVID-19 pandemic continues to impact the non-admitted activity and cost incurred in the ACT.

It should be noted that Special Purpose Account (SPA) costs have been excluded from the 2021-22 NHCDC submission but were included in previous years.

Stage 2 and 3 – Create the Cost Ledger and Create Final Cost Centres

The ACT reported full compliance with the standards in Stage 2 and 3 – create the cost ledger and create final cost centres. The ACT costs centrally within the ACT Health Directorate. The costing of health services is undertaken at the patient level, without the utilisation of any RVUs or other

weighting statistics. The lack of utilising RVUs was noted as posing a challenge for the allocation of overhead and Information and communications technology (ICT) costs. Overheads are currently included in the NHCDC submission based on FTE data.

Stage 4 and 5 – Identify Products and Assign Expenses to Products

The ACT reported full compliance with the standards in Stages 4 and 5 – identify products and assign expenses to products, except for Stage 5.3 Assign Expenses to Products - Work in Progress, reporting partial compliance. Due to the implementation of the DHR system, the ACT has had challenges in costing health services, specifically in-progress patients (i.e., work in progress patient data) and intermediate products. However, once fully operational, the DHR system will improve the accuracy of the cost data submission, in particular pharmacy, providing more detail of the patient journey.

The costs associate with teaching, training, and research are assigned to dummy patients based on feedback from costing managers. Detailed NHCDC reconciliation is undertaken internally, including a thorough process to identify and rectify any discrepancies found.

Stage 6 – Review and Reconcile

The ACT reported full compliance with the standards in Stage 6 – review and reconcile. The costing of health services in the ACT is completed in the Health Department, including a rigorous QA check of the data. If data quality issues are identified during this process, the relevant health service or hospital would be required to rectify the data submission. The ACT then contracts external consultants to complete an independent assessment and QA process of the general ledger and the NHCDC. This ensure that the expenditure outlined in the general ledger reconciles with the costs submitted to IHACPA in the NHCDC.

The ACT completes internal quality assurance processes to ensure the NHCDC contains high-quality data that can be used to develop the national efficient price. QA processes include an annual review of activity data with source feeder systems, trend analysis and a consultation and governance process overlaying the costing process. It is noted that ACT maintains no local costing guidelines to support the AHPCS, noting that this is likely a reflection of the subscale nature of the ACT health system. It has been identified that ACT conducted several annual checks and assessments prior to a formal sign off by the CEO to ensure a robust costing submission to IHACPA.

To ensure all in-scope cost have been included in the NHCDC 2021-22, a reconciliation review was completed between the ACT's general ledger and the costs submitted to IHACPA. ACT's general ledger reconciles with the cost ledger as well as the costs submitted to IHACPA.

10 Recommendations

Recommendation 1: The IFR as a reconciliation process to be discontinued and the jurisdictions to continue to provide IHACPA with a Data Quality Statement outlining exceptions in the application of the Australian Hospital Patient Costing Standards and the general ledger reconciliation.

Several states and territories advised that the IFR process provided little value as a quality assurance or reconciliation process. The process is considered resource intensive and duplicative to functions and processes undertaken either through IHACPA processes or internally within state and territory costing departments.

NSW questioned whether the current model of the IFR was fit for purpose as a means of assuring the Pricing Authority that the cost data is robust and has correctly applied the Standards. NSW found the current IFR to be a time-consuming and resource intensive process, duplicating information already received by IHACPA in the Data Quality Statement (DQS) and the Self-Assessment.

Victoria considers that the assurance aspects of the IFR unnecessary and duplicative of pre-existing assurance processes undertaken within their health department. Similarly, South Australia considers that the DQS provides sufficient assurance regarding the quality of the data, suggesting the assurance component of the IFR unnecessary.

The Australian Capital Territory derived value from the IFR but considered it should be undertaken on a bi-annual basis to reduce the impost on resourcing requirements among jurisdictions.

Recommendation 2: IHACPA, with the NHCDC Advisory Committee, to develop a work plan that investigates the cost variations across the jurisdictions through selected focus areas.

Most states and territories derived significant value from the deep-dive aspects of the IFR process that involved focus on the costing methodology and approaches to specific areas of costing. This was seen to prove instructive for costing representatives and facilitate an understanding of cost variation nationally.

Northern Territory considered that significant value could be derived from understanding variations in the application of the Standards across jurisdictions. Increased transparency of the costing process and results among jurisdictions would be seen to provide valuable insights on specific methodological issues (such as the selection of cost centres and line items), improve standardisation of the scope of cost inclusions and exclusions, and ensure costing discrepancies are identified and actioned appropriately.

Victoria indicates that significant value was derived by participants from the deep-dive aspects of the IFR process and supports the inclusion of a similar piece of work in future iterations of a quality assurance process. They recommend this include a detailed review of costing stages in the context of a focus area or areas. For example, reviewing a specific intermediate product and analysing how jurisdictions cost that product. Feedback from New South Wales supported this position.

Queensland supported the continuation of existing IFR processes relating to the review and analysis of costing variations across jurisdictions. They considered that the knowledge established through this process could be incorporated into future iterations of the Standards to improve costing.

South Australia supports the retention of deep-dives and peer review to facilitate inter-jurisdictional sharing of costing methodologies and the development of an understanding of costing variations nationally. Western Australia provided similar feedback, with a preference for focus on variation in the approach to costing allocations as well as the provision of jurisdictional benchmarks to improve transparency in costing and outputs. In combination with this, Western Australia supported the inclusion of a broader, more representative sample as the basis for future analysis.

Recommendation 3: IHACPA to develop an NHCDC Data Quality Framework to improve the cost and activity data collections in consultation with the states and territories.

States and territories considered that IHACPA was positioned to provide rules and guidance on quality assurance and review processes. As an independent authority administering the NHCDC, this function can be seen to fall within the scope of similar functions already undertaken by IHACPA.

Western Australia supports the development of a template and guidelines to facilitate improved costing submissions. It is considered that this could be paired with provision of a data quality framework that defines quality NHCDC data and outlines key performance indicators to measure the quality of the data received by IHACPA. The key performance indicators are recommended to be both qualitative and quantitative measures to allow for a wholistic assessment of the quality of the data received.

Victoria supports a future IFR process that focuses on enhanced data quality, reconciliation, and consistent cost allocation. They see IHACPA as maintaining a role in the development and assessment of quantitative checks for cost data and establishing clear criteria dictating inclusions and exclusions.

South Australia considers that the IHACPA, from its position as a centralised and independent body, would be well positioned to provide supporting guidance and documentation on the internal processes undertaken to transform the submitted cost data to the final published data. This could include the establishment of a forum for sharing ideas and development of state-wide documentation to help align methodologies and addressing cost variations.

Western Australia advised that there is a lack of clear definitions and measures to determine the quality of the NHCDC. The result is it is difficult to determine whether the data quality has improved over time.

Queensland considered that a review and reconciliation process should focus on enhancing data quality and ensure consistent costing allocations across jurisdictions. To this end, Queensland suggested that IHACPA be responsible for the development of quantitative checks for the cost data and establish clear criteria for the inclusion and exclusion of cost data.



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