Department of Health and Human Services

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

e4609805

James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Downie

Thank you for your letter dated 21 August 2017 regarding the provision of Victoria's Data Quality Statement for the 2015-16 Round 20 of the National Cost Data Collection.

Victoria broadly supports the publication of the Round 20 National Cost Data Collection for the Australian Public Hospitals Cost Report 2015-16 by the Independent Hospital Pricing Authority.

Please find attached a copy of the 2015-16 Round 20 Victorian Data Quality Statement (DQS) at **Attachment 1** including the sign off statement as provided in the template. Consistent with advice provided in prior years, there are a number of key factors that regarding Round 20 National Cost Data Collection cost data and activity data linked to the cost data. Accompanying the DQS is the NHCDC checklist at **Attachment 2**.

If you have queries regarding this advice, please contact Richard Bolitho, Acting Assistant Director, Funding Policy and Systems Development on 03 9096 7132 or via email Richard.bolitho@dhhs.vic.gov.au.

Yours sincerely

Anne Congleton
Acting Deputy Secretary
Health and Wellbeing Division
4 / 10 / 2017

Encl.

VICTORIA State Government

VICTORIAN DATA QUALITY STATEMENT

ROUND 20 (2015-16) NATIONAL HOSPITAL COST DATA COLLECTION

All data provided by Victoria to Round 20 (2015-16) of the National Hospital Cost Data Collection (NHCDC) has been prepared in adherence with the Australian Hospital Patient Costing Standards (AHPCS) Version 3.1.

Data provided to this submission has been reviewed for adherence to the AHPCS Version 3.1 and is complete and free of material errors.

Adherence to the AHPCS Version 3.1 is qualified by the details below.

Overview

Victorian public hospitals are required to report costs for all activity and are expected to maintain patient level costing systems that monitor service provision to patients and determine accurate patient-level costs.

Victorian health services are required to adhere, where possible, to the Australian Hospital Patient Costing Standards (AHPCS) – version 3.1 (or the most recent version in the instance that a successor becomes available), the Victorian Cost Data Collection (VCDC) business rules and specifications and any other guidance provided by the department in the coming year.

Business Rules

Compliance to standards

The Victorian submission to the Round 20 (2015-16) National Hospital Cost Data Collection (NHCDC) is based on the Victorian Cost Data Collection 2015-16.

The business rules for the VCDC collection are published annually by the Department of Health and Human Services, Victoria and provides guidance to health services in the costing and reporting of patient level cost data to the VCDC (http://www.health.vic.gov.au/hdss/vcdc/index.htm).

Exceptions

1. Excluding AHPCS standards relating to:
   (a) **Capital and Depreciation** (DEP 1.002, 1A.002,1B.002,1C.002 1D.002 and 1E.002), Victoria does not include non-cash expenditures such as depreciation as it does not impact upon operational costs and comparisons should not be driven by an asset's estimated life.
   (b) **Teaching and Training costs** (SCP 2A.003), where the sole purpose of the activity is teaching and training Victoria includes these costs as an overhead. Where teaching and training cannot be separated from routine work undertaken, it has been included as a salary and wages expense.
   (c) **Research costs** (SCP 2B.002), these activities and costs are excluded from Victoria's submission pending further developments in the Activity Based Funding work stream.
2. Transitioning to AHPCS standards for:

(d) **Allocation of Medical costs for private and public patients** (Cost 3A.002), Victorian health services will allocate medical expenses only relating to private patients where these can be distinguished between medical expenses relating to public. Otherwise all medical expenses are allocated to patients regardless of funding source.

(i) Victoria's department is currently working with health services to determine their capability to comply with this standard as outlined in V3.1. However Victoria will be reliant on the development of a V4 to the AHPCS to provide clarification and specific guidance on this standards application.

3. Transitioned to:

(e) **Product costs in scope – Blood products** (SCP 2.003), The National Blood Authority expenses are held within the Victorian Department of Health and Human services. The Victorian department provides health services with that blood expenditure data to be allocated and reported to the VCDC. Victoria has been transitioning to reporting these costs to the NHCDC and for 2015-16 are compliant with the national requirements.

(f) **Treatment of Work-In-Progress costs** (Cost 5.002); previous year submissions only reported patients and costs that were discharged during the reporting year (1 July 2014 – 30 June 2015) as well as one prior year costs. For the 2015-16 year Victorian health services are able to report all patients discharged within the reporting year as well as prior year costs up to the 2010-11 year where relevant. This is in accordance with the national reporting requirements.

Activity

There were no significant changes to admission policies from Round 19 to 20. For further details please refer to the Victorian Hospital Admission Policy 2015-16 at https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-hospital-admission-policy-2015-16.

The patient demographics that are linked to the cost data collection are collected based on the specifications outlined in the following manuals:

- Victorian Admitted Episodes Dataset (VAED) manual 25th Edition (Admitted)
- Victorian Emergency Minimum Dataset (VEMD) manual 20th Edition (Emergency)

These patient demographics are then converted to the relevant national minimum dataset or IHPA data set specification based on the Victorian department's interpretation of the specifications.

For further details please refer to Victoria's health data standards and systems link at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems

Victorian admitted specialist clinic patient demographics are currently submitted nationally as aggregate level to the non-admitted patient activity dataset. As we transition to report patient level data, the cost data will be based on the specifications outlined in the Victorian Integrated Non-Admitted Health Minimum Dataset (VINAH) manual.

To enable IHPA to identify Tier 2 classifications and funding source for use in the National non-admitted pricing model, a supplementary file is submitted containing only this relevant non –admitted patient information. This is consistent with the approach taken for last three year's NHCDC submissions.

Scope

Reporting hospitals

The number of hospitals that report to the NHCDC can vary from year to year due to the timing of the submission date required by the IHPA. This has resulted in the following exclusions/inclusions between 2014-15 and 2015-16.

4. Due to technical difficulties at Peninsula Health, the following campuses are not reported in 2015-16:

- 210901250 – 3THN - Rosebud Hospital

- 210902220 – 3FPH - Frankston Hospital
- 210904083 – 3GHR - Golf Links Road Rehabilitation and PCU
- 210904084 – 3MOR - The Mornington Centre

5. New campuses reporting in 2015-16:

- 210A01321 – 3MUF – Mercy Mental Health Ursula Frayne Centre
- 210202260 – 3AGH – Stawell Regional Health
- 210102460 – 3NOW – Portland District Health
- 210404050 – 3BDM – Benalla Health

Ancillary costs for private patients

The majority of Victorian Health Services include ancillary costs for private patients in their NHCDC submission with the exception of:

- Northern Health (Private patient pathology and radiology costs are excluded from the VCDC)
- Barwon Health (Private patient pathology costs are excluded from the VCDC)
- Ballarat Health (Private patient pathology and radiology costs are excluded from the VCDC)
- Peninsula Health (Private patient pathology costs are excluded from the VCDC)
- Western Health (Private patient pathology costs are excluded from the VCDC)
- Alfred Health Caulfield Campus (Private patient radiology costs are excluded from the VCDC)

Non-Admitted contacts

For 2015-16, Victoria reports all levels of contact account classes to the NHCDC for non-admitted specialist clinics that form part of the National Health Reform Agreement. In previous years Victoria had only submitted Public and DVA records.

Admitted Mental Health Services

Victoria has one of the largest publicly funded providers of mental health services in Australia. The NorthWestern Mental Health service is the mental health arm of Melbourne Health. It operates in partnership with Northern Health (Northern Hospital, Broadmeadows Health Service, Bundoora Extended Care and Craigieburn Health Service) and Western Health (Sunshine and Western Hospitals).

The reporting of the admitted activity from this service's partners has been underpinned by a service level agreement which had complicated the allocation of costs to determine the total cost for individual patients. Due to this agreement, the three health services individually provided their portion of the patient cost thereby impacting on combing the total cost for these patients.

In 2015-16 the department in collaboration with Melbourne Health, Northern Health and Western Health have developed a guide for the costing and reporting of these admitted mental health patients. This ensures that the reported admitted mental health activity and cost for the NorthWestern Mental Health service is contained and the full cost is recognised.

Mental Health – Consultation liaison service

Specific guidance has been developed for Mental Health consultation and liaison contacts to be easily identified, costed and reported to the VCDC in 2015-16. This enables the transition of those specific costs to be transitioned to a relevant admitted or emergency patient that has received these services to complete the total cost for those patients.

Reporting of ICU and Mechanical ventilation hours

ICU Hours – Where ICU and CCU coexist, Victoria is unable to distinguish the time spent in a CCU or ICU.

PICU Hours and NICU Hours – PICUs are located at Monash Medical Centre and the Royal Children's Hospital only. NICUs located within four Victorian hospitals - Mercy Hospital for Women, Monash Medical Centre, Royal Women's Hospital and the Royal Children's Hospital.

However, where a patient spends time in a PICU and NICU, Victoria is unable to distinguish PICU from NICU hours.

PsyICU Hours – Victoria does not collect the amount of time measured in hours that a patient spends in a state of psychosis while in an ICU.

Mechanical ventilation hours – Victoria only collects the total duration of Mechanical Ventilation (MV) in hours provided in an approved ICU or NICU only. MV hours provided in a non-approved ICU are not collected.

Mental Health Legal Status – Only patients in Approved Mental Health Service or Psychogeriatric Program in public hospitals whose care is funded by Mental Health Services can report the status. Patients in all other care types, report the 'not applicable' code.

Reconciliation

The reconciliation report is designed to assist the department to understand the completeness of a health service's final submission including the source data by which the VCDC is created and its reconciliation. The data entered into this report is to represent the data used for the final VCDC and NHCDC submissions for FY2015-16.

In accordance with local and national financial reviews it is recommended that a director's attestation will need to be signed when submitting the reconciliation report. This will acknowledge the validity and completeness of the data to be submitted and used through the local and national cost collections.

Assurance

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 development of the National Efficient Price and National Efficient Cost.

Signed:

Director General/Secretary/Head of Ministry/ Department

To receive this publication in an accessible format phone 9096 2404, using the National Relay Service 13 36 77 if required, or email VCDCassist@dhhs.vic.gov.au.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

Queensland Government

18 September 2017

Enquiries to: Ms Toni Cunningham
Senior Director
Health Care Purchasing and Funding Branch
Health Care Purchasing and System Performance Division
Telephone: 3708 5887
File Ref: C-ECTF-17/5708

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST QLD 1300

Dear Mr Downie

Thank you for your letter dated 21 August 2017, regarding the Round 20 National Hospital Cost Data Collection Data Quality Statement.

I am pleased to provide (enclosed) the Data Quality Statement on the template you provided, for the Queensland submission for Round 20 of the National Hospital Cost Data Collection.

Should you require further information, the Department of Health's contact is Ms Toni Cunningham, Senior Director Healthcare Purchasing and Funding Branch, on telephone 3708 5887.

Yours sincerely

Michael Walsh
Director-General
Queensland Health

Office
Level 37
1 William Street
BRISBANE QLD 4000

Postal
GPO Box 48
BRISBANE QLD 4001

Phone
3708 5990

Email:
DG_Correspondence@health.qld.gov.au

NHCDC R20 Data Quality Statement

Healthcare Purchasing and Funding Branch

National Hospital Cost Data Collection (NHCDC) Round 20 (R20) Data Quality Statement

The National Hospital Cost Data Collection (NHCDC) is the primary data collection used to develop the National Efficient Price (NEP). To ensure accurate information is submitted to the NHCDC and subsequently available for the NEP determination, there are robust validation and quality assurance conducted.

Guidelines for preparing cost data are published in the Queensland Clinical Costing Guidelines (QCCG). It is a supplementary document to the Australian Hospital Patient Costing Standards (AHPCS) and is a guide to the Hospital and Health Services' (HHS) costing teams in the application of the AHPCS within the technical environment of the costing system / s used within Queensland Health.

Costing data is prepared for 16 HHSs and the Mater Public Hospitals (Brisbane). Once finalised by the HHS the reconciliation is undertaken and the data transformed into the NHCDC specification format. All data are validated, by the Department of Health and the HHHS prior to submission to the Independent Hospital Pricing Authority (IHPA).

The following data quality statement describes changes in the scope of the collection, costing processes and issues that have been identified in the NHCDC R20 (2015-2016) data for Queensland.

Data Submission

Of the 380 facilities which have been costed at patient or service level data in the 2015-2016 fiscal year (including a number of facilities that are out of scope for the NHCDC such as nursing homes for which cost data is held by the Department of Health), 111 were submitted as part of the NHCDC in R20. These excluded facilities accounted for 5.2 per cent of the state episodes and 2.2 per cent of costs and are all out of scope for the NEP determination.

Changes in Reported Facilities

Since 2014-2015 NHCDC R19 two Queensland facilities have been removed from the NHCDC as they closed when the Lady Cilento Children's Hospital opened on 29th November 2014. The new university hospital located on the Sunshine Coast has been added to the NHCDC R20 and due to an expanded scope for rural and remote HHSs; five additional primary health care centres have also been added to the collection. Following is a summary of the changes:

Table 1 Changes in Reported Facilities

Change	Facility Type	Establishment ID	Facility Name
Removed for NHCDC R20	Recognised Public Hospital – Acute Other	310000007	Royal Children's Hospital
	Licensed Private Acute Hospital – Publicly Funded Activity	310000002	Mater Children's Hospital
Added for R20	Recognised Public Hospital – Acute Other	310000032	Sunshine Coast University Hospital
	Primary Health Centre (Previously Declared Hospital)	310000229	Yarrabah Emergency Service
	Primary Health Centre (Previously Declared Hospital)	310000241	Burketown Health Clinic
	Primary Health Centre (Previously Declared Hospital)	310000242	Camooweal Health Clinic
	Primary Health Centre (Previously Declared Hospital)	310000250	Karumba Health Clinic
	Primary Health Centre (Previously Declared Hospital)	310000251	Dajarra Health Clinic

Changes to Treatment of Overheads

In 2015-2016 Queensland implemented an internal allocation process to redistribute overhead costs to appropriate cost buckets for reporting. Within the clinical costing system, any costs expensed to cost centres classified as indirect (or overhead) are distributed to child departments until all funds are allocated to the patient level; these costs are all assigned to the fixed indirect cost category.

Prior to NHCDC R20, expenditure attached to the fixed indirect cost category could not be apportioned further therefore all costs were reported under the Goods and Services NHCDC line item. For the 2015-2016 submission Queensland developed a process to quantify costs held against the fixed indirect category for direct departments, and attribute these costs to the appropriate NHCDC line item based on the source data. This change has not impacted the ambit of the NHCDC however it has significantly improved the accuracy of the cost bucket allocations thus refining the quality of the Queensland submission.

Changes to Mental Health Costing

In 2015-2016 Queensland completed implementing the clinical costing interface for the Consumer Integrated Mental Health Application (CIMHA) in all HHSs that provide specialised mental health services. This has enabled HHSs to accurately attribute mental health costs to patients receiving care in outpatient and community based health settings; previously these services were cost modelled through the use of virtual patients. Patient level data is now available for all HHSs which deliver non-admitted mental health services which has extended the scope the NHCDC and will support the IHPA's development of the Australian Mental Health Care Classification (AMHCC).

New Feeder Systems for Clinical Costing

Queensland LHNs continually monitor the implementation of new clinical data collection systems to assess whether they can be utilised for clinical costing, and they also work collaboratively with data managers to improve existing systems to attain minimum requirements for costing. A number of new feeder systems were integrated for clinical costing in 2015-2016, these include:

- Allied-One (The Townsville Hospital) – provides patient level data for allied health interventions thus improving the cost allocations for the NHCDC
- CIMHA – outlined above
- The full implementation of blood products at all HHSs

A number of Cerner products were also implemented as part of the roll-out of the digital hospitals program at Cairns Base Hospital and Princess Alexandra Hospital:

- FirstNet – Emergency Department information system
- SurgiNet – Perioperative and anaesthesia information system
- Enterprise Scheduling Manager (ESM) – Non-admitted appointment scheduling system

The above information systems presented challenges with obtaining data extracts for clinical costing which were readily available from the precursory applications. In the absence of system produced data files for clinical costing, Healthcare Purchasing and Funding Branch (HPFB) staff developed extracts to ensure continuity of clinical costing information for HHSs. These data files produce consistent data elements and activity volumes compared to historical applications, however there is currently a missed opportunity in relation to additional data elements that could be made available from these systems to further refine clinical costing. HPFB staff will continue to work with HHSs, and the vendors to progress to full benefits realisation.

Digital Hospital Costs

Queensland is progressing implementation of the integrated electronic Medical Record (ieMR) and digital hospitals initiative across facilities. The ieMR is operational at six Queensland facilities including Cairns Hospital, The Townsville Hospital, Mackay Base Hospital, Royal Brisbane and Women's Hospital, Lady Cilento Children's Hospital and Princess Alexandra Hospital. The facilities have reported benefits to clinical care as clinicians have access to all ieMR patient information at any ieMR location. This enables effective and efficient patient care with improved outcomes resulting from access to comprehensive clinical records. Considerable infrastructure investment is required to support the ongoing expansion of ieMR across Queensland facilities and this has resulted in an increase to the average cost of service delivery.

The four largest facilities transitioning to the ieMR have collectively reported additional costs in excess of $64 million in 2015-2016 expenses, though implementation would be capitalised. The ongoing additional expense for Wi-Fi, portable devices and software to support ieMR is estimated at $20 million; this additional expenditure will increase the R20 NHCDC data for these facilities.

Blood Products

In 2015-2016 Queensland introduced patient level data for blood products for all facilities; in prior years the majority of sites attributed blood costs to virtual patients which were excluded from the NHCDC. The result of this is that the cost of blood products has increased from approximately $20 million to $54.5 million from NHCDC R19 to R20. Although 2016-2017 patient costing is not finalised, preliminary analysis based on the general ledger indicates that the cost of blood products will be similar to 2015-2016.

Patient Travel

The average Queensland cost per episode (or national weighted activity unit (NWAU)) for 2015-2016 is greater than 2014-2015 due to the increasing cost of patient travel.

The Queensland NHCDC R20 submission reported $7.6 billion, of which the Goods and Services category is $513 million (6.7%), of the Goods and Services category $44 million (8.6%) related to patient travel. The actual spend on patient travel including Queensland Ambulance Services was $136 million; following is a summary of the NHCDC submission and actual spend based on the general ledger (GL):

Table 2 Patient Travel Cost Changes

Data Source	2014-2015 NHCDC R19	2015-2016 NHCDC R20	Growth	Growth Per Cent
NHCDC Patient Travel (part of Goods and Service category)	$28,091,567	$44,340,494	$16,248,927	58%
GL Data	$133,074,837	$135,614,934	$2,540,096	2%

There is a significant variance between the GL and the NHCDC submission due to the number of facilities that are allocating patient travel costs to system-generated patients which are excluded from the NHCDC.

The growth between 2014-2015 and 2015-2016 is attributable to improvements in clinical costing processes. The majority of cost centres in which patient travel is expended are indirect overheads, which are allocated to the NHCDC "overhead" product stream. As described in the above section titled "Changes to Treatment of Overheads", HPFB staff have developed a process to redistribute indirect costs to the correct cost type within direct departments which has resulted in the reported growth from the previous NHCDC round.

As evident from the above information, patient travel is significant for states that service a geographically diverse population. Queensland welcomes the IHPA Jurisdictional Advisory Committee (JAC) decision that a separate NHCDC line item be established for patient travel, which separates these costs from the Goods and Services category. The granularity that will be achieved through separating these costs will enable the IHPA and jurisdictions to quantify the additional cost of service delivery.

Teaching, Training and Research

Direct teaching, training and research costs are managed differently across facilities. The majority of facilities are allocating direct training and training costs to patients. This is achieved through directly mapping to a suite of patient level products such as the patient's "admission", "outpatient clinic attendance" or "emergency department attendance", or through the use of the indirect allocation structure to other direct patient care departments. A number of smaller facilities are allocating direct teaching and training to system-generated patients which are excluded from the NHCDC. For all facilities, embedded teaching and training costs are not separately identified and any teaching or training that occurs in the course of patient care is included in patient costing.

For all HHSs excluding one, research is allocated to system-generated patients which are excluded from the NHCDC.

The NHCDC R20 checklist shows the facilities which are directly mapping teaching and training to a suite of patient level products and the HHS that is also allocating research to the patient level. NHCDC product type information is not available for facilities that are allocating direct teaching and training costs to

patients via the indirect allocation structure, therefore the teaching, training and research cost shown on the NHCDC R20 checklist represents only a portion of the cost of these services (12% based on the National Efficient Cost allocation of $282,400,000).

Unlinked Diagnostic data

Pathology, Imaging and Pharmacy data that was not able to be matched or linked through the data matching process has been excluded from the NHCDC. For R20 there were 283,738 unlinked utilisation records which account for $121 million of cost. This should be taken into consideration when comparing the costs of the diagnostic clinics between NHCDC rounds.

Other Issues Identified

The following issues in R20 do not have a significant impact on overall cost outcome (s) but are noted here for completeness:

1. The R20 NHCDC submission included 9,369,253 records of which there were only 682 encounters with zero cost; this comprises less than 0.0073 per cent of records.

ROUND 20 National Hospital Cost Data Collection Sign-Off Statement

All data provided by Queensland to Round 20 (2015/2016) of the National Hospital Cost Data Collection (NHCDC) has been prepared in adherence with the Australian Hospital Patient Costing Standards (AHPCS) Version 3.1.

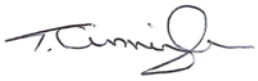
Data provided to this submission has been reviewed for adherence to the AHPCS Version 3.1 and is complete and free of material errors.

Adherence to the AHPCS Version 3.1 is qualified by the following items:

1. Guidelines for preparing cost data are published in the Queensland Clinical Costing Guidelines (QCCG). It is a supplementary document to the AHPCS and is a guide to the Hospital and Health Services' (HHS) costing teams in the application of the AHPCS within Queensland Health. Costing data are prepared for seventeen HHS's and once finalised by the HHS, the reconciliation is undertaken and the data transformed into the NHCDC specification format. All data are validated, by Queensland Health and the HHS prior to submission to the Independent Hospital Pricing Authority (IHPA).

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 development of the National Efficient Price and the National Efficient Cost.

Signed:



Toni Cunningham
Senior Director
Healthcare Purchasing and Funding Branch

NSW GOVERNMENT Health

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
Darlinghurst NSW 1300

Your ref D17-8691
Our ref S17/424

Dear Mr Downie

Round 20 National Hospital Cost Collection Data Quality Statement

Thank you for your correspondence requesting a Data Quality Statement from NSW Health, to be published in the National Hospital Cost Data Collection (NHCDC) Cost Report.

Please find enclosed NSW Health's Data Quality Statement, highlighting the costing methodology applied in respect to data submitted by NSW for Round 20 of the NHCDC (2015-16).

Data provided for Round 20 has been prepared in adherence to the Australian Hospital Patient Costing Standards (AHPCS). This incorporates guidelines for preparation, quality checking and submission.

If you would like more information, please contact Neville Onley, Executive Director, Activity Based Management on 9391 9035 or via email at nonle@doh.health.nsw.gov.au.

Yours sincerely

Susan Pearce
Acting Secretary, NSW Health
11/9/17

NSW Ministry of Health
ABN 92 697 899 630
73 Miller St North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Tel. (02) 9391 9000 Fax. (02) 9391 9101
Website. www.health.nsw.gov.au

DATA QUALITY STATEMENT

NEW SOUTH WALES

Overview

The NSW Round 20 (2015-16) National Hospital Cost Data Collection (NHCDC) is based on the NSW Health District and Network Return (DNR). Guidelines for preparing, quality checking and submitting the DNR are published in the NSW Health Cost Accounting Guidelines (CAG), which align to Version 3.1 of the Australian Hospital Patient Costing Standards (AHPCS).

The DNR is prepared and submitted by each of the 15 Local Health Districts and 3 Specialty Health Networks. In NSW, financial results are published and audited at the District/Network level and not at hospital level.

The DNR includes all products for all Districts/Networks and reconciles to the published financial results. On submission to Activity Based Management (ABM), District/Network DNRs are consolidated and formatted to comply with NHCDC dataset specifications. To comply with the Independent Hospital Pricing Authority's (IHPAs) requirements, ABM includes the work in progress expense from previous Rounds. In Round 20, to better match resource consumption and activity in non-admitted services in NSW, an adjustment was introduced. This may impact the ability to compare the cost for non-admitted patient services over the years.

The DNR is a single submission used to satisfy reporting requirements for the NHCDC, Public Hospital Establishment Collection, Mental Health Establishment National Minimum Dataset and the Health Expenditure submissions. This facilitates reconciliation across all reporting requirements.

Coverage

NSW submitted patient level data for a total of 98 hospitals considered in-scope for activity based funding (ABF) for 2015-16. Byron Central Hospital was opened in June 2016.

Only patient level data is submitted by NSW Health. No aggregate non-admitted patient or teaching, training and research products are submitted for the NHCDC.

Only general fund expense is allocated at the patient level in the DNR. Restricted asset fund expenditure is included but not allocated at the patient level in the DNR. Custodial fund expenditure is not included in the DNR.

Data quality

Data quality processes for Round 20 were further developed from Round 19 initiatives. The DNR module (within the Power Performance Management (PPM) costing system) was completely rebuilt with over 30 enhancements to improve efficiency of the reporting process. The range of validations was further expanded.

The DNR draft submission period enables Districts/Networks to assess the reasonability of aggregate cost results when compared with peer hospitals.

A web-based tool; the Reasonableness and Quality Application (RQ App), is utilised during the DNR draft submission period to enable Districts/Networks to access aggregate results and patient level data quality checks. Each quality check is scored and this scoring is based on either pass/fail logic or a sliding percentage scale. The pass/fail logic is applied to quality checks to ensure errors that should not occur in the data are identified.

Data checks were again informed by the IHPA National Efficient Price Determination Technical Specifications as well as Round 19 NHCDC quality assurance checks.

A data reconciliation spread sheet was completed by each District/Network for Round 20. Enhancements to the reconciliation spread sheet for Round 20 included further itemisation of the expense schedule in the non-admitted section. Enhancements were also made to the encounters reconciliation, with an encounter variance worksheet added to ensure costing officers reconciled encounters from different source systems.

During the draft submission period, teleconferences were held separately with each District/Network Chief Executive, to review their draft submission and highlight any material movement in average cost or data quality issues requiring further investigation or remediation. These teleconferences greatly assisted in the timely analysis of Round 20 cost results.

DNR audit program

The mandatory audit program was refined for the 2015-16 DNR with a few minor changes from 2014-15. Two tests were deleted and the wording in a number of tests updated to provide greater clarity. Risk ratings were also applied to a number of key tests.

Completion of this audit program is part of a robust governance framework encompassing costing. The completion of the audit program is a condition of subsidy in District/Network service agreements with the Secretary, NSW Health.

District and Network DNR audit reports were submitted to local Audit and Risk Board Sub-Committees. District/Network Chief Executives were required to submit an attestation certificate to the Secretary, NSW Health upon completion of the DNR audit program.

ABM engaged a third party to undertake a peer review of six Districts to identify any audit program implementation issues. No major issues were identified with the program.

Technical issues

Costing frequency – the DNR is submitted twice yearly by Districts/Networks to ABM. Data relating to the July to December period is submitted in mid-March. Data relating to the July to June period is submitted in mid-October.

Blood costs – the NHCDC reports on the state share of blood costs as this is the expense that is distributed to and reported in District/Network financial statements. For Round 20 a state-wide blood extract was developed including standardised blood product naming conventions.

Professional indemnity costs – this expense is held centrally by NSW Health and is not distributed to Districts/Networks. It is therefore not reported in the financial statements. To ensure compliance with AHPCS SCP 2.003 expenditure in-scope, this expense is distributed to Districts/Networks and added to the general ledger loaded into PPM2. This adjustment is noted in the District/Network reconciliation schedule that is submitted as part of the DNR.

S100 drug costs – expenses associated with S100 drugs are not linked and included to the relevant non-admitted patient level service event. The NSW CAG standard requires all S100 drug costs to be reported separately.

Work in progress (WIP) – WIP encounters were included in Round 20 where the admission year was either Round 16, 17, 18 or 19. Inclusion of the Round 16, 17, 18 or 19 cost components of the encounter was undertaken by ABM.

Critical care – many critical care services in NSW have the critical care and the step down beds in the one ward. Examples of this include ICU/HDU and CICU/CCU. Typically these services have one cost centre and one ward set up in the Patient Administration System (PAS), with two or more bed types to distinguish the ICU hours/bed days separately to the HDU hours/bed days. The bed type is used to calculate ICU hours.

The final cost allocation reflects appropriate nursing ratios such as 1:2 for ICU/HDU patients. In some instances where a patient only has HDU hours, the cost centre will map to critical care, but there will be no ICU hours. Additionally, only facilities with level 3 ICUs will map their cost centre to critical care, even though locally they may use the ICU bed type.

Medical cost allocation – Visiting Medical Officer expense is not allocated to private patients in the DNR. Staff Specialist costs are allocated to both public and private patients with no adjustments.

Hosted services – a number of Districts/Networks have hosted service arrangements in place. These are for services such as IT. Where appropriate, the expense associated with these services is adjusted for both the host and the hosted District/Network. This adjustment is noted in the District/Network reconciliation schedule that is submitted as part of the DNR.

ABM worked with all Districts/Networks collaboratively to review dummy encounters and the associated linking rule analysis, to improve precision in linking of encounter and feeder data. This work was undertaken in collaboration with the NSW Costing Standards User Group. ABM reported that following this work, their internal review of costs demonstrated greater improvement in linking and therefore associated costs at episode level as a result.

Cost methodology changes

Cost allocation methodology relating to non-admitted patients was further refined to better align with inputs to outputs for Round 20, reflecting further improvement in the data collection.

Cost allocation methodology relating to the Emergency Department (ED) was refined using the Relative Value Units (RVUs) developed as part of the IHPA Emergency Care Costing Study. The current costing methodology no longer uses triage based weights as the drivers for cost allocation, but utilises a combination of location of patient in the ED (such as cubicles or resuscitation bay), diagnosis and provider type of doctor or nurse. The refined costing methodology was applied state-wide to all ABF hospitals except for Royal Prince Alfred Hospital, Blacktown Hospital, Port Macquarie Base Hospital and The Sydney Children's Hospital which used their own RVUs developed as part of the study.

A state-wide extract for oral health was developed for Round 20 along with the adoption of refined RVUs to allocate costs for oral health developed for each dental item.

A state-wide extract was developed for non-emergency patient transport services for Round 20, and RVUs used for the cost allocation methodology for metropolitan Districts/Networks was revised to reflect the actual number of kilometres travelled.

Organ donation costs associated with a single organ donation encounter are recorded in up to five separate general ledgers; the donor patient District or Network; the Western Sydney or Sydney Local Health District abdominal retrieval teams; the St Vincent's Health Network cardiothoracic retrieval team; the Organ and Tissue Donation Service (OTDS) at South Eastern Sydney Local Health District; and pathology costs in the Ministry of Health general ledger. For Round 20 the costs for each organ donation encounter were based on a list of retrievals provided by OTDS and matched to medical and surgical salaries and wages, supply costs and any associated travel expense.

Mental health inpatient nursing RVUs – based on the mental health costing study undertaken in 2014, nursing RVUs were developed in consultation with mental health clinicians. These RVUs were applied in Round 20 costing of mental health data.

Government of **Western Australia**
Department of **Health**
Office of the Director General

Your ref: D17-8686
Our ref: F-AA-53249-4

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Downie

ROUND 20 NATIONAL HOSPITAL COST DATA COLLECTION DATA QUALITY STATEMENT

Thank you for your letter dated 21 August 2017 requesting a Data Quality Statement and Sign-Off Statement to be published in the Round 20 National Hospital Cost Data Collection Cost Report.

Please find the Data Quality and Sign-Off Statements attached.

Yours sincerely

Rebecca Brown

Rebecca Brown
A/DIRECTOR GENERAL

12 October 2017

Att. WA Data Quality Statement
WA Sign-Off Statement

189 Royal Street East Perth Western Australia 6004
Telephone (08) 9222 4222 TTY 1800 067 211
Letters PO Box 8172 Perth Business Centre Western Australia 6849
ABN 28 684 750 332
http://www.health.wa.gov.au

Western Australia Round 20 Data Quality Statement

Participation and coverage

Western Australia (WA) contributed patient level data for thirty-four public hospital sites for Round 20 of the National Hospital Cost Data Collection (NHCDC). All hospitals that are considered in scope for Activity Based Funding are currently part of the NHCDC submission for WA.

The Round 20 submission included Fiona Stanley Hospital (FSH) for the first time after opening in 2014/15 with a staggered uptake of services. FSH becoming fully operational plus the closure of Swan District Hospital and Kaleeya Hospital resulted in a transition of services that impacted the casemix and service provision across a number of other hospitals in the Perth Metropolitan region.

Data Quality

Round 20 was the fourth year Power Performance Management 2 (PPM2) was used in the preparation of the costing submissions for all sites with instances of the patient costing system being managed at each of the four Area Health Services (AHS). Work has been ongoing in terms of data quality and standardisation and all NHCDC submissions were completed in compliance with version 3.1 of the Australian Hospital Patient Costing Standards (AHPCS). Data submissions were extensively reviewed by the Area Health Services, prior to official sign off and submission to the Department.

On submission to the Department, the AHS submissions were tested and reconciled with AHS corrections and resubmissions being made if required. The Department then made adjustments to the data including incorporating Work in Progress (WIP) from previous rounds, before the data was consolidated and formatted in accordance with IHPA specifications. Data matching and validation also occurred to ensure the costed data sets aligned with the activity data submitted to IHPA for other patient collections.

Products costed

WA has provided its most extensive NHCDC submission with patient level coverage of Inpatient, Emergency and Non Admitted patients in accordance with the IHPA data specifications. The costing process has been improved to allow for separate reporting of Admitted Emergency costs at all sites, overcoming a limitation of previous rounds where some sites reported their Admitted Emergency Department costs as part of the Acute Inpatient costings. WA's Outpatient activity was predominantly costed at a patient level however work is continuing on disaggregating and costing the small amount of activity that remains non patient costed and is excluded from the submission.

All WA hospital submissions were reconciled to total accrued operating expenditure as per the audited financial statements with a reconciliation statement supplied for each site.

For Round 20, Teaching and Research costs were identified by site and allocated at a patient level for the purpose of local management use. In accordance with the relevant AHPCS these costs were removed from the costing submission but identified in the reconciliation process.

Costs of corporate services including payroll, human resources and information technology are allocated at an Area Health Service and hospital level and included in the submission.

Blood product costs are managed by the department and not included in the Round 20 submission.

Costs of ancillary services including pathology, imaging and pharmacy, that have not been able to be linked to patient episodes have been costed but excluded from the submission.

Only costs for those patients that were discharged in the reference year (2015/16) were included in the Round 20 submission. These included costs incurred in 2014/15. End of year work in progress, that is, patients admitted during the reference year but not discharged during that year are fully costed and will form part of future submissions. No escalation has been applied to the prior year work in progress.

Aside from the disaggregation of Admitted Emergency Department costs at some sites, there were no significant changes to admission or costing policies between round 19 and 20.

Round 20 National Hospital Cost Data Collection Sign-Off Statement

All data provided by Western Australia to Round 20 (2015 -16) of the National Hospital Cost Data Collection (NHCDC) has been prepared in adherence with the Australian Hospital Patient Costing Standards (AHPCS) Version 3.1.

Data provided to this submission has been reviewed for adherence to the AHPCS Version 3. 1 and is complete and free of material errors.

Adherence to the AHPCS Version 3.1 is qualified by the following items:
1. Blood product costs were not included in the costing submission as required by SCP 2.003 – Product Costs in Scope.

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 development of the National Efficient Price and National Efficient Cost

Signed:

Rebecca Brown
A/Director General

Government of South Australia
SA Health

Office of the Chief Executive

Cit: Centre Building
11 Hindmarsh Square
Adelaide SA 5000

PO Box 287, Rundle Mall
Adelaide SA 5000
DX 243

Tel (08) 8226 0795
Fax (08) 8226 0720

ABN 97 643 356 590
www.sahealth.sa.gov.au

CE17-1062

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Downie

RE: ROUND 20 NATIONAL HOSPITAL COST DATA COLLECTION DATA QUALITY STATEMENT

Thank you for your letter of 21 August 2017 concerning the release of the 2015-16 NHCDC cost data and production of the Round 20 (2015-16) National Hospital Cost Data Collection Cost report.

As requested, attached are South Australia's Data Quality Statement and Australian Hospital Patient Costing Standard Sign-Off Statement to be included in the report.

Should you require any further information please contact Stuart Conboy, Manager Funding Models & Allocations, 08 7425 3632.

Yours sincerely

Vickie Kaminski.

VICKIE KAMINSKI
Chief Executive

06/10/2017

Att: Data Quality Statement
Round 20 National Hospital Cost Data Collection Sign-Off Statement

South Australia 2015-16 Data Quality Statement

Participation and Coverage

South Australia's 2015-16 cost data is produced by the Department for Health and Ageing (DHA) using one instance of the patient costing system. The maintenance of the patient costing system and the processing of data are undertaken centrally by staff within the DHA based on advice from Local Hospital Network (LHN) representatives and with reference to the Australian Hospital Patient Costing Standards v3.1.

As per Round 19, cost data for eight metropolitan hospitals and six large country hospitals were submitted in Round 20. Stand-alone designated mental health hospitals and rehabilitation hospitals are not included in the South Australian cost data.

The data was extensively reviewed by the DHA staff, in conjunction with the LHNs and signed off by the LHNs, before submission to the National Hospital Cost Data Collection (NHCDC). The costing data was subjected to considerable scrutiny, with appropriate corrections and resubmissions as required to ensure that it was fit for this purpose.

Teaching, Training and Research (TTR)

Teaching, Training and Research (TTR) direct costs are not reported at the patient level, however they are reported in the reconciliation. TTR costs have been treated in compliance with the Australian Hospital Patient Costing Standards v3.1.

Blood products

Blood product costs were not included in the cost data submitted.

Work in Progress

In the patient costing process, all work in progress is costed, however only work in progress for patients that were admitted prior to 1 July 2015 and discharged during 2015-16 were submitted. As directed by IHPA the escalation factor was not applied to all work in progress records.

Changes to costing or admission policies between Round 19 and 20 NHCDC collections

There were no material changes in the costing process.

As in previous years, SA has not complied with costing standard 3A.002 – Allocation of Medical Costs for Private and Public Patients. Only medical costs that are reported in the hospitals operational accounts have been included in the costing process. Public and private patients are treated the same in the allocation of medical costs.

There was no change to the admission policy between the two rounds.

Round 20 National Hospital Cost Data Collection Sign-Off Statement

All data provided by South Australia to Round 20 (2015 – 16) of the National Hospital Cost Data Collection (NHCDC) has been prepared using our best efforts in adherence with the Australian Hospital Patient Costing Standards (AHPCS) Version 3.1.

Data provided to this submission has been reviewed for adherence to the AHPCS Version 3.1. Steps taken to promote adherence to the AHPCS Version 3.1 include:

1. Patient costing was carried out at regular intervals throughout the 15-16 fiscal year with each costing iteration being reviewed, amended accordingly and signed off by the respective LHN representatives.
2. Final end of year review workshops were held with all LHN representatives to ensure the iterative improvements carried out during the year were reflected in the final results.
3. An independent financial review was carried out on a sample set of hospitals by a 3rd party nominated by IHPA.
4. Quality Assurance reports generated by IHPA in response to South Australia's submission were received, reviewed by LHN representatives and acted upon accordingly.

As in previous years, meeting some areas of the AHPC standard have been problematic due to difficulties in the quality of reliable data and processes. These include the requirements of the AHPCS with regard to the following costs:

1. Medical Rights of Private Practice costs reported outside the hospital's operational accounts (expenses not controlled by the LHN legal entity)
2. Pathology costs for private patients
3. Blood product expenses
4. Disposal of Capital Assets Proceeds

With acceptance of the above impacts, 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 development of the National Efficient Price and National Efficient Cost.

Signed:

Vickie Kaminski

VICKIE KAMINSKI
Chief Executive
10/10/17

Department of Health and Human Services

Level 1, 99 Bathurst Street, Hobart, Tasmania
GPO Box 125, HOBART TAS 7001, Australia
Ph: (03) 6166 3530
Web: www.dhhs.tas.gov.au
Contact: Ian Jordan
Phone: (03) 6166 3530
E-mail: ian.jordan@dhhs.tas.gov.au
WITS No.: 101742

Tasmanian Government

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Downie James.

Subject: Round 20 National Hospital Cost Data Collection Data Quality Statement

I refer to your letter dated 21 August 2017, requesting that Tasmania provide a 'Data Quality Statement' to be published as part of the Round 20 National Hospital Cost Data Collection (NHCDC) Cost Report.

I note that a recommendation of the Round 19 Independent Financial Review was that an approved and signed jurisdictional statement, in relation to the application of the Australian Hospital Patient Costing Standards, should be included as part of each jurisdiction's future annual NHCDC submissions. I understand this was supported by IHPA's NHCDC Advisory Committee and approved by the Pricing Authority.

Accordingly, Tasmania now confirms that:

- all data provided by Tasmania to Round 20 (2015-16) of the NHCDC has been prepared in adherence with the Australian Hospital Patient Costing Standards (AHPCS) Version 3.1
- data provided to this submission has been reviewed for adherence to the AHPCS Version 3.1 and is complete and free of material errors
- adherence to the AHPCS Version 3.1 is qualified by the following items: No known qualifications
- 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 development of the National Efficient Price and National Efficient Cost.

Should you require any further information, please contact Ian Jordan, Team Leader, Clinical Costing, on telephone (03) 6166 1028 or email ian.jordan@dhhs.tas.gov.au.

Yours sincerely

Michael Pervan
Secretary

19 September 2017

ACT Government
Health

Office of the Director-General

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Downie

Round 20 National Hospital Cost Data Collection Data Quality Statement

Thank you for your letter of 24 August 2017 requesting that ACT Health provide a Data Quality Statement for data provided to the Independent Hospital Pricing Authority (IHPA) for the 2015-16 (Round 20) National Health Cost Data Collection (NHCDC).

As requested please see attached ACT Health's Data Quality Statement at Attachment A. The response provides commentary on all areas as requested, and information on changes between NHCDC Rounds and improvements expected for Round 21 NHCDC.

All data provided by ACT to Round 20 of the NHCDC has been prepared in accordance with the Australian Hospital Patient Costing Standards (AHPCS) Version 3.1 as confirmed in your recent Independent Financial Review.

As you are aware in early 2017 Minister Meegan Fitzharris announced an ACT Health System-Wide Data Review of all data and reporting that is due for completion by 31 March 2018. Unfortunately until such time as the System-Wide Review is complete all data must be released with a standard caveat noting that whilst there are no known errors in the data provided, there is a System-Wide Review underway that will review all aspects of data including the NHCDC. Whilst the review is fortuitous, it does provide a significant opportunity to make a number of improvements to ACT Health's future NHCDC submissions.

We thank the IHPA for their ongoing work in the collation of the NHCDC and hope this statement meets all requirements. If IHPA wishes to discuss this statement further, please do not hesitate to contact Ms Karen Chudleigh, A/g Director Data Management and Governance on (02) 6207 2324 or karen.chudleigh@act.gov.au

Yours sincerely

David Nicol
A/g Director-General
26 September 2017

ACT Government
Health

Attachment A

Australian Capital Territory (ACT) National Hospital Cost Data Collection 2015-16 (Round 20) Data Quality Statement

ACT Health's submission of the Round 20 (2015-16) National Hospital Cost Data Collection (NHCDC) was produced by the Business Performance Information and Decision Support unit in close consultation with Strategic Finance, Canberra Hospital and Health Services (CHHS) and Calvary Public Hospital, Bruce (CPHB). Costing for Round 20 was undertaken in accordance with the Australian Hospital Patient Costing Standards (the Standards) v3.1.

ACT Submitted cost data for the two public hospitals for Round 20 with both submissions reconciling to the total operating expenditure as per the 2015-16 audited financial statements.

Adherence to Australian Hospital Costing Standards (AHPCS) Overview

There has been a significant program of work undertaken with Strategic Finance known as the 'Clinical Costing Review Project'. The scope of the project was to review all cost centres, including how costs are allocated to clinical services and exploring anomalies in an effort to identify opportunities for improvement. This process has resulted in improved allocation of costs to all cost centres with a natural shift of costs between product groups.

Work in Progress

Patients are allocated costs based on their consumption of resources during the reporting year (1 July 2015 - 30 June 2016). Episodes admitted in the collection year but yet to be discharged are costed and will be included in the Round 21 submission.

Teaching, Training and Research

Teaching, Training and Research (TTR) costs were better captured for CHHS due to the results received from the 'Clinical Costing Review project'. Further work needs to be completed for CPHB in Round 21 to better capture costs against these product lines.

Blood Products

ACT only reports the blood costs that are assigned to patients. The cost of blood products supplied to private hospitals is recorded in the activity files and ACT Health's general ledger. But these costs are out of scope for NHCDC and are not reported.

Pharmacy and Diagnostic Data

Pathology, Imaging and Pharmacy datasets including Highly Specialised Drugs are linked according to the data matching rules. Where records are not matched, these records have been costed but considered out of scope and excluded from the 2015-16 NHCDC submission.

Private patient pathology activity and costs are also excluded from the NHCDC.

Other improvements between Round 19 and 20 NHCDC

1. Inclusions of bonuses paid to staff specialists from cost centres outside the CHHS general ledger in accordance with Costing Standard COST 3A.002;
2. Revisions of cost allocations for Canberra Hospital and Health Services;
3. Refinements to linking rules in consultation with both sites;
4. Submission of admitted palliative care patient data at the phase level; and
5. Reconciliation of total NHCDC costs to the Public Hospital Expenditure (PHE) for consistency of reporting results.

Improvements for Round 21 NHCDC

In February 2017 the Minister for Health and Wellbeing Ms Meegan Fitzharris announced an ACT Health System-Wide Review of all data and reporting. On 28 March the Minister released the Terms of Reference (TOR) which in essence provides six pillars of work for completion by 31 March 2018. The six pillars are:

1. investigate the extent, and where possible, the root cause of the current data issues;
2. establish revised governance processes and protocols for data management, reporting and analysis;
3. develop a framework for the provision of essential data reports derived directly from source systems as an interim process and re-building of the ACT data warehouse;
4. implement the framework outcomes;
5. provide a detailed road-map to address existing recommendations from the Auditor-General and ACT Health external advisers; and
6. provide advice on the publication of data for consumers that facilitates improved understanding of ACT Health information, performance, quality and safety, including options for real-time provision of information.

Based on the Pillars there is a significant program of work underway that provides the opportunity to improve all aspects of the NHCDC submission including:

1. revised metadata for all data;
2. development of a new data warehouse to ensure end to end quality assurance processes from source system extraction to final reporting;
3. improving the costing workforce by consolidating staff across the two campuses;
4. Ongoing work to improve the collection and reporting of non-admitted services;
5. Revised governance arrangements to ensure formal change management processes are in place providing transparency of processes;
6. Expansion of the ACT Health Costing Framework including the revision of corporate overheads and the automation of general ledger mappings and allocations; and

7. Improved quality assurance processes on the final products including working closer with clinicians to address anomalies prior to submission.

Summary

In early 2017 Minister Meegan Fitzharris announced an ACT Health System-Wide Data Review of all data and reporting that is due for completion by 31 March 2018. Until such time as the System-Wide Review is complete all data must be released with a standard caveat noting that whilst there are no known errors in the data provided, there is a System-Wide Review underway that will review all aspects of data including the NHCDC. Whilst the review is fortuitous, it does provide a significant opportunity to make a number of improvements to ACT Health's future NHCDC submissions.

.....

David Nicol
A/g Director-General
ACT Health

26 September 2017

NORTHERN TERRITORY GOVERNMENT

DEPARTMENT OF **HEALTH**

Attachment A

Chief Executive
Level 4 Health House
87 Mitchell Street
DARWIN NT 0800

Postal Address
PO Box 40596
CASUARINA NT 0811

T 08 8999 2761
E Catherine.Stoddart@nt.gov.au

File Ref: TRIM No. 7097

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURT NSW 1300

Dear Mr Downie

Re: Round 20 National Hospital Cost Data Collection Sign-Off Statement

Please find attached the requested Sign-Off Statement of adherence to the AHPCS Version 3.1 and the related qualifications.

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 development of the National Efficient Price and National Efficient Cost.

Yours sincerely

Professor Catherine Stoddart
11 October 2017

Round 20 National Hospital Cost Data Collection Sign-Off Statement

All data provided by the Northern Territory to Round 20 (2015-16) of the National Hospital Cost Data Collection (NHCDC) has been prepared in adherence with the Australian Hospital Patient Costing Standards (AHPCS) Version 3.1.

Data provided to this submission has been reviewed for adherence to the AHPCS Version 3.1 and is complete and free of material errors.

Adherence to the AHPCS Version 3.1 was qualified by the below items:

1) 3A.002 – Allocation of Medical Costs for Private and Public Patients.
The NT has included medical costs reported in the Health Services' General Ledger (GL). Medical costs paid from the Private Practice Trust fund, and not an expense of the Health Services, have not been included in the costing analysis. Identifying those expenses in the Trust fund accounts that relate to patient care or other products is a significant and complex exercise, and the materiality of expenses contained in these accounts is considered to be low in the NT.

2) GL 4A.002 – Critical Care Definition:
In Royal Darwin Hospital (RDH), patients in the High Dependency Unit (HDU) are costed in the same way as Intensive Care Unit (ICU) patients.

3) SCP 3F.001 – Matching Production and Cost – Order Request Point
For the purpose of matching, the NT uses the 'date of service' to create the link between patients and services such as an x-ray. The 'date of request/order' information that is available in the patient administration system is currently unreliable and hence, in order to maximise matching services to patients, the NT uses the 'date of service'.

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 development of the National Efficient Price and National Efficient Cost.

Professor Catherine Stoddart
11 October 2017