1. Governance processes

Structure

The Local Health Network (LHN) that encompasses Tasmania currently has four major hospitals, 18 rural sites and two state-wide facilities, with 1.08 million records and a cost of $3 billion.

Guidelines applied to inform costing process

The costing process in Tasmania uses the Tasmanian hospital audited financial statement and then brings in salary wages, workers compensation, recoveries and Departmental cost centres.

Each year the Department's Clinical Costing Unit meets with relevant business managers to:

- Review the previous rounds results
- Review the current rounds cost centre expenditure
- Implement adjustments that are needed to better align the financial ledger to service delivery
- Review current allocations statistics to ensure service delivery is accurate and updated as required

Overhead cost centres are allocated based on discussions with relevant stakeholders on how best to allocate the cost to production cost centres. This could be across the whole LHN, a specific hospital, hospital unit or based on a percentage of a cost centre, salary and wages or goods and services.

Production centres are distributed on an appropriate Relative Value Unit (RVU), a summary of main distribution methods is described below.

Area	**Description**
Utilisation (intermediate) Data	Item cost in feeder system is matched to patient unique identifier with closest date to service delivery. If no match found, it is allocated to unmatched and excluded
Outpatients	Appointment time or estimated appointment time
Contracted	Contract DRG price or bed day cost
Ward Costs	Nurse roster cost per minute by ward time and HMV data
Specialist	Specialist time distributed based on carer data for inpatient, outpatient, or theatre
Theatre	Minutes of each type of theatre staff in the OR, allocated to patient encounter
Emergency	Time in ED, with reduced weighting for triage and wait room time
Counts	Count of defined patient groups to distribute cost as needed

Contracted care arrangements

The total cost for contracted care is determined by summing up a range of contracted natural accounts. This figure serves as the overall expenditure for further cost disaggregation to contracted episodes. The Department ensures that all contracted natural accounts are included in the cost calculation to ensure accurate and comprehensive costing.

To determine the cost of a contracted service, the Clinical Costing Team use a mapping table of contracted Diagnosis Related Groups (DRGs) and value, which is provided by the health service. This table contains information on the agreed value by DRG and region. The agreed value is used as a RVU to calculate the episode cost from the total amount allocated for the contracted episodes in the General Ledger (GL). Currently, our cost falls inside the Goods and Services (G&S) line item and flows through to the appropriate bucket based on this.

In some cases, the cost agreed is a combination of pre/post outpatient appointments and admitted procedures. Where this occurs and the Department have data available, it has to manually split the expenditure to cover the outpatient appointment/s. This can cause issues if splits are incorrectly calculated or advise has not been received from stakeholders.

Each year the Clinical Costing Unit compares the contract value to the RVU GL value to ensure it is as close to a 1:1 ratio as possible. Some variations can occur due to episodes being discharged in one year and invoices received months after the end of the fiscal year.

Recently, the Department has started negotiating with private providers for purchased bed. These have been used as a way of shifting low acuity patients out of hospital wards and into a private bed for observation until discharged.

This arrangement is different from a contracted ward, as patients that utilise one of these beds are not flagged as contracted as they are only occupying a bed for a period and form part of the patient journey. Expenditure for this service comes through using one of the natural accounts related to contracted services and flows through to the goods and service.

Costing and Activity Reporting

Throughout the year data quality checks are run by the Clinical Costing Unit and if issues are identified, they are addressed with the relevant Business Managers.

Quality and Assurance (QA) checks are run throughout the year to ensure costing is accurate and key areas are validated. These checks include:

- Reconciliation from audited financial statement through to submission file
- Checks for negative cost centres, line items and episodes
- Comparison of ledger changes at the line item and cost centre level between years
- Overhead to final ratios are as expected
- Casemix is compared across sites against previous submission and national averages
- Low and high patient costs are reviewed
- Low and high end-class costs are reviewed
- Patient data quality
- Utilisation data between years is reasonable and as expected
- Bucket matrix results are reasonable

The Clinical Costing Unit has also developed a suite of SQL audit reports that are run regularly to ensure that feeder data is as accurate as possible.

Costing data is available to key stakeholders through Qlikview reports, allowing users to view data from a jurisdictional level down to episodic data for the current and previous years.

An annual costing report is written and distributed each year to allow for comments and feedback from key stakeholders. The report covers:

- Costs included in the costing ledger and how this differs to the financial statement
- Admitted acute – Broken down by changes to each major hospital, same day to overnight, medical vs. surgical, elective surgery and bucket analysis
- Emergency department – Average cost, changes in length of stay, admitted vs. non admitted grouped by major hospitals
- Non-Admitted – Average cost, Tier 2 class comparison by major hospitals
- Sub-Acute – Expenditure, changes in average cost and length of stay by major hospitals
- Community Mental health episodes/phases – as this is an evolving area, cost is allocated using length of stay as an RVU. The report allows the visibility of average costs by mental health sites.
- As well as rural sites, work in progress and non-ABF activity

Consistency

Patient costing is undertaken by the Department's Clinical Costing Unit, on behalf of the Tasmanian Health Service annually. Due to Tasmania's size, the Clinical Costing Unit acts as both the LHN and jurisdiction, building and submitting the costing data to IHACPA. As a result, costing is done in a consistent manner throughout the jurisdiction, with minor region differences.

Each year the Clinical Costing Unit meets with the relevant Business Managers and conducts the following checks:

- Review the previous rounds results
- Review the current rounds cost centre expenditure
- Implement adjustments that are needed to better align the financial ledger to service delivery
- Review current allocation statistics to ensure service delivery is accurate and update as required

With regular input from Business Managers, the costing report and reporting tools, Tasmania's costing reported each year is consistent, allowing for service delivery and ledger changes from year to year.

Changes

Allied Health

An issue was identified late in the costing cycle relating to data extracted from the Department's Allied Health information system. Due to clinician data entry changes, four months' worth of allied health data was not extracted. The Clinical Costing Unit worked with the Allied Health team to find a solution, but no adequate change could be found. Any systems improvement will require further work involving the software vendor. As a result, it was decided to build a series of allied health service weights, based on the previous year's LHN data, to distribute the allied health expenditure in 2023-24. This has resulted in more episodes getting a smaller amount of allied health expenditure greatly increasing the number of lines in the Cost C file.

Below are previous changes implemented that are still being used for Tasmania.

Blood/Pathology data

In 2023-24 one of the hospital's pathology unit could not supply blood and pathology data due to system changes, under resourcing and data warehouse expertise. In this instance we used a service weight by DRG based on the same DRGs in another hospital that had blood and pathology data.

Patient Travel/Transport

In Tasmania there is no separate natural account (and as a result ERItem) for patient transport other. This is allocated based on cost centres using the Final Cost Centre Code of "PatTransport-Other". All expenditure in that cost centre is allocated to a non patient product and excluded from the costing study as there is not accurate patient level data and expenditure could be related to a patient, carer/guardian covering either transport and/or accommodation.

Community Mental Health

Community mental health continues to be an area that continues to evolve each year. There have been several changes in data capture and several new services starting within the Tasmanian Health Service. In 2023-24 the costing unit has worked with stakeholders to improve separating the expenditure to align with service delivery and better aligning with the NMDS data.

Home Delivered Services

Tasmania's home delivered outpatient services have been poorly captured in the past, some of these services fell under pharmacy, allied health or ICU in the case of TPN. We have consulted where possible and tried to align cost with service delivery but more work is needed to track and cost these services better.

2. NHCDC 2023-24 result summary

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

Total expenditure for the 2023-24 costing ledger totalled $3.00 billion, incorporating:

- The expenditure portion of the THS audited financial statement, $2.9 billion
- THS salary and wages workers compensation recoveries, $9 million which is offset against THS salaries
- Corporate cost centres that provide a service to the THS totalling $4.5 million
- Imputed expenditure of $1 million
- Work in Progress carried forward into 2023-24 totalling $90 million

In 2023-24 the total expenditure was $3 billion, including $86 million of work in progress expenditure, which is spread throughout the following streams.

- Admitted acute accounts for 46 per cent with a total expenditure of $1369 million
- Emergency Departments account for 10 per cent with a total expenditure of $296 million
- Non-admitted accounts for nine per cent with a total expenditure of $278
- Admitted sub-acute accounts for four per cent with a total expenditure of $111 million
- Other admitted accounts for one per cent with a total expenditure of $35 million
- Mental health accounts for six per cent with a total expenditure of $174 million
- Other non-submitted cost accounts for 19 per cent with a total expenditure of $589 million
- End of year work in progress (WIP) accounts for five per cent, across a range of streams, with a total expenditure of $136

A comparison between 2022-23 and 2023-24 is as follows:

- The audited THS general ledger for 2023-24 was $2.9 billion an increase of 13 per cent on the previous year.
- Total expenditure in the costing ledger totalled $3 billion an increase of 10 per cent from 2022-23.
- Expenditure submitted as part of the NHCDC totalled $2212 compared to $2005 million the year before, resulting in a 10 per cent increase.
- Expenditure not submitted as part of the NHCDC totalled $788 million. Tasmania brings in all expenditure related to NPCR regardless of if it occurs in the LHN or outside. This allows for easier reconciliation between expenditure submitted to the national funding body and costs excluded as part of the NHCDC
- Episodes submitted as part of the NHCDC decreased by three per cent from the previous year. The decrease in episodes is due to a reduction in Tier 2 4063 Covid-19 Response as well as a range of allied health related appointments.

Activity Cost Comparisons

The table below shows the comparison of the number of episodes with full cost by ABF description between 2022-23 and 2023-24:

Table 1 – Comparison of the number of episodes with full cost by ABF Name forming part of the Cost C between FY 2022-23 and FY 2023-24

ABF Name	Type	2022-23	2023-24	Change
Admitted Patient Care	Episodes	170,553	177,660	4%
	Full Cost	$1,457,307,464	$1,603,362,663	10%
Emergency Department	Episodes	174,112	177,868	2%
	Full Cost	$239,030,313	$276,833,625	16%
Mental Health	Episodes	10,403	19,839	91%
	Full Cost	$32,914,849	$31,868,269	-3%
Non-admitted Patient Care	Episodes	680,439	627,878	-8%
	Full Cost	$270,527,481	$294,544,365	9%
Palliative Care (PCC)	Episodes	725	826	14%
	Full Cost	$5,502,630	$5,014,991	-9%

Overall, total expenditure submitted as part of the NHCDC increased by 10 per cent, with the largest increase in the Emergency Department increasing by 16 per cent from the previous year. The number of submitted episodes decreased by three percent.

- Admitted episodes increased by four per cent in 2023-24 with the cost increasing by 10 per cent. The expenditure increase aligns with the general ledger expenditure jumping by 10 per cent overall.
- Emergency Department episodes remained stable compared to the previous year, while the total submitted cost rose by 16 per cent. This was predominately driven by staffing expenditure increasing by 16 per cent.
- Mental health episodes increased by 91 per cent, this was a result of better data capture both from a clinician and data warehouse perspective.
- Outpatient services saw an eight per cent reduction in appointments, while the total cost increased, rising by nine per cent in total expenditure. The decline in outpatient appointments is a result of a reduction in Tier 2 4063 and 2057 Covid-19 Response as well as a range of allied health related appointments. The rise in total cost aligns with the overall expenditure general ledger expenditure.
- Palliative Care episodes increased by 14 per cent while the expenditure decreased by nine per cent.

3. Compliance to the Australian Hospital Patient Costing Standards (AHPCS) Version 4.2

The Tasmanian Costing Unit has followed the current AHPCS costing standards, apart from the areas highlighted below.

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

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

Final cost centres are distributed in three broad categories:

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

Tasmania does not fully comply with the following costing standards:

1.2 Identify Relevant Expenses – Third Party

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

As mentioned previously non-emergency patient transport provided by Tasmanian Ambulance is not charged to the LHN, this area needs further work and investigation to understand it better.

6.1 Review and Reconcile – Data Quality Framework

Tasmania is partially compliant with this standard. The jurisdiction has a robust quality framework in place, using a QA checklist, QA reports and regular correspondence with stakeholders, as well as annual reviews of cost centres with relevant Business Managers. The Clinical Costing Unit also produce a yearly costing report and Qlikview reports, which can be accessed by THS staff as needed.

The financial data is audited both internally and externally as part of the financial statements process and the costing data uses this as a basis. From a costing perspective, some QA testing has been done outside of the Clinical Costing Unit, but not by an internal or external audit unit.

Further work is being done to improve usage of Clinical Costing data as well as investigating if internal and external auditors can review costing data. Tasmania does not comply with 6.1.3.4 relating to Australian Auditing Standards for costing, but as mentioned above, the financial statement of the THS is audited by both internal and external audit units for accuracy.

4 Teacher Training

Teacher Training is only partially recorded at a cost centre level where it has been identified by the relevant stakeholders. This expenditure is then allocated to a non-patient product and excluded from the NHCDC submission. There is no dedicated software available or staff to record Teacher Training. There are several projects underway to improve Teacher Training capture. The State Government is implementing a new payroll system and a part of this will be used to record staff training. The costing unit has a working group with Finance, Human Resources and the Funding Unit to review, and where possible, capture dedicated Teacher Training activities.

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

Standard 5.2 Intermediate Products

Blood and pathology data from one of the four major hospitals could not be sourced. Service weights based on the same DRG as another hospital was used, ensuring the consistency of services allocation across the state.

4. Other relevant information

Issues or major changes between costing submissions have been addressed under the Changes section.

5. NHCDC declaration – please ensure the below declaration is included.

All data provided by Tasmania to the 2023-24 NHCDC has been prepared in accordance with the IHACPA's Three Year Data Plan 2024-25 to 2026-27, Data Compliance Policy June 2023, and the AHPCS Version 4.2.

Best endeavours were undertaken to ensure complete and factual reporting and compliance. Data provided in this submission has been reviewed for adherence to the AHPCS Version 4.2 and is complete and free of known material errors.

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

Approval

The Director, Monitoring Reporting and Analysis, Vicki Sherburd, has reviewed and cleared this Data Quality Statement for release on behalf of the Deputy Secretary, SMR on the 23 of April 2025.

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