## Data Quality Statement

**National Hospital Cost Data Collection 2023-24**

**Instructions**

Jurisdictions are required to address all sections in this National Hospital Cost Data Collection (NHCDC) 2023-24 Data Quality Statement template that must be signed by their respective health department secretary or equivalent to secretariatihacpa@ihacpa.gov.au.

### 1. Governance processes

Provide details across the following areas, where jurisdictions cannot provide more detail, they should indicate as such. Points below are a guide to support commentary on the governance processes used by jurisdictions:

All data provided by Victoria to the 2023-24 NHCDC has been prepared in accordance with the Independent Health and Aged Care Pricing Authority's Three-Year Data Plan 2023–24 to 2025–26, Data Compliance Policy June 2023, and the Australian Hospital Patient Costing Standards (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. Section 3 provides details of any qualifications for Victoria's adherence to the AHPCS Version 4.2.

*1.1 Structure of Local Health Networks (LHN)/Hospitals and Health Services*

Individual health services undertake patient costing and subsequently submit to the Victorian Department of Health (the department) via the Victorian Cost Data Collection (VCDC) for their respective campuses.

Victorian public hospitals are required to report costs for all activity, regardless of funding source, and are expected to maintain patient level costing systems that monitor service provision to patients and determine accurate patient-level costs. The VCDC submission to the department is annual.

*1.2 Costing process guidelines, including the use of relative value units*

The VCDC submission involves a five-phase process to ensure the data submitted meets the reporting requirements and adherence to any guidance provided.

The five phases include:

1. **Phase 1 - receipt of submission**
   Acknowledgment of receipt of files and a summary report of the details submitted for verification.

2. **Phase 2 - file validations**
   The submissions must follow the Victorian Data Request Specifications and where validations of each field have identified critical errors, these must be rectified by the health service and resubmitted.

3. **Phase 3 - linking/matching VCDC to activity**
   The VCDC follows a single submission multiple use format where the collections include several fields that will enable the cost data to be linked and matched to activity records already submitted. Reports on the level of linking/matching are provided to health services for confirmation.

4. **Phase 4 - data quality assurance checks**
   A suite of reports is provided to the health services where records have been flagged as not meeting specific criteria around various patient cohorts. The checks compare the data submitted for the

current year to prior years. It takes into consideration the total costs as well as specific cost bucket costs.

5. **Phase 5 - reconciliation report and Data Quality Statement**
   Reconciliation report - designed to assist the department (and users) to understand the completeness of a final submission including the source data by which the VCDC is created and its reconciliation.
   Data Quality Statement (DQS) - health services complete a DQS including a signed declaration confirming adherence to the national and local requirements including the standards and acknowledging the validity and completeness of the data submitted.

Once the final VCDC has been consolidated, the submission to the NHCDC is developed by the department to ensure that the reporting requirements are met in terms of the final cost centres, line items and activity reported. The NHCDC submission is reconciled to the VCDC, and a brief prepared for sign off by the Executive Director, Funding, Costing, Pricing for the NHCDC data quality statement. The NHCDC submission is reconciled and any issues rectified.

To ensure there is consistent, reliable, and quality costed data, health services adhere to VCDC guidance provided by the department and the most recent version of the Australian Hospital Patient Costing Standards (AHPCS v4.2).

## The Relative Value Unit (RVU)

Allocation of costs at intermediate product levels involves Relative Value Units (RVUs) being updated by health services at regular intervals in accordance with AHPCS v4.2 Part 2, Business rules and AHPCS v4.2 Part 3, Costing Guidelines. Please note that it is Victoria's preference to avoid the use of nationally derived service weights (e.g. the Diagnosis Related Group service weights) as RVUs at an intermediate product level (where DRGs are defined as intermediate products) will bias the integrity of the cost weights recalibration. The development of RVUs is the responsibility of the health services' costing team and/or costing consultants in conjunction with their stakeholders and is to be aligned to the Business rules 5.2A.3 outlined in AHPCS v4.2 Part 2.

*1.3 Costing and activity reporting processes and methodologies*

The VCDC submission process is reviewed annually to ensure that the data submitted meets local and national requirements. Health service costing practitioners undertake reviews, in conjunction with relevant stakeholders, to ensure the underlying information is reflective of the services and the costs of those services.

Improvements in this submission continued in the areas of:

- data quality and refinement,
- implementation of new feeder systems,
- implementation of Electronic Medical Record systems and,
- further refinement on allocated costs at staff level.

Health services individually review allocations and methodologies yearly to ensure that the resources are costed as accurately as possible. These reviews drive ongoing improvements to the costed data results.

*1.4 Consistency of costing practices across the jurisdiction*

Victorian public health service costing practices are consistent in their methods. Victoria's health services follow guidance provided by the department which takes into consideration feedback after consultation with relevant stakeholders and costing practitioners.

To ensure there is consistent, reliable, and quality costed data, health services are required to adhere to VCDC documentation, guidance provided by the department and with the most recent version of the Australian Hospital Patient Costing Standards (AHPCS v4.2). The VCDC documentation and current AHPCS assist health services in the reporting and costing of patient level cost data providing details in relation to:

- **Data Request Specifications** – details of the requirements of the files to be submitted including the structure, values, and validation rules.
- **Business Rules** – guidance of specific criteria and conditions of the reporting and costing requirements to the Victorian Cost Data Collection and most current AHPCS. An example is the Relative Value Unit (RVU) as outlined above.
- **Specific Costing Guidance** – guidance on specific conditions of areas for the reporting and costing requirements to Victorian Cost Data Collection and most current AHPCS. An example is contracted care arrangements. Victorian health services have been advised to refer to the new AHPCS v4.2 Part 3, Costing Guideline 12 on Contracted Care, CG12. Contracted care in Victoria occurs in acute, subacute, non-admitted and mental health patient settings, for diagnostic and clinical services, treatment or support services. Under the arrangement where a health service has a contract role as the service provider, the health service allocates the cost of these patients accordingly but does not submit them to VCDC. Rather the costs for these patients are submitted to the VCDC by the health services receiving the service (purchaser of service) with respective completed episodes' full costs. When a health service purchases service at another hospital (e.g. for intensive care unit or theatre) these patients receive the costs for all their services incurred at the health service (purchasing health service) based on its activity extracts including the overhead cost components. In addition, the expenses of these contracted care patients (incurred at the service provider) are identified and are allocated to the contracted care patients, to achieve the full cost of their completed episodes. Examples of determining contracted care cost include:
    - Transition Care Program (TCP) patients treated at private facilities, have their expenses calculated at agreed rate by diagnosis related group (DRG) or calculated at agreed bed day rate.
    - Mental health patients' cost allocation is based on daily rate or average daily rate for the length of stay (provided by the Victorian Department of Health)

*1.5 Contracted care arrangements across jurisdictions or LHNs/Hospitals*

Some health services have contracted care for services such as locum medical staff, radiotherapy, pain management, obstetrics and gynaecology, mental health and haematology. Expenses related to patients under contractual arrangements are either excluded and aggregated or allocated utilising the same methodology as other patients, depending on which health service is responsible for reporting the activity and costs of these patients.

Issues that may impact costing contracted care for 2023-24 cohorts reported by health services are:

- Receipts of invoices where late data entry contributed to some of the contracted cares not being costed. This may also impact the matching between accrual amounts in GL and activity.
- Where the invoices were charged based on DRG weightings, there may be occasions where records are not coded with DRG weightings for various reasons such as ineligible account class.
- Availability of electronic contracted patients' data at smaller hospitals where this work commenced during 2022-23.

*1.6 Any changes in the above governance processes from the previous year* - Nil

## 2. NHCDC 2023-24 result summary

Provide a summary of the NHCDC 2023-24 results compared to the NHCDC 2022-23 results. Points below are a guide to support commentary on the governance processes used by jurisdictions:

*2.1 Number of hospitals/facilities submitted*

In this 2023-24 submission 38 health services submitted cost data. The following health services were recently amalgamated:

- Kilmore and District Hospital amalgamated with Northern Health on 1 November 2023.
- Castlemaine Health and Maldon Hospital amalgamated to become Dhelkaya Health in March 2022.

New campuses of existing health services were created:

- The Casey Early Parenting Centre is a new campus of Monash Health, that commenced operation in January 2024.
- Monash Health took over Obstetrics & Gynaecology services at Sandringham hospital in February 2023 (campus code 4330)
- The Victorian Heart Hospital (VHH) opened in March 2023 and cardiac services moved from Monash Health's Clayton campus to the VHH.
- Blackburn Public Surgical Centre, previously Bellbird Private Hospital became part of Eastern Health on 1 October 2022.
- Frankston Public Surgical Centre previously Frankston Private Hospital became part of Peninsula Health on 1 September 2022.

Additional health service establishment changes:

- The Women's ceased delivery of Obstetrics and Gynaecology services at Sandringham in February 2023.
- Previously Cranbourne Integrated Care (CICC), part of Monash Health service had an incorrect Establishment ID in use ending in 2112. A new establishment ID was created for CICC of 210902650.
- From 1 July 2023 Western Health became a designated mental health service with some activity previously delivered by Melbourne Health moving under the governance of Western Health.
- In 2022-23, Western District Health Service submitted cost data for Penshurst (campus code 1072) and Coleraine (campus code 2140). Neither of these campuses were included in the 2023-24 Western District Health Service cost data submission. A data quality issue was found at these campuses and as they have low patient numbers the campuses were excluded from the submission. It is anticipated this will have a negligible impact.
- Grampians Health (established in 2021 following amalgamation of Ballarat Health Services, Edenhope Hospital, Stawell Regional Health and Wimmera Health Care Group) have submitted cost data, none was attributable to Edenhope Campus Code 3240
- Mercy Health Werribee submitted data for campus code 1321 Ursula Frayne Centre (UFC) in 2022-23, this campus code no longer exists and wasn't referred to in the 2023-24 submission.

*2.2 Number of records and costs submitted*

**Table 2 Number of records and cost submitted to the NHCDC 2023-24**

| | | 2023-24 | | | 2022-23 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | In scope for NHCDC reporting | | | In scope for NHCDC reporting | | | % Change (In scope for NHCDC reporting) | | |
| Stream | | Records | Cost | Average | Records | Cost | Average | Records | Cost | Average |
| Acute | | 1,940,017 | $12,205,443,651 | $6,291 | 1,790,031 | $10,814,472,943 | $6,042 | 8% | 13% | 4% |
| Subacute | Episodes | 34,468 | $1,037,417,052 | $30,098 | 32,473 | $963,683,623 | $29,676 | 6% | 8% | 1% |
| | Phases | 16,462 | $137,372,862 | $8,345 | 15,824 | $140,104,001 | $8,854 | 4% | -2% | -6% |
| Emergency Department | | 1,911,676 | $2,076,258,453 | $1,086 | 1,870,367 | $1,912,109,699 | $1,022 | 2% | 9% | 6% |
| Emergency Virtual Care | | - | $0 | $0 | - | $0 | $0 | | | |
| Non-Admitted | | 5,502,177 | $2,197,719,410 | $399 | 4,962,830 | $2,012,765,951 | $406 | 11% | 9% | -2% |
| Admitted Mental Health | Episodes | 825 | $35,669,636 | $43,236 | 631 | $28,583,685 | $45,299 | 31% | 25% | -5% |
| | Phases | 30,014 | $822,928,420 | $27,418 | 24,295 | $712,970,811 | $29,346 | 24% | 15% | -7% |
| Community Mental Health | Episodes | 6 | $31,731 | $5,289 | 740 | $283,462 | $383 | -99% | -89% | 1281% |
| | Phases | 356,303 | $826,093,091 | $2,319 | 478,974 | $667,639,147 | $1,394 | -26% | 24% | 66% |
| Ungroupable Mental Health | Episodes | - | $0 | $0 | - | $0 | $0 | | | |
| | Phases | - | $0 | $0 | - | $0 | $0 | | | |
| Other | Episodes | 157 | $2,943,679 | $18,750 | 123 | $3,067,601 | $24,940 | 28% | -4% | -25% |
| | Phases | - | $0 | $0 | - | $0 | $0 | | | |
| **Total** | | **9,792,105** | **$19,341,877,984** | | **9,176,288** | **$17,255,680,923** | | 6.70% | 12.10% | |

## Significant Variation in the 2023-24 submission

### Community Mental Health

As outlined in Victoria's 2023–24 Statement of Assurance (SOA), the 2023–24 Activity Based Funding Mental Health Care National Best Endeavours Dataset (ABF MHC NBEDS) submission reflects updates and clarifications introduced in IHACPA's 2024–25 Technical Specifications. These include:

- Revisions to mental health phase of care and Australian Mental Health Care Classification (AMHCC) business rules, including the requirement for a single phase of care to be reported at any one time for a consumer across settings.
- Clarification regarding concurrent episodes in the community, specifically the requirement for one community episode and phase per consumer at any one time within a Local Hospital Network (LHN).
- Guidance on reporting year-to-date data in quarterly submissions, including 'work-in-progress' episodes.

The reduction in community phases is attributed to the bundling of episodes and phases across establishments within LHNs.
Increased costs were due to several factors, including extended travel and contact time with clinicians.
Additionally, year-on-year data comparisons should be interpreted with caution due to the following variables:

- Protective measures were in place for some Victorian health services in 2022–23, which may have impacted activity and cost reporting.
- Variations in the number of healthcare providers.
- Fluctuations in demand for tribunal hearings.

Austin Health Community Mental Health Program M costs have remained stable, in 2022-23 the costs were $55,181,474.83, and in 2023-23 the costs were $51,886,865.98. The allocation of costs to campuses has changed significantly over the same period, particularly for the Heidelberg Repatriation Campus which in 2022-23 had costs of $8,757,380.92 and in 2023-24 had no costs for Community mental health services. Austin Health service has reported that in 2022-23 Heidelberg Repatriation campus had community mental health activity connected to it, as the data was extracted from CMI and MedTrak, MedTrak provided the additional granularity. In 2023- 24 the submission has all activity aligned to Austin Health campus following standardisation of all Program M data. The data is now consolidated under campus 1031 (Austin) in line with CMI configuration. The FY2024–25 VCDC submission will continue to reflect only campus 1031 for these services.

### Contracted Care

In 2023-24, the total contracted care costs were $316,416,100 which was a 26.59% increase from 2022-23. Public to private contract arrangements increased from $190,431,678 in 2022-23 to $254,735,764 in 2023-24.

The acute admitted patient care funding category was the area where most of the contracted care was funded. Costs of contracted care in 2022-23 by acute admitted patient care funding source was $185,049,079 and in 2023-24 it had increased to $197,111,868.

Many health services use public to private contract arrangements to provide services to patients that were unable to access care during the COVID-19 pandemic.

### Non Admitted

Western Health reported a decrease in in-scope non-admitted patient costs from $119,338,361 million in 2022–23 to $40,248,470 million in 2023–24. This coincided with a major expansion of Western Health's electronic medical record (EMR) system which has impacted Western Health's ability to submit complete non-admitted activity and cost data for 2023-24. As of 2023-24, two changes were implemented to the service event derivation rules (SEDR), the addition of multi-disciplinary case conferences (MDCCs) and the addition of services in which the patient is represented by a carer and the patient is not present.

**Overall Results per Stream (out of scope activity included)**

**The Acute stream** increased in terms of records, costs and average costs. In 2022-23 there were 1,790,034 records and in 2023-24 there were 1,940,023 records. Costs increased from $10,817,369,007 in 2022-23 to $12,209,271,860 in 2023-24.

**The Admitted Subacute stream** records for episodes and phases were relatively stable. Episodes in 2022-23 were 32,482, this increased to 50,937 in 2023-24. Costs in 2022-23 were $968,159,772 increasing to $1,179,977,696.

**The Emergency Department stream** has seen increases across records and costs. In 2022-23 there were 1,870,367 records and this increased to 1,911,676 in 2023-24. In 2023-24 the costs were $1,912,109,699 and this increased to $2,076,258,453 in 2023-24.

**The Admitted Mental Health stream** in 2022-23 number of records were 643, and the records for 2023-24 were 30,869. Episodes costs increased, in 2022-23 they were $44,975,122, in 2023-24 this cost of episodes was $894,516,675. Phases costs in 2022-23 was $ 726,618,779 and this increased in 2023-24 to $851,211,591.

**The Community Mental Health stream** in 2022-23 number of episodes were 740, and the records for 2023-24 were 6. Episodes costs decreased, in 2022-23 they were $ 283,461, in 2023-24 this cost of episodes was $31,731. Phases costs in 2022-23 was $667,639,147 and this increased in 2023-24 to $ 826,093,091.

**The Non- Admitted stream** saw modest decreases in records. In 2022-23 there were 5,669,221 records, this decreased to 5,502,177 in 2023-24. In 2022-23 the costs were $2,291,917,282 this increased to $2,426,892,534in 2023-24.

**The Other Stream** had a decrease in records from 14,372 in 2022-23 to 157 in 2023-24. The costs decreased from $23,028,774 in 2022-23 to $2,943,679. Phases increased in records from zero in 2022-23 to 402,804 in 2023-24. Costs also increased from zero in 2022-23 to $1,814,786,264 in 2023-24.

*2.3 Factors influencing submission*

*Cost and records exclusions*

All expenses within the general ledgers of health services have been used in the allocation to patient treatments. Examples of excluded expenses are specific purpose accounts not relating to the provision of treatment, and capital and depreciation expenses. Examples of included expenses are the National Blood Allocation and Health Share Victoria costs.

Most of the Victorian health services include ancillary costs for private patients in their NHCDC submission except for:

- Peninsula Health (Private patient pathology costs are excluded from the VCDC).
- North West Health Wangaratta (Private patient pathology costs are excluded from the VCDC).
- Mercy Health-Women's (Private patient pathology costs are excluded from the VCDC). Eleven health services use external pathology and imaging services and invoice the private patients and health care funds directly; the cost and activity are excluded. These include:
    - Albury Wodonga Health,
    - Bairnsdale Health,
    - Bass Coast Health,

- Central Gippsland Health,
- Echuca Regional Health,
- Gippsland Southern Health,
- Goulburn Valley Health,
- Latrobe Regional Health,
- Mercy Health – Werribee,
- Swan Hill District Health and
- West Gippsland Healthcare Group.

Costs excluded from the NHCDC are those that have been allocated to patients not yet discharged, out of scope programs not related to activity-based funding and any unlinked costs reported to VCDC.

Facilities excluded

Private health services are excluded from the submission.

*2.4 Key changes from NHCDC 2023-24 to NHCDC 2022-23* – Nil

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

Provide confirmation that your jurisdiction has complied with the AHPCS Version 4.2 at the health services and jurisdictional levels, specifying if any exceptions to the standards have been applied and an explanation for each. Points below are a guide to support commentary on the governance processes used by jurisdictions:

*3.1 Summarisation of general ledger reconciliation*

The table below summarises the reconciliation in dollars for Victoria, for the NHCDC submitted in the 2023-24.

**Table 3.0 General Ledger Reconciliation**

Below is the 2023–24 reconciliation from the VCDC total General Ledger to the final NHCDC submitted costs, incorporating both inclusions and exclusions applied during the VCDC and NHCDC processes.

| | |
|---|---|
| Total General Ledger (GL) | $25,392,436,013 |
| Adjustments to the GL – exclusions (VCDC) | $611,762,788 |
| Adjustments to the GL – inclusions (VCDC) | $ 295,287,225 |
| Post allocation adjustments – exclusions (VCDC) | $1,089,795,520 |
| Post allocation adjustments – inclusions (VCDC) | $ 727,933,590 |
| Adjustments made at the jurisdiction level (NHCDC) | $ 5,097,828,538 |
| **TOTAL Submitted to NHCDC** | $ 19,616,269,982 |

*3.2 Compliance or deviations to the AHPCS Version 4.2*

Jurisdictions should articulate exceptions, deviations or partial compliance with AHPCS Version 4.2. Areas to consider by jurisdictions include:

Stages 1: Have all relevant expenses been identified and included in the NHCDC submission? How is accuracy and completeness of the collected cost data ensured?

The Victorian submission to the 2023-24 National Hospital Cost Data Collection (NHCDC) is based on the 2023-24 Victorian Cost Data Collection (VCDC) submissions. The business rules for the VCDC collection released to costing practitioners provide guidance to health services on the costing and reporting of patient

level cost data to the VCDC. Victorian health services are also required to adhere the Australian Hospital Patient Costing Standards (AHPCS) – version 4.2, the VCDC business rules and specifications and any other guidance provided by the department in the submission year.

All relevant expenses are identified and included in the NHCDC submission (AHPCS Stage 1: identify relevant expenses, Stage 2: create cost ledger, Stage 3: create final cost centres). All hospital activity has been identified and included in the costing process (AHPCS Stage 4: identify products). Costs have been allocated to patients in accordance with allocation methodologies outlined in the AHPCS (Stage 5: assign expenses to products) and VCDC documentation. The process for reconciling cost and activity data (AHPCS Stage 6: review and reconcile) has been completed.

Please note that all prior years' costs relating to patients discharged within the submission year but admitted in prior years have been included. Blood product costs have been included as a line item in the submission, as has the separation of Pharmaceutical Benefits Scheme (PBS) and Non-Pharmaceutical Benefits Scheme (PBS) drugs.

To the best of our knowledge, all Victorian health services have adhered to the guidance and advice provided by the department and the Commonwealth in respect to the treatment of activities and costs related to the impact of COVID-19.

Stage 2: What validation checks are performed? How are discrepancies in data addressed and resolved?

Costing practitioners must ensure data quality checks are undertaken on all feeder activity files, prior to the costing process.

After initial submissions, validation processes are performed. The validations identify records that have been submitted which do not contain the values required. Health services must rectify all critical errors so the file and its contents can be progressed in the process and enable further use of the data. Following validation processes, linking of cost to activity data is undertaken. The VCDC files only contain some patient demographic IDs and/or fields that are used to link to the activity datasets where the full array of patient demographics and clinical details are obtained. Elimination of duplicated of activity details already submitted by health services is then completed. There is an expectation that those records submitted to the activity datasets will have a corresponding costed record.

Examples of critical errors that were detected and resolved include:

- invalid values for 'stream' were reported in a number of Programs. Valid streams are required for data linkage.
- certain values must be unique, such as the unique episode key, in order to be accepted for the submission

In the next phase the linking/matching reports are generated - these identify any record(s) that cannot be linked to the activity datasets. There may be several reasons for these unmatchable records and this report assists health services investigate the reasons for these, thereby improving the data costed and reported. Health services review the levels of matching/linking of the VCDC data to the activity data and vice versa to ensure that all expected activities have been linked/matched. Health services data provided to VCDC have included activities that have been closed off and finalised for the reporting year. Costing practitioners are expected to liaise with their relevant stakeholders who provide the department with their health services' final activity datasets to ensure that details required for costing are captured and reconciled.

Following the linking phase, Quality Assurance (QA) checks are undertaken. These provide a level of understanding of the usefulness of the patient level costed data for development of funding models and interpretation for analysis and reporting. QA checks are performed on records within the admitted, emergency, non-admitted, subacute, and mental health programs. Quality assurance (QA) checks are

performed on final submissions once the file format, structure and value ranges are validated to be correct, and the matching levels are deemed satisfactory. The department provides health services with records that have been flagged for review where they have met certain criteria and tolerances. Health services review and assess whether those records are valid or invalid and provide comments as to the validity within the QA reports.

Health services then produce a Data Quality Statement (DQS) that is authorised by either the Chief Financial Officer or the Chief Executive Officer and this is submitted at the completion of the VCDC process. The DQS is reviewed for discrepancies by the department costing team. Any queries are raised with health services and resolved prior to the NHCDC submission.

The next phase involves the NHCDC costs and episodes correlation to the VCDC submissions. Following this the NHCDC data is submitted to IHACPA and if critical errors are detected, these are investigated and rectified.

Stage 3: What methods are used for cost allocation?

Cost allocation is undertaken using a standardised approach. The VCDC is aligned to the specifications required of the NHCDC. The rigour involved in the cost allocation within the VCDC directly informs the NHCDC. Costing specialists undertake costing allocation according to the Australian Hospital Patient Costing Standards (AHPCS) – version 4.2.

**Allocation of medical costs for private and public patients**

Victorian health services 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.

Stage 4: Have all establishment activity been identified and included in the costing process? What activities, if any, were excluded in the costing process?

Exceptions to the AHPCS standards include the following:

- Capital and Depreciation; Victoria does not include non-cash expenditures such as depreciation as it does not impact upon operational costs.
- Teaching and Training costs; 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.
- Research costs are excluded from Victoria's submission pending further developments in the Activity Based Funding work stream.

Stage 5: How have costs been allocated to patients?

Allocation of costs to patients is undertaken according to the guidance of the Australian Hospital Patient Costing Standards (AHPCS) – version 4.2.

Costing practitioners access the health services general ledger (GL) as the primary source of expense information. The product costing process then draws on all expense information from GL to the delivery of all products relevant to the reporting period.

Where the general ledger includes expenses not applicable to the delivery of patient products, this expense is managed during the product costing process through the 'virtual product- dummy' which are not described as patient or non-patient activity in line with Standard 4.1 Product Types.

Costing practitioners then create a cost ledger that links expenses in the general ledger and cost centres held in the costing system. There are three categories of cost centres, they include overhead, production and final.

Within each cost centre different types of costs are defined to best demonstrate their internal use. Final cost centres reflect the NHCDC line items. In the NHCDC line items, expenses are grouped to represent the following broad categories:

- cost of labor
- pathology
- imaging
- pharmacy
- prostheses
- blood products and services
- all other medical and surgical supplies
- hotel
- all other goods and services
- lease costs
- depreciation
- patient transport.

All products provided by a health service are grouped into product categories that differentiate between patient products and non-patient products. The Patient products include admitted patient products, emergency department patient products and non-admitted patient products. The Non-Patient Products includes hospital boarders, research products, teaching and training products and other non-patient products. Each health service will use data sourced from local information systems to:

- report products identified in line with Standard 4.1 Product Types
- allocate costs in line with Standard 2.2 Matching Cost Objects and Expenses.

Each health service reconciles the measurement of the organisation's final patient products in line with Standard 6.2 Reconciliation to Source Data. All expenses in the final cost centres in the cost ledger are matched to the organisation's final products in a way that represents causality and is credible to stakeholders who understand the production process of that organisation. Intermediate products, such as imaging and pathology tests, in final cost centres are then linked to the final product that they helped produce.

### Stage 6: What is the process for reconciling cost and activity data?

Health services report the cost for all activities performed within their remit. At a minimum, all patient level activities reported to the department must have a corresponding cost record matched to it. That is, those reported to the Victorian Admitted Episode Dataset (VAED), the Victorian Emergency Minimum Dataset (VEMD), the Victorian Integrated Non-admitted Health Minimum Dataset (VINAH) and the Clinical Management Information system (CMI).

A report containing a summary of records matched is provided to health services after each VCDC submission. This report shows the number and percentage of records that have/have not been linked by program.

There are various aspects to linking/matching the cost data to activity data. These include:

1. Linking to activity datasets – there is an expectation that what is reported as activity will have a corresponding cost.
2. Cross program transformations - some costs are combined to align with what is reported in the activity datasets and to allow back year comparisons. These processes of combining costs are performed through cross-program matching algorithms.
3. Phase of care – there is an expectation to identify the cost of patients at a phase of care level within their hospital stay. This level of costing is for the admitted Palliative Care and Mental Health (admitted and community) patients. These costs are reported through a separate file at a date of service level to enable the grouping of resources to the phase that is reported or derived.

To ensure that all records reported either through the activity datasets or the cost data can be used to inform funding models, analysis and benchmarking, the data is linked both ways. That is.

1. Records reported in the activity datasets are matched to the VCDC data; and
2. Records reported in the VCDC dataset are matched to the activity data.

The reports provided to health services are an evaluation of the match levels. Health services review the report to determine if the matching results are acceptable or require rectification and resubmission.

Health services provide comments on records that are unmatched and accepted before proceeding to the next phase. These comments are then included in the Data Quality Statement (DQS) within the justification section on accepting unlinked/unmatched records for sign off. There are instances where some cost records will not find a match to the activity datasets. There are various reasons such as the activity is not required to be reported but is expected to be costed and reported to the VCDC.

## 4. Other relevant information

Please include other information relevant to the 2023-24 NHCDC submission, which may include significant factors and challenges that impacted the NHCDC submission 2023-24.

### 4.1 Monash Health

- Monash Health took over Obstetrics & Gynaecology services at Sandringham hospital in February 2023. There has been an increase in the full year costs in 2023/2024.
- The Victorian Heart Hospital (VHH) opened in March 2023 and services moved from Clayton campus to VHH. There has been an increase in costs for VHH as the hospital has become fully functional and services have been expanded.

### 4.2 Western Health

Western Health reported a decrease in non-admitted patient costs from $133 million in 2022–23 to $41.4 million in 2023–24. This coincided with a major expansion of its electronic medical record (EMR) system, incorporating new modules for appointment scheduling, emergency department data, theatres, and contact recording.

### 4.3 COVID-19 management

As block funding for patients with COVID-19 has ceased and the management of patients with COVID-19 is undertaken in settings with other patients. Costs of the management of patients with COVID-19 is allocated to appropriate areas reflecting the change in practice from isolation to concurrent management of these patients.

### 4.4 PatTran-Other

Victoria is working with health services on a process to accommodate the new 2023-24 NHCDC line item, PatTran-Other. Responses from a survey completed by Victorian costing practitioners, showed that the majority of the practitioners used PatTran and PatTran-Other interchangeably in their general ledger, regardless of the funding body.

The health services in 2023-24 that may have reported patient transport that was funded by the Nationally Funded Centres (NFC's) can be identified from cost centre information below:

| Health service | Cost Centre |
|---|---|
| Alfred Health's paediatrics lung transplants | A1602 |

| | |
|---|---|
| The Royal Children's Hospital, heart transplants | A7161 |
| Monash Health's, pancreas transplants | A5804 |

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

All data provided by Victoria 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

(SIGNATURE of Executive Director)

Andrew Haywood, Executive Director, Funding, Costing, Pricing, Hospitals Victoria Division

25th September 2025