NHCDC Round 28 Data Quality Statement

Healthcare Purchasing and System Performance

National Hospital Cost Data Collection Round 28

Data Quality Statement - Queensland

1. Governance Processes

1.1 Structure of Local Health Networks (LHN)

Queensland's public healthcare system is structured into seventeen distinct entities responsible for delivering health services to the community. The entities are:

- Sixteen Local Health Networks, known in Queensland as Hospital and Health Services (HHS), and
- The Mater Public Hospitals (Brisbane).

The HHS's, who operate as individual statutory bodies governed by their own Hospital and Health Board, provide a broad range of healthcare services, in both the admitted and non-admitted setting, to meet the health needs of Queensland's population. The services include - acute, sub-acute, non-acute, emergency care, facility-based outpatient ambulatory clinics, community mental health, community-based heath intervention and support services.

The 16 HHSs and Mater Public Hospitals (Brisbane) undertake comprehensive costing of their services. This cost data is then provided to the Department of Health (DoH) for compilation and submission to the National Hospital Cost Data Collection (NHCDC). The NHCDC serves as the primary data source for developing the National Efficient Price (NEP). To ensure the accuracy of information submitted for the NHCDC and subsequently used for NEP determination, several data validation and quality assurance activities are undertaken as part of the data transformation process prior to submission to the Independent Health and Aged Care Pricing Authority (IHACPA).

Of the 16 HHSs, 12 employ highly experienced Clinical Costing practitioners who possess the necessary skills and expertise to undertake the costing functions. These teams are supported by the DoH Clinical Costing team who provide technical advice and expertise on costing issues, and clinical costing resource materials including guidelines, standards and audit tools. The DoH Clinical Costing team follows an annual workplan, focusing on identified opportunities to enhance costing practices and management across the State. Existing cost data and system developments to better capture the patient journey are regularly reviewed with the goal to provide the HHSs and DoH with precise cost information that meets both routine management needs and specific data requests.

The DoH Clinical Costing team conducts the costing process on behalf of the remaining four HHSs, which cover rural and remote regions including North West HHS, South West HHS, Central West HHS and Torres and Cape HHS.

In addition to the seventeen entities identified above, public activity is also provided through private hospitals and Queensland's Surgery Connect program. These services are delivered under contract.

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

The Queensland Clinical Costing Guidelines (QCCG) serve as a supplementary document to the Australian Hospital Patient Costing Standards (AHPCS). These guidelines assist HHS costing teams in applying the AHPCS within Queensland Health's environment. The QCCG includes specific chapters on feeder system costing methodologies, covering the selection, use, and application of relative value units. Each HHS applies these guidelines when preparing their costing data, ensuring compliance with AHPCS Version 4.2.

1.3 Costing and activity reporting processes and methodologies

For the period covered in this report (2023-24), there were two costing systems in use across Queensland: CostPro (14 sites) and Power Performance Manager (3 Sites).

Hospital and Health Services (HHSs) undertake costing processes at different frequencies. These range from:

- Daily system-generated updates based on year-to-date data,
- Monthly processes aligned with the fiscal period's general ledger (GL) closure (most common), and
- Biannual full costing processes.

Once the HHSs complete the costing process for the reference year, the data is compiled by DoH with several pivotal steps undertaken including:

- Final data transformation processes,
- Data quality checks,
- Validation procedures, and
- Reconciliation with the general ledger.

1.4 Consistency of costing practices across the jurisdiction

Costing approaches and frequencies are varied across Queensland due to differences in human resource availability to perform monthly costing functions for each HHS. Despite these variations, all sites conduct a formal end-of-year process to ensure data is current and fully reconciled with the General Ledger before handover to the department.

There are also differences based on the functionality of the costing systems. For instance, CostPro utilises a multi-year database, while Power Performance Manager operates on a single-cost-year database. However, the underlying data outcomes from both systems are comparable.

The consistency of costing outputs and outcomes is evident in the data submitted across multiple NHCDC rounds, demonstrating the reliability of the costing processes despite the variations in frequency and system functionality.

1.5 Contracted care arrangements across jurisdictions or LHNs/Hospitals

Contracted care activity is incorporated in the jurisdictional corporate Patient Information System (HBCIS) Interface data feed. Invoiced amounts are allocated into facility specific Costing Departments with Relative Value Units utilised to apportion the charges across specific products. Where these charges are not individually itemised, they are submitted under the Goods and Services Line Item and an appropriate Final Cost Centre.

1.6 Any changes in the above governance processes from the previous year

The governance processes outlined above are unchanged from previous years, with the exception of the establishment of the Statewide Clinical Costing Committee. Comprising of Chief Finance Officers and funding and costing executive leads from various HHSs, the committee sits above the existing Statewide Clinical Costing Working Group and plays a strategic governance role, delivering guidance and oversight to the costing workplan and costing improvements. The working group continues to provide expert advice on technical elements of costing with representation from HHS costing practitioners, costing analysts and the DoH team.

2. NHCDC 2023-24 result summary

2.1 Number of hospitals/facilities submitted

In the 2023-24 fiscal year, the jurisdiction collected data from 830 facilities (Table 1), with costs calculated at the patient or service level. Table 1 below outlines the change in the scope of facilities included in the data set between 2022-2023 and 2023-2024. This data encompassed 18,936,075 episodes, totalling $22.5 billion. This aligns to funding provisioned in 2023-2024 to Queensland's Hospital and Health Services which is reported in Service Agreements at $22.41 billion. The cost dataset includes many facilities outside the scope of the NHCDC, as well as additional costs for out-of-scope services or services lacking patient-centric data. These costed activity records, which accounted for 19.08% of costs ($4.4 billion) and 23.06% of episodes (4,365,861), were excluded from the activity submission. The remaining 383 facilities (Table 2) were included in the NHCDC submission for Round 28.

All Costed Facilities by Facility Type					
IHACPA Fund Source	**Facility Type**	**Round 27 (2022-23)**	**Round 28 (2023-24)**	**Variance**	**%Change**
NEP	ABF Activity Funded Facility	40	46	6	15.00%
NEP	Community Mental Health Facility	90	91	1	1.11%
NEP	Residential Mental Health Facility	29	28	-1	-3.45%
NEP	ABF Contracted Care in Private Facility	51	61	10	19.61%
NEP	Other Public ABF Activity	89	91	2	2.25%
NEC	Block Funded Facility	79	79	0	0.00%
NEC	Block Funded Mental Health Facility	5	5	0	0.00%
NIL	Other Public Facility	412	429	17	4.13%
State Totals		**795**	**830**	**35**	**4.40%**

Table 1: All Costed Facilities by Facility Type

Submitted Costed Facilities By Facility Type					
IHACPA Fund Source	**Facility Type**	**Round 27 (2022-23)**	**Round 28 (2023-24)**	**Variance**	**%Change**
NEP	ABF Activity Funded Facility	40	46	6	15.00%
NEP	Community Mental Health Facility	89	91	2	2.25%
NEP	Residential Mental Health Facility	29	28	-1	-3.45%
NEP	ABF Contracted Care in Private Facility	30	44	14	46.67%
NEP	Other Public ABF Activity	89	91	2	2.25%
NEC	Block Funded Facility	79	79	0	0.00%
NEC	Block Funded Mental Health Facility	4	4	0	0.00%
State Totals		**360**	**383**	**23**	**6.39%**

Table 2: Submitted Costed Facilities by Facility Type

2.2 Number of records and costs submitted

Improved data collection and service expansion have generated notable changes:

- Community Mental Health Improvements:
  - Queensland's focus on improving the counting and costing of community mental health has led to significant progress in collecting phase and episode-level activity data.
  - In addition, there has been enhanced data quality from community mental health teams.
- Satellite Health Centre Program Impact:
  - Increased activity volume in emergency care and outpatient services.
  - Corresponding rise in costs for these areas.
- Emergency Virtual Care:
  - Cost information for this service is included for the first time in the current reporting round.
  - Queensland has quarantined funding for the Queensland Virtual Hospital (Virtual ED) in service agreements to encourage better counting and costing of this service so that data can be used in future funding model development for virtual care.
- Palliative Care Developments:
  - Increase in the overall number of costed episodes.
  - Decrease in episodes with multiple phase records.

These changes reflect ongoing efforts to improve healthcare data collection and service delivery, further details are in tables 5 & 6 in the next section. There has been an overall increase in activity of 4.57% and in submitted cost of 8.67% in comparison to round 27.

Submitted Episodes by ABF Source					
ABF Source	**Activity Type**	**Round 27 (2022-23)**	**Round 28 (2023-24)**	**Variance**	**%Change**
0	Emergency Virtual Care	0	35,355	35,355	100.00%
1	Admitted Patient Care	1,770,054	1,817,742	47,688	2.69%
2	Palliative Care	16,784	14,271	-2,513	-14.97%
3	ABF Emergency Department Care	2,249,422	2,345,430	96,008	4.27%
4	ABF Non-Admitted Patient Care Patient Level	6,998,983	7,314,568	315,585	4.51%
5	ABF Mental Health Care Episode Level Data	141,314	152,023	10,709	7.58%
6	ABF Mental Health Care Phase Level Data	89,931	101,791	11,860	13.19%
State Totals		**11,266,488**	**11,781,180**	**514,692**	**4.57%**

Table 3: Submitted Episodes by ABF Source

Submitted Cost by ABF Source					
ABF Source	**Activity Type**	**Round 27 (2022-23)**	**Round 28 (2023-24)**	**Variance**	**% Change**
0	Emergency Virtual Care	Nil	$ 14,105,983	$ 14,105,983	100.00%
1	Admitted Patient Care	$ 10,113,771,932	$ 10,621,426,063	$ 507,654,131	5.02%
2	Palliative Care	$ 152,538,699	$ 173,420,772	$ 20,882,073	13.69%
3	ABF Emergency Department Care	$ 1,932,841,001	$ 2,222,096,732	$ 289,255,732	14.97%
4	ABF Non-Admitted Patient Care Patient Level	$ 3,071,727,969	$ 3,279,890,299	$ 208,162,330	6.78%
5	ABF Mental Health Care Episode Level Data	$ 251,009,225	$ 296,497,042	$ 45,487,817	18.12%
6	ABF Mental Health Care Phase Level Data	$ 960,992,258	$ 1,304,716,500	$ 343,724,242	35.77%
State Totals		**$ 16,482,881,084**	**$ 17,912,153,391**	**$ 1,429,272,307**	**8.67%**

Table 4: Submitted Costs by ABF Source

2.3 Factors influencing submission

Palliative Care

In the costing system, admitted patients with a palliative care type are costed at episode level. For NHCDC, phase level reporting costs are matched to submitted ABF Activity phase identifiers based on time-date stamps in the activity data for those episodes. Up to five phases may be assigned to any palliative care episode.

The majority of palliative care episodes have a single phase assigned, however when there are multiple phases, the count of unique state record identifiers supplied to IHACPA will be affected in year-to-year reporting. This is because each State Record Identifier (SRI)/Phase Identifier (ID) combination is counted as a separate record in the submitted data for phase-based records.

Palliative Care Episodes and Phases					
ABF Source	Summary Measure	Round 27 (2022-23)	Round 28 (2023-24)	Variance	% Change
1	Costed Episode Count	29	4	-25	-86.21%
2	Costed Phase Count	13,222	14,754	1,532	11.59%

Table 5: Palliative Care Costed Episodes and Phases

Mental Health

In mental health services, cost data is initially recorded at the individual service provision level within the costing system. This detailed information is then aggregated into phases and episodes for NHCDC reporting. This aggregation occurs during the transformation and matching process that converts costing system data into activity submission data.

The level of detail in summarising costed episodes and linking them to state record identifiers varies between the original costing system dataset and the final submitted cost dataset. Recent improvements in collecting phase data have resulted in a shift in reporting patterns: there has been a decrease in episode-level activity reporting, offset by an increase in phase-level activity reporting.

Mental Health Episodes and Phases					
ABF Source	Summary Measure	Round 27 (2022-23)	Round 28 (2023-24)	Variance	%Change
1	Costed Episode Count	3,150	258	-2,892	-91.81%
5	Costed Episode Count	915,860	860,146	-55,714	-6.08%
6	Costed Phase Count	996,901	1,975,615	978,714	98.18%

Table 6: Mental Health Episodes and Phases

Five HHS's have continued to employ the virtual patient costing method for certain community mental health services. This approach is used while they developed their activity and phase-level reporting in specific mental health clinical specialty areas. The cost associated with this virtual patient costing method represented 1.89% of the total submitted mental health activity cost. The DoH Clinical Costing and Mental Health Branch teams are actively collaborating with HHS clinical teams to transition towards using patient-level data for costing these mental health specialty areas.

Mental Health Activity Service Level Costs - Not Submitted against State Record Identifier				
ABF Source	Activity Type	Amount	% of GL	%of Service Cost
5	Mental Health -Service Level Costing	$ 30,318,845	0.13%	1.89%

Table 7: Mental Health Activity Service Level Costs - Not Submitted against State Record Identifier

Teaching and Training

Queensland does not have a feeder system for teaching and research costs and activities, and as such, these are costed using a virtual patient model at the service level. Consequently, the associated costs could not be matched to the activity dataset and were therefore not submitted.

Activity Service Level Costs- Not Submitted against SRI				
ABF Source	Activity Type	Amount	% of GL	%of Service Cost
8	Teaching -Service Level Costing	$ 122,237,833	0.54%	100%
9	Research -Service Level Costing	$ 121,231,195	0.54%	100%

Table 8: Activity Service Level Costs- Not Submitted against State Record Identifier

Patient Transport

A comprehensive patient-level dataset for all patient transport costs is not available in Queensland source systems. Patient-level data is available for retrievals and inter-hospital and has therefore been provided.

A new feeder system was implemented in the four rural and remote HHSs during the 2023-24 fiscal year. This system utilises GL based patient data, where patient identifiers are inserted into GL transaction records and are associated with the Patient Transport Subsidy scheme and non-patient transfer subsidy GL accounts. This system, however, has limitations as not all GL transactions in these accounts include patient-identifying details, resulting in an inability to link to the activity dataset.

It is also important to note that in rural and remote locations, several costed patient-level records in the costing dataset pertain to facilities outside the NHCDC scope, including Primary Health Care Centres and Multipurpose Health Care Services

Patient Transport Subsidy Costs			
Submission Status	Amount	%of GL	% Of Service Cost
Submitted	$ 39,245,944		16.36%
Not Submitted	$ 200,572,349	0.89%	83.64%
Total	**$ 239,818,293**		

Table 9: Patient Transport Subsidy Costs

Cost and records exclusions

Following the extraction and submission of HHS patient costing data from the costing system, the first step in the jurisdictional NHCDC data transformation process is to match these records with the submitted activity dataset. This matching process involves a complex algorithm based on:

- Episode type,
- Date and time fields, and
- Other key elements such as care type.

During this process, some costing records may be consolidated into a single state record identifier, while others may be split based on phase dates and times. A mapping table is maintained as part of the NHCDC data transformation process, which links each original costing episode number to the matched state record identifier and phase identifier (where applicable).

Queensland costs all HHS facilities and services, but not all of these are within the scope of the NHCDC. For jurisdictional purposes, cost records that do not match are retained and are assigned an Activity Based Funding (ABF) Source code. This code is not part of the IHACPA Data Requirements Specification for admitted activity.

The resulting data set of unmatched and matched records ensures a comprehensive reconciliation to GL for the year, and a complete summation of applicable costs at discharge for the reference year.

Matched records will be omitted from the submission if any of the following criteria met:

- They contain missing data elements that would lead to portal submission failure.
- The total cost of the record is negative.
- A portion of the record's cost is negative at either the final cost centre or line-item level, when this occurs only the impacted component of the record is omitted.

Records that are fully or partially excluded from the main dataset are stored in separate tables, serving two important purposes. Firstly, they enable internal reporting and secondly, they provide valuable data for future reviews. By analysing these excluded records, costing methodologies can be refined and improvements can be made to the overall quality of the costing dataset over time.

The costs submitted to the NHCDC are those incurred up to discharge for matched patients. These patients must have been discharged during the reference period, from an in-scope establishment. Patients who remain undischarged during the reference period, regardless of whether they had been admitted during the reference period or during previous years, are excluded. The costs for these patients are included in the general ledger reconciliation.

Facilities excluded

Whilst there were no in-scope facilities excluded in the 2023-24 year, there were 24 facilities with in-scope, ABF activity reported with no patient-level costing.

Most of these facilities were private establishments providing public services for which there was no patient level costing data available. This activity comprised of 22,642 records or 0.67% of reported activity. Costs for this very small percentage of reported activity (approximately 1.07% combined), were spread across other out of scope patient data and included in virtual patient costing for contracted services within the relevant HHSs.

Of the submitted ABF activity data, 99.46% was costed against Queensland facilities at either patient or service level (where patient level data had not been brought into the costing system).

2.4 Key changes from NHCDC 2023-24 to NHCDC 2022-23

Notable changes for the 2023-24 year include: -

- Incorporation of virtual emergency care data,
- Additional ABF activity data from Queensland's new satellite facilities,
- Reporting of ABF related statewide services.

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

3.1 Summarisation of general ledger reconciliation

As part of regular costing system procedures, a complete end-to-end reconciliation of costing data is undertaken within the site-based costing systems databases. Resulting system-generated audit reports are reviewed and issues actioned by the HHS costing teams prior to submission. This GL reconciliation process aligns fully with the annual financial statement for expenses, helping to ensure consistency between costing data and financial records is maintained.

Each HHS is required to provide a costing survey. This survey details the HHS's costing processes, highlights any recognised issues, and provides a systematic end-to-end reconciliation. The survey is approved by HHS Chief Financial Officer, ensuring its accuracy and completeness.

Every step of the NHCDC data transformation associated with cost data has a reconciliation portion to ensure that that all costs within the fiscal year are reconciled back to the source general ledger.

General Ledger Reconciliation Summary					
Sum Group	Summary Measure	Round 27 (2022-23)	Round 28 (2023-24)	Variance	%Change
GL	Total HHS GL	$ 20,472,554,501	$22,494,836,486	$2,022,281,985	9.88%
NHCDC	Total Submitted Costs	$ 16,482,881,085	$17,912,153,391	$1,429,272,306	8.67%

Table 10: General Ledger Reconciliation Summary

As the final steps of the NHCDC transformation process are undertaken by the DoH clinical costing team, the HHS level costing ledgers are not included in this report. These ledgers are where activity and costs are manually adjusted to allow for differences between clinical service delivery models and GL cost centres structures. This management occurs within the costing system with the HHS costing teams ensuring that cost outputs reconcile to cost inputs from the GL. Table 11 below shows the end-to-end reconciliation from the GL to the final submitted costs as part of the jurisdictional data transformation processes. Out of scope costs include a range of services such as oral health, primary health care centres and costs such as capital works and trust.

General Ledger Reconciliation				
HHS	GL Input	WIP Prior	Out Of Scope / Not Submitted	Submitted Costs
CAIRNS & HINTERLAND HHS	$1,428,877,167	$23,109,564	-$231,524,184	$1,197,352,983
TOWNSVILLE HHS	$1,464,468,174	$23,644,375	-$203,399,206	$1,261,068,968
MACKAY HHS	$688,988,675	$10,922,618	-$99,416,610	$589,572,065
NORTH WEST HHS	$275,067,477	$5,511,304	-$93,324,310	$181,743,166
CENTRAL QUEENSLAND HHS	$897,631,823	$17,960,002	-$250,477,876	$647,153,947
CENTRAL WEST HHS	$113,384,729	$5,735,640	-$54,471,923	$58,912,806
WIDE BAY HHS	$933,457,932	$22,234,777	-$229,706,317	$703,751,616
SUNSHINE COAST HHS	$1,802,386,586	$16,752,777	-$379,122,499	$1,423,264,087
METRO NORTH HHS	$4,290,115,575	$43,845,529	-$810,583,988	$3,479,531,586
CHILDREN'S HEALTH QLD HHS	$1,052,039,327	$32,712,341	-$442,710,032	$609,329,295
METRO SOUTH HHS	$3,596,120,632	$43,895,845	-$527,701,890	$3,068,418,742
GOLD COAST HHS	$2,363,572,826	Nil	-$492,151,768	$1,871,421,058
WEST MORETON HHS	$1,037,019,136	$47,253,958	-$207,439,447	$829,579,689
DARLING DOWNS HHS	$1,259,387,344	$30,835,151	-$209,936,606	$1,049,450,737
SOUTH WEST HHS	$219,602,860	$13,244,673	-$107,860,184	$111,742,676
TORRES & CAPE HHS	$340,814,638	$3,908,035	-$208,534,748	$132,279,890
MATER HOSPITALS (Public)	$731,901,585	Nil	-$34,321,506	$697,580,079
QLD	**$22,494,836,486**	**$341,566,589**	**-$4,582,683,095**	**$17,912,153,391**

Table 11: General Ledger Reconciliation

3.2 Compliance or deviations to the AHPCS Version 4.2

Queensland is fully compliant with AHPCS version 4.2. These standards are the basis of the Queensland costing guidelines which have been implemented by the costing teams into the operations of the clinical costing systems. Information is provided below each section of the AHPCS Costing process:

- **Stage 1:** Have all relevant expenses been identified and included in the NHCDC submission? How is accuracy and completeness of the collected cost data ensured?
    - Every facility and service provided by Queensland Health is costed at the patient level wherever suitable feeder system data is available. In cases where patient level data is lacking, costs are instead determined at the service level.
    - All expense accounts from the HHS GL are brought into the costing system with direct and overhead costs assigned from the amounts provided. This includes both linked and unliked patient episodes, and service level episodes. A thorough reconciliation process is undertaken, comparing cost outputs from the costing system to the source GL entries. Audit reports identify structures within the costing system requiring updates to ensure accurate end-to-end reconciliation of the costed system data with the source GL.
    - An annual formal end-of-year costing survey is conducted and signed off by the Chief Financial Officer prior to submission of the costing data to the jurisdiction. This process includes reconciling the dataset.
- **Stage 2:** What validation checks are performed? How are discrepancies in data addressed and resolved?
    - Each HHS has its own quality assurance processes in place to assess the suitability of the data for inclusion in NHCDC.
    - Further checks are then carried out to confirm consistency and ensure proper alignment with the NHCDC costing framework. These additional checks include:-
        - Orphaned cost and encounter records
        - Unmapped departments
        - Unmapped items
        - Invalid / missing product codes
        - Zero-cost encounters
        - Low-cost encounters
        - Negative costs
        - Linking to activity data sets
        - Date / time validations
        - Validations on demographic information
    - A financial reconciliation is undertaken, and the data transformed into the NHCDC data specification format. This information is provided to each HHS for confirmation of results prior to submission to the IHACPA.
- **Stage 3:** What methods are used for cost allocation?
    - The majority of direct costs for patient level episodes are assigned at intermediate product level using relative value units specific to each feeder key and feeder system.
    - In specific scenarios, a limited application of costing ledger fractioning occurs at the GL cost centre level, specifically for hub-and-spoke clinical service delivery models. This process is used when costs are not directly transferred in the general ledger to the cost centres where clinical services are provisioned. Once appropriately reallocated, the costing ledger activity is then processed at the intermediate product level, following standard costing procedures.
    - Overhead costs are assigned within the costing system using simultaneous equations. These overhead costs are also assigned to the patient level using relative value units.
- **Stage 4**: Have all establishment activity been identified and included in the costing process? What activities, if any, were excluded in the costing process?
    - No activity is excluded however not all activity is costed at patient level.

- **Stage 5**: How have costs been allocated to patients?
    - Each feeder system has a dedicated encounter matching process which contributes to the transformation of data into intermediate products which are then costed. The process and associated business rules are outlined in the costing guidelines.
- **Stage 6**: What is the process for reconciling cost and activity data?
    - Internal costing system audit reports and the annual costing data survey ensure that all costing data is fully reconciled to the GL.
    - Before the jurisdiction submits the final activity, each HHS must officially approve and sign off on the activity datasets, confirming their completeness.
    - The jurisdictional NHCDC data transformation process fully aligns and reconciles:
        - Activity data to cost data,
        - Cost data to activity data (including out of scope activity), and
        - Costing records within the fiscal year regardless of admit and discharge back to the published HHS GL.
    - To ensure total costs at discharge are complete, *Work In Progress Prior* costs are added to the reference year costs for episodes admitted in previous years and discharged in the reference year. These costs do not contribute to the reference year cost outcome reconciliation with the source general ledger but are included in the reconciliation of final submitted episode costs.
    - Reconciliation outcomes of patient centric costing data at multiple levels are compared between NHCDC rounds prior to the submission of the data.

4. Other relevant information

Queensland HHSs continually monitor the implementation of new clinical data collection systems to assess suitability for use in clinical costing. These teams also work collaboratively with data managers to improve existing systems in attaining minimum requirements for costing.

This year's new feeds include emergency service and outpatient data from satellite hospitals, along with the introduction of a new allied health feeder system to replace the retired, legacy system.

Unlinked Activity

Pathology, imaging, and pharmacy records that remain unlinked to an episode after the data matching process are currently out-of-scope for the NHCDC. These unlinked records occur for several reasons including: external referrals, legacy clinical systems with no date of order fields (but date of test is collected), planned pre-admission and pre-return presentation tests that occur prior to the episode matching window, and multiple Patient Master Index (PMI) accounts. All unlinked activity is costed and included in the cost per unit calculation for that intermediate product. It is reported at jurisdictional level and is included in the end-to-end cost reconciliation process for the reference year. However, as the feeder system data was not able to be matched to an episode submitted to IHCPA these costs do not form part of the NHCDC cost submission.

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

All data provided by Queensland 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.

Naomi Hebson

Deputy Director-General

Healthcare Purchasing and System Performance Division | Queensland Health