

Ref: HA25-3395

Professor Michael Pervan  
Chief Executive Officer  
Independent Health and Aged Care Pricing Authority  
Via email: [secretariat@ihacpa.gov.au](mailto:secretariat@ihacpa.gov.au)

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NSW Data Quality Statement for National Hospital Cost Data Collection (NHCDC) 2023-24 (Round 28)

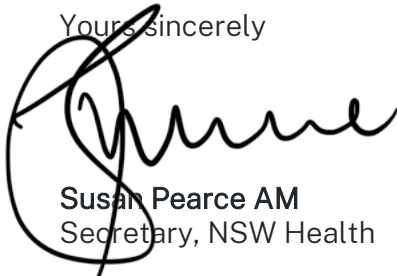
Dear Professor Pervan,



Please find enclosed the NSW Data Quality Statement (DQS) for the National Hospital Cost Data Collection (NHCDC) 2023-24 (Round 28) and the signed declaration. NHCDC data has been prepared in adherence with V4.2 of the Australian Hospital Patient Costing Standards, and is complete and free of any known material issues.

If you require more information please contact Kylie Hawkins, Manager Clinical Cost Data Collections and Standards at [kylie.hawkins2@health.nsw.gov.au](mailto:kylie.hawkins2@health.nsw.gov.au)

Yours sincerely



Susan Pearce AM  
Secretary, NSW Health

Encl. NSW Data Quality Statement – 2023-24 National Hospital Cost Data Collection (NHCDC)

# 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](mailto: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:

- 1.1 Structure of Local Health Networks (LHN)/Hospitals and Health Services*
- 1.2 Costing process guidelines, including the use of relative value units*
- 1.3 Costing and activity reporting processes and methodologies*
- 1.4 Consistency of costing practices across the jurisdiction*
- 1.5 Contracted care arrangements across jurisdictions or LHNs/Hospitals*
- 1.6 Any changes in the above governance processes from the previous year*

The Round 28 (2023-24) National Hospital Cost Data Collection (NHCDC) is based on the NSW Health District and Network Return (DNR). The DNR is prepared and submitted by the Local Health Districts/Specialty Health Networks (LHDs/SHNs) to the Clinical Cost Data Collections and Standards Team, System Financial Performance. Financial results are published and audited at LHD/SHN level, not at hospital level. There were no changes to the structure of districts/networks between Round 27 and Round 28.

Costing is undertaken by LHDs/SHNs in a consistent and standardised manner, with any changes to activity recording or costing practices communicated to LHD/SHN Costing Teams via the Costing Standards User Group which meets regularly.

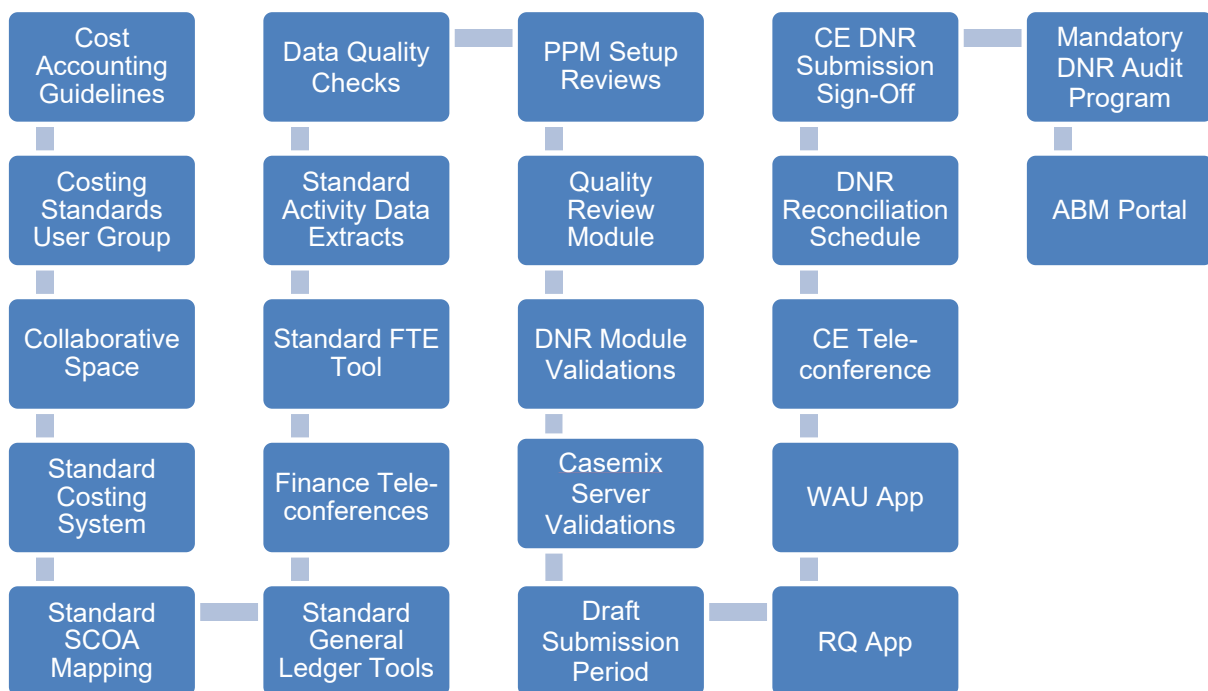
Costing Teams in LHDs/SHNs adhere to the Cost Accounting Guidelines (CAG), which is a series of documents that provide advice and guidelines on costing set-up, methodologies and quality assessments related to the DNR submission. The CAG complies with the Australian Hospital Patient Costing Standards (AHPCS) and is updated regularly to reflect any changes to costing practices within NSW. Volume 2 of the CAG reflects the AHPCS along with NSW specific business rules. Volume 3 reflects technical specifications and provides practical and technical advice on specific areas such as costing system set-ups, standardised allocation methodologies and data extract specifications.

The NSW DNR process contains many areas where quality checks are completed. This includes a DNR module to identify and resolve quality issues prior to the submission of final results. There is a draft DNR period where LHDs/SHNs are able to submit their DNR and have results validated and reviewed. Quality issues can be investigated and fixed, and LHDs/SHNs are then able to resubmit their DNR. LHDs/SHNs are able to submit multiple times during the DNR submission period. NSW provides a number of Applications (Apps) to assist LHDs/SHNs to review their DNR submissions. These include the WAU App, Percentile App (99<sup>th</sup> and 1<sup>st</sup>) and the Reasonableness and Quality App (RQ

App). These apps are updated daily during the DNR submission period to reflect submissions received the afternoon prior. This ensures LHDs/SHNs have the most up to date data to review reflecting their most recent submission. In R28 there was an additional quality assessment provided to LHD/SHNs within the costing software. This new quality module is specific to NSW and incorporated into the new costing system as added functionality.

The final DNR submissions are approved by the LHD/SHN chief executive (CE) at the time of final submission. A reconciliation is provided by LHDs/SHNs at the time of CE sign off.

Figure 1 District and Network Return Quality Assurance Program



In R28 NSW implemented a new costing system, which was used to complete the R28 (2023/24) DNR and NHCDC submissions. The implementation of this new system provided NSW opportunities to review and refine current costing processes. There was a focus on increasing the opportunities for automation of source data extraction/transformation and standardisation across LHDs/SHNs. The cost transformation program incorporating the new costing system allowed NSW to identify areas of the costing process where further value could be added by either reducing manual effort of costing practitioners, increasing access by all LHDs/SHNs to additional data sources to assist in the costing process and adding further value to our existing data reconciliation and analysis processes. The implementation project continues into R29.

For contracted care in NSW, including deferred care, the amount applied was the amount negotiated with individual private hospitals and charged at the encounter level for outsourced services. This expense is reported using the goods and services line item. Splitting the goods and services line item into individual line items has not been deemed feasible given the volume of contracted care within NSW. This is consistent with our approach for line items used for Statewide shared corporate and clinical services.

## 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*

*2.2 Number of records and costs submitted*

*2.3 Factors influencing submission*

- Cost and records exclusions
- Facilities excluded

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

### 2023/24 R28

Hospitals submitted	Total Cost C records submitted	Total NHCDC costs submitted
145	15,799,128	\$21,555,178,044

\*includes UNQbabies

\*\*3494 Unqualified babies excluded, totalling cost of \$743413

### 2022/23 R27

Hospitals submitted	Total Cost C records submitted	Total NHCDC costs submitted
153	15,023,077	\$20,195,523,802

\*includes UNQbabies

The NSW 2023-24 NHCDC includes LHD/SHN ABF Facilities. It also includes all Ambulatory Mental Health which is submitted under LHN199.

Post submission of NHCDC, it was identified that LHN104 included 'duplicates'. These were not originally identified in the Duplicates validation as they had a unique combination of duplicate 'EpiNo' but different EstabIDs. The impacted EstabIDs were 1174D2240 Westmead Hospital and 1174D2030 Blacktown Hospital.

These duplicates totalled 46 service events from the Non-admitted stream, all under Tier 2 10.18 Enteral Nutrition – Home Delivered.

NSW advised IHACPA these duplicate service events should be excluded from the NHCDC submission.

A total cost of \$30,042 (linked cost \$22,303) was excluded. This equated to 46 service events (23 linked service events) being excluded.

In Round 27 NSW requested that Illawarra Shoalhaven LHD (LHN 108) NHCDC submitted records be excluded from NEP determinations. This LHN has been submitted in Round 28 and should now be included once again.

NSW has undertaken a program to review and improve the costing of critical care services in R28. We note that many critical care services in NSW hospitals have critical care and step-down beds in the one ward. An example of this is an Intensive Care Unit (ICU)/High Dependency Unit (HDU) ward. Typically, these services have one cost centre and one ward set up in the Patient Administration System, with two or more bed types to

distinguish the ICU hours/bed days separately from the HDU hours/bed days. In these wards, the bed type is used to calculate ICU hours and to allocate ICU cost separately from HDU hour calculations and cost allocation.

The final cost allocation reflects appropriate costs for ICU and HDU patients. Additionally, only facilities with Level 3 ICUs map their cost centre to critical care, even though locally they may use the ICU bed type.

NSW has worked to refine ICU costing methodology and guidelines in R28, including working with the costing system vendor to separately report the ICU and the HDU expense in areas where they are combined in one cost centre/ward.

### 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 LHN 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

LHN	General Ledger Total	Adjustments to the GL— inclusions	Adjustments to the GL— exclusions	Post allocation adjustment - inclusions	Post allocation adjustment – exclusion	Jurisdictional adjustments	Total costing ledger (NHDCDC Cost C)
117	1,152,368,362	24,260,601	0	28,331,340	-279,359,108	-6,097,834	919,503,361
118	655,448,376	8,476,898	0	11,278,265	-166,730,194	0	508,473,345
102	2,454,183,599	56,547,841	0	46,317,559	-613,341,171	-9,212,601	1,934,495,227
103	2,648,125,820	78,714,141	0	44,510,493	-460,187,280	-9,323,301	2,301,839,873
101	2,378,435,957	61,896,394	0	42,299,039	-435,543,617	-11,245,775	2,035,841,998
108	1,307,011,854	34,081,404	0	11,682,390	-212,361,291	-4,918,708	1,135,495,649
104	2,555,710,752	66,613,812	0	50,655,522	-569,269,665	-9,069,672	2,094,640,749
105	1,211,308,987	31,400,696	-81,000	19,636,706	-296,009,215	-4,229,768	962,026,406
106	2,248,584,491	49,066,388	0	47,700,962	-725,903,899	-7,917,091	1,611,530,851
107	1,136,480,065	29,145,565	-595,916	9,999,652	-174,458,847	-5,183,876	995,386,643
109	3,065,902,313	274,210,629	-207,892,137	60,031,448	-721,102,428	-14,241,555	2,456,908,270
111	1,237,223,644	31,912,958	0	16,449,394	-242,929,177	-3,737,313	1,038,919,506
110	930,901,000	26,743,798	-1,116	9,930,208	-193,183,125	-2,738,766	771,651,999
113	621,302,641	18,344,305	0	6,798,822	-152,004,364	-1,927,680	492,513,724
114	909,253,671	24,117,118	0	25,701,806	-407,074,705	-3,377,846	548,620,044
112	1,283,979,718	32,870,490	0	38,865,809	-528,996,083	-5,332,811	821,387,123
115	167,135,766	1,920,172	0	2,690,257	-54,215,151	-419,462	117,111,582
199			0			0	808,831,696
	26,303,454,574	854,714,023	-208,570,169	489,869,603	-6,592,500,810	-100,620,871	21,555,178,046

Please note in the General Ledger reconciliation provided above, LHN199 is community mental health for all LHNs. This amount is therefore already included in the LHN general ledger total. This amount is removed from the LHN line and added to the LHN199 line under NHDCDC Cost C total.

#### 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?
- Stage 2: What validation checks are performed? How are discrepancies in data addressed and resolved?
- Stage 3: What methods are used for cost allocation?
- Stage 4: Have all establishment activity been identified and included in the costing process? What activities, if any, were excluded in the costing process?
- Stage 5: How have costs been allocated to patients?
- Stage 6: What is the process for reconciling cost and activity data?

Guidelines for preparing and submitting the DNR are published in the CAG, which aligns to the AHPCS. Costing practitioners across NSW adhere to the CAG. Compliance to the AHPCS has been unchanged from R27. NSW Health is partially compliant with the following standards and explanations are noted below.

- Standard 1.2 – Identify Relevant Expenses – Third Party Expenses: There is pathology expense for private and compensable patients that are held centrally and are not included in DNR cost ledgers. This would not impact NEP determinations as the expense is excluded.
- Standard 2.2 – Create the Cost Ledger – Matching Cost Objects and Expenses: The range and extent of service data improves with each DNR submission with LHDs/SHNs adding new service files or refining linking rules. The implementation of the new costing system in NSW currently provides LHDs/SHNs an opportunity to further enhance and refine service data and linking rules. LHDs/SHNs all have the required statewide intermediate products at service level to cost to patients. The improvement in service level feeders relates to localised and/or specialised feeders at LHD/SHN level, or new systems that are coming onboard within NSW at a statewide level that can be leveraged from a costing perspective.

Costs associated with the Newborn and Paediatric Emergency Transport Service (NETS) reflect actual transport costs and exclude pre- or post-transport clinical consultation, assessment, stabilisation or handover related costs. The cost associated with NETS consultations which do not result in patient transport are not included. NSW is working toward providing the full cost of NETS in the NHCDC.

#### **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.

NSW's NHCDC Submission for R28 was impacted by the transition of our activity Data Warehouse, which resulted in a delay in our submission to IHACPA. This transition whilst significantly impacting the timing of the DNR submission, also required significant work from NSW Costing Team to ensure new variables, updated variables and updated data loads were incorporated into our submission. NSW concurrently implemented a new costing system for the R28 submission. Both of these projects required review and update of costing methodologies for the completion of the DNR.

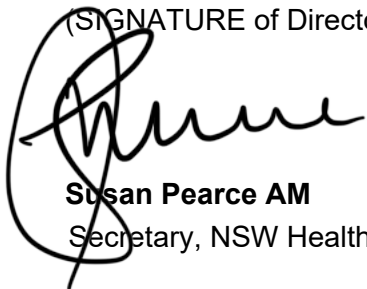
**5. NHCDC declaration – please ensure the below declaration is included.**

All data provided by (Add Jurisdiction) 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 Director General/Chief Executive/Secretary)

A handwritten signature in black ink, appearing to read 'Susan Pearce', written over a large, faint circular watermark or stamp.

**Susan Pearce AM**  
Secretary, NSW Health

## 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](mailto: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			% Change (In scope for NHCDC reporting)		
	In scope for NHCDC reporting			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			
<b>Total</b>	<b>9,792,105</b>	<b>\$19,341,877,984</b>		<b>9,176,288</b>	<b>\$17,255,680,923</b>		<b>6.70%</b>	<b>12.10%</b>	

## 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 VDCD 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 \$2,426,892,534 in 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 NHDC submission except for:

- Peninsula Health (Private patient pathology costs are excluded from the VDCDC).
- North West Health Wangaratta (Private patient pathology costs are excluded from the VDCDC).
- Mercy Health-Women's (Private patient pathology costs are excluded from the VDCDC). 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
<b>TOTAL Submitted to NHCDC</b>	<b>\$ 19,616,269,982</b>

#### 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 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:

<b>Health service</b>	<b>Cost Centre</b>
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

25<sup>th</sup> September 2025

# 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 health 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%
<b>State Totals</b>		<b>795</b>	<b>830</b>	<b>35</b>	<b>4.40%</b>

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%
<b>State Totals</b>		<b>360</b>	<b>383</b>	<b>23</b>	<b>6.39%</b>

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%
<b>State Totals</b>		<b>11,266,488</b>	<b>11,781,180</b>	<b>514,692</b>	<b>4.57%</b>

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%
<b>State Totals</b>		<b>\$ 16,482,881,084</b>	<b>\$ 17,912,153,391</b>	<b>\$ 1,429,272,307</b>	<b>8.67%</b>

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%
<b>Total</b>	<b>\$ 239,818,293</b>		

**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
<b>QLD</b>	<b>\$22,494,836,486</b>	<b>\$341,566,589</b>	<b>-\$4,582,683,095</b>	<b>\$17,912,153,391</b>

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 unlinked 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

# South Australia (SA Health)

## National Hospital Cost Data Collection 2023-24 Data Quality Statement

### 1. Governance processes

- The Department for Health and Wellbeing (DHW) in South Australia (SA) has a dedicated Patient Costing team responsible for coordinating, processing, and supporting the annual costing process on behalf of South Australia's Local Health Networks (LHNs).
- The DHW Patient Costing team manages the major activity inputs - Inpatient, Outpatient, Emergency Department and Community Mental Health data - which are reviewed by each LHN to ensure accuracy. The team also develops the costing ledger, incorporating feedback from LHNs on any changes from previous years.
- DHW is also responsible for generating service files where data is available centrally including, blood products, imaging, and pharmacy.
- LHNs are responsible for the inputs related other feeder files or activity files, as well as for reviewing and validating the final results. This includes contracted care, where LHNs collaborate with external providers to obtain contracted care data where the LHN is financially responsible for the externally delivered services.
- Costing process guidelines followed by DHW are aligned with the Australian Hospital Patient Costing Standards (AHPCS) and ensure consistency across all LHNs. Where applicable, Relative Value Units (RVUs) are used to allocate costs based on the relative complexity or resource intensity of services provided.
- DHW collaborates closely with the LHNs to ensure that all cost and activity data are captured and processed in accordance with the AHPCS Version 4.2.
- All LHN costed data is processed centrally by the DHW Patient Costing team, which applies a standardised costing methodology across the system. While this overarching framework ensures consistency, Local Health Networks (LHNs) may apply different cost drivers in specific cases, depending on the availability and quality of feeder data.
- Some LHNs have more advanced and integrated feeder systems than others. Where feeder data is not available, alternative allocation methods, such as using coded procedures, transfer records, or encounter data, are employed to construct service events and allocate costs appropriately.
- Regular collaboration occurs through weekly costing team catch ups and also a monthly patient costing working group involving DHW and LHN representatives to identify and resolve issues and share updates.
- Each year, the DHW Patient Costing team undertakes a comprehensive patient-level activity review with each LHN. This review ensures data quality and addresses any discrepancies. Costing runs continue until the LHN is satisfied that their data is complete and accurate. Once approved, DHW prepares the final dataset for submission to the National Hospital Cost Data Collection (NHDC).
- Costing data review conducted in November 2024 identified changes in total costs compared to the previous year, as well as variations in average costs across LHNs.



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- Costing is performed at three key intervals throughout the year: at six months (YTD December), nine months (YTD March), and for the full financial year (to June).
- SA Health utilises Power Performance Manager (PPM) by Power Health Solutions as its patient costing system. PPM was used to prepare the 2023-24 NHDC submission and continues to support consistent costing practices.
- Support for costing practitioners is provided at the local level by each LHN. Costing processes and methodologies remain aligned with prior years to ensure continuity.
- Costing data from public hospitals is used to benchmark against the National Efficient Price (NEP), compare performance between SA hospitals, monitor improvement initiatives, and support financial planning and forecasting. LHNs also use this data to identify opportunities for cost efficiency and to monitor service performance.
- Annually, LHNs submit data to the Health Round Table. These submissions are compiled from the data within PPM.

2. NHDC 2023-24 result summary

- Data was submitted for 45 establishments. 21 new establishments were submitted, mainly community mental health (18) as this was the first time South Australia submitted phase level community mental health activity. 3 more establishments submitted non admitted data for 2023-24 compared to 2022-23.
- A total of 3,327,065 records at a cost of \$6.23 billion were submitted for the 2023-24 NHDC, this was compared to 2,931,574 records as a total cost of \$5.43 billion in 2022-23.
- The table below shows the movement between 2022-23 and 2023-24 overall activity and costs.

	Total Activity			Total Costs			Cost Per Episode		
	2022-23	2023-24	Change	2022-23	2023-24	Change	2022-23	2023-24	Change
Acute	421,048	438,757	4.21%	\$3,123,286,275	\$3,391,615,617	8.59%	\$7,418	\$7,730	4.21%
Subacute Episodes	16,261	17,758	9.21%	\$349,440,776	\$432,521,890	23.78%	\$21,490	\$24,356	13.34%
Subacute Phases	3,397	4,088	20.34%	\$25,461,223	\$29,635,877	16.40%	\$7,495	\$7,249	-3.28%
Emergency Department	597,643	603,729	1.02%	\$602,003,596	\$642,877,284	6.79%	\$1,007	\$1,065	5.71%
Non-Admitted	1,878,609	2,176,597	15.86%	\$1,018,436,690	\$1,243,368,329	22.09%	\$542	\$571	5.37%
Admitted Mental Health Episodes	5,437	6,201	14.05%	\$62,871,455	\$69,945,106	11.25%	\$11,564	\$11,280	-2.46%
Admitted Mental Health Phases	9,139	10,387	13.66%	\$247,915,124	\$241,224,224	-2.70%	\$27,127	\$23,224	-14.39%
Community Mental Health Episodes	0	18,614		\$0	\$10,430,767			\$560	
Community Mental Health Phases	0	50,890		\$0	\$171,719,046			\$3,374	
Other Episodes	40	44	10.00%	\$440,696	\$321,442	-27.06%	\$11,017	\$7,306	-33.69%
<b>Total NHDC Submission</b>	<b>2,931,574</b>	<b>3,327,065</b>	<b>13.49%</b>	<b>\$5,429,855,833</b>	<b>\$6,233,659,582</b>	<b>14.80%</b>	<b>1,852</b>	<b>1,874</b>	<b>1.16%</b>

- SA Health does not exclude activity that has not been matched to the IHACPA ABF activity submissions. A matching process is completed on the state record identifier before submitting activity. All activity is retained in the costing dataset, regardless of whether it is successfully linked to the ABF submission.
- The key change for South Australia between 2023-24 and 2022-23 is the submission of mental health phase community activity for the first time in 2023-24. No other major changes.
- SA Health have undertaken a major review of its local funding models, which has resulted in transition of funding for a number of historically blocked funded programs to activity based funded programs. This has resulted in better capture of both costs and the activity in the non-admitted and rural emergency care space.

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

- As part of its commitment to the Australian Hospital Patient Costing Standards (AHPCS) Version 4.2, SA Health regularly reviews and refines its costing processes to ensure the quality, accuracy, and completeness of submitted data. The following outlines key aspects of SA Health's compliance across each stage of the costing cycle:
- **Stage 1: Expense Identification and Completeness:** SA Health ensures that all relevant expenditure is captured through the general ledger and mapped to appropriate cost centres within the costing system. LHNs work collaboratively with DHW to confirm the accuracy and completeness of data inputs. Costing is undertaken in accordance with AHPCS principles and guidelines. SA Health does not cost private patient pathology at the patient level due to insufficient data linkage quality to support accurate allocation.
- **Stage 2: Validation Checks and Data Integrity:** PPM Quality Assurance (QA) reports, along with manual validation checks, are applied throughout the costing process to detect data anomalies, gaps, and inconsistencies. Identified issues are addressed through an iterative review process involving both the LHNs and the DHW Patient Costing Team, ensuring all discrepancies are resolved prior to final submission.
- **Stage 3: Cost Allocation Methodology:** Cost allocation is performed using allocation statistics, Relative Value Units (RVUs), and other appropriate cost drivers, as per AHPCS guidelines. These methods reflect the actual resource consumption associated with each service and patient episode.
- **Stage 4: Activity Inclusion and Exclusion:** All in scope activities are included in the costing process, with minimal exclusions limited to data not aligned to NHDC reporting requirements. Exclusions are discussed with LHNs, supported by regular Power BI reporting to ensure transparency. SA Health's approach ensures that activity is fully captured in line with AHPCS standards.
- **Stage 5: Patient-Level Costing:** Costs are assigned at the patient level using PPM, integrating clinical, service, and financial data to generate detailed and accurate cost profiles for each patient episode. This approach supports robust internal analysis and national benchmarking.
- **Stage 6: Reconciliation of Cost and Activity:** Costed data is reconciled against financial and activity records through detailed comparisons, trend analysis, and LHN engagement. Variances are reviewed, and adjustments are made as needed to ensure internal consistency and alignment with source systems.
- SA Health confirms there are no other material deviations from the AHPCS Version 4.2.

#### *Summarisation of general ledger reconciliation*

LHN/ GL Reconciliation	Central Adelaide Health Network	Northern Adelaide Health Network	Southern Adelaide Health Network	Womens and Childrens Health Network	Country Health Networks (6)	Department (Contracted Care)	SA Health (Total)
General Ledger Total Expenses	\$ 3,380,320,264	\$ 1,109,846,539	\$ 1,602,729,035	\$ 691,931,272	\$ 1,529,404,186	\$ 27,878,758	\$ 8,342,110,055
Adjustments to GL - Inclusions	\$ 4,587,151	\$ 30,521,912	\$ 45,730,553	\$ 17,244,088	-\$ 12,472,572		\$ 85,611,133
Adjustments to the GL - exclusions	-\$ 785,022,084	-\$ 4,724,450	-\$ 8,453,972	-\$ 6,617,567	-\$ 2,912,212		-\$ 807,730,284
<b>Total Costing ledger</b>	<b>\$ 2,599,885,331</b>	<b>\$ 1,135,644,001</b>	<b>\$ 1,640,005,617</b>	<b>\$ 702,557,793</b>	<b>\$ 1,514,019,402</b>	<b>\$ 27,878,758</b>	<b>\$ 7,619,990,903</b>
NHDC Submitted	\$ 2,333,860,518	\$ 1,002,695,824	\$ 1,440,465,166	\$ 584,993,224	\$ 843,766,093	\$ 27,878,758	\$ 6,233,659,583
<b>Variance to Costing Ledger</b>	<b>\$ 266,024,813</b>	<b>\$ 132,948,178</b>	<b>\$ 199,540,451</b>	<b>\$ 117,564,569</b>	<b>\$ 670,253,309</b>		<b>\$ 1,386,331,320</b>
NHDC Out of Scope Excluded Activity	\$ 237,866,777	\$ 105,557,299	\$ 192,467,401	\$ 117,064,206	\$ 667,733,094		\$ 1,320,688,777
Previous Year WIP Costs Included	-\$ 41,767,542	-\$ 22,353,569	\$ 41,882,467	-\$ 9,643,999	-\$ 5,258,941		-\$ 37,141,584
Current Year WIP Costs Excluded	\$ 69,925,577	\$ 49,744,448	-\$ 34,809,416	\$ 10,144,362	\$ 7,779,156		\$ 102,784,126
Variance Explained	\$ 266,024,813	\$ 132,948,177	\$ 199,540,451	\$ 117,564,569	\$ 670,253,309	\$ -	\$ 1,386,331,319
<b>Outstanding</b>	<b>-\$ 0</b>	<b>\$ 0</b>	<b>\$ 0</b>	<b>-\$ 0</b>	<b>\$ 0</b>	<b>\$ -</b>	<b>\$ 1</b>

#### 4. Other relevant information

- Linking private patient pathology data to corresponding patient activity data remains a key area for improvement in 2024-25. Currently, patient-level data is not available for SA Pathology services provided to private patients, which prevents linkage between service-level data and patient encounters. As a result, these costs cannot be included in patient-level costing. Approximately \$12 million in private pathology costs were excluded from pathology costing in 2023-24.
- Interhospital transfers involving aeromedical transport were also not included in the 2023-24 costing data. This continues to be an area of focus for improvement in 2024-25. Patient-level data is currently unavailable for aeromedical transport services. DHW is working closely with SA Ambulance Service (SAAS) to incorporate aeromedical transport costs into the 2024-25 costing process. Approximately \$26.5 million in costs related to aeromedical transfers were excluded from the 2023-24 NHDC submission due to these data limitations.
- SA was unable to reliably cost Emergency Virtual Care activity in 2023-24 due to data and system limitations. Work is currently underway to address this gap, with the aim of incorporating virtual care into the 2024-25 costing process.

**5. For 2023-24, South Australia had a 9% increase in subacute episodes and 24% increase in subacute episode costs. This led to a 13% increase in the average cost per episode compared to 2022-23. Medical, Nursing, On-costs, and Clinical Supplies cost buckets for subacute episodes have increased by 10-28%.**

#### SALHN context

- Over the last 2-3 years SALHN has made significant investment in various Sub-Acute inpatient Services which has altered the mix of cases i.e. changed proportions for Rehab, PC, GEM etc. As a result, comparisons between 2022-23 and 2023-24 are not strictly like-for-like as activity levels have net yet increased at the level of investment.
- Examples of programs include:
- Implementation of Sub-acute Access Plan, including:
  - +32 additional GEM and Psychogeriatric beds (Timor 5 & 6)



OFFICIAL

- +6 additional GEM beds (Banka)
  - Virtual Rehab
  - GEM in the Home
  - Palliative Care Liaison
- Addition of 40 Maintenance Care beds (VITA)

**CALHN context**

- The primary driver of cost increases is maintenance care for older persons.
- Average Length of Stay (ALOS) has increased Maintenance Care which is driving up the cost per episode.



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

All data provided by South Australia to the 2023-24 NHCDC has been prepared in accordance with the IHACPA's Three Year Data Plan 2023-24 to 2025-26, 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.

Dr Robyn Lawrence

**Chief Executive**

**SA Health**

1.8.25



Government of **Western Australia**  
Department of **Health**

Classification: Official  
Our Ref: F-AA-95959-455

Professor Michael Pervan  
Chief Executive Officer  
Independent Health and Aged Care Pricing Authority  
PO Box 483  
DARLINGHURST NSW 1300

Via email: [Michael.Pervan@ihacpa.gov.au](mailto:Michael.Pervan@ihacpa.gov.au)

Dear Professor Pervan

**NATIONAL HOSPITAL COST DATA COLLECTION 2023-24 DATA QUALITY STATEMENT**

Please find attached an updated Data Quality Statement including a sign off declaration. The Data Quality Statement serves to accompany the WA Round 28 National Hospital Cost Data Collection submission.

Should you have any queries, please contact Ian Massingham, Manager, Reform, Analytics and Modelling on (08) 6213 5798 or via email at [Ian.Massingham@health.wa.gov.au](mailto:Ian.Massingham@health.wa.gov.au).

Yours sincerely

Dr Shirley Bowen  
**DIRECTOR GENERAL**

17 September 2025

Att: 2023-24 Data Quality Statement for Western Australia

# 2023-24 Data Quality Statement for Western Australia

## 1. Governance processes

WA's Round 28 (2023-24) NHCDC submission was based on the individual submissions from the five Health Service Providers (HSP)/Local Health Networks (LHN). These are:

- North Metropolitan Health Service (6 hospitals)
- South Metropolitan Health Service (4 hospitals)
- East Metropolitan Health Service (5 hospitals)
- Child and Adolescent Health Service (1 hospital)
- WA Country Health Service (21 hospitals)

The number of public hospitals participating in the NHCDC remains unchanged from the previous round however the HSPs have also submitted costing data for 19 sites undertaking contracted procedures and for 23 providing care in a community mental health setting.

Patient level costing is undertaken by Costing Teams at a HSP level. This cost data was completed in compliance with the Australian Hospital Patient Costing Standards (AHPCS) version 4.2 and reconciles to each HSP's audited financial statements. Data submissions were extensively reviewed by the HSPs, prior to official sign off and submission to the Department of Health (Department). Reconciliation statements were supplied for each participating HSP at site level.

On submission to the Department, the HSP costs were further tested and reconciled, with HSPs making further refinements if required. The Department adjusted the data to incorporate Work in Progress (WIP) from previous rounds and transformed the data in accordance with the IHACPA specifications. Data matching and validation also occurred to ensure the costed data sets aligned with the activity data submitted to IHACPA for other patient collections.

Costing is undertaken annually for the NHCDC submission but HSPs will generally undertake quarterly costing to meet their individual requirements. These include submitting patient cost data to Children's Healthcare Australasia (CHA), Women's Healthcare Australasia (WHA), Health Roundtable and AIHW Public Health Expenditure (PHE).

Costing is undertaken in a consistent manner throughout WA Health and is all conducted using a single instance of the Power Performance Management 2 patient costing system. There is a network of Costing staff within WA Health with representation from the HSPs, the Department and Health Support Services (HSS) who administer and provide technical support for the clinical costing system. Representatives of these groups meet regularly as part of a Business User Group, and intermittently as the WA Clinical Costing Standards Committee (WACCSC). Furthermore, training and support is undertaken at, or across individual HSP costing units depending on levels of staffing. These groups also work towards developing uniform practices and a common understanding of local and national costing issues. In addition to the single state-wide instance of PPM, utilisation of a common Chart of Accounts, and single sources of data for components such as pathology all contribute towards the standardisation of WA Costing.

Each of the HSPs undertake a range of review and assurance measures in the data preparation process, which have several layers of engagement including Finance and Business Officers, hospital based Clinical and Business managers, and HSP level Finance officers and Directors.

Inputs into the costing cycle such as patient fractions and feeder systems, and preliminary results are reviewed by the Costing Teams in conjunction with Finance and Business Officers on a regular basis.

The HSPs also undertake a rigorous quality assurance process prior to submitting their costed data. While no HSPs share identical regimens, there is a high degree of commonality in reviews undertaken and data testing. Each HSP has also developed their own applications to create visualisations and dashboards to aid analysis and benchmarking of results.

The Department continues to refine a suite of quality assurance tests that the HSP's undertake prior to delivering their data. These tests, as well as a central financial reconciliation to the Audited Financial Statements, are signed off at Chief Financial Officer/Executive Director level for each HSP and submitted to the Department as part of their NHDC submission.

Conducting further testing at an HSP level serves to streamline the submission process. The Department continues to test the integrity of the data submitted, and reviews and measures hospital, HSP and state-wide trends and changes across rounds.

WA costing is also supported by tools such as the WA Costing Guidelines publication and the "Clinical Costing QA and Reasonability" application that demonstrates that costing methodologies work as intended. Prior round costing audits also feed into the local processes helping achieve consistency.

## **2. NHDC 2023-24 results summary**

WA contributed patient level data for 37 public hospital sites, from 5 HSPs, for Round 28 (2023-24) of the NHDC, an increase of one site. All hospitals that are considered in-scope for Activity Based Funding are currently part of the NHDC submission for WA. Round 28 was the second year that community mental health costings from an additional 23 sites were included in the submission.

Costs submitted to NHDC in Round 28 were \$8,167,017,870 which represents a 6.6% increase from the Round 27 submission of \$7,587,633,932. All the major activity streams exhibited increases in both cost and activity between rounds except for Non admitted which showed a cost increase of 4.9% alongside a decrease in activity of 7.6%. Acute, Subacute and Emergency Department streams had cost increases of 6.6%, 9.2% and 8.3% along with activity increases of 5.5%, 9.7% and 3.8% respectively.

WA has continued costing for mental health at the phase of care level. This process has not fully matured, and costs were submitted to IHACPA at an episode level with work ongoing with aims to submit at phase level in a future round. In recent years, a significant amount of work was undertaken around submitting contracted care costs and activity, and WA now has a methodology that has enabled inclusion of these for two years. The cost of blood products is not included in the WA submission. Work is ongoing with the aim of being able to include blood product costs in future rounds.

Cost for ancillary services including pharmacy, pathology and imaging that were not able to be matched or linked in the activity matching process have been excluded from the Round 28 submission.

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

The WA Round 28 NHDC submission has been prepared in adherence with the Australian Hospital Patient Costing Standards (AHPCS) version 4.2. with the exceptions of teaching and research; and blood products.

WA is not fully compliant with the costing guidelines for Teaching and Research as they are currently calculated utilising an established local methodology.

The costs are assigned at a patient level but withheld from the annual submission to IHACPA. WA does not currently include the costs of blood products.

All relevant expenses identified and included in the NHDC submission. These reconcile back to the General Ledger and audited financial statements. Activity data is reconcilable back to the central data sources that the centralised Health Support Services provide to the Health Services.

A series of separate documents summarising the general ledger reconciliation and adjustments resulting in the final Round 28 submission will be provided to IHACPA.

#### **4. Other relevant information**

WA Costing guidelines and practices were relatively unchanged since 2021-22. There have been incremental improvements in quality assurance; adoption of the Round 28 IHACPA Data Request Specifications; and a continued expansion of non-Admitted data inclusion criteria for national submission.

Extensive work has been undertaken to refine the submission of contracted services and to submit costed data for Community Mental Health for the first time.

Subsequent to WA's final submission, IHACPA raised a quality assurance issue concerning \$225,690 of negative indirect prosthetic related costs for 797 subacute patients at Fiona Stanley Hospital. Although the amounts were deemed immaterial it was agreed that IHACPA resolve the issue by removing them from the WA submission.

#### **5. NHDC Declaration**

All data provided by Western Australia to the 2023-24 NHDC has been prepared in accordance with the Three-Year Data Plan 2024–25 to 2026–27, 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.

Assurance is given that to the best of my knowledge the data provided are suitable to be used for the primary purpose of the NHDC, which includes the development of the National Efficient Price.

Signed:



Dr Shirley Bowen

**DIRECTOR GENERAL**

17 September 2025

# 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 million
- 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 million

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 million 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 NHDC 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 per cent.

- 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 NHDC 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. NHDC declaration – please ensure the below declaration is included.

All data provided by Tasmania to the 2023-24 NHDC 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 NHDC, 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.



---

Professor Michael Pervan, Chief Executive Officer  
Independent Health & Aged Care Pricing Authority  
PO Box 483  
Darlinghurst NSW 1300  
Via Email: [secretariatihacpa@ihacpa.gov.au](mailto:secretariatihacpa@ihacpa.gov.au)

T 08 8999 2669

File reference  
EDOC2025/343906

Dear Professor Pervan

**RE: Round 28 National Hospital Cost Data Collection Data Quality Statement**

I am pleased to provide the Northern Territory Data Quality Statement (see Attached) to be published as part of the Round 28 (2023-24) National Hospital Data Cost Data Collection (NHCDC) Cost Report, as requested.

I confirm that data provided by the Northern Territory to Round 28 (2023-24) of the National Hospital Cost Data Collection (NHCDC) submitted to the Independent Hospital Pricing Authority has been prepared in adherence with the Australian Hospital Patient Costing Standards (AHPCS) as described in the attached Data Quality Statement for Northern Territory.

Assurance is given that to the best of my knowledge the data provided is suitable to be used for the primary purpose of the NHCDC, which includes development of the National Efficient Price and National Efficient Cost.

Please contact Kirsty Annesley, Director Financial Modelling and Analysis via [Kirsty.Annesley@nt.gov.au](mailto:Kirsty.Annesley@nt.gov.au), as the Northern Territory representative to provide further insight and understanding of the processes undertaken by NT Health when preparing the NHCDC.

Yours sincerely



Chris Hosking  
Chief Executive  
7 January 2026

# Northern Territory Health Data Quality Statement

## National Hospital Cost Data Collection (NHCDC)

### Round 28 (2023-24)

#### 1. Governance Processes

Northern Territory Department of Health (NT Health) is one entity incorporating the Department of Health (system manager) and the Northern Territory Regional Health Service (NTRHS).

The NTRHS extends across five regions Top End, Big Rivers, East Arnhem, Barkly and Central Australia. Providing the full spectrum from primary care, community services, aged care, rehabilitation, mental health, emergency and acute care. The NTRHS and consist of six hospitals and over 70 health care centres working together as one system in partnership with individuals, families, the community, Aboriginal health organisations and stakeholders to provide high quality, evidence-based care.

The six hospitals are located across the regions, with Royal Darwin Hospital (RDH) and Palmerston Regional Hospital (PRH) in the Top End region, Katherine Hospital (KH) in the Big Rivers region, Gove Hospital (GH) in the East Arnhem region, Alice Springs Hospital (ASH) in the Central Australia region, and Tennant Creek Hospital (TCH) in Barkly region. The smaller regional hospitals of KH, GDH, and TCH are supported by the larger hospitals RDH, ASH and PRH for the provision of clinical governance, and specialist support.

NT Health have contractual arrangements with third parties to support health service delivery across the NTRHS, including with private sector partners, diagnostic service providers, highly specialised clinical service partners, ambulance and patient transport providers. RDH also has a contracted care arrangement with the only private hospital in the NT, Darwin Private Hospital.

NT Health activity data submissions to IHACPA are managed by the Data Submission Working Group (DSWG). The working group comprises representatives from across NT Health and subject matter experts from the Department of Corporate and Digital Development (DCDD), the central NT government agency responsible for digital services, data warehousing, reporting and analytics.

The working group meets regularly to monitor data, maintain and refine the business rules, criteria and thresholds applied to validate activity data submissions and produce compliance exception reports in accordance with national standards and reporting requirements. Exception and validation reports are routinely distributed to hospital and operational stakeholders to facilitate data review and remediation in source information system prior to submission.

The submissions working group provides formal data assurance advice and recommendations to executive sponsors as part of the submission approval process through the NT Health Strategic Information Management (SIMC) and Finance Governance Committees (FGC).

There is one patient costing team in NT Health, who are responsible for the NHCDC costing submission ensuring the costing methodology, and processes are compliant with the national costing standards and guidelines and consistently applied at the hospital level across the NTRHS.

The patient costing is a member of the DSWG and provides feedback and advice to the working group on data issues and anomalies identified in the costing process for further investigation and remediation.

The phased implementation of new health information systems and infrastructure across the Territory necessitated the identification and in-depth evaluation of essential and mandatory clinical and administrative data sources and structures in 2023-24 to ensure data completeness, accuracy and robustness. The comprehensive review resulted in the development of new data extracts directly from source system data repositories enabling the testing, reconciliation and validation of input at the point of patient care, to reporting dataset generated through corporate reporting systems and structures.

Improvement in the overall data quality resulted from the increased awareness and understanding of systematic data limitations. Where possible, data anomalies were rectified either directly in the source system by hospital stakeholders or through changes to data protocols and business rules implemented to ensure data consistency and alignment with the Data Compliance Policy, and the Australian Hospital Patient Costing Standards Version 4.2.

Considerable effort was invested in relation to the following priority data areas.

- Blending data sets across the costing period with data sourced and merged from both the legacy and new information systems, due to the implementation role back of the new information system in the emergency department of Royal Darwin Hospital to the legacy system to enable the deployment of system enhancements. Throughout this period all other admitted and non-admitted services continued to use the new information system, and data was manually validated and transcribed across systems by a centralised multidisciplinary team of clinical and administrative staff.
- Development of data extracts and protocols to remove duplicate and conflicting data captured in operating theatres including patient flow, clinical roles and time stamps in operating theatre and recovery data.
- Development of data extracts and protocols to remove out of scope activity not previously captured in clinical information systems including pre-arrival and pre-admission bookings and services not attended by patients or cancelled.
- Testing and correction of patient flow date and time stamp inconsistencies including admitted patient ward movements and transfers of care between treating teams and across hospital facilities.
- Development of data warehouse design solutions to address inconsistent data capture workflows, and variation between data sources and the reporting of episodic patient demographic data.

Power Health Solutions (PHS) are engaged by the NT Health to provide specialised clinical costing software (Power Performance Manger - PPM3), expert technical costing resources and industry best practice advice to support the NT patient costing team.

NT Health patient costing is an iterative process where draft results are shared and reviewed internally with stakeholders and external by PHS. Stakeholder engagement, both clinical and non-clinical, holds a crucial role in guiding the NT Health NHCDC submission. Advice from stakeholders across the NTRHS informs the development of cost models and incorporates the review of relative value units, allocation statistics, cost matching rules, data linking criteria, and the reclassification of expenses in the costing ledger.

Reconciliation and review processes are performed at hospital, product, care type, speciality, ward and unit levels and includes outlier, variation and trend analysis. Feeder level data is also reviewed with operational and source system experts to identify improvement opportunities.

Draft costing results, PPM 3 reports and IHACPA Quality Assurance reports are extensively reviewed and evaluated by patient costing and PHS prior to distribution to NT Health stakeholders through the NT Health, Costing Utilisation Power BI reporting platform.

The Costing Utilisation platform is accessible by all NT Health staff providing visibility and transparency of NT Health NHDC results and facilitates longitudinal analysis over time. Awareness and understanding of patient costing continues to mature across NT Health, with cost data increasingly used to inform and support operational, performance and strategic decision making.

The patient costing unit provides formal validation, reconciliation and quality assurance advice and recommendations through the NT Health, Chief Finance Officer to the Chief Executive Officer as part of the NHDC submission approval process.

## 2. NHDC 2023-24 Result Summary Table

Key changes from NHDC 2022-23 to NHDC 2023-24

Hospital Name	Stream	2023-24			2022-23			Change		
		Records	Total Cost	Average Cost	Records	Total Cost	Average Cost	Records	Total Cost (\$)	Average Cost % change
Royal Darwin Hospital	Acute	76,184	\$552,762,741	\$7,256	78,758	\$477,628,483	\$6,065	-2,574	75,134,258	19.6%
Royal Darwin Hospital	Admitted Mental Health	1,107	\$38,111,769	\$34,428	1,195	\$30,824,522	\$25,795	-88	7,287,246	33.5%
Royal Darwin Hospital	Emergency Department	66,123	\$101,896,889	\$1,541	64,909	\$85,281,607	\$1,314	1,214	16,615,281	17.3%
Royal Darwin Hospital	Non-admitted	200,287	\$110,884,881	\$554	197,946	\$104,772,776	\$529	2,341	6,112,106	4.6%
Royal Darwin Hospital	Other Episodes	4	\$120,967	\$30,242	2	\$33,089	\$16,544	2	87,878	82.8%
Royal Darwin Hospital	Subacute Episodes	108	\$10,303,831	\$95,406	74	\$4,581,500	\$61,912	34	5,722,331	54.1%
Royal Darwin Hospital	Subacute Phases	926	\$9,720,893	\$10,498	664	\$6,869,725	\$10,346	262	2,851,168	1.5%
Alice Springs Hospital	Acute	60,400	\$248,434,771	\$4,113	61,664	\$204,466,013	\$3,316	-1,264	43,968,758	24.0%
Alice Springs Hospital	Admitted Mental Health	321	\$14,279,765	\$44,485	318	\$11,869,133	\$37,324	3	2,410,632	19.2%
Alice Springs Hospital	Emergency Department	46,761	\$47,828,037	\$1,023	46,313	\$43,164,804	\$932	448	4,663,233	9.7%
Alice Springs Hospital	Non-admitted	61,431	\$33,311,129	\$542	61,698	\$30,533,307	\$495	-267	2,777,822	9.6%
Alice Springs Hospital	Subacute Episodes	210	\$8,194,057	\$39,019	127	\$6,858,454	\$54,004	83	1,335,602	-27.7%
Alice Springs Hospital	Subacute Phases	418	\$4,921,195	\$11,773	408	\$3,503,156	\$8,586	10	1,418,039	37.1%
Tennant Creek Hospital	Acute	12,251	\$27,984,549	\$2,284	12,113	\$19,296,027	\$1,593	138	8,688,522	43.4%
Tennant Creek Hospital	Emergency Department	13,257	\$8,061,813	\$608	12,022	\$7,091,598	\$590	1,235	970,215	3.1%
Tennant Creek Hospital	Non-admitted	2,181	\$3,670,337	\$1,683	9,378	\$4,834,670	\$516	-7,197	-1,164,333	226.4%
Tennant Creek Hospital	Subacute Episodes	3	\$952,937	\$317,646	6	\$604,813	\$100,802	-3	348,124	215.1%
Katherine Hospital	Acute	11,595	\$47,626,948	\$4,108	11,683	\$41,219,758	\$3,528	-88	6,407,190	16.4%
Katherine Hospital	Emergency Department	16,404	\$22,169,565	\$1,351	15,858	\$14,618,079	\$922	546	7,551,487	46.6%
Katherine Hospital	Non-admitted	12,420	\$7,970,594	\$642	12,001	\$6,417,475	\$535	419	1,553,120	20.0%
Katherine Hospital	Subacute Episodes	43	\$2,872,792	\$66,809	43	\$2,122,557	\$49,362	0	750,236	35.3%
Katherine Hospital	Subacute Phases	74	\$960,828	\$12,984	48	\$484,818	\$10,100	26	476,010	28.6%
Gove District Hospital	Acute	2,236	\$36,031,217	\$16,114	2,187	\$28,428,610	\$12,999	49	7,602,607	24.0%
Gove District Hospital	Emergency Department	10,259	\$14,084,542	\$1,373	9,720	\$13,848,422	\$1,425	539	236,119	-3.6%
Gove District Hospital	Non-admitted	6,731	\$5,462,258	\$812	5,347	\$3,311,756	\$619	1,384	2,150,503	31.0%
Gove District Hospital	Subacute Episodes	33	\$493,864	\$14,966	46	\$1,125,046	\$24,458	-13	-631,182	-38.8%
Palmerston Regional Hospital	Acute	14,573	\$50,355,078	\$3,455	13,520	\$36,529,598	\$2,702	1,053	13,825,480	27.9%
Palmerston Regional Hospital	Emergency Department	31,757	\$33,687,521	\$1,061	32,964	\$29,151,483	\$884	-1,207	4,536,038	20.0%
Palmerston Regional Hospital	Non-admitted	17,693	\$12,468,743	\$705	25,586	\$12,510,018	\$489	-7,893	-41,274	44.1%
Palmerston Regional Hospital	Subacute Episodes	504	\$44,114,957	\$87,530	518	\$33,921,042	\$65,485	-14	10,193,915	33.7%

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

Data provided by NT Health for Round 28 of the NHDC has been prepared in adherence with Australian Hospital Patient Costing Standards version 4.2 (AHPCS) qualified by the following items:

### AHPCS Stages 1 to 3

#### - Identify Relevant Expenses, Create the Costing Ledger and Create Final Cost Centres

All relevant expenses in the General Ledger are included in the NHDC submission and reconcile to the audited financial statements, including notional expenses for services provided free of charge by other NT government agencies and relevant expenses in charitable gift funds.

NT Health identify long service leave payments to hospital employees by the Northern Territory Department of Treasury and Finance and include these costs in the NHDC submission as shown in the general ledger reconciliation below.

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**NT Health 2023-24 NHCDC General Ledger Reconciliation (Round 28)**


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LHN	General Ledger Total	Adjustments to the GL - Inclusion of 3rd Party Long Service Leave	Adjustments to the GL - Inclusion of Opening Work in Progress	Adjustments to the GL - Exclusion of Out of Scope & Unlinked Episodes	Adjustments to the GL - Exclusion of Closing Work in Progress	Post allocation adjustments	Jurisdictional adjustments	Total Costing Ledger
NT Regional Health Service	\$ 2,256,916,552	\$ 14,172,885	\$ 32,840,248	\$ 714,042,079	\$ 32,298,476	\$ -	\$ -	\$1,557,589,131

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#### AHPCS Stage 4 – Identify Products

All establishment activity has been identified and included in the costing process except for data sourced from the Community Care Information System (CCIS) and the Primary Care Information System (PCIS) that is excluded from the costing process due to data completeness and quality issues.

NT Health did not cost Mental Health Care at the phase of care level due to system and data limitations in 2023/24, and costs have been reflected at the episode level.

#### AHPCS stage 5 - Assign Expenses to Products

Where possible expenses are allocated to intermediate products based on service feeder files. Only when data is not available are product fractions and relative value units used.

Intermediate products are matched to final patient products in accordance with documented linking rules consistent with AHPCS 5.2.

NT Health has standardised matching rules that are applied to link intermediate to final products and considerable data sampling, and iterative processing is performed to validate the accuracy of the linking.

Final cost centres are distributed to patients based on consumption data wherever possible, this includes for example time in operating theatres, emergency department, on wards or under speciality treating teams. Alternatively, utilisation data, relative value units and specific service builders are applied to distribute final cost centres to encounters.

Royal Darwin Hospital has a contracted care arrangement with the Darwin Private Hospital. All associated activity and costs are included in the NHCDC. Contracted care expense at encounter level reflects the price invoiced for the service provided under the contract and is reported against the goods and services line item, consistent with the line items used for NT wide shared corporate services.

#### AHPCS Stage 6 – Review and Reconcile

The NT Health costing process involves data acquisition, processing, validation and reporting stages. The patient costing team perform a range of assurance, validation and reconciliation tests at each stage and implement continuous refinements and improvements in consultation with clinical, finance and hospital stakeholders. Routine assurance process undertaken regularly through the costing period to reconcile cost and activity data include.

- cost reconciliation to audited financial statements,
  - general ledger analysis at account code and cost centre level across years and checks for negative cost centres, line items and episodes
  - overhead cost ratio variation to trend analysis across years
  - consistency of Cost Bucket results across years.
-

- patient activity validation to data submissions and source systems
- case mix and acuity variation at facility and care type level across years.
- completeness testing of feeder datasets against source systems and prior periods

PPM3 clinical costing software also has reconciliation functionality and validation reports to ensure costs and activity loaded into the system are transparent and accounted for throughout the costing process. PPM 3 also has enhanced reporting and visualisation functionality utilised by NT Health to perform trend analysis by volume, time and cost to identify anomalies.

## 4. Other relevant information

NT does not follow the costing guideline set out for Teaching and Training, Research, Posthumous Organ Donation and Mental Health Services as these are not practicable to implement in the NT due either to system or data limitations. However, it should be noted, that AHPCS principles have been followed to allocate costs appropriately.

## 5. NHCDC declaration

All data provided by NT Health to the 2023-24 NHCDC has been prepared in accordance with the Three-Year Data Plan 2023-24 to 2025-26, 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 the NHCDC 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

CHRIS HOSKING

NT Health, Chief Executive Officer



**ACT**  
Government

Health and Community Services

Professor Michael Pervan  
Chief Executive Officer  
Independent Health and Aged Care Pricing Authority

Dear Prof Pervan

**ACT 2023-24 National Hospital Cost Data Collection — Data Quality Statement**

Thank you for your correspondence requesting that the ACT provide a Data Quality Statement (DQS) to accompany its 2023-24 National Hospital Cost Data Collection (NHDCDC) submission.

The DQS is appended to this letter. All data provided by the ACT to Round 28 of the NHDCDC has been prepared, to the best of our knowledge, in accordance with the Australian Hospital Patient Costing Standards (AHPCS) version 4.2 and local assurance processes.

We thank IHACPA for its ongoing work collating the NHDCDC. If you have any questions on this submission, please don't hesitate to contact Ms Kate Chambers, Executive Branch Manager, Health System Performance at [Kate.Chambers@act.gov.au](mailto:Kate.Chambers@act.gov.au) or on (02) 5124 9428.

Yours sincerely

Robyn Hudson  
Deputy Director-General, Policy and Transformation  
Health and Community Services Directorate  
13 September 2025

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## ACT Data Quality Statement – 2023-24 NHCDC Submission

### 1. Governance processes

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

The ACT Local Hospital Network (ACT LHN) is the main mechanism by which government funding flows to public hospitals. The ACT LHN is administered by the Health and Community Services Directorate (HCSD). Canberra Health Services (CHS) is a major public hospital service provider within the ACT LHN. The other public hospital service provider within the ACT LHN is Tresillian, operates the block-funded Queen Elizabeth II Family Centre.

CHS delivers a range of publicly funded acute, sub-acute, primary, and community-based health services and programs through the following 3 public hospitals. All 3 hospitals are included in the ACT 2023-24 NHCDC data.

**The Canberra Hospital (TCH):** is an acute care teaching hospital which is also a tertiary referral centre that provides a broad range of specialist medical and surgical services to ACT and Southeast NSW.

TCH also operates Community Health Centres, Walk-in Centres, providing a range of general and specialist health services to people of all ages, including early childhood services, youth and women's health, dental health, mental health and alcohol and drug services

**North Canberra Hospital (NCH):** On 3 July 2023, the ACT Government acquired Calvary Public Hospital Bruce, providing a path for a major new hospital on Canberra's northside at Bruce – the North Canberra Hospital. NCH is a fully accredited public hospital of around 243 beds located on the north side of Canberra. Services include an Emergency Department, an Intensive Care Unit, a Coronary Care Unit, medical and surgical wards, a Maternity Unit, a voluntary psychiatric ward, and ambulatory care and outreach facilities and services.

Clare Holland House, a facility within NCH, is the main facility for the provision of specialist palliative care across the ACT and surrounding region. The facility provides a mix of 27 inpatient beds, outpatient and residential / community-based services.

**University of Canberra Hospital:** a dedicated and purpose-built rehabilitation health facility. It provides care and support for people over the age of 18 who are experiencing mental illness or recovering from surgery, illness, or injury. It is the largest rehabilitation centre in the ACT and surrounding region, with 84 beds, 75-day places and additional outpatient services.

## **1.2 Costing process guidelines, including the use of relative value units (RVUs)**

Costing was performed in PowerHealth PPM Version 3 in line with the Australian Hospital Patient Costing Standard version 4.2. Allocation bases include standard AHPCS methods (e.g. allocation statistics, duration, activity volumes).

## **1.3 Costing and activity reporting processes and methodologies**

- **Data custodianship:** CHS prepares General Ledger (GL) and agreed feeder extracts; HCSD performs PPM configuration, allocation, validation and submission.
- **Activity data:** Baselined on the submitted ABF activity data for the 2023-24 financial year.
- **Validation:** Datasets passed IHACPA portal validations prior to lodgement. High-level GL to costed amount reconciliations and QA checks were performed by HCSD.

## **1.4 Consistency of costing practices across the jurisdiction**

Costing is coordinated centrally by HCSD using a consistent methodology across TCH, UCH and NCH, in consultation with CHS.

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

Canberra Hospital manages contracts with private hospitals as part of the Territory's elective surgery programs. The contracted care episodes are reported against Canberra Hospital activity with a contracted care establishment identification referring to the contracted private hospital.

Similarly, for costing purposes, these episodes are included in the NHCDC for TCH. The costs for these episodes were estimated using the Relative Value Unit based on the relevant Diagnosis Related Group (rather than actual invoiced amount, which is currently not available).

## **1.6 Changes from the previous year**

The ACT did not submit to the 2022-23 NHCDC, following challenges from implementing the Digital Health Record (DHR). 2023-24 represents a resumption of the costing capability with the ACT, which involved rebuilding PPM processes and configurations, mappings and business rules to produce the costing data.

Some challenges related to the Digital Health Record (DHR) implementation remain in the data, which were surfaced during the costing process. These have been documented and will be targeted for resolution in 2024-25 (e.g. qualified/unqualified newborn days, community mental health, forensic mental health).

## 2. Summary of 2023–24 results

**Hospitals:** Three sites (TCH, UCH, NCH) as noted above.

**Scope:** Patient-level costing excluding non-ABF activity's costs (e.g. Teaching, Training and Research, Commercial services, Directorate functions, etc.) and unlinked services.

Unqualified newborns are excluded from costing.

Number of costed records are summarised in the table below.

Hospital	Number of Costed records	Amount submitted in NHCDC (\$'mil)
North Canberra Hospital	175,195	371.6
The Canberra Hospital	1,210,488	1,534.0
University of Canberra Hospital	38,678	95.4
<b>ACT Total</b>	<b>1,424,361</b>	<b>2,001.0</b>

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

### 3.1 Summarisation of general ledger reconciliation (LHN level)

Site	GL total (\$m)	Costed total* (\$m)	Variance (\$m)	Notes
NCH	394.4	382.3	-12.1	Some additional costs through TCH GL have been identified related to NCH activity (after NCH submission was made)
TCH	1,732.6	1,735.7	+3.1	Considered immaterial
UCH	96.0	95.5	-0.5	Considered immaterial
<b>Total CHS</b>	<b>2,223.0</b>	<b>2,213.4</b>	<b>-9.6</b>	System-level reconciliation variance 0.4%; overall residual issues disclosed above.

\* Note: Amount costed is different to amount submitted in NHCDC due to excluded costs noted in Section 2.

## 3.2 Compliance or deviations to AHPCS Version 4.2

### Overall compliance statement

The ACT prepared the 2023-24 NHCDC in accordance with AHPCS. The following exceptions/limitations are disclosed with planned remedies:

- **Stage 1 – Identify relevant expenses:** Relevant expenses were identified and included. For the 2023-24 submission, input was provided by CHS for GL extract. Joint GL documentation to be strengthened for 2024-25.
- **Stage 2 – Validation checks:** IHACPA portal validations passed. Residual issues documented for 2024-25 remediation.
- **Stage 3 – Cost allocation methods:** Standard AHPCS allocation methods (including RVUs/time/activity) applied within PPM.
- **Stage 4 – Identify products (activity):** All available patient-level activity and feeder data where available were included; activity data tied to the nationally submitted 2023-24 dataset.
- **Stage 5 – Assign expenses to products:** Patient-level allocation executed in PPM. Service mappings were shared with CHS for review and continuous improvements in the future.
- **Stage 6 – Review and reconcile:** Reconciliations performed as noted above.

## 4. Other relevant information

- 2023-24 NHCDC is a significant effort from the ACT, following many challenges from the DHR implementation. Staff from both the Directorate and the hospitals collaborated under significant time pressure to produce the data. Residual issues have been transparently documented for remediation in 2024-25.
- The ACT welcomes the opportunity to improve the quality of the data. The ACT has participated in the Independent Financial Review, including a site visit by the Scyne/IHACPA team occurred on 4 September 2025; the findings will be integrated into the 2024–25 work.

## 5. NHCDC declaration

All data provided by the ACT to the 2023–24 NHCDC has been prepared in accordance with the IHACPA’s Three-Year Data Plan, the Data Compliancy Policy 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.

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.

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