Prepared for the Independent Hospital Pricing Authority

Development of Version 4.0 of the Australian Hospital Patient Costing Standards

Public Consultation Paper

IHPA is calling for submissions on this Consultation Paper
by the closing date of Monday 23rd March, 2015

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List of Abbreviations

ABF	Activity Based Funding
AHPCS	Australia Hospital Patient Costing Standards
AR-DRG	Australian Refined Diagnosis Related Groups
CAC	Clinical Advisory Committee
COST	Costing
DEP	Depreciation
DRS	Data Request Specification
FDR	Feeder System
GL	General Ledger
IHPA	Independent Hospital Pricing Authority
JAC	Jurisdictional Advisory Committee
LHN	Local Hospital Network
MBS	Medicare Benefits Schedule
NAC	NHCDC Advisory Committee
NACDSG	NAC Development Sub-Group
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NHDD	National Health Data Dictionary
NPA	National Partnership Agreement
REP	Reporting
RFQ	Request for Quotation
RVU	Relative Value Unit
SCP	Scope
SPS	Specialised Procedure Suite
TAC	Technical Advisory Committee
TTR	Teaching, Training and Research
TWG	Technical Working Group

Executive Summary

As part of the continuing development of activity based funding (ABF) arrangements for Australian hospitals, the Independent Hospital Pricing Authority (IHPA) has appointed HealthConsult to conduct a body of work that, for convenience, is collectively referred to as the National Hospital Cost Data Collection (NHCDC) development project. This Consultation Papers has been prepared to inform work on the development of Version 4.0 of the Australian Hospital Patient Costing Standards (AHPCS). There is a related Discussion Paper on the evaluation of alternative final cost methodologies. The purposes of this Consultation Paper are to:

- make stakeholders aware of the project and what it is intended to achieve;
- set out the overall approach to, and ideas and suggestions for, developing Version 4.0 of the AHPCS and the associated supplementary educational materials; and
- invite stakeholders to comment and/or provide advice on the suitability of the proposed approach, to suggest changes to the AHPCS (modifications, deletions or additions of Standards), to advise on needs for supporting educational materials, and/or to raise other issues that should be considered.

In reviewing this paper, stakeholders should note that the ideas and suggestions put forward do not represent an IHPA and/or project governance group endorsed position. It is intended that the results of the wider consultation process through release of this public Consultation Paper and additional targeted discussions with key stakeholders across Australia that will take place in February/March, 2015 will allow the development of the drafting framework for Version 4.0 of the AHPCS, which will then be presented to the project governance groups for endorsement.

The AHPCS were first developed in 2009, as part of the implementation of the National Partnership Agreement of Hospital and Health Workforce Reform. They were intended primarily to set out what needs to be done in order to apply best practice costing principles to generating NHCDC data. They have been subject to a number of revisions, including an editorial review of Version 2.0 in 2012 that led to the publication of Version 3.1 of the AHPCS by IHPA in 2014. It is now considered an opportune time, in the context of a series of developments to the NHCDC, to undertake a comprehensive review of the content of the AHPCS and to consider the most appropriate form of associated supplementary educational materials.

The report of the Strategic Review of the NHCDC carried out in 2013 found that the current AHPCS attempt to set standards that describe best practice in patient level costing as well as define business rules that apply to the way in which data should be generated and reported for the purposes of the NHCDC. Stakeholders are invited to provide input on three Options that have been developed, which ask whether the current dual purpose should be clarified and retained, or whether it is better to focus the AHPCS on one or other of the purposes, or whether some other purpose should be formulated. The paper also puts forward a suggestion for revising the structure of the AHPCS so that it is more closely aligned to the way that patient level costing is typically carried out. Stakeholders are invited to comment on whether the current structure should be retained, or whether the proposed revised structure would improve the AHPCS and/or make suggestions for an alternative structure.

The current AHPCS contains 37 standards. This paper considers each Standard and puts forward options for how it might be refined/improved or deleted in the context of each of the Options put forward as to the principal purpose of the AHPCS. It also highlights areas where new standards could be considered for development, specifically the treatment of revenue, the recording of source of funds for a service and the development of a set of Standards for cost modelling sites. Stakeholders are invited to comment on these suggestions and/or to propose other areas where new standards could/should be developed.

Finally, the paper considers the most appropriate form of supporting educational materials that could be developed to assist with the interpretation and use of the AHPCS at the hospital level. The strengthening of the existing guidelines section that is presented with each Standard by the inclusion of examples to illustrate intent is contemplated. Additionally, stakeholders are invited to comment on the value of redeveloping the existing Hospital Reference Manual (last published in 2007) as a supplementary educational resource.

IHPA is inviting submissions on this Consultation Paper, which should be emailed as Microsoft Word or RTF attachment to submissions.ihpa@ihpa.gov.au by **5.00 pm on Monday, 23rd March, 2015**. Other features of the consultation process include the opportunity for stakeholders to participate in discussions and/or focus groups to be held across the country, as well as a public consultation process on the draft of the Version 4.0 of the AHPCS. Stakeholders are also able to provide input via their representatives (public or private sector) on the project governance committees.

List of consultation questions

- Which option best reflects the purpose of the AHPCS that is most suitable for meeting stakeholder needs? Please provide reasons for your choice.
- Are there other options for the purpose of the AHPCS that should be considered? If so, please describe them.
- Is there value in producing a Patient Level Costing Manual/Training Guide in addition to the AHPCS and the NHCDC business rules? If so, please indicate what benefits would be derived.
- Should the AHPCS be restructured to more closely align with the way the costing process is carried out?
- If so, do stakeholders support the alternative structure put forward in this Consultation Paper? Please suggest possible refinements as appropriate.
- If not, are there other structures for the AHPCS that should be considered? Please describe the alternative proposition(s).
- Are the suggested changes to each of the existing standards in the AHPCS appropriate? If not, please indicate those standards where you would like to see a different course of action taken?
- Please suggest any other changes to the existing standards that you believe would result in improvement.
- Should there be a standard on the recording of revenue in the AHPCS? If so, should it be for patient products, non-patient products or both?
- If a standard is developed, should there be a related NHCDC business rule that requires the reporting of revenue for each end-class in each product category?
- Should there be a standard on recording the source of funds for patient products in the AHPCS?
- If a standard is developed, should there be a related NHCDC business rule that requires the reporting of the source of funds for each end-class in the patient product categories?
- Should there be a set of standards that are specific to cost modelled sites (i.e. hospitals that must cost groups of patient service events, rather than individual patient service events)? If so, would the benefits associated with creating such standards outweigh the costs?
- Are there areas where new standards should be developed as part of producing Version 4.0 of the AHPCS? If so, please indicate what they are and provide a brief statement of the purpose of having a standard in that area.
- Do stakeholders believe the current content of the guidelines section provided for each Standard is valuable?

- If not, should the guidelines section be refined to include examples of the application of each standard?
- Please make any other suggestions for developing material that would clarify the intent of each Standard.
- Should the NHCDC Hospital Reference Manual be updated to current practice?
- If so, should it focus on documenting the NHCDC business rules or should it be developed as a generic education and training resource in patient level costing?
- Are there other approaches for revising and updating the NHCDC Reference Manual that would generate value for stakeholders? If so please describe briefly.
- What other supplementary educational materials, if any, should be developed to support the implementation and use of the AHPCS?
- Is the proposed stakeholder engagement strategy suitable for the purposes of the study?
- Are there other processes that could or should be considered to facilitate stakeholder engagement throughout the study?
- Are there other issues that should be considered in developing Version 4.0 of the AHPCS and the associated supplementary educational materials?

1

Introduction

As part of the continuing development of activity based funding (ABF) arrangements for Australian hospitals, the Independent Hospital Pricing Authority (IHPA) has appointed HealthConsult to conduct a body of work that, for convenience, is collectively referred to as the National Hospital Cost Data Collection (NHCDC) development project. This Chapter briefly sets out the context for the project, introduces the full scope of the work, including the two optional components, then describes the purpose of this Consultation Paper, which relates primarily to the part of the project that will develop Version 4.0 of the Australian Hospital Patient Costing Standards (AHPCS).

1.1 BACKGROUND

The AHPCS were first developed in 2009, as part of the implementation of the National Partnership Agreement of Hospital and Health Workforce Reform[1]. They were intended primarily to set out what needs to be done in order to apply best practice costing principles to generating NHCDC data. They have been subject to a number of revisions, including an editorial review of Version 2.0 in 2012 that led to the development of Version 3.0. IHPA then determined that it should receive and consider the report of the Strategic Review of the NHCDC ('Strategic Review') done in 2013 prior to publishing any further versions of the AHPCS. In the event, IHPA published Version 3.1 of the AHPCS in 2014, which addressed a number of the issues raised in the Strategic Review, and decided, in the context of a wider series of developments to the NHCDC, to undertake a comprehensive review of the content of the AHPCS and to consider the most appropriate form of supplementary educational materials.

1.2 THE NHCDC DEVELOPMENT PROJECT

Largely, as part of the process of implementing the recommendations of the Strategic Review, IHPA has formulated the NHCDC development project that consists of four principal activities:

- a costing study using retrospective data to evaluate alternative final cost allocation methods and determine a preference hierarchy of methods for inclusion in the AHPCS (labelled as Stage A1/2);
- a 'live' costing study to further confirm the results (in terms of the preference hierarchy for cost allocation methods) derived from Stage A2 (labelled as Stage A3);
- the production of Version 4.0 of the AHPCS, including associated supplementary educational materials (labelled as Stage B); and
- the development of Data Governance and Data Quality Frameworks for the NHCDC (labelled as Stage C).

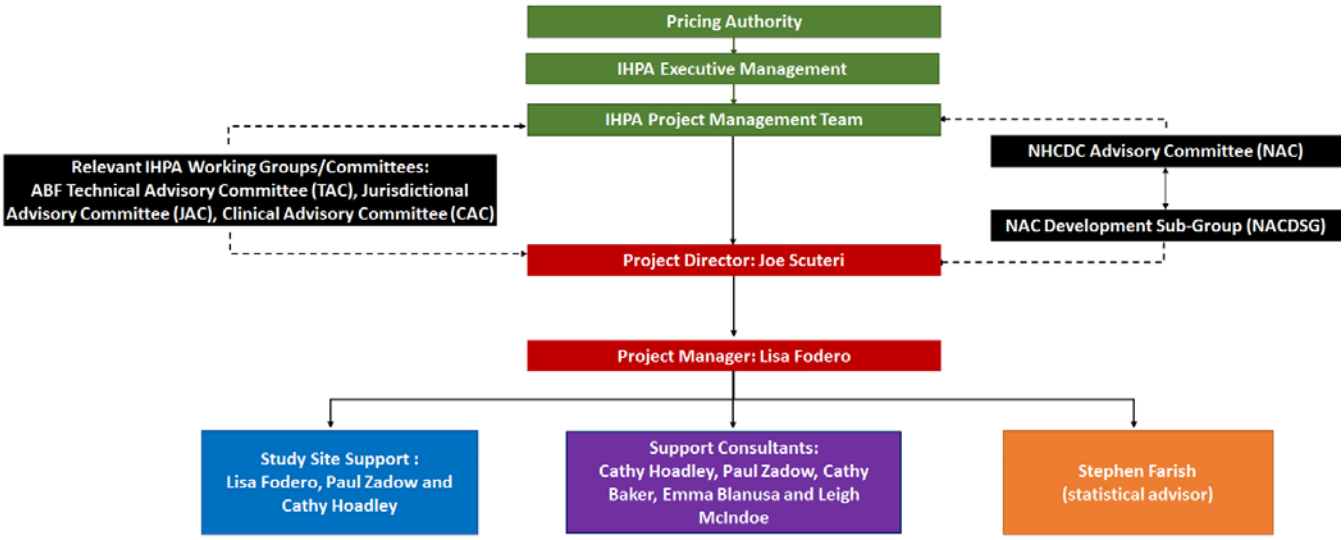
As a result of a Request for Quotation (RFQ) process that covered all four Stages, HealthConsult, was engaged by IHPA in December, 2014 to carry out Stages A1/2 and B of the project. Stages A3 and C are optional components, that have not yet been commissioned by IHPA.

[1] Department of Health and Ageing (2011). Australian Hospital Patient Costing Standards.

1.3 PROJECT MANAGEMENT AND GOVERNANCE ARRANGEMENTS

Figure 1.1 sets out the approved project management and governance structure. The study team will be led by Joe Scuteri who will have endpoint responsibility for the production of all deliverables to the quality standard required by HealthConsult and IHPA. Lisa Fodero will be the day-to-day Project Manager and coordinate the work of the project team. The key governance groups are NHCDC Advisory Committee (NAC) and the NAC Development Sub-Group (NACDSG). These two Groups will meet on a number of occasions throughout the project to consider interim and final deliverables. IHPA's ABF Technical Advisory Committee (TAC), Jurisdictional Advisory Committee (JAC) and Clinical Advisory Committee (CAC) will be involved in the study, as appropriate.

Figure 1.1: NHCDC development project governance and management structure



1.3 PURPOSE OF THIS DOCUMENT

This **Consultation Paper covers only the approach to Stage B of the NHCDC development project that is the development of Version 4.0 of the AHPCS and the associated supplementary educational materials**. It takes account of feedback from an initial set of targeted consultations with key stakeholders, and has been produced to underpin a broader process of stakeholder consultation by inviting public submissions and undertaking a series of targeted consultations across Australia. Its primary purposes are to:

- make stakeholders aware of the project and what it is intended to achieve;
- set out the overall approach to, and ideas and suggestions for, developing Version 4.0 of the AHPCS and the associated supplementary educational materials; and
- invite stakeholders to comment and/or provide advice on the suitability of the proposed approach, to suggest changes to the AHPCS (modifications, deletions or additions of Standards), to advise on needs for supporting educational materials, and/or to raise other issues that should be considered.

IHPA is calling for submissions on this Consultation Paper. Submissions must be emailed as Microsoft Word or RTF attachment to submissions.ihpa@ihpa.gov.au by **5.00pm on Monday, 23rd March, 2015**. All submissions will be published on the IHPA website (www.ihpa.gov.au) unless respondents specifically identify any sections that they believe should be kept confidential due to commercial or other reasons.

Potential respondents should note that the ideas and options proposed in this Consultation Paper have not been endorsed by IHPA or the project governance groups. They are presented as

a mechanism for gauging stakeholder views, as well as to provide a basis for identifying the most appropriate structure and content of Version 4.0 of the AHPCS, and associated supporting educational materials. The stakeholder feedback will be used to develop the drafting framework for the AHPCS Version 4.0.

1.4 RELATED DISCUSSION PAPER

Stakeholders should note that there is a related **Discussion Paper, that deals with approach to evaluating the merits of the final cost allocation methods** (the Stage A1/2 work), which can be read together with this paper. There is some overlap between the two papers, as the two pieces of work are being conducted concurrently, (there is an integrated stakeholder consultation strategy, see Chapter 6) and it is intended that the preference hierarchy developed though undertaking the Stage A1/2 work will be reflected in Version 4.0 of the AHPCS.

It should also be noted that neither this Consultation Paper, nor the related Discussion Paper on the approach to evaluating the merits of the final cost allocation methods cover in any detail those parts the NHCDC development project that have not been commissioned (i.e. Stage A3, the 'live costing study' and Stage C the development of Data Governance and Data Quality Frameworks for the NHCDC). It is intended that similar Consultation Papers for these optional parts of the NHCDC development project will be prepared if IHPA commissions that work.

2

Purpose of the AHPCS

This Chapter discusses the purpose of the AHPCS and presents some options for how the AHPCS might be regarded as part of a set of infrastructure relating to patient level costing and the NHCDC.

2.1 FINDINGS OF THE STRATEGIC REVIEW

With respect to Version 3.0 of the AHPCS, the Strategic Review 'found no evidence to indicate the need for major updates to the content within the AHPCS as rules'. There was, however, a theme with the Strategic Review report that there was a lack of industry input into the standards and hence they should be regarded as NHCDC 'business rules' rather than standards. This finding was made even though IHPA included an open consultation process and invited public submissions as part of the development of Version 3.0. Ultimately the Strategic Review found a need to clarify the purpose of the AHPCS.

2.2 A POSSIBLE MODEL FOR THE AHPCS AND RELATED INFRASTRUCTURE

A review of the current AHPCS suggests that there is an attempt to set standards that define best practice in patient level costing as well as define business rules that apply to the way in which data should be generated and reported for the purposes of the NHCDC. This duality creates confusion and reinforces the perception that the AHPCS are NHCDC business rules and not best practice standards for patient level costing. In fact, based on comparisons with equivalent national and international documents, it is considered that the AHPCS are as complete a set of standards for patient level hospital costing as exists anywhere in the world. That said, it is fair to say that some standards are better characterised as NHCDC business rules.

So, consistent with the finding of the Strategic Review, in developing Version 4.0 of the AHPCS, it is important to be clear about purpose. Based on the results of initial key stakeholder consultations, Table 2.1 sets out a possible hierarchy of related documents that could all be considered NHCDC supporting infrastructure.

Table 2.1: Suggested hierarchy of documents relating to the AHPCS and NHCDC

Document	Purpose	Intended Scope
AHPCS	To define standards that set out 'what to do', which when applied, would represent best practice in patient level costing.	Shorter document than current AHPCS, containing only standards, with illustrative examples to make intent of standard clear.
NHCDC Business Rules	To define the rules to be used when generating hospital cost data to be submitted to the NHCDC.	More detailed document that focusses on NHCDC only, includes all applicable business rules (e.g. mapping to NHCDC cost centres and line items, classification of overheads, timing of submission, file specifications for data transfer, etc.).
Patient Level Costing Manual/Training	To provide guidance to people undertaking costing, focus on 'how to do' costing.	Written as an education and training resource, similar to the 'grey books'

Document	Purpose	Intended Scope
Guide		casemix series that was developed in the early 1990's.

It is envisaged that NHCDC business rules document would mix some of the NHCDC specific content that is in the AHPCS with some of the content that is currently in the NHCDC Hospital Reference Manual (last updated in September 2007 relating to NHCDC Round 11 i.e. 2006/07 data, stakeholders can request this document by email to NHCDC@ihpa.gov.au). Production of a Costing Manual/Training Guide is not currently part of the NHCDC development project, but it was a recommendation of the Strategic Review (recommendation 13), and the initial consultations carried out as part of developing this Consultation Paper, reveal that there are some key stakeholders who support the development of such an educational resource.

Please note that in discussions with IHPA, it has been agreed that the production of a Costing Manual/Training Guide to support people undertaking patient level costing is a different task to the development of 'supporting educational materials' associated with Version 4.0 of the AHPCS, which is part of the Stage B work. As part of developing the supplementary educational materials, the merit of updating the NHCDC Reference Manual, which is quoted as a source for many of the current Standards, will be considered. The options and suggestions for the development of the supplementary educational materials are considered in Chapter 6 of this Consultation Paper.

2.3 OPTIONS FOR CONSIDERATION

With reference to the discussion in Section 2.2 and the hierarchy of NHCDC related documentation presented in Table 2.1, there are essentially three options for defining the purpose of the AHPCS that should be considered, as set out in Table 2.2.

Table 2.2: Options for defining the purpose of the AHPCS and related documents

Option	Description of AHPCS purpose	Implications
1	Retain the current dual purpose of the AHPCS i.e. to define standards for best practice costing and to set out key business rules for generating data to be reported to the NHCDC.	AHPCS Version 4.0 would effectively have the same purpose as Version 3.1, with improved content relating to both standards and NHCDC business rules.
2	Clearly state the purpose of the AHPCS as defining best practice in patient level costing.	AHPCS Version 4.0 defines only standards (i.e. it is less voluminous than Version 3.1), but a separate NHCDC business rules document would need to be produced.
3	Clearly state the purpose of the AHPCS as defining business rules for the NHCDC; in this case the AHPCS should probably be retitled.	No real attempt to define standards, just to specify the business rules that should be adopted for generating data for submission to the NHCDC.

Please note that, if a majority of stakeholders believed it was valuable, a Patient Level Costing Manual/Training Guide could be produced irrespective of which option is chosen for the purpose of the AHPCS.

Consultation questions

- Which option best reflects the purpose of the AHPCS that is most suitable for meeting stakeholder needs? Please provide reasons for your choice.
- Are there other options for the purpose of the AHPCS that should be considered? If so, please describe them.

- Is there value in producing a Patient Level Costing Manual/Training Guide in addition to the AHPCS and the NHCDC business rules? If so, please indicate what benefits would be derived.

3

Structure of the AHPCS

This Chapter explores the possibility of changing the structure of the AHPCS to more closely align it with the costing process.

3.1 CURRENT AHPCS STRUCTURE

The AHPCS Version 3.1 has a three level structure. There are standard categories, standards, and subsidiary standards. Table 3.1 summarises the current structure.

Table 3.1: Summary of the structure of Version 3.1 of AHPCS

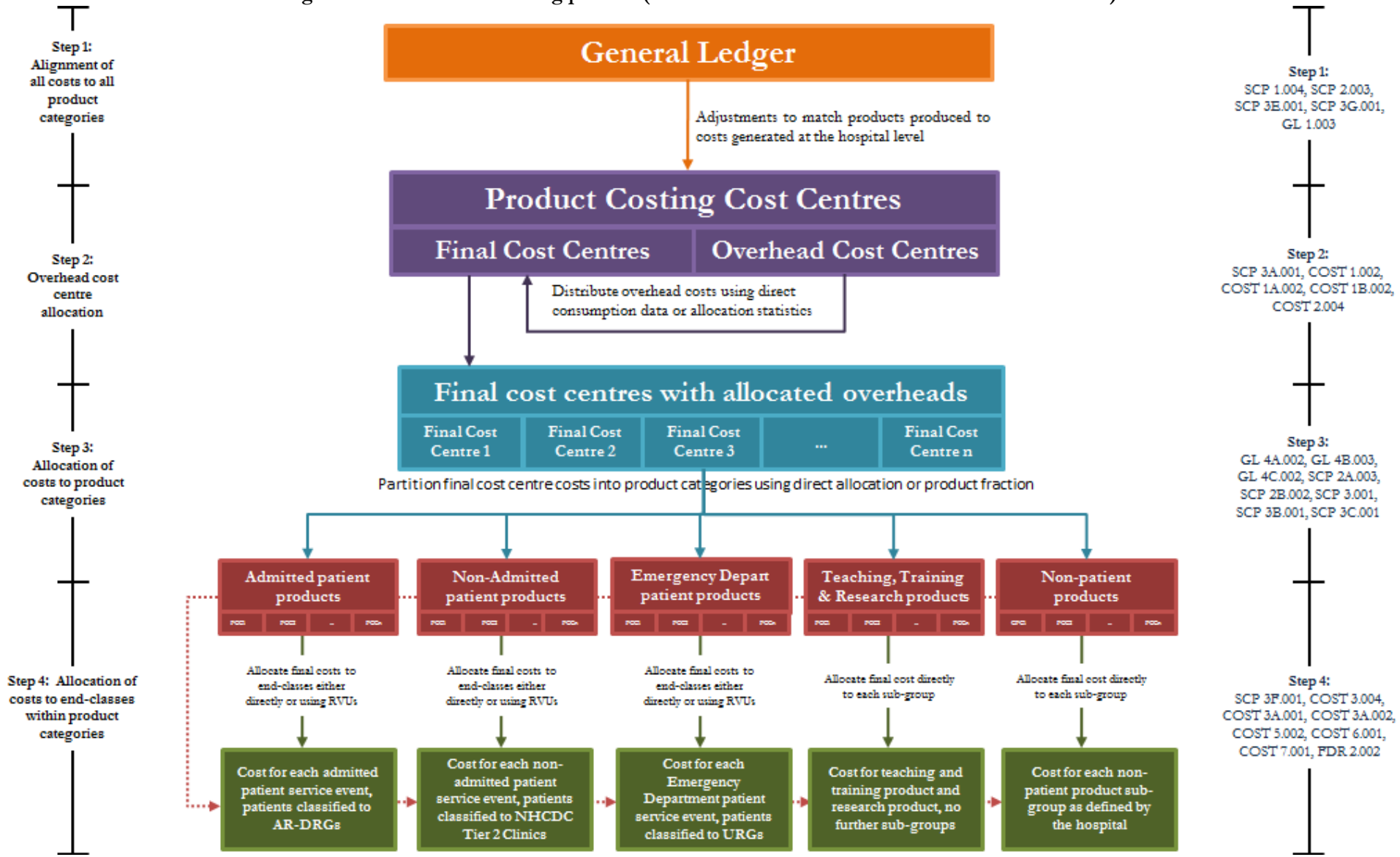
Standard category	Number of first level standards	Number of subsidiary level standards	Total number of standards
Scope (SCP)	3	9	12
General Ledger (GL)	3	3	6
Costing (COST)	7	4	11
Depreciation (DEP)	1	5	6
Feeder Systems (FDR)	1	0	1
Reporting (REP)	1	0	1
TOTAL	**16**	**21**	**37**

As can be seen, the SCP and COST categories together cover 23 of the 37 (62%) standards, while two categories (FDR and REP) have only one standard each. This situation reflects the refinement process that has taken place from Version 1.0 of the AHPCS that has included reworking some standards and assigning them to different categories, as well as the introduction of new standards (e.g. the DEP category was introduced in Version 2.0). So the current structure appears unbalanced.

3.2 A POSSIBLE REVISED STRUCTURE FOR THE AHPCS

There is potential to revise the structure of the AHPCS so that it more closely aligns the standards to the way the costing is carried out. In essence, high quality activity based costing in hospitals requires that production (patient activity and non-patient products) and costs be matched at four levels, taking account of the fact that hospital General Ledgers are not designed for the principal purpose of undertaking product costing. One possible revised structure would align the AHPCS with the product costing methodology diagram that appears in Version 3.1 as Figure 3 (reproduced with minor modifications, as Figure 3.1 in this Consultation Paper). As can be seen, this diagram categorises most of the existing standards into the four step structure in an attempt to make clear 'what to do' at each step of the matching process to achieve a best practice transformation of general ledger data by cost centre to product costs data by end-class in each product category.

Figure 3.1: Overview of costing process (from AHPCS Version 3.1 with minor modifications)



To put the revised structure proposition into context, quoting from AHPCS Version 3.1, (with some amendments to update to current practice), the first step is to manipulate the costs recorded in the general ledger to reflect the products that are being costed (this manipulation is best done inside the costing system, not the general ledger). This process involves identifying those costs incurred in the hospital, as well as those costs generated by the hospital that are necessary for producing the products to be costed (Standards SCP 1.004, SCP 2.003, and SCP 3G.001). In this process care must be taken in treating offsets and recoveries, as distinct from revenue (SCP 3E.001). It then requires alignment of the timing of incurring the costs and producing the products (GL 1.003). It is suggested that this group of standards be titled **"Aligning Production and Cost".**

The second step involves apportioning all costs in overhead cost centres to final costs centres (Standards SCP 3A.001, COST 1.002, COST 1A.002, COST 1B.002, COST 2.004). In performing this function it is important to ensure that the cost centres or parts of cost centres that are associated with non-patient products are allocated their fair share of overheads (if necessary, non-patient product costs centres may then be terminated, and only patient products costed to end-classes, typically individual patient service events). It is suggested that this group of standards be titled **"Allocating Overhead Costs"**.

The third step involves partitioning the final costs centres into product categories. Ideally, a final cost centre will fit entirely within a product category. In practice, this is often not the case and the costs in some final cost centres need to be apportioned across more than one product category (Standards SCP 3.001, GL 4A.002, GL 4B.003, and GL 4C.002). As the focus is on costing patient products it is important to clearly identify the costs associated with non-patient products (Standards SCP 2A.003, SCP 2B.002, SCP 3B.001, and SCP 3C.001). Ideally these costs should be carried in the costing process all the way through to producing final costs for non-patient products. It is suggested that this group of standards be titled **"Allocating Product Category Costs"**.

The fourth step involves, within each product category, allocating the costs in the partitioned final costs centres to end-classes within that category. Ideally for the patient products the end-classes are individual patient services events (i.e. an admitted patient episode, an outpatient service event, or an ED service event, reflecting patient level costing). The allocation processes are complex, and good allocation requires advanced knowledge of hospital operations and well developed systems (Standards SCP 3F.001, COST 3.004, COST 3A.001, COST 3A.002, COST 5.002, COST 6.001, COST 7.001, FDR 2.002). It is suggested that this group of standards be titled **"Allocating End-class Costs"**.

Some standards do not fit neatly into the four step process. Those standards associated with accounting for the relevant capital costs (Standards DEP 1.002, DEP 1A.002, DEP 1B.002, DEP 1C.002, DEP 1D.002 and DEP 1E.002), could comfortably fit within the "Aligning Production and Cost" category, but given different treatment of capital costs in public and private sectors, it is suggested that this group of standards be retained and retitled as **"Allocating Capital Costs"**.

The other standards in the current AHPCS Version 3.1 not identified with a specific step deal with issues relating to the costing process for NHCDC purposes. These issues include the elimination of negative costs (Standard SCP 3D.001), the costing frequency (Standard COST 4.002) and the interpretation of the product costing results (Standard COST 8.001). Also, typically, once the costing process has been completed, the costs reported in all cost centres are mapped to the NHCDC standard line items (Standard GL 2.004), and the cost centres are mapped to the NHCDC standard cost centres (Standard GL 4.004). It is considered that these standards are better categorised as NHCDC business rules, but not to pre-empt the results of this consultation process, it is suggested that they be allocated to a group of standards titled **"Costing Process Rules"**.

If this alternative structure for the AHPCS was adopted, then just using the current Version 3.1 standards (i.e. before any modification) the resultant structure is shown in Table 3.2. As can be seen,

this proposed restructure provides more balance across the standards categories (each category has between five and eight standards). With the exception of the Allocation Capital Costs category, which it is proposed to leave unchanged, the number of first level and subsidiary standards within each category would be determined as part of the re-drafting process.

Table 3.2: Possible revised structure of the AHPCS for Version 4.0

Standard category	Number of first level standards	Number of subsidiary level standards	Total number of standards
Aligning Production and Cost	5	To be determined	5
Allocating Overhead Costs	5	To be determined	5
Allocating Product Category Costs	8	To be determined	8
Allocating End-class Costs	8	To be determined	8
Allocating Capital Costs	1	5	6
Costing process rules	5	To be determined	5
TOTAL	**32**	**5**	**37**

Consultation questions

- Should the AHPCS be restructured to more closely align with the way the costing process is carried out?
- If so, do stakeholders support the alternative structure put forward in this Consultation Paper? Please suggest possible refinements as appropriate.
- If not, are there other structures for the AHPCS that should be considered? Please describe the alternative proposition(s).

4

Refinements to the standards in the AHPCS

This Chapter considers how the existing standards may change, depending on which option is adopted with respect to the purpose of the AHPCS. It then suggests a few areas where new standards might be developed, based on the outcomes of the initial stakeholder consultations.

4.1 REFINEMENT OF EXISTING STANDARDS

Table 4.1 enumerates all 37 standards in Version 3.1 of the AHPCS and makes a suggestion as to how they may change depending on whether the AHPCS remain as a combined document i.e. standards plus some business rules (Option 1), are refocussed as standards with a separate business rules document (Option 2) or are refocussed as business rules and not standards (Option 3).

Table 4.1: Possible changes to the individual standards for AHPCS Version 4.0 depending on Option chosen for the purpose of the standards

Number	Name	Purpose	Standard	Option 1	Option 2	Option 3
SCP 1.004	Hospital Products in Scope	To ensure that all products produced by a hospital are costed in the product costing process.	Hospitals will allocate costs to all hospital products grouped into the categories: • Admitted patient products; • Non-Admitted patient products; • Emergency Department (ED) patient products; • Teaching, Training and Research products; and • Non-Patient products.	Retain and refine to incorporate mental health care type as product.	Retain and refine to incorporate mental health care type as product.	Include in business rules and refine to incorporate mental health care type as product.

Number	Name	Purpose	Standard	Option 1	Option 2	Option 3
SCP 2.003	Product Costs in Scope	To ensure that all costs generated by a hospital in producing patient and non-patient products are identified in the product costing process.	Include, in the product costing process, all costs incurred by, or on behalf of the hospital, that are necessarily incurred in the production of patient and non-patient products, subject to the specific exclusion that the costs of time provided by medical specialists to treat private patients that are not directly met by the hospital, are not to be imputed.	Retain and refine to make clear the intended treatment of the medical costs of private patients for whom MBS benefits are paid, with reference to COST 3A.002.	Retain and refine to make clear the intended treatment of the medical costs of private patients for whom MBS benefits are paid, with reference to COST 3A.002.	Include in business rules and refine to make clear the intended treatment of the medical costs of private patients for whom MBS benefits are paid, with reference to COST 3A.002.
SCP 2A.003	Teaching and Training Costs	To ensure the consistent identification of costs allocated to the 'teaching and training' sub-product category within the 'teaching, training and research' product category.	All costs should be allocated to the 'teaching and training' sub-product where direct teaching and training is clearly the purpose of the cost centre. A portion of the costs of other costs centres should be allocated to the 'teaching and training' sub-product where there is a robust and justifiable method of identifying that part of the costs attributable to direct teaching and training activities.	Retain and revise to reflect the definitions developed as part of IHPA's Teaching, Training and Research development work.	Retain and revise to reflect the definitions developed as part of IHPA's Teaching, Training and Research development work.	Include in business rules and revise to reflect the definitions developed as part of IHPA's Teaching, Training and Research development work.
SCP 2B.002	Research Costs	To ensure the consistent identification of research costs allocated to the research sub-product category within the 'teaching, training and research' product.	All costs should be allocated to the 'research' sub-product where direct research is clearly the purpose of the cost centre. A portion of the costs of other costs centres should be allocated to the 'research' sub-product where there is a robust and justifiable method of identifying that part of the costs attributable to direct research activities.	Retain and revise to reflect the definitions developed as part of IHPA's Teaching, Training and Research development work.	Retain and revise to reflect the definitions developed as part of IHPA's Teaching, Training and Research development work.	Include in business rules and revise to reflect the definitions developed as part of IHPA's Teaching, Training and Research development work.
SCP 3.001	Matching Production and Cost	To ensure alignment between the production quantities measured in each product category and the costs attributed to that product category in the fiscal (costing) period.	For the purposes of product costing, the costs taken from the general ledger and other sources will be manipulated so as to achieve the best match of production to cost measures at the levels of the whole hospital, each product category, each cost centre within a product category, and each end-class within a product category.	Retain if standards are not restructured, otherwise delete in favour of matching standards at each step in costing process.	Retain if standards are not restructured, otherwise delete in favour of matching standards at each step in costing process.	Delete in favour of clear business rules at each step in costing process.

Number	Name	Purpose	Standard	Option 1	Option 2	Option 3
SCP 3A.001	Matching Production and Cost – Overhead Cost Allocation	To ensure that all costs accumulated in overhead costs centres are allocated to the final cost centres before any partitioning of costs into product categories is attempted, ensuring each product category (patient and non-patient) attracts its fair share of overheads.	All costs accumulated in overhead costs centres should be allocated to final cost centres before any partitioning of costs into product categories is undertaken.	Retain, perhaps with minor modification.	Retain, perhaps with minor modification.	Include in business rules, perhaps with minor modification.
SCP 3B.001	Matching Production and Cost – Costing all products	To ensure that all hospital costs are allocated across the full range of products produced by a hospital, thereby allowing reconciliation of costing results to hospital accounts.	All costs should be accounted for in the costing process and allocated, as appropriate, across all patient and non-patient products generated by the hospital in the costing (fiscal) period.	Retain, perhaps with minor modification.	Retain, perhaps with minor modification.	Include in business rules, perhaps with minor modification.
SCP 3C.001	Matching Production and Cost – Commercial Business Entities	To ensure that all hospital costs are allocated across the full range of products produced by a hospital, thereby allowing reconciliation of costing results to hospital accounts.	Commercial business entities should be treated as non-patient products for the purposes of product costing.	Retain, perhaps with minor modification.	Retain, perhaps with minor modification.	Include in business rules, perhaps with minor modification.
SCP 3D.001	Matching Production and Cost – Negative Costs	To ensure that there are no negative costs in the outputs of the product costing process at the end-class level within a product category (e.g. at the patient level for admitted patients).	Hospitals will make adjustments within the costing process to ensure that costing outputs do not contain negative costs at the end-class level in any product category.	Retain, perhaps with minor modification.	Delete and include in business rules.	Include in business rule, perhaps with minor modification.
SCP 3E.001	Matching Production and Cost – Offsets and Recoveries	To ensure that offsets and recoveries are treated consistently for the purposes of product costing.	Hospitals will not offset revenue against costs but cost recoveries may be offset against cost where appropriate.	Retain and improve with further examples.	Retain and improve with further examples.	Include in business rules and improve with further examples.
SCP 3F.001	Matching Production and Cost – Order Request Point	To identify the order request point so as to allow intermediate products/services to be costed to the correct patient service event.	All hospitals will ensure that intermediate products/services ordered as part of patient service events are allocated to one of the following product categories: • Admitted Care; • Non-Admitted Care; • ED Care.	Retain, but consolidate with COST 6.001 and improve wording and include examples to make intent clear.	Retain, but consolidate with COST 6.001 and improve wording and include examples to make intent clear.	Include in business rules, but consolidate with COST 6.001 and improve wording and include examples to make intent clear.
SCP 3G.001	Matching Production and Cost – Reconciliation to Source Data	To ensure that there is a transparent reconciliation of the activity and costs data generated through the product costing process to the activity and costs that were captured in the source data.	Hospitals will produce a statement that reconciles the activity and cost data outputs of the product costing process to the activity and costs that were captured in the source data.	Retain, perhaps with minor modifications.	Delete standard but retain the principle and incorporate in SCP 2.003.	Include in business rules, and require the reconciliation statement to be provided.

Number	Name	Purpose	Standard	Option 1	Option 2	Option 3
GL 1.003	Accrual Accounting	To ensure that the costs of human and material resources consumed in the production of hospital products, is matched to the fiscal period in which those products are produced.	Data used in the product costing process will be drawn from the general ledger and other financial systems that apply accrual accounting principles (in accordance with Australian Accounting Standards).	Retain.	Retain.	Include in business rules.
GL 2.004	Account Code Mapping to Line Items	To ensure that hospitals use a standard set of line items in the product costing process thereby improving the consistency and comparability of the resultant costs data.	Hospitals will map all in-scope costs to the standard list of line items.	Retain.	Delete, and include in business rules.	Include in business rules.
GL 4.004	Cost Centre Mapping	To ensure that hospitals use a standard set of cost centres in the product costing process thereby improving the consistency and comparability of the resultant costs data.	For product costing purposes, all in-scope cost centres should be mapped to the standard list of cost centres at the most detailed level possible.	Retain.	Delete, and include in business rules.	Include in business rules.
GL 4A.002	Critical Care Definition	To ensure that there is a consistent definition of the boundary between Critical Care Units and General wards.	For product costing purposes the following units will be included in critical care: Intensive Care, Coronary Care, Cardiothoracic Intensive Care, Psychiatric Intensive Care, Paediatric Intensive and Neonatal Intensive Care. High dependency, special care nurseries and other close observation units either located within general wards or stand alone will be costed as general wards.	Retain.	Delete, and include in business rules.	Include in business rules.
GL 4B.003	Emergency Department Definition	To ensure that there is a consistent definition of the boundary between ED care and General wards.	The ED does not include any associated or attached short stay admitted units.	Retain, with improved wording to make intent clear.	Delete, and include in business rules.	Include in business rules.
GL 4C.002	Operating Room and Specialised Procedure Suite (SPS) Definition	To ensure that there is a consistent definition of the boundary between operating rooms and specialised procedure suites.	Operating rooms should be separated from SPSs for the purposes of product costing.	Retain, but consider further subdivision of SPS based on materiality of cost.	Delete, and include in business rules, perhaps with further subdivision of SPSs.	Include in business rules, perhaps with further subdivision of SPSs.
COST 1.002	Overhead Allocation Method	To ensure that the product costing processes recognises that both overhead and final cost centres consume the outputs of overhead cost centres.	All hospital overheads will be allocated using an algorithm that reflects the fact that both overhead and final costs centres consume the outputs of overhead cost centres.	Delete.	Delete and include as a business rule.	Include in business rules.

Number	Name	Purpose	Standard	Option 1	Option 2	Option 3
COST 1A.002	Overhead Allocation – Hotel Services	To ensure that hotel services costs remain visible after allocation to the relevant target departments (final cost centres).	All hotel service costs (salaries and wages, and goods and services) will be allocated to the line item "Hotel" at the final cost level.	Retain.	Delete and include as a business rule.	Include in business rules.
COST 1B.002	Overhead Allocation - Overhead Depreciation Costs	To ensure that depreciation costs remain visible after allocation to the relevant target departments (final cost centres).	All depreciation overhead costs will be allocated to the line item called depreciation at the final cost centre level.	Retain.	Delete and include as a business rule.	Include in business rules.
COST 2.004	Overhead Allocation Statistics	To ensure that hospitals use the most appropriate statistic to allocate overhead costs, thereby improving the quality and comparability of the product costing results.	All hospital overhead costs will be allocated using one of an alternative order of allocation statistic.	Retain.	Retain, but emphasise the use of the best possible allocation statistic rather than the NHCDC order.	Include in business rules.
COST 3.004	Final Cost Allocation to patients and other products	To ensure the most appropriate method is used to allocate final cost centre expenses to patients and other products, thereby improving the quality and comparability of the product costing results.	All final costs will be allocated to patients and other products using methods prescribed in this standard.	Retain, revise to reflect results of evaluation of alternative cost allocation methods and consolidate with FDR 2.002.	Retain, revise to reflect results of evaluation of alternative cost allocation methods and consolidate with FDR 2.002.	Include in business rules, revise to reflect results of evaluation of alternative cost allocation methods and consolidate with FDR 2.002.
COST 3A.001	Allocating Clinical Salary and Wages to patients and other products	To ensure clinical salary and wage expenses held in departmental cost centres are distributed to the relevant product categories and final cost centres, before allocating them to patients in each product category.	Clinical salary and wage expenses held in departmental cost centres should be allocated to product categories of admitted and non-admitted patients including Critical Care, Emergency, Operating Rooms and SPSs and any Consultation liaisons, before being allocated to the patients in those product categories.	Retain, but improve wording, particularly to clarify treatment of respect of Consultation Liaison service.	Retain, but improve wording, particularly to clarify treatment of respect of Consultation Liaison service.	Include in business rules and improve wording, particularly to clarify treatment of respect of Consultation Liaison service.
COST 3A.002	Allocation of Medical Costs for Private and Public Patients	To ensure that all patients regardless of funding source receive the correct proportion of costs and that the patient costs are not adjusted or offset with any revenue streams received for that patient. Any costs that are paid for outside of the Hospitals operational accounts such as business units and special purpose accounts must be allocated to the patient.	All costs that relate to patients are allocated based on consumption regardless which cost centres contain the medical salaries expenses.	Retain but redraft to address stakeholder concerns and improve alignment with SCP 2.003.	Retain but redraft to address stakeholder concerns and improve alignment with SCP 2.003.	Include as a business rule but redraft to address stakeholder concerns and improve alignment with SCP 2.003.

Number	Name	Purpose	Standard	Option 1	Option 2	Option 3
COST 4.002	Costing Frequency	To encourage hospitals to conduct activity based costing at regular intervals so as to improve the quality of product costing data, and hence its usefulness to hospital clinicians and managers.	Hospitals should undertake regular product costing, review the results for reasonableness, and use them to refine the costing methods applied for subsequent costing periods.	Retain with minor amendment.	Delete and include as a business rule.	Include in business rules.
COST 5.002	Treatment of Work In Progress Costs	To ensure that all patient costs are allocated to the patient in the reporting period in which the service is delivered, regardless of whether the episode has been completed and that all costs for the reporting period are reconciled against the hospital total costs.	Each patient is allocated their proportion of costs in the reporting period regardless of whether the service event is completed or commenced and that the cost and activity is reported in each period.	Retain, refine wording and include examples to make intent clear.	Retain, refine wording and include examples to make intent clear.	Include in business rules and refine wording and include examples to make intent clear.
COST 6.001	Intermediate Product/Service Matching Method	To ensure that the cost of all intermediate products/services prescribed or ordered during an admitted patient, ED or non-admitted patient service event are captured and attributed to that service event.	Intermediate products/services will be costed to the patient service event in which they are ordered or prescribed. Where there are multiple possibilities for cost attribution, the point of referral or an explicit preference order encounter matching method must be used.	Retain but consolidate with SCP 3F.001 and improve wording and include examples to make intent clear.	Retain but consolidate with SCP 3F.001 and improve wording and include examples to make intent clear.	Include in business rules, but consolidate with SCP 3F.001 and improve wording and include examples to make intent clear.
COST 7.001	Interpretation of Product Costs Data	To facilitate the analysis of interpretation of data generated by the product costing process by suggesting the level of granularity of the data produced for each end-class within a product category.	Hospitals should generate product costs data for each end-class within each product category that identifies the contribution to the costs made by each line item within each final cost centre.	Retain.	Delete and include as a business rule.	Include in business rules.

Number	Name	Purpose	Standard	Option 1	Option 2	Option 3
DEP 1.002	Capital Expenditure	To ensure that all assets used in the production of hospital products are reflected accurately in the Fixed Asset Register and included in product costing.	Hospital product costing should include costs in relation to: • All purchased and leased assets used in producing hospital products including improvements to those assets; and • All donated assets (regardless of whether the assets are purchased with donated funds, donated physical assets or funds granted by the Commonwealth) used in producing hospital products including improvements to those assets. Hospital patient product costing must exclude costs in relation to: • Buildings surplus to requirements for operating a hospital; • Buildings exclusively used for teaching, training, and research purposes (included in the costs of the TTR product); • Buildings used exclusively for producing non-patient products (included in the costs of non-patient products); and • Intangible assets with infinite useful lives. Hospital patient product costing must include: • lease costs • depreciation and amortisation (based on actual cost for purchased assets and fair value for donated assets); • any loss or profit on the sale of assets; • any revaluation increments or decrements that are recognised in the profit and loss; and • any actual interest expense associated with financing asset purchases.	Retain.	Retain.	Include in business rules.

Number	Name	Purpose	Standard	Option 1	Option 2	Option 3
DEP 1A.002	Asset Recognition	To improve the consistency of asset recognition policies across all States and Territories to ensure comparability of product costing data.	The asset acquisition or improvement recognition threshold for all hospital property, plant and equipment should be no greater than $10,000.	Retain.	Delete and include as business rule.	Include in business rules.
DEP 1B.002	Revaluations of Assets	To ensure that all assets requiring revaluation are on the same valuation cycle to ensure comparability amongst States/Territories.	All assets subject to the revaluation method of accounting for property, plant and equipment should be independently valued at 30th June 2012 and then at least every three years following this date. Revaluation increments and decrements that are recognised in the profit and loss should be allocated to products using the same allocation methods as for depreciation and amortisation.	Retain.	Delete and include as business rule.	Include in business rules.
DEP 1C.002	Useful Life	To ensure that all assets used in the production of hospital products are consistently reflected in the Fixed Asset Register.	All hospitals will assign useful lives to assets based on the minimum useful lives provided in this standard.	Retain.	Delete and include as business rule.	Include in business rules.
DEP 1D.002	Classes of Assets	To provide for assets to be grouped into classes that will assist with the allocation of capital expenditure-related costs to final cost centres.	For the purposes of cost attribution, assets will be categorised into the following classes: • Medical equipment; • Plant and non-medical equipment; • Buildings and improvements; • Intangibles.	Retain.	Delete and include as business rule.	Include in business rules.

Number	Name	Purpose	Standard	Option 1	Option 2	Option 3
DEP 1E.002	Allocation of depreciation and amortisation	To set out a consistent method for allocating capital costs, thereby improving the quality and consistency of product costing results.	The allocation methods for capital costs will apply the same allocation principles established by the other costing standards for the allocation of direct and overhead costs. In that context, the allocation of capital costs to end-classes in each product category should occur in three-stages: 1. Allocation of capital costs held in central cost centres to final or overhead cost centres (based on an appropriate allocation statistic). 2. Allocation of capital costs in overhead cost centres to final cost centres (using the same allocation statistic for capital costs as for other costs in the overhead cost centre). Allocation of capital costs in final cost centres to end-classes in each product category (using an appropriate allocation statistic for direct capital costs and for overhead capital costs, the same allocation statistic as for other overhead costs in that cost centre).	Retain.	Delete and include as business rule.	
FDR 2.002	Relative Value Units	Where direct cost allocation is not possible, intermediate product/services costs should be allocated using validated Relative Value Units (RVUs).	Costs of intermediate products/services should be assigned using an RVU scale that reflects their relative costs of production.	Retain, but consolidate with COST 3.004.	Retain, but consolidate with COST 3.004.	Include in business rules, but consolidate with COST 3.004.
REP 1.002	Reporting of Patient Costs	Hospitals will report costed episodes at a level of granularity that allows aggregation into different meaningful categories for benchmarking and informing price-setting.	Hospitals will report the total cost of episodes that are completed within the reporting period by line item, cost centre and order request point.	Retain.	Delete and include as business rule.	Include in business rules.

Stakeholders should be aware that the suggestions made for refinements/changes to each of the existing 37 standards in the AHPCS are only preliminary views that are intended to start discussion about what is required in Version 4.0. The suggestions take account of feedback obtained from initial key stakeholder consultations, but they do not represent an IHPA and/or project governance group endorsed position. It is intended that the results of the wider consultation process through release of this public Consultation Paper and targeted discussions with key stakeholders in each jurisdiction will allow further development and refinement of these initial ideas.

Consultation questions

- Are the suggested changes to each of the existing standards in the AHPCS appropriate? If not, please indicate those standards where you would like to see a different course of action taken?
- Please suggest any other changes to the existing standards that you believe would result in improvement.

4.2 DEVELOPMENT OF NEW STANDARDS

As a result of the initial meetings with key stakeholders, there were a few areas where suggestions were made to develop new standards.

4.2.1 Patient and non-patient product revenue

Some stakeholders believed that the AHPCS, and indeed the NHCDC, would be improved by adding a standard around the measurement and reporting of revenue at the level of each end-class in each product category. For patient products this standard would likely require that the revenue received by the hospital for the patient service would be recorded (in a consistent way) and subsequently reported to the NHCDC. It is argued that such reporting would clarify the issues associated with the distinction between offsets, recoveries and revenue, hence resulting in less distortion and greater comparability of the costs in the NHCDC. It is also noted that the Clinical Costing Standards published by the Healthcare Financial Management Association in the UK include a standard on the "Treatment of income".

Reporting of revenue for patient level products would allow direct comparisons to be made between revenue received and costs. There are clearly commercial issues to be considered in introducing such a standard and related reporting requirement. In particular, there may be issues for the private sector, although the Hospital Casemix Protocol already requires patient charges to be reported to the Commonwealth Department of Health.

Similarly, for non-patient products that are costed (because at least part of the cost is met through the hospital's operating account), the associated revenue could be reported. Again there are commercial considerations, particularly with respect to the operation of commercial business entities by public and private hospitals.

Consultation questions

- Should there be a standard on the recording of revenue in the AHPCS? If so, should it be for patient products, non-patient products or both?
- If a standard is developed, should there be a related NHCDC business rule that requires the reporting of revenue for each end-class in each product category?

4.2.2 Source of funds

A particular issue raised by public sector stakeholders in the initial consultations was the reporting of the source of funds for components of the costs of a patient service. It is possible to contemplate drafting a standard on the source of funds that would indicate where a service is provided as a result of special purpose funding that is not included in ABF allocations. Particular areas of difficulty occur where there is direct Commonwealth and/or Commonwealth/State funding of services, for example, waiting list reduction programs, blood products, Section 100 and Pharmaceutical Benefits Scheme (PBS) drugs. Logically, if there was such a standard the source of funds would be reported to the NHCDC, again to allow more precise analyses of those costs incurred as part of providing a service that are in and out of scope of ABF.

Consultation questions

- Should there be a standard on recording the source of funds for patient products in the AHPCS?
- If a standard is developed, should there be a related NHCDC business rule that requires the reporting of the source of funds for each end-class in the patient product categories?

4.2.3 Developing costing standards for cost modelled sites

Some stakeholders, while acknowledging that the AHPCS, as the name implies, are written to represent best practice in patient level costing, indicated that for many hospitals the standards are simply unattainable. Those hospitals carry out what is usually termed cost modelling, where costs are modelled for all patients in the same end-class in the classification system (e.g. the same AR-DRG for admitted patients) rather than at the level of individual patients. It was considered that it would be useful to have standards which could be applied by those hospitals that must undertake cost modelling at the level of groups of patients (because they do not have the resources to justify the investment required to undertake patient level costing). It was argued that the existence of such standards would improve the quality of cost data generated by cost modelled sites.

Consultation questions

- Should there be a set of standards that are specific to cost modelled sites (i.e. hospitals that must cost groups of patient service events, rather than individual patient service events)? If so, would the benefits associated with creating such standards outweigh the costs?

4.2.4 Other areas where stakeholders consider new standards should be developed

Stakeholders may consider that there are other areas for which new standards should be developed. Issues that are sometimes raised in discussion include the possibility of developing a standard relating to classifying costs into fixed and variable, or a standard that sets out best practice processes that should be used to audit costing data. This Consultation Paper invites stakeholders to propose areas where new standards may be beneficially developed, as part of the production of Version 4.0 of the AHPCS.

Consultation questions

- Are there areas where new standards should be developed as part of producing Version 4.0 of the AHPCS? If so, please indicate what they are and provide a brief statement of the purpose of having a standard in that area.

5

Need for supplementary educational materials

This Chapter explores options for the development of supplementary educational materials that may assist with the interpretation and use of the AHPCS at the hospital level.

5.1 CURRENT GUIDELINES IN THE AHPCS

In the AHPCS Version 3.1, as part of presenting every standard, there is a section that sets out guidelines. On closer examination, some of the guidelines provided are very detailed and supported by material in the Attachments to the Standards (e.g. GL 2.004 and GL 4.004) whereas, for other standards, the guidelines are fairly brief. Recalling that the principal purpose for setting a Standard is to set out 'what to do' rather than "how to do", this level of supporting material may be appropriate.

Through initial consultations, some stakeholders expressed the view that the Guidelines could make the intent of the Standard clearer by including examples of application of its application. It is considered that such examples could be included within the current framework for presenting the AHPCS. Care would need to be taken so that the AHPCS does not evolve into an even longer, more complex document than Version 3.1. Additional complexity and/or length are likely to create barriers to usage.

Consultation questions

- Do stakeholders believe the current content of the guidelines section provided for each Standard is valuable?
- If not, should the guidelines section be refined to include examples of the application of each standard?
- Please make any other suggestions for developing material that would clarify the intent of each Standard.

5.2 UPDATING THE NHCDC HOSPITAL REFERENCE MANUAL

The last version of the NHCDC Hospital Reference Manual was published in September 2007 for Round 11 (2006/07 data) of the Collection (stakeholders can request this document by email to NHCDC@ihpa.gov.au). The Reference Manual principally outlined the methodology for submitting hospital cost data to the then Department of Health and Ageing. It was designed to be used by hospital personnel involved in the costing process, as well as by Department, and State and Territory Health Authority personnel, and other stakeholders. The Reference Manual states that it does not assume that the audience necessarily has an in-depth knowledge of either hospital costing or accounting issues.

The content of the Reference Manual included:

- background information on the NHCDC including its aim, use of the collected data and contact personnel (i.e. coordinators) in each State/Territory and by sector;
- descriptions of patient costed and cost modelled sites, service weights and AR-DRG version 5.1;
- information on the types of files and software provided by the Department (e.g. NHCDC Combo data submission template, The Microsoft Excel Quality Assurance template, etc.);

- an overview of the types of reporting and presentation of the results, as well as a description of the AR-DRG numbering system;
- description of NHCDC data types (e.g. patient care type, patient type, NHCDC patient category, NHCDC data classification – admitted and non-admitted);
- description of NHCDC volume counts by product (e.g. separations for acute admitted, bed days for rehabilitation, presentations for ED, service events for non-admitted etc.);
- description of NHCDC costs and accounting requirements which included definitions for direct and overhead costs, corporate and capital related costs, reporting of depreciation and notional or imputed costs, accrual accounting and expenditure offsets etc.);
- description of the NHCDC cost buckets;
- description of different types of service weights (e.g. nursing, ward medical, medical and surgical supplies, pharmacy, operating theatre etc.) and the difference between conditional and unconditional service weights;
- the cost calculation process using a cost modelled methodology;
- the cost calculation process using a patient costed methodology; and
- the quality assurance process including the role of the hospital, state and territory health departments and the department of health in the quality assurance process.

The Reference Manual is quite a long document (137 pages), it mixes reference material (generally definitions taken from METeOR and/or developed specifically for the NHCDC) with methodological advice on how to cost (emphasises the use of PC Combo and the reporting templates, which was the software provided to participating hospitals by the then Department of Health and Ageing) with specifications for how the data were to be provided to the NHCDC for Round 11. As such the Reference Manual has some parts that could form part of a Costing Manual/Training Guide (as discussed in Chapter 2) but much of its current content would more logically fit with an NHCDC Business Rules document.

The most recent version of the Reference Manual is now seven years old, and there have since been numerous changes to the environment (principal amongst which are the move of the NHCDC's governance to IHPA, and a much greater proportion of hospitals using patient level costing). The changes are so significant that much of the content of the current Reference Manual would no longer be relevant. Nonetheless, it is possible to contemplate developing a current version of the Reference Manual, but a decision would need to be taken, as to whether the document was written as an education and training resource (i.e. the Costing Manual/Training Guide referred to in Chapter 2) or as an NHCDC Business Rules document (also referred to in Chapter 3). It is not likely that the same document could effectively serve both purposes.

Through the initial consultations with key stakeholders, we found mixed views on the value of the Reference Manual. As indicated in Chapter 2, there is some support for the development of a Costing Manual/Training Guide. It was emphasised that such a Training Guide would be independent of the NHCDC and be suitable for use as part of a generic training program in patient level costing. There was not much support for a Reference Manual that set out details relating to NHCDC data. It was noted that many States/Territories now have their own requirements as to how patient level costing should be done, and a national document in this regard would not be helpful. Rather, it was sufficient for IHPA to issue a Data Request Specification (DRS) for the NHCDC as per the usual process, and State/Territory Health Authorities would comply.

This discussion is offered to facilitate the process of the broad base of stakeholders forming a view on the need to update the NHCDC Reference Manual. It takes account of the feedback obtained from the initial process of key stakeholder consultation, but the views put forward do not represent an IHPA and/or project governance group endorsed position. It is intended that the results of the wider

consultation process through release of this public Consultation Paper and targeted discussions with key stakeholders in each jurisdiction will allow the determination of an approach that best meets stakeholder needs for the AHPCS Version 4.0.

Consultation questions

- Should the NHCDC Hospital Reference Manual be updated to current practice?
- If so, should it focus on documenting the NHCDC business rules or should it be developed as a generic education and training resource in patient level costing?
- Are there other approaches for revising and updating the NHCDC Reference Manual that would generate value for stakeholders? If so please describe briefly.

5.3 OTHER OPTIONS FOR THE DEVELOPMENT OF SUPPLEMENTARY EDUCATIONAL MATERIALS

Stakeholders may consider that there are other types of educational supplementary materials that should be developed. Besides the options proposed above, stakeholders are invited to suggest any other supplementary educational materials that they feel may assist with the interpretation and use of the AHPCS at the hospital level.

Consultation questions

- What other supplementary educational materials, if any, should be developed to support the implementation and use of the AHPCS?

6

Stakeholder engagement strategy

HealthConsult recognises that effective stakeholder engagement will be a critical success factor for the NHCDC development project. This Chapter sets out **an integrated stakeholder engagement strategy for Stages A1/2 and Stage B of the study, as they are being conducted in parallel**, which reflects three overarching aims:

- to create multiple opportunities for stakeholders to provide input into the study and ensure that their concerns are understood and that their views are respected and properly considered;
- to partner with stakeholders in the execution of the study to ensure that the results are fit for purpose and to build support for the study outcomes; and
- to build stakeholders' knowledge and understanding of the purposes of, and the processes associated with, the NHCDC.

With these aims in mind, we have designed a stakeholder engagement strategy that is built on a partnership approach. Our liaison with stakeholders will be transparent and collaborative. The proposed strategy recognises the value of stakeholder input and expertise and seeks to work collaboratively with stakeholders, including those at the participating study sites to achieve outcomes that are beneficial to all parties. It recognises that the successful completion of the study will be the result of developing effective relationships with all stakeholders.

At the project initiation meeting, the communication protocols to facilitate the smooth progression of tasks and to clarify roles and responsibilities of respective parties were agreed with the IHPA Project Management Team. It is agreed that communications will reflect a culture of collegiality, openness and flexibility. And, the following stakeholder engagement strategies will be applied:

- **Open and targeted stakeholder consultation processes (written):** across the various Stages of the work, we will use a mixture of open and targeted written consultation processes supported by discussion papers and/or deliverables in draft form. These processes will enable us to receive stakeholder input and advice on the suitability of the approach we propose to take, as well as the fitness for purpose of the draft deliverables we produce. We will take advice from the IHPA Project Manager and the project governance Committees/Groups on the best approach to use for each aspect of the project. We envisage:
  - **Stage A2 (Feb/Mar, 2015)**, a targeted consultation process that invites stakeholder feedback on a Discussion Paper that sets out the methodology for evaluating the merit of various allocation methods that could be used in the final cost allocation process;
  - **Stage B (Feb/Mar, 2015)**, an open consultation process (using the IHPA website) that invites key stakeholder feedback on a Consultation Paper (this document) that sets out options for the purpose and structure of the Version 4.0 AHPCS, suggestions for key areas of refinement, and options for the development of educational supplementary materials, including the possible revision and update of the NHCDC Reference Manual; and
  - **Stage B (May/Jun, 2015)**, an open consultation process (using the IHPA website) that invites key stakeholder feedback on the draft of the Version 4.0 AHPCS and the associated educational supplementary materials.
- **Targeted stakeholder consultation processes (in-person, either face-to-face or by telephone):** again, across the various Stages, we will use a mixture of interviews and focus groups with key

stakeholders to receive input and advice on their issues and concerns, the suitability of the approach we propose to take to deal with the issues, and the fitness for purpose of the draft deliverables we produce. The consultations will target key stakeholders in jurisdictional health authorities as well as costing practitioners working in public and private hospitals and LHNs (or equivalent), and other interested groups (e.g. clinicians, academics, costing product suppliers). We envisage that the key stages at which we will run these consultations will be:

- **Stage A2 and B combined (Dec, 2014)**, a targeted consultation process involving initial discussions by telephone with key IHPA staff, key state/territory health authority costing staff, and representatives of the private sector to discuss the issues the project is designed to address, to receive advice on the costing approaches to be tested, to identify opportunities to further improve the structure and content of the AHPCS (including supplementary educational materials) and to consider options for selecting and recruiting study hospitals for Stage A2 (this process has been completed);
- **Stage A2 and B combined (Feb, 2015)**, a targeted consultation process involving a visit to each state/territory for face-to-face interviews and focus groups to receive feedback on our methodology (as set out in the two Consultation Papers) of the merit of the various allocation statistics that could be used in the costing process; and the options for the structure of the Version 4.0 AHPCS, suggestions for key areas of refinement, and stakeholders needs for the development of educational supplementary materials including the possibility of revision and update of the NHCDC Reference Manual;
- **Stage A2 (Mar, 2015)**, a program of site visits to the participating study hospitals to work through the detailed costing process at each site, both in terms of the costing they have performed for 2013/14 and to decide the best approach to the re-costing (i.e. by transfer of the detailed input data to HealthConsult to do the re-costing, or by hospital staff applying the agreed allocation methods to produce re-costed data locally for transfer to HealthConsult in NHCDC format); and
- **Stage B (May/Jun, 2015)**, a targeted consultation process involving attendance at, and presentations to, meetings of the key IHPA governance committees (determined through consultation with the IHPA Project Manager and NACDSG) to receive feedback on the draft of the Version 4.0 AHPCS and associated educational supplementary materials.

These stakeholder engagement strategies will be supplemented by a range of interactions as part of the project management and governance processes (not reflected above), which will provide another important opportunity for stakeholder input. Importantly, as well as executing this strategy, HealthConsult will also respond to issues that may arise, and formulate and execute new engagement strategies, as needed.

Consultation questions

- Is the proposed stakeholder engagement strategy suitable for the purposes of the study?
- Are there other processes that could or should be considered to facilitate stakeholder engagement throughout the study?

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Next Steps

This Consultation Paper reflects a summary of the work in progress on the development of Version 4.0 of the AHPCS. HealthConsult and IHPA are aware that there are a number of important areas of the work that need to be developed in more detail. In particular, a drafting framework for Version 4.0 of the AHPCS will be developed that takes account of the results of this stakeholder consultation process.

The release of this Consultation Paper provides stakeholders with the opportunity to comment on the ideas and options that have been put forward, so that those comments may inform the development of the drafting framework. Importantly, it also allows stakeholders to raise issues for consideration by HealthConsult and IHPA that have not been covered in this paper, which may need to be addressed in developing Version 4.0 of the AHPCS and the associated supplementary educational materials.

Consultation questions

- Are there other issues that should be considered in developing Version 4.0 of the AHPCS and the associated supplementary educational materials?