TASMANIA – NEW ISSUES 2017 UPDATE – IHPA DATA

Thank you for the opportunity to comment on your proposed treatment of IHPA data for the 2017 Update and future years.

Recommendation 1

Tasmania supports the proposed use of the 2015-16 IHPA data in the 2017 Update given:

- the outcome of the preliminary versus final analysis of the 2014-15 IHPA data, like that for the 2013-14 data, did not reveal material differences between the two; and
- the January data release (previously considered preliminary) is now effectively the final release, given announced changes in the underlying data collections which have previously fed into this data.

Recommendation 2

Tasmania does not consider the proposed use of the number of PHE ED occasions in 2013-14 to estimate the number of ED occasions for hospitals not covered by the EDNMDS is the best available option, notwithstanding that it is superior to the CGC considered alternative of ignoring the missing data and only using the already submitted 2015-16 data. Tasmania recommends, as the first best alternative option, that the Commission require jurisdictions to provide the 2014-15 and 2015-16 missing data thorough a special data request. Jurisdictions should not find this request difficult as the state and territory systems that previously used to collect this data for national reporting would still be operational and this data should be readily available. The IHPA could be asked to review this data to ensure it is comprehensive and does not result in any double counting.

The underlying driver of this issue is that some hospital emergency care data that was previously mandated for national reporting (2013-14 and earlier) is no longer mandated for national collection (2014-15 and onwards). Consequently, hospital emergency care data for some smaller hospitals is not being nationally collected. As acknowledged in the paper, although the proportion of ED data impacted is small, it is not uniformly distributed across remoteness areas, such that ignoring this data results in disproportionate material negative impacts on smaller jurisdictions with greater concentrations of regional and remote populations, notably the Northern Territory and Tasmania.

However, the recommended alternative of using the 2013-14 (complete) data set as a proxy for later years, while preferred to simply omitting the emergency care data for these smaller hospitals, risks incompatibilities with more recent data leading to problems such as double counting activity, continuing to count activity for closed hospitals and not capturing activity for new hospitals.

Recommendation 3

Consistent with our comments above, Tasmania does not consider that the ongoing use of the 2013-14 data until either the next methodology review or until the IHPA advises that the EDNMDS data capture is sufficiently comprehensive is the first best approach and reiterates our previous recommendation that the Commission seek the required data through a special data request. We also note that the National Health Information Standards and Statistics Committee is commencing a review of the national emergency care data collections in late 2016 and the loss of this data will be covered in this review, leading perhaps to other alternative solutions in the immediate to longer term.

Finally, in closing, we note several inaccuracies in data attributions in the paper. Specifically, emergency department data is sourced from the Non-admitted patient emergency department care national minimum data set (NAPEDC NMDS), incorrectly referred to as the EDNMDS in the paper. Emergency service data is sourced from the Activity based funding: emergency service care national best endeavours data set (ABF ESC NBEDS), also incorrectly referred to as the EDNMDS in the CGC paper.

regards
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