3 Evaluation of utility

This chapter sets out the results from the consultations with data collectors and users by means of a survey. Information is presented on the users and uses of the NMDS, the importance and usefulness of the NMDS and individual data elements, and possible areas for data development. Comments provided by respondents on individual data elements are included in Chapter 5 of this report.

Respondents

A copy of the survey is at Appendix 2 and the 17 people who responded to the survey are listed. One respondent answered the first two questions only and supplied comments (not rankings) on data elements. For the remaining 16 responses, a few did not answer all questions and so the responses may not always total 16.

Respondents were asked to indicate whether they were responding as individuals or on behalf of their unit or section within an organisation or the organisation as a whole. The responses received were:

- 15 on behalf of a unit within an organisation
- 4 as individuals
- 3 on behalf of an organisation.

Some respondents nominated more than one category.

Respondents were asked to indicate from a list of 15 user groups the main group to which they belonged (or identify additional user groups). A list of the user groups is presented in Question 1.1 of the survey (Appendix 2). The main user groups identified (Table 3.1) were the state and territory health authorities which collect and provide the NMDS data for national collation. All authorities responded to the survey providing comments from both a data collector and data provider perspective. There were responses from two areas of the health authority for some states and territories.

Some Australian Government departments and agencies responded, as did a university lecturer. Two units within the AIHW (the Hospitals and Mental Health Services Unit and the National Data Development and Standards Unit) also provided responses.

Uses of the NMDS specifications and NMDS-based data

The survey sought information on the NMDS specifications and NMDS-based data being used, specifically:

- why they use the NMDS specifications or NMDS-based data
- how they access the specifications and the data
- their familiarity with the specifications and the data
- their frequency of use.

Purpose

Respondents were asked to indicate the three most common purposes for which they use the NMDS specifications and/or NMDS-based data – see Question 2.1 of the survey (Appendix 2). The three most common purposes were (Table 3.1):

- collection and reporting of NMDS-based data
- statistical reporting
- comparisons and benchmarking.

Other uses for the NMDS specifications and NMDS-based data included:

- policy advice
- planning and monitoring hospital resources
- management and purchasing of hospital services
- health services research
- health education and training
- facility planning.

Level of use

The data are used at more than one level, in particular at both state/territory and national level. Some respondents also used the data at hospital or group level. From the 16 surveys there were 31 indications of use, with by far the most common uses being at state or territory and national level.

Access to NMDS specifications

The most common source used to obtain access to the NMDS specifications was state/territory data specifications, closely followed by the *National health data dictionary,* the *National health data dictionary* online and the Knowledgebase (the predecessor to METeOR). Some users obtained access through hospital-based specifications or AIHW annual data reporting specifications.

Table 3.1: Purposes for which the NMDS specifications and NMDS-based data are being used, by user group

User group	Compare/ benchmark	Collect/ report NMDS-based data	Manage/ purchase hospital services	Statistical reporting	Policy advice	Plan/ monitor hospital resources	Health services research	Facility planning	Other
State or territory health authority (10 responses)	✓	✓	✓	✓	✓	✓	✓	✓	✓[(a)]
Australian Government Department of Health and Ageing	✓		✓			✓			
Other Australian Government department or agency (3)	✓	✓	✓	✓	✓		✓		
Australian Institute of Health and Welfare (1)	✓	✓		✓					
University or other research organisation (1)	✓	✓	✓		✓	✓	✓	✓	✓[(b)]

(a) To check costings. (b) Education and training

Source of NMDS-based data

The *Australian hospital statistics* publication (and internet tables) was the most common source of NMDS-based data identified by respondents. The second most common was state or territory hospital databases. These two sources accounted for more than 50% of use. Other sources included:

- state and territory data as supplied under the Australian Health Care Agreements (AHCA)
- Department of Health and Ageing *State of our public hospitals* publications
- state or territory publications
- the AIHW's National Public Hospital Establishments Database (both external and internal users)
- other AIHW publications.

Knowledge and frequency of use

All respondents were familiar or very familiar with the NMDS specifications and/or the NMDS-based data.

NMDS specifications were used:

- occasionally (seven respondents)
- fortnightly or monthly (two respondents)
- weekly (five respondents)
- daily (two respondents).

The NMDS-based data were used:

- occasionally (five respondents)
- weekly (eight respondents)
- daily (three respondents).

Utility

Survey participants were asked to rate the importance and usefulness of the NMDS (overall and for each individual data element) and to indicate which data elements need to remain unchanged, modified or deleted.

Assessing importance involves rating the significance of the data element in a national data collection on public hospitals. In assessing usefulness, respondents were asked whether the data element met current information requirements. Importance could be rated as 'not important', 'important', 'highly important' or 'unsure' and usefulness as 'not useful', 'useful', 'highly useful' or 'unsure'.

A rating of 'highly important' and 'highly useful' suggests that the data element be unchanged. If rated 'highly important', but 'not useful', the definition may need to be modified and if rated as both 'not important' and 'not useful', a data element may need to be deleted from the NMDS.

Table 3.2 summarises the respondents' ratings. Not all respondents rated every data element and so the frequencies will not add to the total number of respondents for every data element. One survey respondent provided comments only, not individual ratings and so the maximum number of responses to each data element is 16. Comments on each data element are included in Chapter 5 of this report.

Thirteen of the 17 respondents rated the NMDS as highly important and 12 rated it as highly useful. Two respondents considered it to be not important but none thought it to be not useful. The NMDS was considered to be useful in time-series analysis and in providing consistent definitions for data collection. Comments emphasised the need to assess the impact of any proposed changes on long term consistency of the data.

Some respondents mainly used the data specifications for supply of annual data to the AIHW and to the Department of Health and Ageing. Others use it to provide a breakdown of expenditure and activity items for comparative purposes, and in policy development. Several respondents use it as the 'only nationally comparable data source for public hospitals' and noted that it is used in the *Report on government services* and by the National Health Performance Committee. Comments also stated that the NMDS is a useful source for general statistical information about Australian public hospitals, in its own right and in comparison with ABS data on private hospitals.

Some were critical of the quality of the data, its relevance and the difficulties in comparing among jurisdictions. One comment pointed to the increased burden due to the mismatch for some data elements with current state accounting standards. To the extent that definitions are inadequate, data consistency can be compromised.

Table 3.2: Importance and usefulness of the NMDS, individual data elements and data element concepts

	Importance				Usefulness			
Data element	Not important	Important	Highly important	Unsure	Not useful	Useful	Highly useful	Unsure
NMDS for public hospital establishments	2	1	13	1	0	3	12	2
System level expenditure elements								
Capital expenditure - gross	3	3	8	2	3	4	6	3
Capital expenditure - net	3	4	8	1	3	5	6	2
Indirect health care expenditure	4	9	2	1	5	8	1	2
Establishment identification data elements								
Establishment identifier	4	3	9	0	2	4	9	1
Establishment number	2	4	10	0	0	5	10	1
Establishment sector	3	2	10	0	1	3	10	1
Region code	8	0	7	1	5	4	6	1
State/territory identifier	2	2	12	0	0	4	11	1
Establishment type	2	2	12	0	0	4	11	1
Geographical location of establishment	3	2	10	1	5	3	7	1
Establishment level expenditure elements								
Administrative expenses	2	9	5	0	0	11	4	1
Interest payments	3	7	4	2	4	8	3	1
Depreciation	2	7	7	0	0	11	4	1
Patient transport	2	9	5	0	1	9	4	2
Repairs and maintenance	2	8	4	2	0	10	3	3
Superannuation employer contribution	2	8	5	1	0	10	4	2
Domestic services	2	8	6	1	1	10	3	2
Payments to visiting medical officers	2	8	6	0	0	10	5	1
Drug supplies	2	6	8	0	0	9	6	1
Food supplies	2	9	5	0	0	11	4	1
Medical and surgical supplies	2	6	8	0	0	9	6	1
Other recurrent expenditure	2	6	7	1	1	8	6	1
Salaries and wages	2	5	9	0	0	9	6	1
Salaries and wages—registered nurses	2	5	9	0	0	9	6	1
Salaries and wages—enrolled nurses	2	5	9	0	0	9	6	1
Salaries and wages—student nurses	4	7	4	1	3	9	2	2
Salaries and wages—trainee/pupil nurses	5	6	4	1	4	8	2	2

(continued)

Table 3.2 (continued): Importance and usefulness of the NMDS, individual data elements and data element concepts

	Importance				Usefulness			
Data element	**Not important**	**Important**	**Highly important**	**Unsure**	**Not useful**	**Useful**	**Highly useful**	**Unsure**
Salaries and wages—salaried medical officer	2	5	9	0	0	9	6	1
Salaries and wages—other personal care staff	2	8	6	0	2	9	4	1
Salaries and wages—diagnostic and health professionals	2	6	8	0	0	10	5	1
Salaries and wages—administrative and clerical staff	2	7	7	0	1	9	5	1
Salaries and wages—domestic and other staff	2	7	7	0	1	9	5	1
Revenue data elements								
Patient revenue	2	6	8	0	1	7	6	2
Other revenues	2	7	7	0	1	8	5	2
Recoveries	2	8	6	0	1	9	4	2
Other data elements								
Full-time equivalent staff	2	6	8	0	1	8	6	1
Specialised service indicators	3	3	9	1	3	5	8	0
Occasions of service	3	3	9	1	1	5	8	2
Type of non-admitted patient care	2	4	9	1	2	5	7	2
Type of non-admitted patient care (public psychiatric, alcohol and drug)	3	4	8	1	1	5	7	3
Individual / group session	2	5	7	2	2	5	6	3
Group sessions	2	6	6	2	3	5	5	3
Number of available beds for admitted patients	3	4	9	0	2	5	8	1
Teaching status	5	6	5	0	3	9	4	0
Supporting data element concepts								
Hospital	2	5	9	0	0	7	7	2
Hospital boarder	3	10	3	0	2	11	3	0
Non-admitted patient	2	4	10	0	1	6	8	1
Overnight-stay patient	3	4	9	0	1	5	9	1
Patient	2	4	9	0	1	5	10	0
Same-day patient	2	4	10	0	1	5	10	0
Separation	2	3	11	0	1	5	10	0

Suggestions for data development

Respondents were asked to nominate areas for development of the NMDS, including new or modified data elements, possible changes to the scope or other priorities for the development of definitions. The views of respondents are summarised in this section. Chapter 5 contains the detailed comments on individual data elements and data element concepts.

Changes to the NMDS

Scope description for the NMDS

The scope of the NMDS for Public Hospital Establishments as published in the NHDD is:

> ... establishment-level data for public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans' Affairs, and alcohol and drug treatment centres.
>
> From version 9 Patient level data remains in the new National Minimum Data Set (NMDS) called Admitted patient care. This new NMDS replaces the version 8 NMDS called Institutional health care.
>
> Similar data for private hospitals and free standing day hospital facilities is collected by the Australian Bureau of Statistics in the Private Health Establishments Collection.
>
> Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.

This needs to be updated to remove the reference to Department of Veterans' Affairs hospitals which no longer exist. A possible new definition, which would not change the scope of the NMDS is:

> … establishment-level data for public hospitals, including psychiatric hospitals, dental hospitals and other special purpose hospitals such as those for rehabilitation, palliative care and alcohol and drug treatment.
>
> All Australian public hospitals are included, except those not within the jurisdiction of a state or territory health authority (hospitals operated by the Australian Defence Force, correctional authorities and hospitals located in offshore territories).

Definition of an establishment

The definition of an establishment needs to be clearer and more useable. Hospitals and organisations which span traditional units present a challenge. The NHDD specifies that hospitals are as defined by the state or territory, which results in differences that reduce comparability between jurisdictions. Whether or not to include in the hospital data business units such as cafeterias and car parks and those that may provide services to other hospitals (such as laundry services) is an issue.

A major difficulty is the configuration of organisational and physical structures (for example between networks and campuses) that comprise a hospital. Clinical activity data may be reported at campus level but financial information relating to a hospital may be compiled at a network or area health service level. This is one example of a more general issue relating to the organisational level at which 'establishments' are defined and reported for this NMDS. The definitions need to be reviewed following the development of a restructured NMDS and aligned with those used for the reporting of capital expenditure through the 'Government health expenditure' NMDS, which is under development.

Public versus private hospitals

A related issue is the categorisation of public and private hospitals varies between jurisdictions. A selection of hospitals that predominantly provide public hospital services but

are privately owned and/or operated is listed in Table 3.6. In *Australian hospital statistics 2004–05* Hawkesbury Base and Port Macquarie hospitals were reported as public hospitals although prior to 2003–04 they were reported as private hospitals. For 2004–05, the Mersey Community Hospital in Tasmania which previously operated as a private hospital providing predominately public services on a contracted basis merged with the Northwest Regional Hospital and is now categorised as a public hospital. A further issue is the status of hospitals operated by non-government organisations such as churches, which are variously regarded as public and private.

A guiding principle is that hospitals which report to the Public Hospital Establishments NMDS should ideally not also report to the PHEC unless any overlap is known and quantified.

Approach to resolving issues relation to the definition of an establishment and public versus private hospitals

These issues could be addressed separately. A tighter definition of a private hospital may achieve greater comparability within the Public Hospital Establishments NMDS and ensure that there are no gaps or overlaps between the NMDS and the PHEC. However, the issue of defining a hospital 'establishment' would remain.

One approach to improve comparability would be to change the focus of the NMDS to public hospital services, rather than public hospitals. At a minimum establishment identifiers could be developed to indicate relationships between networks and individual service units. If this is not possible, a separate data element for networks (or similar) could be developed.

Another approach is to introduce a hierarchical reporting structure, similar to that now used for the Mental Health Establishments NMDS. It allows reporting at different levels and the relationships between reporting entities to be reflected within the NMDS data. One of the benefits of this approach is that it is less critical to define an 'establishment'. All relevant data relating to the provision of hospital services would be captured at some point in the health services reporting hierarchy. A second benefit is that the distinction between public and private hospital is unimportant. The critical issue is whether the hospital is delivering public hospital services.

Table 3.3: Selected hospitals that predominantly provide public hospital services but are privately owned and/or operated, 2004-05

State	Hospital	How reported
NSW	Hawkesbury Base	Public hospital
Vic	Mildura Base	Public hospital
Qld	Noosa	Private hospital
WA	Joondalup	Private hospital
WA	Peel	Private hospital
SA	Southern Districts War Memorial Private Hospital	Public hospital for services provided under contract and a private hospital for services provided to private patients
SA	Modbury	Public hospital (publicly owned – privately operated)
Tas	May Shaw District Nursing Centre	Public hospital (reports total expenditure only)
Tas	Toosey	Public hospital (reports total expenditure only)

Admitted versus non-admitted patient definitions

Some respondents commented on confusions in the definitions of admitted and non-admitted patients and the variation in admission practices between jurisdictions and hospitals, which are blurring the distinction between admitted and non-admitted patients. These confusions are affecting the reporting of non-admitted patient occasions of service and admitted patient cost proportions and the assessment of the impact of increased use of same-day surgery, changes to emergency department operations and changes to outpatient services. One respondent also noted that current use of 'admitted patient' (in the NPHED and the National Hospital Cost Data Collection or NHCDC) is inconsistent with the Organisation for Economic Cooperation and Development (OECD) definition of admitted patient.

Recurrent expenditure items—input categories

Recurrent expenditure is disaggregated into input categories such as administrative expenditure, cost of drug supplies and cost of medical and surgical supplies. Respondents sought changes to these categories to achieve a better representation of hospital expenditure. One suggestion was to align the expenditure categories with the NHCDC *cost buckets*. There are limiting factors. For example, in NPHED theatre nurse salaries are counted in nurses' salaries, but in NHCDC theatre nurse salaries are counted in theatre costs.

Another suggestion was for expenditure to be disaggregated in a more detailed manner, for example pharmacy by the WHO's ATC classification system.

Table 3.4 lists the current input categories and the potential output categories, indicating how expenditure data could be disaggregated using both axes. The extent to which such disaggregation could be achieved would be likely to be limited. However the marginal totals and subtotals could be worth collecting as a first step to improving these data.

Recurrent expenditure items—output categories

The only output expenditure currently reported is the admitted patient cost proportion (IFRAC), which is not formally part of the NMDS. There was support for the disaggregation of expenditure data by output categories. Categories could include admitted patient (acute, psychiatric, rehabilitation and other), non-admitted patients and emergency department.

Alternatively, the HEAC work based on the OECD *International Classification for Health Accounts* 'Functions of personal health care' could be useful when considering suitable categories. Under the OECD system, functions of personal health care are classified by both *basic functions of care* (curative, rehabilitative and long-term nursing care) and *mode of production* (in-patient, day care, outpatient and home care).

Table 3.4: Expenditure input and output categories

		Possible output categories (1)							
		Admitted patient—acute	Admitted patient—psychiatric	Admitted patient—rehab	Admitted patient—other	**Admitted patient—total**	Non-admitted patient	Emergency department	Total
Current input categories (2)	Administrative expenses								X
	Depreciation								X
	Domestic services								X
	Drug supplies								X
	Food supplies								X
	Interest payments								X
	Medical and surgical supplies								X
	Other recurrent expenditure								X
	Patient transport								X
	Payments to VMO's								X
	Repairs and maintenance								X
	Superannuation								X
	Total non-salary expenditure								X
	Salaries and wages								X
	Total expenditure	X	X			X			X

(1) Other possible output categories could be based on the OECD International Classification for Health Accounts.

(2) Other possible input categories could be based on National Hospital Cost Data Collection categories.

X Current reporting requirements—NMDS and IFRACs (informal).

Inter-hospital transactions

There are concerns that expenditures are being double-counted as a result of inter-hospital transactions. For example, the expenses incurred by large hospitals supplying laundry or kitchen facilities (or maintenance services) to smaller hospitals on a fee for service may be reported by both hospitals.

This method of accounting for the provision may be acceptable in describing the operating costs and revenues of individual establishments. However when expenses and revenues are consolidated to a regional and state level, they are counted twice. From the expenditure and revenue questionnaire, it appears that this is occurring in four states, and probably occurs in all states and territories.

The extent of the double counting is unknown, although Victoria has estimated it to be around $85 million per year in that state. The expenditure totals would be affected and also affect calculations for items such as admitted patient cost proportions.

Conversely, data may be excluded from hospital transactions if it is allocated to an outside entity. For example, Tasmanian psychiatric hospitals report zero medical officers because the officers are 'employed' by another entity, even though they provide services to Tasmanian hospitals. A hierarchal reporting structure would resolve this problem.

Public and private hospital data consistency

Consistency between public and private sector standards is important. The NMDS is also used in the PHEC and any changes to the NMDS need to ensure that comparability of public and private hospitals data is not diminished.

Extending the NMDS

Hospitals not currently included

One respondent proposed expanding the scope of the collection to include hospitals which are not currently included—for example, hospitals run by the Department of Defence, corrections authorities, and public hospitals in Australia's external territories. There is an eight bed public hospital on Christmas Island run by the Indian Ocean Territory Health Service, through the Australian Department of Transport and Regional Services. There are three medical services (each of which includes a two bed hospital ward) on the Australian Antarctic Division stations, Casey, Mawson and Davis. A hospital also operates on Norfolk Island.

Public hospital services

Some respondents noted that the NMDS currently describes public hospitals rather than public hospital services. It may be worthwhile expanding the NMDS to cover expenditure (and perhaps other data such as full-time equivalent staff) on public hospital services at the region and state level.

Counting public hospital services would encapsulate those public hospital services which are purchased from the private sector, and support services such as pathology which are purchased by hospitals from non-hospital entities (public and private). If data were collected on purchasing of services, the result could be more comparable data about public hospital service funding and provision.

The new Mental Health Establishments NMDS incorporates this type of reporting structure, with different data requirements at the state, region, organisation and service unit level (Figure 3.1). Together, the data will provide a comprehensive picture of public mental health service provision that is not readily available for public hospital service provision. This structure would effectively make operational (and expand on) the two tier system of 'network-level' and 'establishment-level' data which is currently reported in the NMDS.

An appropriate hierarchical reporting structure could be based on entities such as states and territories, administrative regions, networks, establishments and campuses. Most data would be reported at the lowest level possible (or applicable) in the state or territory but could be reported at the higher levels if not available at lower levels.

Expenditure reported in *Australian hospital statistics 2004–05* is largely expenditure by hospitals and does not include all expenditure on hospital services by the state or territory government. Similarly, reported revenue is largely revenue received by individual hospitals, and does not include all revenue received by the state or territory government for provision of public hospital services.

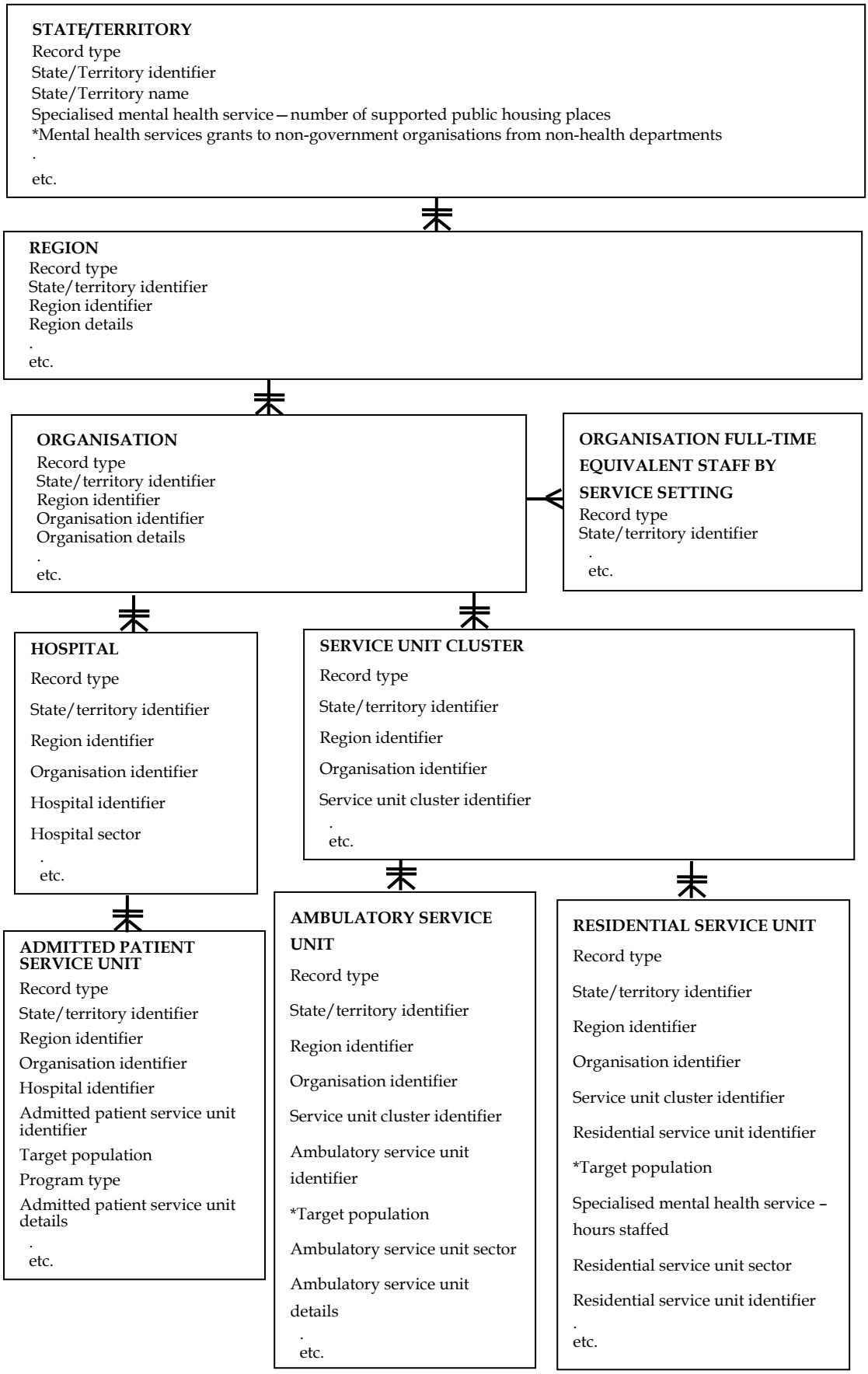
For example, expenditure on public hospital services purchased by the state or territory government (at the state or area health service level) from privately owned and/or operated hospitals is not included unless the privately owned and/or operated hospital has been reported as a public hospital.

One survey response which supports the 'reporting public hospital services' approach suggested that the scope of the NMDS be made consistent with clause 36 of the Australian Health Care Agreements 2003–2008. Clause 36 of the AHCA state that:

> (states or territories agree) to work with the Commonwealth and other States that have signed agreements to develop a comprehensive, standardised system for determining recurrent health expenditure in relation to the *services* provided under this Agreement by June 2005. If such a system cannot be developed collaboratively, the Commonwealth will determine the nature of such a system.

Such consistency could be considered, or at least mechanisms developed to ensure that differences between the NMDS and the AHCA collections are known and understood.

Figure 3.1: Data model underlying the NMDS – Mental Health Establishments (Abbreviated 1 page example)



Safety and quality

Several respondents suggested an increased focus on safety and quality data collection.

For example, could clinical indicators (such as those in the ACHS dataset) be reported by all public hospitals instead of just a voluntary sample, so that performance and quality of care could be assessed?

Another respondent suggested including sentinel events in the NMDS. Although some adverse events are reported in patient-level morbidity data and some sentinel events data may be obtained from those data, it may be possible to include a count of sentinel events at the establishment level. However, qualitative data which is needed to allow interpretation of these numbers would not be easily included in the NPHED.

The quality accreditation/certification status items are currently collected for the NPHED but are not included in the NMDS. Adding these to the NMDS would give information on accredited hospitals using these quality standards.

The data elements are:

- Establishment—quality accreditation/certification standard status (ACHS EQuIP).
- Establishment—quality accreditation/certification standard status (Australian Quality Council).
- Establishment—quality accreditation/certification standard status (International Organisation for Standardisation 9000 quality family).
- Establishment—quality accreditation/certification standard status (Quality Improvement Council).

Performance indicators

One respondent suggested that it would be beneficial to develop the NMDS so that performance indicators which are needed for AHCA-related purposes can be derived from this NMDS. New data elements may be required to support these indicators.

One respondent suggested NMDS collections incorporate the work being done by groups such as the Health Roundtable benchmarking group. Health Roundtable Limited (www.healthroundtable.org.au) is an organisation of health executives (generally public hospital chief executive officers) which researches and discusses best practice procedures in hospitals. It also collects, analyses and publishes information comparing organisations and identifying ways to improve operational practices.

Operating theatre efficiency

One respondent suggested that increased work on operating theatre utilisation and throughput would be worthwhile. This could include information such as numbers of theatres, opening hours and numbers of patients or procedures.

System and establishment level data

Three data elements in the NMDS are collected at a state or territory health authority level ('system level'). These are *Capital expenditure – gross (accrual accounting), Capital expenditure – net (accrual accounting)* and *Indirect health care expenditure.* All other data elements are collected at establishment level.

Measuring capital expenditure

AIHW publications present some information on capital. For example *Australian hospital statistics* shows estimates of depreciation for public hospitals in each state and territory. *Health expenditure Australia* shows a time series of capital consumption (depreciation) and outlays on capital by sector.

Integrated capital accounts would supply useful information on the economics of health in Australia. Such accounts would cover the key variables of investment (capital expenditure or capital formation), capital stock, and depreciation (capital consumption). The accounts would ideally be dissected by type of asset (buildings, information technology etc.), by segment of health (particularly hospitals), by state or territory and by public or private sector.

The AIHW, under the guidance of HEAC, is investigating the possibility of compiling experimental integrated accounts. This project has begun with hospitals, because of the large amount of capital in that sector and because the data sources are relatively rich. However it is not possible at present to compile such integrated accounts, even for hospitals, owing to deficiencies and inconsistencies in the available data. For example data is usually only available for depreciation, but not for capital expenditure or capital stock.

Another difficulty is that different jurisdictions (and, perhaps, area health services or hospitals within jurisdictions) assemble their capital estimates using different accounting conventions and other rules. For example, the thresholds that distinguish capital items from recurrent items differ from jurisdiction to jurisdiction, as do the bases of evaluation (historical or replacement cost, etc.) and the assumptions about asset lives or depreciation rates.

Despite these difficulties, work is progressing and will be presented progressively to HEAC and to AHSAC during 2006–07. If the project proves successful, it would be possible to enhance the capital items in the Public Hospital Establishments NMDS. A more ambitious longer term goal is to develop nationally-agreed standards for the reporting of capital data, as part of a new NMDS covering all government expenditure on health.

Persons to be consulted for future data development

Most respondents were satisfied with the data development process, whereby submissions for data development are sent to the HDSC, SIMC and the NHIMPC.

Respondents nominated a wide range of stakeholders to be consulted, including

- state or territory health authority staff
- data collectors and processors
- data users
- hospitals and health care providers
- casemix experts (specifically for work on the admitted patient cost proportion)
- costing officers
- policy development officers.