Outpatient activity - comparing apples to oranges or maybe banana's!

Introduction: In Australia, it is known that there are variations in the counting rules for non-admitted patient services across states/territories. However, the extent to which those variations make a material difference in the number of non-admitted services reported by states/territories is not known. This study was designed to objectively analyse the overall volumes of non-admitted patient services that might be funded under national ABF arrangements; the variations in the counting rules for non-admitted patient services across states/territories; and the extent to which those variations make a material difference in the reported state/territory activity data.

Methods: The methodology consisted of four stages. First, a specification was prepared for extract of non-admitted patient data (aggregate level data broken down into a number of counts across the variables hospital, clinic, setting type, session type, and financial status) from state/territory health authority systems. Second, the requested data as well as copies of documentation on local counting rules for non-admitted patient services and mappings to NHCDC Tier 2 Clinics (i.e. the classification system adopted for national reporting) was obtained by liaising with state/territory representatives. Third, the provided data and associated counting rules were analysed. Fourth, the final report was produced for consideration by ABF stakeholders.

Results: High-level analysis of key characteristics of the documentation/data revealed:

- **Coverage:** included all public hospitals, in all states/territories; although many expressed concerns that the available data does not reflect all the services provided in public hospitals;
- **Data source:** aggregate level data from seven of eight states/territories; two of the seven states/territories reported using under-pinning patient unit record-level data;
- **State/Territory-level clinic categories:** broad variations (i.e. no two states/territories use the same classification); and
- **Unit of count:** Occasions of Service (OOS) per National Health Data Dictionary (NHDD).

Examining the breakdown of the reported data by session type, setting type and financial class revealed that:

- **Session type:** only one State and one Territory included data on non-face-to-face services;
- **Setting type:** most States/Territories, except one of the Territories, reported very few non-hospital based services (i.e. the community/outreach services represented less than 5%); and
- **Financial class:** there was significant variability in the reporting of privately referred OOS, which formed a significant component of the non-admitted services in three of the States, but were not wholly reported in two other States and one Territory.

Analysis of the effectiveness of the NHCDC Tier 2 clinic classification system was then undertaken. No State/Territory had activity mapped to all NHCDC Tier 2 clinics. One State populated 68 out of 81 NHCDC Tier 2 clinics. One of the territories, had the least number of NHCDC Tier 2 clinics populated (i.e. 38 out of 81). Analysis of the ten clinics with the highest reported volumes of non-admitted services State/Territory showed that only two NHCDC Tier 2 clinics (obstetrics and orthopaedics) appear in the top 10 in all States/Territories. The mismatch between the reported data and the classification system is highlighted by one of the Territories where two clinics account for 53% of the reported services.

We then examined some key measures of utilisation. After adjustments, public outpatients utilisation per 1,000 population ranged from 376 to 856 (a range of nearly 2.3 to 1). Again, after adjustments, the ratio of public outpatients to all admitted services ranged from 1.47 to 3.52 (a range of nearly 2.4 to 1). So even when the scope is narrowed to outpatients, the use of existing data for national ABF with a national efficient price is likely to significantly distort funding allocations. Separate state/territory level prices could be used to ameliorate this problem, but there is still likely to be distortion across LHNs within states/territories due to differences in the local application of outpatient counting rules.

Conclusions: The high variability in the data provided was not, for the most part, due to lack of documentation. In fact, most states/territories rely on the NHDD and associated counting rules in their documentation (hence, they are consistent). There are really three issues to be addressed in counting rules development; first, the suitability of the current counting rules framework for ABF purposes; second, the need to develop clear definitions for the allocation of services into the ABF workstreams; and third the need to improve the consistency with which the counting rules are being applied. Lastly, our analysis highlighted issues with the NHCDC Tier 2 clinics classification system that could be addressed by using actual data in the refinement process and mapping data to NHCDC Tier 2 at hospital level.