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

WA Health Funding and Purchasing Guidelines 2016–17

better health ▪ better care ▪ better value

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Contributors
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FOREWORD

The Western Australia (WA) health system is currently undergoing significant reform as it continues to build its vision to deliver a safe, high quality, sustainable health system, for all Western Australians. The 2016-17 financial year will be one of significant reorganisation for the public health system with the replacement of the *Hospitals and Health Service Act 1927* with the new *Health Services Act 2016*.

This legislation provides a new governance structure aimed at facilitating greater accountability including clearly defining the roles of the State and Commonwealth (the funder), the Department of Health Chief Executive (the system manager), the Department of Health (as the purchaser) and the health service providers or contracted health entities (as provider), as per section 6 of *the Health Services Act 2016*.

The *Health Services Act 2016* also provides for Service Agreements between the system manager and the health service providers, as well as Commission Service Agreements, between the health service providers and the Mental Health Commission (see part 5 of *the Health Services Act 2016*). The Service Agreements between the purchaser and provider are the primary legally binding instruments articulating the budget, performance and operational targets of health service providers.

With expenditure on health services almost doubling in the last ten years, highlighting the continued increase in demand for public hospital services in WA, ensuring our health system is dedicated to providing patient focused, effective, efficient and sustainable healthcare is a priority.

I am pleased to present the *Funding and Purchasing Guidelines 2016-17* which acts as a reference tool to inform and provide transparency of the WA health system funding, purchasing and resource allocation process, including the development and management of the delivery of health services through Service Agreements with health service providers, with increased emphasis on performance management and accountability.

As a system it is essential we strive for clinical service excellence matched with financial prudence.

Dr D J Russell-Weisz
DIRECTOR GENERAL
WA DEPARTMENT OF HEALTH

WA Health Funding and Purchasing Guidelines

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1.0 Overview

WA Health delivers high quality health services to approximately 2.6 million people across 2.5 million square kilometres with the demand for services continuing to grow. It is expected in 2016-17 that the WA Health system will provide; approximately: 1.1 million emergency department episodes of care; 630,000 admitted episodes of care; and more than 2.5 million non-admitted and community service events, indicating an overall increase in activity of 2.4 per cent from 2015-16.[1] To meet and fund this increasing service demand, the State government has allocated $8.6 billion to WA Health for 2016-17, approximately $400 million more than in 2015-16.

Some drivers explaining this increased demand include; changing community health needs and expectations, an ageing population, and the burden of chronic diseases, all of which are placing more complex demands on the WA Health system and impacting the costs of health service delivery.

To support the sustainability of our health system, WA Health is undertaking comprehensive structural reform and implementing innovation to the health system in order to ensure high quality care, efficient performance and greater accountability.

1.1 The Funding and Purchasing Guidelines 2016-17

1.1.1 Purpose of the Guidelines

The WA Health Funding and Purchasing Guidelines 2016-17 (the Guidelines) provide information to stakeholders including Health Service Providers, the Mental Health Commission (MHC) and the wider WA community about the funding acquisition, purchasing policies and mechanisms and the resource allocation process for health services in WA.

The Guidelines are a reference guide, underpinning the Service Agreements between the Department of Health (the Department) and each Health Service Provider and forms part of the *Purchasing and Resource Allocation Policy Framework (PRAF) process.*

Service Agreements are the legal instrument contractually binding the Department and Health Service Providers, as pursuant to Section 46 of the *Health Services Act 2016*.

[1] Western Australian state budget 2016-17. *2016-17 Budget Papers, available at* http://www.ourstatebudget.wa.gov.au/Budget-Papers/

Handy Tip:
Click on **blue text** within these Guidelines to go to directly to the sections or websites mentioned

Further information on the Policy Framework can be found here.

Key objectives of the Guidelines are to:

- explain the funding principles and models underlying the allocation of resources across WA Health with a particular focus on the operation and implementation of Activity Based Funding (ABF) and Activity Based Management (ABM) to key stakeholders
- provide an overview of the Funding and Purchasing Cycle as per *Figure 1*
- reinforce the Funder, System Manager, Purchaser and Provider roles within the new devolved governance structure (*Figure 4*)
- increase the collaboration with Health Service Providers and other key contributors to encourage further feedback opportunities.

The Guidelines are aligned to the WA Health Strategic Intent 2015-2020 to deliver a *"safe, high quality, sustainable health system for WA"*. A key enabler of the Strategic Intent is financial management, "*the commitment to managing resources effectively and efficiently by delivering services within allocated budgets, ensuring value for money and achieving financial sustainability".*

Further information on the WA Health Strategic Intent can be found here

1.1.2 Overview of the Guidelines for 2016-17

The 2016-17 Guidelines build on the 2015-16 version to explain the funding, purchasing and resource allocation cycle.

What's new in 2016-17?

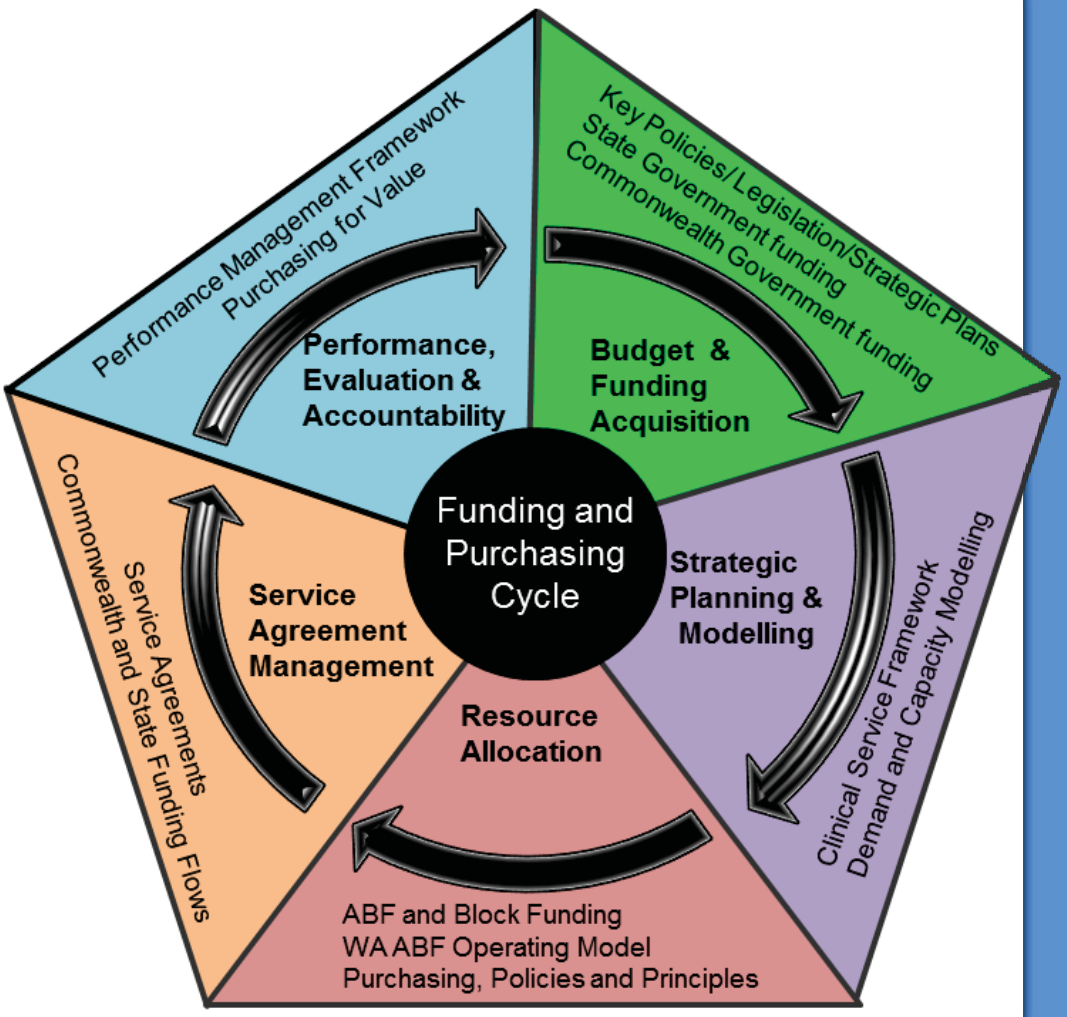
- The structure and content of the Guidelines has been updated to broaden the scope from budget and allocation to encompass the entire funding, purchasing and resource allocation process.
- An overview of the Health Reform program is provided including the new *Health Services Act 2016*, how this has been operationalised and how these changes impact on the funding, purchasing and resource allocation process (section 1).
- Detail about the costing, counting, classification and modelling methodologies involved in the resource allocation process.
- Further detail regarding pricing for health service delivery including the National Efficient Price, the Projected Average Cost, the State Price, the Health Service Allocation Price and transition funding mechanisms applied in the Service Agreements.
- A brief overview of the OBM Framework and key purchasing policy strategies to be put in place over the coming years.

- **Section 2: Budget and Funding Acquisition** – provides an overview of the funding and budget process including funding provided from both State and Commonwealth Governments.
- **Section 3: Strategic Planning and Modelling** – outlines the key elements that inform the modelling and resource allocation process including classifying, counting and costing of delivered activity and the key strategic planning for the WA Health system - the *WA Health Clinical Services Framework* (CSF).

- **Section 4: Resource Allocation** – this section incorporates the funding parameters (section 2) and projected capacity and demand growth rates (section 3) to develop projected activity profiles. Also following established national concepts, State strategic pricing policies are incorporated to the WA Health operational resource allocation model. This section also briefly outlines future approach to purchasing policy to be implemented in future years aimed to improve efficiency and accountability.
- **Section 5: Service Agreement Management** – in parallel with the resource allocation process (section 4), Service Agreements outlining the activity targets, associated funding, and other parameters, are developed for each Health Service Provider. This section also includes information on the funding profiling (both Commonwealth and State) and resource disbursement mechanisms and process to Health Service Providers.
- **Section 6: Performance, Evaluation and Accountability** – this section outlines the mechanism for reviewing and managing performance against activity targets outlined in the Service Agreements (section 5).

Figure 1 depicts the funding, purchasing and resource allocation process including, the key influences on each section of the cycle and the associated reform program impacting all sections in the cycle.

Figure 1: Funding and Purchasing Cycle and Key Influences



Click here to receive more information regarding the *Better health, better care, better value WA Health Reform Program 2015-2020*

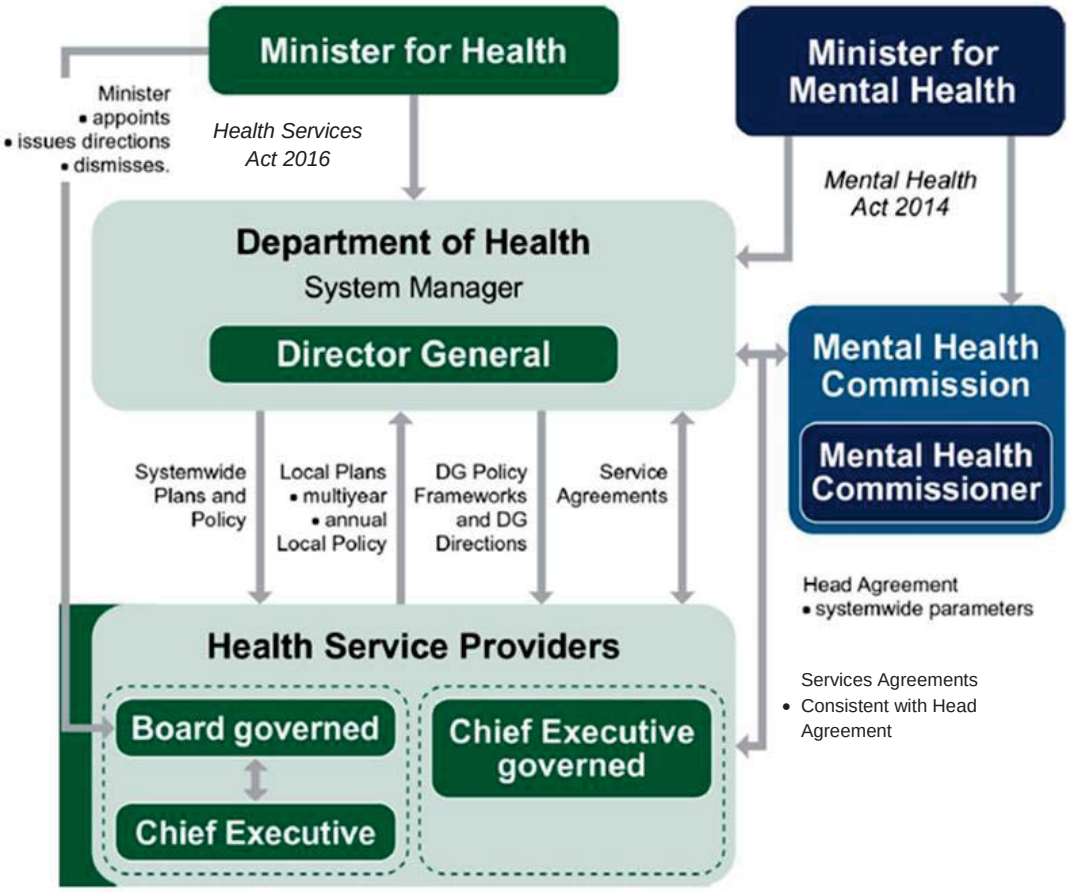
Click here to access the *Health Services Act 2016*

1.2 The Case for Reform

1.2.1 Overview of Reform Program

The *Better health, better care, better value: WA Health Reform Program 2015-2020* describes the health reform program which aims to ensure the WA community continues to receive high quality care and improved health outcomes into the future. The health reform program focuses on key enablers for driving improved performance and delivery of healthcare and includes reforms in governance, purchasing and system performance, financial management and support services.

Figure 2: WA Health Governance Structure



1.2.2 Governance Reform

On 23 February 2016, the Minister for Health introduced the new *Health Services Bill 2016* to replace the existing *Hospitals and Health Services Act 1927*. The new *Health Services Act 2016* received Royal Assent on 26 May 2016 and was enacted on 1 July 2016. The *Health Services Act 2016* includes significant changes to the governance of the WA Health system through greater devolution of functions and powers that will impact on the funding and purchasing process, as indicated in *Figure 2*, including:

Department of Health as System Manager

The Department, led by the Department CEO (Director General), is the System Manager responsible for the overall management, performance, budgets and strategic direction of the WA Health system. The Director General reports to the Minister for Health.

Health Service Providers and Boards

Health Service Providers are separate, board-governed statutory authorities, legally responsible and accountable for the delivery of contracted health services for their local areas and state-wide communities.

Health Support Services

Health Support Services (HSS) are providers of non-clinical services established as a chief executive-governed Health Service Provider that is a statutory authority accountable for the delivery of support services. The HSS incorporates the functions and replaces the previous Health Corporate Network (HCN) and Health Information Network (HIN).

The Mental Health Commission

The Mental Health Commission (MHC) is responsible for planning and purchasing mental health, alcohol and other drug services (*Commission health services*) in Western Australia.

From 2016-17, the purchase of these services will occur through two levels of agreements: the Head Agreement between the Department and the MHC and Commission Service Agreements between the MHC and Health Service Providers.

Did you know?
the Mental Health Commission's budget represents approximately 7.5% of the total WA Health Budget.

Service Agreements

Annual Service Agreements between the Department and each Health Service Provider are the legally binding mechanism establishing the budget, purchasing mechanism, performance measures and operational targets for the Health Service Provider. The parameters, roles and responsibilities in relation to the Service Agreements are outlined in section 5 of the *Health Services Act 2016*.

Head Agreement

The Head Agreement establishes the primary relationship and the purchasing framework for Commission health services by the MHC from the WA Health system.

The Head Agreement must state; system wide funding caps and performance standards and roles, responsibilities and accountabilities of the Department in the provision of services and of the MHC as a Purchaser of services.

The Head Agreement will enable the Department to ensure the ongoing safety, quality, reliability and sustainability of mental health services, clinical governance arrangements and coordination of mental health services across the WA Health system pursuant to section 44 of the *Health Services Act 2016*.

Commission Service Agreements

The Commission Service Agreements detail the purchasing arrangements for Commission health services from Health Service Providers as set out in the *Health Services Act 2016*.

The Commission Service Agreements must be consistent and aligned with the Head Agreement pursuant to section 45 of the *Health Services Act 2016*

Policy Frameworks

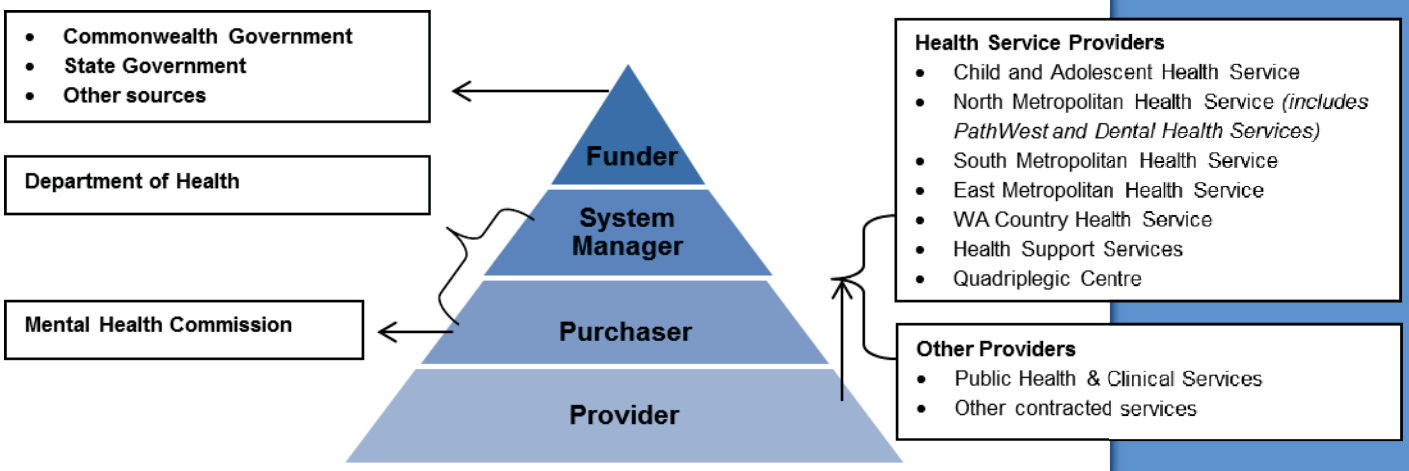
As the System Manager, the Director General may issue binding policy frameworks which are legal instruments to manage the WA Health system at a strategic level. All policy frameworks reflect the strategic role of the Department as the System Manager.

Further information on the Policy Framework can be found here.

1.3 Funder, System Manager, Purchaser and Provider Roles, Responsibilities

The key elements of WA Health governance structure are the roles, responsibilities and relationship between the System Manager and the Funder, Purchaser and Provider for the delivery of health and support services, as outlined in *Figure 3* below.

Figure 3: Funder, System Manager, Purchaser and Provider Roles



Key policies and plans impact the Funder, System Manager, Purchaser and Provider roles. A summary of these and key roles are outlined below.

1.3.1 Funder Roles and Responsibilities

A significant role of the Department of Treasury (WA Treasury) and the Australian Commonwealth Government is to provide the required funding for public health services in WA. Additional funding is also received from other sources such as, private health insurance, workers' compensation, motor accident insurance and cross-border arrangements.

1.3.1.1 Western Australian Government through WA Treasury

WA Treasury has a central role in managing WA public sector finances and in providing expert analysis and advice on the strategies and frameworks necessary for maintaining the State's economic and financial position. This includes the development of economic and revenue forecasts, and the on-going monitoring of developments in the State's economy and major revenue bases. Health is a key portfolio of the WA Government.

For more information on **NHRA** click here National Health Reform Agreement

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1.3.1.2 Australian (Commonwealth) Government

The Australian Government allocates funding to the State and Territory Governments to provide health and hospital services. The Australian Government funds public health and hospital related services through the NHRA, between the Commonwealth and all jurisdictions.

On 1 April 2016, the *Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding* was signed providing a commitment to develop an addendum to the current NHRA that will commence on 1 July 2017 and operate for three years (for further information refer to Section 2.1.1 Changes to Commonwealth Funding).

1.3.2 System Manager Roles and Responsibilities

As defined in the *Health Services Act 2016,* the Department, through the Director General, is the System Manager for the WA Health system. The Department is also the Purchaser for public non-mental health services from Health Service Providers.

The role of the Department as System Manager is to provide:

- strategic leadership, planning and direction of the WA Health system
- recommending to the Minister for Health the amounts that may be allocated from the health portfolio budget to Health Service Providers
- overseeing, monitoring and promoting improvements in the safety and quality of health services
- entering into Service Agreements with Health Service Providers outlining budget, activity and performance measures
- arranging for the provision of health services by contracted health entities
- monitoring performance and taking remedial action when performance does not meet expected standards
- managing system-wide industrial relations and setting conditions of employment for Health Service Provider employees.

The Director General has several mechanisms of remediation:

- issuing binding policy frameworks and directions to Health Service Providers
- agreeing performance objectives with Chief Executives of Health Service Providers
- evaluation and performance management of a Health Service Provider under the Service Agreement
- assessing compliance, performance, safety, quality, and patient services via powers of investigation, inspection and audit
- power to conduct an inquiry into the functions, management or operations of Health Service Providers.

1.3.3 Purchaser Roles and Responsibilities

The Department and the MHC are the Purchasers of public general health services and also Commission health services respectively in WA, as defined by the *Health Services Act 2016*.

1.3.3.1 Mental Health Commission

The MHC is responsible for policy, planning and purchasing of Commission health services. The MHC does not provide direct Commission health services as these are delivered by the WA Health system through Health Service Providers.

In accordance with section 44 of the *Health Services Act 2016* the Department has entered into a Head Agreement with the MHC for 2016-17. The Head Agreement outlines the roles, responsibilities and accountabilities of the Department and the MHC in regards to funding, purchasing and performance.

Under section 45 of the *Health Services Act 2016*, from 2016-17 the MHC has entered into bi-lateral Commission Service Agreements with Health Service Providers for the delivery of Commission health services.

1.3.4 Provider Roles and Responsibilities

The Department purchases services from Health Service Providers, HSS and other service providers, both public and private, for the delivery of a range of healthcare and support services.

Each provider is engaged by a Service Agreement outlining the purchased activity, associated funding and other requirements to be delivered such as safety and quality measures and performance reporting.

Click here for more information on Mental Health Commission (MHC)

Outside of the Service Agreements between the Department and Health Service Providers, various divisions within the Department also provide or contract health services including:

- Public Health and Clinical Services, such as Environmental Health
- System Policy and Planning, such as Aged and Continuing Care
- Other divisions of the Department, such as Health Networks including Cancer and Palliative Care Network.

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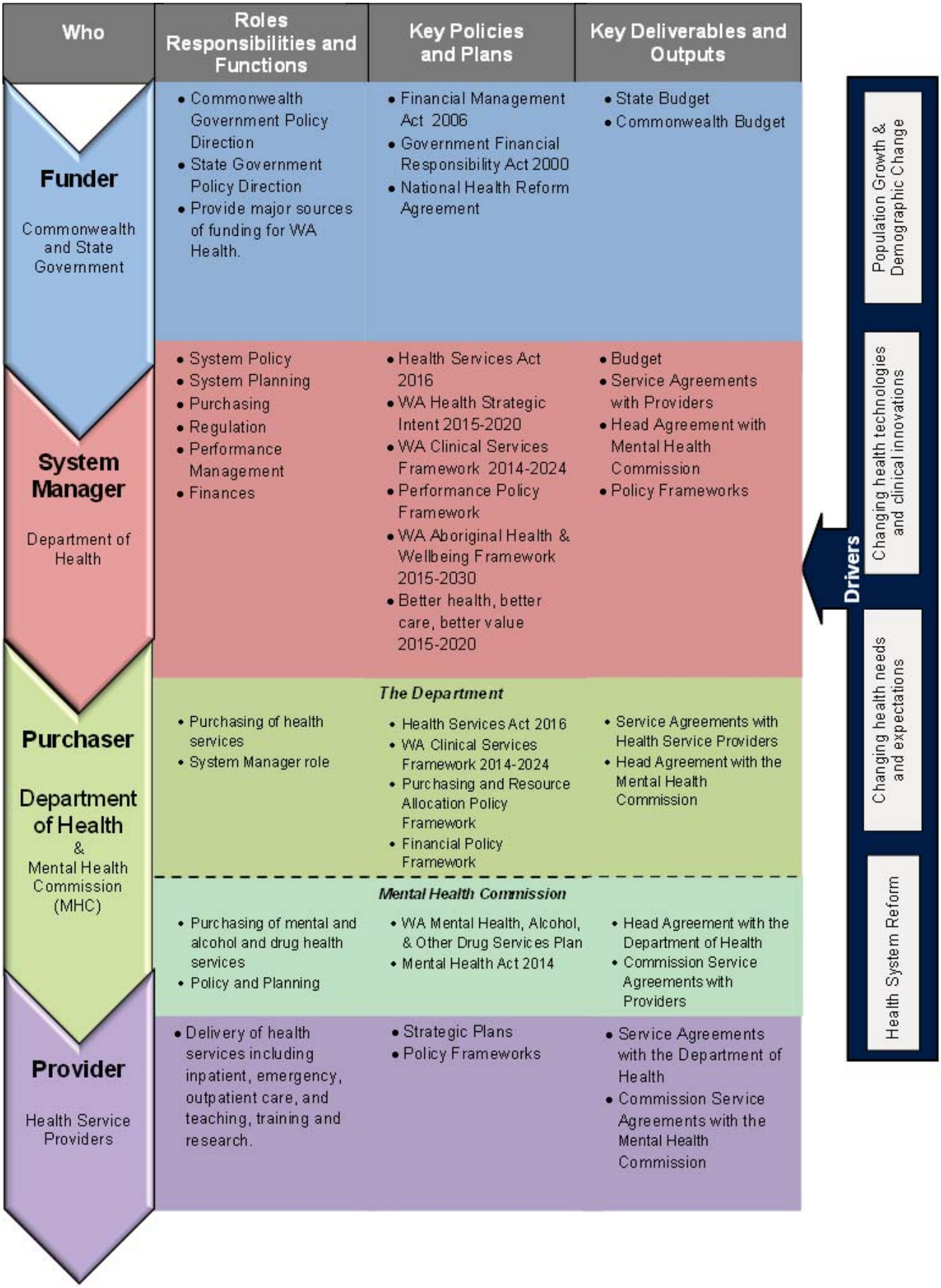
Figure 4: Key Accountabilities of the Funder, System Manager, Purchaser and Provider



Click here for more information on the Child and Adolescent Health Service

Click here for more information on the East Metropolitan Health Service

Click here for more information on the North Metropolitan Health Service

Click here for more information on the South Metropolitan Health Service

Click here for more information on the WA Country Health Service

1.3.5 Health Service Providers

In accordance with the *Health Services Act 2016*, the Health Service Providers are separate board-governed statutory authorities, legally responsible and accountable for providing health services for their local areas and communities.

There are seven Health Service Providers from 1 July 2016, as follows:

1. Child and Adolescent Health Service (CAHS)
2. East Metropolitan Health Service (EMHS)
3. North Metropolitan Health Service (NMHS)
4. South Metropolitan Health Service (SMHS)
5. WA Country Health Service (WACHS)
6. Health Support Service (HSS)
7. Quadriplegic Centre

Funding mechanisms differ according to the type of hospital. The Department funds all metropolitan hospitals under an ABF methodology. For rural areas, the Department also funds all Regional and Integrated District hospitals under an ABF methodology. Small hospitals and nursing posts are block funded.

The Commonwealth, under the NHRA, funds WA small rural hospitals and some of the WA metropolitan and Integrated District hospitals through a block funding mechanism. All other hospitals are funded under an ABF mechanism.

For a list of the ABF funded hospitals, small rural block funded hospitals and nursing posts within each Health Service Provider refer to *Tables 1, 2 and 3*.

The role of the Health Service Providers is as follows:

- providing safe, high quality, efficient and economical health services to their local communities
- monitoring and improving the quality of health services
- accountable for delivering health services in accordance with Service Agreements with the Department including funding, performance measures (e.g. clinical, financial, safety and quality, audit) and operational targets
- employing health service staff
- contributing to and implementing system wide plans issued by the Department
- complying with policy frameworks and directions issued by the Director General

- developing policies to suit the local context, within the guidelines of the policy frameworks set by the System Manager
- maintaining land, buildings and assets controlled and managed by the Health Service Providers
- consulting with health professionals working in the Health Service Providers and consultation with health consumers and community members about the provision of health services
- cooperating with other providers of health services, including providers of primary healthcare, in planning for, and providing, health services.

The Minister can also issue directions to Health Service Providers with respect to the performance of their functions. [2]

Which WA Hospitals are considered Adult Tertiary Sites?

Adult Tertiary Sites are; Royal Perth Hospital, Fiona Stanley Hospital, Sir Charles Gairdner Hospital and King Edward Memorial Hospital.

[2] Health Reform Fact sheet – The Role of Health Services and Boards (Feb 2016) https://healthpoint.hdwa.health.wa.gov.au/healthreform/Documents/Governance%20Fact%20Sheets%20and%20FAQs/Fact%20Sheet%20-%20The%20Role%20of%20Health%20Services%20and%20Boards.pdf

Table 1: List of WA Health ABF Hospitals

Child and Adolescent Health Service	East Metropolitan Health Service	South Metropolitan Health Service	North Metropolitan Health Service	WA Country Health Service
• Princess Margaret Hospital • Perth Children's Hospital	• Armadale Kelmscott Memorial Hospital • Bentley Hospital • Royal Perth Hospital • St John of God Midland Public Hospital • Kalamunda Hospital	• Fiona Stanley Hospital • Fremantle Hospital • Peel Health Campus • Rockingham General Hospital • State Rehabilitation Centre • Murray District Hospital	• Graylands Hospital • Joondalup Health Campus • King Edward Memorial Hospital • Osborne Park Hospital • Sir Charles Gairdner Hospital	**Regional** • Albany Hospital • Broome Hospital • Bunbury Hospital • Geraldton Hospital • Hedland Health Campus • Kalgoorlie Hospital **Integrated/District** • Busselton Hospital • Derby Hospital • Esperance Hospital • Kununurra Hospital • Nickol Bay Hospital (Karratha) **ABF Funded By WA*** • Collie Hospital* • Carnarvon Hospital* • Katanning Hospital* • Margaret River Hospital* • Merredin Hospital* • Moora Hospital* • Narrogin Hospital* • Newman Hospital* • Northam Hospital* • Warren Hospital (Manjimup)*

**These hospitals are block funded by the Commonwealth but ABF funded by WA. Refer to Section 4.2.1 WA ABF Operating Model Adjustments to the IHPA Model for further explanation on funding of these hospitals.*

Table 2: Block Funded Small Rural Hospitals

Hospital Name	Hospital Name
Augusta Hospital	Leonora Hospital
Beverley Hospital	Meekatharra Hospital
Bridgetown Hospital	Morawa Hospital
Boddington Hospital	Mullewa Hospital
Boyup Brook Soldiers Memorial Hospital	Nannup Hospital
Bruce Rock Memorial Hospital	Narembeen Hospital
Corrigin Hospital	Norseman Hospital
Cunderdin Hospital	North Midlands Hospital
Dalwallinu Hospital	Northampton Hospital
Denmark Hospital	Onslow Hospital
Dongara Multi-Purpose Health	Paraburdoo Hospital
Donnybrook Hospital	Pemberton Hospital
Dumbleyung Memorial Hospital	Pingelly Hospital
Exmouth Hospital	Plantagenet Hospital
Fitzroy Crossing Hospital	Quairading Hospital
Gnowangerup Hospital	Ravensthorpe Hospital
Goomalling Hospital	Roebourne Hospital
Halls Creek Hospital	Southern Cross Hospital
Harvey District Hospital	Tom Price Hospital
Kalbarri Health Service	Wagin Hospital
Kellerberrin Memorial Hospital	Wickham Health Centre
Kojonup Hospital	Wongan Hills Hospital
Kondinin Hospital	Wyalkatchem Hospital
Kununoppin Hospital	Wyndham Hospital
Lake Grace Hospital	York Hospital
Laverton Hospital	

The Department also funds nursing posts to deliver supporting health services across the State, as per *Table 3* below.

Table 3: List of WA Health Nursing Posts

Nursing Post Name	Region
Burringuarrah	Midwest
Coral Bay	Midwest
Cue	Midwest
Leeman	Midwest
Mt Magnet	Midwest
Sand Stone	Midwest
Shark Bay	Midwest
Wiluna	Midwest
Yalgoo	Midwest
Marble Bar	Pilbara
Bremer Bay	Great Southern
Jerramungup	Great Southern
Tambellup	Great Southern
Northcliffe	South West

Further information on State Budget Papers can be found here

For more information on **NHRA** click here National Health Reform Agreement

What is a local hospital network (LHN)? is an organisation that provides public **hospital** services in accordance with the National Health Reform Agreement. A **local hospital network** can contain one or more **hospitals**

2.0 Budget and Funding Acquisition

The budget and funding for health services in WA is a combined State and Commonwealth responsibility. Expenditure on health services in WA has grown from $4.8 billion in 2008-09 to $8.6 billion in 2016-17 representing an increase of almost 80 per cent in health investment over eight years. The 2016-17 WA Health budget represents an increase of 5 per cent in overall expenditure relative to the 2015-16 Estimated Actual[3]. The Commonwealth funding component of the 2016-17 budget is approximately $2 billion, as per the NHRA. It should be noted that additional funding is provided by the Commonwealth through direct grants for specific programs.

2.1 Commonwealth Funding

In August 2011, the NHRA was agreed by the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.

The intention of the NHRA was to deliver a nationally unified and locally controlled health system through:

- introducing a number of financial arrangements for the Commonwealth and States and Territories in partnership
- confirming states and territories' lead role in public health and as System Managers for public hospital services
- improving patient access to services and public hospital efficiency through the use of Activity Based Funding (ABF) based on a National Efficient Price (NEP)
- ensuring the sustainability of funding for public hospitals by the Commonwealth providing a share of the efficient growth in public hospital services
- improving the transparency of public hospital funding through a National Health Funding Pool (NHFP)
- improving local accountability and responsiveness to the needs of communities through the establishment of Local Hospital Networks (LHNs) and Medicare locals
- new national performance standards and better outcomes for hospital patients.

[3] Western Australian state budget 2016-17 – Part 6 Minister for Health; Culture and the Arts Accessed via: http://static.ourstatebudget.wa.gov.au/16-17/bp2/2016-17-wa-state-budget-bp2-part6.pdf?

A number of entities were formed to oversee the development of the necessary metrics for the new national funding approach, including; the calculation of a national benchmark price; the development of national cost weights and specific loadings, the development of approaches to pricing for safety and quality and also manage the disbursement of ABF resources on behalf of the Commonwealth. The key entities are as follows[4]:

- Independent Hospital Pricing Authority (IHPA)
- The National Health Funding Pool (NHFP)
- The National Health Funding Body (NHFB)
- Australian Commission on Safety and Quality of Health Care (ACSQHC)

Independent Hospital Pricing Authority

The IHPA is an independent government agency whose powers and functions are established through the National Health Reform Act 2011 to facilitate the introduction of a nationally consistent approach to activity based funding.

Each year, the IHPA produces a NEP for services provided by hospitals on an activity basis and a National Efficient Cost (NEC) for hospital services that are block funded. The NEP and NEC form the basis for determining the majority of the Commonwealth Government's contribution towards the funding of public hospital services. The *Pricing Framework for Australian Public Hospital Services* outlines the principles, scope and methodology to be adopted in setting the NEP and NEC.

The IHPA is also responsible for developing and specifying classification systems for healthcare and other services provided by public hospitals including specific cost weights for admitted, emergency and non-admitted services, and associated data requirements and standards; specific costing studies and inter-jurisdictional service payments disputes.

The National ABF Program within the Health System Purchasing Directorate at the Department is responsible for coordinating WA Health's contribution to national pricing policy and is actively involved with the IHPA in the development and revision of national classification systems.

[4] The National Health Performance Authority ceased operations as an agency on 1 July 2016, however the functions were transferred to the AIHW and ACSQHC.

National Efficient Price (NEP)
The 2016-17 NEP is $4,883 per National Weighted Activity Unit (NWAU[16]).

Calculation of the NEP
The 2016-17 NEP is based on the calculated average cost of public hospital activity for the 2013-14 financial year of $4,588 per NWAU(16), indexed at a rate of 2.1% p.a. Consistent with the NHRA, Cwlth directly funded programs have been removed prior to determining the underlying cost data of the 2013-14 reference cost.

Click here for more info on Understanding the NEP

For more information on **IHPA** click here Independent Hospital Pricing Authority

Visit the National Health Funding Pool Act 2012 to access relevant legislation

Who is the Administrator?

The Administrator of the National Health Funding Pool is an independent statutory office holder, distinct from Commonwealth and State and Territory government departments. The Administrator is not subject to the control or direction of any Commonwealth Minister.

For more information click here

National Health Funding Body

The primary function of the NHFB is to assist the Administrator of the National Health Funding Pool in the performance of his functions.

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The Administrator - National Health Funding Pool

The National Health Funding Pool (NHFP) consists of eight state and territory bank accounts held with the Reserve Bank of Australia (RBA).

The bank accounts that make up the Pool are known as State Pool Accounts (SPA) and were established under state and territory legislation for the purpose of:

- receiving all Commonwealth block funding
- receiving activity based state and territory public hospital funding
- distributing funds and making payments according to the NHRA guidelines.

The NHFP is headed by an Administrator (NHFP Administrator), who is an independent statutory office holder; independent of Commonwealth, State and Territory government departments who is responsible for:

- calculating and advising the Commonwealth Treasurer of the Commonwealth contribution to the NHFP under the NHRA
- overseeing payment of Commonwealth funding determined under the NHRA into the SPA established at the RBA under State legislation
- reconciling the estimated and actual volume of service delivery, informed by the results of data checking activities undertaken by the NHFB, and incorporating the result of this reconciliation into the calculation of the Commonwealth contribution by the NHFP.

National Health Funding Body

The NHFB is an independent statutory authority whose function is to support the NHFP Administrator in carrying out his or her functions under Commonwealth and State legislation.

A key function undertaken by the NHFB on behalf of the NHFP Administrator is the calculation of the Commonwealth funding contribution to each State and Territory. As part of this process, States and Territories make an annual submission to the NHFP Administrator of the estimated ABF and block funded activity they expect to deliver in a given financial year. The NHFB, on behalf of the NHFP Administrator, uses these activity estimates to calculate the Commonwealth funding due to each jurisdiction. The NHFP Administrator uses the calculation outcomes to advise the Commonwealth Treasurer of the activity based and block funding appropriation due to each State and Territory.

Additionally, the NHFB supports the NHFP Administrator in undertaking a reconciliation of the activity estimates against actual activity delivered during the financial year, with variances leading to adjustments in Commonwealth funding to jurisdictions.

WA Health actively manages this reconciliation process with the NHFB as the outcomes could significantly impact the financial certainty and stability of the WA Health system.

Australian Commission on Safety and Quality of Health Care

The ACSQHC was initially established in 2006 by the Australian, State and Territory governments to lead and coordinate national improvements in safety and quality in healthcare. The Commission works in partnership with patients, consumers, clinicians, managers, policy makers and healthcare organisations to achieve a sustainable, safe and high-quality health system.

The ACSQHC and IHPA have established a Joint Working Party (JWP) to consider potential approaches to pricing for safety in public hospital services in Australia. The JWP is tasked with providing advice to the ACSQHC and IHPA on potential approaches including elements of safety and quality within the national Pricing Framework for Australian Public Hospital Services and the likely benefits to the Australian community

Changes to Commonwealth Funding of Public Hospital Services

In the 2015-16 Commonwealth Budget it was stated that from 1 July 2017, the Australian Government intended to modify the method of determining its contribution to the funding of public hospitals to movements in the Consumer Price Index (CPI) and population growth.

However, on 1 April 2016, the *Heads of Agreement between the Commonwealth and the States and Territories on Public Hospital Funding (Agreement)* was signed forming the basis for further negotiations regarding the funding of public hospital services. The Agreement provides a commitment to develop an addendum to the current NHRA that will commence on 1 July 2017 and operate for three years, ceasing on 30 June 2020. The Agreement will retain most of the existing funding methodology including the calculation of both the NEP and the NEC.

The ACSQHC strategic priorities over the next four years are in the following areas

- patient safety
- partnering with patients, consumers and communities
- quality cost and value
- supporting health professionals to provide safe and high-quality care.

For more information click here

Consistent with clause A (1) of the NHRA the Commonwealth contribution to hospital services from 1 July 2017 until 30 June 2020 will continue to be based on ABF, where practical, and block funding for public hospital services better funded through block grants.

The Commonwealth will continue to fund 45 per cent of the efficient growth of services however, this will be subject to a 6.5 per cent national funding cap, based on the calculated growth of overall Commonwealth funding, as outlined in the Agreement.

2.2 WA State Budget

2.2.1 Constrained Fiscal Environment

Following a period of above trend expansion, economic growth is continuing to moderate as business declines from record high levels and major resource projects continue to transition from construction to the production and export phase.

The State's revenue base remains under significant pressure. In 2016-17 General Government Revenue is expected to be 3.1 per cent lower than in 2015-16, the third consecutive year of declining revenue.

The continuing weakness in the revenue outlook has resulted in the Government implementing new initiatives to further limit the growth in spending. The 2016-17 Budget includes the impact of the new Government Wages Policy, limited to 1.5 per cent indexation, announced in February 2016, and an extended Agency Expenditure Review (AER) program. These and previous measures underpin low expense growth projections averaging just 2.4 per cent across the forward estimates period, substantially below the average of 7.7 per cent recorded over the previous decade.

Click here for more information regarding the Government Wages Policy

What is the Agency Expenditure Review (AER)?

Due to the weak revenue outlook, the Government has implemented a number of initiatives to further limit growth in spending, including the AER

Click here to find out more about the AER, including the objectives

Figure 5: General Government Revenue and Expenditure Growth Rates

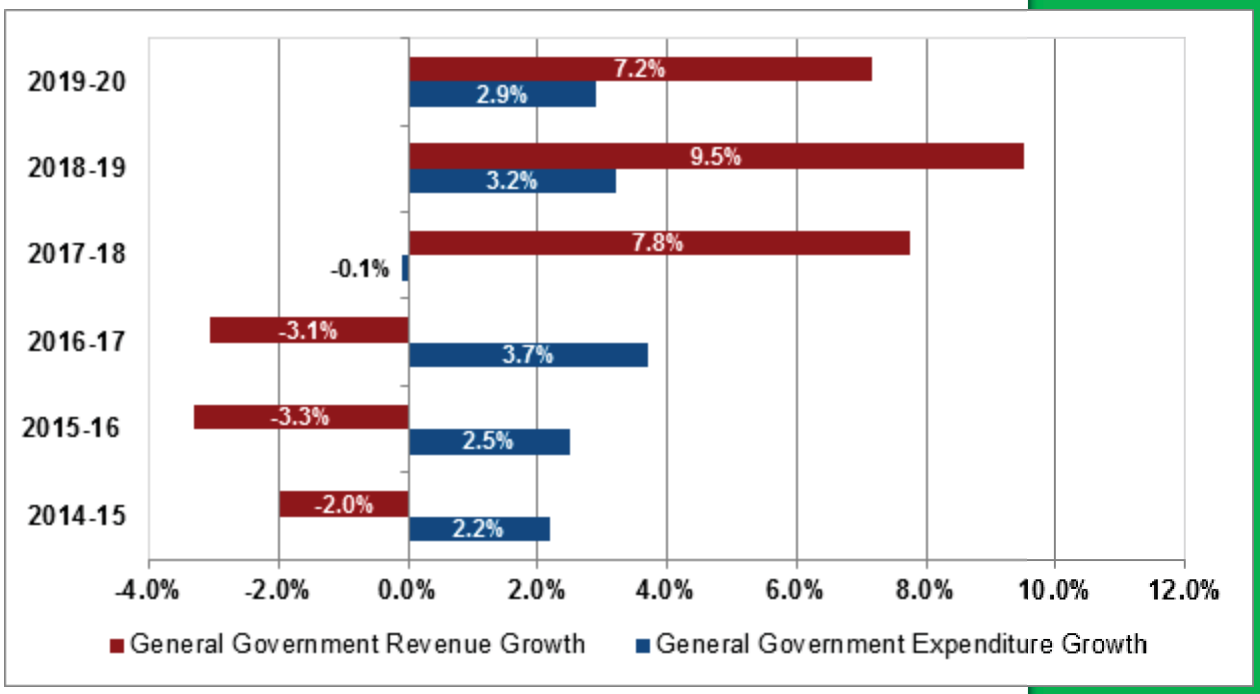


Figure 5 Source:
2016-17
State Budget Papers

2.2.2 Health Spending

Health sector funding continues to be the largest proportion of government expenditure at approximately 29 per cent of total State Government expenses, followed by Education at 16 per cent and Law and Order at 10 per cent.

Figure 6: Health Funding as a Proportion of Total Government Expenditure

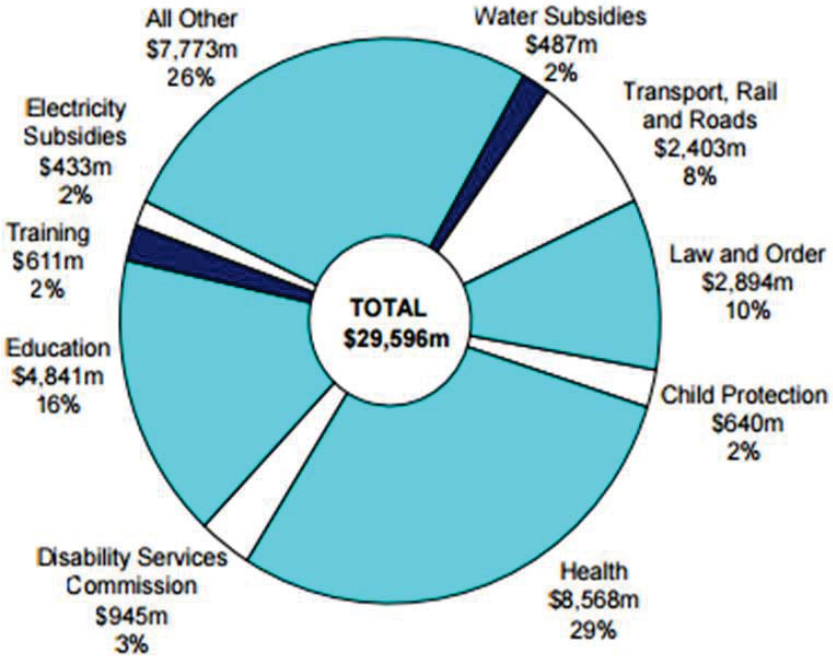


Figure 6 Source:
2016-17
State Budget Papers

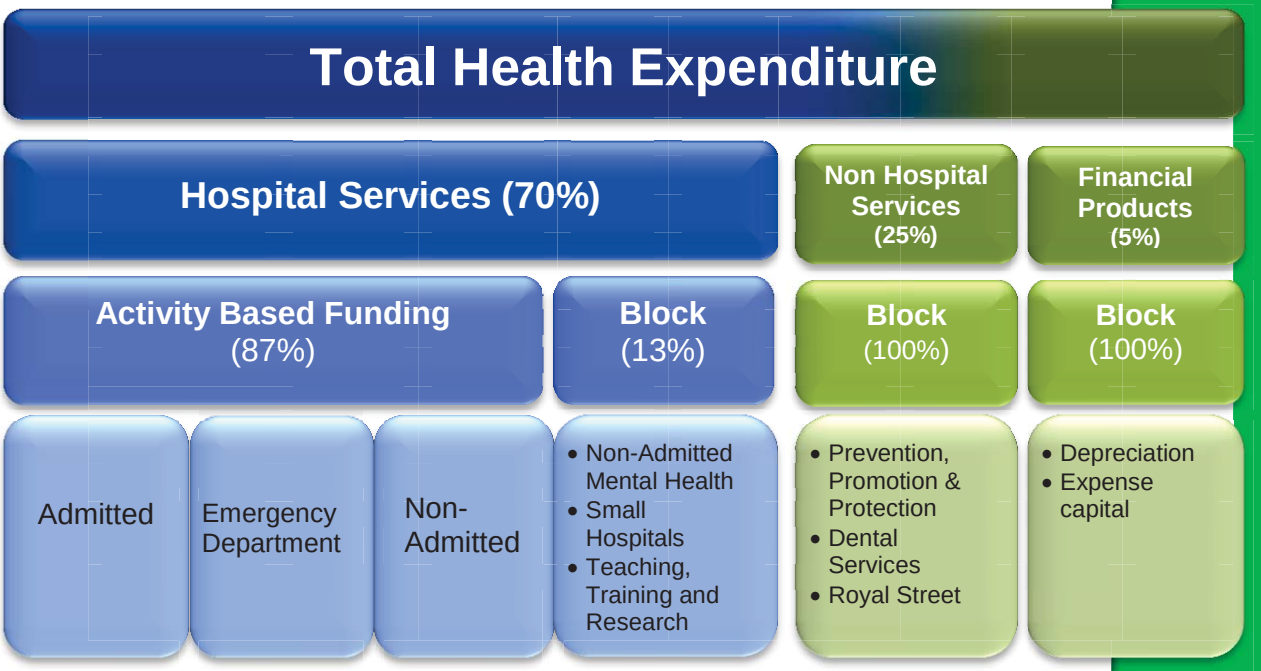
WA Health's approved expenditure limit for 2016-17 is $8.6 billion, reflecting an increase of 4.8 per cent ($395.3 million) relative to 2015-16 estimated outturn. This provides an annual average expense growth of 3.2 per cent over the forward estimates. This is a strong outcome in a tight fiscal and economic environment in which overall government expenditure is expected to grow at an average of only 2.4 per cent.

Table 4: WA Health's Expenditure Limit in 2016-17 and Forward Years

	2015-16 Est Act $m	2016-17 $m	2017-18 $m	2018-19 $m	2019-20 $m	Avg Annual Growth Rate
Expense Limit	**8,173**	**8,568**	**8,591**	**9,073**	**9,277**	
Growth		*4.8%*	*0.3%*	*5.6%*	*2.3%*	*3.2%*

In broad terms, budget expenditure for WA Health is categorised into Hospital Services, Non Hospital Services and Financial Products as outlined in *Figure 7*.

Figure 7: WA Health's Budget Expenditure Categories



The budget categories for hospital services include; admitted (inpatient services including acute, sub-acute and non-acute services); emergency department; and non-admitted (outpatient) services. It also includes the provision of Teaching, Training and Research (TTR) activities.

The non-hospital services budget category includes programs and initiatives that seek to provide:

- health prevention and promotion interventions (to reduce the likelihood or at least slow down the advancement of a disease or disorder)
- palliative care services that focus on preventing and relieving suffering and on supporting the best possible quality of life for patients facing serious illness, and their families
- Dental Services, Pathology and Diagnostic Services and External Services provided by Health Service Providers
- Emergency Patient Transport and Rural Patient Travel Assistance Services
- services that specifically target Aboriginal health
- strategic and system-wide direction and leadership of WA's health system.

Financial products include depreciation, expensed capital, borrowings and resources received free of charge.

For a detailed breakdown of the budget relative to the service expenses refer to *Table 5*.

Table 5: WA Health's Service Summary

Expense	2015-16	2016-17	Variance	
	$'000	$'000	$'000	%
1. Public Hospital Admitted Patients	4,477,664	4,731,074	253,410	5.7%
2. Home-Based Hospital Programs	33,115	35,225	2,110	6.4%
3. Palliative Care	33,014	33,626	612	1.9%
4. Emergency Department	735,820	766,911	31,091	4.2%
5. Public Hospital Non-Admitted Patients	907,248	951,780	44,532	4.9%
6. Patient Transport	211,573	215,858	4,285	2.0%
7. Prevention, Promotion and Protection	578,891	603,704	24,813	4.3%
8. Dental Health	105,468	106,569	1,101	1.0%
9. Continuing Care	462,648	477,969	15,321	3.3%
10.Contracted Mental Health	627,255	645,357	18,102	2.9%
Total Cost of Services	8,172,696	8,568,073	395,377	4.8%

Source: 2016-17 West Australian Budget Paper

2.2.3 Budget Settings for Activity Based Hospital Services

The State Government budget settings for health activity delivered by WA Health including activity purchased by the MHC are set using the National ABF Framework, and are informed by the annual Pricing Framework[5] published by the IHPA[6].

As shown in *Table 6*, the 2016-17 Budget provides for Activity Based Hospital Services expenditure of $5 billion representing growth of 5 per cent ($240 million) relative to the 2015-16 estimated outturn, and an annual average growth rate of 4.3 per cent over the forward estimates.

[5] IHPA is required to release an annual pricing framework that provides the technical specifications for the counting and classification of activity based services including inpatients, emergency department services, outpatient services, sub-acute and mental health adjustments.

[6] IHPA was established under *the* NHRA 2011 to oversee the phased implementation of a consistent national approach to ABF.

Table 6: ABF Hospital Services Expenditure

2016-17 Approved Hospital Services Expenditure		2015-16 *estimatedout turn*	2016-17
Approved Activity	WAUs	858,781	**879,392**
Demand Growth	*%*	*4.6%*	*2.4%*
Approved Sate Price	$	5,626	**5,767**
Cost Growth	*%*	*-1.1%*	*2.5%*
Approved ABF Expenditure	$M	**4,831**	**5,072**
Overall Growth	*%*	*3.5%*	*5.0%*

State Budget Demand Growth

Consistent with prior years, the 2016-17 activity settings determined by WA Treasury have been established using demand projections forecast that are consistent with age-weighted population growth and historical hospital activity information.

Cost Growth – National Efficient Price and Projected Average Cost (PAC)

The IHPA uses information on hospital services costs submitted by all jurisdictions through the National Hospital Cost Data Collection (NHCDC) to calculate service cost weights, price indexations parameters and the Projected Average Cost (PAC)[7] of delivering hospital services. Services that are directly funded by the Commonwealth such as Highly Specialised Drugs and Early Stage Breast Cancer PBS (Section 100 Funding), Pharmaceutical Reform Agreements (Efficient Funding of Chemotherapy and PBS Access Program) and Blood Program expenditures are netted from the calculated national average cost in order to derive the NEP. NEP estimates are a major determinant in deriving Commonwealth Government funding for in-scope public hospital services.

[7] The Projected Average Cost (PAC) calculated by the IHPA is the closest measure to a national average cost of delivering hospital services in Australia and it is used by WA Health as a benchmark for pricing hospital services in the State and for comparing service delivery costs with other jurisdictions and also the Australian average.

Visit IHPA for more information on **National Efficient Price** (NEP) and **How to calculate a WAU**

The calculated net average cost of public hospital activity, that is, excluding directly funded (*outside ABF*) Commonwealth programs, for 2013-14 was $4,588 per National Weighted Activity Unit (NWAU). This value was then indexed at a rate of 2.1 per cent per annum to arrive at the 2016-17 NEP of $4,883 per NWAU.

The PAC and the NEP are used as measures to determine the State Price for healthcare services provided by public hospitals, where the services are funded on an activity basis. They provide a price signal for the efficient cost of providing public hospital services.

The WA ABF funding model includes the cost of those services netted from the estimated PAC in its price and for that reason the PAC is used as a State benchmark to determine an initial total expenditure view for ABF services.

Since the 2013-14 Budget, the pricing targets for activity based funded hospital services have been set with reference to the PAC:

- the 2013-14 Budget provided for a strategy to converge the cost of providing activity based hospital services to the PAC by 2017-18
- the 2015-16 Budget extended the convergence strategy transition timeframe to 2020-21.

The new 2016-17 IHPA Pricing Framework revealed a number of challenges in achieving the proposed convergence strategy timeframe including:

- a decline in the indexation factor used in determining the NEP from 3.0 per cent in the 2015-16 Pricing Framework to an estimated 2.1 per cent in the 2016-17 Framework
- an increasing divergence between the PAC and the State Price.

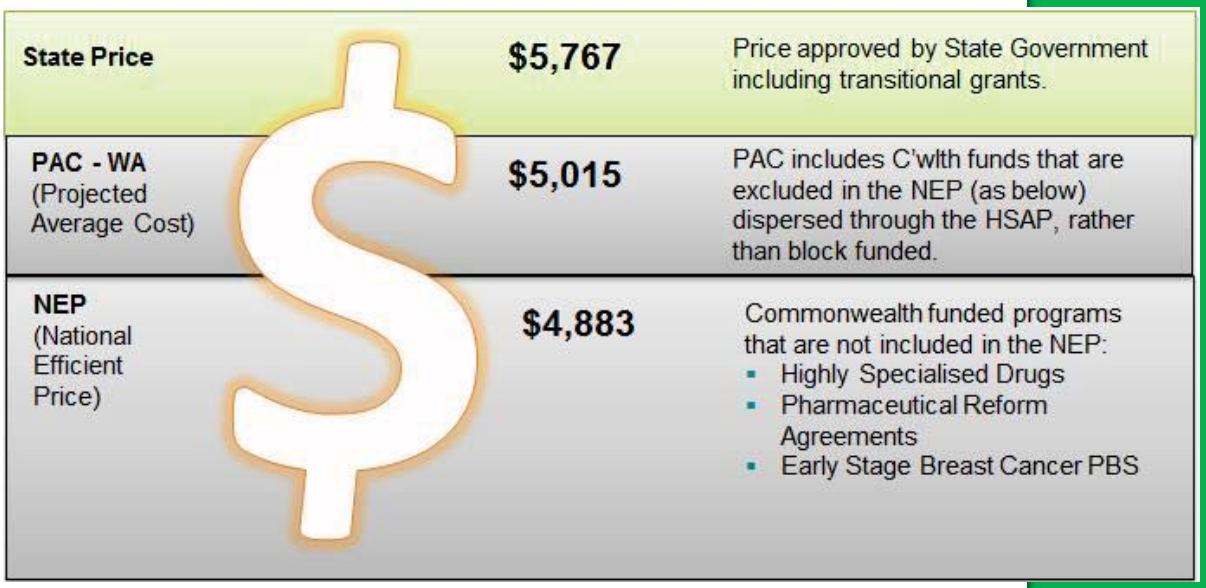
In view of the above, maintaining the convergence strategy to the PAC by 2020-21 would not have been realistic for the State and would imply a negative cost growth for hospital services of 0.6 per cent per annum. Accordingly, the 2016-17 Budget:

- decouples the price settings for ABF hospital services from the national cost benchmark
- provides for cost growth in line with public sector wages policy (1.5 per cent per annum)
- requires a 1 per cent per annum efficiency dividend in ABF from 2017-18 onwards

- reinvests the savings from the AER of non-hospital services into ABF Hospital Services. For further information on the AER refer to Section 2.2.5 Corrective Measures below.

As the Budget stated provision for cost growth for hospital services of 1.5 per cent is significantly lower than the cost indexation of 2.1 per cent provided in the 2016-17 IHPA Pricing Framework, continuance of a strong price discipline is required to achieve future equivalence with the PAC to which the State Price will continue to be benchmarked against in order to demonstrate the cost of providing hospital services in WA relative to other jurisdictions.

Figure 8: Summary of Pricing



For further information on WA Health pricing policy including the Health Service Allocation Price (HSAP) refer to Section 4.2.3.3 Health Service Allocation Price.

2.2.4 Block Funded Services

Block funding from the Government is provided for small rural hospitals and for non-admitted mental health services. Small rural hospitals have high fixed costs and fluctuating demand for services, and are not suited to be funded on an activity basis. Non-admitted mental health services will transition to an ABF environment over the next few years, as the IHPA, in conjunction with jurisdictions, work on the development of a new classification methodology for these services. TTR activities, although block-funded by the Government, are dispersed based on the ABF service allocation methodology by WA Health.

Block Funded Services are cost escalated for 2016-17 as outlined in Section 4.1.2 Block Funding Allocation for 2016-17

Click here to find out more about the Indexation Policy for Non-Government Human Services Sector

Table 7: Cost and Demand Escalators for Block Funded Services.

	Escalator	Notes
Demand	2.47%	2016-17 Age Weighted Population Growth Rate
Demand	1.36%	2016-17 Mental Health Age Weighted Population Growth Rate
Cost	1.50%	Consistent with the 2016-17 Government Wages Policy

2.2.5 Indexation for Non-Government Human Services Sector

An indexation rate is determined for each financial year under the State Government Non-Government Human Services Sector Indexation Policy. For 2016-17, an indexation rate of 1.6% applies to all eligible new and existing contract arrangements set under Delivering Community Services in Partnership Policy 2011 (the DCSP Policy). The DCSP Policy has been effective since 1 July 2011 and applies to all Public Authorities that provide funding for, or purchase community services from, not-for-profit organisations.

The cost and demand escalators underpinning Block Funded Services are outlined below:

2.2.6 Corrective Measures

The following corrective measures and their estimated financial impacts are reflected in WA Health's 2016-17 Budget settings.

Table 8: Financial Impacts from Corrective Measures.

Corrective Measures	2015-16	2016-17	2017-18	2018-19	2019-20	Total
	$'000	$'000	$'000	$'000	$'000	$'000
1% Efficiency Dividend	-	-	-	-	52,698	52,698
2014-15 Targeted Voluntary Separation Scheme	9,593	9,833	10,079	10,331	-	39,836
Agency Expenditure Review (Tranche Three)	-	-	47,481	52,496	48,275	148,252
Reduction in Indexation for Non-Salary Expenses	-	2,719	6,649	11,258	-	20,626
Revised 1.5% Public Sector Wages Policy	-	19,477	67,609	122,866	185,605	395,557
Total	9,593	32,029	131818	196,951	286,578	656,969

One per cent Efficiency Dividend

The 1.0 per cent efficiency dividend to be applied in 2019-20 is a continuation of measures introduced in prior budgets whereby savings targets were applied to General Government sector appropriation-funded agencies.

2014-15 Targeted Separation Scheme (TSS) for Non-Hospital Services

Cabinet mandated that all ongoing salary expense savings from the previously implemented 2014-15 TSS be returned from 2015-16 onwards to the State Consolidated Account.

These salary expense savings for Non-Hospital Services amount to $39.8 million over the forward estimates.

Agency Expenditure Review

The objective of the AER is to ensure that, as the economic environment change over time; main programs delivered by agencies remain a Government priority and continue to be delivered in an efficient and effective manner. The 2016-17 WA Health budget settings include AER savings targets endorsed by Government of $47.5 million in 2017-18, $52.5 million in 2018-19 and $48.3 million in 2019-20. The savings target was applied to the budget settings for Non Hospital Services.

Implementation of the AER process will be led by the Department through an independently-chaired Project Board.

Reduction in Indexation for Non-Salary Expenses

As part of the 2015-16 Mid-Year Review an annual (cumulative) 1.5 per cent reduction in indexation for appropriation-funded non-salary expenses was applied. The application of this indexation change has resulted in a $20.6 million reduction over the period 2016-17 to 2018-19.

Revised 1.5 per cent Public Sector Wages Policy

The 2016-17 Government of Western Australia Public Sector Wages policy requires that increases in wages and associated conditions for all industrial agreements be limited to 1.5 per cent per annum. A budget adjustment of $395.6 million has been applied to WA Health's budget settings in order to reflect the new policy.

For more information regarding the Targeted Separation Scheme click here

Click here for more information regarding the Government Wages Policy

2.3 Service Delivery Initiatives in the 2016-17 Budget

Replacement of the Medical Imaging System

The 2016-17 Budget provides $52.6 million to enable the replacement of WA Health's Medical Imaging System, the Picture Archiving and Communication System-Radiology Information System (PACS-RIS). A new PACS-RIS will improve WA Health's medical imaging service delivery through technology enhancements which will enable improved clinical healthcare outcomes by providing a centralised platform for medical imaging, allowing practitioners to access current and historical images at the point of care, promoting consistency and better management of data transfer, as well as substantially improving accessibility options for clinicians.

Monitoring of Drugs and Dependence System (MODDS)

The 2016-17 Budget provides for a reprioritisation of existing funding for the Asset Investment Program of $1 million for the replacement of MODDS with a new system that will provide clinicians with up-to-date and transparent information on a patient's medication history including a complete and accurate account of a patient's use of controlled and other similar drugs.

iPharmacy System

Existing capital funding of $1.364 million has been reprioritised for an upgrade of the existing pharmacy system used for the procurement, distribution and dispensing of medicines in WA public hospitals. The upgraded system will align WA Health's pharmacy system with the Commonwealth Government's streamlined Pharmaceutical Benefit Scheme claims process and will be compliant with the National Safety and Quality Health Service hospital safety requirements.

Commissioning and Development of the Perth Children's Hospital (PCH)

The 2016-17 Budget provides $40.8 million to support the delays in construction and the operational commissioning of the PCH including the provision of Information Communication and Technology systems at the new hospital.

Want to know more about the Perth Children's Hospital click here

Information regarding the State Quadriplegic Centre can be accessed here.

State Quadriplegic Centre

The 2016-17 Budget has provided $0.5 million for the commencement of planning work around the redevelopment of the State's existing Quadriplegic Centre. The redevelopment of the current facilities will include consideration of contemporary models of care, to assist people with spinal cord injuries to live to their maximum potential and closer to the community.

PlusLife

In its commitment to maintain high quality health service delivery, the Government is providing a capital grant of $10 million to PlusLife, WA's only bone bank. This investment will provide for the development of a new purpose-built processing and laboratory facility.

Joondalup Mental Health Observation Area

Recognising the need for safe treatment of mental health patients presenting to emergency departments, the 2016-17 Budget provides (with contribution from Ramsay Health Care) for the construction of a new 10 bed Mental Health Observation Area at Joondalup Health Campus at an estimated total cost of $7.1 million.

State Epilepsy Service Relocation

The Budget provides $1.4 million for the reconfiguration and upgrade of a section of Ward G51 at Sir Charles Gairdner Hospital (SCGH) to facilitate the expanded and upgraded provision of epilepsy and epilepsy monitoring services for patients at SCGH.

Neurotrauma Research

The 2016-17 provides $1 million as continued support towards the Neurotrauma research program that is improving the lives of people affected by brain and spinal cord injury in WA.

ICT Minor Works Program

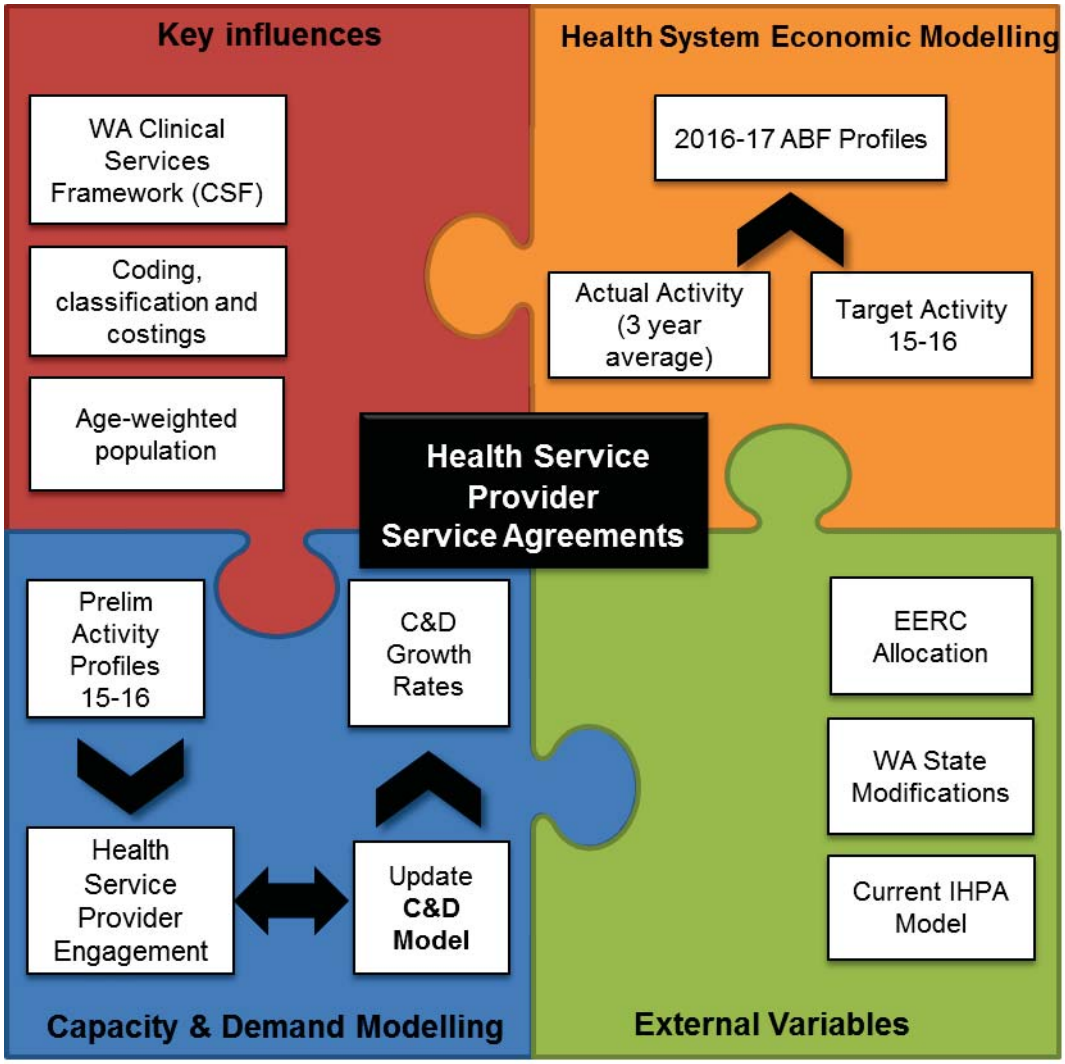
The 2016-17 Budget provides for the conversion of $4 million of recurrent funding (from 2016-17 and 2017-18) to capital funding to enable the implementation of WA Health's ICT Minor Works Program. The program will provide strong technical and project level support to address critical backlog maintenance issues within the available funding limitations.

3.0 Strategic Planning and Modelling

3.1 Introduction

Section 3 outlines some of the key elements influencing and informing the resource allocation process. Figure 9 outlines some of these key elements, such as coding, classification, counting and costing of activity. It also outlines the WA Health Clinical Services Framework (CSF) which informs the capacity and demand modelling process and the underlying growth rate applied to activity profiles.

Figure 9: Activity Based Funding (ABF) WA State Modifications and Modelling



3.1.1 WA Health Clinical Services Framework

The CSF is the main government endorsed clinical service planning framework document for the WA public health system. The CSF provides a blueprint for the whole health system in planning for healthcare services, workforce, infrastructure, technology, and budgeting in line with the WA Health Strategic Intent. The CSF is based on the most up-to-date demographic data and projections of future health service needs. This assists with the preparation and planning for emerging clinical challenges such as changing demographic, increasing complexity of disease, environmental factors, service capabilities and government policy. The CSF provides site level detail about the quantity of both admitted and non-admitted services relative to clinical specialty. The CSF has also been expanded to include a range of non-hospital services provided across WA including Aboriginal health, ambulatory care, child health, dental care, mental health, primary care and public health. Underpinning the CSF is the development of new Models of Care and targeted consultation with both clinical and community stakeholders.

Click here for more information on the WA Health Clinical Services Framework

3.2 Admission, Readmission, Discharge and Transfer Policy

The Admission, Readmission, Discharge and Transfer (ARDT) Policy is a mandatory policy within the PRAF which outlines the criteria for counting and classifying admitted care activity across the WA Health system. It ensures the activity data complies with the mandatory national reporting obligations to ensure correct classification and appropriate funding of activity.

For more information on the **ARDT** click here Admission, Readmission, Discharge and Transfer Policy for WA Health Services

3.3 Classification, Counting and Costing of Health Activity

High quality accurate and timely data is essential to the efficient operation of the WA Health system. The correct classification, counting, coding and capturing of data contributes to the funding, purchasing and resource allocation process by providing information that can be used to:

a) inform the setting of health activity levels and the funding and budget allocations for Health Service Providers
b) provide information to measure and assess performance against targets ensuring system accountability
c) provide information to the System Manager and Health Service Providers to enable the accurate development of policies and plans for appropriate healthcare delivery
d) provide reliable information to national bodies to guide national performance reporting, price setting and funding allocation.

The WA Health ABF operating model allocates funding on the basis of the number of patients and the types of treatments at a set price. This type of casemix funding requires timely and accurate data collection around:

- classifying the reasons for patient attendance – using appropriate clinical groupers according to the type and complexity of health service care provided
- counting patients treated – using information extracted from existing Patient Information Systems according to the type of health service provided (e.g. Hospital Morbidity Data System (HMDS) for admitted patients).
- costing patients treated – using dedicated hospital costing systems that feed costing data collections.

3.3.1 Classifying Patients

The IHPA is responsible for developing and specifying the national classification systems for healthcare and other services provided by public hospitals and their associated data requirements and standards.

Classifications aim to provide the healthcare sector with a nationally consistent method of categorising patients, their treatment and associated costs. Rules for collecting and coding clinical data need to be the same across Australia to ensure that all jurisdictions are obtaining and providing information the same way.

There are various service categories in Australia that have classifications being used nationally or in development stage, as outlined in the *Table 9*.

Table 9: Patient Service Category or Care Type and Classification

Patient service category/ care type	Classification
Admitted acute care	Australian Refined Diagnosis Related Group (AR-DRG)
Emergency Care	Urgency Disposition Group (UDGs) and Urgency Related Group (URGs)
Non-admitted care	Tier 2 Non-Admitted Care Services
Subacute and non-acute care	Australian National Subacute and Non-Acute Patient (AN-SNAP)
Teaching, Training and Research	In development. Currently Block funded
Mental Health Care (Admitted)	Australian Refined Diagnosis Related Group (AR-DRG) with modified pricing
Mental Health Care (Non-Admitted)	In development. Currently Block funded

3.3.2 Development of New National Classifications

The IHPA, in consultation with jurisdictions, leads the process of refinement and, where necessary, development of new clinical care classifications, to ensure they remain clinically relevant and appropriate for activity based funding purposes.

Mental Health Care

A new national classification system for mental health services, the Australian Mental Health Care Classification (AMHCC) Version 1.0 has been developed by the IHPA. The classification will apply to the admitted and community settings. The IHPA implemented the AMHCC for reporting from 1 July 2016 and aims to implement it for pricing of mental healthcare from 1 July 2017.

Non-Admitted Care

The IHPA has commenced work to develop a new national classification for non-admitted services that will replace the current Tier 2 classification. Development of the Australian Non-Admitted Care Classification (ANACC) commenced in 2016 and is expected to be completed in 2018.

Teaching, Training and Research (TTR)

There is currently no national classification for TTR. Development of a national classification for TTR will be progressed by the IHPA in 2016 and is expected to be completed by June 2017.

Emergency Care Services

Work to inform the development of a new classification for emergency care services is progressing in 2016-17, with the IHPA undertaking a national costing study. A new national classification system is scheduled for completion by December 2017 and proposed for implementation from 1 July 2018.

3.3.3 Counting Patients

In an ABF environment, the counting of patients is another essential part of determining future demand and casemix to inform funding and activity levels. Each time a patient is discharged from hospital and/or seen in a non-admitted setting, an episode of care occurs. The episode of care refers to the phase of treatment or overall nature of treatment received. A patient can receive more than one episode of care during their hospital admission due to a change in care type (e.g. from acute to sub-acute care).

Visit IHPA for more information on TTR Teaching, Training & Research

In an admitted patient setting, a patient may have a number of diagnoses and procedures recorded, with a principal diagnosis being assigned after investigations have been undertaken. This principal diagnosis is the main driver for the allocation of the episode of care to a specific DRG.

Upon finalisation of the episode of care, expert clinical coders classify and record this information into Patient Information Systems. This activity is then inputted into datasets managed centrally by the Department.

For further information on counting of patients refer to the ARDT Policy.

3.3.4 Costing Patients

WA hospitals undertake costings of all hospital level activity each financial year. This patient-level costing data includes all Admitted, Emergency Department and Non-admitted hospital activity. Costing data is reconciled against Audited Financial Statements and is used by the Department in analysing the service delivery efficiency of different hospitals and as an important parameter when defining purchasing policies including the pricing strategy to be applied for ABF services.

Further, this costing information is also used by the IHPA, which coordinates the annual NHCDC. Every jurisdiction in Australia is required to provide costing information as part of the NHCDC process.

The NHCDC informs the national public sector pricing parameters and the construction of cost weights for the different categories of hospital services.

3.4 Capacity and Demand Modelling Process

The capacity and demand modelling process outlined in this section uses and builds on prior year's activity data (classified, counted and recorded as per Section 3.3 Classification, Counting and Costing of Health Activity) in conjunction with the CSF and other variables. This information is used to calculate service category growth rates, applied each financial year in developing Health Service Providers preliminary activity profiles. As depicted in *Figure 9*, this modelling process informs, along with other key considerations, the final activity profiles which are included in Service Agreements between the Department and each Health Service Provider.

The capacity and demand modelling process involves the following steps:

a) projection of future demand (Status Quo)
b) modification of projections by applying quantified scenarios (Scenario Demand)
c) redistribution of activity based on infrastructure and service delivery changes (Capacity Modelling).

a) Status Quo Demand

Time series analysis of historical activity is undertaken to project demand activity for admitted and emergency department services.

There are key assumptions with modelling demand that are required to be understood when interpreting results. The assumptions relate to events that are often unpredictable both in magnitude and timing. It is assumed that the:

- demand is not restricted by workforce, bed capacity or funding constraints
- level of service in base year is adequate and continuing
- policies in place in the base year, as reflected, are maintained or not changed significantly.

The resultant model is referred to as the Status Quo Demand model. It reflects the growth rates over the historical period and the distribution of activity to hospitals without incorporating changes in infrastructure and/or service delivery.

b) Scenario Demand

Scenario Demand modelling applies changes to the assumptions of the Status Quo Demand model, thus restrictions on growth or the impact of changing policies can be applied or modelled.

In most cases, admitted scenario modelling considers estimation of the impact of efficiency measures on service demand. For example, community interventions could be expected to result in a decrease in the number of admissions to hospital, or efficiency measures within hospitals can result in shorter lengths of admitted stay.

In addition to the above scenario modelling assumptions, a population element is also added to the model, using the "*C band*" of *WA Tomorrow*, Department of Planning Population Projection. The ratio of the *WA Tomorrow* population projection to the status quo population is then applied to the activity counts to calculate a projected scenario activity.

c) Capacity Modelling

The Capacity model aims to link demand for health services with the ability of hospitals to provide these services. The resultant model requires a balance between the complexity of the real life flow of patients to hospitals and hospital beds with the necessity of building a feasible model that is flexible and robust. Note that it is not possible to include every extent of patient behaviour within a mathematical modelling framework. In line of the model limitations, some factors that may influence patient preferences are not explicitly modelled.

The Capacity model is developed by altering the flow of patients from where they would be expected to go, based on current flows (old hospital), to where they would be expected to go based on new infrastructure and service configuration (new hospital) underpinned by the CSF.

The modelling is performed as an iterative process, with output being analysed and interpreted to modify inputs to the model. Health Service Providers contribute much of the required analysis, including commenting on the level of modelled activity and providing information on the expected impact of changing service configuration and its timeframe.

Click here to receive more information about the Department of Planning Population Projection

Overview
Budget and Funding Acquisition
Strategic Planning and Modelling
Resource Allocation
Service Agreement Management
Performance, Evaluation and Accountability

4.0 Resource Allocation

This section builds on Section 3 Strategic Planning and Modelling to explain the national funding principles for 2016-17 and how these principles are applied and, when necessary, modified to suit WA Health needs and better inform and develop activity profiles and associated funding allocated to Health Service Providers. The resource allocation process is the final stage before the annual Service Agreements between the Department and Health Service Providers are finalised and signed.

4.1 National Funding Principles and Models

The scope of Public Hospital Services qualified for Commonwealth funding under the NHRA comprises all admitted patient services, including hospital-in-the-home (HITH); all emergency department services and also non-admitted services.

The scope of non-admitted services is independent of the setting in which they are provided, providing that the service meets the definition of a *Service Event* which is: *"an interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record"*.

The IHPA, established under the NHRA 2011, determines the NEP for public hospital services funded on an ABF basis; calculates the NEC for public hospital services that are block-funded; develops classification systems and national price weights and determines adjustments to these price weights to reflect justifiable expected variation in service delivery costs.

Costing information used for the 2016-17 NEP and NEC determination is sourced from the NHCDC Round 18, relating to the 2013-14 financial year, which is then indexed to arrive at the 2016-17 values.

4.1.1 IHPA National ABF Adjustments

It is widely acknowledged that there are legitimate and unavoidable variations in the costs of delivering hospital services. Some of these cost variations have been recognised and applied to the IHPA funding model through specific price weight variations.

The 2016-17 IHPA model adjustments are outlined, in order of precedence of application, in *Table 10*.

Handy Tip:
Click here to find out more about IHPA's Education Tools

*National ABF Adjustments Table sourced from the National Price Determination 2016-17 *Chapter 5 - Adjustments*

Visit IHPA for further information

Table 10: National ABF Adjustments 2016-17 *

IHPA National NEP Loading	Amount to be applied
Paediatric Adjustment Is in respect of a person who: (a) is aged up to and including 17 years; and (b) is admitted to a *Specialised Children's Hospital* (Appendix E) *(refer to the National Price Determination 2016-17).*	Refer to column headed 'Paediatric Adjustment' in the tables of Admitted Acute Price Weights (Appendix H) *(refer to the National Price Determination 2016-17).*
Specialist Psychiatric Age Adjustment (≤ 17 years, in MDC 19 or 20) Is in respect of a person who is aged 17 years or less at the time of admission, with a mental health-related principal diagnosis (Major Diagnostic Category [MDC] 19 or 20) and has one or more Total Psychiatric Care Days recorded.	Admitted Acute Patient: 21 per cent (except patients admitted to a Specialised Children's Hospital, who will receive 10 per cent)
Specialist Psychiatric Age Adjustment (≤ 17 years, not in MDC 19 or 20) Is in respect of a person who is aged 17 years or less at the time of admission, with a principal diagnosis which is not mental health-related (not in MDC 19 or 20) and has one or more Total Psychiatric Care Days recorded.	Admitted Acute Patient: 24 per cent (except patients admitted to a Specialised Children's Hospital, who will receive 45 per cent)
Specialist Psychiatric Age Adjustment (> 17 years, not in MDC 19 or 20) Is in respect of a person who is aged over 17 at the time of admission, with a principal diagnosis which is not mental health-related (not in MDC 19 or 20) and has one or more Total Psychiatric Care Days recorded.	Admitted Acute Patient: 32 per cent
Outer Regional Adjustment[1] Is in respect of a person whose residential address is within an area that is classified as being *Outer Regional*.	Admitted Acute or Admitted Subacute Patient: 8 per cent

Remote Area Adjustment[1] Is in respect of a person whose residential address is within an area that is classified as being *Remote*.	Admitted Acute or Admitted Subacute Patient: 18 per cent
Very Remote Area Adjustment[1] Is in respect of a person whose residential address is within an area that is classified as being *Very Remote*.	Admitted Acute or Admitted Subacute Patient: 23 per cent
Indigenous Adjustment Is in respect of a person who identifies as being of Aboriginal and/or Torres Strait Islander origin.	Admitted Acute, Admitted Subacute, Emergency Department, Emergency Service or Non-admitted Patient: 5 per cent.
Radiotherapy Adjustment Is in respect of an Admitted Acute Patient with a specified ICD-10-AM 9th edition radiotherapy procedure code recorded in their medical record.[2]	Admitted Acute Patient: 26 per cent
Dialysis Adjustment Is in respect of an Admitted Acute Patient with a specified ICD-10-AM 9th edition renal dialysis code who is not assigned to the AR-DRG L61Z Haemodialysis or AR-DRG L68Z Peritoneal Dialysis. [2]	Admitted Acute Patient: 26 per cent
Intensive Care Unit (ICU) Adjustment (a) Is not represented by a newborn/neonate AR-DRG identified as 'Bundled ICU' in the tables of Price Weights (Appendix H); but (b) Is in respect of a person who has spent time within a Specified ICU.[3] *(refer to the National Price Determination 2016-17).*	0.0436 NWAU(16)/hour spent by that person within the Specified ICU.
Private Patient Service Adjustment Is in respect of an Eligible Admitted Private Patient.	Admitted Acute Patient: Refer to column headed 'Private Patient Service Adjustment' in the table of Price Weights at Appendix H. Admitted Subacute Patient: Refer to Appendix F for applicable adjustment *(refer to the National Price Determination 2016-17).*

Table 10 Source:
National Price Determination 2016-17
Chapter 5 - Adjustments

Private Patient Accommodation Adjustment Is in respect of an Eligible Admitted Private Patient.	Admitted Acute or Admitted Subacute Patient: Refer to Appendix F for applicable adjustment *(refer to the National Price Determination 2016-17).*
Multidisciplinary Clinic Adjustment Is in respect of a non-admitted service event where three or more healthcare providers (each of a different specialty) are present, as identified using the non-admitted 'multiple healthcare provider indicator'.	Non-admitted Patient: 55 per cent

4.1.2 Block Funding Allocation for 2016-17

Consistent with the National ABF model developed by the IHPA as per the NHRA, the following public hospital services are currently block funded:

- Non-Admitted Mental Health
- Teaching, Training and Research (TTR)
- Community Service Obligation (CSO).

Non-Admitted Mental Health

In 2016-17, non-admitted mental health services continue to be block funded. The determination of funding allocation is attained by escalating the previous years' block funded amount by cost and age-weighted population growth. The Department works closely with the MHC and Health Service Providers to determine priority areas for targeted services purchasing.

The AMHCC system being developed by the IHPA also applies to non-admitted and community mental health services. The AMHCC will be implemented nationally for data collection, classification and reporting from 1 July 2016 and it is intended to be used for pricing of mental health services from 1 July 2017.

Teaching, Training, and Research

For 2016-17, the IHPA will continue to determine block funding amounts for TTR activity based on jurisdictional advice. The TTR allocation for WA Health in 2016-17 is consistent with the methodology used in 2015-16. TTR funding distribution relates to the activity profiles for each site, consistent with the WA Health costing methodology.

Under the NHRA, the IHPA was required to provide advice to the Standing Council on Health on the feasibility of transitioning TTR funding to an activity based system by 30 June 2018. IHPA's advice is that the work undertaken to date indicates that the development of systems which underpin ABF are feasible for teaching and training. The findings of a national costing study completed in early 2016 will inform the development of a teaching and training classification system.

Community Service Obligation – Efficient Funding of Small Hospitals

Because of diseconomies of scale and volatile activity, some smaller hospitals do not fare well under an ABF model. Since the introduction of the NHRA, the IHPA has funded these smaller hospitals under the NEC model. The NEC represents the average cost of a block funded small hospital and determines the Commonwealth Government contribution to block funded hospitals.

Small hospitals in country WA are considered CSO hospitals and therefore receive Commonwealth funds through the NEC model. Similarly, the Department block funds these hospitals.

Under the NEC model, hospitals are assigned to a size-locality group matrix where different cost weights apply. These cost weights are then multiplied by the NEC figure calculated for the year. Generally, a hospital in a remote location would have a higher weight component than a similar sized hospital in a regional area and hence attract larger funding.

Ten of the integrated (district) hospitals in rural WA receive Commonwealth funding through the NEC model, however, the Department has chosen to fund these hospitals within the WA ABF framework. *Table 1* under Section 1.3.5 Health Service Providers of these Guidelines include a complete list of hospitals for each Health Service Provider and their associated funding approach.

4.2 WA Health Resource Allocation

The WA ABF methodology is underpinned on the clear role delineation of Funder, System Manager, Purchaser and Provider, outlined in Section 1.3 Funder, System Manager, Purchase and Provider Roles, Responsibilities of the Guidelines.

WA Health has been using ABF funding methodologies for hospital services for some years. Since 2012 however, the State has aligned its ABF methodology to the national program led by the IHPA.

To read more about the Community Service Obligation (CSO) click here

IHPA determines a **National Efficient Cost (NEC)** for services that are not suitable for activity based funding, such as small rural hospitals. The NEC determines the Commonwealth Government contribution to block funded hospitals.

Click here for more information on Understanding the NEC

Activity Based Funding (ABF)

For Commonwealth funding purpose an ABF activity comprises of in-scope public hospital services in the manner described at clause A32(c) of the NHRA.

An ABF Activity may take the form of a Separation, Presentation or Service Event.

Source: Independent Hospital Pricing Authority (IHPA) Online Glossary

4.2.1 WA ABF Operating Model Adjustments to the IHPA Model

Although the WA ABF operating model is closely aligned with the National ABF model, adjustments to the IHPA model are necessary to appropriately reflect specific funding requirements to WA's unique service delivery environment. These model adjustments are outlined below:

Contracted Satellite Dialysis Services

For the WA ABF model, the weighted activity related to the contracted satellite dialysis services in the metropolitan area has been scaled to return the real expenditure related to these contracts. This expenditure is less than the standard cost of hospital delivered dialysis. This approach and relevant calculations are always reviewed and compared with the latest NHCDC available data.

NEC Funded Hospitals

Service Agreements for WACHS include ten ABF Integrated (district) hospitals that, under the current IHPA definition are treated as NEC funded hospitals. This approach is annually reviewed as part of the annual NEP and NEC comparative analysis process.

Graylands/Selby Hospital Activity

Inpatient mental health activity is consistent with the IHPA 2016-17 model. The exception is Graylands/Selby Hospital activity, which is generally of a long-stay nature. Selected Graylands wards have moved to a DRG-based activity allocation. The remaining wards continue to be weighted using bed-state dataset information as per previous years. This approach is required due to the impact of long stay patients on the Graylands campus. WA Health is currently participating in the development of the new AMHCC system being developed by the IHPA which is expected to address these issues.

Provision of Public Hospital Services with Private Providers

Service Agreements for the provision of public hospital services with private providers are not consistent with the National ABF model. To facilitate performance reporting for the WA Health and reporting to State Government, the agreed activity as specified under these specific contract agreements is converted to the equivalent IHPA 2016-17 cost weight model activity profiles.

Discount Factor for Private Patients

The Service Agreements between the Department and the Health Service Providers are developed for a total expenditure profile which includes weighted activity related to private patients in public hospitals. The IHPA model, however, applies a discount for these private patients in order to offset revenue that States and Territories receive from alternative funding sources. The WA ABF model currently does not utilise the DRG discount for private patients or the bed day accommodation adjustment applied to the IHPA model.

Ambulatory Surgery Initiative

Services delivered under the Ambulatory Surgery Initiative are not in-scope for the NHRA. Activity related to this program is in-scope however, under the WA ABF model with the IHPA cost weight schedules discounted for the medical cost component of the episode of care, which is funded under the Medicare Benefits Schedule. The value of the scaling factor used to adjust for the medical costs component is based on NHCDC costing information.

4.2.2 Cost Weights

Cost weights are calculated by the IHPA using information submitted by all jurisdictions as part of the NHCDC process. The IHPA cost weight schedule for hospital acute admitted patients is presented in a Diagnostic Related Group (DRG) format. DRGs are the standard method of classifying hospital acute admitted activity. DRGs group together cases that are clinically and also cost homogeneous. There are currently 807 DRGs in the latest Australian Refined Diagnosis Related Groups (AR-DRG) classification, version 8.0.

A DRG cost weight can be calculated as the ratio of the average cost of all episodes in a single DRG to the average cost of all episodes across all DRGs. The DRG cost weights relativities are used for appropriately counting and funding acute admitted services delivered by hospitals.

Other hospital service category groups also use NHCDC information and similar principles of constructing cost weight relativities for appropriate classification, counting and funding of health services.

Sub-acute and non-acute admitted patient services utilise the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification, version 4.0.

Non-admitted services currently utilise the Tier 2 non-admitted services classification, version 4.1.

CLASSIFICATION SYSTEM ACRONYMS

ESRG	Extended Service Related Group
URG	Urgency Related Group
DRG	Diagnosis Related Groups
AN-SNAP	Australian National Sub-acute and Non-Acute Patient

Click here for more information on the National Efficient Price (NEP) Determination 2016-17

Emergency Department services utilise the Urgency Related Groups (URG) classification, version 1.4 or the Urgency Disposition Groups (UDG) classification, version 1.3, in cases where the necessary information to derive a URG is not available.

The IHPA National Efficient Price Determination 2016-17 publication contains detailed information on all cost weight schedules mentioned above.

4.2.3 Methodology for Distribution of the WA Health Budget

Under an ABF environment, funding received by the Department from the Commonwealth and State governments is based on the projected volume of services to be delivered in a given period.

The initial step in the WA Health resource allocation process is the development of service activity profiles for the Health Service Providers. These activity profiles are a representation of the ABF service target to be delivered by a Health Services Provider constructed on a weighted activity basis. Services are classed as admitted (i.e. acute admitted, sub-acute and admitted mental health), Emergency Department, or non-admitted.

The activity profile process has multiple iterations, through which refinements are made. These various iterations are made in partnership with Health Service Providers, enabling a joint development and understanding of planned service delivery, in preparation for the final Service Agreement.

Through this process, the Department as System Manager is able to allocate funding fairly and equitably to Health Service Providers based on agreed forecast service delivery. The Service Agreements between the Department and Health Service Providers formalise the agreed service delivery and also the performance and accountability requirements associated with ABF and all other contracted health services.

In developing the above described service activity profiles, the Department uses activity classification standards that are appropriate and in line with the WA ABF operating model capabilities.

For admitted activity, profiles are developed using the Enhanced Service Related Groups (ESRG) classification system. The ESRG classification system has approximately 127 groupings in comparison to the IHPA designated AR-DRG classification level which has approximately 800 groups.

Emergency department activity profiles are modelled using the URG and/or UDG. Non-admitted activity profiles are modelled using the Tier 2 clinic classification. Both service category activity profiles are developed in line with the IHPA classifications for those services.

The preliminary activity profiles are informed by trends in historical actual activity, prior year Service Agreement targets, and the Capacity and Demand Model (described in Section 3. 4 Capacity and Demand Modelling Process) calculated growth rates. Paediatric and Mental Health components are separately identified.

Historical trends in actual activity enable both the Department and the Health Service Providers to review service developments at different sites. For the 2016-17 activity profiles, actual data from 2012-13 to 2014-15 has been used. While this data has no direct impact on the preliminary current year targets, the trend analysis serves as a mechanism to validate the forecasted growth.

Activity targets set in the prior year Service Agreements provide the baseline from which growth factors can be used to determine current year initial activity targets. In the preliminary activity profiles, admitted and emergency department activity are escalated by growth rates determined in the Capacity and Demand Model factors. Utilisation of these growth rates ensure adherence to CSF principles.

In the absence of such a model for non-admitted services, age-weighted population growth factors are used to escalate non-admitted activity from baseline figures.

Paediatric services are separately identified for each Health Service Provider enabling activity profile planning for state-wide child and adolescent services. Mental health activity is also distinctly identified and modelled for planning purposes through an iterative process with the MHC.

What does ABF allocation mean for WA Health Service Providers?

WA Health funds Health Service Providers for the majority of their activity. ABF enhances public accountability through transparency and drives technical efficiency in the delivery of health services.

'Activity' reflects the services delivered to patients, residents and clients, extending to their families, carers and the community.

e.g. 'Activity' is not limited to hospital casemix as can include community care grants, chronic disease programs, preventative health programs, shared maternity care, subacute care, step down care, living well when older and education, training, research and supervision.

4.2.3.1 Influences on Current Year Targets

As the Service Agreement process develops throughout the year, a number of factors also influence the current year targets such as:

Budget Constraints

As part of the State budget construction, the Economic and Expenditure Review Committee (EERC) determines the price and volume of hospital weighted activity which the WA Treasury will fund within a given financial year. The amount of weighted activity allocated to Health Service Providers is adjusted to fit within these parameters.

Changes to the IHPA model

The EERC determination of price and volume of hospital weighted activity is based on the current year National ABF model as the relevant year's IHPA model is not available at the time. As such the preliminary activity profiles need to be revised and, if necessary, adjusted to account for methodological differences, following the release of the relevant year's IHPA model.

The Department works in conjunction with Health Service Providers to develop final ABF activity profiles. The Department endeavours to address all issues identified by Health Service Providers within the constraints and parameters outlined above.

4.2.3.2 Pricing

As outlined in Section 2.2.3 Budget Settings for Activity Based Hospital Services the State Price approved for WA Health ABF activity takes into consideration both the NEP and PAC as well as State budget constraints.

The State Price for 2016-17 is $5,767.

Figure 10: State Approved Price Setting

The State Price includes a differential cost per Weighted Activity Unit (WAU) component of $752 when compared to the calculated PAC. This differential cost reflects the divergence in the service delivery costs for the WA Health system when compared to the PAC. The PAC is the closest measure to a national average cost of delivering hospital services in Australia.

In 2016-17, the State budget signalled the intention to decouple the State Price from the National Framework. Nevertheless WA Health is committed to significantly reduce the magnitude of the differential cost over time by introducing strategic purchasing policy programs and increased system accountability to further drive efficiencies in the delivery of health services while ensuring safety and quality of care is maintained at current high standards.

For more information about these programs refer to Section 4.2.5 Purchasing Policy Strategies and System Accountability.

Although the WA Health system has achieved considerable reduction in the rate of cost growth over the last few years, significant work is still needed to achieve the necessary gains in service delivery efficiency when compared to the national average.

4.2.3.3 Health Service Allocation Price

In 2016-17, the Department has introduced a single HSAP per WAU. This price is still significantly higher than the PAC, reflecting the higher costs of service delivery in the WA Health system. For 2016-17 the single HSAP is $5,560.

The differential between the HSAP and the State Price is associated to Transition Grants to Health Service Providers, necessary as WA Health evolves to a more mature and efficient system.

Although activity costing and therefore cost weight relativities have been improving over the last few years, they still do not properly account for some of the service delivery cost differentials between tertiary and non-tertiary sites. Therefore, the Transition Grants include a Tertiary Hospital Loading, reflecting their higher service delivery costs due to increased complexity and severity of their patient's casemix.

ABF activity is expressed in one currency known as **Weighted Activity Units** (WAU).

WAU are counted and classified using consistent guidelines issued by IHPA. They provide a way of comparing and valuing each public hospital service *(whether they be admitted, emergency and specialist non admitted services)* by applying a weighting for its clinical complexity.

What is the Health Service Allocation Price (HSAP)?

The HSAP is the price that Health Service Providers are funded.

Transition Grants

Are dispersed as block funding to Health Service Providers to account for the current service delivery cost environment. This includes a loading factor to tertiary sites. It is intended to be progressively reduced to fully converge to the HSAP in future years.

Further, tertiary hospitals utilise the bulk of the pharmaceuticals that are part of the PBS section 100, which as explained earlier, although funded directly from the Commonwealth to jurisdictions, are included in the unit price in the WA ABF operating model. The Department is currently working towards incorporating these service differentials in a State modified cost weight schedule, therefore removing the need for a separate Tertiary Hospital Loading.

The current WA Health pricing framework for hospital services purchasing is depicted in Figure 11.

Figure 11: Summary of WA Health's Pricing Framework for 2016-17

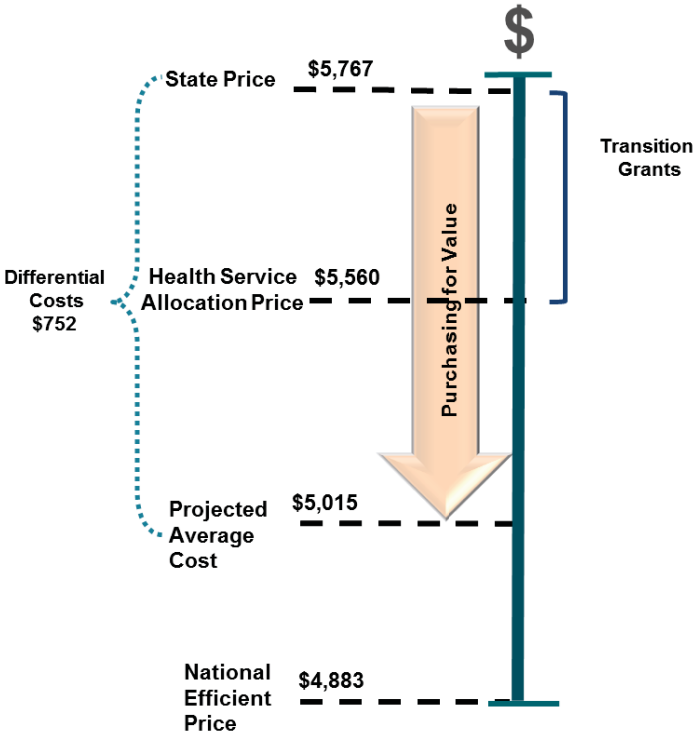
Transition Grants
Dispersed as block funding to Health Service Providers to account for the current service delivery cost environment. This includes a loading factor to tertiary sites. It is intended to be progressively reduced to fully converge to the HSAP in future years.

Health Service Allocation Price (HSAP)
The HSAP is the price allocated to Health Service Providers in the annual Service Agreements. The Department has implemented a single HSAP for 2016/17. It is the intention to progressively reduce the gap between the HSAP and the PAC in coming years.

Differential Costs between PAC and State Price
This differential cost reflects the differences in the service delivery costs for the WA health system when compared to the national average cost for hospital services

Projected Average Cost (PAC)
PAC includes Commonwealth funds that are not included in the NEP:
- Highly Specialised Drugs
- Pharmaceutical Reform Agreements
- Early Stage Breast Cancer PBS
- Pharmaceutical Reform Agreements.

National Efficient Price (NEP)
NEP is the base price set by IHPA per WAU.



Significant reforms to the WA Health system over the next few years aim to not only eliminate the need for Transitional Grants but also to approximate the HSAP to the national average cost (PAC) of delivering hospital services, hence significantly decreasing differential costs for the State.

4.2.4 Method for Distribution to Other Budget Holders

4.2.4.1 Department of Health Divisions

The Department comprises of seven divisions;

- Office of the Director General
- Office of Deputy Director General Reform
- Public Health
- Clinical Services and Research
- System Policy and Planning
- Purchasing and System Performance
- System Corporate Governance.

For 2016-17, the Department will continue to use a budget-to-budget methodology for Departmental divisions. This method considers new initiatives, organisational re-alignment, or the cessation of activities that were previously undertaken.

4.2.4.2 Health Support Services

In 2016-17 HSS has its own Service Agreement. This Service Agreement is different to the Health Service Provider Service Agreements as it does not include ABF or hospital activity. The HSS Service Agreement includes a Schedule J (Cash Budget), Schedule K (Capital Works Program) and Schedule M (Revenue Plan).

The Health Service Provider Service Agreements include a Schedule N which shows the expenditure budget that is notionally allocated to the Health Service Provider for the provision of services by HSS.

4.2.5 Purchasing Policy Strategies and System Accountability

As the Department transitions to the System Manager role and matures as a Purchaser in the new devolved governance model, the Department needs to ensure a strong focus on purchasing policy setting, system-wide planning, effective service purchasing through Service Agreements with Health Service Providers and increased accountability through the monitoring, review and evaluation of implemented purchasing policy strategies.

As part of the System Reform, the Department aims to further improve the purchasing functions through the development of purchasing policies and strategies for the short, medium and long term basis with the objective to:

- provide System Manager clarity as Purchaser
- transition towards improved business as usual practices (incorporating national and WA Health reform projects)
- strengthen the funding, purchasing and resource allocation process, by providing greater transparency and accountability.

The above objectives will be formulated by introducing a number of purchasing principles, including:

- identifying best practice and lessons learnt from implementation of purchasing policy and strategies, both nationally and internationally, consistent with current context of WA Health
- introducing mechanisms to improve Health Service Providers accountability for contracted deliverables, through implementation of the funding, purchasing and resource allocation process, commencing for the 2017-18 budget.

These initiatives centre on the creation of value in purchasing healthcare, and imply the continuous improvement towards high quality effective healthcare, delivered in an appropriate setting, in a standardised manner, following recognised best practice and approved models of care to maximise patient outcomes relative to service costs.

Some programs have already been in operation, such as the Performance-based Premium Payments Program. This program operates as an incentive payment mechanism designed to improve the quality and safety of care provided in a number of priority clinical areas, including fragility hip fracture treatment, stroke model of care and acute myocardial infarction.

The Performance-based Premium Payments Program is designed to recognise and reward services which provide a very high level of best evidence-based care and reimburse service providers for any additional costs and tasks associated with participation in the scheme, including data collection and submission.

Details regarding the Performance based Premium Payment Program 2016-17 are available here

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4.2.6 The State Transition to an Efficient Practice (STEP) concept

The concept of purchasing for value is the core of the Department's long term health services purchasing strategy to achieve system sustainability. The State Transition to an Efficient Practice (STEP) concept is to be implemented in future years and will be the mechanism to operationalise identified core purchasing policies.

The STEP Concept framework consists of short (1-3 years), medium (4-6 years) and long term (7-10 years) strategies aiming to increase efficiency in which service provision is delivered in the WA Health system. This framework will align with the WA Health reform initiatives, Strategic Intentions, Principles and Priorities and the National Health Reform Agreement (or its replacement).

Four key purchasing themes, form the key elements of the STEP Concept:

- Activity Management
- Pricing
- Incentive and Disincentive Programs
- Minimizing unwarranted variation in costs

The STEP Concept and its overarching strategic purchasing framework will continue to evolve ensuring cost effective services are delivered to achieve maximum health gain for those in need.

Information on the Purchasing and Resource Allocation Policy Framework can be found here

5.0 Service Agreement Management

As previously outlined in Section 1.2.2 Governance Reform, the *Health Services Act 2016* delineates the statutory requirements for Service Agreements. The Director General, as System Manager, enters into annual Service Agreements with Health Service Providers. These contractual agreements establish a Health Service Provider's budget, performance measures, operational targets and accountability mechanisms.

The purchasing principles, as outlined in the Service Agreements between the Department and the Health Service Provider are to improve:

- patient access to services
- public hospital efficiency
- standards of clinical care
- system performance, transparency and accountability for financial and service performance.

It is anticipated that the 2017-18 Service Agreement schedules will be revised to reflect the services contained within the revised Outcome Based Management (OBM) Framework.

The revised OBM Framework, to be introduced for the 2017-18 financial year, categorises the programs and services WA Health delivers. The OBM Framework requires the identification of agency level government desired outcomes towards achieving the relevant government high-level strategic goals and assists in the identification and distribution of resources to the relevant areas of the Department, as outlined in the PRAF. The performance reporting, monitoring evaluation and management of the Health Service Providers is undertaken as prescribed in the Performance Policy Framework.

For specific information on the *Health Services Act 2016* and Service Agreements refer to the PRAF.

5.1 Development and Consultation Process for Service Agreements

The development of Service Agreements is a collaborative and consultative process between the Department as System Manager and Purchaser, and the Health Service Providers.

The Service Agreement development process involves continuous interaction between parties, where Health Service Providers are asked to provide feedback and comments. For 2016-17 there were three formal drafts provided to Health Service Providers in February, April and May.

Following the third and final draft of the Service Agreements, which includes the final State Government budget parameters, bi-lateral negotiations are held between the Director General and the Health Service Providers to make final decisions on any pending matters. The Service Agreements are then finalised and signed by the Director General, the relevant Health Service Provider Board Chair and Chief Executive.

It should be noted that for 2016-17 the Service Agreement development process was finalised on 1 July 2016 however, in future years, as per the *Health Services Act 2016* (section 47(1)(b)), the Service Agreement process is required to be finalised one month prior to the expiry of the existing Agreement of 30 June 2017.

5.1.1 Service Agreement Management and Amendment Process

Any amendments required to Service Agreements within the financial year must follow a mandatory process. This process is outlined in the *Health Services Act 2016* and incorporated into the Service Agreement Management Policy within the PRAF. This Policy also outlines all other management processes involved including dispute resolution and timeframes.

5.2 Service Agreements for 2016-17

Service Agreement schedules summarise the services expected to be undertaken and associated funding to be received by Health Service Providers. The Schedules include information for the current year and three years of the forward estimates. A brief description of each of the Schedules is provided below:

Summary of Activity and Funding

This schedule summarises the information presented in the specific schedules demonstrating a view of the total allocation of activity and

Visit the Service Activity Amendment Framework and the Service Agreement Management

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Click here to access the 2016-17 Service Agreements

funding for the Health Service Providers. The Summary outlines the activity as WAUs and associated budget allocation by service category as well as public health and specific purpose programs, mental health and financial production information for all hospitals in the Health Service Provider's catchment area.

Schedule A – ABF Inpatient

This schedule provides the WAU allocation and budget for admitted (inpatient) services by care type (i.e. acute/sub-acute) by site within the relevant Health Service Provider. The schedule does not include admitted mental health services.

Schedule B – ABF Emergency Department

This schedule provides the WAU allocation and budget for all sites with an Emergency Department within the relevant Health Service Provider.

Schedule C - ABF Non-admitted (patient-level)

This schedule provides the WAU allocation and budget for all sites with non-admitted services that have been recorded in an approved Patient Information System, excluding non-admitted mental health services.

Schedule C1 – ABF Non-admitted (aggregate)

Where non-admitted outpatient care is known to occur but is not captured in an approved patient information system, separate allocations are identified. The schedule also does not include mental health services.

Schedule C2—Inpatient Paediatric ABF Activity and Funding

This schedule summarises inpatient Paediatric ABF activity and funding including TTR allocation. This information is part of Schedule A above but is separately identified for reporting.

Schedule D2—Non-ABF Small Rural Hospitals

Under activity funding arrangements, small and/or remote hospitals receive specific (block) funding to ensure they remain viable—although calculated under an activity funding model, block funding is classified as non-ABF.

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Schedule E—Non-ABF Public Health Programs

WA Health recognises that some health service programs have a specific purpose with a distinct expenditure profile. These programs are identified by funder type.

Schedule F—Teaching, Training and Research

WA Health recognises that direct TTR are distinct products from the delivery of services to patients. TTR is identified by service type (e.g. inpatient, Emergency Department, non-admitted) with the calculation based on ABF activity but treated as block funding (non-ABF). TTR is not included in setting activity targets and expenditure limits for clinical service delivery.

Schedule G—Non-ABF Special Purpose Programs

This schedule includes the State Government/Department of Treasury savings initiatives related to the WA public service that have been provisioned by the Department of Health at this time.

Schedule G1—Estimate of other costs already included in funding

This schedule identifies the RiskCover Premium for the Health Service Provider. This item has been incorporated within the funding determinations and is separately provided for information only.

Schedule I - Non-ABF Financial Products

This schedule identifies key financial elements included in the Health Service Provider allocations. It includes some items (e.g. depreciation, notional interest) that have been provisioned by the Department of Health.

Schedule J - Cash Budget

The Cash Budget schedule specifies the funding available to the Health Service Provider to meet the deliverables as agreed in the Service Agreement. This schedule provides a breakdown of the approved cash budget associated to the funding types and, where possible, service delivery categories. This includes an allocation for Special Purpose Programs, discretionary cash allocation to maintain operational cost including cost related to capital (Budget Expense Capital). The cash budget also takes consideration of “own sourced revenue” generated by the Health Service Provider but only to the extent of the approved budget position. It is the responsibility of the Health Service Provider to declare divergence from the approved position.

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Schedule K - Capital Works Program

This schedule reflects the total capital works program for the Health Service Provider. This may include the capital and the recurrent budget for each project to provide a true position for the capital works program. Note that this position is current from 1 July until Mid-Year Review where cash flow may be amended.

Schedule M - Revenue Plan

The purpose of the Revenue Plan is to record how the approved expenditure is being funded within the Department of Health's approved revenue parameters. It is usually a mixture of State Government funding, Own Sourced Revenues, Commonwealth funding, accrual type revenues with no associated cash, (e.g. depreciation) and other expenditure where there are no revenues, (e.g. accrued salaries).

Schedule N - Estimate HSS Budget Allocation

This schedule records the expenditure budget that is notionally allocated to the Health Service Provider for the provision of services by the HSS entity. The schedule outlines the expenditure budget by the five key functions (groups of services) delivered by HSS: Finance, Contracting, Human Resources, Information Technology and Supply. The notional allocation recorded in this schedule does not form part of the Health Service Provider's 2016-17 budget.

Schedule P and P1– IP ED and OP ABF Activity and Funding

This schedule identifies the different components of allocated ABF funding, that is, the PAC, the HSAP (standard) and the Tertiary Price Loadings, which are, separately identified for information only.

Schedule Q—Mental Health Commission Funding

This schedule includes Commission health services activity and funding for inpatient, non-admitted and TTR services. It also includes Specific Purpose Funding.

The detail associated with mental health funding is incorporated in the separate Commission Service Agreements negotiated with each Health service Provider under the parameters set in the Head Agreement. Summary information provided in the schedule Q of the Service Agreement is required to provide a total budget position for the Health Service Providers.

Schedule T—Better Health Outcomes for Aboriginal People

This schedule identifies key strategies and the measures Health Service Providers are expected achieve in furthering better health outcomes for Aboriginal people.

5.2.1 Mental Health Services

As outlined in Section 1, following the introduction of the *Health Services Act 2016*, budget allocations relating to Commission health services are appropriated to the MHC. The MHC directly purchases these services from Health Service Providers through Commission Service Agreements, which sit under the Head Agreement between the Department and the MHC.

As noted earlier, a summary of the activity and budget is provided in the Service Agreements under Schedule Q.

5.3 Funding Flows

WA Health's financial responsibilities are governed by legislation including the *Financial Management Act (2006)* and associated subsidiary legislation; Treasurer's Instructions administered by the Department of Treasury and general accounting standards and concepts. This framework clearly identifies the roles, responsibilities and accountabilities of all budget holders.

Consistent with the NHRA, each jurisdiction is required to maintain a RBA administered account for purposes of receiving Commonwealth funding.

The RBA account (termed as the State Pool Account) receives all Commonwealth ABF and block funding. Annually, the NHFP Administrator reports to the Commonwealth Treasurer on the total deposits and payments for each jurisdictions State Pool Account (SPA).

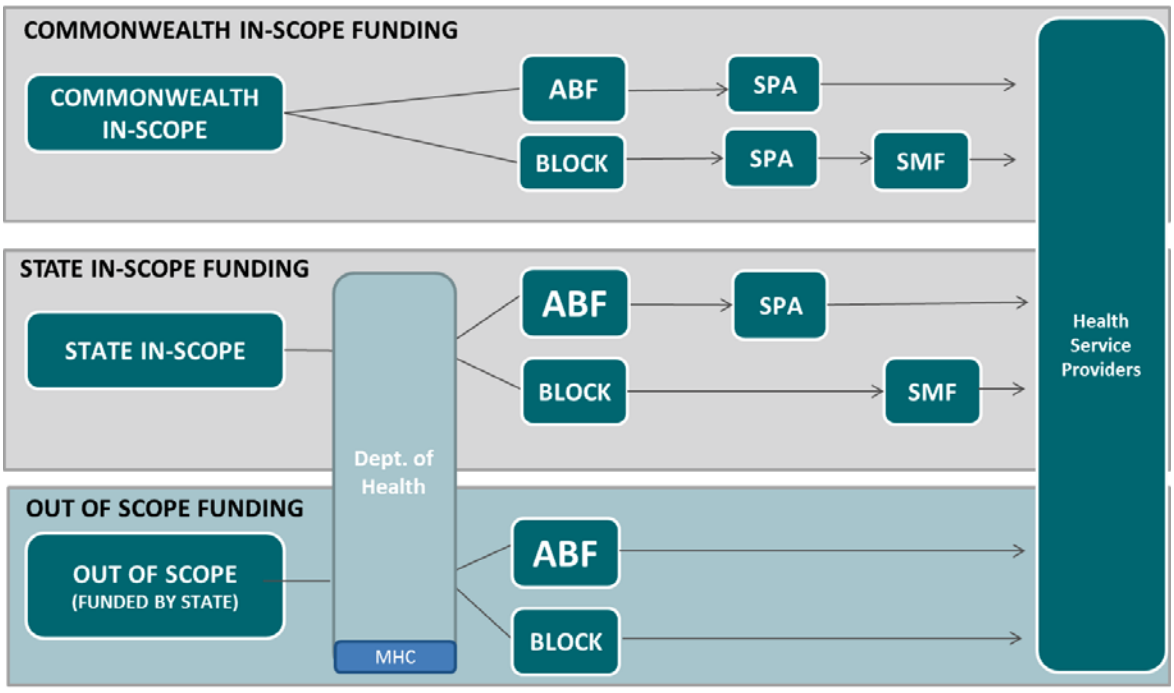
The Department's final activity estimates to the NHFP Administrator provide the forecast in-scope service delivery for each Health Service Provider within the state. Therefore, Commonwealth ABF funding for in-scope services is paid directly from the SPA to each Health Service Provider as it can be easily linked to the forecast service delivery levels provided to the NHFP Administrator.

The block funding submission is done at aggregate level. Commonwealth block funding for in-scope services is transferred from the SPA to the State Managed Fund (SMF), where it is then disbursed based on the Service Agreements between the Department and Health Service Providers.

State in-scope and out-of-scope ABF funding is paid by the WA Treasury into an account administered by the Department. In-scope ABF funding is then paid into the SPA to provide a 'line of sight' to the NHFP Administrator, after which the monies are disbursed to the Health Service Providers. Out-of-scope ABF funding is paid to the Health Service Providers based on the Service Agreements. The NHFP Administrator is not required to report on a jurisdiction's out-of-scope contributions.

The state's in-scope and out-of-scope block contributions are deposited into the Department's administered account. The in-scope block contributions are paid into the SMF to provide a 'line of sight' to the NHFP Administrator. The state out-of-scope block funding is paid directly to the Health Service Providers as there are no Commonwealth reporting requirements attached with this funding.

Figure 12: Payment Flows



SPA State Pool Account
SMF State Managed Fund
HSP's Health Service Providers

6.0 Performance, Evaluation and Accountability

Performance, Evaluation and Accountability are essential to the management of Health Service Providers and are the concluding component of the funding, resource allocation and purchasing cycle (*Figure 1*).

Performance management involves:

- on-going review of the performance of Health Service Providers
- identifying a performance concern and determining the appropriate response to the concern
- determining when a performance recovery plan is required and the level of intervention required
- determining when the performance intervention needs to be escalated or de-escalated.

This section provides an overview of the current performance management structure in WA Health including the Performance Policy Framework and *Performance Management Policy (PMP) 2016-17.* The PMP is WA Health system's performance management component of the Service Agreements between the Department, led by the Director General as the System Manager and each Health Service Provider.

This section also outlines some of the key reforms and initiatives in place or development to improve the WA Health system efficiency in service delivery while maintaining or increasing quality and safety, improved alignment of funding to outputs and outcomes and increased accountability as WA Health tries, in the near future, to align its performance with other jurisdictions.

6.1 Performance Management

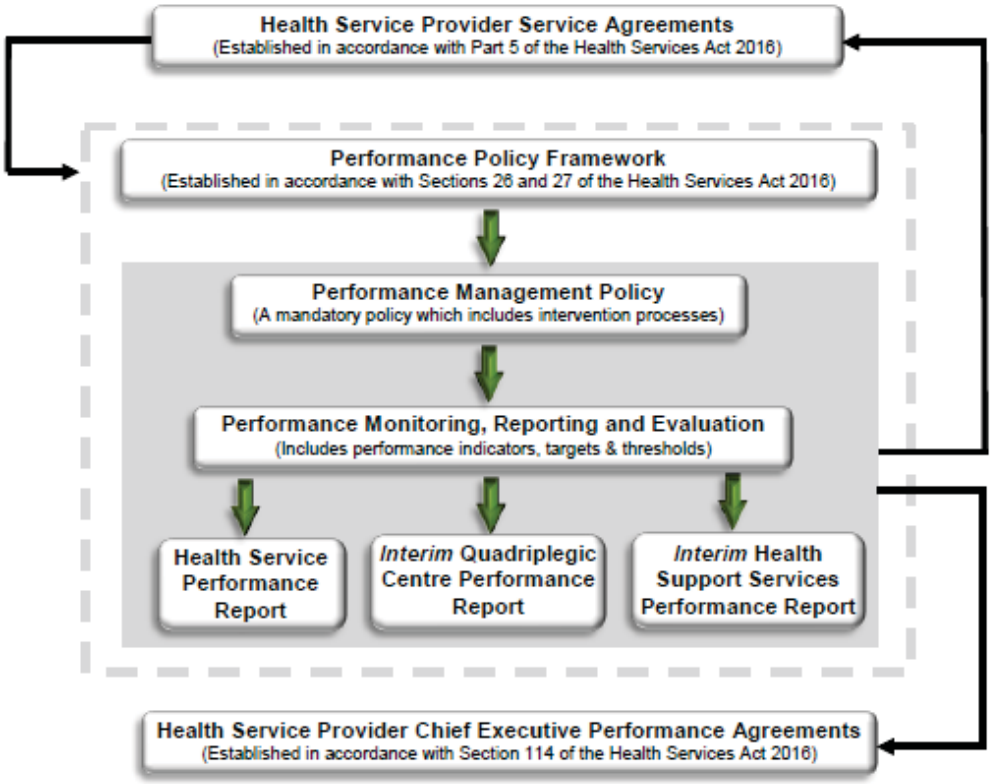
6.1.1 Performance Policy Framework

In accordance with the *Health Services Act 2016* from 1 July 2016, the Director General has issued binding Policy Frameworks to Health Service Providers to ensure a consistent approach to matters across the WA Health system. The *Performance Policy Framework* is a key Policy Framework enabling the System Manager, to undertake effective system-wide performance management based on the agreed Service Agreements between the Department and each Health Service Provider.

Figure 15 outlines the linkages between the Service Agreements and the Framework including the mandatory PMP and monitoring, reporting and evaluation involved.

Click here to access the Performance Policy Framework

Figure 13: Performance Policy Framework Strategic Linkages



Source: Performance Management Policy 2016-17

6.1.2 Performance Management Policy (PMP)

The PMP, based on a performance management cycle has matured, since its introduction in 2010-11, to become a system-wide performance management policy, unified with and strengthened by State and National health reform agendas and other key policy drivers.

Importantly, the PMP reflects the introduction of the new legislation and necessary changes arising from the *Health Services Act 2016*. The PMP also aims to drive better performance through a greater focus on monitoring and analysing performance, incentivising good performance and addressing poor performance through tiered intervention and support, where required. As effective performance management is ongoing, a continual process of reviewing, observing and communicating with staff and key stakeholders will be applied to provide constructive and actionable feedback about their Health Service Provider performance.

For more information on the PMP click here Performance Management Policy 2016-17

Overview
Budget and Funding Acquisition
Strategic Planning and Modelling
Resource Allocation
Service Agreement Management
Performance, Evaluation and Accountability

Performance indicators outlined in the PMP support, guide and track progress - providing feedback to Health Service Providers to inform and improve health service delivery, and promote accountability and transparency.

6.1.3 Performance Reporting and the Health Service Performance Report (HSPR)

The performance and the PMP indicators are supported by the monthly Health Service Performance Report (HSPR) 2016-17. The HSPR 2016-17 is aligned to the strategic priorities and enablers in the *WA Health Strategic Intent 2015-20* with a strong focus on safety and quality.

HSPR indicators range from delivery of hospital services such as Elective Surgery patients treated within boundary times and unplanned hospital readmissions to other indicators including Aboriginal employment and Childhood immunisation. For the detailed list of indicators which are reported monthly by the HSPR and provided to Health Service Providers refer to the PMP.

6.1.4 Performance Indicator Targets

The performance indicator targets and thresholds in the PMP play a pivotal role in performance reporting. The Performance Projects Board and Department Executive Committee (DEC) endorse performance indicators. In consultation with key stakeholders, the suite of performance indicators, targets and thresholds are endorsed by DEC, which is chaired by the Director General.

Targets have been established by adopting the most appropriate alignments to WA Health's strategic objectives by considering the following:

1. existing National policy based targets
2. existing State policy based targets
3. previous performance baselines, the results of the stress testing methodology, or expert advice from data custodians/providers.

6.1.4.1 Performance Thresholds

The performance evaluation involves an assessment for each of the performance indicators at four levels of performance thresholds:

Highly Performing

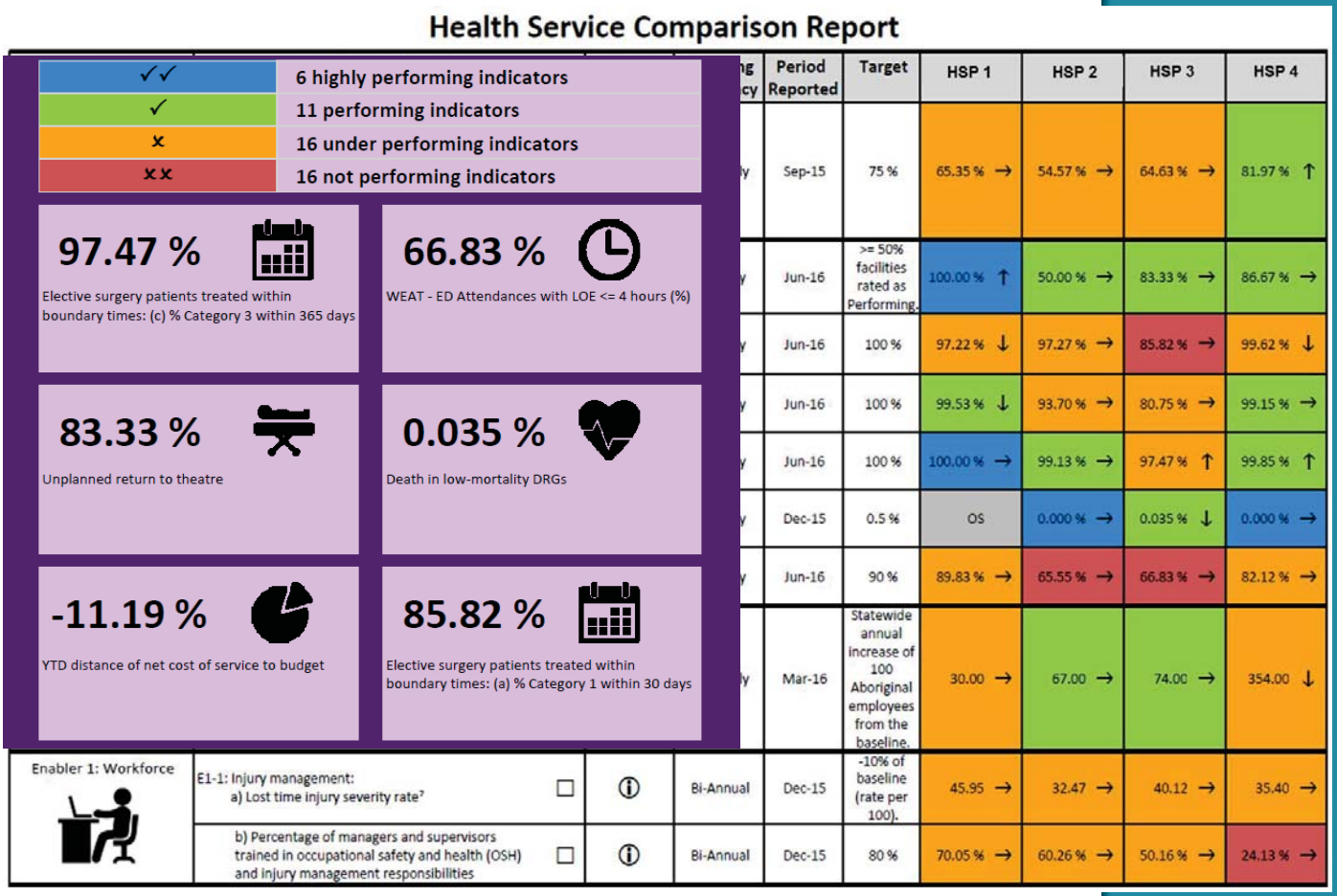
Performing

Under-Performing

Not Performing

Performance thresholds, measured against the relevant target, have been set for each performance indicator following rigorous stress testing and consultation with data stakeholders. These thresholds establish the levels of performance. The level of performance will determine whether any action needs to be taken in relation to identifying and resolving poor performance, or acknowledging excellent performance.

Figure 14: Examples of the HSPR and Performance Thresholds



6.1.5 Performance Monitoring and Evaluation

Performance is monitored regularly against performance indicator targets and thresholds specified in the HSPR 2016-17, the Interim Quadriplegic Centre Performance Report (QCPR) 2016-17 and the Interim Health Support Services Performance Report (HSSPR) 2016-17.

Performance review meetings between the Department, as the System Manager, and each Health Service Provider will initially be held monthly for the first quarter of 2016-17. Thereafter, the performance review meetings will be on a quarterly basis when no performance concerns are identified. Sustained high performance may lead to less frequent performance review meetings. If performance concerns are identified the frequency of the performance review meetings will be held monthly until performance issues are resolved.

The meetings aim to assist Health Service Providers to manage issues proactively, with appropriate support to achieve performance targets and avoid the need for further action. The discussion is interactive and enables Health Service Providers to raise relevant issues. The meetings cover previously agreed actions, flag potential or emerging performance issues, and identify risks affecting future performance. Actions and requirements of the Health Service Providers and the System Manager must be recorded clearly.

6.1.6 ABM Clinical Variation and Benchmarking application

The Department of Health ABM Clinical Variation and Benchmarking application has been developed to establish a standard ABM data set that is accessible and provides consistent, comparable and customisable information to support the needs of both the Department and Health Service Providers. The application shows national acute, newborn and subacute patient level benchmarking which will enable the Department as System Manager in conjunction with Health Service Providers to manage unwarranted cost, clinical variation and evaluate models of care to inform policy and key decisions to drive patient centred quality care in a more efficient and sustainable manner.

6.1.7 Future State

The Department proposed purchasing policy strategies, as outlined in section 4.2.5 and 4.2.6 will require further enhancement of the current performance monitoring and evaluation framework and mechanisms to improve Health Service Providers accountability for contracted deliverables through Service Agreements in order to realise the Strategic Intent and priorities of the WA Health system.

Appendix 1: List of Commonly used Acronyms and Abbreviations

Acronym	Description
ABF	Activity Based Funding
ABM	Activity Based Management
ACSQHC	Australian Commission on Safety and Quality of Health Care
AER	Agency Expenditure Review
AMHCC	Australian Mental Health Care Classification
ANACC	Australian Non-Admitted Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient
ARDT	Admission, Readmission, Discharge and Transfer Policy
CAHS	Child and Adolescent Health Service
CPI	Consumer Price Index
CSF	Clinical Services Framework
CSO	Community Service Obligation
Cwlth	Commonwealth
the Department	Department of Health
DRG	Diagnosis Related Group
Department CEO	Director General
EERC	Economic and Expenditure Reform Committee
EMHS	East Metropolitan Health Service
ESRG	Enhanced Service Related Groups
HCN	Health Corporate Network
HIN	Health Information Network
HSAP	Health Service Allocation Price
HSPR	Health Service Performance Report
HSS	Health Support Services
Health Service Providers	WA's seven Health Services: CAHS, EMHS, NMHS, SMHS, WACHS, HSS and the Quadriplegic centre
ICT	Information and Communications Technology
IHPA	Independent Hospital Pricing Authority
JWP	Joint Working Party
KPI	Key Performance Indicator
LHN	Local Hospital Network
MHC	Mental Health Commission
NEC	National Efficient Cost
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NHFB	National Health Funding Body
NHRA	National Health Reform Agreement 2011
NMHS	North Metropolitan Health Service
NWAU	National Weighted Activity Unit
OBM	Outcome Based Management
PAC	Projected Average Cost (also known as National Average Cost)
PCH	Perth Children's Hospital
PMF	Performance Management Framework
PMP	Performance Management Policy
PRAF	Purchasing and Resource Allocation Policy Framework
RBA	Reserve Bank of Australia
SCGH	Sir Charles Gardner Hospital
SMF	State Managed Fund
SMHS	South Metropolitan Health Service
SP	State Price
SPA	State Pool Accounts
State Government	Government of Western Australia
TTR	Teaching, Training, and Research
UDG	Urgency Disposition Group
URG	Urgency Related Group
WA Treasury	WA Department of Treasury
WA	Western Australia
WACHS	WA Country Health Service
WAU	Weighted Activity Units

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