



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

WA Health Funding and Purchasing Guidelines 2017-18



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Contributors

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FOREWORD

The Western Australia health system has experienced rapid but not sustainable growth in health expenditure over the past decade. Against this background, the WA health system faces the challenge to continue to pursue its vision of delivering safe, high quality and sustainable health services for all Western Australians. In view of this, it has become critically important that value is created in purchasing health services by ensuring best patient outcomes relative to costs.

Since the *Health Services Act 2016* came into effect, a significant reorganisation of the WA health system has taken place. In this new structure there are four distinct roles: Funder, System Manager, Purchaser and Providers. The Director General, as System Manager, plays an increasingly important role in providing strategic leadership and stewardship in overseeing and protecting the WA health system.

In support of the System Manager, the Department of Health (the Department) has undertaken a number of initiatives in setting the direction for the WA health system including:

- establishing support to the Minister of Health's Sustainable Health Review, prioritising the delivery of patient-centred, high quality sustainable health care across the State
- the completion of a Safety and Quality Review for the WA health system, providing recommendations for improvement in safety and quality under the new governance model
- the implementation of the Outcome Based Management Framework through the Service Agreements between the Department and Health Service Providers, providing transparency in the purchasing and resource allocation process
- the development of the Purchasing for Value Policy, focusing on creating value in purchasing healthcare aimed at maximising patient outcomes relative to service costs.

These initiatives are complementary and are crucial to ensure a more responsive, accountable and efficient health system benefiting all Western Australians.

In light of the current challenges facing the WA health system, it is essential that we continue to strive for increased efficiency, accountability and transparency in funding and purchasing.

I am pleased to present the WA Funding and Purchasing Guidelines 2017-18 which act as a reference tool to inform and provide transparency of the WA health system funding, purchasing and resource allocation processes.



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

WA Health Funding and Purchasing Guidelines 2017-18

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1 Overview

Health expenditure in Western Australia (WA) has grown substantially from \$4.8 billion in 2008-09 to \$ 8.9 billion in 2017-18. This represents an increase of 85 per cent over nine years. This rapid growth in health expenditure poses a challenge to the WA health system as it strives to provide high quality health services to a population of approximately 2.6 million dispersed across 2.5 million square kilometres.

Some of the challenges faced by the WA health system include:

- a growing and ageing population
- escalating demand for emergency care and hospital beds
- unsustainable expenditure growth
- chronic disease related costs
- lower number of GPs per capita than the Australian average clustered in affluent metropolitan areas
- diseconomies of scale and scope of services
- a vast geographical region and dispersed population
- costly advances in medical technology and pharmaceuticals
- persistent inequity in health status, in particular amongst the Aboriginal population
- increasing community expectations.

To ensure the WA health system is sustainable, a comprehensive structural reform has been put in place to support high quality care, efficient performance and greater accountability.

1.1 The Funding and Purchasing Guidelines 2017-18

1.1.1 Purpose of the Guidelines

The WA Health Funding and Purchasing Guidelines 2017-18 (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 form part of the *Purchasing and Resource Allocation Policy Framework*. Key objectives of the Guidelines are to:

- provide an overview of the Funding and Purchasing Cycle as per Figure 1



Handy Tip:
Click on [blue text](#) within these Guidelines to go to directly to the sections or websites mentioned

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Further information on the [WA Health Strategic Intent](#) can be found [here](#)



Click here to access the [Health Services Act 2016](#)

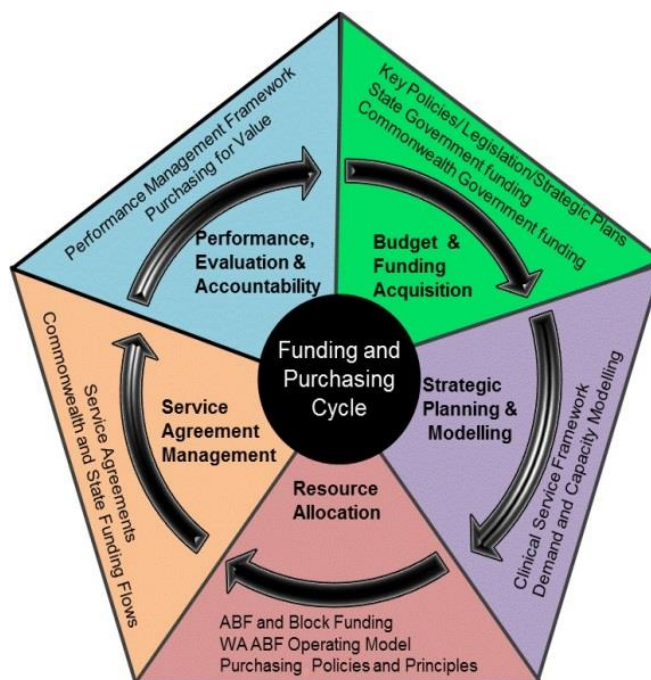
- explain the funding principles and models underlying the allocation of resources across the WA health system, with a particular focus on the operation and implementation of Activity Based Funding (ABF) and Activity Based Management (ABM) to key stakeholders
- reinforce the governance structure in place for the WA health system and outline the Funder, System Manager, Purchaser and Provider roles, responsibilities and accountabilities within this devolved governance structure ([Figures 2, 3 and 4](#))
- increase the collaboration with Health Service Providers and other key contributors to encourage further feedback opportunities
- explain the rationale behind the concept of creating value in purchasing health care and the long-term State Transition to an Efficient Practice (STEP) strategy envisioned for the WA health system.

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”.

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

Figure 1: Funding and Purchasing Cycle and Key Influences



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1.2 Governance Model

Since the *Health Services Act 2016* (the Act) was enacted on 1 July 2016, the WA health system has transitioned into a devolved governance structure creating a clear distinction between the roles of the System Manager and the Health Service Providers as separate statutory authorities. This structure, depicted in Figure 2, provides clear roles, responsibilities and accountabilities at all levels of the system governance model enabling decision-making closer to service delivery and patient care.



Click here for more information regarding the [Better health, better care, better value WA Health Reform Program 2015-2020](#)

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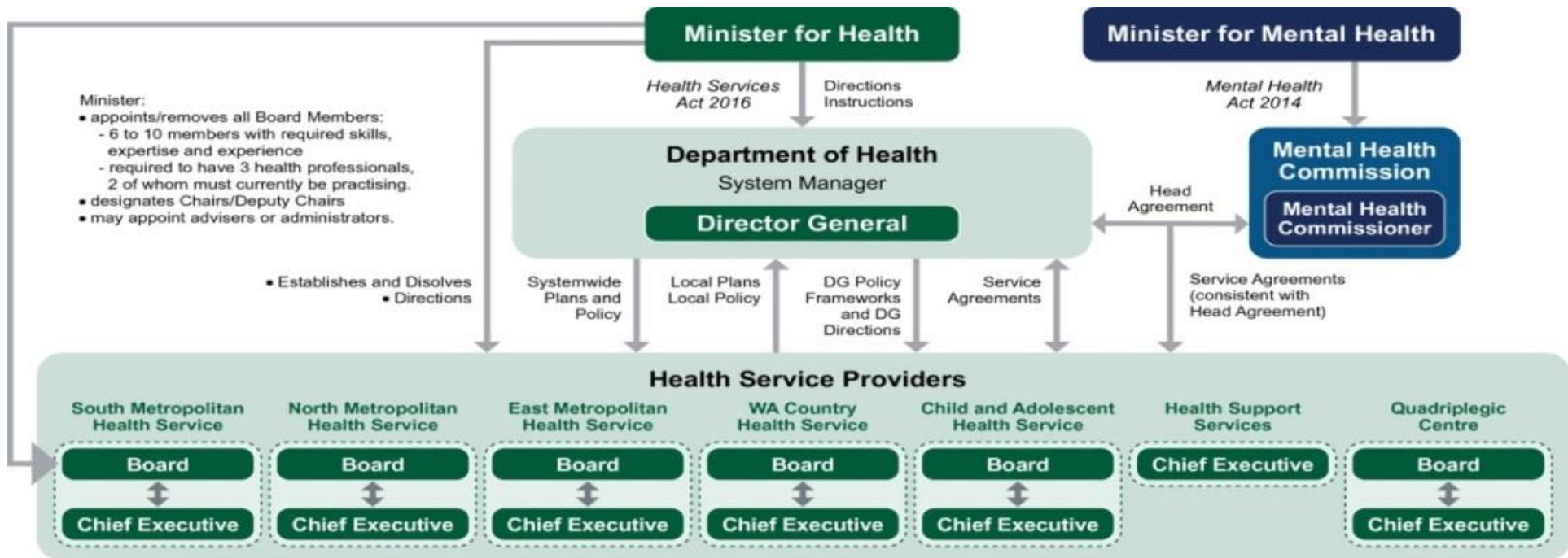
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Figure 2: WA health system Governance Structure



The establishment of health service entities as separate statutory authorities impacts on the purchasing and resource allocation process and relationships. The specific roles and responsibilities are described below.

Director General as System Manager

The Department CEO (Director General) is the System Manager responsible for the overall management and performance of the WA health system.

The Director General reports to the Minister for Health and provides leadership and stewardship over the strategic direction of the health system. This includes the development of an overarching system-wide strategy, effective service planning, setting high level strategic priorities and goals for the WA health system.

The Department of Health

The role of the Department is to support the Director General in the performance of all legislative functions, including his/her functions as a System Manager under the Act.

The Act also provides mechanisms for the System Manager to govern the relationships between the WA health system and Health Service Providers and other agencies such as the MHC.

Health Service Providers and Boards

Health Services have been established as separate board-governed Health Service Providers that are statutory authorities, legally responsible and accountable for the delivery of health services for their local areas and communities.

Health Support Services

Health Support Services (HSS) has been established as a chief executive-governed Health Service Provider that is a statutory authority, legally responsible and accountable for the delivery of support services. HSS incorporated and replaced the previous Health Corporate Network (HCN), Health Information Network (HIN) and Health Supply Network (HSN).

Mental Health Commission

The MHC is responsible for planning and purchasing mental health, alcohol and other drug services (Commission health services) in Western Australia. The MHC does not directly provide health services as these are delivered by Health Service Providers.



Click here for more information on [Mental Health Commission \(MHC\)](#)

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Further information on the [Policy Framework](#) can be found [here](#).

The purchase of these services occurs 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.

Service Agreements

Service Agreements between the Director General and each Health Service Provider are the legally binding mechanism establishing the budget, purchasing principles and mechanism, performance measures and operational targets for the provision of health services by each Health Service Provider. The parameters, roles and responsibilities in relation to the Service Agreements are outlined in Part 5, Division 3 of the Act.

Mental Health Head Agreement

In accordance with section 44 of the Act the Director General enters into a Head Agreement with the Mental Health Commissioner. 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 enables the Department to ensure the ongoing safety, quality, reliability and sustainability, clinical governance arrangements and coordination of Commission health services across the WA health system.

Commission Service Agreements

Under section 45 of the Act, the MHC enters into bilateral Commission Service Agreements with Health Service Providers for the delivery of Commission health services.

The Commission Service Agreements detail the purchasing arrangements for Commission health services from Health Service Providers and must be consistent and aligned with the Head Agreement pursuant to section 44(3) of the Act.

Policy Frameworks

As the System Manager, the Director General may issue binding policy frameworks to Health Service Providers to ensure service coordination, integration, effectiveness, efficiency and accountability in the provision of health services. Policy frameworks contain

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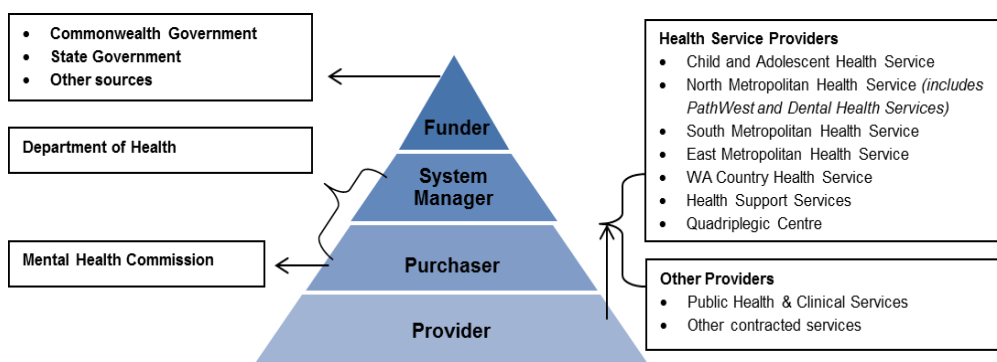
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reference to mandatory requirements and minimum standards, as well as supporting information.

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

The WA health system governance structure can be explained in terms of the roles, responsibilities and relationship between the System Manager and the Funder, Purchaser and Provider 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.

Western Australian Government through WA Treasury

WA Treasury has a central role in managing the 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 the largest portfolio of the WA Government.

Australian (Commonwealth) Government

The Australian Government allocates funding to State and Territory Governments to provide health and hospital services. The Australian

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For more information on **NHRA** click here [National Health Reform Agreement](#)

Government funds public health and hospital related services through the *National Health Reform Agreement* (NHRA), between the Commonwealth and all jurisdictions.

An addendum to the NHRA came into effect on 1 July 2017 bringing about changes to the Commonwealth funding arrangements that will be in place for the next three years (2017-18 to 2019-20). For further information refer to [changes to Commonwealth Funding](#).

1.3.2 System Manager Roles and Responsibilities

As defined in the Act, the Department, through the Director General, performs the System Manager functions 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 in supporting the System Manager is:

- providing 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
- promoting the effective and efficient use of available resources in the provision of health services
- 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 to performance objectives with Chief Executives and Boards 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

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- 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 Commission health services respectively in WA, as defined by the Act. The Department and the MHC enter into bilateral Service Agreements and Commission Service Agreements with each Health Service Provider outlining the purchased activity, associated funding and other requirements to be delivered such as safety and quality measures and performance reporting. Health Service Providers must comply with these bilateral Agreements.

1.3.4 Provider Roles and Responsibilities

The Department and the MHC purchase services from Health Service Providers and also contracted health entities for the delivery of a range of healthcare and support services.

There are seven Health Service Providers, 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

The roles of the Health Service Providers are 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



Click here for more information on the:

[Child and Adolescent Health Service](#)

[East Metropolitan Health Service](#)

[North Metropolitan Health Service](#)

[South Metropolitan Health Service](#)

[WA Country Health Service](#)

[Health Support Service](#)

[Quadriplegic Centre.](#)

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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.

- 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 for Health and the Director General can also issue directions to Health Service Providers with respect to the performance of their functions. A summary of key accountabilities of the funder, system manager, purchaser and provider is provided in Figure 4.

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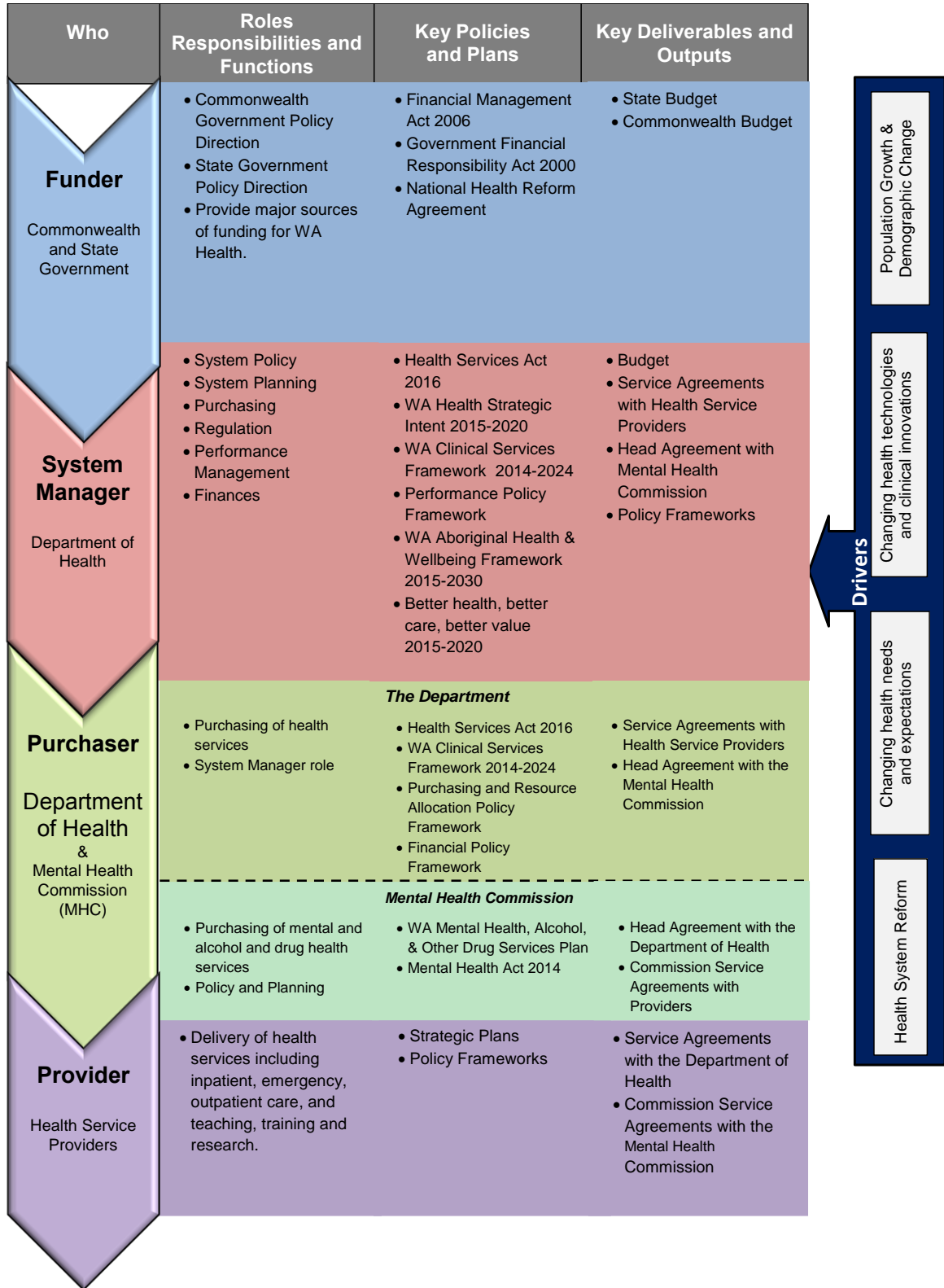
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Figure 4: Accountabilities of the Funder, System Manager, Purchaser and Provider





Click here for more information on the [OBM Framework](#)



Click here for more information on the [Sustainable Health Review](#)

1.4 WA Health System New Initiatives

1.4.1 Outcome Based Management

The State Government Outcome Based Management (OBM) Framework is now the mandatory performance management framework for WA State Government agencies. The OBM Framework directly links Outcomes, Services and Key Performance Indicators (KPIs) to State Government goals and priorities. It allows the State Government to measure the success of funded services to deliver desired outcomes.

The WA health system implemented the OBM framework on 1 July 2017. The new OBM Framework and four mandatory OBM policies specify the requirements that Health Service Providers must comply with in order to ensure the integrity of the OBM Framework across the WA health system.

The 2017-18 Service Agreements between the Department and Health Service Providers reflect the newly implemented OBM Framework.

1.4.2 Sustainable Health Review

As the System Manager is moving towards a mature commissioning model, the Department must develop a strategic approach to policy, planning, purchasing and performance functions.

In June 2017, the WA Government announced the Sustainable Health Review to prioritise the delivery of patient-centred, high quality and financially sustainable healthcare across the State. The Sustainable Health Review will consider a range of key areas including:

- ways to improve patient pathways and transition including through primary, secondary and tertiary healthcare
- the mix of services across the health system, including sub-acute, step-down, community and other out-of-hospital services to deliver care in the most appropriate setting
- ways to encourage and drive digital innovation, and the most effective use of new technology, research and data
- opportunities to drive partnerships across all sectors and levels of government
- ways to promote safer and more efficient services
- implementation of the review's recommendations.

A Panel has been established to conduct the Sustainable Health Review and will undertake consultation with Health Service Provider

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Boards, the Mental Health Commissioner, consumer advocates, and front-line staff and health leaders and will engage a whole of government approach in the articulation of recommendations. The Panel will submit an Interim Report to Cabinet, through the Minister for Health, by December 2017 and a Final Report and recommendations by March 2018.

1.4.3 Review of Safety and Quality for the WA Health System

Providing safe and high quality care to patients and the community is the core business of the WA health system. To that effect, there are a range of existing safety and quality policy, reporting and monitoring requirements and processes currently in place including those outlined in the *WA Strategic Plan for Safety & Quality in Health Care 2013-2017* and the *Clinical Governance Safety and Quality Policy Framework*.

Notwithstanding this, a Safety and Quality Review was commissioned in recognition of the need for continuous improvement in safety and quality and the need for assurance processes to be safeguarded in times of system change.

There is also recognition that the current transition period presents an opportunity, as new roles, responsibilities and accountabilities are reinforced, to ensure that the systems, processes and other assurance mechanisms that are put in place now are fit for-purpose for the years to come.

The *Safety and Quality Review* was completed in July 2017 and provided a number of recommendations. The Department and Health Service Providers will work together to address all recommendations of the review over the coming 12 to 18 months.

1.4.4 Purchasing for Value Policy

Given the increasing cost pressures faced in funding and providing public health services in WA and the need to contain recurrent expenditure growth, a series of strategies and recommendations to improve the efficiency of the WA health system have been put forward as part of the *Purchasing for Value Policy*.

The *Purchasing for Value Policy* focuses on incentive and efficiency driven purchasing policies, leading to the provision of health services that can be accurately planned, resourced and managed to deliver high quality patient outcomes at an established Efficient Practice.

Efficient Practice occurs when high quality effective healthcare is delivered in an appropriate setting, in a standardised manner,



Click here for more information on the [WA Strategic Plan for Safety and Quality in Health Care 2013-2017](#)



Click here for more information on the [Review of Safety and Quality for the WA Health System](#)

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following recognised best practice and approved models of care, to maximise patient outcomes relative to service costs.

The recommendations proposed as part of the *Purchasing for Value Policy* will be put in place through the State Transition to an Efficient Practice (STEP) strategy, a multi-year process of staged development, application, monitoring, evaluation and review of purchasing policies and resource allocation strategies to increase the efficiency and accountability of the WA health system.

More information of the *Purchasing for Value Policy* and principles associated with it is available in [section 5](#) of these Guidelines.

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2 Budget and Funding Acquisition

The budget and funding for health services in Western Australia is a combined State and Commonwealth responsibility. Expenditure on health services in Western Australia has grown from approximately \$4.8 billion in 2008-09 to \$8.9 billion in 2017-18 representing an increase of 85 per cent in health investment over nine years. The 2017-18 WA Health budget represents an increase of 1.4 per cent in overall expenditure relative to the 2016-17 Estimated Actual. The Commonwealth funding component of the 2017-18 budget is approximately \$2.1 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 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)
- new national performance standards and better outcomes for hospital patients.

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.



Further information on State Budget Papers can be found [here](#)



For more information on National Health Reform Agreement click [here](#)



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**

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National Efficient Price (NEP)

The 2017-18 NEP is \$4,910 per National Weighted Activity Unit (NWAU[17]).

Calculation of the NEP

The 2017-18 NEP is based on the calculated average cost of public hospital activity for the 2014-15 financial year of \$4,682 per NWAU(17), indexed at a rate of 1.6% p.a. Consistent with the NHRA, CwIth directly funded programs have been removed prior to determining the underlying cost data of the 2014-15 reference cost.



For more information on **IHPA** click here [Independent Hospital Pricing Authority](#)

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The key entities are as follows¹:

- Independent Hospital Pricing Authority (IHPA)
- The Administrator - 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 NHRA to facilitate the introduction of a nationally consistent approach to ABF.

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 team within the Purchasing and Contracting Unit at the Department is responsible for coordinating the Department's contribution to national pricing policy and is actively involved with the IHPA in the development and refinement of national classification systems.

The Administrator - National Health Funding Pool

The 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

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

- 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.

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



Visit the [National Health Funding Pool Act 2012](#) to access relevant legislation



Who is the NHFP 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.

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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.



The ACSQHC strategic priorities are:

- 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](#)

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 and quality 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

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 provided a commitment to develop an Addendum to the current NHRA to commence on 1 July 2017 and operate for three years, ceasing on 30 June 2020.

The NHRA Addendum was agreed by States and Territories and signed in April 2017. Consistent with clause A(1) of the NHRA the Commonwealth contribution to hospital services 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, it is important to note that this funding 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.

The NHRA Addendum also introduce funding and pricing mechanisms for safety and quality in service delivery as well as incentive mechanisms for the provision of accurate and timely activity data for reconciliation purposes.

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 growth declines from record high

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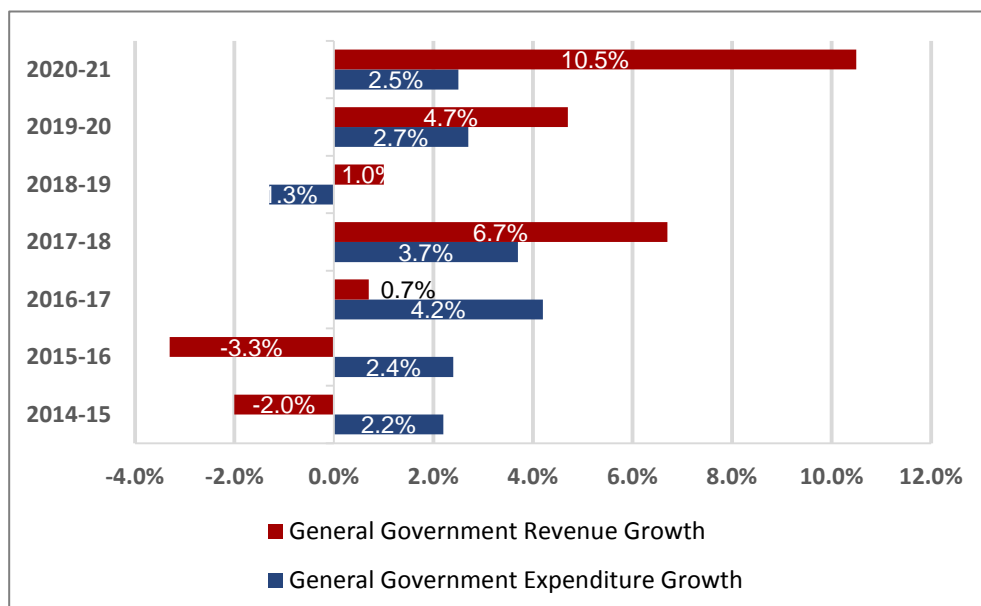
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levels and major resource projects continue to transition from construction to the production and export phase.

General Government Revenue Growth is expected to grow at an average of 5.7 per cent over the 2017-18 Budget and forward estimates period as per Figure 5.

Figure 5: General Government Revenue and Expenditure Growth Rates



Given the weak revenue outlook, Government has implemented new initiatives to contribute to budget repair, with further details of these measures included under [section 2.2.9](#). The combination of these measures and previous savings measures underpin low General Government expense growth projections averaging just 1.0 per cent across the forward estimates period, substantially below the average of 7.7 per cent recorded over the previous decade.

2.2.2 Health Spending

The approved expenditure limit for the WA health system for 2017-18 is \$8.9 billion, reflecting an increase of 1.4 per cent (\$124.2 million) relative to 2016-17 estimated actual. This provides an annual average expense growth of 1.0 per cent over the forward estimates. This is a sustainable outcome in a tight fiscal and economic environment in which overall government expenditure is expected to grow at an average of only 1.9 per cent.



For more information on the Addendum to National Health Reform Agreement [click here](#)

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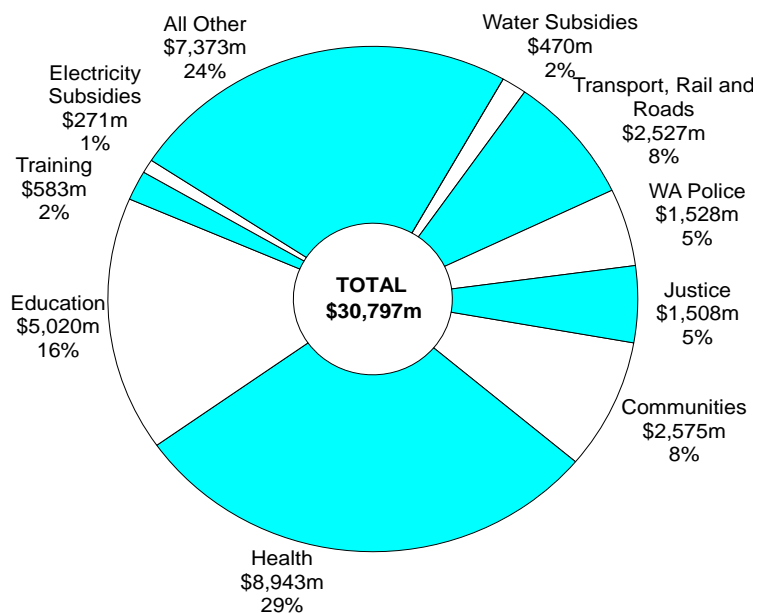
Table 1: WA Health's Expenditure Limit in 2016-17 and Forward Years

	2016-17 Est Actual \$m	2017-18 \$m	2018-19 \$m	2019-20 \$m	2020-21 \$m	Avg Annual Growth Rate
Expense Limit	8,818	8,942	8,781	8,996	9,223	
<i>Growth</i>		1.4 %	-1.8%	2.4%	2.5%	1.0%

Health expenditure 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.

As a proportionate share of General Government spending, Health expenditure is stabilising around 29 per cent in 2017-18 and across the forward estimates indicating that health expenditure is growing in line with the rest of the General Government sector.

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



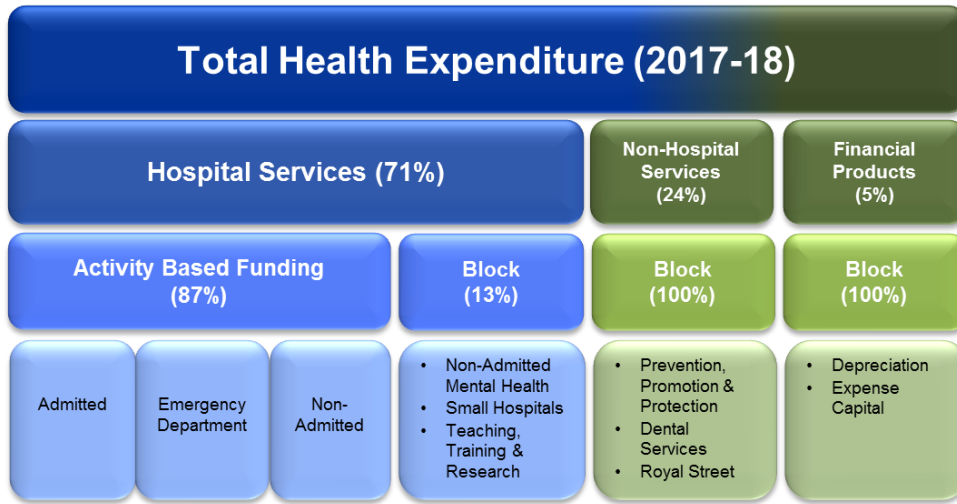
The components of the Health budget are classified between hospital services, non-hospital services and financial products, as outlined in Figure 7, with the components comprising:

- **hospital services** providing emergency, admitted surgical and medical and other non-admitted treatment services
- **non-hospital services** including programs that are generally delivered outside the hospital setting namely: prevention and promotion services; palliative care services; dental services, patient transport services; Aboriginal health services; system-wide support services, as well as strategic and system-wide

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- direction and leadership provided by the Department
- financial products** are expenses relating to depreciation, borrowing costs and expensed capital.

Figure 7: WA Health’s Budget Expenditure Categories



More specially 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), Non-Admitted Mental Health and Small Rural Hospital activities.

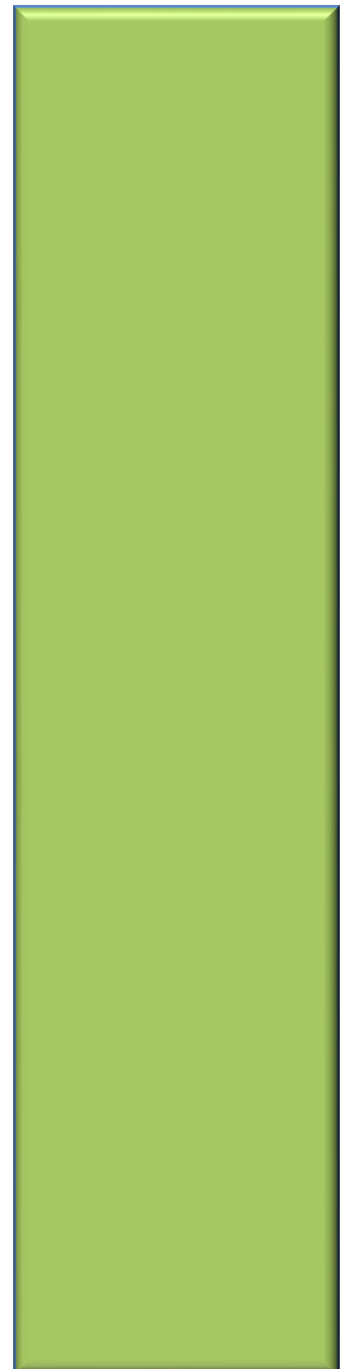
2.2.3 Outcome Based Management (OBM) Framework

To provide greater transparency into how the WA health system delivers, reports and measures the success of health service provision, the 2017-18 Budget has been established in the new OBM Framework. Table 2 shows the categorisation of the budget settings in the new OBM Framework between hospital services and non-hospital services.

Table 2: Hospital and Non-hospital services under the new OBM Framework

Service	Category
1. Public Hospital Admitted Services	Hospital Services (ABF)
2. Public Hospital Emergency Services	Hospital Services (ABF)
3. Public Hospital Non-Admitted Services	Hospital Services (ABF)
4. Mental Health Services	Hospital Services (ABF and Block) & Non-Hospital Services(a)
5. Aged and Continuing Care Services	Non-Hospital Services
6. Public and Community Health Services	Non-Hospital Services
7. Community Dental Health Services	Non-Hospital Services
8. Small Rural Hospital Services	Hospital Services (Block Funded) and Non-Hospital Services ^(b)
9. Health System Management – Policy and Corporate Services	Non-Hospital Services
10. Health Support Services	Non-Hospital Services

(a) Non-hospital services include those programs funded by the Mental Health Commission; and
 (b) Includes non-hospital services for Royalties for Regions related programs.



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A detailed breakdown of the budget relative to the service expenses is provided in Table 3.

Table 3: WA health system - Service Expenses Summary

Expense	2016-17 Est Actual	2017-18	Variance	
	\$'000	\$'000	\$'000	%
1. Public Hospital Admitted Services	4,034,735	4,253,002	218,267	5.4%
2. Public Hospital Emergency Services	761,847	804,479	42,632	5.6%
3. Public Hospital Non-Admitted Services	792,978	838,848	45,870	5.8%
4. Mental Health Services	688,913	715,431	26,518	3.8%
5. Aged and Continuing Care Services	548,671	485,156	-63,515	-11.6%
6. Public and Community Health Services	1,134,991	1,038,497	-96,494	-8.5%
7. Community Dental Health Services	111,224	110,192	-1,032	-0.9%
8. Small Rural Hospital Services	291,353	264,304	-27,049	-9.3%
9. Health System Management - Policy and Corporate Services	198,427	194,425	-4,002	-2.0%
10. Health Support Services	255,176	238,193	-16,983	-6.7%
Total Cost of Services	8,818,315	8,942,527	124,212	1.4%

Source: 2017-18 WA Health Budget Statement

2.2.4 Realignment of Budget Settings

The 2017-18 Budget realigns the mix of funding between hospital and non-hospital services based on expenditure outcomes under the OBM Framework, without any additional impact on the State's financial position over the forward estimates. Importantly, due to the realignment of budget settings, the 2017-18 Budget is not comparable to the 2016-17 Budget or the 2016-17 Estimated Actual, but is comparable to the 2015-16 Actual.

Realigning current budget settings between hospital services and non-hospital services is necessary to ensure consistency between the way in which the system allocates its resources, and incurs expenditure in the provision of health service delivery.

2.2.5 Budget Settings for Activity Based Hospital Services

The State Government budget settings for health activity delivered by the WA health system, including activity purchased by the MHC, are



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set using the National ABF Framework, and are informed by the annual Pricing Framework published by the IHPA

As shown in Table 4, the 2017-18 Budget provides for ABF hospital services expenditure of approximately \$5.6 billion, representing growth of 2.4 per cent (\$131.1 million) relative to the 2016-17 Estimated Outturn, and an annual average growth rate of 3.3 per cent over the forward estimates.

Table 4: ABF Hospital Services Expenditure

Hospital Services Expenditure		2016-17 estimated outturn (a)	2017-18 approved
Approved Activity	WAUs	891,067	907,938
<i>Demand Growth</i>	%		1.9%
Approved State Price	\$	6,098	6,129
<i>Cost Growth</i>	%		0.5%
Approved ABF Expenditure	\$M	5,434	5,565
<i>Overall Growth</i>	%		2.4%

(a) 2016-17 Estimated Outturn for actual spending reflected in the OBM Framework.

State Budget Demand Growth

Consistent with prior years, the 2017-18 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)² 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

² 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.

² 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**

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calculated national average cost in order to derive the NEP. The NEP estimates are a major determinant in deriving Commonwealth Government funding for in-scope public hospital services.

The calculated net average cost of public hospital activity, that is, excluding directly funded (*outside ABF*) Commonwealth programs, for 2014-15 was \$4,682 per National Weighted Activity Unit (NWAU). This value was then indexed at a rate of 1.6 per cent per annum to arrive at the 2017-18 NEP of \$4,910 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 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 2013-14, the WA health system's budget ABF settings have been set in line with the national activity classification system and Government's purchasing intentions tied to the provision of hospital activity at a State price.

The approved State Price for 2017-18 is \$6,129 per Weighted Activity Unit (WAU) signifying an increase of 0.5 per cent over the 2016-17 Estimated Outturn of \$6,098 per WAU.

Price growth has been established at 1 per cent per annum over the forward estimates, with a 0.5 per cent efficiency dividend applied to growth from 2016-17 to 2017-18 to drive financial sustainability in public hospitals and to reduce the cost disparity between WA and the national average.

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Figure 8: Summary of Pricing



State Price	\$6,129	Price approved by State Government including transitional grants.
PAC - WA (Projected Average Cost)	\$5,062	PAC includes C'with funds that are excluded in the NEP (as below) dispersed through the HSAP, rather than block funded.
NEP (National Efficient Price)	\$4,910	Commonwealth funded programs that are not included in the NEP: <ul style="list-style-type: none"> ▪ Highly Specialised Drugs ▪ Pharmaceutical Reform Agreements ▪ Early Stage Breast Cancer PBS

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](#).

2.2.6 Activity Settings

As previously indicated in table 4, the 2017-18 WA Budget provides for activity settings of 907,938 WAUs, an increase of 16,871 WAUs (or 1.9 per cent) over 2016-17 Estimated Actual, and an annual average growth of 2.3 per cent over the forward estimates.

These activity settings in 2017-18 are estimated to provide for over 652,000 inpatient episodes of care; over 1,052,000 emergency department episodes of care; and over 2,434,000 service events in outpatient clinics and community settings.

2.2.7 Block Funded Services

Block funding from 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 new classification systems for these services. Teaching, Training and Research (TTR) activities, although block-funded by the Government, are dispersed based on the ABF service allocation methodology by the WA health system.



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

Table 5: Cost and Demand Escalators for Block Funded Services

	Escalator	Notes
<i>Demand</i>	1.89%	2017-18 Age Weighted Population Growth Rate
<i>Demand</i>	1.12%	2017-18 Mental Health Age Weighted Population Growth Rate
<i>Cost</i>	1.50%	Consistent with the previous Government Wages Policy

2.2.8 Non-Hospital Services

Non-hospital services expenditure of \$2.17 billion in 2017-18 represents a reduction in growth of 3.9 per cent (or \$88.8 million) from the prior years, and an annual average expense growth of -5.9 per cent for non-hospital services over the forward estimates.

Expenditure for non-hospital services in the 2017-18 Budget accounts for 24 per cent of total Health expenditure, a decrease of 2 per cent from 26 per cent prior to budget realignment.

The decrease in non-hospital services budget settings is a result of the reprioritisation of funding to hospital services, as well as material decisions made by Government as part of the 2017-18 Budget process as illustrated below.

Table 6: Budget Adjustments for 2017-18 for Non-Hospital Services

	2017-18 \$'000	2018-19 \$'000	2019-20 \$'000	2020-21 \$'000	Total \$'000
Realignment of Non-Hospital Services to Hospital Services	(91,017)	(334,831)	(304,573)	(246,385)	(976,806)
Revision to Indexation for Non-Salary Expenses	(4,077)	(7,867)	(10,797)	(16,758)	(39,499)
Sub-total for Realignment	(95,094)	(342,698)	(315,370)	(263,143)	(1,016,305)
Home and Community Care Agency Expenditure Review - Tranche 2	(17,745)	(273,386)	(273,386)	(273,386)	(837,903)
Non-Government Human Services Sector Indexation	(4,426)	(5,353)	(5,516)	(5,718)	(21,013)
Total Adjustments for Non-Hospital Services	(164,746)	(673,933)	(642,547)	(592,701)	(2,073,927)

2.2.9 Material Adjustments and Corrective Measures

The following section details material adjustments and corrective measures impacting the WA health system budget settings stemming from the 2017-18 Budget.

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Home and Community Care

On 1 February 2017, bilateral agreements between the Commonwealth and the State were announced for transitioning responsibility for aged care and disability services in WA from the State Home and Community Care to the Commonwealth Home Support Program (CHSP) and National Disability Insurance Scheme (NDIS).

These bilateral agreements have resulted in the redirection of \$838.9 million of Commonwealth and State Revenue from WA Health's budget settings to the Disability Services Commission (DSC) for the transition to the CHSP and NDIS.

Agency Expenditure Review

Agency Expenditure Review – Tranche 1

Savings from the Agency Expenditure Review (AER) (\$148.3 million from 2017-18 to 2019-20) were reinvested from non-hospital services into ABF services as part of the 2016-17 Budget. The resulting overall budget impact was neutral, as the reduction in budget settings for non-hospital services was offset by an increase in the budget for ABF services.

Agency Expenditure Review – Tranche 2

As part of the 2017-18 Budget process Government approved the return of WA health system's AER savings previously reinvested in hospital services, to the Consolidated Account, resulting in a reduction of \$148.3 million for the WA health system.

The return of AER savings has been achieved through a further reduction in the non-hospital services budget settings. The budget settings for hospital services has therefore been protected, whilst there is a 'double impact' of AER savings on the non-hospital services budgets.

In establishing the new 2020-21 forward estimate, a further AER savings adjustment of \$50.5 million has been reflected in WA health system's budget settings.

Reduction in Indexation for Non-Salary Expenses

Given the continued deterioration in the State's finances and low inflation environment, on 1 May 2017 Cabinet approved the reduction of indexation for appropriation-funded non-salary expenses for General Government agencies from 1 per cent to 0 per cent.



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Implementation of this corrective measure for non-salary expenses has resulted in a \$39.5 million decrease in budget settings from 2017-18 to 2020-21

Non-Government Human Services Sector (NGHSS) Indexation

Adjustments to NGHSS indexation funding are made after revised Consumer Price Index (CPI) and Wage Price Index (WPI) rates are published, with the NGHSS indexation rate being a composite mix of the two economic indicators.

For 2017-18, an indexation rate of 0.83 per cent applies to all eligible new and existing contract arrangements set under the *Delivering Community Services in Partnership Policy 2011*. The change in indexation rate for 2017-18 has resulted in a cumulative reduction in funding of \$21 million from 2017-18 to 2020-21.

2.3 Service Delivery Initiatives

The following initiatives have been funded as part of the 2017-18 Budget process.

Meningococcal Vaccination Program

The 2017-18 Budget will provide funds to the Western Australian Meningococcal Vaccination Program for *A, C, W and Y strains*. This four-year vaccination program targets those in the age bracket of 15-19 years, both in school and out of school. The vaccination is expected to control recent outbreaks of the illness and improve vaccination coverage in the community.

Fremantle General Dental Clinic

The 2017-18 Budget provides funds for the relocation of the Fremantle General Dental Clinic to a refurbished ward in Fremantle Hospital. This refurbishment will cost \$2.99 million in 2017-18 and will be internally financed. This new arrangement will provide support for special needs patients as well as relocating the existing clinic.

Patient Administration System

The 2017-18 Budget has reprioritised and reallocated recurrent expenditure to capital of \$13.7 million to continue the rollout of the Patient Administration System. This system will provide a standardised platform for patient administration within WA health system's hospitals, thereby increasing efficiency, safeguarding hospital business continuity and lowering operating costs by removing the duplication of support services.

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Fiona Stanley Hospital ICT Equipment and Assets Upgrades

As part of the 2017-18 Budget, \$13.6 million of capital investment for the replacement and upgrade of Information Communications Technology (ICT) equipment and assets at the Fiona Stanley Hospital (FSH) have been approved. The replacement of these assets will enhance clinical performance and provide support for service delivery.

Fire Safety Issues at Royal Perth Hospital

The 2017-18 Budget has reprioritised \$9.962 million of capital funding over four years from WA Health's Asset Investment Program for infrastructure maintenance to address fire safety issues at Royal Perth Hospital (RPH). These works will ensure that RPH complies with the accreditation requirements of the Australian Council of Healthcare Standards.

Da Vinci Surgical System

Capital funds of \$4.95 million have been provided in the 2017-18 Budget to procure the Da Vinci Surgical System for FSH that will enable robotic assisted state-of-the-art minimally invasive urological surgeries. The robotic system provides better 3D vision, magnification capabilities and precise removal of cancerous tissues with less blood loss, resulting in patients having faster recovery times and improved surgical outcomes.

Perth Children's Hospital

Additional funding of \$24.6 million has been allocated to enable the successful commissioning and transition of services to the Perth Children's Hospital (PCH), which is expected to be operating in 2018.

2.3.1 Election Commitments Funded in the 2017-18 Budget

Let's Prevent Program

The 2017-18 Budget provides \$2.1 million of internal funding over four years for the Let's Prevent Program to educate and encourage participants to make the changes necessary to avoid chronic conditions that have the potential for significant impact on their lives.

Patient Opinion

Existing funding of \$0.8 million over four years will be reprioritised for an opinion tool that allows patients to provide feedback regarding their health care experience.

Peel Youth Medical Service Hub

The 2017-18 Budget provides \$5 million for the establishment of greater youth health and mental health services in the Peel region.



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Find Cancer Early

Funding from the Royalties for Regions program provides \$1.6 million over four years for the expansion of the Find Cancer Early Program to operate more widely in regional areas. This program provides community education about the early signs and symptoms of bowel, lung, prostate, and breast and skin cancer.

Expand the Ear Bus Program

Funding of \$2.8 million over three years through Royalties for Regions (\$2.5 million of recurrent funding and \$0.3 million of capital funding), is allocated for the expansion of the Ear Bus Program to address areas of unmet demand. This program provides an ear screening service, with the additional funding aimed at targeting the population of the Kimberley region.

Meet and Greet Service

Investment of Royalties for Regions funding of \$1.9 million will facilitate the expansion of the Meet and Greet Service offered by Government for people travelling to Perth from rural and remote areas for medical treatment.

Government is also committed in delivering the remaining health election commitments over the longer term, noting that more complex commitments require robust scoping and planning activities in order to be successfully implemented.

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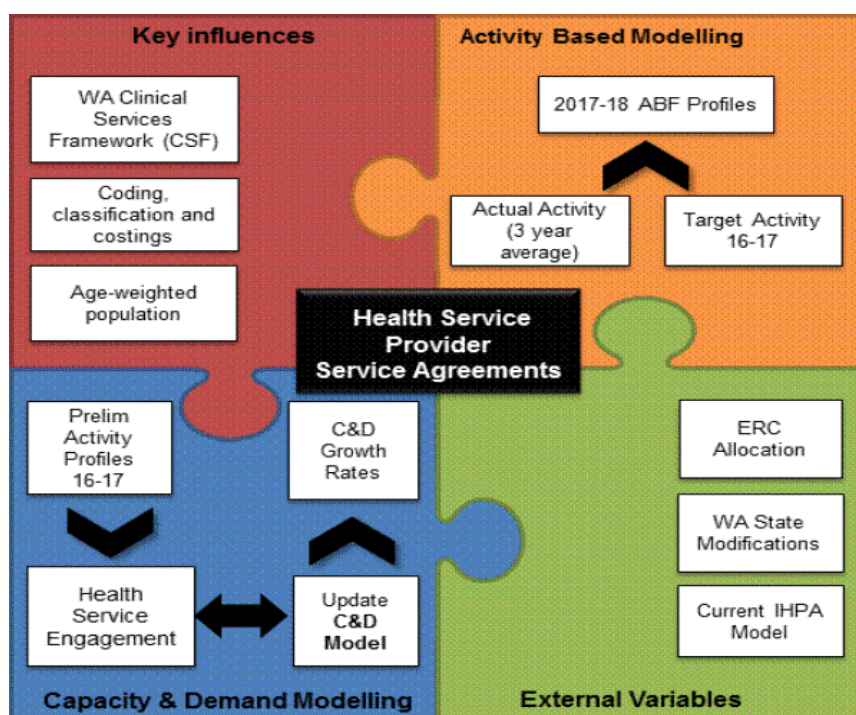
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3 Strategic Planning and Modelling

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




 Click here for more [information on the WA Health Clinical Services Framework](#)

3.2 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 and has also been expanded to include a range of non-hospital services provided

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For more information on the **ARDT** click here

[Admission, Readmission, Discharge and Transfer Policy for WA Health Services](#)

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.

3.2.1 Admission, Readmission, Discharge and Transfer Policy

The *Admission, Readmission, Discharge and Transfer Policy* (ARDT) is a mandatory policy 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.

3.2.2 Classification, Counting and Costing of Health Activity

High quality accurate and timely data is essential for 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 system 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.

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3.2.3 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 Table 7.

Table 7: 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

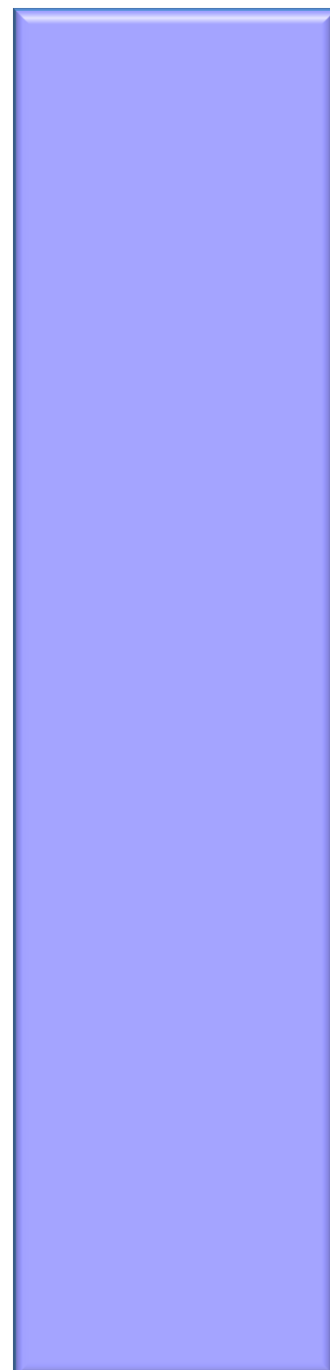
3.2.4 Development of New National Classifications

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 ABF purposes.

Mental Health Care

A new national classification system for mental health services, the Australian Mental Health Care Classification (AMHCC) has been developed by the IHPA. The classification applies to the admitted and community settings. Version 1 of the AMHCC was finalised in early 2016 and was implemented for reporting purposes on a best endeavours basis from 1 July 2016. The use of the AMHCC for pricing and funding purposes is delayed until robust costing data is available.

IHPA has commenced the development of Version 2 of the AMHCC.



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Visit IHPA for more information on TTR
[Teaching, Training & Research](#)

Non-Admitted Care

The IHPA is continuing to develop the new Australian Non-Admitted Care Classification (ANACC) System for non-admitted services that will replace the current Tier 2 classification. The ANACC will be able to better describe patient complexity and more accurately reflect the costs of non-admitted public hospital services.

Teaching, Training and Research (TTR)

There is currently no national classification for TTR. The IHPA is continuing the development of the key technical requirements to introduce ABF for teaching and training.

A public consultation on the draft Teaching and Training classification has commenced. Work is also continuing to determine the feasibility of an ABF approach to Research.

Emergency Care Services

Work to inform the development of a new classification for emergency care services is progressing, following the completion of a national costing study. A new classification system is scheduled for completion by early 2018 and proposed for implementation from 1 July 2018.

3.2.5 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).

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, specialist clinical coders classify and record this information into Patient Information Systems. This activity is then inputted into datasets managed centrally by the Department.

3.2.6 Costing Patients

WA hospitals undertake costings of all hospital level activity each financial year. This patient-level costing data includes all Admitted,

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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.

3.3 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 the [section 3.2.2](#) 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.

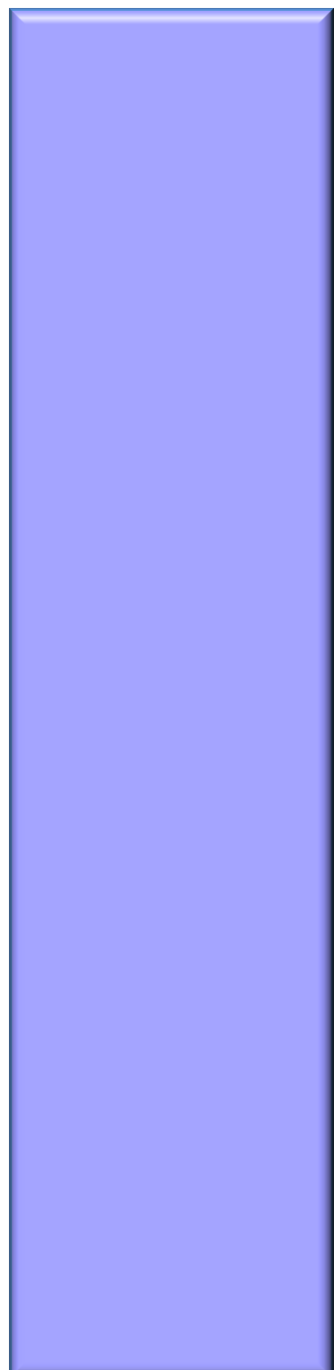
The capacity and demand modelling process involves the following steps:

- 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).

3.3.1 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.



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Click here to receive more information about the [Department of Planning Population Projection](#)

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.

3.3.2 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.

3.3.3 Capacity Modelling

The Capacity model aims to link projected demand for health services with the ability of hospitals to provide the scale and scope of projected 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

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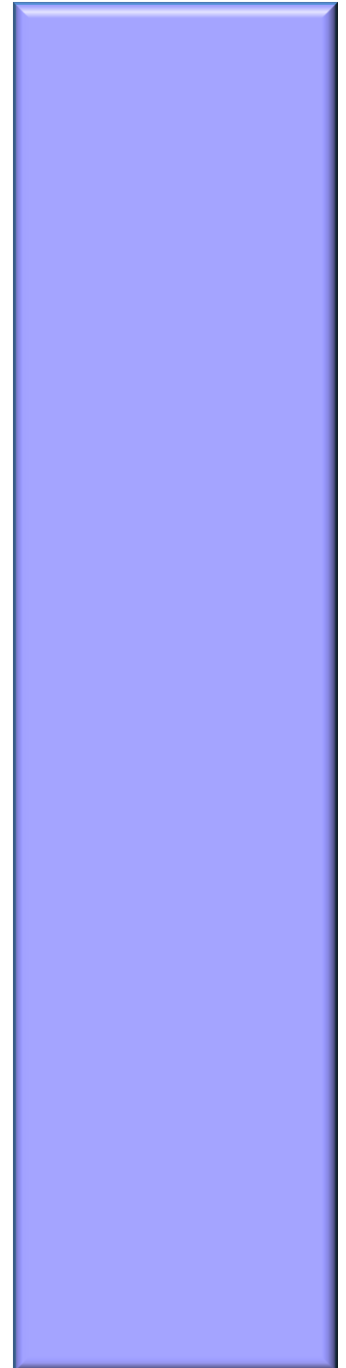
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infrastructure and service configuration (new hospital) underpinned by the CSF.

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.



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Handy Tip:

Click here to find out more about [IHPA's Education Tools](#)

4 Resource Allocation

This section builds on [section 3](#) Strategic Planning and Modelling to explain the national funding principles for 2017-18 and how these principles are applied and, when necessary, modified to suit the needs of the WA health system to develop activity profiles and associated funding allocated to Health Service Providers. The resource allocation process is the last 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 delivered, 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 2017-18 NEP and NEC determination is sourced from the NHCDC Round 19, relating to the 2014-15 financial year, which is then indexed to arrive at the 2017-18 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 2017-18 IHPA model adjustments are outlined, in order of precedence of application, in table 8.

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Table 8: National ABF Adjustments 2017-18 *

IHPA National NEP Loading	Amount to be applied
<p>Paediatric Adjustment</p> <p>Is in respect of a person who:</p> <p>(a) is aged up to and including 17 years; and</p> <p>(b) is admitted to a <i>Specialised Children's Hospital</i> (Appendix E) (refer to the <i>National Price Determination 2017-18</i>).</p>	Refer to column headed 'Paediatric Adjustment' in the tables of Admitted Acute Price Weights (Appendix H) (refer to the <i>National Price Determination 2017-18</i>).
<p>Specialist Psychiatric Age Adjustment (≤ 17 years, in MDC 19 or 20)</p> <p>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.</p>	Admitted Acute Patient: 28 per cent (except patients admitted to a Specialised Children's Hospital, who will receive 10 per cent)
<p>Specialist Psychiatric Age Adjustment (≤ 17 years, not in MDC 19 or 20)</p> <p>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.</p>	Admitted Acute Patient: 46 per cent (except patients admitted to a Specialised Children's Hospital, who will receive 44 per cent)
<p>Specialist Psychiatric Age Adjustment (> 17 years, not in MDC 19 or 20)</p> <p>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.</p>	Admitted Acute Patient: 32 per cent
<p>Outer Regional Adjustment ³</p> <p>Is in respect of a person whose residential address is within an area that is classified as being <i>Outer Regional</i>.</p>	Admitted Acute or Admitted Subacute Patient: 8 per cent
<p>Remote Area Adjustment ⁴</p> <p>Is in respect of a person whose residential address is within an area that is classified as being <i>Remote</i>.</p>	Admitted Acute or Admitted Subacute Patient: 20 per cent
<p>Very Remote Area Adjustment ⁵</p> <p>Is in respect of a person whose residential address is within an area that is classified as being <i>Very Remote</i>.</p>	Admitted Acute or Admitted Subacute Patient: 25 per cent
<p>Indigenous Adjustment</p> <p>Is in respect of a person who identifies as being of Aboriginal and/or Torres Strait Islander origin.</p>	Admitted Acute, Admitted Subacute, Emergency Department, Emergency Service or Non-admitted Patient: 4 per cent.
<p>Radiotherapy Adjustment</p>	Admitted Acute Patient: 27 per cent

³ The Outer Regional Adjustment, Remote Area Adjustment and Very Remote Area Adjustment are the Remoteness Area Adjustments for the purposes of the 2017-18 National Price Determination.

⁴ Refer Appendices B and C in the Determination for valid ICD-10-AM 10th edition codes.

⁵ Refer to Appendix D in the Determination.



*National ABF Adjustments Table sourced from the [National Price Determination 2017-18 Chapter 5 - Adjustments](#)

Visit [IHPA](#) for further information

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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](#)

IHPA National NEP Loading	Amount to be applied
Is in respect of an Admitted Acute Patient with a specified ICD-10-AM 10th edition radiotherapy procedure code recorded in their medical record. ²	
<p>Dialysis Adjustment</p> <p>Is in respect of an Admitted Acute Patient with a specified ICD-10-AM 10th edition renal dialysis code who is not assigned to the AR-DRG L61Z Haemodialysis or AR-DRG L68Z Peritoneal Dialysis. 2</p>	Admitted Acute Patient: 25 per cent
<p>Intensive Care Unit (ICU) Adjustment</p> <p>(a) Is not represented by a newborn/neonate AR-DRG identified as 'Bundled ICU' in the tables of Price Weights (Appendix H); but</p> <p>(b) Is in respect of a person who has spent time within a Specified ICU.³</p>	0.0427 NWAU(17)/hour spent by that person within the Specified ICU. <i>(refer to the National Price Determination 2017-18).</i>
<p>Private Patient Service Adjustment</p> <p>Is in respect of an Eligible Admitted Private Patient.</p>	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 <i>(refer to the National Price Determination 2017-18).</i>
<p>Private Patient Accommodation Adjustment</p> <p>Is in respect of an Eligible Admitted Private Patient.</p>	Admitted Acute or Admitted Subacute Patient: Refer to Appendix F for applicable adjustment <i>(refer to the National Price Determination 2017-18).</i>
<p>Multidisciplinary Clinic Adjustment</p> <p>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'.</p>	Non-admitted Patient: 55 per cent
<p>Emergency Care Age Adjustment</p> <p>Is in respect of an Emergency Department or Emergency Service patient, with the rate of adjustment dependent on the person's age.</p>	Emergency Department or Emergency Service Patient who is aged: 65 to 79 years: 14 per cent Over 79 years: 21 per cent

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4.1.2 Block Funding Allocation for 2017-18

Consistent with the National Pricing Framework 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)
- Small Rural Hospitals (SRH)

Non-Admitted Mental Health

In 2017-18, non-admitted mental health services continue to be block funded. The IHPA makes the determination of the block-funding allocations with advice provided by jurisdictions. The Department works closely with the MHC and Health Service Providers to determine priority areas for targeted services purchasing.

Teaching, Training, and Research

For 2017-18, the IHPA will continue to determine block funding amounts for TTR activity based on jurisdictional advice. The TTR allocation for WA Health in 2017-18 is consistent with the methodology used in previous years. TTR funding distribution relates to the activity profiles for each site, consistent with the WA ABF modelling methodology.

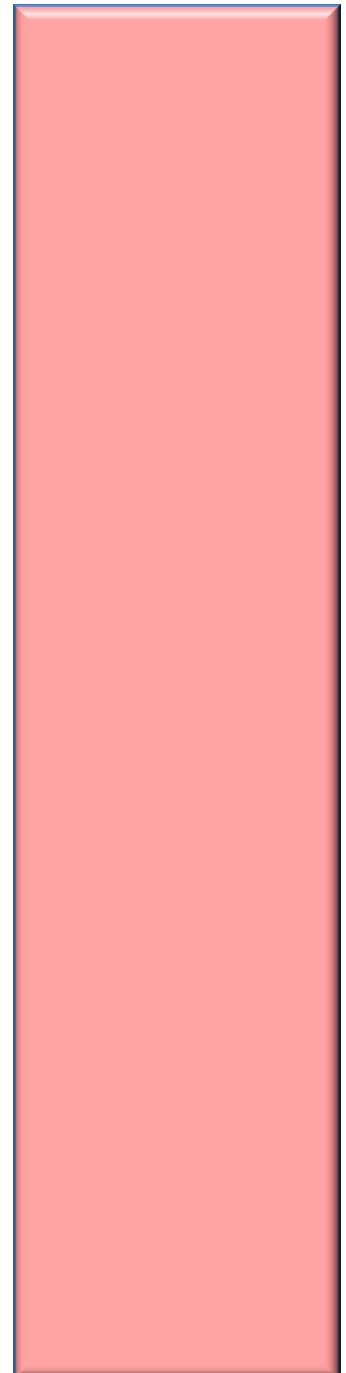
Small Rural Hospitals

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 Community Service Obligation hospitals and therefore receive their share of Commonwealth funding 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.

Nine 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. Tables 9 to 11 include a complete list of all WA public hospitals for each Health Service Provider and their associated funding approach.



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Table 9: 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
<ul style="list-style-type: none"> Princess Margaret Hospital Perth Children's Hospital 	<ul style="list-style-type: none"> Armadale Kelmscott Memorial Hospital Bentley Hospital Royal Perth Hospital St John of God Midland Public Hospital <p>ABF Funded By WA*</p> <ul style="list-style-type: none"> Kalamunda Hospital* 	<ul style="list-style-type: none"> Fiona Stanley Hospital Fremantle Hospital Peel Health Campus Rockingham General Hospital State Rehabilitation Centre <p>ABF Funded By WA*</p> <ul style="list-style-type: none"> Murray District Hospital* 	<ul style="list-style-type: none"> Graylands Hospital Joondalup Health Campus King Edward Memorial Hospital Osborne Park Hospital Sir Charles Gairdner Hospital 	<p>Regional</p> <ul style="list-style-type: none"> Albany Hospital Broome Hospital Bunbury Hospital Geraldton Hospital Hedland Health Campus Kalgoorlie Hospital <p>Integrated/District</p> <ul style="list-style-type: none"> Busselton Hospital Derby Hospital Esperance Hospital Kununurra Hospital Nickol Bay Hospital (Karratha) Northam Hospital* <p>ABF Funded By WA*</p> <ul style="list-style-type: none"> Collie Hospital* Carnarvon Hospital* Katanning Hospital* Margaret River Hospital* Merredin Hospital* Moora Hospital* Narrogin Hospital* Newman Hospital* Warren Hospital (Manjimup)*

*These hospitals are block funded by the Commonwealth but ABF funded by WA.

Table 10: 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 the table below.

Table 11: List of WA Health Nursing Posts

Nursing Post Name	Region
Burringurrah	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



Activity Based Funding (ABF)

For Commonwealth funding purposes 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



Click here for more information on the [National Efficient Price \(NEP\) Determination 2017-18](#)

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4.2 WA Health System Resource Allocation

The WA ABF methodology is underpinned by the clear role delineation of Funder, System Manager, Purchaser and Provider, as outlined in [section 1.3](#) of these Guidelines.

WA health system 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.

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 nine ABF Integrated (district) hospitals that under the current IHPA definitions are treated as NEC funded hospitals (see [table 9](#)). 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 2017-18 framework, the exception being 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. The Department is currently participating in the development of the new AMHCC system led 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 Department and reporting to State Government, the agreed activity as specified under these specific

contract agreements is converted to the equivalent IHPA 2017-18 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 that includes weighted activity related to private patients in public hospitals. In this total expenditure profile, the expected hospital own source revenue is already factored in the calculations. The IHPA model, however, applies a discount for private patients in public hospitals 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 funding. The 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.

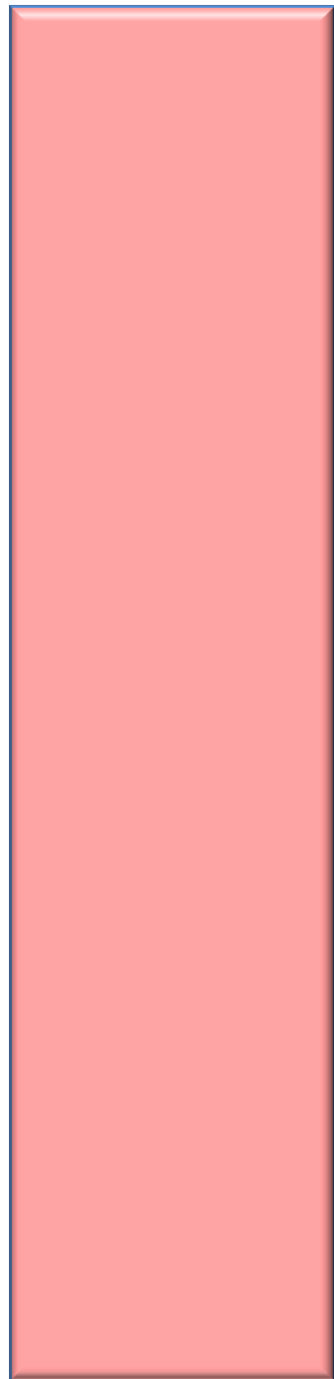
4.2.2 Cost Weights

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 DRG format. DRGs are the standard method of classifying hospital acute admitted activity. DRGs group together cases that are clinically and also cost homogeneous.

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



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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.

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

The IHPA *National Efficient Price Determination 2017-18* 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 Department's 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 Service 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.

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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 the [section 3.3](#) 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 2017-18 activity profiles, actual data from 2013-14 to 2015-16 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.

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 Expenditure Review Committee (ERC) determines the price and volume of hospital weighted activity that 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.



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.

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Changes to the IHPA model

The ERC 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 the [section 2.2.5](#) Budget Settings for Activity Based Hospital Services the State Price approved for the WA health system ABF activity takes into consideration both the NEP and PAC as well as State budget constraints. The State Price for 2017-18 is \$6,129.

Figure 10: State Approved Price Setting



The State Price includes a differential cost per Weighted Activity Unit (WAU) component of \$1,067 when compared to the calculated PAC. This differential cost reflects the current 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.

The WA health system 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 Purchasing for Value Policy in [section 5](#) of the Guidelines.

4.2.3.3 Health Service Allocation Price

The Department's Health Service Allocation Price (HSAP) is still significantly higher than the PAC, reflecting the higher costs of service delivery in the WA health system. For 2017-18 the single HSAP is \$5,829.



What is the Health Service Allocation Price (HSAP)?

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

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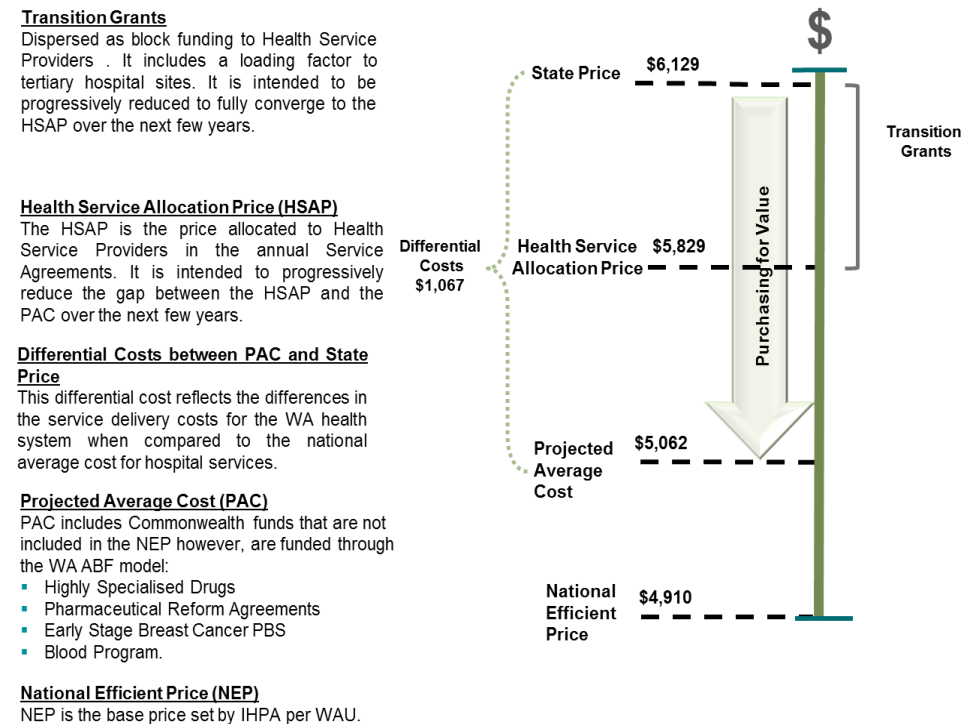
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The differential between the HSAP and the State Price is associated to Transition Grants to Health Service Providers, necessary as the WA health system evolves to a more mature and efficient system.


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.

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 in future years. The current WA health system pricing framework for hospital services purchasing is depicted in Figure 11.

Figure 11: Summary of WA health system Pricing Framework for 2017-18



Transition Grants are closely monitored and need to be based on evidence of legitimate and unavoidable cost pressures. Significant reforms to the WA health system purchasing policy and strategies over



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.

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the next few years aiming to increase the efficiency of health service provision and system accountability, 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 a number of divisions:

- Office of the Director General
- Strategy and Governance Division
- Public and Aboriginal Health Division
- Clinical Excellence Division
- Purchasing and System Performance Division

For 2017-18, 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

As a Health Service Provider in its own right, the Health Support Services (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 does have its own service category under the OBM Framework and this is reflected in the HSS Service Agreement 2017-18.

The value of work undertaken by HSS (e.g. information technology, corporate functions) on behalf of each Health Service Provider is included in their Service Agreements against each OBM Service schedule.

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5 Purchasing for Value Policy

5.1 Purchasing Policy Strategies and System Accountability

In the new devolved governance model, the Department as System Manager and Purchaser must ensure that a strong focus on purchasing policy setting, system-wide planning and effective service purchasing through Service Agreements with Health Service Providers is attained, leading to increased accountability through the monitoring, review and evaluation of implemented purchasing policy strategies.

The Department will introduce mechanisms to improve Health Service Providers accountability for contracted deliverables, through implementation of the funding, purchasing and resource allocation process, commencing from the 2018-19 budget.

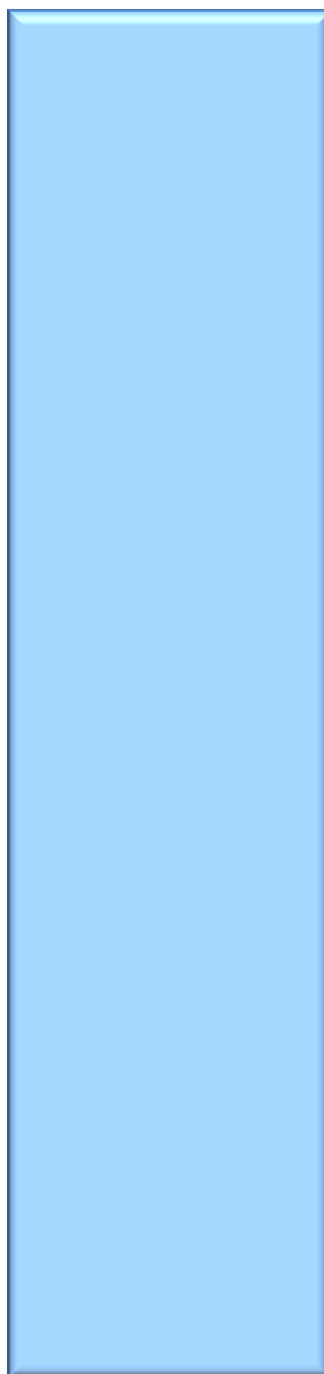
These initiatives centre on the creation of value in purchasing healthcare aiming to maximise patient outcomes relative to service costs. To maximise patient outcomes relative to service costs, purchasing policies require the right balance of incentives (and disincentives) to allow hospital executives, managers and clinicians to find best practice to improve performance outcomes.

5.2 Context of Purchasing for Value Policy

The WA health system currently experiences unsustainable budget growth and challenges related to chronic disease, health inequity and an ageing population. Growth in healthcare cost has not corresponded to increases in activity delivered. An increasing gap between the cost to deliver hospital services compared to the national average has constrained the state budgetary environment, inhibiting innovation in health services through developments in technology and research.

With the background of these continuing challenges, adjustments to health service provision are necessary for the WA health system to deliver efficiently and effectively. Given the Department, as System Manager, plays a key role in setting health purchasing policy, the concept of Purchasing for Value will set a clear direction to increase efficiency, accountability and transparency for the WA health system.

The *Purchasing for Value Policy* proposes significant changes to the way the WA health system undertakes strategic planning of health activity purchasing. Strong emphasis on setting incentive and efficiency driven health system purchasing policy will drive the concept of Purchasing for Value to represent the establishment of Efficient Practice in the WA health system.



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Efficient Practice represents a model of 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.

Key purchasing policy and strategies will be implemented through a phased program (2018-19 to 2027-28), articulated through the State Transition to an Efficient Practice (STEP) strategy, made up of short, medium and long term recommendations.

5.3 The State Transition to an Efficient Practice Strategy

The STEP strategy will be the mechanism to operationalise the direction of creating value in purchasing health services. It is a long term process that will be implemented in a staged approach in collaboration with Health Service Providers intended to not reduce funding but rather assist providers to deliver better care more efficiently.

The STEP strategy will ensure the Department clearly articulates signals to Health Service Providers that encourage and drive efficiency, and Health Service Providers will be responsible for responding to these signals. When fully implemented, the WA health system will be operating with greater efficiency, improved accountability and transparency across the state. The STEP strategy identifies recommendations around four key purchasing policy themes:

1. Activity management
2. Pricing
3. Incentive and disincentive programs
4. Minimising unwarranted variation

Figure 12: Key Themes of the STEP Strategy



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The recommendations identified in the STEP strategy will support the WA health system to optimise state-wide planning strategies; efficiently re-allocate resources and review and evaluate the outcomes of implemented purchasing strategies.

The *Purchasing for Value Policy* and the STEP strategy recommendations align with the WA health system priorities and support work being undertaken across the Department in pursuit of efficiency, accountability and the creation of value. Although the scope of the recommendations is centred primarily on hospital settings, they also include non-hospital settings due to the integrated nature of health services delivered through the Continuum of Care concept.

5.4 Consultation Process

The consultation process for the *Purchasing for Value Policy* and the STEP strategy has commenced and will be progressed through to the end of 2017. This will include the Department Executives and also Health Service Providers. An Implementation Plan will describe the process by which the recommendations will be actioned, the engagement of relevant stakeholders, the management of risks, effective monitoring, review and evaluation of implemented strategies and the management of available financial and non-financial resources.

The implementation process will ensure collaboration, transparency and accountability within the Department and between the Department and stakeholders. It will also aid the Health Service Providers, by providing a clear outline of the Department's purchasing direction, which will assist them in effectively responding to purchasing and pricing signals from the Department and developing their own service delivery strategies.

5.5 How will Purchasing for Value be achieved through the STEP?

In the short term, the STEP strategy will introduce funding adjustments and broaden the scope of performance targets to increase accountability and drive system improvements.

During this period, investments in managing demand, assessing and developing new models of care and introducing safety and quality initiatives to improve service delivery will be also be identified.

The medium term of the STEP strategy will focus on continuing and refining the introduced policies and mechanisms to progress towards increased system transparency and accountability.



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During the final term of the STEP strategy the WA health system will clearly show significant efficiency gains through the implemented recommendations, reflected in lower costs of service production and the close approximation of the state price to the national average price.

Improving the efficiency of the WA health system will require time, commitment and collaboration. The STEP strategy provides a platform from which the Department and Health Service Providers can coherently, transparently and systematically work in collaboration towards this goal.

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6 Service Agreement Management

6.1 Purpose and Principles of Service Agreements

The purpose of Service Agreements is to establish the scope of services and targeted levels of activity that are within the overall expenditure limits for Health Service Providers set by the Director General in accordance with the State Government's purchasing intentions and strategic priorities. This then forms the basis of payment and performance assessment of the contracted services.

The key principles that underpin the delivery of the Service Agreements are to:

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

These principles are achieved by the Department and the Health Service Providers working in partnership with a commitment to high quality and safe patient-centred health service delivery.

To that effect, the development of Service Agreements is informed by a wider strategic context related to the delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians. The following key policy documents are considered as part of the development process:

- *WA Health Funding and Purchasing Guidelines 2017-18*
- *WA Health Clinical Services Framework 2014-2024*
- *WA Health Outcome Based Management Framework*
- *WA Health Strategic Intent 2015-2020*
- *National Health Reform Agreement.*

Figure 13 provides a summary of the resource allocation and performance assessment cycle relating to the development of Service Agreements in accordance with legislative requirements.



Click here to access the
[2017-18
Service Agreements](#)

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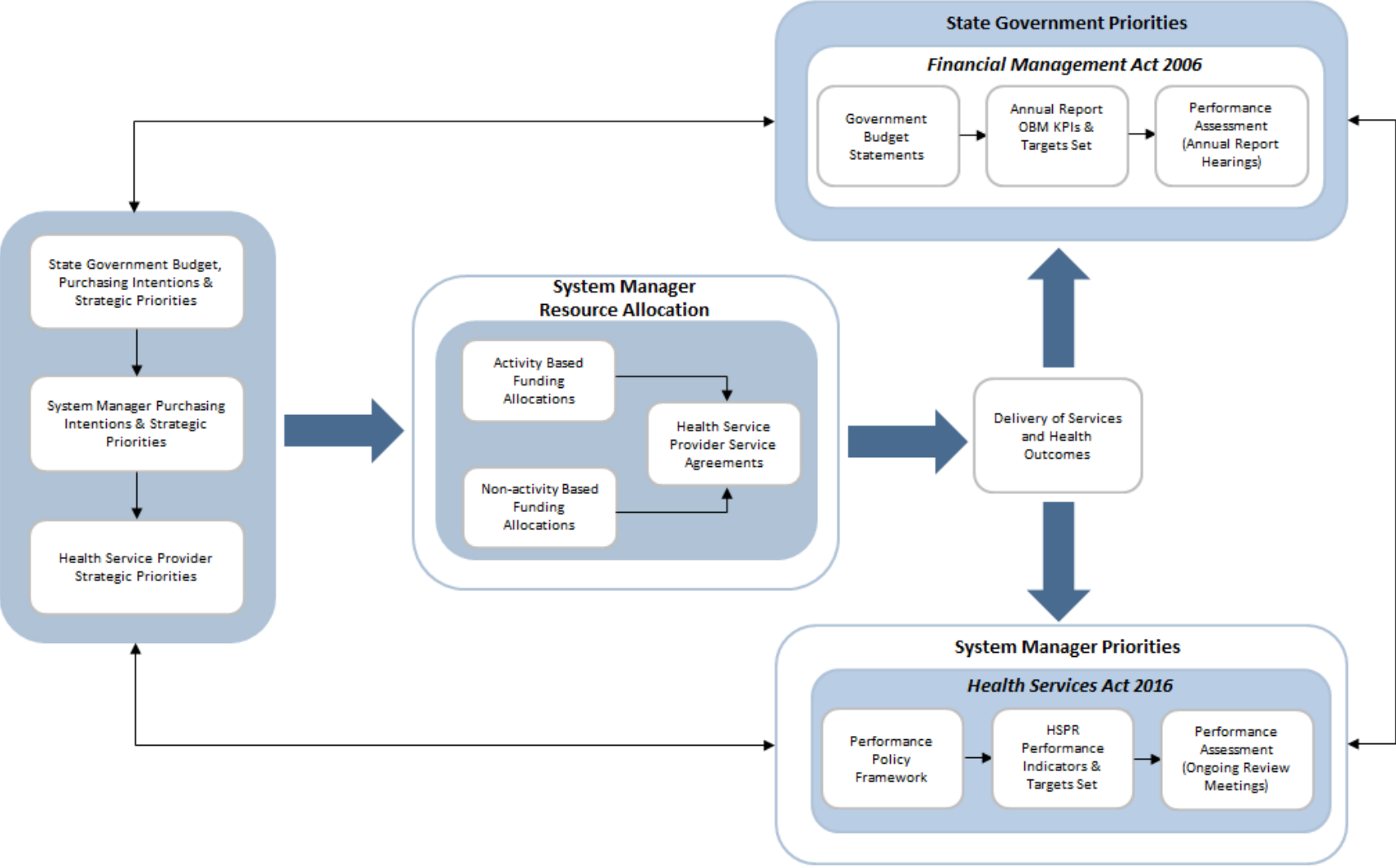
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Figure 13: Resource Allocation and Performance Assessment Cycle



6.2 Governance Arrangements

In the new devolved governance model for the WA health system, the Department has the responsibility for strategic policy and planning; system performance monitoring and intervention (where required); and purchasing linked to state-wide planning, budgeting and regulation.

Annual service appropriations will continue to flow to the Department from Government, with the Department using this funding to purchase health services and shared services through Service Agreements.

Accountability for service delivery and performance will rest with Health Service Provider Boards (or Chief Executive for HSS) and will be monitored by the Department through the *Performance Management Policy Framework*.

With each Health Service Provider being a separate statutory authority, Health Service Provider Boards (or Chief Executive) will be responsible for ensuring compliance with the WA health system and whole-of-government legislation, regulations, policies and standards.

In this new governance environment, the Service Agreements are critical to establishing strong financial management and driving accountability. The delineation of roles and accountabilities for the Department as the purchaser of services and the Health Service Providers as the providers of services is integral to the management and operationalisation of the Service Agreements.

6.3 Outcome Based Management Framework

The WA health system operates under an OBM Framework, in accordance with its legislative obligation as a WA Government Agency under section 61 of the *Financial Management Act 2006* and Treasurer's Instruction 904. The OBM Framework translates how government resources the WA health system.

The OBM Framework describes how outcomes, services and KPIs are used to measure WA health system's performance towards achieving the relevant overarching whole-of-government goals. KPIs measure the effectiveness and efficiency of the services provided by the WA health system in achieving the stated desired outcomes.

As part of the *WA Health Reform Program 2015-2020*, significant collaborative work has occurred between Health Service Providers and the Department to develop a revised and contemporary OBM Framework for the WA health system.



Click here to receive more information regarding the [Better health, better care, better value WA Health Reform Program 2015-2020](#)

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From 2017-18, the funding provided by the Department to Health Service Providers and detailed within the Service Agreements are aligned to the services detailed in the OBM Framework, providing transparency on the resource allocation process. This alignment will ensure that there is a clear link between the budget appropriation, service agreement and annual reporting processes supporting the process of strengthening WA health system efficiency and accountability.

The ten OBM services are detailed below:

1. Public Hospital Admitted Services
2. Public Hospital Emergency Services
3. Public Hospital Non-Admitted Services
4. Mental Health Services
5. Aged and Continuing Care Services
6. Public and Community Health Services
7. Community Dental Health Services
8. Small Rural Hospital Services
9. Health System Management – Policy and Corporate Services
10. Health Support Services.

Further detail on the OBM Framework can be viewed in the [OBM Policy](#).

6.4 Service Agreement Development Process and Timeframes

The Service Agreements are developed annually and cover a single financial year period and a forecast period of three years. The forecasted allocations are calculated based on WA Government approved indexation factors and are provided within the Service Agreements for planning purposes.

Service Agreement development is a consultative process between the Department and the Health Service Providers, and includes:

- the drafting of several iterations of the Service Agreement, in accordance with the Department's funding, purchasing and resource allocation principles
- the management of strategic issues raised by Health Service Providers.

6.4.1 Service Agreement Drafting

A rigorous preparation process that consists of the development of two drafts and a final executed Service Agreement, is undertaken in consultation with the Health Service Providers.

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This process ensures that the final Service Agreements include the approved funding allocations based on critical elements such as:

- feedback received from the Health Service Providers
- Department policy decisions and purchasing intentions
- discussions with Department budget holders
- application of State Budget parameters
- the final IHPA National Pricing Framework.

In order to allocate funding efficiently and effectively, the Department determines an agreed volume of activity paid at an agreed price for a range of service categories.

The consultation process with the Health Service Provides takes into consideration key drivers such as:

- State and Commonwealth funding commitments
- State Government activity requirements and caps
- cost and demand pressures
- wage increases as a result of enterprise bargaining
- efficiency dividends and savings requirements
- purchasing policies and principles
- new initiatives and existing contract arrangements.

Additionally, cost and volume indexation factors are applied on a range of programs as appropriate.

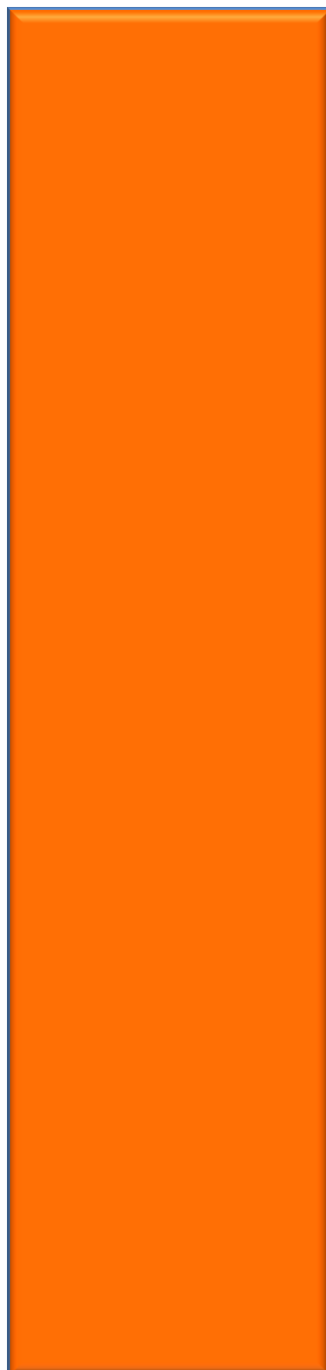
The funding amounts are measured and allocated using the ABF model, block funding or special purpose payments and are aligned to the OBM Framework.

Supplementary information is provided separately from the Service Agreements to Health Service Providers. This could include information on the ABF Model, Revenue Plan, Cash Budget and Capital Works funding.

6.4.2 Service Agreement Issue Management

As part of Service Agreement development, an issue management process is used to ascertain and assess the key strategic issues of each Health Service Provider.

The issue management process is outlined during the initial bilateral meetings between the Department Executive and the Health Service Provider Chief Executives, held after the first draft of the Service Agreement is released.



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Each Health Service Provider is required to submit a formal letter from the Board's Chair to the Director General outlining their key strategic issues after their initial bilateral meeting.

The Health Service Providers must also submit appropriate evidence to substantiate each issue raised.

The evidence required must be provided as a briefing note, approved by the Chief Executive and the Board Chair of the Health Service Provider, and must include:

- the background to the issue
- a discussion of the relative priority of the issue compared with existing programs already included in the Service Agreement
- the requirements and impacts of the issue on the Health Service Provider
- a detailed funding breakdown (with attached workings) that includes actual costs and three out-year forward estimates, as appropriate
- a discussion about how the subject of the issue (e.g. program) will operate if issue raised does not lead to a change
- recommendations based on the outcomes expected for the issues raised.

Additionally, ABF related issues are also captured through the feedback process undertaken for the *Clinical Services Framework* update between the Department and the Health Service Providers.

6.4.3 Service Agreement Consultation Process

The aim of the consultation process is to encourage an open dialogue between the Department and Health Service Providers while providing a forum to discuss key strategic issues and agree to the terms of establishing the Service Agreements.

Outcomes of the initial bilateral meeting, held in March, between the Department and Health Service Providers inform the Service Agreement second draft development process.

A second bilateral meeting between the Assistant Director General, Purchasing and System Performance and Chief Executives of the Health Service Provider is held in early May to finalise outstanding issues.

A third bilateral meeting is held in late May between the Director General, as System Manager, and the Health Service Provider's Board and Chief Executive to agree to the terms of the Service Agreement prior to its finalisation.

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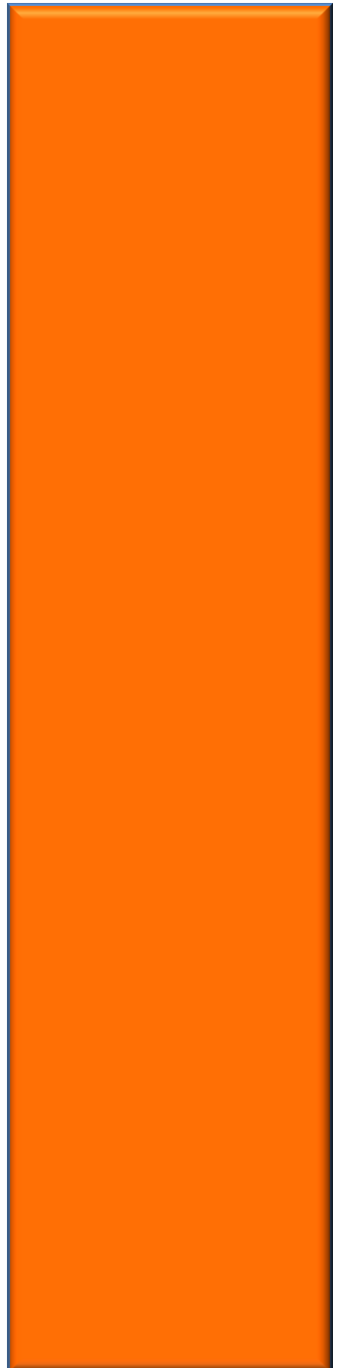
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6.4.4 Service Agreement Timeframes

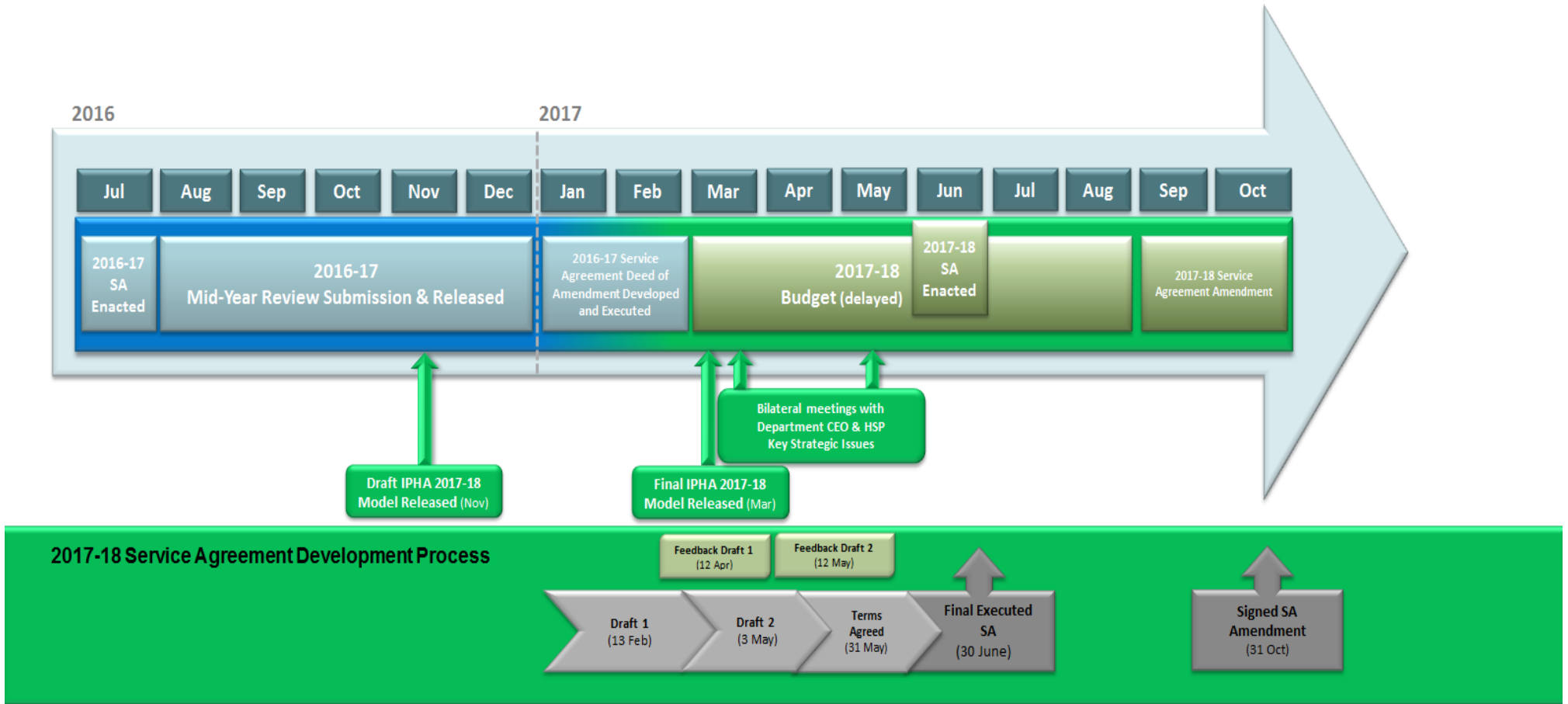
To comply with section 49 of the Act, the terms of the Service Agreement must be agreed one month (31 May each year) prior to the expiry of the existing Service Agreement. The terms of the Service Agreement must be executed at the commencement of the new agreement (1 July each year).

The development timeframes, as impacted by the WA State election and hence, delayed State budget for the 2017-18 financial year are depicted in Figure 14.



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Figure 14: Budget and Resource Allocation Timeframes in an Election Year



In a standard year (where there are no delays to the handing down of State budget), the final executed Service Agreement will still occur on 1 July. However, there will be no need for an amendment process to occur prior to the Mid-Year Review process.

6.5 Amending a Service Agreement (Deed of Amendment)

6.5.1 Criteria

An amendment to the terms of the Service Agreement will occur when there is a change to the System Manager's purchasing intentions. This could occur from:

- State and Commonwealth Government funding decisions
- System Manager funding decisions (maybe as a consequence of Health Service Provider initiatives/requests)
- Approved transfer of budget between Health Service Providers.

6.5.2 Legislative requirement

To comply with section 50 of the Act, the terms of Service Agreements can be amended as long as written notice is provided by either party for proposed amendments and the terms are agreed by both parties.

6.5.3 What may cause an amendment

Despite best efforts to ensure that the purchasing intentions of the System Manager and the Commonwealth are reflected in the executed Service Agreements, there may be instances where amendments to the budgets detailed in the Service Agreement are required to be made post-execution. These amendments could result from the following:

- State Governments Mid-Year Review process
- State funding commitments and contractual arrangements
- Commonwealth funding commitments and contractual arrangements
- System Manager funding decisions and purchasing intentions
- Health Service Provider higher priority initiatives or one-off events that cannot be funded within existing allocations
- Significant budget transfers between Health Service Providers
- Under or over achievement of activity targets, resulting in adjustments to funding (as occurs between the Commonwealth and the State).

6.5.4 Notices of amendment

A Health Service Provider must provide the written notice of amendment as a request to the System Manager with relevant documentation related to the amendment. As per the legislative requirement, the request must be in a written format and be signed by an officer who is authorised to sign and legally bind the party it represents. The written correspondence can be delivered by hand, post or email. The System Manager will provide a written Notice of Intent to Amend and would refer to an event (e.g. Mid-Year Review) or similar that is expected to lead to an amendment.

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6.5.5 Amendment Windows

Amendment windows have been identified to formalise agreed amendment requests and System Manager intention to amend. Amendment Window periods will include:

- An initial Amendment Window period from January to February, after the WA State Budget Mid-Year Review process and in line with the release of the first draft of the Service Agreement for the next financial year. This Amendment Window period will capture changes since budget setting until the cut-off date for the Mid-Year Review.
- Extraordinary Amendment Window periods that will manage urgent priorities that occur through unforeseen or unpredictable circumstances. An Extraordinary Amendment Window may be authorised at the Director General's discretion. It is expected that a delayed State Budget with budget parameter changes would require amendments to the executed Service Agreement.

6.5.6 Signing the Service Agreement Deed of Amendment

The Health Service Provider signatory has a prescribed timeframe from the date the Service Agreement Deed of Amendment is sent to review the changes, execute (sign) and return back to the Department on the acceptance of the amended terms. The amended terms of the Service Agreement will take effect once both parties have accepted the amendment terms. The variation becomes an addendum to the original Service Agreement and forms the revised basis on which the Service Agreement will be conducted.

6.5.7 Where amendments cannot be agreed

In situations where parties cannot agree on a term of the amendment, section 50(2) of the Act states that the Director General, will make the final decision and advise the Health Service Provider accordingly. The decision is required to be included in the amended Service Agreement.

6.5.8 Recommending amounts to the Minister

To comply with section 20(1)(c) of the Act, the System Manager will recommend to the Minister for Health the amounts that may be allocated from the monies appropriated from the Consolidated Account to Health Service Providers for approval in June each year.

This is to ensure transparency is provided to the Minister for Health of the amounts being allocated to each Health Service Provider through the Service Agreement, given that one single budget appropriation is received for the WA health system. For Deeds of Amendment, the Minister for Health receives a notification.

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7 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, purchasing and resource allocation 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 WA health system performance management structure which includes the *Performance Policy Framework* and the *Performance Management Policy 2017-18* (PMP). The PMP is WA health system's performance management component of the Service Agreements.

7.1 Performance Management

7.1.1 Performance Policy Framework

In accordance with the Act, 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 with each Health Service Provider.

Figure 15 provides a schematic representation of the strategic linkages of the Service Agreement to the key elements of the *Performance Policy Framework*, which includes the PMP 2017-18.



Further information on the [Performance Policy Framework](#) can be found [here](#).



Click here to access [Performance Management Policy 2017-18](#).

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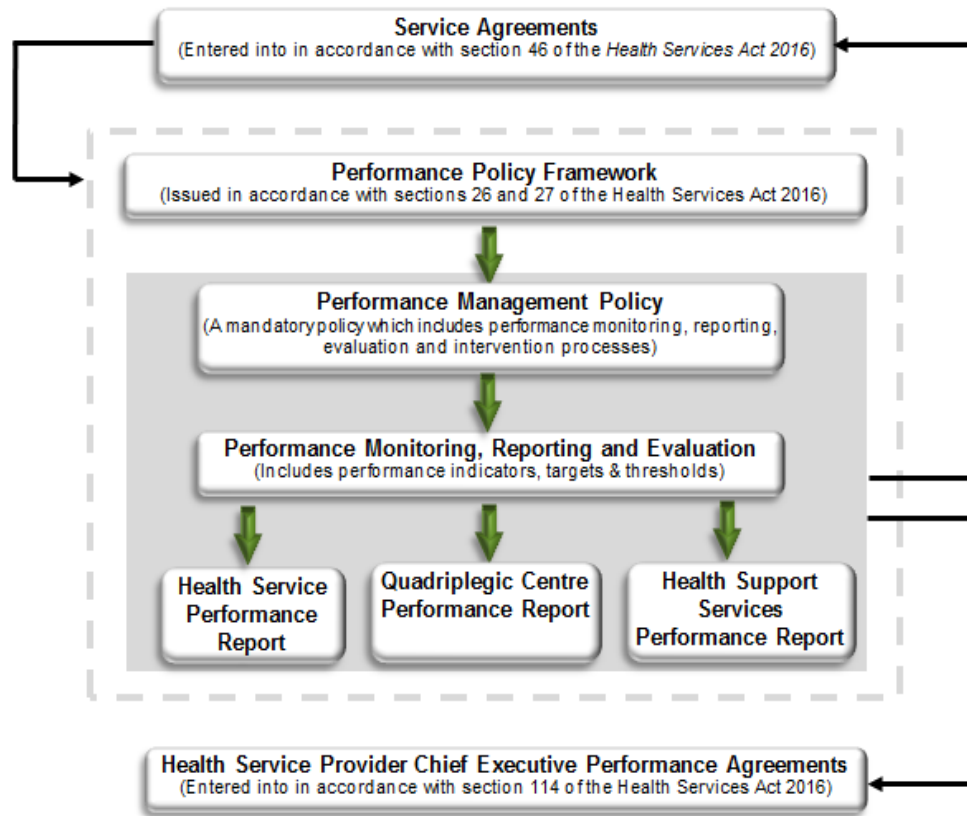
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Figure 15: Performance Policy Framework Strategic Linkages



Source: Performance Management Policy 2017-18


7.1.2 Performance Management Policy (PMP)

The PMP aims to support WA health system’s vision to deliver a safe, high quality, sustainable health system for all Western Australians.

The PMP provides Health Service Providers a common set of performance objectives. All the performance indicators in the PMP 2017-18 are aligned to the four priorities and seven enablers detailed in the WA Health Strategic Intent 2015-20. Each performance indicator is an integral part of the WA health system’s performance management cycle. The PMP provides a transparent reporting, monitoring, evaluation and intervention framework to drive improvement and achieve better outcomes.

7.1.3 Performance Reporting

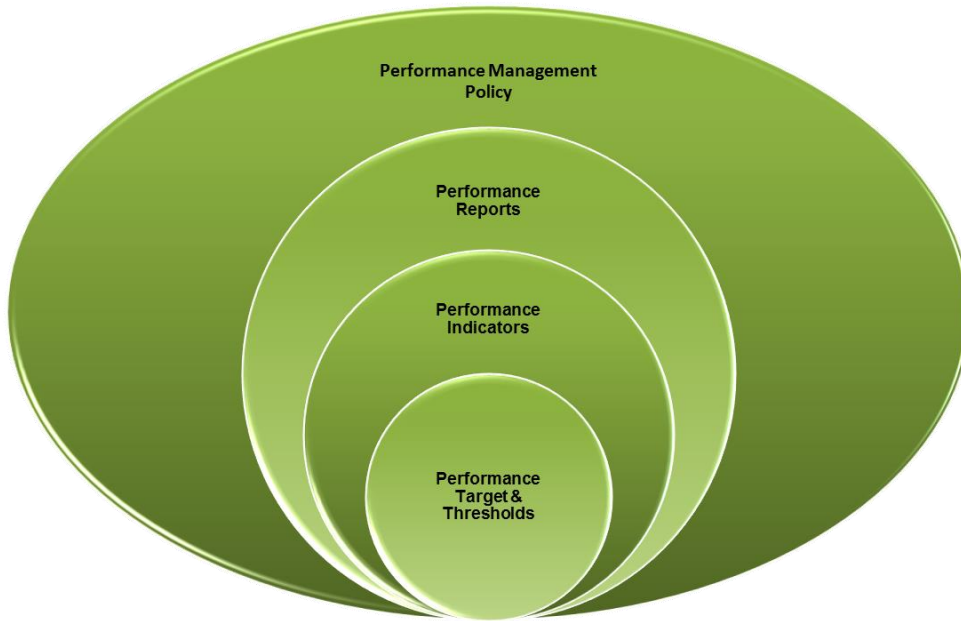
Figure 16 illustrates the relationship between the integrated components of the PMP and the pivotal role of performance reporting.



 Further information on the [WA Health Strategic Intent](#) can be found

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Figure 16: Performance Management Policy Components



The performance reporting components of the PMP are the:

- *Health Service Performance Report (HSPR)*
- *Quadriplegic Centre Performance Report (QCPR)*
- *Health Support Services Performance Report (HSSPR).*

7.1.4 Performance Indicator Targets

The performance indicators, targets and thresholds in the PMP play a key role in performance reporting. In consultation with subject matter experts, the suite of performance indicators, targets and thresholds in the PMP have been endorsed by the Director General.

The System Manager has the discretion to include additional performance indicators in 2017-18 to address emerging priorities as required.

7.1.5 Performance Thresholds

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

Performing	
Under-Performing	
Not Performing	

These thresholds establish performance levels. The level of performance determines whether any action needs to be taken in relation to identifying and resolving poor performance.

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7.1.6 Performance Monitoring and Evaluation

Performance is monitored regularly against performance indicator targets and thresholds specified in the PMP.

Performance review meetings are held between the System Manager, and each Health Service Provider. The frequency of the meetings is based on Health Service Provider performance achievement against the required standards. The performance review meetings are held 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 are held monthly until performance issues are resolved.

The meetings assist Health Service Providers 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.

Supporting performance indicators may be monitored and evaluated at the discretion of the System Manager to aid system performance management.

7.1.7 Future State

The Department proposed Purchasing for Value Policy and the implementation of the STEP strategy, as outlined in [section 5](#) of the Guidelines will require further enhancement of the current performance 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.

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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
CAHS	Child and Adolescent Health Service
CHSP	Commonwealth Home Support Program
CPI	Consumer Price Index
CSF	Clinical Services Framework
Cwlth	Commonwealth
the Department	Department of Health
Department CEO	The Chief Executive Officer (Director General) of the Department of Health
ERC	Expenditure Reform Committee
EMHS	East Metropolitan Health Service
ESRG	Enhanced Service Related Groups
FSH	Fiona Stanley Hospital
HCN	Health Corporate Network
HIN	Health Information Network
HSAP	Health Service Allocation Price
HSPR	Health Service Performance Report
HSS	Health Support Service
Health Service Providers	WA's five Health Services: CAHS, EMHS, NMHS, SMHS and WACHS
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
NDIS	National Disability Insurance Scheme
NEC	National Efficient Cost
NEP	National Efficient Price

Acronym	Description
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 Framework
RBA	Reserve Bank of Australia
SCGH	Sir Charles Gairdner Hospital
SMF	State Managed Fund
SMHS	South Metropolitan Health Service
SP	State Price
SPA	State Pool Accounts
State Government	Government of Western Australia
STEP	State Transition to an Efficient Practice
System Manager	Term used for the Department CEO to reflect his role as being responsible for the overall management of the WA health system
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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